1982
BLAINE HOUSE
CONFERENCE ON AGING

A REPORT OF
CONFERENCE PROCEEDINGS
AND
RECOMMENDATIONS

MAINE COMMITTEE ON AGING
AND
BUREAU OF MAINE'S ELDERLY
MAINE DEPARTMENT OF HUMAN SERVICES
STATE HOUSE
AUGUSTA MAINE 04333

MAINE COMMITTEE ON AGING
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January 1983

Governor Joseph Brennan
State House
Augusta, ME 04333

Dear Governor Brennan:

On October 6 and 7, the Maine Committee on Aging and the Bureau of Maine's Elderly sponsored the ninth Blaine House Conference on Aging. The conference was held at the Augusta Civic Center and Augusta Armory and was attended by 400 delegates. It is with pleasure that we transmit to you this account of the conference. We trust that you and the members of the 111th Legislature will find the enclosed recommendations worthy of consideration and action.

The resolutions passed by these delegates reflect careful consideration of the issues and a dedication to improving the quality of life of Maine's older population.

We anticipate your continued support for older people in Maine. The Maine Committee on Aging and the Bureau of Maine's Elderly look forward to working with you, the legislature, and citizens in implementing many of the enclosed recommendations. Thank you.

Sincerely,

Trish

Trish Riley
Director
Bureau of Maine's Elderly
Department of Human Services

John B. Truslow

John B. Truslow, M.D.
Chairman
Maine Committee on Aging

I

INTRODUCTION AND OVERVIEW

TABLE OF CONTENTS

WHAT IS THE BLAINE HOUSE CONFERENCE ON AGING?

The Blaine House Conference on Aging is held every two years to formulate public policy direction for issues affecting older people in Maine. The Conference is attended by 300 older people from throughout the State, who are chosen in their local area.

Prior to the Conference state-wide public hearings and mini-conferences are held to determine areas of interest and concern to older people.

The next step consists of developing working discussion papers by resource people familiar with the complexities and issues surrounding a topic. These papers are studied by the delegates prior to the conference and form the basis of workshop discussion. These papers are abstracted in this report.

During the Conference each workshop, chaired by a member of the Maine Committee on Aging, develops a series of resolutions designed to address some of the issues raised during the workshop. They outline legislative and administrative actions which need to be taken in the following two years to improve the quality of life for older people in Maine.

These resolutions are proposed by the delegates and are voted on during the workshop. Those resolutions which are passed by the workshops, as well as resolutions from the floor, are discussed and voted on by delegates on the second day of the Conference.

In an effort to more thoroughly address a limited number of resolutions, the Committee on Aging considers the priorities of the five area agencies on aging, along with the Committee's own goals and selects from the resolutions its top priorities for the upcoming legislative session.

The Blaine House Conference on Aging is a mutual effort of the Maine Committee on Aging, Department of Human Services, Bureau of Maine's Elderly, area agencies on aging, other aging organizations, and the older people of Maine. The enclosed report represents their concerns.

This report was prepared by the Maine Committee on Aging. Copies of this report and the full workshop discussion papers may be obtained by writing to the Maine Committee on Aging, State House Station 11, Augusta, Maine 04333.

UPDATE ON 1980 BLAINE HOUSE CONFERENCE ON AGING

The 1980 Blaine House Conference on Aging passed 47 Resolutions calling for legislative and administrative action in such issue areas as home based care, housing options, taxation policy and information needs. Much has happened since that Blaine House Conference. New legislation has been enacted responding to the Blaine House Conference resolutions. New programs for the elderly have been developed. At the same time, federal budget cutbacks have forced some new directions for state and local agencies and organizations serving Maine's elderly. Many issues discussed at the Blaine House Conference on Aging provided direction to the 1980 White House Conference on Aging delegates. See the White House Conference on Aging report for more information.

We can be proud of the progress that has been made in Maine for older people over the past two years. We can be proud of our legislature, our Governor, our State government and most importantly, the older people statewide who continue to work for change.

Below, the progress since the 1980 Blaine House Conference on Aging is summarized.

HOME BASED CARE

L. D. 1620 An Act to Require the Department of Human Services to Provide Home Based Care as an Alternative to Institutional Care

The Blaine House Conference on Aging called for in various resolutions an increase in home based care for the elderly as opposed to nursing home care. The 110th Legislature heard from over 1,000 elderly people who attended a hearing on the Home Based Care bill which the Committee on Aging submitted as a result of the Blaine House Conference on Aging. The Legislature clearly responded to those older people who asked for home based care with the passage of L.D. 1620, An Act to Require the Department of Human Services to Provide Home Based Care as an Alternative to Institutional Care which was funded with $1.25 million for two years for elderly, handicapped and adult protective services clients.

VICTIMIZATION OF THE ELDERLY

The first session of the 110th Legislature enacted into law L.D. 1639, An Act Concerning the Protection of Incapacitated and Dependent Adults. This bill established clear, consistent standards for the provision of services to remedy neglect, abuse and exploitation of incapacitated and dependent adults, including the elderly.

The second session of the 110th Legislature went one step further and enacted a mandatory abuse reporting law which the 1980 Blaine House Conference on Aging had asked the Maine Committee on Aging to submit. L.D. 1847, An Act to Require Mandatory Reporting of Elderly Abuse

requires certain professionals to report suspected cases of abuse, neglect and exploitation of incapacitated adults. The law also provides for optional reporting by any person, including professionals, who knows or has reasonable cause to suspect that an incapacitated or dependent adult has been abused, neglected or exploited.

Medicare Supplement Insurance - Medigap

The 1980 Blaine House Conference on Aging found that many elderly purchase duplicative and unneeded private supplemental health insurance policies in their attempts to allay their fears of inadequate coverage under Medicare.

L. D. 455, An Act to Establish Minimum Standards for Medicare Supplement Insurance Policies was enacted and regulations have been set in place which allow the Bureau of Insurance to enforce minimum standards for these insurance policies which assure consistency in policies and will prevent abusive sales practices and purchase of duplicative policies by providing the consumer with accurate information.

EMPLOYMENT AND RETIREMENT

Flexible Manpower Policies

The 110th Legislature enacted L.D. 1556, An Act to Promote Greater Efficiency through Alternative Working Hours in State Government which encourages Maine State government to create more part-time jobs, shared jobs and flexible working hours.

Expand Hiring of the Elderly

Another resolution called for the placement of special desks in Maine Manpower Offices to respond to the special employment needs of the older worker. In response, a VISTA grant was received which provides a job developer in Lewiston's Manpower Office who works with the private sector to increase unsubsidized jobs for the elderly.

HOUSING

Elderly Householder's Tax and Rent Refund Program

A Special Legislative Session of the 110th Legislature enacted income guideline changes for the Elderly Householder's Tax and Rent Refund Program and the Elderly Low Cost Drug Program over a two year period.

The new income guidelines were revised for the 1981 program from $5,000 to $6,000 for a single member household, and from $6,000 to $6,700 for a household of two or more.

The law also changed the guidelines for application for the 1982 program to $6,200 for a single person and $7,400 for a household of two or more.

Shared Housing

Shared housing was a goal of the Blaine House Conference. Through a grant to Central Senior Citizens Association, the Bureau will assure at least one shared home will be operating by 1983. This program will afford us an opportunity to learn more about shared housing based on practical experience.

ENERGY

Home Energy Assistance Program

The Blaine House called for automatic issuance of home energy assistance checks to SSI recipients. While the Maine Committee on Aging advocated for such a direct mailing, we were not successful. The Maine Committee on Aging did succeed in getting a higher benefit provided to households with elderly members due to the potential of accidental hypothermia among the elderly.

NURSING AND BOARDING HOME RESIDENTS RIGHTS

L.D. 1659 An Act to Establish Rights for Residents of Nursing, Boarding and Foster Homes.

L.D. 1659 was enacted by the 110th Legislature, responding to a resolution from the 1980 Blaine House Conference on Aging.

It establishes the right of residents to form resident councils, requires the reporting of alleged violations of residents rights or conduct of resident care, and provides that a long term care facility which receives public funds may not discharge or transfer any person based solely on a change in their source of payment for care.

MISCELLANEOUS RESOLUTIONS

Toll-Free Social Security Number

The Blaine House Conference on Aging instructed the Maine Committee on Aging to bring pressure on the General Services Administration for a toll free telephone number. The Maine Committee on Aging did so. A number was finally established and it is 1-800-322-9401.

A REPORT FROM THE 1980 WHITE HOUSE CONFERENCE ON AGING

to the

1982 BLAINE HOUSE CONFERENCE ON AGING

From the 1980 Blaine House Conference on Aging came a representative delegation to the White House Conference on Aging and a strong platform of key issues for them to present in Washington on behalf of Maine's elderly.

We are pleased that 45 of the 50 issues brought from the Blaine House Conference were indeed translated into key White House Conference recommendations.

While the White House Conference on Aging did not allow voting on individual resolutions, a poll of all delegates was conducted jointly by the NRTA/AARP and the U.S. Senate Special Committee on Aging. That poll provided delegates an opportunity to vote and showed that the ten significant issues considered most important by the majority of delegates were:

1. Social Security: Preserve the financial integrity of the Social Security system through emphasis of the "earned right principle" of the program. While asserting that the use of general revenue funds would jeopardize the fiscal integrity of the Social Security system, the recommendation calls on the Congress to take appropriate measures to assure the financial stability of the funds.

2. Health Policy: Charges the Congress and the President to develop a national health policy which would guarantee full and comprehensive health services to all Americans. Involvement of all levels of government and the private sector was recommended.

3. Social Security/Medicare and Medicaid: Endorsed the validity of the Social Security system as the foundation of economic security for all Americans. Preserve current levels of Medicare and Medicaid funding, reaffirms support for the minimum benefit, current levels of Social Security benefits, and cost of living increases granted at the currently specified times.

4. Social Security/Minimum Benefit, Cost of Living: Supports the maintenance of the Social Security minimum benefit to current and future beneficiaries, continued cost of living increases without unnecessary postponement, the expansion of Social Security coverage to all gainfully employed persons, and opposes changing the system to a voluntary social insurance program.

5. Age Discrimination in Employment: Calls for the elimination of mandatory retirement and other forms of discrimination against older workers. In addition, it calls on employers to hire older workers on a part time, temporary or shared basis, and emphasize flexible work schedules.

6. Long Term Care: Develop a comprehensive national health plan which includes a long term care community based health system. In the interim, the recommendation supports the expansion of Medicare and Medicaid to provide case management, in-home health, mental and social services. In addition, the recommendation calls for increased funding to assure an integrated, coordinated, community-based continuum of care system to maintain the maximum independence of the elderly, and urges the protection of the rights of the institutionalized elderly.

7. Social Security: Transfer of general revenue funds to support the Social Security system should the Congress deem such action necessary.

8. Housing: Supports adequate rental assistance for low and moderate income elderly renters. It also supports the current 25 percent rent-to-income ratio for low income housing.

9. Home Based Care: Expanded home health and in-home services based upon individual needs, more flexible eligibility requirements, emphasis on reimbursement at local rates, simplified administrative requirements and tax incentives to families who provide care for dependent elderly.

10. Inflation: Asserts that the highest priority be given to the use of macroeconomic policies to stop inflation.

You can see that Social Security appeared most frequently but delegates were divided on how to insure its integrity. Recommendation one votes against a general revenue fund transfer, while number seven votes for it.

Likewise Blaine House Conference on Aging concerns about providing home care options and flexible work opportunities for elderly were strongly endorsed in Washington.

Maine's delegation met regularly between the 1980 Blaine House Conference on Aging and the White House Conference on Aging held in December, 1981. We visited area agencies, participated in service programs and spoke to older citizen groups. While representing different opinions, we worked long and hard to forge a platform based on the Blaine House Conference on Aging to which we all committed ourselves. Throughout the Conference, the entire delegation held caucuses to share information, to try to overcome the negative forces at the Conference, and to provide fair information to the press about Conference developments. While the Social Security workshop was a heated and difficult one riddled by special interest groups as reported in the press, the remaining 13 workshops ran smoothly. Great progress was made in asserting opinions to shape public policy in aging for the future.

1980 WHITE HOUSE CONFERENCE ON AGING DELEGATION

DELEGATES

June Perkins, Springvale
Elizabeth Knight, Tenants Harbor
Susan Brown, Houlton
Anthony Wedge, Portland
Mae Parker, Auburn
George Forbes, Waldoboro

ALTERNATES/OBSERVERS:

Mickey Friedman, North Bridgton
James Fletcher, Machias
Elenora Favre, Ocean Park
Virginia Norman, North Monmouth
Donald Simpson, Waterville

CONGRESSIONAL APPOINTMENTS:

John Truslow, M.D., Biddeford (Senator Mitchell)
Laurence Bagley, Winthrop (Senator Cohen)
C. Murray Cott, Kennebunk (Rep. Emery)
Glen Torrey, East Poland (Rep. Snowe)

NATIONAL APPOINTMENTS:

Howard Dana, Portland (Delegate)
Eleanor Voorhees, Bath (Delegate)
Rep. David Brenerman, Portland (Alternate/Observer)
Stephen Farnham, Presque Isle (Alternate/Observer)
Andrew Fennelly, Yarmouth (Alternate/Observer)

STATE COORDINATOR

Trish Riley, Director, Bureau of Maine's Elderly

1982 BLAINE HOUSE CONFERENCE ON AGING

The 1982 Blaine House Conference on Aging was attended by 300 delegates from throughout the State of Maine.

The workshops focused on the six areas of Retirement/Employment Income, Health Care Costs, Home Based Care, Alternative Living Arrangements, Quality of Long Term Care and Utilities. The Conference voted on and approved 46 resolutions concerning these and other issues, fifteen of which require legislative action. Only one-fifth of these initiatives called for funding.

As with the 1980 Blaine House Conference, emphasis was placed on those initiatives which would enable an older person to remain in their own home or community through home based care, and alternative living arrangements, as well as ensuring quality of care for those unable to do so.

We hope that all delegates to the 1982 Blaine House Conference on Aging are committed to working for the resolutions passed at the Conference as were the delegates to the 1980 Blaine House Conference on Aging. We all need to work together to assure a strong advocacy voice for Maine's elderly in the coming two years.

MEMBERS OF THE MAINE COMMITTEE ON AGING

John B. Truslow, M.D., Chairman
Alice Bourque
Rep. David Brenerman
Susan Brown
Sen. Gerard Conley
William Cunningham
James Flanagan
Fr. Valmont Gilbert
Norman Hall
Rep. John Joyce
Rosaire Paradis, Jr.
Mae Parker
Wilfred Pombriant
Margaret Russell
Louise White

STAFF:

Romaine Turyn, Staff Director
Marjory Blood, Ombudsman
Kathy Durgin-Leighton, Ombudsman Assistant
Terry Folsom, Administrative Assistant
Special thanks to Joanne West

BUREAU OF MAINE'S ELDERLY

John Baillargeon
Melissa Catlin
Natalie Dunlap
Betty Forsythe
Elaine Fuller
Anne Gardner
Waldo Gilpatrick
Betty Hodsdon
Frederick Lawler
George Levesque
Stephanie Martyak
Walter Oakes
Jane O'Rourke
Thomas Randall
Patricia Riley, Director
Doris Russell
Pamela Waite
Betty Welton
Jeanne Boylan
Cindy Crabtree
Jolene Roop
Dorothy Fabian

II

BLAINE HOUSE CONFERENCE ON AGING RESOLUTIONS 1982

RESOLUTIONS

1982 BLAINE HOUSE CONFERENCE ON AGING

RETIREMENT/EMPLOYMENT INCOME

SOCIAL SECURITY:

1. BE IT RESOLVED that the Blaine House Conference on Aging supports the 1981 White House Conference on Aging recommendations which opposed any reduction in benefits to Social Security recipients and encouraged the Administration to make every possible and fiscally responsible effort to maintain the current income protection provided by the Social Security system.

   In order to accomplish the foregoing, BE IT FURTHER RESOLVED that

   1. The cost of living adjustment in Social Security continue to be based upon the consumer price index.

   2. The Blaine House Conference on Aging expresses its concern that the high level of unemployment negatively affects the amount of revenue in the Social Security system.

   3. Interfund borrowing continue as a short-term solution to Social Security funding.

   4. The age levels for entitlement and for full benefits in the Social Security system remain as currently in effect.

   5. The Social Security fund be treated separately from the unified federal budget.

   6. A statute of limitations of five years be instituted on the collection of overpayments in the Social Security and Supplemental Security Income programs.

   7. The resource guidelines (or assets) for Supplement Security Income be raised annually according to the cost of living.

EMPLOYMENT - TITLE V:

2. BE IT RESOLVED that Title V of the Older Americans Act be continued and treated as a separate piece of legislation, independent of other federal spending decisions and that the income guidelines for Title V of the Older Americans Act be raised to 150% of the OMB poverty guidelines.

EMPLOYMENT - STATE:

3. BE IT RESOLVED that we support the establishment of an advisory group to the Human Rights Commission to study the problem of age discrimination and to make recommendations for the development of policies and procedures.

We support the state in developing flexible manpower policies, including flex and expanded part-time positions, and in investigating age discrimination.

MAINE STATE RETIREMENT:

4. BE IT RESOLVED that the state retain its current retirement system and maintain its integrity.

TAX RELIEF:

5. The Blaine House Conference on Aging recognizes that property tax relief for communities is vital to their financial future and that property tax relief and home based care are vital concerns of older people. THEREFORE BE IT RESOLVED that the state address these problems by increasing the sales tax by one cent with most of the revenues going to municipalities through the revenue sharing formula to help relieve property taxes and $7Million being distributed equally to supplement tax relief and home based care for the elderly.

HEALTH CARE COSTS

REIMBRUSEMENT:

1. BE IT RESOLVED that the state adopt a prospective system for hospital reimbursement which would be mandatory for both hospitals and payers, and that all payers should be required to pay the same amount for the same service except when different payment amounts can be justified. If a federal waiver is necessary to provide equity among payers, then it should be pursued.

COSTS:

2. BE IT RESOLVED that rising health care costs be addressed by the following:

   A. Legislation be introduced to require that physicians indicate on a published list available to consumers whether or not they accept Medicare assignment and that there be a notice in the physicians' office;

   B. That the legislature provide for equity among payers for the cost of nursing home services;

   C. Itemized bills be provided to Medicare patients and that Medicare forms be signed after services are provided;

   D. That Medicare and other insurers be encouraged to explore the cost-effectiveness of intermediate care coverage.

ADVOCACY:

3. WHEREAS many elderly are conditioned to attitudes or are in circumstances which leave them unable to make decisions or even inquiries affecting their own health and therefore cannot or

will not aggressively represent themselves to the delivers of medical services,

BE IT RESOLVED that an advocacy program be established by the Bureau of Maine's Elderly. This program would be responsible for:

1. Supporting the elderly in receiving appropriate medical care at reasonable cost;

2. Promotion of case management; and

3. Providing information in clear, understandable language such as comparative costs and benefits of alternative levels of care, including home based care, to all health care professionals and consumers.

EDUCATION:

4. BE IT RESOLVED that the Bureau of Maine's Elderly and the Maine Committee on Aging work in cooperation with the physicians' organizations and other appropriate organizations to provide education for physicians on the problems and needs of the elderly such as cost of service and second opinions.

HOME BASED CARE

CARE MANAGEMENT

1. WHEREAS, the Home Based Care Program has been a successful experiment,

BE IT RESOLVED that the Blaine House Conference on Aging support the existing Home Based Care Program and that the Legislature be asked for continued support and expansion of Home Based Care, and BE IT FURTHER RESOLVED that the Department of Human Services carry out continued evaluation of care management, cost effectiveness and quality of care.

STATEWIDE PLANNING

2. WHEREAS the Blaine House Conference on Aging fully endorses the recent progress on the part of the Department of Human Services toward the development of Home Based Care in Maine, and

WHEREAS there is a need for further expansion of Home Based Care and a need to build coordination among the multitude of agencies and funding mechanisms to deliver effective home care to Maine's older citizens.

3. BE IT RESOLVED that the Blaine House Conference on Aging recommends that the Commissioner of the Department of Human Services expand the State Long Term Care Committee to include consumers and representatives of provider organizations and Area Agencies on Aging and that this Committee be charged with

the responsibility for providing strong advocacy, coordination and statewide planning on all matters related to Home Based Care.

3. WHEREAS there is a need for expansion of home based care, therefore

BE IT RESOLVED that the Blaine House Conference on Aging support the Department of Human Services' efforts to study the feasibility of expanding home based care services under the Medicaid Program, with or without a waiver.

STANDARDS

4. WHEREAS the Bureau of Maine's Elderly Advisory Committee is already working on the Personal Care Assistant (PCA) issue and the development of feasible standards regarding Personal Care Assistants, therefore

BE IT RESOLVED that the Blaine House Conference on Aging delegates commend the Bureau of Maine's Elderly Advisory Committee for those efforts and that the Bureau of Maine's Elderly Advisory Committee continue to work on development of feasible standards.

FUNDING

5. WHEREAS older persons have stated formally and informally for years that their highest goal is to remain in their own homes, and

WHEREAS every older person also wants to avoid entering a nursing home unless it is absolutely unavoidable, and many older people would rather die with dignity in their own homes than leave their homes and end their lives in a nursing home, and

WHEREAS 1,000 older citizens came to the Legislature in May, 1981 and dramatically and sincerely prompted the passage of the Home Based Care Act, and

WHEREAS the implementation of the Home Based Care Program has assisted hundreds of nursing home eligible elder people to remain in their homes and avoid nursing home placement, therefore

BE IT RESOLVED that the Blaine House Conference on Aging of 1982, supports the continuation and expansion of L.D. 1620 Home Based Care Program at a minimum funding level of $6,000,000 of the 1983-1985 biennium, and

BE IT FURTHER RESOLVED that the funding support of this L.D. 1620 Home Based Care Program be considered the very highest priority of the Blaine House Conference on Aging, as the Conference represents the older citizens of Maine and their families.

ALTERNATIVE LIVING ARRANGEMENTS

1. BE IT RESOLVED that the Blaine House Conference on Aging urge the Legislature to approve funding for the next biennium to implement case management assessments of all current and future residents of boarding homes and foster homes and furthermore that the size, services and programs of such facilities be assessed so that an effort can be made to match individuals and their needs to an appropriate facility.

2. BE IT RESOLVED that the Blaine House Conference on Aging urge the Legislature to continue and expand congregate housing services programs for the elderly.

3. BE IT RESOLVED that the Blaine House Conference on Aging urge the Legislature to approve funding of approximately $91,000 for the next biennium to continue the implementation of a home-sharing program as a pilot demonstration at a time when the elderly citizens of the State of Maine will be affected by the decrease in the availability of present housing options.

4. BE IT RESOLVED that the Blaine House Conference on Aging recommend that the Governor appoint a committee to study the licensing category, Food and Lodging, as it pertains to older people. The committee should include, but not be limited to representatives from the Department of Human Services, Licensing Division, Medical Services, Bureau of Maine's Elderly, Fire Marshall, Legal Services for the Elderly, Maine Committee on Aging (MCoA), Area Agencies Administration and a minimum of two elderly people, age 60 and over. Furthermore the study should be time limited, to be presented in June of 1983.

5. BE IT RESOLVED that the Blaine House Conference on Aging recommend that, due to the extremely high cost of custodial care, reductions in federal housing funds and lack of housing alternatives for elderly people, the Bureau of Maine's Elderly should work with other state and local agencies to identify and develop funding resources to achieve the following:

   a. to develop a rent subsidy program for those elderly persons who cannot afford their present rental housing;

   b. to maintain and renovate existing housing for the elderly;

   c. to implement a program with which to convert large older homes into multiple units;

   d. to provide assistance for families through ordinance review, tax incentives or direct funds with which to renovate, supplement or add on to their own homes to house elderly family members.

QUALITY OF LONG TERM CARE: INCENTIVES, SANCTIONS, AND CERTIFICATION

1. BE IT RESOLVED that the 1982 Blaine House Conference on Aging direct the Maine Committee on Aging to annually recognize outstanding achievements in the field of long term care which improve quality of life of elderly people in Maine.

2. BE IT RESOLVED that the 1982 Blaine House Conference on Aging urge the Department of Human Services to expand the membership and purpose of the Home Based Advisory Committee to include educators in gerontology and geriatrics, consumers and other appropriate individuals to serve as advisory to the Commissioner and state agencies in the coordination and policies for all home based care.

3. BE IT RESOLVED that regional administrators of the Maine Home Based Care Act and the regional Quality Assurance Review Committees explore with Vocational Technical Institutes and the adult education program directors in local school districts the feasibility of promoting and providing training in family care for dependent and semi-dependent people, and that the Department of Human Services advocate on the state level with the Department of Education for a standard model curriculum and funding for such a program.

4. WHEREAS the majority of long term care facilities in Maine provide a level of care that meets life safety and health care standards, and

   WHEREAS the majority of long term care facilities in Maine welcome and are responsive to corrective deficiencies as a result of present state operational standards, and

   WHEREAS the present enforcement mechanisms sufficiently address the most prevalent violation of state code, and

   WHEREAS there are serious and repetitive violations that cannot be appropriately addressed with the present enforcement mechanisms, therefore

   BE IT RESOLVED that the legislature investigate a system of civil actions that considers the imposition of civil fines commensurate with the seriousness of the violations and considers the impact of civil finds on the quality of care of those affected.

5. BE IT RESOLVED that the Blaine House Conference on Aging support legislation to authorize the Superior Court to place into receivership long term care facilities when it is necessary for the residents' health and safety.

UTILITIES

1. WHEREAS it is essential that telephone service be available to the elderly,

   WHEREAS it is inevitable that telephone costs and rates will increase, and

   WHEREAS those increases would put basic services beyond the reach of many who need telephone services, and

   WHEREAS it is evident that inadequate knowledge of the public's use of local telephone service makes rational planning impossible, therefore

   BE IT RESOLVED that the Blaine House Conference on Aging direct the Maine Committee on Aging, Area Agencies on Aging, Public Utilities Commission, Public Advocate's Office, and telephone industry to initiate a program to gather such information as may be needed to assist the above in planning telephone service to meet the needs of the elderly.

2. WHEREAS transportation is necessary to all citizens to attain the day-to-day necessities; and

   WHEREAS many elderly citizens are likely to require assistance for these purposes in order to remain in their homes; and

   WHEREAS several factors are threatening to reduce the availability of transportation to the elderly for these purposes, therefore

   BE IT RESOLVED that a flexible system of transportation continue to be made generally available to elderly citizens, especially for priority purposes such as medical appointments, food shopping and nutrition programs,

   BE IT RESOLVED that the Aging Network, in cooperation with the regional transportation programs, will work to develop incentives to encourage the increased participation of volunteers in the provision of transportation services.

3. WHEREAS the goal is to reduce the level of useage of energy in the future while maintaining the level of quality of life to the greatest extent possible, and

   WHEREAS the rapidly increasing costs of energy are becoming an increasing problem to many, and

   WHEREAS the problems are economically and technologically complicated problems, the solution for which the expertise resides in the public utilities industry and the Public Utilities Commission, therefore

BE IT RESOLVED that the Maine Committee on Aging draft legislation that would require gas and electrical utilities to submit a plan to the Public Utilities Commission to deal with the above issues within a year.

RESOLUTIONS FROM THE FLOOR

1. WHEREAS the legal process has become an important tool for Maine's elderly to secure their right to live with dignity and decency, and

   WHEREAS in the past institutional barriers have obstructed Maine's elderly in their access to the legal process, and

   WHEREAS Legal Services for the Elderly, a nonprofit corporation established under the Older Americans Act, has been effective in meeting the needs of older residents for legal assistance in securing adequate medical care, in their dealing with Federal and state agencies, with suppliers of fuel, power and heat, and with those who would exploit and abuse them, and

   WHEREAS Federal financial assistance for this agency will be decreasing, and will no longer adequate for the need, and

   BE IT RESOLVED by the 1982 Blaine House Conference on Aging that the State of Maine appropriate funds to maintain and increase the present level of services of Legal Services for the Elderly, Inc.

2. BE IT RESOLVED that the Blaine House Conference on Aging support continued adequate levels of funding for federally subsidized housing for the elderly.

3. WHEREAS victimization of the elderly causes them to be more fearful of crime than of their economic insecurity and their waning physical health to the extent that they abandon much of their freedom in order to remain safe, therefore

   BE IT RESOLVED that the legislature support legislation providing for stiffer penalties if the crime is committed against the elderly.

4. WHEREAS the Blaine House Conference on Aging recognizes that the present referendum drive to index the State Income Tax unfortunately is retroactive to January 1, 1981, and

   WHEREAS if passed, this referendum would cause an immediate multi-million dollar deficit in the state budget, and

   WHEREAS because this deficit may be made up by making cuts in the state budget which affect the elderly, therefore

   BE IT RESOLVED the Blaine House Conference recommends opposition to this referendum on November 2.

5. WHEREAS the purpose of the Uniform Crime reporting form is to record data on crimes committed in Maine, and

   WHEREAS the age of the victim of crimes is not included on this form, therefore

   BE IT RESOLVED that the Bureau of Public Safety be required to record the age of victims of crime to determine more accurate information.

6. WHEREAS the Home Based Care Program has been very successful in assisting frail older people to remain in their own homes, and

   WHEREAS the already exist waiting lists of elderly people who desperately need service, and

   WHEREAS the Blaine House Conference has supported greatly increased funding for Home Based Care beginning in July, 1982 therefore

   BE IT RESOLVED that the Blaine House Conference support $350,000 of supplemental appropriations to adequately care for elderly people until July, 1983.

7. WHEREAS the possibility of a nuclear war increases daily, and

   WHEREAS a nuclear war will effect every person in our country, young, middle-aged and old, and

   WHEREAS massive new government expenditures on nuclear weapons precludes meeting the legitimate needs of many, many people therefore

   BE IT RESOLVED that the Blaine House Conference on Aging, on behalf of the people of all ages in Maine, supports an immediate and mutually verifiable freeze on the further research, development and deployment of all nuclear weapons by all nations.

8. WHEREAS there exists reimbursement for only one visit per month per patient outside of the hospital, the incentive is to frequently incur costly hospitalization, therefore

   BE IT RESOLVED that there be established an expanded reimbursement mechanism under Medicare for physicians' visits to nursing homes and private homes.

9. WHEREAS the 1982 White House Conference on Aging Act (P.L. 95-478, Title II) finds that there is a great need for a more comprehensive long-term care policy responsive to the needs of older persons. This act mandates that the final report of the White House Conference on Aging, which shall include a statement of a comprehensive coherent national policy on aging, together with recommendations for the implementation of the policy,

shall be submitted to the President no later than 180 days following the conference and the Secretary (Department of Health and Human Services) shall within 90 days after submission of the report transmit his recommendations for administrative action and legislation necessary to implement the recommendations contained in the report, and

WHEREAS a poll of the White House Conference on Aging delegates revealed that one of the priority issues was the development of a national health policy which would quarantee full and comprehensive health services to all Americans, and

BE IT RESOLVED that the Blaine House Conference on Aging endorse the recommendations of the White House Conference on Aging and urge that from these recommendations a national health policy with separate statements pertaining to residential long-term care be developed without delay, and

BE IT FURTHER RESOLVED that the Governor in the State of Maine convey this message from the Blaine House Conference on Aging delegates to the President and to the Secretary of the Department of Health and Human Services.

10. WHEREAS there has been no mention of the many mental disabilities of the elderly in our communities and the potentially greater numbers of older often frail older persons and

WHEREAS this conference should address the value of developing practical coordination and cooperation between the State Department of Mental Health and Mental Retardation and the Department of Human Services, therefore

BE IT RESOLVED that there be

1. Professional, clinical screening of older persons known or recognized by their primary physicians and/or their families as needing current diagnosis, and

2. The availability of clinical and social work staff from the well equipped staffed mental health institutions in Maine - preferably to make home-visits to the individual, confer with the families and plan with all concerned to give temporary voluntary admission for purposes of residential diagnosis, treatment evaluation and aftercare services in the community, and

3. That after-care services be comprehensive treatment and health maintenance oriented for the person at risk, and

4. That there be recognition that care-takers, whether family or others in the community need sound information and education regarding the clients gero-psychiatric needs, with the goal of improving community attitudes toward mental health.

11. WHEREAS L.D. 1620 is named the Home Based Care Act and

WHEREAS the elderly hope that their care will be efficiently and humanely managed and

WHEREAS the elderly prefer not to be considered a "case"

THEREFORE, BE IT RESOLVED that programs within the Department of Human Services change the term from case management to care management.

III

MAINE COMMITTEE ON AGING PRIORITIES

MAINE COMMITTEE ON AGING PRIORITIES

In an effort to more thoroughly address a limited number of resolutions, the Committee on Aging met twice to discuss the resolutions and the legislative and/or administrative action necessary to implement them. After reviewing the priorities expressed at the Conference and those set by the area agencies on aging, the Committee considered its goals and selected the following to be their priority resolutions for the upcoming legislative session.

Maine Committee on Aging Priorities

from the

1982 Blaine House Conference on Aging Resolutions

Legislative Priorities of the Maine Committee on Aging:

1. Continuation and expansion of LD 1620, Home Based Care Program at a minimum level of $6,000,000 for the 1984-85 biennium.
   (Home Based Care #5)

2. Supplemental appropriation of $375,000 for the remainder of FY 83 to adequately fund the care for elderly individuals served by LD 1620.
   (Floor #6)

3. Legislation requiring a mandatory prospective payment system for hospitals.
   (Health Care Costs #1)

4. Legislation to require that physicians indicate on a published list available to consumers whether or not they accept Medicare assignment.
   (Health Care Costs #2)

5. Legislation to authorize the Superior Court to place into receivership long term care facilities when their plant operation places the resident's health and/or safety in jeopardy.
   (Quality of Long Term Care #5)

6. Funds to maintain and increase the present level of availability of Legal Services for the Elderly, Inc.
   (Floor #1)

7. Continuation and expansion of Congregate Housing.
   (Alternative Living Arrangements #2)

8. Funding to implement case management assessments of all current and future residents of boarding homes and foster homes.
   (Alternative Living Arrangements #1)

9. Review and study carefully the budget request submitted by the Department of Human Services.

10. Monitor legislation presented by the Maine Municipal Association to raise the sales tax by 1¢ for the purpose of relieving the property tax burden on municipalities.
    (Retirement/Employment Income #5)

11. Monitor legislation on the Maine State Retirement System. (Retirement/Employment Income #4)

12. Monitor legislation providing for stiffer penalties if the crime is committed against the elderly. (Floor #3)

13. Advocate that itemized bills be provided to Medicare recipients and that Medicare forms be signed after services are provided. (Health Care Costs #2)

IV

WORKSHOP DISCUSSION PAPERS

EMPLOYMENT/RETIREMENT INCOME WORKSHOP

October 6, 1982

Chairman: Rep. David Brenerman, Member, Maine Committee on Aging
Co-Chairman: Don Simpson, Delegate, White House Conference on Aging
Resource Personnel: Patricia Ryan, Human Rights Commission; David Bustin, Commissioner, Maine Department of Personnel; Charles Sherburn, American Federal of State, County and Municipal Employees; Anne Gosline, Maine State Employees Association; Kay Rand, Maine Municipal Association; Lucille Craib, Social Security Administration; Phil Gingrow, Maine State Retirement System; Paul LeVecque, Bureau of Income Maintenance, Department of Human Services; Jack Leet, Maine Association of Retirees; Tony Neves, Bureau of Taxation; Clyde Bartlett, Maine Chapter, American Association of Retired Persons

Delegates:

John Aliberti
Doris Baxter
Everett Baxter
Ken Berry
Collett Berube
Frazier Botting
Amy Bradshaw
Mr. & Mrs. Stanley Bragdon
Clara Bunker
Barbara Clark
Arthur Cramer
Stephanie Eaton
Myrtie Ellis
Tom Endres
Jim Flanagan
Margaret Ford
Neota Grady
Cora Hancock
Laurence Harpe
Edward Harriman
Louise Hobart
Irving Hunter
Elvie Johnson
Gordon Johnston
Irma Johnston
Lucille Kelley
Nan Kelley
Mabel Kennedy
Arthur Lambert
Theodore Landry
Willie Lash
Fred Lawler
Alice Lewis
Clair Lewis
Gary Locke
Gordon Manser
John Masterman
Grover McLaughlin
Laurel McNelly
Annabelle Mikkelson
Albert More
Caroline Morris
Helen Papsin
Louise Peacock
Lou Rancourt
Carl Rogers
Doris Russell
Mary Sawyer
Winifred Stone
Marion Thomas
Glen Torrey
Pam Waite
Fulton Weed
Sr. Nola Wells
Joseph Wolfberg

ABSTRACT OF WORKSHOP PAPER ON RETIREMENT INCOME/EMPLOYMENT

(Copies of full text available from Maine Committee on Aging)

SOCIAL SECURITY

According to a preliminary analysis of 1980 Census Data, the average annual income of Maine's elderly was only $3,001 in 1980.

Social Security or Old, Survivors, and Disability Insurance (OASDI) is the corner stone of retirement income for most Americans. Since inflation has eroded the value of fixed, non-indexed sources of income, cost of living adjustments provided by Social Security stand between many older persons and poverty. An important issue is whether these adjustments should continue on a timely basis and whether and how they should be indexed.

The National Commission on Social Security Reform in a report due January 1983 is considering a proposal to make wages, not prices, the determinent for future benefit increases and would keep benefit hikes at 1.5% below the increase in wages. When wages rise faster than prices, beneficiaries would share in the increased standard of living. However, under unfavorable economic conditions, beneficiaries would share the same misfortune as the working population.

Such a solution reflects Reagan's concern that the Social Security System is on the road to bankruptcy. However many people disagree and aruge that the administration wants Social Security cut in order to justify defense increases.

Proposals to retain the solvency of Social Security without reducing the level of current benefits include:

- injecting general revenues into the Social Security System either temporarily during periods of high unemployment or permanently.

- permitting borrowing among the three Social Security trust funds (Old Age and Survivors Insurance, Disability Insurance and Health Insurance) and from the general treasury to meet short term deficits.

- requiring federal, state, and municipal employees to join the system.

Other schemes to finance next century's deficit call for benefit cutbacks. They include:

- subjecting half of Social Security benefits to federal taxation. Taxing these benefits would not affect lower-income recipients but would reduce net benefits to higher-income recipients in proportion to their marginal tax rate.

- calling for an end to "double dipping", a practice that enables former federal employees to receive federal government pensions as well as Social Security.

- increasing the retirement age from 65 to 68, phased in over time.

Question:

Should cost of living adjustments to Social Security continue on a timely basis, and should they be indexed? If so, how?

SUPPLEMENTAL SECURITY INCOME (SSI)

The other principle public benefit program available to older people is Supplemental Security Income (SSI). Unlike Social Security, SSI is a means-test program which only gives benefits to those with low incomes and assets. However, even receipt of both Social Security and SSI benefits fails to guarantee a minimum income above the poverty threshold. For aged families with SSI and Social Security Income alone, 50% were living below the official poverty line in 1977.

The 1980 White House Conference on Aging recommended that the federal portion of SSI should be increased to 125% of the poverty level as defined by the Census Bureau, and that state supplements to the federal payment should be increased. The SSI assets test should be eliminated as an eligibility factor, and the allowed earning level should be lifted in order to encourage employment.

Question:

Should the state supplement to the federal portion of SSI be increased in order to raise the amount of the SSI payment?

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

Older peoples' need for an adequate retirement income can be addressed through the employment of older Americans. Title V of the Older Americans Act funds the Senior Community Service Employment Program which provides employment for thousands of older citizens, especially minority and low income older persons. The White House Conference on Aging recommended that the program be supported and expanded.

AGE DISCRIMINATION

The Maine Human Rights Commission has been processing age discrimination complaints since 1971. Of 480 complaints filed in 1981-82, 96.5% were in the area of employment. Over 10% of the complaints dealt with age discrimination in employment.

A joint survey of the Bureau of Maine's Elderly and the Maine Human Rights Commission revealed that only 2% of Maine State employees are over the age of 65. A survey of attitudes revealed a definite age bias affecting management decisions, although the workers favored the end of mandatory retirement, flexible work places and affirmative action for older workers.

Positive attitudes coupled with negative action toward older workers disclose myths and stereotypes so pervasive that age discrimination is unavoidable. An advisory group to the Human Rights Commission could be established to study the problem of age discrimination and make recommendations for the development of policies and procedures.

Question:

Should an advisory group to the Human Rights Commission be established to study the problem of age discrimination and make recommendations for the development of policies and procedures?

STATE EMPLOYMENT OPPORTUNITIES

Despite an automated applicant tracking system and an expanded certification process designed to facilitate state employment of groups such as older workers, State employment opportunities are mitigated by a State Personnel Rule which denies State government retirees the opportunity for regular work in the system. The Maine State Retirement System Law, Title 5 MRSA §1123, allows retired employees to work approximately halftime without losing retirement income. However, State Personnel Rule Chapter 8, Section 4.A. bans "persons receiving retired pay benefits through or from the Maine Retirement System" from working for more than ninety days in any calendar year and restricts their employment to non-status appointments, i.e., those that are of a temporary project or emergency nature. In the Spring of 1982 the State and the bargaining representatives for the majority of State employees agreed to remove the limit of 90 working days annually for retirees reemployed in non-status positions. However, the restriction on reemployment in regular positions, which constitute the majority of job openings was not removed. The Department of Personnel cites opposing pressures to "protect the fiscal stability of the Maine State Retirement System and to provide new or improved employement opportunities to others who are not able to draw retirement benefits.

However, 5 MRSA §1123 directly addresses the reemployment of retirees as previously discussed and there is no room on the part of the Department of Personnel to over-ride this statutory provision with agency rule-making. This is arbitrary and discriminating and, unless eliminated, will continue to prevent older people from finding work. The Bureau of Maine's Elderly has agreed to conduct a study with the Department of Personnel concerning reemployment of retirees in other states.

Question:

Should the State Personnel Rule Chapter 8, Section 4.A be completely abolished?

While the Maine State Retirement Law equitably addresses the issue of reemployment of retirees, it discriminates against older workers who become disabled. Title 5 MRSA §1122 provides that "eligible members, while in service and prior to attaining age 60 or reaching the normal retirement age for a particular group of employees, if earlier" may retire on a disability retirement allowance. This allowance equals 66 2/3% of the disabled worker's average final compensation as opposed to 50% for workers over 60 who have completed 25 years of service. These provisions are highly discriminating against retirees, most of whom are over 60 and results in substantially less pay and benefits for older workers who become disabled. The Age Discrimination in Employment Act allows discriminatory treatment which can be justified due to cost factors. The Human Rights Commission is investigating whether Maine"s discrimination against disabled older workers is lawful by evaluating reliable cost information and other statistics.

In 1981, L.D. 1556, "An Act to Promote Greater Efficiency Through Alternative Working Hours in State Government" was passed which encouraged alternative working hours such as flexible hours on a daily basis, job sharing and part-time employment. Flexible time options have generated the most interest. In August, 1982, twelve positions were shared. However, all but one of the incumbents are under 45. Also, there has not been a dramatic increase in the number of part-time positions, an area in which older workers express greatest interest.

Question:

Should the State continue to develop flexible manpower policies, including flex and expanded part-time positions?

STATE RETIREMENT AND/OR SOCIAL SECURITY

Maine provides retirement benefits to its State employees, not Social Security. An employee can retire and receive full benefits at 60 after 25 years of service or prior to age 60 at a reduced benefit after 25 years of service. These benefits, however, are lower than other New England states and legislatively restricted to a 4% annual increase.

Last year, the Legislature requested a Social Security study to address the issue of the State Retirement System's integration with Social Security. The normal method by which a state joins Social Security is by a vote approved by the majority of employees. A state may define the "coverage group" for Social Security integration. It may determine which groups are covered and which are not. Once a state has joined, it must remain integrated for at least 5 years.

Social Security provides portability, good disability, survivor, and medical benefits and full indexing to the Consumer Price Index (CPI). Such attributes must be weighted against the possibility that the Maine State Retirement System would be subsumed by integration with Social Security and the financial difficulties which the Social Security System now confronts. The recently formed Maine Association of Retirees believes that Maine has a good retirement system and would like to see it strengthened rather than integrated with a worrisome Social Security System.

Question:

Should the State maintain its current retirement system, change to Social Security or integrate the two systems?

HOME EQUITY CONVERSION

A potential source of income for some older people is home equity conversion. This allows older people to "cash-in" the value of their homes while retaining residency and receiving income to meet expenses.

In August 1982, the Department of Human Services submitted an application for funding of a project which would coordinate resources of the Bureau of Maine's Elderly, University of Maine School of Law, Maine Savings Bank, Maine State Housing Authority, and area agencies on aging to explore the potential for home equity conversion in Maine, develop plans and demonstrations and provide training and education to elderly consumers, service providers and professionals. A Task Force would conduct a market study in order to develop feasible home equity conversion plans. Estate planning programs would be established for elderly homeowners, continuing educational conferences would be offered to professionals and service providers and financial planning seminars would be offered statewide to help elderly people begin to make important personal decisions about home equity conversion.

One form of home equity conversion being explored is property tax deferral. This would allow older homeowners to post-pone paying property taxes until they sell their home or die. The State would pay the taxes to the municipality, and these payments would accrue with interest as a loan to the homeowner. The loan is secured by home equity, and upon death or prior sale of the home, the total loan is repaid to the state.

Initial capitalization and long range cash flow needs of a tax deferral program would require public financial support. However, a properly structured program could eventually become self-financing.

A simple and divisible plan such as tax postponement could precede marketing more complex home equity conversion plans.

Question:

Should the Maine Legislature create a property tax deferral program?

HEALTH CARE COSTS WORKSHOP

October 6, 1982

Chairman: Alice Bourque, Member, Maine Committee on Aging
Co-Chairman: Murray Cott, Delegate, White House Conference on Aging
Resource Personnel: Bob Clarke, Maine Health Facilities Cost Review Board; Grant Heggie, Maine Hospital Association

Delegates:

Gersha Aronson
Mollie Baldwin
Harold Blaisdell
Antoinette Boucher
Carol Brocker
Hazel Bridges
Aubrey Burbank
Mr. & Mrs. Walter Burlingame
Willard Callender
Laura Cathcart
Phoebe Cropley
Bill Cunningham
Nan Dunlap
Eleanora Favre
Wilfred Ferland
Elizabeth Fletcher
James Fletcher
Archie Gaul
Stan Hanson
Joyce Harmon
Payson Hunter
Lenoard Janes
Leitha Joy
Valarie Lamont
Ruth Landon
Maxine Landry
Anita Levesque
Irene Lindsey
Sr. Jean Little
Eileen Lonsdale
Dan Lowe
Thelma McLaughlin
Dana McKay
Lee Miles
Don Miller
Martin Needham
Kathleen O'Meara
Lula Osnoe
Yvonne Pelletier
Mary Plissey
Louise Preble
Laura Richards
Dorothy Ruszkenis
Emily Saunders
Muriel Scott
Margaret Smith
Fred Spear
Don Stewart
Louise White
Mary Wright

ABSTRACT OF WORKSHOP PAPER ON HEALTH CARE COSTS

(Copies of the full text available from the Maine Committee on Aging)

About 95% of the nation's older people are enrolled in Medicare's hospital insurance program, representing $25.1 million in 1980. With the percentage of people aged 65 and older expected to nearly double from 11% to 19% of the total population in the next 70 years, the Medicare program and health care costs in general will be affected. Over 41% of the total patient days in 1980 in Maine were for individuals aged 65 years or older, indicating lengthy hospital stays. With the increasing older population, we can expect that the proportion of older patients to younger patients will in all likelihood continue to increase. The future of the health care system will therefore have dramatic implications for older people.

As the following statistics indicate, the costs of health care and particularly hospital care have increased dramatically in the last two decades.

A. U. S. Health Care Costs

1960	1980
$ 27 billion	$ 247 billion

B. Yearly Increases (1970-1979)

Goods & Services	Hospital Care
7.6%	13.3%

C. Health Care's Share of the G. N. P.

1965	1980
6.1%	9%

The increases in health care costs can be attributed to general inflation, an increase in the number, skill level and salary of hospital employees, as well as the cost of new technology. Changes in the age composition of the population, general price trends, individual behavior and increased expectation are other important factors that made up the health care cost picture.

It has also been asserted that the nation's system for paying medical bills rewards inefficiency, does not promote incentives for cost containment as a result of the fee-for-service system and therefore needs to be overhauled.

Who Pays and How

There is a retrospective payment structure in Maine which is used by Medicare, Medicaid and Blue Cross which has assured reimbursement to hospitals for expanding labor and non-labor resources.

An average of ninety percent of a hospital's revenue comes from payments for services provided to patients, with the remaining 10% coming from individuals, foundations and corporations in the form of contributions and earned interest income. The Medicare and Medicaid program pay for about half of that, with Blue Cross paying about 25%. The other quarter is paid by commercial insurance, small non-commercial insurance programs and self-paying patients.

It is important to know how these different parties pay the hospital bill. The Medicare and Medicaid programs pay hospitals on the basis of "allowable" costs which hospitals incur in providing care to the beneficiaries of the program. Allowable costs are determined by the Federal Department of Health and Human Services. Blue Cross pays hospitals according to a negotiated contract which also pays on the basis of costs. However, Blue Cross adds to Medicare's allowable costs several other payment categories including hospital capital requirements and a contribution toward bad debts. Even though Blue Cross pays on the basis of costs, they are required in Maine to pay hospitals at least 84% of the hospital charges.

The commercial insurance companies and the private pay patient on the other hand do not pay costs of services but must pay the hospitals' charges, i.e. the prices of hospital sets for its services which are higher than the cost of the service.

Because Medicare, Medicaid and Blue Cross don't meet the hospital's total financial requirements, the shortfalls are made up through increased charges for all commercially insured and self-pay patients, creating an inequity among payers.

Current Activities

In May 1981, Governor Brennan asked the Health Facilities Cost Review Board to evaluate whether current voluntary efforts to contain hospital costs in Maine were effective. The Board found that the retrospective cost reimbursement method does not contribute to the efficient production of services in hospitals because hospitals are paid on the basis of what they spend, so there is no incentive to reduce costs.

The Board's major recommendation was that the State adopt a prospective system for hospital reimbursement which would be mandatory for both hospitals and payers. Prospective reimbursement is a method of paying hospitals according to pre-established rates of payment for fixed periods of time regardless of the actual costs incurred by the hospitals. The Board also recommended that all payers should be required to pay the same amount for the same services except when different payment amounts can be justified. A federal waiver would be necessary to allow prospective reimbursement under the Medicare/Medicaid programs.

Maine's Bureau of Insurance issued final rules effective July 1, 1982 to regulate the sale of Medicare Supplement Insurance policies in the State of Maine.

The rules require a standardization of coverage for all Medicare supplement insurance policies, as well as a simplification of terms and benefits of such policies and contracts. These rules provide for an outline of coverage and comparison tables in every Medicare supplement insurance policy sold in Maine, which will reduce misleading or confusing sales practices. The rules also clarify what nursing home coverage is provided under Medicare and requires Medicare Supplement policies to clearly state whether they provide nursing home care. Medicare Supplement insurance policies must also provide certain levels of coverage for services that are not covered under Medicare Part A and Part B.

The rules also require that each policy have attached to it a publication entitled "Guide to Health Insurance for People on Medicare", which provides a comprehensive discussion of the Medicare program and the need for Medicare supplement insurance.

The Maine Committee on Aging formed a subcommittee in September, 1981 to study the high cost of health care and its affects on Maine's older people. The Committee held three public hearings to discuss with consumers their concerns and perspectives on the rising cost of health care.

The Committee found the following:

1. The average consumer of health care is not aware of the hospitals or physicians' charges because they are not involved in the decision-making process about their care and often only see the total cost because insurance pays the bulk of the bill.

2. Unlike any other system, the elderly consumer authorizes a blank check for health care services without knowing whether those services have been performed. This happens when a Medicare beneficiary signs a Medicare admission and billing form upon admission to the hospital which says that the beneficiary certifies that the information on the form is correct, that the beneficiary authorizes release of information and the beneficiary authorizes payment.

3. Contrary to the misconception that because someone else is paying the bill, older people do care how much health services cost.

4. The physician is the key link between the patient and the health care system.

5. It is the consumer's perception that physicians are ordering too many unnecessary and duplicative tests.

6. Consumers are very confused about what Medicare covers and what private insurance coverage they need.

7. Consumers are interested in obtaining understandable itemized bills from hospitals so that they could understand what charges were and check whether the services were provided.

8. The itemized bill is misleading because it represents what the private pay patient and the private health insurance company pays the hospital for services. Medicare and Blue Cross/Blue Shield pay less than the charge. The private payer and the private insurance policy holder is being charged to help pay for the Medicare and Blue Cross patients's hospital services.

9. Often, the physician is unaware of what services and procedures cost and it was felt that if doctors were more aware of the costs, they would be more selective in what they order for a patient.

10. Consumers felt that they should know if physicians accept Medicare assignment because physicians who don't cause a hardship for low income elderly.

11. A great deal of criticism was leveled at the T.V. commercials which advertise deceiving Medicare Supplement Insurance policies.

12. The cost of hospital supplies, such as a $2 charge for a tylenol was questioned. It was suggested that patients be allowed to bring medications and supplies with them rather than getting charged by the hospital.

13. A surprising number of examples were given to the Committee of duplicate billings to different third party payers for the same service.

14. The consumer's perception is that hospitals and physicians are over billing and are going unchecked while Medicare recipients are getting service cuts.

RECOMMENDATIONS OF AD HOC HEALTH CARE COST SUBCOMMITTEE

A. Support prospective reimbursement for hospitals with a maximum statewide revenue cap as well as a system to provide equity among third-party payers for hospital services.

B. Education/Information Activities.

The Committee recommended that Insurance Analysts be available through each area agency on aging to meet with and assist elderly to understand Medicare and analyze their individual insurance coverage as to whether it is sufficient or duplicative. The Committee has tried to establish volunteer analysts with funding for support raised from various private funding sources.

The Committee also recommended the development of a health information booklet which would explain such issues as

- Patient's rights when in a hospital
- importance of patients discussing their plan of care with their physicians
- right to a second opinion
- right to shop around for a doctor who accepts Medicare assignment
- right to appeal Medicare determinations concerning hospital eligibility and how to pursue that right.

The Committee intends to develop public service announcements for T.V. and radio to clarify numerous health care issues and offer important information to the public.

The Committee also recommended that a law be passed in Maine to require physicians when applying for licensure or renewal to provide information as to whether or not they accept Medicare assignment and a list distributed statewide.

Itemized bills would provide necessary information to consumers about what medical services were provided and at what cost. A private health insurance company told us that they reduce their payments to hospitals by approximately 10% by using itemized bills and correcting hospital billing errors that were made. Could Medicare and Blue Cross/Blue Shield realize similar savings if itemized bills were used for both hospital and physician services?

C. Medicare Admission Form

The current form used by the Health Care Financing Administration of the Federal Department of Human Services for Medicare payments assures payment before services are provided. The legality of such prior assurance should be looked at. The Ad Hoc Committee would like to examine the feasibility of a new admission form that would tie Medicare payment to a sign-off from the patient after review of an itemized bill.

QUESTIONS:

1. Should the 1982 Blaine House Conference on Aging endorse prospective reimbursement for hospitals? Should the 1982 Blaine House Conference on Aging endorse equity among payors for hospital services?

2. Should hospitals provide itemized bills to all patients, or just when requested?

3. Should legislation be introduced to require that physicians be required to indicate whether they accept Medicare assignment upon licensure?

4. Are health insurance analysts needed statewide? Should state funding be sought to provide health insurance analysts?

5. Would a Health Information Booklet be useful to consumers?

HOME BASED CARE WORKSHOP

October 6, 1982

Chairman: Margaret Russell, Member, Maine Committee on Aging
Co-Chairman: June Perkins, Delegate, White House Conference on Aging

Resource Personnel:
Jane Morrison, Western Older Citizens Council
Elizabeth Weaver, Central Senior Citizens Association
Jane Watkins, Eastern Task Force on Aging
Sharon Michaud, Aroostook Regional Task Force of Older Citizens
Jim Gorman, Diocesan Human Relations Services
Norma Mengel, Maine Community Health Association
Steven Tremblay, ALPHA I
Elaine Fuller, Bureau of Maine's Elderly, Dept. of Human Services
Francis McGinty, Deputy Commissioner, Dept. of Human Services

Delegates

Larry Bagley
Eunice Baumann-Nelson
Marjorie Bither
Elsie Borgford
Ephnem Boucher
Virginia Bradbury
John Brown
Nina Byron
Robert Carberry
Karen Carlson
Alice Cody
Eunice Curry
Jean Denny
Dorothy Fabian
Steve Farnham
Joanne Felbaum
Agnes Flaherty
Kaye Flanagan
Betty Forsythe
Madeleine Freeman
Elaine Fuller
Norman Gardner
Albert Goodrich
Frema Grant
Laura Griffin
Phil Groce
Sonia Hitchcock
Bernice Jenuskevice
Elizabeth Locke
Teivy Manual
Antionette Martin
Elaine Masterman
Harold McElman
Hartson McKenney
Sharon Michaud
Joanne Miller
Eloise Moreau
Joe Morris
Jane Morrison
Adrienne Nadeau
Roger Newton
Jane O'Rourke
Shirley Ouprie
Lorette Pelletier
Betsy Perry
Rachel Phalen
Owen Pollard
Patricia Powell
George Pray
Thelma Pray
Tom Randall
Claire Roger-Anctil
Alice Rogers
Laurette Rush
Don Sharland
Patricia Sheehan
Charlie Small
Carl Smith
Edith Stephenson
Jan Thomas
Nona Thornton
Janice Watkins
Elizabeth Weaver
Tony Wedge
Elizabeth Wilson
Eileen Zahn
Virginia Zulieve

ABSTRACT OF WORKSHOP PAPER ON HOME BASED CARE

(Copies of full text available from Maine Committee on Aging)

I. Home Based Care Act

1. Background

The Home Based Care Act (HBCA), enacted in 1981, provided funds for a variety of in-home services. It was designed to bring a balance to the Long-Term Care (LTC) system which has long been characterized by fragmentation, a bias toward institutionalization, and a lack of official recognition of the legitimate and essential roles of families and others in the community in caring for frail adults. The law required the Department of Human Services (DHS) to establish and administer programs for in-home care and community support services as an alternative to nursing home care and made $1.25 million available for home care for the biennium to be spent on elderly, handicapped and Adult Protective Services (APS) clients. Any services could be provided which would enable adults with long-term care needs to be served at home.

The law disallowed funds for people whose primary disability is mental retardation or mental illness and allowed the Department to conduct demonstration projects, utilize a variety of providers, use federal and private funds and use vouchers to allow clients to purchase services directly.

Rules for implementing the program were developed by the three Bureaus', Rehabilitation, Maine's Elderly and Social Services, with the assistance of an advisory group. Five informal public meetings were held around the state to discuss the draft rules before the formal public hearing on them.

The Bureau of Maine's Elderly required that a short functional assessment form be completed to identify what activities an older person could or could not perform to determine whether or not he was "at risk". The funds were distributed statewide through a population based formula. Eight percent of the funds were to be available to pay for the cost of assessment, reporting, data collection, and case management. Five percent of the $1.25 million was set aside to serve non-elderly clients who did not meet definitions of handicapped or APS. The five area agencies on aging were chosen as lead agencies, ALPHA I as lead agency for the handicapped and the Bureau of Social Services would administer their funds through their own APS staff.

Finally, the Bureau of Medical Services agreed to classify all elderly clients served under the Home Based Care Act as if they were seeking nursing home placement to determine whether or not they were at risk of such placement.

2. Eight Months of Experience in the Program

The program started in Aroostook County in January 1982 serving 13 people initially.

Statewide as of mid-August 303 elderly persons (60+ over) had received services paid for under the Home Based Care Act. The recipients ranged from those who were moderately impaired to some extremely functionally impaired persons. The average monthly cost to maintain these people at home was $416, of which $283 came from Home Based Care Act funds. This figure excludes the cost of case management.

The most frequently purchased service was Personal Care Assistance with 49.7% of the Home Based Care funds being used for this service. Included in the PCA category are family caretakers. Since the program started, 46 cases have been approved by the Bureau of Maine's Elderly to pay family members, with daughters being the most frequent relative being paid.

The duties of a personal care assistant are to assist the client with such activities as dressing, food preparation, moving in and out of bed, walking, routine bathing, and other household tasks.

The PCA oftentimes is a certified nurse's aide. The PCA may be employed, supervised and directed by the client (consumer-directed) or the services of a PCA may be purchased from a provider agency. The ultimate goal of the program is to meet the needs of the individual client through a flexible PCA program.

The cost of PCA services varies, depending on the provider. When the PCA service is being purchased from a family member, neighbor, or other individual, the reimbursement is negotiated on a case by case basis. PCA, to date, have ranged from $3.50 per hour to $17.00 per hour. The lower costs generally reflect payments made to individuals and higher costs are paid to Hommaker/ Home Health agencies.

3. Provider Comments on the Program

Although the program has funds to serve disabled adults under 60, this part of our presentation concerns itself only with the recipients who are 60 or over, the population for whom 75% of the money was targeted.

Overall there seems to be agreement that the Home Based Care program "Has made a significant impact on the well being of Maine's elderly".

The Maine Community Health Association listed some of the observed outcomes of the program as seen from the perspective of their membership:

Strengths

1. The publicity surrounding the Home Based Care Act has increased consumer awareness of the availability of home based care, and thus decreased the fear of nursing home placement as the only option.

2. Flexible funding provided by the Home Based Care Act has been used to fill gaps in individual/family plans of care.

3. Flexible regional planning has contributed to the potential for meeting different needs in different areas of the state.

4. The data being collected has the potential for contributing to a sound data base for home care planning: it is essential that complete cost and service data is collected.

5. Involvement of home care provider associations and other groups in the Advisory Committee which drafted the rules for implementation of Home Based Care Act was and continues to be useful.

Maine Community Health Association described its perceptions of the weaknesses of the program as follows;

1. Failure to fully integrate Home Based Care Act funded services into the broader home care system has led to some disruption of existing systems and to costly duplication.

2. Failure to fully utilize the existing home care network of professional expertise in public health, home health and homemaker agencies to build cost-effective and service effective assessment and case management systems resulting in duplication.

3. Failure to facilitate development of consistent standards for all state funded home care services to ensure safe and cost efficient care.

4. Lack of emphasis on client and worker protection is evident in the failure to require adequate training and supervision for all workers reimbursed under LD 1620 funds.

5. Failure to develop a validated assessment tool and to use a truly multidisciplinary approach to achieve a wholistic client/family centered assessment and care plan.

4. Issues

The issues before us therefore, relate primarily to case management, funding of services, and standards especially as they relate to personal care assistants.

Case Management

Maine Community Health Association recommends that lead agencies should be directed to utilize to the fullest (through contractual relationships), the statewide home care network of community health nurses, rehabilitation therapists and social workers who have well developed assessment, case management, coordination and treatment skills instead of continuing to build a costly duplicative system. Contractual relationships will facilitate this function.

The aging network responds that the case management system is not a "new bureaucracy" but was initiated in response to the 1978 Amendments to the Older Americans Act which required the aging network to serve elderly in "greatest social or economic need". An assessment tool was developed to help determine that need. Each individual entering the long term care system is assessed to determine what the individual can and cannot do for themselves. For the individual clients and families involved it was important to assist them with the tasks of juggling four to five agencies, each with different eligibility requirements, to make the needed arrangements. The goal of the program is that one contact with a case manager at the area agency on aging will quickly bring about the package of services needed from various agencies.

With the assessments, monitoring and information collecting being done by a single agency for the targeted population, the state and agencies for the first time can get a clear picture of who the clients are, what kinds of needs they have and where the gaps in services occur. It makes it possible for them to do client oriented planning.

Funding of Case Management

Both the Maine Community Health Association and the Homemaker Council expressed concern about the use of funds to develop case management capability in area agencies on aging - funds that they perceive as having been used previously to purchase direct services. Some area agencies on aging had provided blocks of money to agencies to spend on clients as they chose. Some of that money is now being held by the area agencies on aging to purchase services from those same agencies as well as other agencies for their high priority casemanagement clients. This is one way of assuring that the services are directed to those in greatest need and are designed to respond to individual need rather than fit people to rigid proram requirements. For FY 83 the Area Agencies on Aging are planning on utilizing 8.2%, or $638,700 of their total resources for case management costs.

A time study of the Case Management program is presently being conducted to arrive at an hourly cost for case management activities. This then becomes a cost that can be measured on a client basis to determine the cost of in-home care.

Standards

The Maine Community Health Association recommends that "through the vehicle of a Home Care Council or other Task Force, consistent statewide standards for all state funded home care services, including Home Based Care Act services should be developed. These standards should address administrative structure and functioning, fiscal responsibility, case management services, supervision, and direct services of all types and levels.

It was the intent of the legislature to develop a low cost, flexible PCA program which also assured quality services. The Home Based Care Act regulations set forth standards for personal care assistants.

Approximately 80% of the care given to older people is given by family members. It is oftentimes more comfortable and natural for people to be cared for by family and neighbors than by someone who works for a professional agency. Home Based Care Act funds allow the client to maintain dignity by compensating a family member or neighbor for personal care assistance. The case managers, with the client and family, do have to monitor PCA services, but rigid standards for PCAs could negate the value of this service. The case managers have found that costs of existing providers are high and that some services are not available. While the associations are correct that formal competency tests are not conducted nor are licensing standards imposed, the service has been provided at significantly lower cost and with high client satisfaction. A formal and anonymous assessment of client and family satisfaction with the home based care program is now being conducted.

In addition to continuing the Home Based Care Act Advisory Committee, Quality Assurance Review Committees consisting of providers, institutional and community services, and consumers have been established in each region as one mechanism to evaluate the system of services, the care planning for individuals, and the services provided. However, each provider agency retains the responsibility for the standards of practice for their specific service.

Summary Questions - HBCA

1) Does duplication of service exist? If so, where and how can it be overcome?

2) Should formalized standards be developed for Case Management and Personal Care Assistance and other home care services? If so, how and by whom?

3) Should Title III funds of AAA's be used for case management?

4) Should there be a Home Care Advisory Council or Task Force?

II. Adult Protective and Severely Physically Disabled Clients of the Home-Based Care Program.

To round out the picture of the experience under the act, we cannot omit the aid that has gone to the two other groups targeted for services, adult protective clients of the DHS and severely physically disabled clients.

Adult Protective Services - Long Term Care (1620) Funds

Prior to the implementation of 1620 Long Term Care, individuals who were incapacitated and in danger often had to be removed from their homes to other supervised arrangements for safety. Long Term Care Funds allows Adult Protective Services caseworkers the flexibility to purchase goods or services to provide protection, meeting the needs of individuals in their own homes or residence of choice.

Of the total Long Term Care dollars, 5 percent were allocated for Adult Protective Priority Clients. In the first five months of the program, Adult Protective Services used these funds to provide protection to 27 individuals. Through the Adult Protective Services Case Management System, the caseworker evaluates with the individual, as much as possible, the strengths and needs of his situation, formulating a case plan to meet these needs. The caseworker advocates for services, monitors the quality of the service provided, and reviews the progress toward the completion of the case plan.

The most critical need met with these funds was for personal care and supervision which might include meal preparation, light housekeeping and checking on the well being of the individuals. Most importantly it allowed for the purchase of these services from someone who was familiar to the adult.

In one case these funds have helped to prevent inappropriate instutionalization by allowing for the purchase of weekend and after-hour services personalized to meet individual needs. This gives the Adult Protective Services caseworker time to make a case plan to remove the cause of the jeopardy, build on the individual's own strengths and advocates for family and community resources so that removal from the home is not necessary to make the individual safe.

With this kind of case management and the flexibility of the use of Long Term Care Funds, Adult Protective workers can provide protection while allowing the individual as much control over their own lives, using the least restrictive measure possible.

AN OVERVIEW OF PERSONAL CARE SERVICES PROVIDED TO SEVERELY PHYSICALLY DISABLED INDIVIDUALS THROUGH LD 1620, CHAPTER 1625.

In October, 1981 the State of Maine Department of Human Services through its Bureau of Rehabilitation contracted with Adapt-

ive Living for Physically Handicapped Americans (ALPHA I) to implement personal care services for severely physically disabled adults under LD 1620, Chapter 1625.

Individuals who qualify for this program are functionally quadriplegic (have lost use of arms and legs) and capable of establishing and directing, with training, if necessary, their own personal care support system. Essentially this entails hiring, training, managing and firing, if necessary, individual(s) to provide assistance with routine bladder and bowel functions, transfers, meal preparations, bathing, shopping, light housework and any other similar activity of daily living.

Presently, there are 39 program participants. Eight of these individuals (20% of them) have relocated from nursing homes to apartments in the community. Nine individuals have either completed or are in the process of completing the ALPHA I Transitional Living Program provided at Congress Square Plaza in Portland, which enables one to live in her/his own apartment independently. Three individuals have completed and one is entering the IBM computer programming training conducted at Bangor Community College. Two individuals are law students at the University of Maine School of Law. Nine individuals are currently involved in post secondary education. Seven individuals are homemakers. Two individuals were terminated from the program due to their inability to manage their Personal Care Assistance system.

III. Medicaid Waiver to Provide Home and Community-Based Services

Background

The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) enacted a total of $130 billion reductions in federal domestic expenditures over the next three years.

However, Section 2176 of the 1981 Reconciliation Act, added a new provision to Title XIX of the Social Security Act, granting the Secretary of Health and Human Services the authority to waive existing statutory requirements in order to permit states to finance through the federal-state Medicaid Program non-institutional services for elderly and disabled persons who otherwise would require care in Medicaid certified institutional care facilities.

A state is permitted under the terms of the new waiver provision to establish limits on the amount, duration and scope of services rendered to eligible individuals. The state may also establish a per capita ceiling on the total cost of each client's care. The average per diem cost of community-based care provided may not exceed the cost of providing institutional care to eligible individuals.

Recipient Eligibility Under the Waiver

Under current Title XIX regulations, states are allowed to establish special, higher income and resource standards governing

the Medicaid eligibility of institutionalized recipients than apply to individuals living at home.

Low income elderly whose limited income from Social Security, private pensions and/or earnings push them over the basic SSI means test are expected to be the principal beneficiaries of this change.

If a state elects to establish a higher income eligibility standard for Medicaid reimbursable home and community-based services under its waiver program, it must require all recipients with income and resources above the categorical eligibility standard (SSI standard) to share in the cost of providing such services according to a new schedule established by the state Medicaid agency.

Current State Activities

As of July 15, 1982 thirteen of the twenty-nine (29) states that had applied for the Medicaid home and community-based waiver had their waiver requests approved.

The Maine Department of Human Services has not applied for a waiver to date, but is still considering the possibility of making application.

Major Factors Maine Must Consider

The following reviews some factors which must be taken into account in the consideration of application by Maine for a Medicaid Home and Community-based Services Waiver:

1. Average Per Capita Expenditures -

Assurances must be provided in the waiver application that average per capita expenditures will not exceed average per capita expenditures without the waiver.

A state will have a difficult time demonstrating that its waiver request is approvable unless: (a) it plans to include in the population eligible for Title XIX - reimbursable non-institutional services a significant number of current recipients of Medicaid-certified institutional services; and/or (b) it can offer convincing evidence that the number of residents in Title XIX-certified institutions will increase at a rate sufficient to offset the added federal costs of non-institutional services contemplated under the waiver request.

2. Services to be Offered -

The selection of the services to be provided is one of the most critical choices state officials must make. The decision regarding the types of reimbursable services to offer under the state's waiver program will be influenced by a number of factors.

The Department of Human Services has indicated an interest in providing case management services, respite care, and adult

day health services under the waiver if Maine applies. The preference for a limited number of services is based on the state's preference for a controlled level of expenditure under the waiver.

3. Higher Income Eligibility Criteria -

In developing a waiver proposal, Maine must consider whether higher income eligibility criteria should be established as permitted in the regulations. This decision will be influenced by the type of waiver proposal the state is planning to submit (i.e., a waiver request limited to eligible developmentally disabled clients versus an "umbrella" request for all eligible aged, blind and disabled recipients.) Because elderly persons simply are more likely to have income from other sources which disqualified them for SSI benefits, a waiver primarily aimed at assisting elderly people should establish a higher income eligibility criteria to achieve its goal.

If on the other hand, there is a concern about the increased number of people who would become eligible and how much they would cost, then maintenance of the current eligibility criteria would be preferred.

To date, the Department has indicated a preference for a controlled eligible population so that costs can be controlled.

4. Types of Waivers -

If Maine seeks Medicaid reimbursement for existing services across the state, then a "statewideness" waiver need not be sought (Section 1902 (a)(1)). If Maine intends to limit services to a designated segment of eligible beneficiaries in need of long term care, it should request a waiver of the "comparability"requirement (Section 1902 (a)(10)).

Summary Question - Waiver

What action should DHS take regarding Medicaid waivers for home and community-based services?

ALTERNATIVE LIVING ENVIRONMENTS WORKSHOP

October 6, 1982

Chairman: Susan Brown, Member, Maine Committee on Aging

Co-Chairman: Mickey Friedman, Delegate, White House Conference on Aging

Resource Personnel:

Catherine Cobb, Boarding Home Program, Dept. of Human Services
William Inlow, Central Senior Citizens Association
Elizabeth Grantham, Adult Protective Services Unit, Dept. of Human Services
Lillian Sears, Western Older Citizens Council

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Gladys Babb
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Clarice Murphy
Mary Newton
James Normington
John Notis
Lawrence Read
Carol Timerlake
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Fred Wookey

ABSTRACT OF WORKSHOP PAPER ON ALTERNATIVE LIVING ARRANGEMENTS

(Copies of full text available from Maine Committee on Aging)

For the past several years the Aging Network in Maine...the Maine Committee on Aging, the Bureau of Maine's Elderly and the five Area Agencies on Aging...has emphasized the need for a variety of alternative living options for the elderly. Alternatives were viewed as needed by the elderly who could no longer live independently as well as the elderly who could care for themselves. The purpose of this workshop paper is to review the progress that has been made in developing alternative living environments and to examine directions for the future. The alternatives reviewed in this discussion include: boarding homes, foster homes, congregate housing and shared housing.

Boarding Homes

As defined by regulations, boarding homes provide personal care, supervision and social services to "defectives, dependents, delinquents, aged, blind or other persons 16 yeras of age or over" who are ambulatory and do not require care provided at intermediate care facilities, skilled nursing facilities or hospitals.

While regulations also outline requirements for boarding home facilities, in general, boarding homes consist of multiple occupancy bedrooms, bathrooms which are shared among residents and common dining and activity rooms.

There are currently 280 licensed boarding homes in Maine serving over 3,000 individuals. The majority of boarding home residents are elderly although a significant percentage are mentally retarded or chronically mentally ill. There are boarding homes in every county and in both urban and rural areas of the state.

During the last several sessions of the Legislature there have been a number of bills proposed to change aspects of the Boarding Home Program. As a result of discussions on the bills, the Legislature determined that the Boarding Home Program needed improvement. It viewed the program as lacking a clear focus with the Department of Human Services because different Bureaus had different responsibilities for the program. The Legislature also determined that better communication between the Department of Human Services and the Department of Mental Health and Mental Retardation was needed as each Department had responsibilities for serving client groups living in boarding homes. As a result of legislative concerns, a Boarding Home Study group was created to review the Boarding Home Program and to make recommendations to the Legislature.

The Boarding Home Committee was comprised of 15 people, including 5 legislators, a representative of the Department of Human Services, a representative of the Department of Mental Health and Mental Retardation, 3 boarding home operators, a representative from the Maine Committee on Aging, Advocates for the Developmentally Disabled, Com-

munity Support Services Project, and an advocate attorney.

After months of review and discussions, the Boarding Home Committee agreed that there were encouraging signs that the program was being improved through actions taken by the epartment of Human Services such as shifting administrative responsibility for the program to one Bureau in the Department of Human Services - The Bureau of Medical Services, and hiring a Director for the program. However, the Committee concluded that there was room for improvement to ensure that boarding home residents would be able to select quality care.

As a result, the Study Committee proposed legislation. Unfortunately, the Legislature determined that the proposal was submitted too late in the session and chose not to review the legislation. Summarized below are the major recommendations that were proposed to the Legislature:

1) There was unanimous agreement that a standardized assessment of boarding home residents' abilities, needs, and independent living skills is essential to determine care and services needed on an individual and population group basis. The results of the assessments will provide the basis for assuring appropriate placement and service provision as well as determining on a statewide basis the types of boarding homes and community support needed. The bill proposed included the following:

$100,000 to provide funds for assessments for potential boarding home residents to be conducted by community case management agencies. The funds would provide for 5 case managers to the Area Agencies on Aging funded through the Bureau of Maine's Elderly to conduct assessments of elderly applicants for boarding homes; additionally

$100,000 to provide funds to the Bureau of Mental Health for 5 case managers to conduct assessments of mentally ill and mentally retarded boarding home applicants and to develop case plans for provision of mental health services.

Thus far, there has been little progress made toward this recommendation.

A legislative study order was passed, which authorizes the Department of Human Services to direct the development of an assessment tool and referral system to assist persons considering boarding home care. A committee is currently developing one Department-wide assessment tool. Other issues identified by the Study Group have been remedied already by the new principles of reimbursement to boarding homes, and other administrative actions taken by the Department of Human Services.

2) A second major recommendation from the Boarding Home Study Group was to ask the Legislature to appropriate funds

to provide support services to 50 units of shared, group or congregate housing which will be discussed later in this paper.

The last session of the Legislature appropriated funds to add 60 new boarding home beds in different areas of the State. The Department of Human Services has developed some preliminary guidelines to determine where the new boarding home beds are most needed. The areas identified are: Bucksport, Bridgton, Rumford, Lincoln/Millinocket, York County and Sanford.

The Department of Human Services has determined that small boarding homes are the size it wants developed. Therefore, they will be seeking applications for 6 bed boarding homes.

Once assessments are conducted on an ongoing basis, the boarding home program can begin to assure that services to meet the needs identified through the assessment, are provided to the individual. It is difficult to determine what services are actually needed prior to a comprehensive assessment of the boarding home resident's ability to function, both physically and mentally.

Questions:

1. Should the Maine Committee on Aging continue to pursue funding for assessments of individuals to determine their appropriateness for boarding home care and need for services in boarding homes?

2. Is a boarding home of 6 beds the preferred size for a boarding home?

3. Should the Aging Network advocate with the Department of Human Services that elderly individuals be assessed prior to admittance to the 10 new boarding homes?

Adult Foster Homes

The rules governing the adult foster care program define an adult foster care facility as a residence, other than a boarding care facility, operated for the purpose of providing boarding care for four or fewer residents, sixteen years of age or older. There are currently 296 homes which could potentially provide care to 730 adults. The program is intended to allow individuals who can no longer live by themselves to remain somewhat independent and live in a family like atmosphere. Approximately, half of the licensed foster homes provide care to the elderly. Like boarding homes, foster homes also serve the mentally retarded and mentally ill.

There is no standard assessment for foster home placement, and therefore, there is no tool to help determine whether an individual is "in need of" foster care. Currently, the Department of Human Services and the Department of Mental Health and Mental Retardation

each place individuals in adult foster homes even though there is no statewide policy regarding who is appropriate for adult foster care.

Procedures have been developed by the Adult Foster Care Program which sets standards that must be met prior to approval as an Adult Foster Care facility. These involve life safety standards and the homes must pass a yearly inspection by the State Fire Marshall's office, as well as yearly water test for other than municipal water supplies. A community care worker from the Department of Human Services evaluates the home yearly for safety, cleanliness, pleasantness and wholesome family surroundings. However, there is no formal mechanism for determining the capability of the operator.

The Department of Human Services points out several weaknesses in the program. They are as follows:

- The program needs to take more steps to provide emergency or respite care, especially for the elderly

- Based on a law vacancy rate, more adult foster care facilities are needed

Additional concerns about the Foster Care Program have been raised as ollows:

1) Funds are being directed into a program that little is known about. There is no state policy regarding adult foster homes and no plan exists for how, where and when homes will be developed.

2) Functional assessments are not conducted on the adult foster home population to identify if placements are appropriate or if client service needs are being met.

3) Although approximately 50% of the adult foster home population is over 60, and there is no formal role established for the Area Agencies on Aging or Bureau of Maine's elderly.

4) There is no formal training available to adult foster home operators.

Question:

Should the Aging Network be involved in the adult foster home program? If so, how?

Congregate Housing

As defined by state regulations, congregate housing provides housing facilities and social and health services to functionally impaired elderly persons who are no longer able to live independently

yet do not require the constant supervision or intensive health care available at nursing homes.

In Maine and nationwide, congregate housing is in an early development stage. Three congregate housing projects (located in Old Town, Rockland and Farmington) are currently in operation in the State and two additional projects (located in Brunswick and Portland) will open by the end of the year. Approximately 100 elderly will be served by these five projects. These project represent either HUD federally designated or DHS state certified congregate housing programs. For purposes of this paper only federally designated or state certified congregate housing programs will be discussed.

There are a number of common features among these congregate housing projects. Each of these projects is a federally subsidized apartment complex for the elderly. Each offers an accessible elevator building containing private, fully equipped apartments and common dining, kitchen, lounge and laundry areas. Financial assistance for the operation of these facilities is provided by the Federal government through HUD or FMHA.

Each of these projects offers an array of on-site services including case management,[1]. meals, housekeeping, personal care, nursing services and transportation. Services are provided to tenants on an individual, as needed, basis. Most services are provided through existing community agencies such as home health agencies, area agencies on aging and homemaker agencies.

Funds for these services programs are provided through Federal demonstration funds (for Old Town, Rockland and Brunswick) and state demonstration funds (for Farmington and Portland).

At each of these apartment complexes a small percentage of the total tenant population consists of impaired elderly who require the on-site congregate housing services program (CHSP). These tenants may be referred as CHSP tenants. Other tenants living in the complexes are "independent" functioning elderly who do not require the array of on-site services.

The integration of the impaired with the independent in these programs was planned for two major reasons: (1) to create a residential (non-institutional) character to the building and program and (2) to encourage the informal support of CHSP tenants by other tenants. For those projects now in operation these goals appear to have been met.

In summary, congregate housing offers fully accessible, subsidized, private apartments with access to common dining and activity areas. In addition, it offers an array of community based health and social services coordinated through a mechanism of professional assessment and service planning.

When the Maine legislature appropriated demonstration funds for congregate housing in 1980 it was interested in congregate housing as an alternative to boarding homes for the elderly. Boarding homes offer shared bedrooms, dining rooms and activity rooms; congregate housing offers private, fully equipped apartments as well as shared common dining and activity areas.

There are also major differences between boarding homes and congregate housing in terms of the way in which elderly receive supports (meals, personal care, etc.) in these settings. In boarding homes a number of intensive services (i.e. 24 hour supervision, administration of medications, preparation of 3 meals a day, etc.) are provided to all residents even though some may not require this degree of support. In congregate housing, tenants perform tasks they are capable of performing and support is provided only when necessary. This ensures that supports supplement rather than supplant the capabilities of tenants.

While the housing and service features of boarding homes and congregate housing are vastly different, the segment of the elderly population which they both serve is similar.

Boarding home residents and congregate housing tenants are generally low income, functionally impaired and, prior to moving to a boarding home or congregate housing, were in need of different living arrangements.

The two groups are also similar in that they generally do not require intensive health care or constant supervision.

That the characteristics of elderly living in boarding homes and congregate housing are similar suggests that congregate housing is an alternative to boarding homes for the elderly. The suitability of congregate housing as an alternative may be examined in light of the features and cost effectiveness for the State of Maine of this living arrangement when compared with boarding homes.

Regarding the future of congregate housing, it is important to recognize that creating congregate housing requires housing resources to establish facilities and social service resources to establish services programs. Due to Reagan administration policies the future availability of new subsidized housing resources will be extremely limited and the likelihood of federal funding for social services in congregate housing is highly unlikely due to Reagan administration policies.

It therefore appears that the future availability of social service resources for congregate housing will require a commitment of state funds. Funds will be needed to continue the two state demonstration programs and if additional projects are to be developed to provide social services in these settings.

Question:

Should the Aging Network support a legislative request to continue and expand congregate housing service programs for the elderly?

Shared Housing

Unlike the previously described housing alternatives which are designed for impaired elderly, shared housing is an option for the relatively independent functioning elderly.

The term "Shared Housing" refers to a living situation in which at least two unrelated persons live together in a dwelling unit, each having one's own private space and sharing other common areas, such as kitchen, living and dining areas.

The term "Shared Housing" places equal emphasis on both words. It is physically distinguished from other options in that it is a single dwelling unit that is shared. A dwelling unit by definition is one that contains all the interior space necessary for living; i.e. bedrooms, living/dining areas, kitchen and bathroom or bathrooms. "Shared Housing" is socially distinguished from other options in that an unrelated "family of choice" shares a single dwelling unit.

One major difficulty home sharing addresses is economic. Sharing reduces the cost of shelter and attendant costs. Other gains from sharing are increased social contact and assistance with home maintenance and upkeep.

There are two program appraoches that will accomplish "Shared Housing": (a) a "house" or "apartment sharer" is paired with a "house" or "apartment seeker" either through individual initiative or through the auspices of a match-up agency, (b) some agent (religious or community organization) will sponsor a "shared living residence" of anywhere from 3 to about 15 persons.

Several appraches to developing shared housing in Maine were initiated since the last Blaine House Conference. A survey of individuals on a waiting list for subsidized housing was conducted. The initial survey of 63 individuals on the waiting list for subsidized housing resulted in a response from six. Those individuals seem to favor shared housing but not for themselves.

Although there was evidence of interest, more in-depth study is needed to achieve clear cut answers.

Further study has been initiated by the Bureau of Maine's Elderly. A grant has been given to and matched by Central Senior Citizens Association, one of the five area agencies on aging. Results from Central's Home Sharing Project are expected to be:

1. A file of data and information of various home sharing models in existence.

2. An identification of potential "home sharers" - 200 individuals interviewed for possible home sharing.

3. Identification of barriers to home sharing, and ways to remove the barriers.

4. Development of a system for matching and follow-up of home sharers.

5. Actual matches of home sharers.

Projects or components of this home sharing project can be replicated in other areas of the state. As with any project, follow up, publicity, and including prospective home sharers in the planning would be important.

The other products of Central Senior Citizens' home sharing project need not be duplicated in other parts of the state. Those projects - the file of data on various home sharing models and information on barriers to home sharing - will be applicable and usable statewide.

A determination of the future of "shared housing" in Maine needs to be made.

Questions:

1. Should there be "Shared Housing" statewide?

2. Should there be coordinators available to promote and encourage shared housing?

QUALITY, SANCTIONS AND INCENTIVES FOR LONG TERM CARE WORKSHOP

October 6, 1982

Chairman: Rosaire Paradis, Member, Maine Committee on Aging

Co-Chairman: Mae Parker, Delegate, White House Conference on Aging

Resource Personnel:

Beverly Tirrell, South Portland Health Services
Isabella Tighe, Bureau of Medical Services, Dept. of Human Services
Jack Hunt, Legal Services for the Elderly, Inc.

Delegates

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Kaye Hulsey
Susan Johnson
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Isabelle Martin
Stephanie Martyak
Carol Mercer
Ken Morgan
Lois Morrison
Fannie Moulton
Joyce Nye
Armand Plante
Lib Sanborn
Madeline Smith
Erwin Szawlowski
Peter Walsh
Peggy Winston
Marie Wolf
Jean Worsham

ABSTRACT OF WORKSHOP PAPER ON QUALITY OF LONG TERM CARE: INCENTIVES, SANCTIONS AND CERTIFICATION

(Copies of full text available from Maine Committee on Aging)

Introduction

This paper will examine some issues relating to quality of long term care, with primary focus on two aspects of long term care; namely nursing home care and home based care services. Because of the extensive subject matter which could be discussed, and because of limited time and space, this paper will concentrate on specific methods of addressing quality issues. Specifically, the nursing home care discussion will center on two sanctions for enforcement of quality of care in nursing homes...receivership and a system of fines and penalties. The home care examination will center on the issue of quality of care provided in a home sitting by proprietary, non-proprietary and non-agency providers.

Quality of Care in Nursing Homes

The task of evaluating quality of care in nursing homes is a difficult one for a number of reasons. First, because the nursing home provides a great many services to the residents, evaluation of overall quality of care is difficult due to all of the factors involved.

Second, because usually the most important factors contributing to high quality of care in nursing homes are related to the treatment of residents by staff with respect, dignity, compassion and friendliness, quantification of such factors is almost impossible.

Third, the ability of residents to evaluate homes or to act on those evaluations is limited due to the limited physical and mental capacities of many of the residents.

Finally, placement choices are severely limited because there are a limited number of homes that the consumer can choose from which are close to home, relatives and friends. Some facilities admit patients based on the amount of care needed, rather than on the need for care. Some facilities require a guarantee of a specified period of time of private pay rates as a condition of admission before converting to Medicaid Assistance. Facilities sometimes deny admissions based on source of payment.

Government's efforts to regulate nursing homes have usually been drastic ones which have not been totally sucessful. Adequate enforcement mechanisms have not been available, with most states relying upon the remedies of delicensure and closure to ensure compliance with the state's determination as to the minimal quality of care. Because these remedies result in transfer trauma among residents, increased nursing home bed shortages, displacement of nursing home em-

ployees and deprivation of a substantial property interest of the owner, they are not utilized frequently and only where nursing homes are in flagrant violation of important standards of care.

In recent years, numerous state legislatures have enacted revisions to their nursing home legislation to provide enforcement mechanisms such as civil fines and receivership to more effectively address the various quality of care issues.

Civil Fines

A civil fines or civil forfeiture system is a system whereby the regulatory agency directly assesses a facility a monitary amount for identified deficiencies in quality of care. Regulations are classified into categories which carry larger fines according to the severity of the violation. A total of 27 states have civil fines systems established by statute.

The intent of a civil fine system is to remedy deficiencies rather than to punish the homes.

A fines system is also attractive in that it provides a possibility of revenue for the state which may recover the cost of the assessment process. Fines can also be put back into the state's general revenue fund or into specific programs that encourage quality nursing home care.

In principle, the amount of the find should exceed the expenses which a facility may avoid by violating the law. All state fines statutes set specific amounts or ranges of amounts generally falling in the range of $500 to $5,000 for serious violations and $50 to $1,000 for less significant violations. Most statutes also provide for forfeiture of $25 to $1,000 a day for continuing violations.

A civil fine system is only effective if the fines are actually collected, and a variety of means of collection are provided by the various state statutes. The most common is a civil action by the Attorney General or County (District) Attorney to collect in court. Some states allow the state to collect directly from funds owed the facility, usually out of the Medicaid Program. While this assures collection, it could result in a negative effect on care received by Medicaid patients. Other states add the sum of the fine to the license and allow the state to revoke the license if it fails to pay the civil fine.

The American Bar Association points out two practical problems with civil fines. "First, nursing home costs are sufficiently elastic so that many facilities may be able to cover the forfeiture out of funds which would otherwise be spent on care delivery rather than cut their profits. To some extent this behavior can be deterred by denying Medicaid or Medicare reimbursement for the cost of paying for forfeitures, by requiring that the forfeiture be paid by receiving reimbursement components intended to provide profit, or by closely monitoring conditions in the facility and further penalizing any deterioration of care."

An even more serious problem, the American Bar Association notes, is "the impact of civil (fines) on a facility which, either because of poor management or lack of resources, is already losing money or is in the process of being abandoned. In these situations an imposition of a forfeiture may only hasten the deterioration of the facility."

Despite these problems, a civil fines system can be an important component of an effective nursing home enforcement system.

Currently the Department of Human Services is considering a civil fine system for Maine's nursing home enforcement system.

Question:

1. Should the Department of Human Services submit a nursing home civil fines bill to the 111th Legislature?

Receivership

Because closure of a nursing or boarding home can have devastating effects on the residents, 15 states have established receivership provisions in their statutes which allow courts under certain circumstances to place homes in receiverships.

An enforcement mechanism which can keep a facility open and allow rehabilitation while new ownership is sought or which can maintain adequate conditions while preparing residents for an orderly transfer prior to the facility's closure was necessary. Receivership provides the mechanism to respond to these needs to protect residents.

Receiverships are used when the facility is operating without a license to the detriment of the welfare of the residents; when a facility intends to close but has not arrange for orderly transfer of its residents; when an emergency exists in a facility which threatens the health, safety or welfare of residents; or when a condition exists in a facility which is in substantial violation or habitual violation of the standards of health, safety or resident care.

The court, upon finding that any of the above conditions exist, can appoint a qualified receiver to operate the facility and to remedy the conditions which consituted grounds for the receivership, to protect the health, safety and welfare of the residents and to preserve the assets and property of the Residents, the Owner and Licensee.

Some problems which have surfaced in the use of receiverships include the financing of the rehabilitation or relocation activities; the difficulty in finding qualified receivers; the lack of under-

standing of the remedy by the judiciary; and the potentially long amount of time it may take a receiver to accomplish the task of rehabilitation.

The Maine Committee on Aging drafted a receivership statute which was considered by the second session of the 110th Legislature, and which was withdrawn. The Maine Health Care Association (MHCA) raised some concerns about that draft bill which centered on their belief that the underlying philosophy of the bill was "that the State should be able to take over a private nursing home for a period of up to two years and continue to operate the property as a nursing home, without sufficient protections and safeguards to the owner." Since that time, the bill has been redrafted to respond to many of the concerns raised, and we hope will be endorsed by the Governor who will introduce it in his package to the 111th Legislature this fall.

Question:

1. Should the Blaine House Conference on Aging endorse a receivership bill for nursing and boarding homes?

Quality of Care in a Home-Based Setting

The issue of quality of home based care services is a difficult issue to address. It involves a number of subjective and complex matters and is not readily subject to measurement. In this discussion, observations and impressions are therefore offered in an attempt to address this elusive issue.

Quality of home based care can best be addressed by attempting to determine whether services are being provided in an effective and responsible manner. As increased public dollars are made available to provide home based care services, it is important to consider quality issues. However, it is also important to consider that "most long term care services are provided by family and friends or are purchased through private resources, despite substantial and growing public subsidies."[1] An estimated 60 to 80 percent of all long term care services are provided by families. These services range from personal services to transportation services to meal preparations. Currently, some family members are being provided financial assistance through L.D. 1620, the Home Based Care Act to assist them in providing home based care for their relatives. This raises the issue of whether family members reimbursed with public dollars should be evaluated as to the quality of care being provided, and how that evaluation can be accurately conducted. As to whether the services provided by the family are effective and responsive to the client's needs, such a determination is made in the initial assessment conducted before any expenditure is authorized.

1. Cost Containment in Long Term Care: Options and Issues in State Program Design, Lewin & Associates, Inc., January, 1981.

The Maine Community Health Association (MCHA) contends that "the client/family assessment is critical in determining the health and social status, the level of care needed, the type of worker to provide the care, and the level of supervision needed to assure the safety of the client and the worker." The issue of whether assuring the "safety" of the client and worker is a necessary component to quality care is still one which is open for further discussion. If the desires of the client are first consideration, many contend that clients have the "right" to live in what some may consider unsafe conditions.

The Maine Community Health Association also admits that safe quality care is essential to meeting the needs of the individual. The key to safe home care is matching the client's needs with the appropriate worker who has adequate training, judgements and skills to work independently in the home. All workers must have access to professional consultation and supervision as necessary, particularly as the needs of the client/family change. In providing safe care the MCHA urges consideration of the following components:

1) If the predominent client needs are health related, the assessment must be done by a qualified health professional.

2) Workers providing care must have the appropriate education, experience, and judgement to work independently in the home environment.

3) Supervision of care must be appropriate to the levels of workers involved, the level of care needed, and the degree of functional ability of the client/family unit to manage their own care.

4) There must be a mechanism for coordaintion of the services and workers when a mix of services are delivered.

5) A sound administrative system is important to ensure sound fiscal and personnel management to protect the client and worker against fraud and abuse.

6) An objective evaluation of the care given is needed as well as the outcome of that care and the soundness of the administrative management of services.

7) Except where a client or family is capable of hiring and directing the worker, the Maine Community Health Association believes the only safe system is for workers to be a part of a whole system of home care under the auspices of an agency who has well established standards of care and professional supervision.

The observations by the Maine Community Health Association present some important points which are vital to a quality home based care program. Whether the issue of quality is necessarily synonymous with "safe" is still debatable and one that should be further pursued.

Furthermore, the issue of what"appropriate education, experience and judgement" constitutes is also one which must be further explored.

The Maine Community Health Association's last observation is one which warrants further examination and discussion. Again, the issue of a "safe system" of home care is raised. Furthermore, the suggestion that "workers...be a part of a whole system of home care under the auspices of any agency who has well established standards of care and professional supervision" is one which needs further explanation. What constitutes such an agency? Is the Maine Community Health Association suggesting that such agencies be certified or licensed? Would both proprietary and non-proprietary agencies be included? Homemaker agencies? These are questions which the Maine Community Health Association position papaer has raised which warrant further discussion.

Finally, do the type of agencies providing service have any correlation with the quality of care provided? The Home Health Services Association* observed that -

> "giving a patient a choice between several providers regardless of whether they are profit or non-profit, will naturally lead to a choice of the agency which has the reputation for delivering the best quality care."

On the other hand, the Department of Health and Human Services has found that

> "traditional providers of services and physicians...who refer patients...tend to take an opposite position - that increased choice and competition will adversely affect the quality of care."

However, the Department of Health and Human Services found that "our...review of home health operations certainly does not provide sufficient basis to confirm or contradict either of these positions. However, on the basis of our conversations with those most directly associated with the delivery of services...we gain the impression that there are generally no significant differences in the caliber of services being delivered by the different types of agencies. Furthermore, we sense that the quality is typically quite high."

The Department of Human Services, Bureau of Maine's Elderly will be conducting a client/family satisfaction survey during the month of October. Although the information obtained will be somewhat subjective, it will still provide useful information to the Department of Human Services and lead case management agencies.

*Home Health Services Association, Washington, D.C., Competition: An Emerging Force in a Change Home Health Field, A Supplemental Analysis, November, 1981

Questions:

1. Should a further examination of the issue of quality and its correlation to safety in home based services be made? If so, how, and on what services?

2. Should criteria for the assessment of quality in home based services be established? If so, by whom?

3. Should the Department of Human Services take steps to assure that more non-institutional long term care services are available to older citizens?

UTILITIES WORKSHOP

October 6, 1982

Chairman: Wilfred Pombriant, Member, Maine Committee on Aging

Co-Chairman: George Forbes, Delegate, White House Conference on Aging

Resource Personnel:

Paul Fritsche, Public Advocate's Office
Barbara Morris, Southern Maine Senior Citizens
Rodney Quinn, Secretary of State
Al Warren, New England Telephone

Delegates

Ames Alden
Laurel Atkinson
John Baillargeon
Paul Belanger
Helen Berube
Winnie Black
Marion Blanchard
Al Blood
Pat Born
Herbert Brown
Paul Colson
Rodney Crockett
Geneva Davis
Keith Dexter
Elva Dilling
Millie Diringis
Hilda Doten-Doyon
Jennie Downing
Keith Gates
Helen Goodine
Elsie Holt
Frank Leonard
Ursula Levesque
John McGuire
Louise Murchison
Francis Noyes
Harriet Noyes
Merton Perkins
Loretta Sharpe
Dana Sidelinger
John Telow
Charles Wright

ABSTRACT OF WORKSHOP PAPER ON UTILITY SERVICES

(Copies of full text available from Maine Committee on Aging)

Introduction

There are a number of issues affecting older citizens in the State which need to be considered at the Blaine House Conference on Aging. Although each issue is distinct, each has been identified as needing study by older citizens. Therefore, we included several topics under the general theme of Utility Services. Included in this discussion are transportation services, the requirement of driver exams for individuals over age 75, telephone use by older persons and electricity dilemmas.

Transportation

Determining the adequacy of existing transportation resources is a difficult task due to the following:

1. Most of use do as much or as little as our resources will allow us, especially in terms of our mobility. This makes it difficult for planners and providers to determine whether people's transportation needs are really being met and what additional services are necessary. It's difficult to judge what services are needed as opposed to "nice" to have.

2. Transportation resources tend to be available only in our larger cities or towns, while the majority of Maine people live in rural areas.

3. There is very little real information or data available on which to make decisions.

4. Formal needs assessments are complex and costly.

Consequently, there were various management, policy, and legislative actions taken in the late seventies which brought above more planning and greater input into the decision making process, increased funds, more efficient use of available equipment, and the development of more extensive and better planned bus routes. The Department of Human Services began to require social service programs to make as much use as possible of local transportation providers, rather than having their own transportation networks. In 1979, the Legislature enacted LD 1556, requiring regional, coordinated transportation systems, in accordance with annual regional operations plans. The Bureau of Public Transportation was also established at that time to encourage the development and maintenance of a permanent and effective public transportation system, with particular regard to low income, elderly, and handicapped residents.

Despite this increasing coordination and better use of resources, it has been necessary to make reductions in transportation services.

Although the primary funding sources for transportation services in Maine have been able to maintain their level of financial support; inflation has increased the cost of gasoline, vans, buses, and insurance rates. There has also been cutbacks in federal support for all types of social service programs and development funds to municipalities. Recently program priorities on the state and local level have also been concentrating resources to in-home services and to those frail elderly most in need. This has also resulted in cuts in transportation services in some areas of the state.

Recent new requirements that the transportation systems receiving federal funds be increasingly available to the general public have also strained existing resources and created competition among the elderly, the handicapped, the poor, and the general public for the remaining available transportation resources.

Legal requirements, state policies and procedures, and agency mandates affecting those involved in transportation services should ensure that the most crucial problems of those most in need will be met. The basic issue is whether you feel the transportation needs of older people are reasonably being met.

Consider the following:

1. Do existing planning and bureaucratic procedures ensure adequate public input and accountability?

2. Are the most important needs being met overall? Should transportation be made a high priority with greater resources, possibly redirecting the recent reduction of resources to the frail older people and in-home services?

3. Transportation providers are generally told by most older people that transportation for medical needs is adequate, but that more transportation is needed for meal programs, food shopping, and for social and recreational activities. Do you agree?

4. If transportation needs are not being adequately met, are the shortages significant enough to request special additional funds from the Legislature? Who should determine the funding level? For what client group should funding include cost of needs assessments or marketing studies?

5. How many older people are aware of what agency or group in their area is responsible for allocating local transportation resources, and how input can be given? What steps might or should be taken to insure greater awareness of these procedures and more input by older people in these decisions?

6. What other non-traditional means and incentives might be devised or suggested to meet some transportation needs?

7. What can be done to increase participant contributions to the transportation programs? Many who could afford to give do not do their share.

Another transportation issue deals with the well elderly person who is still able to drive. The current state requirement of a formal road test every two years for drivers 75 years or older has recently been publicized, and it has developed into a topic worthy of discussion by the Blaine House Conference on Aging.

The discussion centers on the current law 29 MRSA 545B which states that "any person who has attained his 75th birthday shall pass a driver's examination before his motor vehicle operator's license may be renewed." The law originated most likely because aging drivers generally experience some loss in faculties and a driver's examination to those 75 and over was considered as a protection to both the elderly driver and to other drivers on the road.

That contention is fiercely debated, however, by accusations that the law is discriminatory and that any loss is almost invariable compensated for by increased judgement or caution on the part of the driver.

Rodney S. Quinn, Secretary of State, has provided the following facts for your consideration.

In 1981, there were 12,781 biennial tests of elderly drivers. Thirty percent of those or 3834 individuals were required to take their tests more than once. Mr. Quinn points out, however, that many individuals fail the examination the first time because of nervousness, bad habits or by being frightened by the process. In 1981, less than 20 individuals were actually taken off the road as a result of test failure.

1978	10,826 tests administered	2955 persons failed
1979	12,386 " "	3311 " "
1980	13,008 " "	3423 " "
1981	12,781 " "	3834 " "

Maine is one of only fifteen states that requires drivers over the age of 75 to pass an eye exam and road test in order to keep their drivers licenses.

Maine accident figures show people above 75 are considerable better drivers than those under 25. Interpreted another way the figures may indicate that elderly drivers use more caution and better judgement resulting in better driving records. An informal survey of automobile insurance companies in the Augusta area showed a reduced premium to individuals 65 years and older. Although the information is inconclusive, it indicates older people are considered a better insurance risk.

Secretary of State Quinn is considering a new program which will use the personnel now employed under the examination system and would require no additional hiring. It is a voluntary program of driver education.

Drivers approaching a 70th birthday would receive a packet containing a driver's manual, current safety bulletins and a letter describing the voluntary evaluation system. The procedure would include a short briefing and an on the road evaluation, followed by suggestions for improving driving habits.

The evaluation would not be given for the purpose of pulling licenses. If improvements are needed, the individual would be provided with information necessary to improve the weaknesses identified through the program.

QUESTIONS:

1. Should the Blaine House Conference on Aging support the repeal of the existing law requiring those over 75 to take a driver's examination every 2 years?
2. Does the Blaine House Conference on Aging support the concept of a voluntary program which contacts drivers approaching the 70th birthday and offers the opportunity to review driver skills?
3. Does the Blaine House Conference on Aging believe the voluntary program should be available to licensed drivers of any age?

Telephone Use by Older People

Last year, New England Telephone presented a proposal to the Public Utilities Commission which would have tested the concept of "measured services" in the Portland area. Instead of a flat rate for unlimited local calls, a customer can choose to pay a lower monthly rate plus a charge for each call. Each call is priced according to:

1) number of local calls made

2) distance of local calls

3) length of call

4) time of day of call

For a variety of reasons, the proposal was not accepted by the PUC.

The Committee on Aging studied the proposal and raised a number of questions about it. During the review of the proposal, we discovered that we know very little about the use of the telephone by older persons and how important a role it is in their lives.

Barbara Morris, Southern Maine Senior Citizens Association, prepared the following paper about Human Values and Telephone Use.

In contemplating telephone billing in terms of "message units" as opposed to flat rates, it is profitable also to examine the pro-

posed change in light of human values and how a shift will affect each one of us both now and in future years. Much has been said about one class of users subsidizing another class; however, the concept of general subsidy for the good of all is part of our national well-being. Those who do not use highways contribute to their upkeep. Those who are past using schools pay for education for the common good. Because communications is part of the national fabric, it also seems proper that we maintain general use, unhampered by an intricate toll system.

Let us examine the need where it is clearly evident: in the lives of the handicapped and elderly. Let us also remember that, while many of us will never be handicapped, short of the obvious alternative, we will all be old. This is the future.

The daily reassurance call to elderly or other shut-ins has become a necessary commonplace; the elderly often call each other. Such calls would easily account for almost all the message units a month; it would be understandable if the system broke down in favor of saving units to call family.

Yet reassurance calls are brief. Telephoning into the general community to talk at some length has other uses. For lonely, isolated people it may be the major prop to emotional health or even physical well-being. Here are a few of the callers.

In a single nursing home like K. and Sis. Their entire life space has dwindled to half of an institutional room. Both have telephones. K., an old woman, telephones her large extended family constantly and cannot be persuaded to leave her room for recreational opportunities lest she miss an incoming call. Sis, born with hydrocephaly and spinal bifida, is only thirty and already a veteran of nursing home life. She is surrounded by elderly and her telephone is her only entry to a younger world that will never be hers.

E. is an old woman who has become afraid of everyone. Teenagers throw rocks at her house. This winter she was without food delivery for many days and finally summoned the courage to telephone a neighbor. She now receives calls.

C. and L. are crippled with arthritis. Canes and arm braces are treacherous aids in a Northeast winter when the footing is slipperty for weeks at a time. The telephone is their only way of remaining a part of community life.

The above are only a few of those who would be affected by message unit use. As one of them commented on the process of aging, "You just have to get used to the idea that getting older is giving up and giving up . . . until some day you have to give up yourself."

"Giving up" is common to all of life, for one fourth of the population can expect to be widowed before 65. After that, the "giving up" of spouses rises rapidly, as does the relinquishing of siblings and friends. Pervasive loneliness is common to the old.

One might review his/her own telephone use and multiply that need by the factors of loneliness or bereavement.

Physical isolation is not always due to weather. The older person may live in a rural or suburban area, be unable to drive and live alone. The city resident may be afraid of the streets and purse snatching. The diminishing of funds may prevent entertaining and the ordinary comings and going typical of the younger citizen.

The "giving up" can easily develop into depression. Alcoholism increases, and the suicide rate after 65 rises dramatically for men. As one national authority says, "Perhaps the most preventable are suicides relating to depression." Other effects are also legion; depression may keep a person from eating, and malnutrition may occur. Malnutrition often triggers other physical and brain disorders. The one constant and certain treatment for depression, despite other means of medical intervention, is human contact.

Most families with older relatives know well the importance of unrestricted telephone use. The message unit would most certainly diminish freedom of communication. Relatives might well supplement the cost of a flat rate to an older person, but message units would only cause uncertainty and familial stress. Those with aged parents know how likely it is that the elderly callers would keep records of whom they call, where they call, and how long they talk. Surely telephone subscribers will not descend to petty quarreling that the Joneses use the phone more than the Smiths and that one person "subsidizes" another. Surely one day each of us will be the recipient of more than we may pay; time and aging are great levelers for us all. What we set as practice today will be tomorrow's heritage. Let there be a reconsidering and a search for decent, caring options.

During the discussion in the workshop we hope to have you react to the ideas expressed in the paper prepared by Barbara Morris. Additionally we ask that you consider the following questions and be prepared to discuss them in the workshop:

QUESTIONS:

1. Is the telephone important to older people?

2. Would the lower cost of measured service force older people into using the telephone less, resulting in increased isolation?

3. It is often asserted that the telephone is important to older persons so that friends and family can call in to check on the individual and that the older individual rarely needs to call out. Do you agree with that statement?

Electricity

The Maine Committee on Aging developed a questionnaire which was administered to elderly citizens in 1981 in order to determine their opinions on a series of issues. The one-page questionnaire was completed by 2,449 elderly Maine residents.

Almost one-third of the elderly who responded to the questionnaire indicated "money/financial problems" as the worst problems facing older people. The "high cost of heating/fuel/electricity" was the second most frequently mentioned concern.

Electricity as the primary heating source is in comparatively high use by elderly as opposed to other segments of society, although no accurate data is available by age grouping. The use of electricity as a primary heat source for federally assisted housing is a major contributing factor to the high utilization of electricity by elderly, especially in certain areas of the state.

In the past, when provided the opportunity to present testimony on proposed rate increases by utility companies, the Maine Committee on Aging has typically taken the position that elderly individuals do not want special rates and that rates should be based on usage, with low usage and conservation being rewarded. Because the elderly tend to use smaller amounts of electricity and tend naturally to conserve, it was perceived as the best approach to encouarge conservation, and wise use of electricity, ideally resulting in lower costs.

Because of the rising costs of electricity, the average monthly cost of heating a home with electricity in 1978 was $55 a month, compared to $78 in 1981. With the high degree of concern with cost, the question becomes whether it is feasible to pursue the position that elderly persons do not want separate rates based on their income and age as opposed to rates based solely on usage.

Past Programs - Lifeline Program

In 1975, the Maine Legislature enacted the Older Citizens Lifeline Electrical Service Law designed to "insure an adequate electric utility service to older citizens at a price they can afford" through the creating of a one year demonstration program.

Three electric utilities were directed to participate in the program and the areas of Portland and Rockland, Bangor and Ellsworth, and Caribou and Fort Kent were chosen as the communities where low income older people would be allowed to obtain electricity at rates more favorable than other residential customers. The program began December 1, 1975 and served 2,619 low income older people. The law provided that, should implementation of the program cause a loss of revenue to a utility, additional revenue could be obtained from other customers in the demonstration communities to cover the loss of revenue from implementation of lifetime rates to low income older people.

All considered, the program ran smoothly. There was some adverse public reaction to the surcharge, especially in Caribou and Fort Kent where the surcharge was relatively high. Among participants themselves, the program was popular.

The evaluation of the Lifeline program, which ended in early 1977, indicated that the program provided significant benefits in the form of cheaper electric rates to participating low income older people. It did not impose significant financial burdens on the participating utilities. The users of the lifeline program showed about the same pattern of consumption as they did in years prior to the program.

Current Activities

The Public Advocates Office has indicated that it has supported the elimination of the customer charge and the substitution of a minimum bill which would have the effect of reducing bills for all low residential users. In addition, they will be seeking, in the now pending Central Maine Power rate design case, to have a fair allocation of cost among the residential, commercial and industrial classes such that the residential class does not end up paying more than its fair share. Additionally, they will support inverted rates which provide lower rates for lower usage, and a higher pre-unit rate for the higher blocks of usage. Lastly, it would be possible, after all the above steps have been taken, to determine that a deviation from those cost-based steps would be appropriate to provide below cost lifeline service for the residential class for essential needs. Since that benefit will result in other customers paying more, it might be wisest to limit the benefit to those people, both older and younger, who have limited financial resources. The Central Maine Power Company rate design case had little if any testimony relating to lifeline rates. It would probably be necessary to begin a new proceeding which would be lengthy under Section 114 of the Public Utility Regulatory Policies Act of 1978, which provides that a state may approve a vote for essential needs which is below the cost to the utility of providing that service.

The other alternative, if the Legislature appears supportive, would be to ask the Legislature to enact a law requiring the Public Utilities Commission to institute a lifeline rate by a deadline. The Public Advocate is now drafting proposed lifeline legislation for possible inclusion in the Governor's legislative package. They would welcome the comments of the delegates to the Blaine House Conference on Aging regarding lifeline or any other public utility issue.

QUESTIONS:

1. Does the Blaine House Conference on Aging support the position of the Public Advocate's Office, including the fair allocation of cost among residential, commercial and industrial classes, and inverted rates for lower usage?
2. Does the concept of a lifeline rate make sense for elderly and low income persons?

V

STATEMENTS OF SPEAKERS

BLAINE HOUSE CONFERENCE ON AGING
October 6, 1982

WELCOMING REMARKS

John B. Truslow, M.D., Chairman
Maine Committee on Aging

I am Dr. John B. Truslow of Biddeford, Chairman of the Maine Committee on Aging. I have the honor of sharing the chairpersonship with Trish Riley, Director of the Bureau of Maine's Elderly - and in our joint behalf to welcome you to the 8th Blaine House Conference on Aging. The Maine Committee on Aging is pleased to see many returning delegates to the Blaine House Conference on Aging and delighted to see many new delegates.

Once again it will be our responsibility in this Conference in the short period of two days, to review the issues before us in the workshops, to study them carefully and to try to develop creative and responsible resolutions to the issues discussed. You have been provided with workshop papers. These are not designed either to limit the discussions or to present a check list for coverage. Their purposes are principally two - to suggest an appropriate area of discussion, and, particularly for the less articulate of us, a frame of reference for specific issues. Let us remember we are not here for ourselves, but in so far as possible, to represent the interests of those unable to be here. Just in the age group 60 and over in Maine we are 191,000 or 17% of the total state population. Our purpose is to be aware of the challenges of growing older and to seek ways to assist individuals to meet these challenges by maximizing our own individual resources and capacities, mobilizing attitudes and capabilities of support in our families and our communities, and falling back on public funds primarily to help us to help ourselves, and to assume some of the necessary burden of sickness and poverty and human frailty.

There will be a reception for the White House Conference on Aging delegates this afternoon after we have completed today's work in the Fort Western Room of the Civic Center. I hope you all can attend, to talk with the delegates to learn about their experience in Washington, and perhaps their views on the impact of the conference on national policy and legislation.

The Blaine House Conference this year is being run on a somewhat tighter budget and therefore tighter time schedule, than ever before. The five area agencies on aging should be recognized for contributing more than they have every before toward the cost of running this conference. In addition, Central Senior Citizens Association did all the arranging for the play scheduled for this evening. The Owl Players from Vermont will present "An Elderly Gentleman Seeks..."

The lower budget means that tomorrow's meeting will be held at the Augusta Armory. We are also asking that delegates make a donation tomorrow for the lunch. We will remind you of this tomorrow.

At this point the program calls for my summary of the 1980 Blaine House Conference on Aging update, circulated to all of you as delegates to this conference. It is a record deserving reiteration and praise, but given the purposes of time, there is another matter needing our earliest consideration.

The Planning Committee for the Blaine House Conference on Aging this year was composed of older representatives from each area agency on aging. The Planning Committee made a decision, based on experiences and impressions of recent conferences, that only delegates over age 60 be allowed to vote in the workshops and in the general session. It resulted from a lengthy discussion and a substantial final vote and principal arguments included: the primary identification of those age 60 and over with the issues raised at the Conference, the enormous influence already of full-time staff personnel upon the shape and form of programs, and upon the views of our older citizens whether Board members or clients of the programs, and indeed the influence at the Conference of their special role as resource people.

For a majority of staff persons involved in Maine in programs and advocacy for the elderly, one can imagine this appears to be pretty rough treatment, and it has not been surprising to hear several voices raising questions as to the fairness or the propriety of their deprivation of voting rights in this Conference, solely by virtue of age. Increasing numbers of us appreciate our debt to these young and healthy and daily-aging clericals and professionals in programs for the aging which are being steadily underfunded in terms of public funds.

I have introduced this matter to anticipate its appropriate consideration in "The Overview of Workshop Rules and Procedures", following the address by Commissioner Petit, and to suggest that its deliberation at this time in view of our time constraints for the discussion of some very pressing issues, be voluntarily limited to a vote by people age 60 and over.

1. Support or rejection of the Blaine House Planning Committee's decision to recommend that only delegates over 60 be allowed to vote.

For my part, I pledge that this issue, whatever the outcome of this vote, shall be a matter of early concern and study by the Maine Committee on Aging so that there will be no questions about the guidelines for voting in future Blaine House Conferences. (The over 60 delegates voted to allow all delegates regardless of age to vote in the workshops and in the general session).

Now, I shall turn the meeting over to Trish Riley, the Director of the Bureau of Maine's Elderly, who will introduce to you, Michael R. Petit, Commissioner of the Department of Human Services.

WORKSHOP SESSION
October 6, 1982

ADDRESS

Michael R. Petit, Commissioner
Department of Human Services

Since I was asked to be the first speaker here today, I thought it important to help set the tone for this two day session.

The topics you are discussing are critical and controversial. Undoubtedly some of your workshop discussions will become heated with debates about who is right, which idea is best - which method is most effective.

My office has great sympathy with such controversy - closing down nursing and boarding homes does not always win friends. Similarly the creation of the Home Based Care Program in the area agencies on aging stimulated some great debates about whether or not those agencies are the best able to perform that important work. But we have made those tough decisions because older people required and deserved more comprehensive and improved services.

The issues over the next two days should not be reduced to turf battles between agencies nor should they be influenced by the political promises of various campaigners. They must focus not on agencies and programs but the people for whom we must advocate and direct our collective sill, interest and resources.

My office receives hundreds of letters a month - many pertain to President Reagan's reductions in social and health services. Among the most compelling are those from elderly people around the state who are often reluctant to ask for government help, despite their need. I want to share some excerpts from those -

"Dear Commissioner Petit:

I am writing on behalf of my neighbors who are in their seventies. Their house burned down and they bought a trailer and had to have a well drilled so must make larger payments each month. He is a diabetic, in a wheelchair, and has had a leg amputated. She cares for him - she is always cold and always exhausted. She won't go to a doctor and says her religious faith keeps her going. She has had many worries and many times they've completely run out of food. Relatives, friends and neighbors help but they are being drained financially."

In another long letter an elderly son of a very old mother wrote and outlined all the family's expenses and income. He said, "My sister voluntarily took leave of absence from her job to come and care for mother who is bed-ridden and has only a small Social Security check each month. Medicaid will pay for her in a hursing home but we want

to keep her home. We need money for taxes, drugs, food. I need a reply as soon as possible as we are all going down the drain."

Finally, from a widow -

"Dear Commissioner:

Please excuse my writing for my eyes are almost blind. My check is due soon but my oil is nearly gone and I cannot pay my other bills. Furnace went bad, water pipes froze in the back room. I pay for four kinds of medicine, my electric bill, my groceries and a cord of wood is $70. Now I even need help to plit it. My birthday is this month - 88 years. Never did I see times like they are now - God, pity the poor - they sure do need it. I lived through Hoover days and nearly starved to death."

To argue about which agency does what, to argue over which politician gets credit for what program is insignificant in light of these compelling needs. It is that need which this Conference must address. These three letters show the spirit and independence of the old.

The old survived one depression only to find another one in their old age. They have relied first on self, families and community but many are finding these resources, for the first time, inadequate to meet their needs. Increasingly as they look to their federal government for help, they often encounter only the empty rhetoric of economic theories to anser them. We are getting very little help from Washington these days as we try to answer the needs described in these three letters.

I believe things are different here for I believe there is widespread commitment - in and out of government - to address the cry for help in these and so many other letters. I do not believe we are satisfied with federal budget cutting which slashes away at programs for the child, disabled and elderly while we build more and more nuclear weapons. How can it be that in a country that remains as wealthy as this one many of our elderly in Maine must struggle to provide food and heat? What kind of values do we hold dear when we allow our federal government to cut food stamps and health benefits to the old and poor?

I do not question the need to end fraud and abuse in government and I do not question the need to reduce the role of government in individual's lives. But those goals are not met by eliminating or drastically reducing basic income, health and social services to the poor.

The letters I cited show quite clearly that government services - as a last resort - are critical to retaining the independence of low income people. If we value the family and the community we need to support them when they need help.

In the past 4 years the aging network and the Department have worked closely together to develop solutions to meet elderly needs. Indeed we are in the process of resolutionizing the long term care system so that it responds to individual needs and so that it recognizes that 80% of the care of the old is provided by families - not government.

In the last 30 years care for the elderly has stripped them of their independence by placing them in institutions where their days are regimented and their rights minimized. Because of federal policy, Maine was spending more than $100 million a year on institutional care and only a small percent of that amount on home care.

I do not think this bias reflects the needs and wishes of the elderly. Instead we have begun to redirect our government resources to a balanced system which recognizes the abilities and independence of the elderly.

When the Brennan Administration took office in 1979 we still had an imbalanced and uncoordinated system of services - it was a system that responded well to the needs of special interest groups but not well enough to elderly needs. We had a higher than average percentage of our elderly in nursing homes and in a five year period we had doubled the number of those beds from 4,000 to 8,000 - with no end in sight.

Keep in mind that a new nursing bed costs about $35,000 to bring on line and $15,000 yearly to generate.

We had a patchwork of services each with different eligibility and funding requirements. Too many elderly who wanted to stay at home were bounced from agency to agency. Instead of a coordinated system, we had a fragmented system.

Because of the concerns the elderly were expressing through such forums as this Blaine House Conference on Aging, we knew some elderly who were entering nursing homes did not need that level of care but they had no choice - no alternatives.

Because of the great changes in family life in America in the last 40 years, nursing homes will always be needed by the very sick and impaired. They should be of the highest quality and many of those in Maine are. But many older people can receive the care they need at home or settings other than nursing homes and boarding homes.

We have taken action to close down nursing and boarding homes which do not meet our high standards of care. We do not intend to tolerate less than the highest quality of care in our institutions and it is for this reason we have closed the nearly 300 beds in the last year or so.

The money saved by these decisions are not the reason why we have taken the steps we have, but by closing institutions and limiting the growth of institutional beds, we are able to provide funds for home care and other alternatives. We can also assure a higher quality of care in those facilities.

Unfortunately cuts in federal funds mean less money available for inspection of nursing homes. However, we do not intend to allow the quality of care in our nursing homes to deteriorate. Although a few facilities will be reviewed for physical deficiencies every year as in the past, we do intend to focus our efforts on facilities most in need of improvement. In every facility we will continue the 6 months review of the quality of care received by each resident. We will also do unannounced random surveys of the few facilities we do not feel the need to review annually. And, of course, we still have the Ombudsman Program. In this way we believe our system will continue to assure quality in our nursing homes.

We have also redirected the boarding home program, expanded the Adult Foster Home Program and developed new housing initiatives for the elderly. The Legislature passed the Governor's congregate housing legislation and today we have a program in Farmington and one to open soon in Portland - converting an old school into apartments. Congregate housing provides apartments for frail elderly who can no longer live alone and makes needed services available.

Through the work of the Bureau of Maine's Elderly and the Maine State Housing Authority, we are also taking large, energy inefficient homes or no longer used inns and converting them into smaller congregate homes in rural parts of Maine. We are working to develop shared homes and to provide means for older people to convert the value of their homes into regular, monthly cash payments - while retaining lifetime occupancy in that home. While the federal government has severly reduced available support for elderly housing we continue our commitment and are developing new means to assure that older people have adequate housing.

Perhaps the greatest achievement we have all worked together to accomplish in the last 3 years has been the creation of the Home Based Care Program. Through that program the area agencies on aging provide needed case management and work with older people and their families to arrange the full array of services needed to keep that older person at home. No longer do older people get tossed from agency to agency; now the case manager works with them to find the help they need.

Through the Home Based Care Act about 600 elderly, disabled and abused, exploited or neglected adults are being served at home, at a cost that is less than the cost of nursing home care. You all deserve praise for the excellent work you have done in implementing this program. You have proved its value and you certainly have the Governor's and my support to continue the program.

The program is working because we have begun to see a decline in waiting lists for nursing homes and an increase in the number of vacant nursing home beds. The program is flexible enough to meet needs in our most rural communities and has even employed neighbors, friends and others to meet an older person's needs.

For those older people who are no longer fully capable of independent decisions, life poses even more threats. Some are being abused, neglected and exploited. Governor Brennan and the Legislature have increased the resources of the Department to provide adult protective services and we now have a law on the books which requires the mandatory reporting of adult abuse. Through these efforts we hope to eliminate or at least reduce the risk of abuse to the most frail and needy adults.

Each day my office receives letters from older people who fear they will have to leave their home. I am pleased to report that in nearly every instance we can now respond with speed and quality services to meet the desire of those older people to remain at home.

The Home Based Care Act is no longer an experiment - it is a proven and effective program to provide needed and appropriate service which must be continued and expanded. You, the delegates to the Blaine House Conference on Aging, should be proud of your record of achievement. Your good ideas have been translated into new and important programs and policies.

Let me close by reminding you again of those older people who require some help to retain their independence. They are your neighbors, your spouses, and may be yourselves. You know them better than I. Over these next few days, think of them.

All the talk of getting government out of people's lives must be balanced against the needs of those citizens and the value we as a society place on their independence.

INTRODUCTION OF THE HONORABLE JOSEPH E. BRENNAN, GOVERNOR

I have the honor today of introducing to you the Governor of Maine, Joseph E. Brennan. Over the past few years, as I have served as Chairman of the Maine Committee on Aging, we have worked closely with the Governor and members of his staff. The Governor has met several times with the members of the Committee on Aging. He listens carefully to the opinions, concerns and desires expressed by the older citizens of the state. Under this administration, Maine has continued to be among the leaders in the nation in terms of constructive programs for the elderly and enlightened leadership in the Blaine House and the Legislature. We modestly presume that derives in no small part from the fact that it has become a custom over the years for many of the Blaine House Conference on Aging resolutions to become legislative and gubernatorial initiatives. We regard this as a custom worthy of continued acceptanece and fulfillment. Ladies and gentlemen, Governor Brennan of the great State of Maine.

GENERAL SESSION
October 7, 1982

ADDRESS

The Honorable Joseph E. Brennan
Governor

I am proud to join you again at what has become, over a period of years, one of the most constructive of annual meetings that I know of.

Over the years the many Maine people who have participated have taken a true leadership role in directing public policy on behalf of Maine's senior population.

Many of the services and programs which today are familiar to us are the results of the concerns you have raised and the priorities you have suggested.

Indeed, the very existence of the Bureau of Maine's Elderly and the five area agencies on aging came about from legislation based on the recommendations of an early Blaine House Conference.

With your advice and support State government has made progress in developing policies that are compassionate and effective.

Over the past four years, we have worked together to forge a more balanced long-term care policy.

The Governor's Task Force on Long-Term Care, which I appointed in 1979, developed a 215 page report containing 50 recommendations.

Those recommendations became an important first step in reforming long term care in Maine.

Likewise we have addressed many of your concerns, and today, as you struggle with difficult issues, I would like to review some of the successes we have achieved together over the past four years.

First, we have responded to the problems and challenges of the new federalism. The State of Maine could not and cannot replace every dollar that is cut or proposed for elimination by Washington. But we have maintained our strong commitment to critical social programs.

Last year the Legislature demonstrated its sensitivity as well. It voted to restore most of the money cut from the Title XX program.

In addition, the Department of Human Services has made effective use of the Social Services Block Grant funds through a client-oriented system of planning.

Through that plan client groups like the elderly at risk of institutionalization are assured priority status for needed services such as homemakers and meals on wheels.

The Department has also taken aggressive actions to close down nursing homes and boarding homes which do not meet our high standards.

The message is now clear. The State of Maine will no longer tolerate anything less than the highest quality of care. This policy, along with that of limiting the growth of nursing and boarding home beds, means we also can add funding for what has been a strong priority of yours, home-based care and appropriate alternatives to nursing home care.

One of these alternatives is congregate housing. Because I share your belief in these alternatives, I proposed a congregate housing program for Maine. The Legislature passed the bill and as a result we have a congregate housing facility now open in Farmington.

I visited it just a couple of weeks ago. Another will open soon in Portland where an old school is being converted into apartments.

These and other options provide housing for those who can no longer live alone but who do not need or do not want the restrictive environment of a nursing home. The federal government may have severely reduced available support for housing for the elderly, but we are continuing our commitment and as these examples demonstrate finding new ways to make sure that older people have appropriate housing choices.

Along the same lines, I am proud that the Legislature acted last year on another program that has been a concern of yours - voting to make more people eligible for the elderly householders tax and rent refund program.

Four years ago, when I campaigned for office, I made one of my major themes my deep belief, a belief shared by you, that we must support programs that enable the older citizen to continue to live in his or her own home with dignity.

The programs I have mentioned address housing, but there is more to independence than keeping a roof over one's head. So I am especially proud that the record of the past four years includes the Home Based Care Act which, as you know, makes it possible for older people and their families to receive the services needed that make it possible to live at home.

Some 600 elderly are being served at home under the program at a cost that is less than that of nursing home care, and the Home Based Services that are provided supplement the purposes of another significant piece of legislation - the recodification of the Adult Protective Services Law. The law now recognizes the right to the least restrictive environment and requires police, doctors, therapists and others to report suspect cases of abuse of elderly adults.

I would like to mention two other issues briefly. Some months ago Congressman Claude Pepper invited me to come to Washington to talk about the great success we in Maine have seen since we abolished mandatory retirement. I could no go, but I sent him a letter endorsing in the strongest possible terms similar legislation on the federal level. I based that recommendation on two things. First - the very positive results that we have seen in Maine, and second - the simple fact that denying a person the right to a job, for nothing more than age, is a denial of basic social justice.

I am confident that under Congressman Pepper's leadership, our success will be repeated nationally. I am sure that everyone here knows about Congressman Pepper's outstanding work as the nation's leading champion of the elderly, so it was a distinct pleasure for me to have the opportunity earlier this year to sit down and meet privately with him. I talked to him in Washington about an issue of very grave concern to elderly and others in Maine, including many of you, the issue of weatherization.

Weatherization is an example of the best kind of government program. It works. Rather than simply bailing out people from a high fuel bill, it makes it possible for them to achieve permanent reductions in their use of oil, which, of course makes it consistent with our national policies of reducing our dependence on imported oil. It is especially significant for our elderly so many of whom exist on fixed incomes, often in large older homes. The Reagan administration would like to eliminate the program altogether, but they recognize that Congress won't pass that so they are talking publicly about reducing the amount of money that we can spend on each house. The result will be less work done on more homes. To me it's just one more example of how the administration in Washington is concerned more with numbers and with the bottom line than they are with actually helping people. The program has worked in Maine.

Since it began, we've made it possible for more than 30,000 homes to be weatherized, with about 22,000 to go. It would be a shame to see our funding sources for this program dry up. Let me assure you the State's commitment to what has been a very successful program will continue.

We cannot, however, be satisfied with the progress that has been achieved. We have challenges ahead. There is one very serious and immediate challenge on the November ballot in the form of a referendum on tax indexing. As I am sure you know, this is an effort to curtail what is known as "bracket creep" which means you pay more taxes when you earn more money.

For State government, passage of this referendum would mean an immediate deficit of more than 30 million dollars. It means we will have to cut that much in services, or raise that much in additional taxes. For Maine's elderly it means, at best, nothing to the majority on low or fixed incomes, but it very likely means more than that. There would be the real prospect of reductions in State services to the elderly, and there would be the even greater likeli-

hood of higher taxes. That has been the experience of other states. In Minnesota, for example, the sales tax went up 25 percent, the gas tax increased 20 percent, local property taxes went up around the state, and, ironically, the state had to impose a seven percent income tax surtax. What's more, the state's credit rating went down which means Minnesota taxpayers had to pay higher interest rates when the state borrowed money. So while indexing may sound good, may seem like a quick, easy solution, we must be very concerned about the results, and for Maine's elderly a combination of reduced services and higher taxes could well be the result of this ill-conceived plan.

So I would urge you, in the strongest possible terms, to talk to your friends and neighbors to be sure they know about the real dangers this indexing idea would mean for Maine's elderly population.

There are other challenges ahead as well. There is the challenge of a rapidly growing aging population. There are now 195,000 people in Maine over the age of 60 and their ranks are increasing.

Most are not institutionalized and do not require in-home services, but they suffer from age discrimination and some need services that are being ended in order to free up funding for home care and other programs for the frail elderly. So there is the challenge of meeting their needs. If, for example, a low income older person can no longer drive, but is otherwise independent, and he or she loses transportation service funding, what becomes of that person? That person becomes home-bound, not because of illness or impairment, but because of the lack of a ride to buy groceries. How can we meet that need?

There is the challenge of income. The Social Security System is, at best, financially ailing, at worst, under attack. What means can we find to ensure adequate incomes?

There is the challenge of responding to the new attitudes abroad in the nation, a meanness of spirit emanting from Washington. An attitude that turns social justice upside down by promoting a tax policy that gives more to those who have a lot, and a social policy that provides that those who have little, get less.

An attitude that justifies cutting housing for the elderly and weatherization so that more and more can be spent on unneeded weapons.

So I see one of the great challenges ahead of you, that of mobilizing support in the community. Support for what you feel needs to be achieved next within government, and support for alternatives within the community so that institutions and neighborhoods and individuals will step in and provide volunteer help where goverment dollars have been cut.

And most of all, the challenge for all of us as we consider public policy in aging is to keep in mind the size and diversity of our elderly population. We must keep in mind the needs of all the elderly, whatever their circumstances, whatever their requirements, wherever they live.

Thank you.

VI

CONFERENCE PROGRAM

1982

BLAINE HOUSE
CONFERENCE ON AGING

A forum of Maine's Elderly
concerning policy and program developments
in aging

Sponsors
The Maine Committee on Aging
and
The Bureau of Maine's Elderly
Department of Human Services

OCTOBER 7, 1982
THE AUGUSTA ARMORY
AUGUSTA, MAINE

Members of the Maine Committee on Aging

John Truslow, M.D., Chairman	Biddeford
Alice Bourque	Biddeford
Rep. David Brenerman	Portland
Susan Brown	Houlton
Sen. Gerard Conley	Portland
William Cunningham	Augusta
James Flanagan	Portland
Fr. Valmont Gilbert	Augusta
Norman Hall	Sanford
Rep. John Joyce	Portland
Rosaire Paradis, Jr.	Madawaska
Mae Parker	Auburn
Wilfred Pombriant	Biddeford
Margaret Russell	Augusta
Louise White	Bangor

Members of the White House Conference on Aging Delegation

June Perkins	Springvale
Elizabeth Knight	Tenants Harbor
Susan Brown	Houlton
Anthony Wedge	Portland
Mae Parker	Auburn
George Forbes	Waldoboro
Mickey Friedman	No. Bridgton
James Fletcher	Machias
Elenora Favre	Ocean Park
Virginia Norman	No. Monmouth
Donald Simpson	Waterville
John Truslow, M.D.	Biddeford
Laurence Bagley	Winthrop
C. Murray Cott	Kennebunk
Glen Torrey	E. Poland
Howard Dana	Portland
Eleanor Voorhees	Bath
Rep. David Brenerman	Portland
Stephen Farnham	Presque Isle
Andrew Fennelly	Yarmouth
Trish Riley	Augusta

PROGRAM

8:00	REGISTRATION	
9:00	CALL TO ORDER	Trish Riley, Director Bureau of Maine's Elderly Dept. of Human Services
	WELCOMING REMARKS	John B. Truslow, M.D., Chairman, Maine Committee on Aging
	INVOCATION	Father Valmont Gilbert
	NATIONAL ANTHEM	Birdie Katz
	PRESENTATION OF WORKSHOP RESOLUTIONS	
9:30	EMPLOYMENT/ RETIREMENT INCOME	Rep. David Brenerman, Chairman
10:00	HEALTH CARE COSTS	Alice Bourque, Chairman
10:30	HOME BASED CARE	Margaret Russell, Chairman
11:00	ALTERNATIVE LIVING ENVIRONMENTS	Susan Brown, Chairman
11:45	INTRODUCTION OF THE GOVERNOR	John B. Truslow, M.D.
11:50	ADDRESS	The Hon. Joseph E. Brennan, Governor
12:00	LUNCH	
1:00	AREA AGENCY ON AGING REGIONAL CAUCUSES	
	PRESENTATION OF REMAINING WORKSHOP RESOLUTIONS	
1:15	QUALITY, SANCTIONS & INCENTIVES FOR LONG TERM CARE	Rosaire Paradis, Chairman
1:45	UTILITIES	Wilfred Pombriant, Chairman
2:15	RESOLUTIONS FROM THE FLOOR	
3:00	ADOPTION OF CONFERENCE RESOLUTIONS	
	ADJOURNMENT	

Special thanks to:

Central Senior Citizens Association's Augusta Meal Site for catering today's lunch

Le Club Calumet in Augusta for hosting dinner for the Blaine House Conference delegates on October 6

The Owl Players from Vermont for their performance for the delegates on October 6

Capitol Area Regional Vocational Technical Center and Augusta Lumber for providing manpower and materials to construct a ramp at Le Club Calumet to make it accessible to the handicapped

Central Senior Citizens Association for sponsoring the Owl Players and for initiating and coordinating the effort to build the Calumet Club's ramp.

The Augusta Chapter of the American Red Cross for providing nurse coverage for the conference.

VII

SELECTED PRESS REVIEWS

Senior citizens list their top legislative issues

By GLENN ADAMS
Associated Press Writer

A move to ensure that legislative priorities of Maine's senior citizens are set solely by older people was soundly rejected Wednesday as the Blaine House Conference on Aging got underway.

The two-day conference, a regular event for the last dozen years, drew 350 delegates — including dozens of young and middle-aged social workers, nursing-home operators and community action officials — to decide which programs should be presented to the 1983 Legislature.

The defeat of the proposed age restriction on which delegates could vote allows the younger delegates to participate. They also cast ballots in the age restriction vote.

Maine Committee on Aging Chairman John Truslow said some delegates apparently were bitter because they felt younger people "took over the discussions" during last year's conference.

As delegates met in six committees to hammer out their priorities, officials for the state Bureau of Elderly and the Maine Committee on Aging — state government's top advisory group for senior citizens — declined to speculate on what issues may emerge into legislation.

Participants said the liveliest discussion was in the home-based care committee, which proposed a resolution that home-based care be elevated from its demonstration status to an ongoing program.

The program, which provides services to enable 600 people to stay at home instead of going to nursing homes or hospitals, is "very successful," said Truslow, who is 70.

It was set up this year with a $1.25 million legislative appropriation. While delegates shied away Wednesday morning from asking for a new appropriation, state Rep. John Joyce, D-Portland, urged them to "put dollar signs in there."

"When we see dollar signs, we all light up and tilt," said Joyce, who was not a delegate.

Those that are not rejected will be reviewed by her agency and the Committee on Aging, which Truslow said will draft bills within "a couple of months." Seventy-eight resolutions emerged from last year's conference.

Neither he nor Ms. Riley would speculate on what the legislation would deal with. Truslow said the initial conference sessions would be characterized by "maneuvering and seeing who will give what."

A major product of previous conferences has been the abolition of mandatory retirement in Maine, imposed first for public employees and then extended to the private sector in 1980, said Ms. Riley.

She said 75 percent of the delegates are older than 60, "and many are well into their 80s." Truslow said about half of those attending were first-time delegates.

Truslow said Maine's elderly enjoy considerable political clout because a large proportion vote, they are well organized and "the quality of our full-time people (in area agencies) is extraordinary."

"But if we don't use our power wisely it will kick us back in the face," said Truslow.

KENNEBEC JOURNAL, OCTOBER 7, 1982

Conference votes down age cutoff

AUGUSTA (AP) — A move to ensure the legislative priorities of Maine's senior citizens are set solely by people aged 60 and older was soundly rejected Wednesday as the Blaine House Conference on Aging got under way.

The two-day conference drew 350 delegates — including dozens of young and middle-aged social workers, nursing-home operators and community-action officials — to decide which programs should be presented to the 1983 Legislature.

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"When we see dollar signs, we all light up and tilt," said Joyce, who was not a delegate.

Trish Riley, director of the Bureau of Elderly of the Human Services Department, said each of the committees may submit up to five resolutions for consideration Thursday, when Gov. Joseph E. Brennan is scheduled to address the group.

Those that are not rejected will be reviewed by her agency and the Committee on Aging, which Truslow said will draft bills within "a couple of months." Seventy-eight resolutions emerged from last year's conference.

Neither he nor Ms. Riley would speculate on what the legislation would deal with. Truslow said the initial conference sessions would be characterized by "maneuvering and seeing who will give what."

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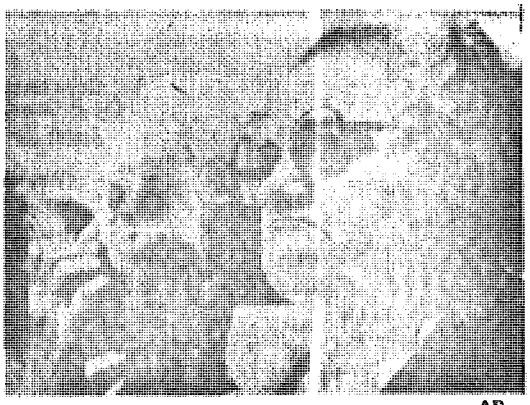

AP

Louise Hobart, left, of Freeport and Harriett Noyes of Oxford listen to discussion at the conference.

PORTLAND PRESS HERALD
OCTOBER 7, 1982

Senior citizens support nuclear freeze

By The Associated Press

Senior citizens passed resolutions favoring the nuclear freeze and Maine's home-based care program Thursday as the two-day Blaine House Conference on Aging wound down.

They also voted in favor of state laws requiring driving and eye tests for drivers older than 75, and eye tests for those older than 55.

But the senior citizens came out against a proposal to index state income taxes. It goes before Maine voters Nov. 2.

The indexing vote came before a luncheon speech by Gov. Joseph Brennan, who urged the 350 conference delegates — most of whom are older than 60 — to oppose indexing.

"I urge you, in the strongest possible terms, to talk with your friends and neighbors, to be sure they know about the real dangers this indexing idea would mean for Maine's elderly population," said Brennan.

KENNEBEC JOURNAL
OCTOBER 8, 1982