1978

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

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

DAVID E. SMITH
COMMISSIONER

Governor Joseph Brennan
State House
Augusta, Maine 04333

Dear Governor Brennan:

On October 17 and 18, the Maine Committee on Aging and the Bureau of Maine's Elderly sponsored the seventh Blaine House Conference in Aging in Augusta which was attended by 1000 elderly delegates. It is with pleasure that we transmit to you this account of the conference. We trust that you and the members of the 109th Legislature will find the enclosed recommendations worthy of consideration and action.

The topics considered in five workshops on October 17 were developed as a result of statewide public hearings and from meetings with and priorities from elderly leaders in each area agency on aging. We believe the recommendations herein are representative of the diverse strengths and needs of Maine's 170,000 elderly as stated to us by Maine's older citizens and by leaders in the aging network.

On behalf of the Maine Committee on Aging and the Bureau of Maine's Elderly, we wish to express our sincere appreciation to all those who participated as delegates or as resource personnel who contributed to the successful conference. It is through these mutual efforts that we can continue to organize to express the issues as they affect Maine's older citizens. We pledge our support to work on continued efforts to improve the quality of life of Maine's older population.

We anticipate your continued support for the elderly in Maine. The Maine Committee on Aging and 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,

Floyd G. Scammon

Floyd G. Scammon, Chairman
Maine Committee on Aging

Trish Riley

Trish Riley, Director
Bureau of Maine's Elderly

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INTRODUCTION

The Blaine House Conference on Aging is a forum of Maine's elderly designed to stimulate public policy direction by the elderly themselves. The first day of the conference consists of workshops developed following statewide public hearings and meetings with elderly leaders. Each workshop consists of approximately forty elderly delegates and professional resource people who develop background papers on the workshop topic in cooperation with the Maine Committee on Aging and Bureau of Maine's Elderly staff. These papers are studied in advance by the delegates and formulate the basis of workshop discussions.

It should be noted that the workshop discussion papers are utilized as a tool to stimulate discussion at the workshop. Both concepts and facts may have been appropriately disputed during the workshop. The discussion papers are not intended to represent what actually occurred during the workshop, as the workshop might have discussed topics not included in the paper, and all issues in the discussion paper might not have been addressed during the workshop session.

The discussion papers have been abstracted herein. Copies of the full papers are available by writing to the Maine Committee on Aging, State House, Augusta, Maine 04333. Each workshop, chaired by a member or a volunteer of the Maine Committee on Aging, develops recommendations for consideration by the full 1,000 delegates on the second day of the conference.

Thirty-four resolutions, printed here, were enacted by the 1978 Blaine House Conference on Aging. In an effort to more thoroughly address a limited number of resolutions, the Committee considered the priorities of the five Task Forces on Aging along with the Committee's own goals and developed its top priorities for the legislative session. These priorities are listed at the conclusion of this report.

The Blaine House Conference on Aging is a mutual effort of the Maine Committee on Aging, Bureau of Maine's Elderly, and other elderly organizations. The enclosed report represents their concerns as collated by the Maine Committee on Aging and Bureau of Maine's Elderly. Copies of this report may be obtained by writing to the Maine Committee on Aging, State House, Augusta, Maine 04333.

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PERSONNEL AND DISCUSSION PAPERS

PRE-SESSION WORKSHOPS

BLAINE HOUSE CONFERENCE ON AGING

Holiday Inn, Augusta

October 17, 1978

ABOLISHING MANDATORY RETIREMENT IN THE PRIVATE SECTOR: HOW TO ACHIEVE AN ORDERLY PHASE-IN

Chairman:	Katherine Cutler, Volunteer Ombudsman Aide, Maine Committee on Aging
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Abstract of
Abolishing Mandatory Retirement in the Private Sector: How to Achieve an Orderly Phase-In

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

L.D. 1634 **An Act to Prohibit the Practice of a Mandatory Retirement Age** enacted by the 108th Legislature went into effect on July 1, 1978 and compelled the State Planning Office, in consultation with the Maine Committee on Aging, to study and evaluate "proceedings to be followed for an orderly phase-in of the prohibition against mandatory retirement in the private sector" and report its findings and recommendations to the 109th Legislature no later than January 31, 1979. Subject to those recommendations, it was the intent of the Act that "the final phase of prohibiting the use of a mandatory retirement age, namely, the prohibition of this age, effective January 1, 1980, for employees of the private sector shall be addressed during the 109th Legislature."

It is the premise of this workshop that legislative intent is clear and compels us not to debate the efficacy of forced retirement but rather to discuss how it should be banned in the private sector. Although a formal report has not been issued by the State Planning Office, this paper will discuss initial findings of that study and the concerns raised by various businesses and labor representatives with whom informal meetings were held to discuss this issue.

The following have been identified as potential problems which should be overcome if the ban on forced retirement is to be extended to the private sector:

QUESTION 1: Will there be a conflict with federal legislation regarding mandatory retirement?

Federal legislation abolished mandatory retirement for most federal employees but simply raised the mandatory retirement age to 70 for private employers. Further, it exempts (a) employers with fewer than 20 workers, (b) tenured college and university faculty, and (c) employees with pensions of $27,000 or more a year. That is, these groups and employees in the private sector over age 70 can still by law be forced to retire.

Some believe that passage of this federal legislation which amended the Age Discrimination in Employment Act means that Maine need not consider additional legislation. This is not true if Maine intends to meet legislative intent and extend L.D. 1634 to the private sector and ban forced retirement (federal law allows forced retirement at 70 or older).

The State Planning Office, through a committee representing the Bureau of Maine's Elderly, Maine Committee on Aging, and legislators, designed the following questions and suggests the following initial responses:

QUESTION 2: What will be the maximum effect upon employment of abolishing mandatory retirement ages? Will the Employment Security Commission require more funds?

QUESTION 3: What will be the maximum effect upon promotion rates of abolishing mandatory retirement ages? Can we devise ways to prevent any slowing in promotion rates from blocking the achievement of our affirmative action goals?

Two concerns often expressed in discussions about the abolition of mandatory retirement are that it will increase unemployment and slow promotion rates. The question underlying these concerns is whether the number of workers who will continue beyond their present retirement ages will be greater than the economy can absorb.

Should it be the case that the economy could not absorb them, there would be more cases of hardship in the labor force—more persons unable to find work and more persons blocked from promotion in their careers—an increased drain on the unemployment insurance fund and greater difficulty in achieving our affirmative action goals of hiring and promoting more women and minorities. Whether we must expect these consequences depends upon the number of workers now subject to mandatory retirement who will choose to continue working if allowed to do so and upon the ability of the economy to absorb these.

Because the federal law has eliminated for most workers the most significant barrier—compulsory retirement before age 70—the effect of any state law upon the labor force participation of older workers will be minor.

The State Planning Office, after extensive study, concludes that we may expect that a state law prohibiting compulsory retirement ages entirely **would increase the labor force by no more than 525 persons a year during the next decade.** Since this constitutes less than fifteen one-hundredths of one percent of the state labor force, we conclude that its effect upon unemployment and promotion rates will be neglible.

QUESTION 4: What will be the maximum effect upon labor costs of abolishing mandatory retirement? Will this make Maine firms less competitive in national markets?

The estimate above of the number of older workers we expect the abolition of compulsory retirement to add to the labor force (525 a year) suggests that the aggregate effect on labor costs and upon the state's competitive position in the national economy will be negligible.

QUESTION 5: What sorts of difficulties will different industries and different size firms encounter in adopting formal performance standards?

We have assumed in this paper that a law abolishing compulsory retirement

ages would allow an employer to require the retirement of a worker failing to perform his job adequately provided the criteria by which his performance is judged are the same for workers of every age. We have assumed, in other words, that, like L.D. 1634, any legislation to ban mandatory retirement in the private sector will allow employers to use non-discriminatory standards and criteria to judge worker performance. To assist employers, should the Maine Human Rights Commission be compelled to develop guidelines and training in non-discriminatory standards and criteria?

An age test is easy to administer. The employer simply specifies the age at which workers are to retire. Assessing the quality and quantity of work produced by every employee is much more difficult. Every job must be reviewed and reasonable goals set for the incumbent of the position. Then ways must be devised to measure the degree to which an incumbent attains those goals and an acceptable minimum performance specified. Finally, every employee must be regularly evaluated with respect to his performance. One of the questions the State Planning Office study is designed to address, therefore, is whether the abolition of compulsory retirement and the substitution of performance criteria for an age will be problematic for employers and whether there is anything the state can do to help them make the transition. Of particular concern are the difficulties which may be encountered by small employers who do not have personnel officers trained to design evaluation procedures.

While eliminating forced retirement may complicate an employer's performance evaluation system (i.e. he can no longer dismiss a worker simply because of his age), it will not impose new demands for worker evaluation. While it is feared that the cost of non-discriminatory standards and criteria of job performance may be prohibitive, it must be recognized that employers must now assure non-discriminatory standards to comply with the U.S. Civil Rights Act. In order to assure compliance with Title VII of this Act, employers must assure that their employment practices do not have a negative effect on a particular group (i.e., minorities or women). If job requirements result in women not being employed in a particular job, the burden shifts to the employer to show that the job requirements are "job-related" (i.e., predictive of success on the job) and must further show that there are no other requirements which are predictive of success and which would **not** have an adverse impact on females. Employment practices which are neutral on their face and which are equally applied to all workers often have an adverse impact on a specific segment of the population. Such practices are generally unlawful discrimination. Employers currently must defend all of their employment practices as being job-related and must have eliminated all practices which have an adverse impact on women, minorities, handicapped persons, etc. Under current state law, employers must now eliminate any practices which have an adverse impact on particular age groups. The only exception has been retirement.

Some employers are worried that the substitution of individual evaluations for compulsory age limits will mean that appeals by workers who do not want

to retire will require extensive documentation and long, complicated procedures to settle. They also worry that it will be difficult to prove to a degree sufficient to justify forced retirement that a worker lacks such important but hard to measure qualities as enthusiasm, initiative, creativity, and flexibility. However, this is an employer's dilemma in evaluating any employee, not just older workers.

QUESTION 6: What difficulties will the law create for multi-state employers, and would the extension of L.D. 1634's language to the private sector impose additional burdens on private employers in complying with ERISA?

According to Helene Benson, Division of ERISA Coverage, Department of Labor, Washington, D.C., the new federal law will not require most employers to amend pension plans. Generally, plans will not need to be amended to comply with the new Federal Age Discrimination law. Generally, pensions only need to be submitted through the ERISA amendment process if benefits are accrued beyond a normal retirement age because this changes the formula for computing benefits. That is, most pensions will not need to be amended through ERISA to change from a forced retirement age to a normal retirement age, nor will they generally need to be amended to comply with Maine law, as that law provided for a normal retirement age. If an employer wanted to allow workers to accrue pension benefits beyond normal retirement age, he would need to amend his pension through ERISA.

Elyse Soucy of Union Mutual further explains the importance of "normal retirement age" in the law, stating:

> Pensions, a growing element of employee fringe benefits, could be most directly affected by the prohibition of a mandatory retirement age **unless** the law expressly authorizes the use of a "normal retirement age" or another ascertainable date for computational purposes. In setting up pension plans, it is necessary to make assumptions about the period during which benefits will accrue, will be funded, and will be paid out to ensure that enough funds will be available to purchase benefits when someone retires. This is not to say, however, that the pension plan's "normal retirement age" must necessarily correspond to an actual retirement age, or vice versa. Once the plan is soundly designed and funded, it can easily accommodate variations in actual practice by use of actuarial equivalencies. For example, assume that a plan is designed to be fully funded in 25 years, with pay-out commencing at age 65. If employee X actually retires at age 60, after 25 years of service, the pension payments can begin immediately by actuarially adjusting for the extended pay-out period (i.e., five years or longer than originally projected). This is no problem. As another example, assume that employee Y has 25 years of service at age 65 but desires to continue working and is fully capable of doing so. The plan's integrity can easily be maintained in the face of the variation by stopping further funding at age 65, and adjusting the

payments upward, when they begin, to account for the shorter-than-projected pay-out period and the increased time the funds were available to earn interest. The critical point here is that pension planning capability and plan integrity must be maintained even if mandatory requirement ages are forbidden.

Helene Benson of the Department of Labor also sees little problem regarding pension plans for multi-state employers for two reasons: (1) very few workers will be protected, and (2) ERISA protects the normal retirement age so that multi-state employers could simply maintain the same normal retirement age in Maine as in other states. That is, in Maine, a worker or employer would cease contributing to a pension plan at the normal retirement age but a worker could continue to work and collect his full pension, in larger monthly payments, when he actually retired.

Pursuant to the problem of protecting employees' pension rights, the Department of Labor issued on September 22, 1978 (Federal Register, Volume 43, No. 185) proposed rules regarding the implementation of the new federal law outlawing mandatory retirement in the public sector and raising the age in the private sector to 70. In these proposed rules, the Department of Labor interprets through the new federal law the following:

A) Employers may not reduce employee benefits such as life insurance for over age 65 workers unless such age-based reductions are justified by actuarily significant cost considerations.

B) Employers may cease to provide benefits to workers at the age when similar government benefits are available so long as older workers receive the same benefits as younger ones, i.e., when a worker is eligible for Medicare, an employer may cease providing health insurance.

C) An employee hired **after** a normal retirement age could be excluded from that employer's pension. An employee hired at an age less than five years prior to a normal retirement age may be excluded from a **defined benefit plan,** regardless of whether or not that plan is covered by ERISA. No employee hired prior to a normal retirement age may be excluded from a defined contribution plan.

D) Generally it will be unlawful to reduce or terminate long term disability payments before age 70, unless justified by extensive age-related cost justifications.

Finally the proposed federal regulations clarify that the Department of Labor "will scrutinize carefully as a potential subterfuge to evade the purposes of the Act any plan providing for an unusually low "normal retirement age."

QUESTION 7: Will the law create problems for multi-state unions and collective bargaining?

We have found no special difficulties the law will cause multi-state unions.

According to Adelard LeCompte, Secretary-Treasurer of the Truck Drivers, Warehousemen, and Helpers Union Local No. 340 of the Teamsters,

> The issues of extending L.D. 1634 to the private sector would not create any problems or affect this Local in any way. Our contracts are negotiated according to the requirements set by the federal government pertaining to discrimination and age. Our pension plan rules are 25 years of service and age 60 for full coverage. Age 60 is not mandatory for a reduced pension."

QUESTION 8: What procedures and how much time will be required to change fixed retirement age pension plans to variable age ones?

We recommend that employers be allowed to establish normal retirement ages for calculating eligibility for full and partial pension benefits. The only changes in pension plans which will be required, if this recommendation is adopted, therefore, are actuarial adjustments in liabilities and benefits to reflect new assumptions concerning probable retirement ages and survival rates of beneficiaries. Paul Brennan, an independent actuary with Peat, Marwick, and Mitchell, Inc. of Boston, explains that amending pensions would be a one time cost and estimates that cost to companies as between $500-$1300, depending upon the size of the pension plan.

QUESTION 9: With the abolition of mandatory retirement, can an employer force a worker to remain in the work force until age 70?

Federal law in ERISA restricts the setting of a normal retirement age, the age at which full benefits are available. As defined by ERISA, normal retirement age is the earlier of—

a) the time a plan participant attains normal retirement age under the plan, **or**

b) the later of—

   1. the time a plan participant reaches age 65, or
   2. the 10th anniversary of the time a plan participant commenced participation in the plan.

Since most private pension plans are covered by ERISA, it is unlikely that normal retirement age would be raised beyond age 65 unless federal legislation were enacted.

REDUCING BARRIERS TO QUALITY CARE IN NURSING HOMES

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Abstract of
Reducing Barriers to Quality Care in
Long Term Care Facilities

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

INTRODUCTION

The health care system has grown tremendously in recent years as we near a national health policy which insures quality lifelong health care. The Bureau of Maine's Elderly and the Maine Committee are committed to a philosophy that the health needs of older people must be served in the continuum of quality health care. It has come to the attention of the Maine Committee on Aging's Nursing and Boarding Home Ombudsman Program that there continue to be barriers to providing quality care in Maine's long term care facilities.

The purpose of this discussion paper is to consider those frequently mentioned barriers to quality care and to explore appropriate resolutions.

WORKSHOP ISSUES

The issues to be addressed in this paper have all been identified either through the Nursing and Boarding Home Ombudsman Program or through a conference that the Maine Committee on Aging sponsored in June 1978 on "Nursing Homes and the Community: What the Future Can Hold." The issues identified which impede quality care in nursing homes can be broken into two broad categories: (1) reimbursement mechanisms, and (2) physician services. The specific concerns with funding refer to the Department of Human Services' Principles of Reimbursement, which are the regulations through which nursing homes are paid.

BACKGROUND

There are three levels of care: skilled nursing care, intermediate care, and boarding care. When the term "nursing home" is used, one generally means an intermediate care facility.

Skilled nursing facilities (SNF's) are charged with the care of individuals requiring skilled nursing and/or rehabilitative services on a daily or continuing basis.

Intermediate Care Facilities (ICF's) provide health related care and services to individuals who do not require the degree of care that a hospital or SNF provide but who, because of their mental or physical conditions, require care and services above the level of room and board.

Boarding homes are primarily engaged in providing three or more persons with personal care, supervision, and social services for defectives, dependents, delinquents, aged, blind, or other persons 16 years of age or over who are ambulatory.

Because costs of care have risen so rapidly, a number of financing mechanisms have been created to assist the great majority of people who could not otherwise afford care. Medicaid, or Title XIX of the Social Security Act, is one such funding mechanism. Medicaid is a jointly funded federal-state program which is voluntary on the part of the State. If the State elects to participate, the single state agency which administers the medical assistance programs submits a state plan setting out which categories will be provided and particulars of eligibility and administration.

Approximately 75% of the nursing home residents in Maine are assisted by the Medicaid program. The cost of nursing home care has increased dramatically in recent years and the Medicaid Program has expanded to meet the increases. In Maine, according to the Department of Human Services, the increase in Medicaid costs to nursing homes over the past year has risen 30%. Approximately 20% of the nursing home residents pay their own bills. An additional 5% have their board and care paid by Medicare. Medicare is the program authorized by Title XVIII of the Social Security Act which provides health insurance to most individuals age 65 and over, and for others who meet specified disability requirements. To qualify for Medicaid, an individual's income must not exceed $533.40 per month.

In the State of Maine, Medicaid is administered by the Department of Human Services' Bureau of Medical Services. A system of Principles of Reimbursement is developed by that Bureau which stipulates what the Department will pay to the nursing home as allowable costs under the Medicaid program.

HISTORY OF REIMBURSEMENT TO LONG TERM CARE FACILITIES

In 1975, a payment system for reimbursing nursing homes based on actual patient costs was mandated by law. This cost-reimbursement system replaced the flat rate reimbursement system which had paid facilities a fixed rate for each patient. The cost-reimbursement system was designed to increase the quality and availability of services to patients by paying facilities for their actual allowable costs for providing services, plus a profit margin. Boarding homes with a licensed capacity of 7 or more beds are also reimbursed according to the cost-reimbursement system

Integral to the cost-reimbursement system is a set of general guidelines, known as the Principles of Reimbursement, which stipulate when and how facilities' rates of payment are determined. In the early 60's the costs of long term care were beginning to escalate due to an annual growth rate of 11.4% allowing for population growth and inflation. New facilities were built and

day room-dining-activity areas and other improvements were instituted, and quality of nursing home staff was beginning to improve. As costs of the Medicaid program went up and public attention was drawn to the rising cost of government, the priority of the Department became one of containing costs.

To address the issue of cost containment, the Department established new Principles of Reimbursement adopted this year, still based on a retrospective system of reimbursement. The rate for reimbursement is established on the basis of past expense experience, and is adjusted at subsequent cost reviews. Reimbursement is provided on the basis of an approved budget on which an interim per diem rate is established, which is retroactively adjusted upon audit (review by the State).

Included in the new Principles was the addition of "prior approval." Prior approval refers to expenses that a facility deems to be necessary to provide for its residents but which the Department has the authority to decide whether the expense is justified. Facilities may get the expense approved as an allowable cost to insure that the expense will be reimbursed.

This system of paying nursing homes is based upon their actual costs, yet regulations restrict services which are allowed. To provide additional services such as additional personnel, special equipment, or to hold a bed for a hospitalized resident, a facility must get a prior approval to insure reimbursement.

ISSUES

1. The issue of prior approval is raised by nursing home providers as a barrier to providing quality care. Prior approval is required for certain things, for example, staff education. If an administrator sends staff to an educational seminar without receiving prior approval for this expense, often necessary because there may not be time to receive prior approval, the facility runs the risk of not being reimbursed. The Division of Licensing and Certification's response is that prior approval is not an issue because prior approval is not a requirement mandated by the Department, and nursing homes are not required to comply. The provider runs the risk, however of a possible audit exception (refusal of reimbursement) without prior approval in areas of services over and above what the Department has indicated as reimbursable — for example, requests for reimbursement for attendance at educational programs, for additional nursing staff, for additional consultative staff such as dietary, medical records, social services, and for the employment of any relative to the owner of the facility.

To many nursing home providers and advocates of quality care, the prior approval mechanism does nothing but allow the Department of Human Services to impose arbitrary limits on those very things that could improve the quality care — aide staffing, licensed nurses, other qualified staff, and staff education.

2. Staffing patterns imposed by the Department of Human Services are also frequently articulated as a barrier to quality care. The staffing plan is developed through a Level of Care Plan which has levels I, II, and III within each ICF. Each level represents the nursing care time required to meet the needs of each patient in a nursing home. These levels represent characteristics of the patient's needs or the acuity of his needs. The Department translates the time necessary to care for each patient into numbers of personnel required to care for the patients in each facility. This becomes the approved staffing pattern for reimbursement. The Department maintains that the three level of care plan improves greatly the quality of care delivered prior to the present Principles of Reimbursement.

The stated problems with this system include:

1. The pattern is rigid and more flexibility is needed,
2. If there happen to be vacant beds on the days the evaluation is done, no additional staffing time is allowed when there are admissions to these beds;
3. The mix of residents changes unpredictably and with a "bare bones" staffing pattern, there is no back-up when additional staff is needed.
4. The licensed nurse hours per resident are restricted and do not permit a facility to use licensed practical nurses instead of unlicensed aides in order to provide a higher quality of care;
5. The criteria are applied to private paying residents as well as Medicaid recipients. If a facility wants to offer better quality services to its private paying residents, they either must be discriminatory in staff assignments or charge the private paying residents to subsidize the Medicaid residents.
6. Employment status depends on a fluctuating resident census.

3. Closely related are the problems encountered by providers with the Department's prior approval criteria for social work coordinators and resident activities coordinators. This system, like the one previously described, is based on the resident census at the time of the survey. The allowable cost permitted by the Department is one-half hour per resident per week, not to exceed 40 hours. Any time beyond that spent with a resident must be prior approved or the administrator runs the risk of not having that expense reimbursed. One must consider that part of this time is consumed by planning, recording plans and progress, and preparation time.

The Department of Human Services' position is that the Principles of Reimbursement now provide for additional personnel to make available essential services to residents of long term care facilities. Two areas include patient activities and social services. Prior to the present Principles, these functions were expected to be assumed by nursing staff or other designated staff.

4. In a survey based upon observations made in nursing homes and which is

intended to serve as a useful resource tool, reimbursement for continuing education of in-home staff was raised as an issue. Survey results indicate a range of variability concerning the adequacy of educational resources. Although in-house continuing education programs existed, facilities stated they would be more willing to send staff to outside workshops if they would be assured of reimbursement. Continuing education programs are considered to be an important component in recruiting and training motivated and qualified staff, which are essential to quality care. In the survey, many facilities emphasized that nurses aide level positions require on-going education, as nurses aides contribute greatly to the resident's care.

Providers are reluctant to incur expenses for education that may be disallowed. The Department in the past has delayed decisions on what was approved both for tuition and expenses. The system becomes so regulated it becomes difficult for nursing home administrators to make flexible decisions in the residents' best interests.

QUESTION: Should prior approval be necessary to pay for continuing education and nurses' training and certification?

5. It has been suggested that the present Medicaid reimbursement procedures do not allow for sufficient services provided by qualified staff, particularly physical and occupational therapy services. The Maine Committee on Aging supported legislation that resulted from the 1977 Interim Conference on Aging which would have allowed nursing homes to be reimbursed directly for occupational and physical therapy services. The Department through its regulations has circumvented the intent of the legislation by stipulating that these services must be delivered by a home health agency, outpatient unit of a hospital, or SNF, and by a nursing home **only** if documented that these services are unavailable from the above.

6. A major ramification of the highly regulated Principles of Reimbursement is the charge often made that Medicaid residents are discriminated against in nursing home facilities. Several facilities reported to the Nursing Home Ombudsman Program that they planned to close their doors to Medicaid patients rather than reduce the quality of care which results from complying with the minimum standards set by the Department.

The Nursing Home Ombudsman Program is contacted frequently for assistance in locating an available bed in a long term care facility for an individual who is eligible for Medical Assistance. These individuals are told repeatedly that nursing homes are filled but that their name will be placed on a waiting list. When the Nursing Home Ombudsman Program is contacted for assistance in locating a bed for a private pay patient, the same facilities with long waiting lists previously were able to take the patients immediately. The Nursing Home Ombudsman Program is told by nursing home providers that this situation exists because of the facilities' dissatisfaction with the Principles of Reimbursement.

7. The seventh issue identified as a barrier to quality care is that current principles do not provide for staff to assist in transfer assistance and resident discharge. There are confusing policies existing with the entire discharge process. The negative effect is called transfer trauma, which is the result of the involuntary or voluntary transfer of a nursing home resident from his present facility to another.

The Nursing Home Ombudsman Program has documented instances of severe trauma and physical deterioration resulting from the relocation trauma including one fatality. The preliminary study conducted by the Maine Committee on Aging shows the need for a special geriatric social service unit within the Department which can assist families and residents by preparing them for transfer by counseling them during the pre-transfer period and by following up after the transfer to the new facility to help with the adjustment to the move.

The second major focus of this workshop concerns the issue of physician services as they relate to quality care in long term care facilities. There is a general reluctance on the part of the physicians to accept or care for patients in nursing homes, which obviously affects the quality of care available. There are physicians who refuse to care for patients in nursing homes, and some of those who do treat nursing home residents have insufficient time, concern, and understanding of geriatric patients necessary to provide quality physician services.

The survey mentioned earlier indicates that some physician do not take seriously their requirement to attend patients at least every sixty days and what occurs during this visit is also variable. If the patient has remained unchanged, the review may encompass a cursory review of medications and brief progress notes.

The following is a summary of views stated by one nursing home medical director in Maine:

A. Physician performance:
   1. Few physicians in the area have any interest in caring for nursing home patients and no doubt will never have, no matter what they are paid. Lack of M.D. interest/compliance has led to many state imposed rules that increase paperwork and cost of care. In most cases the nursing home and not the physician is penalized.
   2. Most patients are over treated and under cared for.

B. Amount of time vs. need for professional consultation — A physician who assumes responsibility for a large number of nursing home patients has to spend much time and effort on nonpatient care functions for which there is no compensation, such as numerous phone calls from the home, paperwork, and maintenance of a duplicate record system at the office.

C. Medical Records

1. The records are often chaotic with each home using different forms and no logical organization of information.

2. There is duplication of effort with respect to recording information and much redundancy.

3. Professional notes are long and often contain little useful information.

D. Nurses/Aides

Most of these individuals truly care about their patients but feel excessive paperwork and forms keep them from spending time with the patients. Most feel they are understaffed with respect to aides. Nurses have little leeway to act and think independently. Their potential is not being utilized. Care at this level has the greatest meaning with respect to the quality of the patient's life.

E. Types of Medical Problems

These tend to be relatively stereotyped and for the most part one is dealing with chronic degenerative disease and acute minor problems that lend themselves to management in a standard fashion by protocol.

F. Audit

The current state audit focuses too much on nonessentials, such as whether MD telephone orders are signed and not enough on real issues that affect quality of care. This is caused because (a) they are unable to make the physician accountable, and (b) most records are source oriented and illegible and therefore not suitable for meaningful audit.

Summary and Questions:

1. Does the staffing plan defined by the Department present a barrier to quality care? Should the staffing patterns for a facility be based on current resident census?
2. Should there be additional time allowed for services to residents per hour per week for social services coordinators and activity coordinators (presently allowed one-half hour per resident per week)?
3. Should prior approval be necessary to pay for continuing education and nurses' training and certification?
4. Should the Blaine House Conference on Aging reaffirm its commitment that these services ought to be reimbursed directly to the nursing home?
5. Should there be a law which stipulates that there will be no discrimination based on income?
6. Should there be developed a special discharge planning social service unit within the Department of Human Services to assist the resident and family in the transfer or discharge process?

7. Should legislation be passed allowing paramedics and nurse practitioners to see patients under the supervision of the nursing home medical director or those area physicians who are willing to take a meaningful interest and be accountable?
8. Should the state require the adoption of the Problem Oriented Record in all homes that receive funds from them and that this system be standardized with respect to forms?
9. Should research funds be sought for the full development and implementation of the Problem Oriented System in a pilot group of nursing homes? The goals would be:

   a) develop a Standardized Nursing Home Medical data base.

   b) development of medical protocols for the management of the common medical problems specific to this population.

   c) development of a more meaningful audit system to measure both individual performance of physicians and allied health personnel and the function of the system itself.

   d) develop a mechanism for continuous updating of the system.

   e) research the effects of such a system on quality of care as contrasted with the current non-system.

   f) determine the proper role and function of each member of the health care team in a POS.

   g) research computer applications to this model.

Developing More Effective Transportation Services: Alternatives to the Current System

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Abstract of
Developing More Effective Transportation Services:
Alternatives to the Current System

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

I. Background

During the late 1960's and early 1970's various types of single agency human service transportation systems existed throughout Maine. The majority of these systems served only one type of clientele whose participation in a specific program necessitated the existence of a special transportation system. These transportation systems were usually small, and funded by one funding source.

During the middle 1970's expanded Federal and State government transportation resources became available (i.e. non-elderly Title XX, PSSP, UMTA, 16(b) (2) and Highway Department Section 147 funds, etc.). These transportation resources were administered by different agencies on the federal level and then were administered by their various state agency counterparts at the state level.

After an examination of existing transportation services, the State of Maine Department of Human Services decided to coordinate and therefore better utilize the maze of existing transportation funding through one regional transportation provider in each region which, depending on funding mechanisms, would receive all transportation funds administered by the Department.

This action caused many changes in the transportation delivery system at the regional level. The magnitude of change and the designation of which agency and what type of agency would become this regional transportation provider varied greatly from region to region.

There are nine agencies in the State of Maine providing social service transportation. Eight of these are assigned geographic areas which, taken together, cover the entire state. One other, the Maine Indian Transportation Association, provides transportation directly to the Indian reservations, thus over-lapping to some extent the geographic area of three other transportation providers.

No two of these transportation agencies provide identical services. There are three major reasons for this fact:

1. The basic structures of the transportation providers differ. Two are independent agencies, some are programs within area agencies on aging, and some are programs within Community Action Programs.

2. There are large differences in the operating budgets of each of the transportation providers.
3. Each transportation provider has a unique ratio of urban/rural territory.

These inherent differences lead to differing client populations and priorities for services in each area.

The success of these existing coordinated transportation systems is under review and we will here examine some of the existing barriers and achievements of this method of transportation service provision and possible means of improving transportation services.

1. How well do existing transportation services meet the needs of older people?

On a statewide basis, transportation is generally available for anyone over sixty years of age to go to an appointment with a doctor, to attend a health clinic, or go to a hospital. In most urban areas, this service is available at any time. In rural areas, travel to urban areas — where most hospitals and doctor's offices are located — is usually available on a weekly basis, due to the cost of the high number of miles involved.

One of the largest problems faced by transportation providers is the high cost of transporting people needing cobalt and dialysis treatments. These treatments are needed on a regular basis for long periods of time, and are usually very expensive.

Another necessary category of service is referred to as "personal services." This includes grocery shopping and filling prescriptions. By shopping at grocery and drug stores within shopping mall complexes, other needs (clothes, hairdressing appointments, etc.) can be met. Personal services is usually offered once a week.

Transportation to meals programs is also generally available statewide, although this service is not available on a daily basis.

2. What are the gaps in service delivery?

Gaps in the service are measured by the demand. Experience indicates that in some service areas, gaps exist in every category other than the above-described absolutely necessary transportation. The following needs have been particularly illustrated:

1. Visitations—There are a number of unmet requests for services to transport spouses, relatives, or friends to visit patients confined to a nursing home or hospital. This transportation is done on a space-available basis only, and they do not meet the actual demand.
2. Rides for the confined—There are many elderly people residing in nursing homes who never leave the premises. Transportation providers

have been asked to organize rides, either to shopping centers or simply in the country, in order to allow these people to leave the nursing home occasionally.

3. Socialization/Recreation—There is a very large demand for transportation to attend meetings and special outings of senior citizen clubs. This is only provided in two of the nine service areas, and is paid for by the area agency on aging in that area.
4. Education/Employment—Some requests are received for transportation to educational facilities and for employment.

These four areas comprise the bulk of the gaps in transportation services to older people. It is important to note at this time that in some areas many complaints are received concerning the need for additional transportation to meals programs and for medical and shopping trips. Another complaint, usually levelled in areas that do not have private car service, is that older people cannot manipulate the buses and vans that are used, and therefore refuse the services offered.

The greatest barrier to expanding existing transportation services is the lack of funding. It has been recommended that a funding request be submitted to the 109th Legislature.

One of the highest costs to current transportation programs is insuring vehicles. Insurance companies, until this year, had a special category for vehicles used in social service transportation. The Commissioner of Insurance has this year ruled that this category would be eliminated. Social service transportation providers are now in a general pool with all public providers, including taxis and public buses. As an example, the cost of insurance to one transportation provider jumped from $5,000 to $14,000 in the past year. Although self-insurance is a very expensive operation, a statewide self-insurance system for social service transportation systems could, in the long run, save a great deal of money.

Title XIX — Medicaid

The Maine Department of Human Services Task Force on Transportation has recommended that Title XIX pay **all** Medicaid eligible transportation, thus freeing up Title XX dollars which now pay for medical rides for Medicaid recipients. In Maine, the Department will presently only pay transportation where other services such as existing programs, family and friends are not available (i.e. ambulance service and emergencies).

In Maine, the federal law is interpreted in the Medical Assistance Manual as "ambulance services licensed by Maine Department of Human Services can be reimbursed from Title XIX for services performed . . . when the use of other methods of transportation is contraindicated, a licensed physician must certify the medical necessity of ambulance service."

The state may provide Title XIX transportation in excess of its current provision in either of two ways:

1) As an "item of service" for which the reimbursement is approximately 70% federal and 30% state, **or**
2) Through an assurance that Medicaid will pay for transportation to Medicaid eligible rides. This system is paid 50% federal and 50% state.

The Bureau of Medical Services states that the following criteria would need to be met if Title XIX picked up eligible transportation as an item of service:

1) Service must be available on statewide basis to all Title XIX eligibles. (This requires the Medicaid agency to assure that funding exists to meet this requirement on a continuous basis.)
2) The service would have to be provided within the State, and outside the State transportation to necessary medical services is not available within the State.
3) It would have to available on an "as needed" basis (twenty-four hours a day and seven days a week).
4) The service must be provided by the most economical means and in sufficient quantity to be practical.
5) Accurate records must exist to identify the specific service rendered and reimbursement made.

By federal law, the State of Maine must "specify that there will be **provision for assuring** necessary transportation of recipients to and from providers of service and describe the methods that will be used." Currently, Maine Title XIX pays only for ambulance and emergency needs. However, the Health Care Financing Administration in HCFA-AT-78-51 discussed federal regulations regarding Medicaid payment of transportation and notes that Medicaid recognizes that "unless needy individuls can actually get to and from providers of services, the entire goal of a state Medicaid program is inhibited at the start." The State of Maine agrees with this philosophy but, in an apparent effort to contain Medicaid costs, seeks to provide necessary transportation under Title XX and the Older Americans Act coordinated transportation programs statewide, not through Title XIX. Transportation providers argue that Title XIX should as a program pay for the cost of transporting its clients.

According to current law, the State must **now** assure that medical transportation be available statewide, be provided outside the state and be available on a twenty-four hour basis. These assurances must be made regardless of what system is used to transport eligible riders.

The coordinated transportation providers are asking only that Medicaid pick up those eligible riders now being served in their programs and transported to Title XIX eligible medical trips. To reimburse transportation providers for Medicaid riders would require specific definitions and regula-

tions to be developed by the Department of Human Services to define which transportation services Title XIX will pay for and to require available statewide service. Under the Medicaid program, there are no specific federal standards with regard to vehicles used to provide transportation and regulations would need to be developed in this regard. However, there appear to be no restrictions against using existing transportation program vehicles.

The Bureau of Medical Services in discussing possible use of Title XIX for transportation believes that in liberalizing what transportation Title XIX will pay for, the demand will increase, since all SSI and AFDC recipients are eligible for Title XIX. Further research is needed if in fact any reasonable estimates can be developed. However, the State could develop restrictive guidelines which would make unlikely major growth of eligible riders. Such regulations would require careful study and development. Further, the Bureau notes that Medicaid expenditures are on the increase. Last year Maine's Title XIX budget was $113 million and it is expected to increase almost 20% this year. Although the Medicaid program has no ceiling for federal funds, it generally requires a 30% and sometimes a 50% state match. Each new service added and each inflationary (or other) cost increase requires a proportionate increase in state dollars.

Further, federal law requires that transportation can only be reimbursed as an item of service when furnished by a provider to whom a direct vendor payment may be made by the State. When this vendor system is used, federal regulations require the identification of the specific individuals being provided the service. In addition, Title XIX clients are also eligible under Title XX and, it has been argued, have equal rights to Title XX money for transportation.

In summary, it is suggested that Title XIX reimburse Title XX transportation providers directly for eligible rides provided during normal working hours of transportation programs while Title XIX continue to provide directly for out-of-state and emergency transportation as it currently operates. Further, to provide transportation as an item of service would require 30% state match and the development of regulation, authorization and enforcement which could require additional staff.

The State of Massachusetts currently reimburses providers for medical transportation through Title XIX. In Massachusetts the provider may bill Medicaid directly or a volunteer driver can be personally reimbursed by Medicaid for eligible rides provided. The state can impose restrictions on scope of transportation services it will reimburse. For example, the state could require shared rides or could refuse to pay for taxi provided rides because of high costs. In Massachusetts, a state appropriation provides the match. In Maine, state dollars could likewise be used. In Massachusetts, the state develops a rate to reimburse providers for transportation and will directly reimburse the area agencies on aging with Title XIX for eligible rides provided.

Less than 1% of the total Medicaid budget in Massachusetts is used for transportation although they reimburse extensively to nearly 300 providers for this service. In order to be reimbursed with Medicaid dollars, a provider agency must get funding from other sources. Since transportation providers in Maine receive dollars from Title XX, Title III, PSSP and others, they would be eligible as Medicaid providers if so certified.

A statewide estimate of cost to the Medicaid program is $250,000 per year. If these rides were provided as an item of service under Medicaid (via a 70/30 match), Title XX and other funds would be freed up to pay for non-Medicaid transportation services. A 30% state match would be required.

Questions still exist concerning (a) who will provide match to Title XIX, (b) how will billing be done, (c) how will Medicaid eligible rides and clients be certified and reported, and (d) how will statewide available service be guaranteed. It is suggested that the Bureau of Maine's Elderly, the Bureau of Resource Development, the Bureau of Mental Retardation and the Bureau of Medical Services meet and develop responses to these questions and a plan to resolve them and report back to the Maine Committee on Aging.

Title XX Transportation Priorities

The Department of Human Services Task Force on Transportation states that priorities for use of Title XX transportation dollars should be set at a state level. What rides should Title XX pay for elderly transportation and what percentage of Title XX dollars should fund each priority (i.e., meals programs, medical, personal needs, recreation such as clubs and centers, nursing home residents, adult protective cases)? While priorities for Older Americans Act dollars are set at a local level by the area agencies on aging, Title XX priorities will be set by state officials. What priorities and percentages should be recommended for Title XX elderly transportation?

ADVOCATING FOR IMPROVED HOUSING SERVICES: THE NEED TO EXPAND EXISTING PROGRAMS

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Abstract of
Advocating for Improved Housing Services:
The Need to Expand Existing Programs

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

Who Are Maine's Older People?

There are currently over 170,000 people aged 60 or older living in Maine. This group is rapidly growing, and it has been estimated that, between 1970 and 1985, the elderly population will have increased by at least 30%. Many of these older people are among the state's poorest citizens. In 1975 approximately two-thirds of the elderly population were categorized as living "below low income" or at the "low to intermediate income" level. In addition, older people today are living an average of 20 years longer than the older people of the previous generation. These population characteristics impact greatly on the housing situation of older people in Maine.

Where Do Older People in Maine Live?

1. **Home**

The majority of Maine's older people live in their own homes. Approximately 70% of the elderly population resides in single family homes throughout the state.

2. **Apartments—Private Market Housing**

The last census count listed approximately 5,000 elderly renters. Apartments for rent are generally available in larger towns and cities.

3. **Apartments—Publicly Assisted Housing**

Seven thousand units of elderly public housing exist in the state. Similar to the private market rentals, these units are generally available in larger towns and cities.

4. **Eating and Lodging Facilities**

Eating and lodging facilities, often older hotels, exist in the state where some elderly people live. A number of these facilities are located along the coast and sometimes serve a transient population.

5. **Foster Homes**

Elderly people placed in foster homes are unable to live independently in the community for one reason or another. Foster care provides the individual with the necessary supports for residential but not institutional living.

6. **Boarding Care Facilities**

Boarding care facilities provide older people with meals, personal care,

supervision, and social services. Such care and services are provided twenty-four hours a day.

7. **Intermediate Care Facilities**

These facilities provide health related care services on a twenty-four hour basis to persons who could not live independently yet do not require continuous skilled nursing care.

8. **Skilled Nursing Facilities**

These facilities provide skilled nursing or rehabilitative services on a daily or continuing basis.

Approximately 6% of Maine's older people live in boarding care, intermediate care and skilled nursing facilities.

What Are Some of the Problems with Where Older People in Maine Live?

Homeowners

Over two-thirds of Maine's older people live in owner-occupied homes. Fully 87% of elderly couples "below low income" live in their own homes, while more than half of single elderly people "below low income" are homeowners.

Rising costs of home ownership have compounded the difficulties older people face in keeping their homes in repair. Nationwide, more than three-fourths of all housing occupied by older people was built prior to 1940. Around 200,000 homes in Maine are over 40 years old, and of these, between 70-100,000 are in need of some basic repair. The combination of a deteriorating housing stock and lack of income has forced many of Maine's elderly to forego needed repairs.

In addition to the burden of inflation, elderly homeowners are experiencing difficulties due to a loss of functional capacity which can accompany aging. This results in a reduced ability to perform routine upkeep chores as well as tasks to meet basic personal needs. Elderly homeowners are finding their living arrangements coming under increasing pressures, both economic and personal.

Vaious programs exist which provide repair services for the homes of older people and supportive services for the older people residing in their homes.

Some programs include funds directly specifically at home repair and energy retrofitting needs. The **Farmers Home Administration 504** program provides grants and loans to remove health and safety hazards in the homes of low income older people. However, funding for this program is insufficient, as demonstrated by the fact that the number of grants made to counties last year was minimal (approximately two per county). Only $300,000 was made available under this program to provide for home repair for older people.

Title XX of the Social Security Act, administered by the Bureau of Resource Development, provided $16 million last year to address the needs of low income people in the State. Of this, only a third of a million dollars was earmarked for housing services, and these funds are distributed under three categories: direct service, resource development, and counselling. Home repair programs represent a direct service area. At this time, older people in only one out of Maine's five task forces on aging regions have access to Title XX direct service funds for home repair services. It is unlikely that this source will be available in other regions and refunding for the single available program is in question as well, as the Bureau is setting new priorities which focus a greater effort on resource development rather than direct service.

Income eligible elderly people in Maine may obtain full grants for labor and up to $350 for materials to retrofit their homes to conserve energy and income through the **Community Services Administration Winterization Program.** Administered by the local Community Action Program agencies, the program assisted 455 households of older people with retrofitting in 1976, down from 515 in 1975. A very small number of Maine's elderly households are receiving this direct service and the program currently has a waiting list.

Comprehensive programs designed to meet the home repair needs of Maine's older people do not exist statewide. Also, the limited number and types of existing programs are underfunded.

In addition to maintenance costs and energy costs, other costs of home ownership have risen. Taxes are cited by upper income people both as their first and their second largest expense. Low income elderly have been provided with some relief in this area due to the **Elderly Householders Tax and Rent Refund Program.** In 1976, 12,284 households took advantage of this program, saving an average of $200 on their tax bills.

Programs to compensate older homeowners for their losses in functional capacities now exist and will be expanding. Existing services are provided by area agencies on aging. Transportation for health needs is available statewide. Other services such as transportation for shopping and personal needs, home-delivered meals, and home health aide and homemaker services are available in most areas of the state.

The expansion of in-home services to older people in Maine is expected. The Bureau of Maine's Elderly has made the study of how to provide comprehensive home care services a priority in its 1979 State Plan on Aging, and the area agencies on aging are placing increasing emphasis on the provision of in-home supportive services.

Apartment Renters—The Private Rental Market

Elderly people living in rental housing suffer economic and personal pressures similar to those of the elderly homeowner.

The rental market is high priced for Maine's elderly. An example of market rents for a one-bedroom apartment range from $221 a month in York County to $178 in Hancock County. These rent figures were developed by the Department of Housing and Urban Development based on a review of county rental housing units. These rents are intended to reflect the average monthly cost of rent and utilities for an apartment in "adequate condition." These rent figures suggest that many of Maine's elderly renters may be living in less than adequate housing, in light of the fact that the average monthly income of an older person in Maine is $237.50.

Additional problems facing elderly renters include the structural barriers existing in many of the buildings where rental units are available. Inaccessibility to community services and programs represents another problem area for the renter.

Some financial relief is available to renters as a result of the Elderly Householders Tax and Rent Refund Program, the same program available to elderly homeowners. In 1977, approximately 7,350 elderly renters took advantage of this program.

As with people in their own homes, renters also have a need for an array of home repair and home care services.

Apartment Renters—Public Housing Programs

Elderly public housing facilities, offering 7,000 units across the state, are generally located in larger sized communities. These facilities operate with rent subsidies from the Federal government which insures that older people living in these apartments pay no more than 25% of their income for rent.

This housing alternative is considered highly desirable by many of Maine's elderly. Waiting lists for vacancies exist throughout the state, and occupants of these apartments almost never move out by choice.

A growing need of public housing renters is for increased supportive care services.

Eating and Lodging Facilities, Foster Homes, Boarding Care Facilities, Intermediate Care Facilities, Skilled Nursing Facilities

It is beyond the scope of this paper to examine the variety and complexity of problems that can be related to living in these settings. However, it is important to note that a significant number of people residing in care facilities do not require the level of care that is provided, yet they have no feasible housing alternative.

Is There a Need for Another Housing Alternative for Maine's Elderly?

For most older people in Maine, the housing alternatives described above will adequately meet their needs. However, a growing number of older people

are experiencing increasing difficulty in their living situations. Aging is a process involving a gradual change in needs and abilities. Many low income older people who were once able to maintain themselves in their own homes are now experiencing greater losses of functional ability. The degree of these losses is such that any measure of in-home supportive services is insufficient to allow them to remain in their homes and apartments. The extent of the loss of functional ability, however, is not to the degree that total institutional care is required. This group might then be referred to as those capable of semi-independent living.

A housing alternative designed specifically to meet the needs of the growing number of semi-independent elderly is congregate housing. Congregate housing facilities offer not only shelter but also supportive services such as housekeeping and chore services, transportation services, and social and recreational opportunities. This combination of shelter with services provides the semi-independent elderly with a feasible alternative living situation. Congregate housing projects offer their tenants fully equipped private apartments in which they have the facilities that allow them total privacy when they desire it. On the other hand, gathering places exist at the facility such as the common kitchen, dining area, and recreational room where any variety of small or large group activities can be shared.

Why is Congregate Housing Generally Unavailable?

The identification of a need for congregate housing has been longstanding. In the early 1960's John F. Kennedy proposed this housing model for less independent elderly persons. However, it was not until the Housing and Urban Development Act of 1970 that financing for congregate housing was specifically authorized. Despite this statutory authority, few congregate projects exist, largely because funding for the shelter or housing component has not been matched with funding for the support services component. As a result, the packaging of housing services with supportive services has been difficult to design and implement as funds have only been available for housing and shelter services.

In order for congregate housing to begin developing successfully, a means will have to be determined whereby both shelter services and support services can be effectively funded and provided.

The Congregate Housing Demonstration Program in Vermont

Through the combined efforts of the Vermont Office on Aging and Vermont Housing Finance Agency, a program has been developed to demonstrate the feasibility and usefulness of congregate housing in Vermont. The demonstration program has resulted in the development of five congregate facilities across the state.

Program components:

(a) Housing and shelter services

All of the housing in the Vermont Demonstration program will be subsidized under the federal Section 8 Housing Assistance Payments Program. Tenants will pay only 25 percent of their income for rent, and the Section 8 program pays the rest. Other housing services include administration, security, recreation, and maintenance.

(b) Supportive services

Services available to tenants when needed include meals, personal care services, housekeeping, transportation, and social activities. These services are funded by Title III and Title VII of the Older Americans Act.

Each congregate project has established a contract with an area agency on aging for the provision of supportive services. These services are funded from a special Title III fund created by the Vermont Office on Aging after approval by each of the area agencies on aging.

Could Congregate Housing Be Developed in Maine?

The development of congregate housing in Maine would require the effective combination and coordination of shelter services and supportive services. Potential resources in both the shelter service and supportive service categories have been identified.

The initial implementation of congregate housing in Maine would require the aging network to develop funds to meet the supportive services component of providing this type of housing.

Existing funding sources that could be utilized for congregate housing in clude Title III and Title VII of the Older Americans Act which is administered through area agencies on aging. The development of congregate housing in Maine might first be tested as a demonstration model project following the example of Vermont's program.

Shelter Services

HUD 202

This program assists sponsors to develop rental or cooperative housing facilities, and funding for congregate projects is available through this source. The program involves long term direct loans to eligible private non-profit sponsors. HUD 202 funding is provided with HUD Section 8 rental assistance payments. Section 8 provides a rent subsidy so that low income tenants pay no more than 25 percent of their gross adjusted income for rent.

Farmers Home Administration

FmHA Section 515

This program is designed to provide rental and cooperative housing and related facilities for rural residents. This program provides loans to construct, purchase, improve, or repair rental or cooperative housing. In addition, this programs provide long term financing and rent subsidies which can be utilized for cooperative or congregate housing.

Maine State Housing Authority

As with the HUD and FmHA programs, the Maine State Housing Authority programs provide long term financing and rent subsidies which can be utilized for cooperative or congregate housing.

It has been suggested that the housing expertise of the Maine State Housing Authority be combined with the aging services expertise of the Bureau of Maine's Elderly in an effort to develop and implement congregate housing projects.

REDUCING THE COST OF DENTURES, EYEGLASSES AND HEARING AIDS

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Abstract of
Reducing the Cost of Eyeglasses, Hearing Aids, and Dentures

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

In September 1976, the U.S. House Subcommittee on Health and Long Term Care issued its report, "Medical Appliances and the Elderly: Unmet Needs and Excessive Costs for Eyeglasses, Hearing Aids, Dentures, and Other Devices." Congressman Pepper introduced the report by stating: "the elderly of this nation are entitled to the best health care that is available in the United States. As this report demonstrates, they are not getting it. There are two reasons: The lack of federal (and State) assistance to help the elderly obtain desperately needed devices and the lack of adequate safeguards to protect them from abuses in purchasing these aids."

EYEGLASSES

NEED FOR EYEGLASSES

The issues associated with corrective lenses for the elderly represent one of the clearest examples of both: (1) older peoples' need for medical appliances; and (2) the inadequacy of the existing pricing and delivery system.

The magnitude of the eyeglass need is reflected in the following statistical information. Older Americans suffer from chronic vision impairment more frequently than from any other ailment (except arthritis). Presently over 20 million Americans over 65, or 92% of the nation's elderly, require and own eyeglasses or contact lenses. And of this group, over five million are in need of new corrective lenses.

Countless additional elderly need eyeglasses but do not have them because, as indicated in the House Subcommittee's report and other studies, many of these older people cannot afford such an expense.

COST OF EYEGLASSES

The eye care industry consists of three levels: (1) manufacturers of frames and lenses, (2) wholesale laboratories which distribute manufactured goods and fabricate completed eyeglasses, and (3) retailers, including opthamologists, optometrists, and opticians who dispense the finished product to consumers.

The Federal Trade Commission examined manufacturers', wholesalers, and retailers' prices to document price inflation. They found that an unfinished single vision glass lens begins at a price around $2.30, increases at the wholesale level to about $6.90, and ends up at the retail level costing between $14 and $29. Fashion frames showed mark-ups of 300% to 600% over

manufacturers prices, while standard frames were marked up about 200%.

In 1975, U.S. consumers spent over $4 billion on eye care services. About $1 billion was spent for diagnostic eye examinations, and another $2.3 billion was spent for corrective lenses and frames.

During the past decade, the Department of Health, Education and Welfare, the Federal Trade Commission, the U.S. Congress, and several consumer groups have investigated the production and delivery systems for eyeglasses. All have concluded that prices are often unreasonably high, and consequently prohibit many from obtaining needed corrective lenses.

Many of the elderly in Maine are among the group who need, but cannot afford, eyeglasses. In light of the facts that the average yearly income of Maine's elderly is $2,844 and that neither Medicaid or Medicare coverage includes eyeglasses for persons over 21, it is evident that there is a great need to reduce the cost of eyeglasses for the elderly.

CURRENT MEANS OF ACHIEVING COST REDUCTION

Statewide Lions Clubs now give free eyeglasses to low-income people and raise funds in the communities to support this endeavor. One should contact local Lions Clubs for further information.

SUGGESTED SOLUTIONS

1. Extended Medicaid Coverage

Many studies regarding the high cost of eyeglasses for the elderly have concluded that one method of providing coverage to some elderly would be by expanding coverage under the Medicaid Program. This would help only those receiving Supplemental Security income (SSI) or found eligible as a medically needy Medicaid recipient. Currently there are approximately 20,000 aged SSI/Medicaid recipients in Maine.

2. Cost Sharing

Another alternative suggested is a "cost sharing" alternative to full Medicaid coverage. A State Medicaid plan could impose a deductible or co-payment amount in accordance with federal guidelines. This feature requires some additional administrative steps on the part of the recipient, provider, and state agency. The savings from the imposed cost sharing feature would have to be compared with additional cost of administration.

However, a barrier to expanding the (Medicaid) program to cover these services is lack of state funds. The current state funds are barely adequate to finance current services. With the current climate, to obtain state financing will be extremely difficult.

3. **Increased Price Advertising**

Another area related to reducing eyeglass cost — quite different from public assistance programs — involves industry advertising. A study conducted by Prof. Lee Benham of Washington University found that the mean price of eyeglasses in states with restraints on advertising was 25% higher than in states where advertising was permitted. Comparing the most restrictive states with the least restrictive states, he found that mean costs differed by more than 100%. Benham demonstrated a positive correlation between the difference in prices and the presence or absence of advertising restraints.

Although there are no restrictions on price advertising in Maine, there is a general lack of price advertising in the state, which has been identified by some as one major contributing factor to the high cost of eyeglasses. Consequently, it has been recommended that steps be taken to actively encourage the state and eye care associations to initiate informative advertising campaigns among retailers of eyeglasses.

Such price advertising would serve to reduce prices by informing the public of price alternatives (so that a greater percentage of the public will purchase from sellers who offer lower prices) and by inducing greater price competition among sellers (resulting either in reduced prices or deterrence of future price increases).

4. **Volume Purchasing**

Finally, a variety of interested parties have recommended "volume purchasing." According to an HEW report, volume purchasing saves considerable money by taking advantage of lower costs available through direct purchases from manufacturers.

An example of lower costs that result from volume contract arrangements is the group purchasing plan operated for employees of the State of Michigan. They purchase glasses under contract for about $14, compared to an average retail price of about $35.

This alternative would appear to require a "purchasing" agent of considerable size. It has been suggested that State Medicaid programs or state programs for the elderly could most readily assume such a role.

HEARING AIDS

NEED

Over one-half of all persons 65 and over suffer from impaired hearing, according to the Federal Council on Aging and the American Speech and Hearing Association. Of these 5.3 million elderly who have a hearing impairment, over 17% have a problem with both ears. For 8% of the elderly, the hearing impairment is so serious that they are simply unable to hear words spoken in a normal voice.

HEW reports that for millions of these older Americans, the solution to their hearing impairment is the use of a suitable hearing aid.

COST OF HEARING AIDS

According to a report by the Retired Professional Action Group, a national consumers advocacy organization, cost estimates for the component parts of a hearing aid (such as a magnetic microphone, magnetic receiver, transistors, capacitors, etc.) average about $30. With labor, advertising and promotional expenses, total costs average about $75. The manufacturer sells the hearing aid to the dealer at almost twice the cost, or about $140. The average retail price of a hearing aid is about $350, or about two and one-half times the wholesale price.

A U.S. Congressional subcommittee stated that these high costs represent evidence of overpricing. The National Hearing Aid Society has defended this high mark-up and claims that it is due to the fact that dealers supply a variety of other services, such as audiological tests, fitting, and counseling about use and maintenance, in addition to the actual hearing aid.

In attempting to purchase needed hearing aids, the elderly must confront "excessively" high prices and a virtual lack of coverage under Medicaid, Medicare, and other health benefit programs.

SUGGESTED SOLUTIONS

1. Public Service Approach

A representative of the Licensing Board for Hearing Aid Dealers suggested what he terms a "public service approach." There could be established a hearing aid bank of used and discarded hearing aids for needy elderly. This could be accomplished by getting all the dealers in Maine together and establishing several areas throughout the State, each located if possible in the larger cities. Except for a small service charge, there would be no cost to the needy. A screening process could be established to determine "need."

2. Service Clubs

Some have recommended that a direct appeal be made to the various service clubs throughout the State. Such clubs as the Kiwanis, Lions International, and Rotary would be alerted to the low-income elderly population's need for funds with which to purchase hearing aids and would be requested to provide funds for these aids.

3. National Health Insurance

Another possible plan to reduce hearing aid costs involves including such coverage on the national health insurance package. How this plan might be implemented has yet to be articulated.

4. **Volume Purchasing**

Same principle as with eyeglasses.

5. **Cost Sharing**

Same principles as discussed under eyeglasses.

6. **Extension of Medicaid**

Same principle as discussed under eyeglasses.

DENTURES

NEED

Dental problems such as tooth decay and periodontal disease are so widespread among the elderly that half of all persons over 65 are without any natural teeth. While a majority of these do have the dentures they require, 6.2% have neither natural teeth nor dentures and 30% have dentures which are ineffective and which require refitting or replacement (according to the National Center for Health Statistics).

These dental care problems are serious because the lack of teeth or the use of faulty dentures frequently means that elderly people may be forced to choose foods that are easier to chew but lower in nutritional value. Such elderly tend to avoid foods like meat, raw vegetables, and fresh fruits because of the difficulty in chewing them. Yet these foods are essential dietary ingredients for older persons. In short, "people without natural teeth require high quality dentures in order to avoid dietary imbalance, borderline nutritional deficiencies, and even malnutrition." (from HEW Subcommittee Report).

COST

The cost of dentures, like many other professional services for the elderly, varies widely. The cost, which includes extraction, x-rays, making of impressions and the purchase of the dentures from the laboratory can vary on the open market from less than $500 to over $1,000.

The actual cost of the teeth and other materials which go into the making of dentures represents no more than 5-10% of the cost paid by the patient. In most cases, 75% of the final fee goes to the dentist, while the remainder goes to the laboratory which makes the dentures.

CURRENT MEANS OF ACHIEVING COST REDUCTION

1. **People's Regional Opportunity Program (PROP)**
   140 Park Street, Portland

PROP, a non-profit commuinity action organization, is the sponsoring agent for the Cumberland County Denture Program. This program offers dentures — free of cost — to local low-income elderly.

The organization is CETA staffed and therefore has reduced administrative costs; however there is no guarantee of continued staffing. There is no operating overhead related to rental of space or equipment because necessary facilities are donated. All of the dental services are also donated, with each of the approximately 40 participating dentists making a commitment to furnish denture related services to a given number of patients.

For each denture, however, there is a $70 laboratory fee. This cost is either paid by the dentist or by PROP with monies collected from fund raising efforts.

The program appears to be quite effective, having supplied 80 dentures in a recent four month period.

2. **Bangor Adult Dental Clinic**
103 Texas Avenue, Bangor

Citizens for Adult Dental Care, the organization responsible for the Bangor Adult Dental Clinic, is presently comprised of concerned area residents including low-income people, clergy, community workers, health professionals, and representatives of the Penobscot Valley Dental Society.

The clinic serves low-income persons 51 years of age or older. The fee for dental work, based on a sliding scale, is used to help support the clinic. Although the local hospital donates floor space, equipment use, some staff time, and some dental supplies, and even though the dentists donate their time, office, and staff, because of unavoidable preparation charges, there is a "modest" fee for partial and full dentures. This fee usually is about $100 but may be as high as $140.

3. **YORK County Dental Clinic** (York County Community Action Program) **Alfred**

The York County clinic also charges according to a sliding scale. For those who qualify, dentures may cost as little as $100, but never higher than $140. Of this fee, $90 goes to the dentist and the remainder toward administration costs.

4. **National Health Care Dental Program**

Another means by which some low-income older people can receive dentures at a reduced cost is by obtaining dental services from any one of 10 dentists across the State who are participating in the National Health Care Dentist Program.

This program is sponsored by HEW and is designed to provide dental services for low-income people in areas that have been designated "dental service shortage" areas. Dentists are first placed with existing service-oriented or nonprofit organizations. Each of the local organizations then sets a fee for services, based on a person's income. It is a mandate of the National Program, however, that no person be denied service based on inability to pay.

SUGGESTION

1. **Denture Technologists** (denturists)

It is thought by some that denture costs could be reduced if some of the services now provided by the professional — and more expensive — dentist could be provided by a non-professional — and therefore less expensive — denture technologist.

Since there are no "denture technology" schools in this country and since most legislation allowing for "denture technologists" requires successful completion of such a curriculum, there are currently no denture technologists practicing in this country. Therefore it is difficult to ascertain what effect such technologists might have on the cost of dentures in the United States.

In Canada, "denture therapists" (as they are referred to) have been practicing for a couple of years. Unfortunately, however, no published studies are yet available regarding the impact this particular alternative has had on prices of dentures or quality of dentures.

2. **State/Dentist Alliance**

It was suggested that an effort is needed to identify the people in need of dentures and match them with dentists and others in the denture delivery system willing to assist. This effort would require coordination between representatives of Maine's aging network to identify older people in need and representatives of the denture delivery system to identify individuals willing to assist. To achieve this coordination, it has been recommended that an alliance be formed between the Bureau of Maine's Elderly and the State Department of Health, Dental Division.

1978

BLAINE HOUSE

CONFERENCE ON AGING

A forum of Maine's older citizens
concerning policy and program developments
in aging and priorities before the
109th Session of the Maine Legislature

Sponsors

The Maine Committee on Aging

and

The Bureau of Maine's Elderly

OCTOBER 18, 1978

THE CIVIC CENTER

AUGUSTA, MAINE

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David Fenton	Augusta
Viola Gibson	Calais
Jacqueline Hanley	Wayne
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Sarah Morse	Cherryfield
Thomas Perkins	Blue Hill
Ralph Petersen	Auburn
John Riley	Brunswick
Floyd Scammon, Chairman	Orono
Dr. Henry Thacher	Augusta
Dr. John Truslow	Biddeford

Special thanks to the many who contributed their time and expertise to the Blaine House Conference on Aging workshops and made possible today's conference. The workshop resource personnel merit particular thanks for compiling discussion papers and stimulating active discussion throughout their workshop.

PROGRAM

9:00 A.M.	REGISTRATION	
10:00 A.M.	CALL TO ORDER	Floyd G. Scammon, Chairman, Maine Committee on Aging
	NATIONAL ANTHEM	Diane Salisbury
	INVOCATION	Rev. Arthur Durbin
	WELCOME	Patricia A. Riley, Director, Bureau of Maine's Elderly
10:30 A.M.	INTRODUCTION OF THE SPEAKER	Floyd G. Scammon
	ADDRESS	The Honorable James B. Longley Governor
11:00 A.M.	PRESENTATION OF WORKSHOP RESOLUTIONS	
	ABOLISHING MANDATORY RETIREMENT IN THE PRIVATE SECTOR: HOW TO ACHIEVE AN ORDERLY PHASE-IN	Katherine Cutler
	REDUCING BARRIERS TO QUALITY CARE IN NURSING HOMES	Dr. John Truslow
	DEVELOPING MORE EFFECTIVE TRANSPORTATION SERVICES: ALTERNATIVES TO THE CURRENT SYSTEM	Jacqueline Hanley
11:45 A.M.	LUNCHEON	
1:00 P.M.	INTRODUCTION OF THE KEYNOTE SPEAKER	Jackson P. Libby
	KEYNOTE ADDRESS	Dr. Arthur Flemming, Chairman, U.S. Commission on Civil Rights; former Commissioner, Administration on Aging, Department of Health, Education and Welfare
1:30 P.M.	PRESENTATION OF WORKSHOP RESOLUTIONS	
	ADVOCATING FOR IMPROVED HOUSING SERVICES: THE NEED TO EXPAND EXISTING PROGRAMS	Mabel Wadsworth
	REDUCING THE COST OF DENTURES, EYEGLASSES, AND HEARING AIDS	Floyd G. Scammon
2:15 P.M.	RESOLUTIONS FROM THE MAINE COMMITTEE ON AGING	Viola Gibson
2:30 P.M.	COMMENTS AND RESOLUTIONS FROM THE FLOOR	
3:00 P.M.	ADOPTION OF CONFERENCE RESOLUTIONS	
	ADJOURNMENT	

STATEMENTS OF SPEAKERS

WELCOMING REMARKS

Trish Riley

It is a particular pleasure to welcome you here today. I think you all know that the Blaine House Conference on Aging is a most significant event for all of us in the aging network in Maine. In fact, I think it is fair to say that this is the single most important day for all of us involved in aging in Maine. It is so because you who are elected representatives of the 170,000 older people in this state come here to pass resolutions which will become state law and public policy for generations to come. What you do here today will direct the Maine Committee on Aging in its advocacy with the state legislature and the Bureau of Maine's Elderly in setting its future directions and future policies.

Floyd Scammon mentioned that this is one of many Blaine House Conferences on Aging. We should take a minute to look back and find out what has happened since the Blaine House Conference began. Maine had one of the first Property Tax and Rent Refund Programs for elderly citizens in the nation. It had one of the first low cost drug programs for older citizens in the nation. We were the first state in the nation to abolish mandatory retirement in the public sector. We have had significant victories in the legislature regarding nursing home reform. We have one of the few federally funded demonstration projects in adult day care here in the State of Maine. All of these achievements are the direct result of your work at these Blaine House Conferences on Aging.

As I look at the busy agenda before us today, I conclude that there are two rules of thumb that we are to follow. One is that people like me shoud give short speeches, and the other is that we need to follow parliamentary procedure if we are to proceed efficiently. We have with us Leonard Morry who will be helping me with parliamentary procedure. As most of you know, these sessions in the past were run by Representative Kathy Goodwin who had a good deal of experience in parliamentary procedure. So it occurred to me that before beginning the planning for today's session, I should call Kathy and ask, "How did you do it? What were the rules?" I went over and collected from her four or five pages on parliamentary procedure and her advice on how to keep this large delegation organized.

She reminded me that, to begin our planning for that first two-day Blaine House Conference in 1973, she and I and various members of the Maine Committee on Aging traveled around the state. We were in every single county in the state, and I don't remember how many thousands of miles we put on Kathy's car. We went to meal sites, to senior citizen clubs, and to area agencies on aging. Kathy would give a speech, and then we would hear all sorts of comments, ideas, and motions—your suggestions. I might add that we may possibly be the only two people who ever got lost in Aurora, Maine.

We realized in that summer of 1973 that older citizens had so many important ideas, ideas that needed to be articulated in Augusta, not just left in a club in Aurora or in Machias or in the little towns around the state. And that's where the idea came from, from the Committee on Aging and from that experience, for this two-day conference. What I'm talking about basically is the series of workshops that we have been having since that 1973 Blaine House Conference. Yesterday, 200 delegates whom you elected met here in Augusta to discuss position papers put together by various professional people. They discussed those papers, and you have in front of you a set of resolutions that came from that workshop session. From the workshop sessions you analyze the problems, analyze what we have learned, and come up with the resolutions which we will consider today. What I want to stress here is that what we are doing here today is acting upon ideas from you and from the 170,000 people you represent, not ideas from Augusta. That is the whole purpose of this conference and that is why this conference has been successful for so long a period of time. I would also remind you that last year every bill in the Maine Committee on Aging suported on your behalf before the legislature was enacted, and I am willing to bet that no group, particularly a citizen group, has a record like that with the Maine State Legislature. We thank the many helpful legislators and many of you who have been active for a long period of time. Still we cannot afford to become carried away by our victories. It was no easy task to win those victories, to meet with that kind of success. As Kathy and I were talking about that 1973 Blaine House Conference on Aging, we picked up the proceedings, the booklet that is published after every one of these conferences, and began to flip through it. There were some happy memories, including a speech by Jack Libby. I would remind you that in 1973, interestingly enough, four of the workshops were the same workshops we had yesterday — housing, transportation, nursing homes, and health. This proves that despite our legislative successes, there are still basic needs that we have yet to meet. In fact, with so much attention being given now to limiting spending of taxpayer dollars, as you take up these resolutions today, it is important to balance your needs with the constraints on state spending and to articulate to government what it is that older people really need and really want.

So we have a very hectic day ahead of us and I cannot stress strongly enough how important it is. I will reiterate that the resolutions you pass here today become law, become the direction of state government, the Bureau of Maine's Elderly and the Maine Committee on Aging. Yours is certainly an enormous responsibility.

I would like to go over the agenda with you today because we have had a change. As you know, the special session of the Legislature has gone into session this morning, and therefore Governor Longley will not be able to join us until 11:15 today. What we would like to do is change the schedule around and begin to consider some of the workshop resolutions now. Each chairman of each workshop will present to you the resolutions, copies of which you have

before you. On the last page of those resolutions you have general rules. I would like to quickly go through those rules so we know where we stand when we begin. First of all, all of you are delegates. All of you can speak. The workshop chairmen will make presentations of the resolutions as a whole. If you object to any one of them, if you want to debate any one, if you want to amend any one, if you want to question any one, go to either microphone and we will have two staff people there. Go to that microphone and say, "I would like this resolution set aside." The delegates will then vote on the rest of the plank and then come back to those resolutions which have been set aside. The only other major rule I want to alert you to is that any delegate wishing to speak more than twice on one resolution will need to get the permission of the whole body. We know that many of you want to speak and we do not want to allow anyone the opportunity to unnecessarily dominate the microphone. I think you see the rest of the rules in front of you. When we have questions, which we are bound to have, we will rely heavily on Leonard Morry. Later this afternoon there will undoubtedly be issues that are not addressed in the workshop resolutions. There will be an opportunity for you to present resolutions from the floor. And, again, those will be proposed, seconded, debated, amended, and voted upon. We would appreciate it if you would write out your resolutions beforehand and we will have one of the staff bring them up here for me to read. I think probably that is enough of the details for now, and I think we can probably get through at least one of the workshops before Governor Longley speaks. Thank you.

INTRODUCTION OF GOVERNOR JAMES B. LONGLEY

by Floyd G. Scammon

When our forefathers brought forth upon this continent a new nation, I believe they conceived that there would always be statesmen who would be willing to give their time and talents to the administration of our government, statesmen who wrote our constitution, who developed the system of laws, men who had been successful in their own business and were not dependent upon what they were doing for the government for their living, who were happy and willing to give of their time and talents for the benefit of the nation. Statesmen today are rare. They are few and far between. But we are very fortunate today that we have a statesman as Governor of the State of Maine. And I am proud and privileged to stand on this platform and introduce to you a true statesman, the Honorary James B. Longley, Governor of the State of Maine.

Address of
Governor James B. Longley

As Governor, it is my privilege today to welcome two very important groups to Augusta — the Blaine House Conference on Aging and the Maine Legislature. However, I want to do more than welcome both groups. I want to call on both for help.

Earlier today, I asked the 108th Maine Legislature to return $20 million of over-collected taxes to the people of Maine. I have, in effect, asked the legislature to help me to restore more faith and confidence in our government here in Maine by demonstrating to the people that we in Augusta are indeed concerned for the heavy tax burden being carried by our citizens.

Now, I would like to ask for your help, to ask you as representatives of aging groups throughout the state to share with the remainder of the state your wisdom, your experience, and your common sense and reason.

Maine, like other states throughout the country, has problems which, if they are going to be solved, are going to require the total resources of the state — not just financial resources and government services but our valuable human resources, resources which you have to offer. I refer specifically to problems in such areas as child abuse and neglect, drug and alcohol problems among our youth. Government by itself, I submit, is never going to be able to solve these problems which are deep rooted in our society.

That is why, today, I would like to ask the Blaine House Conference on Aging to undertake a study to determine how the Conference and the various senior citizen groups in Maine can help in these areas, how their efforts can be coordinated to provide volunteers to assist existing agencies.

I would, therefore, like to ask the conference to appoint a committee to sit down with our Commissioners of Human Services and Mental Health and Corrections and determine how a roster of senior citizen volunteers could be utilized in conjunction with efforts we already have underway in these critical areas. We would also share with this group an update of our own efforts and things we are trying to accomplish in such areas as child abuse and prisoner rehabilitation.

I am convinced that there exists among the membership of this conference and within the various organizations for the elderly and retired in this state valuable expertise that can be used in resolving complex social problems — problems that, we have found, cannot be resolved by dollars alone.

The problems we desperately need help on are those, I feel, which have been caused by breakdowns in such institutions in our society as the home and by a loss of values and morals in a complex and demanding society. I believe the

people of your age group, more than any other, have the capacity, experience, and knowledge to help us return to those values and morals in particular areas of need.

I would consider it a personal favor, to the people and family of Maine and to me as the Governor who is addressing this Blaine House Conference for the final time, if you would seriously consider this request and determine how you and your members can help. I believe that if this fifth annual conference could plant the seed for continuing involvement in these critical areas that this could become a hallmark for this great conference.

Again, I welcome you to this fifth annual conference and wish you well in all of your endeavors.

Thank you.

Introduction of the Keynote Speaker

by Jackson P. Libby

I have been asked to introduce the speaker of the day. I have been on the platform several times, and I believe that on at least one occasion I had the pleasure of introducing him. However, the honor I have today surpasses all other occasions. Why? Because I certainly did not expect this privilege and because in the eyes of humanity, Dr. Flemming continues to grow in stature and we know from his past experience in all matters of human rights that he has certainly become one of the foremost spokesmen for us, the aging, in the country today.

He was born in Kingston, New york in 1901. He learned at Ohio Wesleyan, American University, and George Washington University. He holds honorary degrees from these schools and several others. He has been an instructor at these schools and president of three others. He has been a member of the U.S. Civil Service Commission, the Manpower Commission, and chaired the Labor Management and Policy Commission. He has been director of the Office of Defense Mobilization and, during this time, was a member of the National Security Council and, by invitation of the President, participated in meetings of the Cabinet. He has been Secretary of the Department of Health, Education, and Welfare, and chaired the White House Conference on Aging in 1971 which I had the privilege of attending. Since 1974 he has been Chairman of the U.S. Commission on Civil Rights. As a result of a report on age discrimination recently completed by the Commission, Congress has just enacted a series of amendments outlawing age discrimination in federally funded programs. Floyd Scammon, Chairman of the Maine Committee on Aging, has this to say: "Dr. Flemming is a true friend of Maine's Elderly whose record in developing excellent programs and policies for older adults speaks for itself. I am certain that his speech at our conference will charge all Maine's people to take a keener interest in older people and to realize the urgent need for public education to a broad range of age discrimination." So you can see that, at 73, this man continues to work to make life better for all people, including us.

I could go on telling you things that I have here, but, with the exception of saying that he was married 44 years ago and has two daughters and three sons, I quit and let him take over. Will you now greet in a good old Maine tradition the keynote speaker, Dr. Arthur Flemming.

Keynote Address of

Dr. Arthur Flemming

Chairman, U.S. Civil Rights Commission
Former Commissioner, Administration on Aging

I am delighted to be here with you today. I recall during the five years that I served as U.S. Commissioner on Aging many kind relationships with the State of Maine. I recall being here for another Blaine House Conference. I recall holding a public hearing in this state. I recall my talks with leaders from this state. This state is outstanding as far as its work in the field of aging is concerned, and you are indebted to your leaders for the quality of leadership that they are providing, and I know that, in turn, they provide leadership for the nation as a whole. So I am delighted to have the opportunity of being here with you. I am here in my capacity as Chairman of the U.S. Commission on Civil Rights.

The U.S. Commission on Civil Rights came into existence in 1957 as a part of the Civil Rights Act that was passed that year. The Commission is a nonpartisan commission made up of six members, no more than three of whom can be members of the same political party. The members are appointed by the President and confirmed by the Senate. All the members have other duties and responsibilities. It is in a very real sense a citizen committee. The full-time work is done by a staff director and a staff in Washington and in our nine regional offices. The Commission is assisted by state advisory committees. One such advisory committee is located right here in the State of Maine. The Commission from the beginning has full responsibility for issues in the field of civil rights. It has performed two roles: the role of identifying basic issues in the field of civil rights, conducting field investigations, holding hearings, evaluating evidence, and making recommendations to the President and to the Congress. In addition, it has the responsibility of serving as an oversight agency for all of the departments and agencies of the federal government in the civil rights area. Here again, we conduct investigations, hold hearings, evaluate evidence, and make findings and recommendations to the President and to the Congress. Last week the President signed into a law a bill to extend the Commission for another five years. When Congress voted to extend the life of the Commission, it also voted to extend the jurisdiction of the Commission to include discrimination on the basis of handicap and discrimination on the basis of age. So here you see the connection between the Civil Rights Commission and the field of aging. Not only will we be concerned with discrimination on the basis of race, color, national origin, creed, and sex, but in addition we will be concerned with discrimination on the basis of handicap and discrimination on the basis of age. Not only are we confronted with racism in this coun-

try, not only are we confronted with sexism in this country, but we are also confronted with ageism. By ageism, I mean the practices which result in individuals being discriminated against on the basis of their age. I mean practices which result in individuals being denied, for example, jobs or being denied services not on the basis of the merits of the individual case but solely and exclusively on the basis of age. As a nation, we need to to everything within our power to wipe out ageism just as we also work on wiping out racism and sexism.

During the years that I served as U.S. Commissioner on Aging, I did travel throughout the nation. As I listened to groups of older citizens, I felt that I was listening to a certain message the older persons were trying to convey to our nation, to our society. One message, for example, was the message that they want to be in a position where they can make their own decisions regarding their own lives. They don't want other persons making those decisions for them. Another message was the message that they want to be in a position where they will have access to the kinds of services that will enable them to live in their own homes for as long as possible. Another message was the message that they must continue to be involved in life, they don't want to be put on the shelf. Still another message that came through time and time again was that, above everything else, they want to be treated with dignity. Let me focus on two of those messages.

Take that message that they want to be in a position where they can make their own decisions regarding their own lives. We all know that increasing numbers of older persons can be placed in that position if we can keep increasing the levels of national income as far as older persons are concerned. We know the interrelationship between the issues that confront us in the income areas and the area of Social Security. We know that over the period of the past few years the nation has confronted and still confronts a number of issues in the area of Social Security. I know that some persons discover they can capture the headlines by alleging that Social Security was on the verge of bankruptcy. Those statements were indefensible. They were cruel statements. The Congress that adjourned just a few hours ago did pass Social Security legislation, and I am sure that you realize and appreciate the fact that the action taken by them put the Social Security system on a sound fiscal basis through the turn of the century. Congress has passed what Congresses have done since the beginning of the Social Security system, and what Congresses will continue to do. They have taken both the short term and the long term fiscal issues. They have taken the kind of action that it is necessary to take to keep this system on a sound basis. The full faith and credit of the U.S. Government is that of the Social Security system. If anyone here has on their worry list the question of whether or not you are going to receive Social Security checks, I can say categorically that you can strike that from your list. That system is on a sound financial basis and it will continue to be on a sound financial basis.

Let's go to the second message. Older people want to continue to be involv-

ed in life. They don't want to be put on the shelf. That message came through loud and clear at the second White House Conference on Aging just as it has continued to come through loud and clear. The issue that has symbolized that message more than any other issue has been the issue of compulsory retirement. I recall as some of you do that the delegates to the second White House Conference on Aging went on record as being totally opposed to personnel policies that require retirement at a given age irrespective of the merits of the individual case. I am so happy to have the delegates go on record in that particular matter because I have long felt that policies that call for retirement at a given age without regard to the merits of the individual case represent unsound public policy. In the first place, they are simply a lazy person's device for dealing with a potentially difficult personnel issue. After all, if you have a policy of that kind in effect in the public or private sector, no one has to make any decisions. The calendar makes the decision for you. If you haven't got a policy of this kind in effect, then some person or group of persons will have to make what are sometimes difficult decisions. I have likewise long felt that a policy of that kind is in direct conflict with the Judeo-Christian concept of the dignity and worth of each human being. There is no way to look a person squarely in the eye and say "You've done a great job. You're continuing to do a great job, but you've reached a particular age and there's no more place for you," without violating that person's dignity. I am thrilled that in our nation we are beginning to make substantial progress in dealing with this issue. I am thrilled that the legislature of this state eliminated compulsory retirement as far as the public sector is concerned. I hope that the legislature of this state will follow and eliminate compulsory retirement not only in the public sector but also in the private sector. The Congress of the United States is providing us with the leadership in this area. As some of you know, under the leadership of Congressman Pepper of the State of Florida, during the second session of the 95th Congress a bill was passed by both houses of Congress and signed into law by the President which eliminates compulsory retirement on the basis of age as far as federal employment is concerned completely. There is no retirement age in the federal government from here on out. In addition to that, this law also takes the Age Discrimination in Employment Act and moves the upper level from 65 to 70. This represents real progress in combatting ageism as far as the field of employment is concerned. We need to keep at it until we eliminate these policies completely that call for compulsory retirement on the basis of age irrespective of the merits of the case.

In 1975 the Congress, when it was considering the Older Americans Act that year, not only took a look at this question of ageism in the area of employment, but it also decided to look at the question of ageism when it comes to the delivery of services supported in whole or in part by federal money. And it indicated that it was the desire of the Congress to outlaw discrimination on the basis of age in the delivery of services supported in whole or in part by federal funds. Before any laws became effective, Congress turned to the Civil Rights Commission and directed the Commission to make an indepth study and to report

back to the President and to the Congress. We filed our report in February of this year. We first of all identified some services that are supported in whole or in part by federal funds. We included in our list community mental health centers, legal services, vocational rehabilitation, social services under Title XX, the Comprehensive Employment and Training Act, foodstamps, medical assistance, vocational education, basic education, and admissions policies in the field of higher education. Next, we examined what was going on in the delivery of these services in a half a dozen areas throughout the country, utilizing our staff for the purpose of conducting field investigations. Those areas were San Antonio, Texas; St. Louis, Missouri; Jackson, Mississippi; Seattle, Washington; Chicago, Illinois; and Augusta, Maine and other communities in the State of Maine. Through these field investigations, over time, persons were interviewed as to what was going on in the delivery of services. In addition, the Commission held formal public hearings on this matter in San Francisco, Denver, Miami, and Washington, D.C.

We found that there was discrimination on the basis of age, particularly in relation to older persons, in these service programs supported in whole or in part by federal funds. We asked administrators, "Why is it that you are discriminating, for example, against older persons?" For example, we found that as we took a look at the community mental health centers throughout the country, out of the total number of persons that they had served, only 3-4% of the total number were 65 and over. In our public hearings, for example, we had administrators of these programs before us as witnesses. We asked "Why?" Sometimes they would say, "Older persons don't come to us." Then we would say, "Do you go to older persons? Do you carry out an outreach program?" Often the response was "No, we don't have the funds." When they said they didn't have money, we said, "Well, have you ever thought of using volunteers to reach the older person and let them know what services are available?" But in many instances when they were pressed very hard, they would finally say, "Look, we have limited resources. We think it's a better investment of the taxpayers' money to focus on younger persons than it is to focus on the older person." They didn't put it as bluntly as I am going to put it now, but their message came through rather loud and clear. After all, the older people are not going to be around very long. My Commission in its report condemned practices of this kind in just as emphatic a way as we could. We condemned them as being in conflict with the concept of the dignity and worth of each human being. In our letter of transmittal to the President and Congress, we said this: "We have given consideration to age discrimination as it relates to all the age groups. We have taken note of the fact, however, that the Age Discrimination Act of 1975 is a part of the 1975 amendments to the Older Americans Act of 1965. For that reason, we have given special consideration to the impact of age discrimination in the delivery of federally supported services on the lives of older persons. We are shocked at the cavalier manner in which our society neglects older persons who often desperately need certain federally supported services and benefits. Reasons advanced for such neglect

are devoid of feelings of respect and compassion for women and men who have contributed much to their families, to their community, and to our nation." We also said that we think that the act that was passed in 1975 could be improved in order to achieve the objectives of eliminating age discrimination in the delivery of services supported in whole or in part by the federal government. For example, in the preamble the Congress talked about "unreasonable" discrimination on the basis of age. We recommended that the word "unreasonable" be stricken from the preamble, to read "discrimination on the basis of age." The law as it passed originally did not provide for a right of action on the part of individuals who felt that they had suffered because of a violation of the law. We recommended that the right of action be provided. We also recommended that the power of the Department of Health, Education, and Welfare to pass on the regulations of other departments be strengthened. We likewise recommended the elimination of certain exceptions. To make a long story short, the Older Americans Act of 1978 has now passed the Congress. It is on the President's desk and will undoubtedly be signed. Included are some of the recommendations we made for amending the Age Discrimination Act. The word "unreasonable" is out. There is a right of private action provided. The authority of the Department of Health, Education, and Welfare has been strengthened. Some of the exceptions have not been taken out, but the effective date of the act has been set at July 1, 1979. In the meantime, the regulations promulgated by the Department of Health, Education, and Welfare are to be subjected to very close scrutiny, and if an interpretation is made that good relations canot be put out under existing law, further recommendations will be made for amendments to the law.

This past year under the Older Americans Act about half a million dollars has been made available to states and communities to help them in connection with the delivery of services to older persons. When the Age Discrimination in Employment Act becomes effective, if it is administered in a vigorous manner, it will open up for older persons resources in excess of that half a million dollars now available under the Older Americans Act. That is what it can mean to us as far as the field of aging is concerned, from a practical point of view. But it can mean the elimination of practices which are rooted in ageism and which are based on a lack of respect for the dignity and worth of older persons. Those practices need to be rooted out. The Age Discrimination in Employment Act provides all of us in the field of aging with an unparalleled opportunity to be of service to older persons. I said at the beginning of my remarks that the jurisdiction of the Civil Rights Commission has now been extended to include discrimination on the basis of age. This means that one of our oversight responsibilities will be to keep in touch with the federal departments and agencies to determine whether or not they are doing an effective job when it comes to the implementation of the Age Discrimination in Employment Act when it becomes effective on July 1, 1979. Personally, I welcome that assignment. I welcome that opportunity of continuing to be involved in a

meaningful way in the field of aging. There isn't any question in my mind but that all of us working together have got to keep coming to grips with ageism whether we find it expressing itself in the field of employment , or whether we find it expressing itself in the area of the delivery of services that are financed in whole or in part by federal funds.

My favorite story coming out of the White House Conference on Aging is the story of George Black. George Black is still living as far as I know and is now around 94 or 95 years of age. He is a member of the black community in Winston-Salem,North Carolina and is expert in making bricks by hand. In the early 1970's our government made it possible for him to go to Guiana in Latin America to teach others how to make bricks by hand. When he came back, he said, "I have always prayed to the Lord that my last days would be my best days. The Lord has answered my prayers." The Lord had answered his prayers because he had been given the opportunity of continuing to be involved, of continuing to be of service to his fellow human beings. It seems to me that you and I can enlist in the cause of doing away with ageism in the country. We can have the satisfaction of knowing that we are helping to answer the prayers of millions of older persons throughout our nation that their last days should be their best days. Thank you for all you have done, all that you are doing, and all that you will do to make the last days the best.

RESOLUTIONS AND RECOMMENDATIONS

AS AMENDED AND ENDORSED BY THE

GENERAL SESSION

OF THE SEVENTH

BLAINE HOUSE CONFERENCE ON AGING

RESOLUTIONS

1978 Blaine House Conference on Aging

ABOLISHING MANDATORY RETIREMENT IN THE PRIVATE SECTOR: HOW TO ACHIEVE AN ORDERLY PHASE-IN

1. WHEREAS, it is a responsibility of state government not only to insure adherence to reasonable and just laws regarding human rights issues but also to provide assistance and support to those required to comply with those laws;

   BE IT RESOLVED that, when the abolishment of mandatory retirement is extended to the private sector in Maine, the Maine Committee on Aging and the Bureau of Maine's Elderly will, in cooperation with organizations of labor and management in the private sector, assist in every reasonable manner the private sector to design and implement age-neutral reasonable criteria and standards of job performance to be used for the purpose of determining when employment should be terminated, or whenever any other action is taken relative to an employee's status.

2. BE IT RESOLVED that the legislation accomplishing the extension of the prohibition of the use of a mandatory retirement age to the private sector contain the same provisions regarding the use of a "normal retirement age" as found in P.L. 1977 Chapter 580.

3. WHEREAS, the 1978 Blaine House Conference on Aging re-affirms its unqualified support for the principles and objectives contained in Public Law 1977 Chapter 580, and

   WHEREAS, after studying the possible problems of extending a similar prohibition to the private sector and listening to the concerns expressed by representatives of that sector, the Conference participants find the potential problems to be ones that can be reasonably resolved,

   BE IT RESOLVED that the Conference urges the 109th Legislature to carry out the intent of Public Law 1977 Chapter 580 and enact a bill to extend such a ban to the private sector. This prohibition should encompass all employees in the private sector, without any exemptions. The implementation date for this new law should be January 1, 1980.

REDUCING THE COST OF DENTURES, EYEGLASSES, AND HEARING AIDS

1. WHEREAS, the Blaine House Conference believes it discriminatory for Medicaid to provide certain benefits to younger persons and not to older persons,

BE IT RESOLVED that the Medicaid program be amended to provide eyeglasses, hearing aids, and dentures to the elderly in the same manner now provided by Medicaid to those under 18 years of age, and that further, the legislature appropriate the required seed dollars to match the federal funds necessary to implement the program.

2. WHEREAS, the Blaine House Conference on Aging recognizes the increasing costs of eyeglasses, dentures, and hearing aids, and

   WHEREAS, the Blaine House Conference on Aging recognizes the substantial purchasing power of the state's 170,000 over 60 population,

   BE IT RESOLVED that this purchasing power be developed through the creation of two volume purchasing coordinator positions charged with negotiating contracts to reduce the cost of dentures, eyeglasses, and hearing aide and the attendant services for Maine's elderly.

3. BE IT RESOLVED that the Legislature set up a revolving senior citizen Dental Health Loan and Grant fund administered by the Bureau of Maine's Elderly and establish requirements for guidelines for administration of such funds.

DEVELOPING MORE EFFECTIVE TRANSPORTATION SERVICES: ALTERNATIVES TO THE CURRENT SYSTEM

1. BE IT RESOLVED that regional transportation providers be organized as corporations for the purpose of assuring transportation available in each region within the limit of available funds, and those corporations develop management plans which meet the approval of a Board of Directors representing the public and those receiving services. The target date would be October 1, 1979.

2. BE IT RESOLVED that, in the development of transportation priorities, while it is understood that socialization is a concern for some older people, transportation to and from doctors, dentists, and for other health and medical needs be the number one transportation priority.

3. BE IT RESOLVED that the Title XIX state plan be amended, beginning now and fully implemented not later than April 1, 1979, to assure that Title XIX will pay for transportation services for Title XIX eligible clients for eligible medical trips, thus lessening the burden of providing transportation from social service funds.

4. BE IT RESOLVED that the Blaine House Conference recommend that the legislature raise the sum of $75,000 to provide match funds to amend the Medicaid state plan to cover the cost of transportation for SSI Medicaid recipients.

5. BE IT RESOLVED that the State Insurance Commissioner be requested to make a study of justification of present insurance categories for social ser-

vice transportation providers and to report said study to the Commissioner of Human Services on or before December 1, 1978.

ADVOCATING FOR IMPROVED HOUSING SERVICES: THE NEED TO EXPAND EXISTING PROGRAMS

1. WHEREAS, there is a critical need for improved housing services for older people, especially those with low fixed incomes throughout the State of Maine,

   BE IT RESOLVED that,

   a) every effort possible of the Maine State Housing Authority and Bureau of Maine's Elderly be directed toward offering diversity and choice in housing including inter-generational living;

   b) all efforts and resources are to serve those with the greatest need and those in rural areas as equitably as those in larger towns and cities throughout the State, and

   c) strengthen the informational services to elderly regarding housing resources available to them.

2. BE IT RESOLVED that the Blaine House Conference urges the Bureau of Maine's Elderly and the Maine State Housing Authority to pursue the development of congregate housing for the elderly in Maine and provide localities with more information regarding resources.

3. BE IT RESOLVED that the Blaine House Conference urges the state Legislature to allow increasing the bonding authority of the Maine State Housing Authority and with the Bureau of Maine's Elderly explore funding sources to implement other home repair and rehabilitation programs.

4. WHEREAS, there is no specific standing Committee in the Legislature dealing with housing, and housing needs are critical in the State of Maine,

   BE IT RESOLVED that the State Legislature form a standing committee on housing.

5. WHEREAS, approximately 70% of older people reside in their own home, and more than three-fourths of these homes were built prior to 1940, and lack of income and inability to make repairs has resulted in deterioration of these homes,

   BE IT RESOLVED that the Maine State Housing Authority and the Bureau of Maine's Elderly concentrate their focus and explore funding sources to implement home repair and rehabilitation programs.

   BE IT FURTHER RESOLVED that low income clients should not be penalized with increased taxes as a result of moderate repairs. Inflation will take care of any increase in Social Security and the older homes will continue to deteriorate unless there is assurance that their taxes will remain stationary.

REDUCING BARRIERS TO QUALITY CARE IN NURSING HOMES

1. BE IT RESOLVED that an ad hoc committee be created by the Legislature to study existing legislation, regulations, and policies under which nursing homes operate and to evaluate such legislation, regulations, and policies in respect to the quality of life and the total physical, emotional, and social needs of the residents. Such an ad hoc committee will specifically address (a) the need for the establishment of an appeals review board, independent of the Department of Human Services, to review decisions pertaining to the Principles of Reimbursement and the licensing regulations and residents' appeals, and (b) the need for the adoption of a system of fines and graduated sanctions for facilities with deficiencies in meeting licensure standards, particularly in the area of resident care and resident rights. It is the specific intent of this resolution that the Committee include private citizens with no affiliation with financing agencies, providers, or regulators.

2. BE IT RESOLVED that the Maine Committee on Aging study alternatives for eliminating discrimination against Medicaid residents in nursing homes and present legislation directed toward this goal in the next session of the legislature.

3. BE IT RESOLVED that a standardized curriculum for basic nurse aide certification as presently offered by the Maine State Department of Education and approved by the Maine State Board of Nursing be adapted to include the holistic geriatric approach to resident care.

   BE IT FURTHER RESOLVED that financial assistance under either the Principles of Reimbursement or as the Legislature deems appropriate be made available to make available sufficient nurse aide educational opportunities to attend such courses.

4. BE IT RESOLVED that legislation and administration of regulatory services be revised to accomplish the removal of those barriers which inhibit the efficient use of middle level health practitioners, such as family nurse practitioners and physician assistants, in the delivery of quality coordinated nursing home care.

5. BE IT RESOLVED that the State of Maine will incorporate into the Principles of Reimbursement those psycho-social services which are presently restricted to private practitioners. This will include reimbursement to licensed mental health practitioners and social workers functioning as nursing home consultants, their fees to be determined by representatives from the Department of Human Services, the disciplines involved, and the Bureau of Maine's Elderly.

RESOLUTIONS FROM THE MAINE COMMITTEE ON AGING

1. BE IT RESOLVED that the time be extended which allows an individual

residing in a nursing home to keep his home/apartment beyond the six months presently allowed, to one year.

2. BE IT RESOLVED that mental health services be reimbursed by TITLE XIX (Medicaid) when provided by a mental health center outside its facility.

3. BE IT RESOLVED that the Maine Committee on Aging request from the legislature additional monies to support staff expansion of its Ombudsman Program.

4. BE IT RESOLVED that the Maine Committee on Aging support the expansion of the Low Cost Drug Program for the Elderly by increasing the number of drugs covered within current income guidelines.

5. BE IT RESOLVED that the Maine Committee on Aging support a transfer of assets bill which mutually prevents potential Medicaid fraud yet will not jeopardize older people who may want to give personal valuables to relatives or friends.

RESOLUTIONS FROM THE FLOOR

1. BE IT RESOLVED that the Maine Committee on Aging encourage the Maine Legislature to change the eligibility criteria of the Elderly Householders Tax and Rent Refund Program and the Elderly Low Cost Drug Program from $5,000 to $6,000 for a household of one and from $6,000 to $7,500 for households of two or more.

2. BE IT RESOLVED that the Blaine House Conference urges the State Legislature to present legislation for an on-going year-round fuel assistance program for low income elderly in Maine.

3. BE IT RESOLVED that the Bureau of Maine's Elderly and appropriate professionals work to reduce the cost of hearing aids and seek state reimbursement to provide hearing aids to low income elderly as inexpensively as possible.

4. WHEREAS, dentures are essential to the good health and nutrition of older people, and

   WHEREAS, the high cost of dentures prohibits many older people from purchasing dentures,

   BE IT RESOLVED that legislation be reintroduced to allow denturists to provide dentures directly to clients.

5. BE IT RESOLVED that a bill be presented to the 109th Legislature that one cent of the tax on every gallon of gasoline sold in the State of Maine be set aside for social service transportation.

6. WHEREAS, access to quality health care, especially in rural areas like Maine, is a major problem for older people and others, and

   WHEREAS, the high costs are preventing many ill older people and others from receiving decent health care,

   BE IT RESOLVED that the Blaine House Conference support the passage of a National Health Care Program.

7. BE IT RESOLVED that the Blaine House Conference on Aging support the suggestions and recommendations made by Governor Longley regarding volunteer service by older people and the recommendations of Dr. Flemming regarding efforts to end age discrimination.

8. WHEREAS, older persons and other homeowners are faced with an increasing burden of paying property taxes, and

   WHEREAS, It is morally right and fiscally responsible to help people stay in their own homes,

   BE IT RESOLVED that the Blaine House Conference on Aging of 1978 support the passage by the State Legislature of a Homestead Act, exempting from taxation the first $20,000 of assessed valuation of a person's primary residence.

Maine Committee on Aging Priorities from 1978 Blaine House Conference on Aging

1. Resolution #3 from Mandatory Retirement workshop — Be it resolved that the Conference urges the 109th Legislature to carry out the intent of Public Law 1977 Chapter 580 and enact a bill to extend such a ban to the private sector. This prohibition should encompass all employees in the private sector, without any exemptions. The implementation date for this new law should be January 1, 1980.

2. Resolution #3 from Dentures, Eyeglasses, and Hearing Aids workshop — Be it resolved that the Legislature set up a revolving senior citizen Dental Health Loan and Grant fund administered by the Bureau of Maine's Elderly and establish requirements for guidelines for administration of such funds.

   The Committee is considering a pilot project for one or two counties which would provide some cost and need data before attempting this on a statewide basis.

3. Resolution #3 from Transportation workshop — Be it resolved that the Title XIX state plan be amended, beginning now and fully implemented not later than April 1, 1979, to assure that Title XIX will pay for transportation services for Title XIX eligible clients for eligible medical trips, thus lessening the burden of providing transportation from social service funds.

   The Committee is considering amending the PSSP legislation to clarify that PSSP funds may be used to match federal funds, so that PSSP money could be used as the match for Title XIX.

4. Resolution, #1 from Nursing Homes workshop — Be it resolved that an ad hoc committee be created by the Legislature to study existing legislation, regulations, and policies under which nursing homes operate and to evaluate such legislation, regulations, and policies in respect to the quality of life and the total physical, emotional, and social needs of the residents. Such an ad hoc committee will specifically address (a) the need for the establishment of an appeals review board, independent of the Department of Human Services, to review decisions pertaining to the Principles of Reimbursement and the licensing regulations and residents' appeals, and (b) the need for the adoption of a system of fines and graduated sanctions for facilities with deficiencies in meeting licensure standards, particularly in the area of resident care and resident rights. It is the specific intent of this resolution that the Committee include private citizens with no affiliation with financing agencies, providers, or regulators.

   The Committee has reaffirmed its commitment to deal with the problems and issues outlined in this resolution but will not immediately move to establish an ad hoc legislative subcommittee until some other avenues have

been explored. This resolution is a priority of the Committee and the issues will be addressed in some form.

5. Resolution #5 from the Maine Committee on Aging — Be it resolved that the Maine Committee on Aging request from the legislature additional monies to support staff expansion of its Ombudsman Program.

6. Resolution #4 from the Maine Committee on Aging — Be it resolved that the Maine Committee on Aging support the expansion of the Low Cost Drug Program for the Elderly by increasing the number of drugs covered within current income guidelines.

   The Committee will support this resolution administratively.

7. To enact a sales tax exemption on meals purchased from various institutions for use in the elderly meals programs.

SELECTED STATEWIDE PRESS REVIEWS

Kennebec Journal, Oct. 18, 1979

Physician Complains About His Colleagues

NURSING HOMES CRITICIZED AT WORKSHOP

By Betty Potter, KJ staff writer

The quality of care provided by long-term nursing home facilities drew fire from persons attending one of the workshop sessions Tuesday during the first day of the Blaine House Conference on Aging.

The group included representatives of health care providers, staff members of the Bureau of Maine's Elderly and the Committee on Aging, a few senior citizens and a few who are patients in nursing homes.

They outlined complaints which they want brought up in resolutions to be presented to the full delegation today at the Augusta Civic Center.

Their major concerns were:

—Lack of humanism in long-term health care.

—Frustrating state regulations and policies which don't take total patient care into consideration.

—Discrimination against Medicaid patients by nursing homes.

—A lack of mental health care for the elderly.

—A lack of interest by physicians in long term health care patients.

Doctors criticized

The latter concern and others were addressed in a paper presented to the conference by Dr. Charles Burger, who charged that few physicians in the Bangor area have any interest in caring for long-term nursing home patients.

Dr. Burger, who was the medical director for three nursing homes for a six-month period, said he doubts if the physicians ever would be interested in long-term patients, no matter how much they were paid.

"Getting them to see their patients is a hassle, and most would not come at all except for the 60-day visit rule," he charged.

He said the doctors' attitudes have led to many state-imposed rules that increased paper work and the cost of care. In most cases, Burger said, the nursing homes — not the physician — were penalized.

Burger's paper stated that most patients were over-treated and under-cared for.

The physician charged that medications are often given unnecessarily, sometimes causing serious problems. Psychotrophics and antihypertensives can cause blackout spells, he said, and patients on insulin or oral diabetic drugs can often be more easily controlled with proper diets.

Burger also criticized the medical records kept by nursing homes, describing them as "chaotic." He complained of the lack of standard forms and of illegible notes by doctors.

Nurses' aides, he said, are given little leeway to act and think independently. But he said most of them care about their patients and feel that excessive paperwork and forms keep them from spending time with them.

Other complaints

Health care providers at the session said they are stymied by the state's Principles of Reimbursement, the state's attempt to keep nursing home health care costs from skyrocketing.

State staffers say the principles work. Nursing home administrators disagreed, claiming that the policy has cut services to the residents.

Administrators complained that they can't hire middle level social and mental health care practitioners — whom they say are sorely needed — because the state won't reimburse them for such services. They can hire psychiatrists or psychologists, they said, but that is rarely done.

Administrators said they would also like to be compensated for training nurses' aides. They said the aides are closer to the patients than anyone else and need continued education.

Members of Bureau of Maine's Elderly and the Committee on Aging said an ad hoc committee should be created by the Legislature to study regulations and policy under which nursing homes operate. They said patients should be evaluated for their total need, which would go beyond such basics as nutrition, physical and mental needs and sanitary care.

"We have to have better regulations and a more sensitive group of regulators," Dr. George Pauk, Portland, told the group.

The committee also said the nursing homes should be forced to accept Medicaid patients. Members said some patients who need nursing home care have to remain in hospitals, stay in homes where the people can no longer care for them or go without care because there is such a long waiting list at the homes.

Administrators said they have to reserve some beds for private patients because they pay more for their care than Medicaid patients.

Andrew Fennelly, administrator at Brentwood Manor, said they have to make out a budget, and that private patients pay for any extra services offered. If they made room for all the Medicaid patients, some services would have to be cut, he said.

There were also workshop sessions Wednesday on housing, transportation and other problems facing the elderly.

Over 1,200 persons are expected for today's session at the Augusta Civic Center as the conference continues.

Portland Press Herald, Oct. 19, 1978

ELDERLY WOULD STOP INDUSTRY FROM ORDERING RETIREMENTS

By Peter Jackson

AUGUSTA (AP) — Some 800 advocates for Maine's elderly threw their support behind resolutions Wednesday urging the Legislature to outlaw mandatory retirement in private industry.

The delegates to the annual Blaine House Conference on Aging voted unanimously in favor of three resolutions urging restrictions on private employers similar to those placed recently on state government.

Guest speakers in the packed Augusta Civic Center auditorium included Gov. James B. Longley and Dr. Arthur Flemming, chairman of the U.S. Commission on Civil Rights.

Flemming, in his 70s, was an adviser to President Eisenhower, and he praised the gray power group for its work and tagged mandatory retirement laws "a lazy person's device" for skirting alternative retirement methods.

"No one has to make any decisions," he said. "The calendar makes the decision for you."

The gray-haired delegates were greeted Wednesday morning by a group of pickets representing the Maine State Employees Association, which wants the state to use its $20 million surplus to beef up employee salaries instead of for tax rebates.

A random sampling of several delegates showed many of them stand behind the demonstrators. Said one: "They'll give the money back this year, and then when they don't have it next year, you'll pay for it."

Another commented, "I'm all for the state employees out there, because they've really taken a back seat since Longley came in."

The resolutions passed at the convention ask the Legislature to require private businesses to begin using "age-neutral" retirement standards by Jan. 1, 1980. Lawmakers have already implemented a similar policy for state employees and have pledged to consider the question for the private sector.

The delegates further suggested that the convention's sponsors, the Bureau of Maine's Elderly and the Maine Committee on Aging, be assigned the task of meeting with private employers to iron our potential problems with implementing the resolutions.

But mandatory retirement was only one of the myriad issues addressed at the convention. Many delegates spent Tuesday attending workshops on each issue, developing the proposals that were passed, changed or rejected on Wednesday.

Among the resolutions passed was one urging free eyeglasses, hearing aids and dentures for senior citizens receiving Medicaid and another designed to improve the quality of life of nursing home residents.

The Medicaid resolution called it "discriminatory" that persons younger than 18 years can quality for the health aids, while senior citizens cannot.

A resolution urging the Legislature to appoint an ad hoc committee to evaluate present and proposed regulations affecting the state's nursing homes was overwhelmingly approved by the delegates.

Kennebec Journal, Oct. 19, 1978

Agency Found Discrimination Routine

TREATMENT OF THE AGED CRITICIZED

By Betty Potter, KJ staff writer

The chairman of the U.S. Commission on Civil Rights said Wednesday that he is shocked by "the cavalier manner in which society ignores older persons."

Dr. Arthur Flemming, the keynote speaker at the Blaine House Conference on Aging at the Augusta Civic Center, said that the elderly are discriminated against in service programs and in employment opportunities.

Flemming told 1,200 conference delegates that the agency uncovered serious problems in a recent in-depth study of discrimination against the mentally handicapped and the aging.

The review, Flemming said, covered a variety of programs and services supported by federal funds, from mental health and vocational rehabilitation centers to the food stamp and CETA programs. It found that discrimination was routine.

He said the agency found that mental health centers ignore the problems of the elderly, and said that only three or four percent of their patients are senior citizens.

Flemming said the centers complained that the elderly would not take an active part in their programs. But he said the centers had made no effort to conduct an outreach program to attract the elderly.

The attitude of clinic personnel, Flemming charged, is that "it's a better investment to focus on young people; the older people aren't going to be around very long."

Flemming, the former commissioner of the Administration of Aging, said such an attitude is deplorable. He said it denies the dignity of the elderly.

The agency's findings were relayed to Congress, Flemming said, and a bill was passed which will put some teeth into the Older Americans Act of 1978. He said he expects the bill to be signed into law soon.

The older law bars "unreasonable discrimination" against the elderly, Flemming said. The new measure deletes the word "unreasonable" and also provides an avenue of response by those who feel their rights have been violated.

Dr. Flemming promised the group that the agency would keep track of the new bill to make sure it is administered properly when it is signed into law.

Flemming said the desires of the elderly are clear:

- "We want to be in a position to make our own decisions regarding our lives."

- "We want access to the kinds of services which will allow us to live in our own homes."
- "We want to be involved instead of being put on the shelf."

And most of all, he said, the elderly want to be treated with dignity.