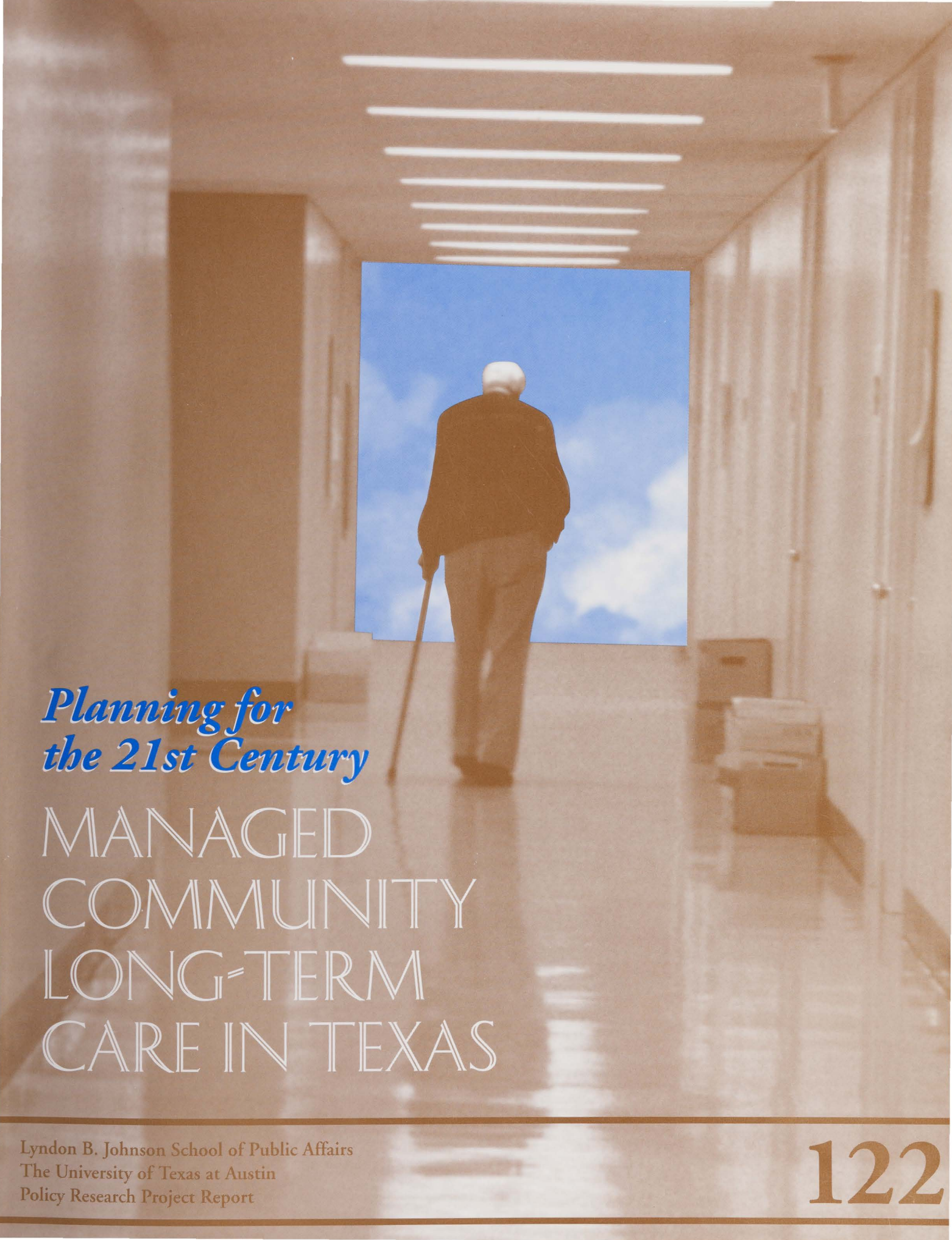

Planning for the 21st Century

MANAGED COMMUNITY LONG-TERM CARE IN TEXAS

Lyndon B. Johnson School of Public Affairs
The University of Texas at Austin
Policy Research Project Report

122

Lyndon B. Johnson School of Public Affairs
Policy Research Project Report
Number 122

Managed Community Long-Term Care in Texas: Planning for the 21st Century

A report by the
Policy Research Project on
Managed Community Long-Term Care in Texas
1997

Library of Congress Catalog Card No.: 97-73906
ISBN: 0-89940-732-3

Cover design by Doug Marshall
LBJ School Publications Office

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Dean's Foreword

The Lyndon B. Johnson School of Public Affairs has established interdisciplinary research on policy problems as the core of its educational program. A major part of this program is the nine-month policy research project, in the course of which two or more faculty members from different disciplines direct the research of ten to thirty graduate students of diverse backgrounds on a policy issue of concern to a government or nonprofit agency. This "client orientation" brings the students face to face with administrators, legislators, and other officials active in the policy process and demonstrates that research in a policy environment demands special talents. It also illuminates the occasional difficulties of relating research findings to the world of political realities.

This report is the product of a policy research project conducted in the 1996-97 academic year with client support from the Texas Comptroller of Public Accounts. In addition, numerous individuals contributed to the research and academic efforts. The study informed Senate Bill 273 of the 75th Legislature, a bill proposing to develop a comprehensive guide to senior services. The policy research project participants designed a prototype for a Consumer Awareness Tool, one component of the Guide, designed to help older individuals and their families assess their individual needs in order to make proactive decisions about their long-term care options. Future research will require that the comprehensive consumer guide, including the Consumer Awareness Tool, for senior services be evaluated statewide.

The curriculum of the LBJ School is intended not only to develop effective public servants but also to produce research that will enlighten and inform those already engaged in the policy process. The project that resulted in this report has helped to accomplish the first task; it is our hope that the report itself will contribute to the second.

Finally, it should be noted that neither the LBJ School nor The University of Texas at Austin necessarily endorses the views or findings of this report.

Max Sherman
Dean

Foreword

Given the heavy involvement of families in keeping pace with demands at work, with their children, community activities, and, in many case, with care giving, there is little time to make informed decisions about choices that provide the best possible care for elders in need of assistance. The "Consumer Awareness Tool for Long-Term Care Decision Making" developed as a result of a policy research project directed by Jacqueline Angel, Ph.D., at the Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, is an excellent tool for families in need of accurate and useful information. We think the tool will be especially useful to minority families who have, traditionally, tended to care for elderly family members in the community rather than in institutional settings. The Consumer Awareness Tool is an important component of a guide that has the ingredients for informed decision making: a directory of service providers, information about available services, assistance to identify and assess options, and available in a variety of formats. We salute Dr. Angel, her graduate students, and her colleagues for compiling this very worthwhile document.

John V. Diaz
Regional Administrator
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Administration on Aging

Executive Summary

The research undertaken in the policy research project *Managed Community Long-Term Care in Texas: Planning for the 21st Century* was in response to a trend taking shape in our nation: through changing attitudes and technological developments, families are not as close-knit as before, and the old are routinely reaching more advanced ages before dying. Additionally, states are struggling to adjust to the increased demand for long-term care, while simultaneously designing a managed community long-term care infrastructure that accommodates consumer preferences in the most cost-effective manner.

American families formerly relied solely upon themselves to care for their elderly relations. With the advent of Social Security and changing family mores, the government took on more of a role in elder care. Nationally, however, the government is now reducing its interest, leaving an uncertain future. State and local governments are struggling with decreasing funds and an increasing population to serve. No longer can we be assured that family members or the government will be able to care for us as we age.

As more of our elders require assistance, whether it is formally given in a care center, or provided in the home by family members, they and their families have a growing need for information that will help them make the right choices for their lives. Sometimes these decisions are as simple as "Who will take Grandmother to the hair stylist today?", but often they are as emotionally wrenching as deciding when to place Grandmother in a nursing home and how to pay for it.

Families do have choices when making elder care decisions, but we do not understand how as consumers they make their buying decisions. What questions are raised among family members? What care options are considered? What bearing do ethnicity and socioeconomic status have on the decisions?

Understanding long-term care choices has important policy implications as well as familial ones. Because we do not understand how families or individuals make their long-term care choices, we cannot guide them to make the best choices, nor can we provide the information regarding long-term care resources that they may need or want. We embarked on this research project for two reasons: first, to understand how consumers make choices, and second, to discover how we could best reach them as they are about to make those choices or, better yet, to reach them while they have plenty of time for thoughtful consideration.

Too often, long-term care decisions are made at moments of crisis. The family has been aware of an elderly member slowing down or having difficulty, but the repercussions have not been addressed. Suddenly, usually after a serious, life-changing illness, the family must scramble to make a decision. Sometimes houses are sold and lifestyles changed in order to pay for the care. If families had already considered the options available and made plans, they might not have had to make such serious lifestyle changes.

Today in Texas, there is no centralized source of information about long-term care for elders. The 75th Legislative Session is preparing to vote on the adoption of a statewide consumer guide for senior citizens (Senate Bill 273). To help redress this problem, we are developing an interactive tool that will enable families and policy makers to decipher long-term care issues: the Consumer Awareness Tool for Long-Term Care Decision Making.

This interactive tool will allow seniors and their families to explore the wide-ranging issues that affect their long-term care choices, and to make those choices that best fit their needs and desires. It will also enable policy makers to identify and respond to family needs on a statewide basis.

To develop consumer products to promote proactive decision making, three key issues that state and local policy-makers must consider are raised in Chapter 1:

1. Given the consumers' circumstances, what should they know to make informed decisions about long-term care?

2. How much information is necessary, and is it available and easy to access? Is the format current, accurate, and easy to understand? For example, if consumers would like to shift from a traditional fee-for-service plan to a managed care plan, would they know what the advantages and disadvantages are? Is a referral number available should the consumer want additional or more specific information or help? A recent national survey indicates that consumers have great difficulty understanding basic health-care system concepts. What information and services/resources are currently available, and to what extent are consumers aware of these options?

3. What is the best method or methods of combining all this information so that providers, both private and public, can best serve the consumer?

Chapter 2 provides a literature review of six subject areas pertinent to the discussion of long-term care: Housing/Living Arrangements, Financial and Legal, Medical/Long-Term Care Insurance, Long-Term Care (including managed care), Family Supports/Relationships, and Successful Aging. Within Chapter 3, we give the specific aspects of the Tool along with the typology we have developed to apply to it. To help fine-tune the Tool's appendices, we conducted two focus group sessions. The results we gleaned from these sessions, as well as the additional questions they raised, are presented in this chapter.

This guide, as discussed in Chapter 3, will:

"(1) contain a directory of service providers for senior citizens, in a format developed by the interagency work group created under Subsection (b) 403.026 and arranged by geographical area if appropriate;

(2) contain comprehensive information on services available to senior citizens, including long-term care services, housing assistance, meals, personal care, and transportation;

(3) enable a senior citizen or other person assisting a senior citizen to identify and assess each option available for meeting a senior citizen's individual needs;" and (1) prominently display: (A) the regional toll-free access number of the appropriate area agency on aging; and (B) the toll-free number of the Texas Department on Aging."

Furthermore, the bill proposes that "(k) The comptroller shall make the guide available to the public through the Internet; and each area agency on aging and, on request, to another stage agency in electronic format [as well as] to as many senior citizens in the agency's service area as possible (section 101.031, b)."

Chapter 4 delves more deeply into the specifics of developing the appendices, which are "scripts" meant for consumer interaction. We explain what scripts are and how they work with the quiz and the typology. We look at the selection process for subjects and the corresponding creation of a script on various topics related to long-term care planning.

Chapter 5 contains our summary and recommendations, detailing ways to promote access to and choices in community-based long-term care, including services and supports. It is followed by our references and appendices, which contain representative topical scripts.

Without planning and preparation, many seniors and their families will find themselves in the dark about long-term care alternatives. They need information about the long-term physical and social needs of a diverse aging population, including both in-home and community-based long-term care, and incorporating managed-care principles, in order to make effective decisions.

Utilizing print and the information technology of the Internet, we hope to reach a broader section of the population, so they can begin early to prepare for the possibility of using long-term care services and supports. As consumers become more familiar with long-term care options, and managed care continues to infiltrate new markets, the hard decisions will be made much easier in an environment in which information is readily available and in which stereotypes are reduced. The fears of elderly Texans and their families can be greatly eased by knowing fully what the options for long-term care are, and by being prepared, financially and emotionally, when the time comes.

Chapter 1. Managed Community Long-term Care in Texas: Planning for the 21st Century

Introduction

Thousands of Texans face long-term care decisions every year, and that number is growing significantly. Long-term care broadly refers to medical, social, and personal care services needed by individuals who have lost some capacity to care for themselves because of a chronic illness or condition. Without adequate planning and preparation, many seniors and their families will have a difficult time finding solutions to meet their long-term care needs. The cost of such inadequate decision-making about long-term care alternatives is often the independence, dignity, and health of an individual. In addition, there is a substantial monetary cost when inappropriate or more intensive services than necessary are provided.

According to a 1990 study prepared by The Daniel Yankelovich Group, Inc., "Many Americans are either uninformed or misinformed about long-term care and how they would pay for it" (Yankelovich, 1990, p. 4). A recurring theme is the lack of public information regarding options for individuals or families in choosing a desired long-term care arrangement. This lack of education makes it difficult for many Texans to incorporate personal preferences into the decision-making process for long-term care. The problem is further complicated by the fact that the state does not have a single entry access point for long-term care services, and that individuals and family members often rush their long-term care decision because of a sudden incapacitating illness. For example, the Health and Human Services Task Force Commission on Long-Term Care reported that "many people think only of institutional services when they or their family members face a need for long-term care, causing many inappropriate or premature placements in institutions" (Texas Health and Human Services Commission, 1994, p. 45). In fact, many experts agree that if people had access to sufficient informal and formal long-term care supports in the community, the number of individuals cared for in nursing homes could be reduced.

Focus of the Policy Research Project

States must increasingly rely on strategies that redirect existing federal and state dollars to more efficient and effective delivery systems. State policy-makers are recognizing the importance of consumer direction and control of service systems. It is important to increase choices in long-term care because the current system is fragmented and complex, creating hardships on Texas families. Often the elderly and their family members are unaware of the options available when deciding about long-term care. As a result, a person may enter a nursing home prematurely if other options were not considered. As consumers have overwhelmingly stated their preference for remaining in their homes as

long as possible, the chief objective of this policy research project, *Managed Community Long-Term Care in Texas: Planning for the 21st Century*, has been to examine ways to increase access to, and choices in, home and community-based long-term care alternatives for elderly Texans.

This report examines ways to facilitate the decision-making process regarding long-term care. Specifically, the report presents a consumer awareness tool for seniors and their families that can be instrumental in the long-term care decision-making process. Further, the project will develop a "consumer awareness tool" prototype, designed to help consumers identify their desires, needs, and alternatives for support services or long-term care choices long before the senior or family feels compelled to make irrevocable decisions that may leave nursing home care the only remaining option. This consumer awareness tool consists of four basic elements: a questionnaire for long-term care decision making that identifies the user's needs and preferences for long-term care services (see Appendix A), a scoring algorithm for the questionnaire (see Appendix A), a set of profile types that categorize the user's needs and preferences for long-term care services based on their responses to the questionnaire (see Appendix A), and a set of scripts that provide pertinent information related to the types of needs and preferences they have indicated (see Appendices C through R). This will be discussed further in Chapters 3 and Chapter 4.

Ultimately, but beyond the scope of this policy research project, a future study will determine whether or not consumers would want to use a customized interactive information tool that would educate, guide, and inform older individuals and their families in the decision-making process regarding long-term care, and whether or not consumers would find this tool helpful.

Although the 50 states share many of the same challenges regarding long-term care, Texas has some unique characteristics that makes the task even more complex. The demographic characteristics, vast land mass, and cultural diversity are manifested in several ways in the state's senior population, and pose specific challenges in determining the best options regarding senior services. As the Texas population ages over the coming decades, the importance of providing high quality, cost efficient long-term care services that meet the needs and preferences of consumers will become even more significant.

Demographic Trends Affecting Long-Term Care Utilization

Although younger on average compared with other states, the Texas population is growing older. Whereas one in eight Texans was elderly in 1900, by the year 2030 one in five is expected to be over the age of 65. The Texas senior population will more than double from the current 1.7 million to a projected 3.9 million in 2020 and will represent more than 15 percent of the state population (Moorhead, 1996, p. 11). Such rapid growth in the number of Texans who will survive into their seventh, eighth, and ninth decades, and the record number of baby boomers who will retire early in the next century, raise

serious concerns about the future demand on long-term care services and the ability of the state to meet that demand.

Senior Texans are themselves aging, and are expected to be the fastest growing segment of any age group in the state. The number of Texans over age 85 will double between 2000 and 2010 (Moorhead, 1996, p. 11). In 1995, 43 percent of Texas' nursing home residents were aged 85 years or older (Moorhead, 1996, p.11). Given the association between advanced age and infirmity, the most elderly Texans face the greatest need for personal assistance and institutional nursing care.

While the elderly population is becoming ever larger, a greater proportion will be minority group members from the state's large immigrant population, especially those from Mexico and Central America. The number of Hispanics 65 years or older will more than double by 2010 and should exceed 1.6 million by 2030. Furthermore, the number of elderly African-American Texans will more than triple by 2030 to more than 400,000. Other minorities, primarily Asian-Americans, will grow faster than any other elderly group, rising from 13,000 in 1990 to nearly 750,000 by 2030 (Moorhead, 1996, p.11).

The growing racial and ethnic diversity among Texas seniors has consequences for health and long-term care planning and service utilization, because minority groups' preferences and needs for long-term care services may differ from those of the majority. A mounting body of evidence suggests that cultural factors affect the choices that individuals make regarding long-term care and influence the role the family plays in the care of elderly persons. This influences the overall assistance package that Texas seniors will need and be able to rely on or willingly accept (Angel, 1996, p.5)

In Texas, there is a larger proportion of elderly persons in rural areas than in urban areas. Approximately 9 percent of the urban population in Texas is 65 years and over compared to 16 percent of the rural elderly population (Rural Health in Texas, 1995, p. 5). In 1994, the elderly accounted for at least one-fifth of the population in more than 50 Texas counties. Most of those counties were rural (Moorhead, 1996, p. 8). The potential consequence of this pattern is significant, because there are disproportionately fewer long-term care services in many rural areas of Texas, and in some areas no services are available.

Currently, there is widespread debate over whether the public or the family should be responsible for the care of the elderly when they become disabled. The expectations and willingness of adult children to provide care will continue to be challenged as attitudes and families' capacity to bear the cost of caring for a frail parent continue to change. Several family characteristics are worth noting. First, it is anticipated that between 14 and 17 percent of female baby boomers will remain childless and will therefore be unable to rely on their children for assistance. Second, the increase in the number of women entering the labor force has grown dramatically since the 1960s, giving rise to a different set of expectations and abilities among adult children in Texas to care for their elderly parents. Third, the rise in the aged-dependency ratio (the ratio of the number of persons per 100 aged 65 and over to the number of persons per 100 aged 18 to 64) will increase

the demand for health and disability services. In Texas, the aged-dependency ratio (a measure of demand placed on society) has been rising, and will continue to do so well into the next half-century (Angel, 1996, p. 5). This will increase demands on the state and seriously strain its fiscal resources.

Long-Term Care Infrastructure in Texas

Federal funding streams dedicated to long-term care flow through state and local agencies to consumers along different paths. In Texas, state agencies such as the Texas Department of Human Services, Texas Department of Health, Texas Department of Mental Health and Mental Retardation, Texas Rehabilitation Commission, and the Texas Department on Aging provide direct funding for long-term care and for health and social services. In addition, state general revenue pays for a large portion of long-term care services. Local funds generated through such agencies as the local Area Agencies on Aging and Community Mental Health and Mental Retardation Centers also contribute to long-term care services. Finally, private, non-profit foundations, such as the United Way and Goodwill, fund some long-term care services.

Typically, state and federal legislation and agencies administering long-term care funds set priorities for who gets long-term care services and what services will be offered. Factors that determine eligibility include age, diagnosis, severity of disability, and income criteria. The criteria for determining these factors vary considerably among the different agencies. The differing criteria bar many people from receiving services even if they have the kinds of needs that are met by the programs, and even if they cannot afford to pay for long-term care services on their own.

In addition to eligibility criteria, funding constraints often limit services to individuals. Programs may also limit the number of individuals that can be served, the amount of services a person can receive, and/or the length of time such services will be made available. All this can result in people not being able to receive an appropriate array or adequate amount of services. In some cases, services may be limited geographically, leaving people in certain communities without access. The result of all these limitations is a complex patchwork of services that consumers must attempt to negotiate. The net effect is that the current system does not satisfy the needs of many Texans.

Financing for acute, post-acute, and long-term care services is splintered among many payers. Long-term care for the elderly is financed primarily by Medicaid; acute care for the elderly is financed primarily by Medicare (National Association of Insurance Commissioners, 1996, p. 5). As a result, primary responsibility for these sectors of care is divided sharply between the federal and state governments, resulting in a strong incentive for the federal government to shift costs to the states and vice-versa (Wiener and Skaggs, 1995, pp. 3-4). This results in an uncoordinated service delivery system, costing seniors more than necessary. Additionally, consumer choices for senior services may be limited because of the competing interests of publicly funded services such as Medicaid and Medicare.

Decision-Making for Long-Term Care

Each year, long-term care decision-making involves millions of elders, family members, and professionals, each of whom may have specific obligations and interests. The decisions concern at the least: 1) where an elder with long-term care needs should live; 2) what sort of care the elder needs and therefore ought to receive; and 3) who ought to provide the long-term care services. The decision-making process is often complicated by a host of logistical issues such as finances, family work schedules, living space, and responsibilities. Conflict can arise from a disparity between a senior's actual and perceived ability to make decisions, an uneven distribution of caregiving burdens, an uncertain sense of spousal or family obligations, a lack of clarity about roles and power, and emotional discord between and within decision makers (McCollough, 1995, pp. 1-2).

Despite the fact that most elderly wish to remain in familiar community settings, frequently they are not able to do so, because of economic, social, and health factors and cultural preferences (Angel, 1991, p. 48). For example, family members may feel that the senior cannot live alone because of the onset of physical incapacity coupled with a language barrier (Burr, 1990, pp. 96-101). For some family members, a general lack of information makes it difficult to integrate personal preferences into the decision-making process. Still others find that personal preferences cannot be given proper consideration, because decisions are made in a crisis when an undesirable outcome may be imposed on the senior (Groger, 1994, pp. 86-87).

Although the empirical literature on long-term care decision-making is sparse, it suggests several factors. First, members of the elderly population differ in both their preference for, and access to, long-term care services, programs, and settings. This can affect both the probability of suffering from a debilitating chronic illness and the number and types of services used by these elderly individuals. Second, individuals vary in the number of constraints they face (e.g., chronic illness), the kinds of informal supports available, financial capacity, etc. They experience varying degrees of difficulty understanding how to make informed choices and how to gain access to specific components of the system. Finally, older consumers and their families use a combination of strategies to help them gain access to long-term care, and they rely on different channels to choose options available to them (Angel, 1996, p. 12). Each of these factors contributes to the decision-making process.

Long-term care decision-making is thus an enormously complex process, because it involves a series of medical, social, and personal decisions, made incrementally over time by multiple decision-makers, rather than a single, well-defined, time-bound decision made, as in acute care, by the dyad of physician and patient (McCollough, 1995, p.2). The series of decisions, made in social, cultural, economic, and health contexts, influences pathways into care and the eventual outcome that determines the type of care an individual receives. Rarely, however, does long-term care decision-making follow an ideal model in which a person has access to "perfect information," is able to gather all relevant data and information, and uses these resources to reach decisions that maximize his or her wellbeing.

Family Role in the Decision-Making Process

Historically, the family's role in long-term care decision-making has been important. Currently, family members are the ones who usually respond to changes in an older family member's ability to care for himself or herself. While "families invented long-term care" (Kane, 1995, p. 15), they continue to be involved when the need for care goes beyond their abilities. When the older family member gradually or suddenly requires help with daily living, the family begins the search for long-term care services. The need to consider alternatives or options can arise not just from physical changes in abilities but from the emotional perception that more help will be needed in the future.

The way families respond to long-term care needs depends on a range of factors. The specific situation and existing relationships determine whether family help is needed and whether family members are able and willing to give it. Whether the family exists at all, and factors such as geographical distances between family members, also determine the degree of family involvement.

There are many implications for the entire family when it recognizes a member's need for long-term care services. This can be a difficult time for both the aging person and the family. Parents can have a difficult time accepting the reality that they are getting old because it jeopardizes their independence. Correspondingly, their adult children may have a difficult time accepting the situation, because it increases their responsibility.

This time of decision making can be confusing and frustrating for both parties. No system currently exists to help families make clear choices about long-term care and services. Where does one go for accessible, reliable, and easy-to-understand information about what to do and how to proceed? Unfortunately, there are so many more questions than answers.

The physical and financial aspects of caring for an older family member are not the only "demands family members must face. Old issues of parent-child relationships may be rekindled, or dormant sibling rivalries may resurface. These emotional aspects of family relationships — and simply talking about the future — are often the most difficult hurdles to overcome" (Equitable Foundation and Children of Aging Parents, 1995, p. 3).

When a family member finds herself or himself in a situation of giving care to an elder, many of the demands can be overwhelming. It is important that caregivers take care of themselves to avoid exhaustion, depression, or illnesses resulting from "trying to do it all." With all these implications, it is easy to see why and how families delay planning for emergencies. "And, all too often, the burden of having the toughest decisions falls to the adult children, often the daughter" ("Advice for the Elderly," 1997, p. K-1).

Chapter 2. Literature Review

Although the empirical literature on the process of long-term care decision making is sparse, there is voluminous research regarding the many factors that may influence decisions. Kane and Kane have reported that multiple variables come to bear on the final selection of services (1987, pp. 353-365). These variables include level of income, culturally-based attitudes, social networks, health and medical issues including characteristics of the health care delivery system, the senior's personal preferences or tasks that must be performed, the family's ability to cope, and even media cues (Angel and Angel, 1997, pp. 8, 98, 135; Verbrugge and Jette, 1993, 1-14).

One of the challenges of this research project was to review and synthesize the empirical literature on long-term care, with a two-fold objective. First, it was imperative to be familiar with the present, expert knowledge in the field. The following analysis of the research informed the development of the Consumer Awareness Tool "scripts," which will be discussed in Chapters 3 and 4. Second, the literature review allowed the research group to identify the broad categories which frame the topic of long-term care.

In order to organize the immense literature, the concerns of the elderly were categorized into six broad areas: (1) long-term care services and medical care, (2) housing and living arrangements, (3) legal matters, (4) financial factors, including health insurance and long-term care insurance coverage, (5) family relationships and social support, and (6) successful aging and leisure. In reality, these categories cannot remain discrete. For example, financial and legal matters are rarely separate issues. Furthermore, some readers may organize the information in entirely different categories, and the subtopics within each category may be thought of in different ways.

Long-Term Care Services and Medical Care

Long-term care is defined in many different ways. The following comprehensive definition of long-term care is commonly accepted and used for the purposes of this report:

> Long-term care is a set of health, personal care, and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity (Kane and Kane, 1987, p.18).

Services intended to address the temporary needs of the frail elderly are not part of this definition for long-term care. Furthermore, this definition focuses on functional problems, which are often linked to health conditions. However, because long-term care is often intertwined with acute health care, the distinction between the two can be blurred (McCollough and Wilson, 1995, p. 37).

Although it is the elderly, especially people over 85 years of age, who typically need long-term care, people of any age with physical, mental or cognitive impairments that interfere with the ability to function independently may have a need for an array of long-term care services. Functional disabilities can arise at birth, as a result of accidents or illnesses, or as a result of the normal aging process. According to the Texas Special Census, 17 percent of adults over 65 years of age need services; of those adults 85 years or older, 60 percent have functional disabilities that may require long-term care (Texas Department of Human Services, 1992, p. 10).

Because long-term care is increasingly defined on the basis of the population served, it is important to understand the diverse population groups that may require long-term care and their often distinct service needs. For instance, the long-term care needs of chronically mentally ill adults may be quite different from the long-term care needs of children living with their families. Even within the elderly population, disparate resources and diverse needs make it difficult to typify long-term care needs.

Long-term care consists of a range of services and informal supports intended to assist with routine, chronic, and episodic events related to an individual's functional disability for an extended period, often for the life of the individual. Table 2.1 lists the array of comprehensive long-term care services recommended by the Texas Health and Human Services Long-Term Care Task Force Report. It is important to note that such an ideal continuum of care exists only on paper.

Table 2.1.
Recommended Comprehensive Long-Term Care Services

Information and referral	Service management/case management
Assessment, planning and evaluation	Transportation
Access to legal assistance	Community integration
Adult day care	Housing, shelter, and home modifications
Foster care	Emergency response systems
Homemaker and chore services	Personal assistance services
Food, meal services, and nutrition counseling	Durable medical equipment
Nursing care	Physical, occupational, and speech therapy
Medical supplies	General medical services
Hospice care	Respite care
Individual, group, and family counseling	Assistive devices
Caregiver training and support	

Source: Adapted from Texas Health and Human Services Long-Term Care Task Force Report, 1994, p. 54.

For many Texans, long-term care is often equated with care in a nursing home. The conceptual definition of long-term care focuses not on the place of service, but on the help that compensates for functional disabilities. Therefore, long-term care services may

be delivered in a variety of settings including an institution, a home or residence, or in what are referred to as community-based settings. Institutional-based long-term care includes skilled nursing facilities, state mental hospitals, intermediate care facilities, personal care homes, group homes, and congregate-care homes. In-home long-term care may include visiting nurses, homemaker and chore services, personal assistance services for activities of daily living, and home-delivered meals. Examples of community-based care include respite care, day care, sheltered workshops, senior citizen centers, transportation, and day rehabilitation services.

Informal care, provided by family members or friends, is the primary source of long-term care. Research shows that not only do families provide most long-term care; today they provide more care and more difficult care to larger numbers of old people over longer periods (McCollough and Wilson, 1995, p. 43). A national profile of family members who provide long-term care reveals that adult children are most frequently the primary caregivers, followed by spouses, siblings, and other relatives. Irrespective of the relationship to the person receiving care, most of these caregivers are women and approximately one-third are working outside the home (McCollough and Wilson, 1995, p. 43).

Medical Care

Elderly people are more likely to have chronic conditions and certain illnesses that increase their need for medical care than the total population. Respiratory conditions and injuries are the leading acute conditions in the elderly population and usually require medical attention. The likelihood of hospitalization and the average length of stay increase with age. Seniors are also more likely than younger people to visit a physician (Rice, 1996, pp. 4, 20-27, 31 and 35).

Traditional medical care, a system characterized by "fee-for-service," was once the primary means of providing medical care services. In fee-for-service plans, the insured or self-paying consumers (patients) go to the physician of their choice and pay for medical care services rendered. Privately insured consumers are reimbursed according to their health insurance plan. Medicaid, Medicare, Veterans Administration and other government-sponsored health care programs reimburse physicians, hospitals and medical-related services according to program regulations (Whigham-Desir, 1996, p. 2).

Alternative medical delivery systems are increasingly chosen by individuals, employers, insurers and governments concerned about increased health care costs and spending, as well as accessibility to and quality of medical care. Medicare (which provides acute care for individuals 65 years of age and older) and Medicaid (which covers medical care for low income elderly, as well as other eligible populations) are increasingly incorporating "managed care" models to provide medical care services to the nation's elderly population.

Several managed care models exist, and they share the following common characteristics:

1. a network of primary care providers who manage a patient's medical care and, in effect, provide a medical home for the patient and control the use of medical services;

2. a capitated payment system that allows pre-payment for medical services available to members enrolled for a contract period; and

3. financial incentive, or financial risk, designed to encourage participating physicians and managed care plan administrators to make cost efficient decisions in providing medical care (Blumberg, pp. 2-5; Texas Health and Human Services Commission, 1997, pp. 105-107).

Although there are many variants, the major managed care models include:

1. Health Maintenance Organization (HMO) - The Health Maintenance Act of 1973 and subsequent amendments define an HMO as a system of comprehensive health care service provided to a geographically defined group of voluntary enrollees under a fixed, pre-paid contractual agreement;

2. Primary Care Case Management (PCCM)- A network of providers are paid through the traditional "fee-for-service" but also receive a specified amount for coordinating patient care, or "gatekeeping" activities; and

3. Preferred Provider Organization (PPO) - A network of providers offers medical services at a discounted fee-for-service rate. Enrollees using providers outside the network will any add additional fees (Association of Maternal and Child Health Programs, 1996, pp. 42-43).

Housing and Living Arrangements

In the past ten years, housing policy for the elderly has focused on the development of supportive living arrangements for frail older persons (Pynoos and Golant, 1996, p. 319). The increasing number of people age 75 and over and their expressed preferences for alternatives to nursing homes have given rise to new housing approaches to long-term care. Older persons, family members, and most professionals agree that the nursing home is the option of "last resort" (Pynoos and Golant, 1996, p. 303). Instead, supportive housing refers to arrangements where there is a closer match between types of services and levels of care provided and the extent of the resident's need than is typically found in nursing homes. This potential to better match residents' needs to housing and services is strongly preferred by many Americans and offers a better alternative to nursing homes.

The literature on support systems for long-term care and housing describes a continuum-of-care framework for the range of housing and services available to elderly individuals. However, the availability of institutional and home- and community-based services varies

considerably among areas in the United States because of current long-term care policy and financing. This tends to be a "form follows funding" situation in which policies and financing are "decentralized, categorical, and limited" (McCollough and Wilson, 1995, p. 45). Theoretically, along this continuum of long-term care there are several types of housing and services designed to meet individual needs in the aging process. The continuum ranges from living at home alone, with contracted formal and/or informal services, to living in an institutional setting, such as a nursing home. In the center of the spectrum are both licensed and unlicensed forms of housing called retirement homes, care homes, assisted living, continuing care retirement communities (CCRCs), etc. These facilities vary with respect to what services are provided and at what cost (McCollough and Wilson, 1995, p. 51).

More on Assisted Living as an Alternative

The American Association of Retired Persons defines assisted living as "any group or residential program that is not licensed as a nursing home, that provides personal care to persons with need of assistance in the activities of daily living and that can respond to unscheduled needs for assistance that might arise" (Gordon, 1996, p. 3). Currently, assisted living policy is defined according to state regulation of the industry (Gordon, 1996, p. 3). In Texas, assisted living facilities include "personal care homes" and are regulated by the Texas Department of Human Services.

States are in the process of defining standards for assisted living that address the quality of care, safety, and other consumer protection measures (Gordon, 1996, p. 5). There is a consumer and regulatory movement to define assisted living at the national level so that families can be ensured of high-quality service, well-trained workers, safety and adequate health measures (Mathews, 1997). What is important to any universal definition is balancing health and safety regulations with provisions for provider flexibility and consumer autonomy. Providers are interested in regulation that enables them to provide high-quality service at a low cost (Gordon, 1996, p. 5).

States are considering assisted living care as an alternative to nursing homes. For this to be workable, it must be cost-effective. Few studies have been conducted that examine the cost-effectiveness of assisted living. One notable exception is Oregon, where assisted living has shown promise as a cost-effective alternative to nursing home care. Where assisted living is a Medicaid-covered service for nursing-home-certifiable clients, state costs of assisted living are approximately 80 percent of total public costs of nursing homes. Private rates of assisted living facilities (which are not regulated) are 80 percent less than the private rates of nursing homes (Kane, 1993, p. viii). Texas is among those states that have authorized Medicaid waivers for assisted living. The Texas program funds up to 22,000 residents in a range of settings, including assisted living, at a rate of $30 to $40 per day (Mollica, 1996).

Some research shows that if assisted living is to be a feasible alternative, choice and autonomy are the two most important features to be considered (Yee et al., 1996, p. 8; Gordon, 1996, p. 8). Another study concluded that existing state regulations make it

harder and more expensive to develop assisted living models that take into account the features of choice and autonomy (Kane and Wilson, 1993, p. 104; Gordon, 1996, p. 9). Other research suggests that states "move away from the traditional 'safety' model for establishing assisted living standards" (Gordon, 1996, p. 9).

For a Texas personal care home provider, assisted living is defined as an umbrella for all levels of long-term care: full board and care, respite care, personal care (Mathews, 1997). In assisted living, a provider assists an individual with performing activities of daily living. The distinction comes with the acuity of the needs: the goal is, or should be, that the recipient is in a home or facility that provides the assistance levels he or she needs. Often the distinction between institutional and personal care is defined by the degree of personal interaction between staff and residents (Mathews, 1997).

Legal Matters

The massive growth in the elder population is predicted to create major stresses in the economic and societal framework of the United States. Even today, issues such as increases in health costs, competition for limited government dollars, and the failure of the existing social framework to deal adequately with the many dimensions of aging have highlighted the need to provide specialized legal assistance for seniors. This particular facet of legal practice is commonly known as "elder law."

The term "elder law" is a relatively new one. Over the past decade, the legal profession has begun to recognize a cluster of specialized legal areas as being particularly important to older persons. Elder law encompasses traditional areas of legal practice such as estate planning and probate, as well as public benefits such as Medicare and Social Security, and issues such as planning for long-term care placement and health-care decision making.

Legal problems that affect the elderly are growing in number. Our laws and regulations are becoming more complex. Actions taken by older people with regard to a single matter may have unintended legal effects. Table 2.2 lists some of the many different fields of elder law.

Many of the attorneys who specialize in elder law are also familiar with the networks of other professionals (such as ombudsmen, social workers, geriatric care managers, or other elder care professionals) who can provide related services to older persons. They may also be trained in the mental and physical effects of the normal aging process.

Table 2.2.
Select Areas of Elder Law

Preservation/transfer of assets seeking to avoid spousal impoverishment when one spouse enters a nursing home

Medicaid

Medicare claims and appeals

Social security and disability claims and appeals

Supplemental and long-term health insurance issues

Disability planning, including use of durable powers of attorney, living trusts, "living wills" for financial management and health care decisions, and other means of delegating management and decision making to another in case of incompetence or incapacity

Conservatorships and guardianships

Mental health law

Probate

Estate planning, including planning for the management of one's estate during life and its disposition on death through the use of trusts, wills and other planning documents

Management of trusts and estates

Elder abuse and fraud recovery cases

Age discrimination in employment

Long-term care placements in nursing home and life care communities

Housing issues, including discrimination and home equity conversions

Nursing home issues, including questions of patients' rights and nursing home quality

Health law

Retirement, including public and private retirement benefits, survivor benefits and pension benefits

The broad range of legal areas covered by elder law delves into what might seem arcane minutiae of the topics noted above. For instance, estate planning not only includes the management of an estate during the person's lifetime and planning how the estate will be divided upon the person's death, through wills; it also covers trusts, asset transfers, tax planning, and other methods of managing assets. Long-term care planning includes nursing home issues such as quality of care, admissions contracts, prevention of spousal impoverishment, and resident's rights. It also includes evaluating the proposed plan/contract covering the life care or retirement community. Planning for possible incapacity through choosing in advance how health care and financial decisions will be made if the individual is unable to do so (methods include durable powers of attorney, health-care powers of attorney, living wills, and other means of delegating the decision making) presents the senior citizen with an often bewildering array of choices.

Social Security (retirement and disability and survivor's benefits) and other public (veterans, civil service) and private pension benefits have spawned a vast labyrinth of legal hurdles and complexities. Medicare, Medicaid, medigap insurance, and long-term care insurance have assumed a growing importance because of governmental policy making. Housing issues, including home equity conversion and age discrimination, have also become items of importance to Texas seniors, especially with the possibility of home equity legislative reform in Texas.

Recent initiatives by the U.S. Congress and several states to restrict eligibility for federal assistance (e.g., Medicare and Medicaid) have been of special interest to seniors. Many people would be interested in knowing how to shift the costs of their care to governmental entities, rather than burdening family members or diminishing their present-day quality of life by diverting scarce assets towards insurance plans (Dobris, 1989, pp. 378-380). Not surprisingly, one of the specialties in the practice of elder law is financial and legal planning for senior citizens, aimed at preserving savings and assets.

The range of public assistance available to senior citizens is intertwined with so-called "welfare" programs. Current political battles at the national and state levels regarding "welfare" keep elder law in a constant state of flux. It is imperative, therefore, that Texas' aging population have access to competent legal advice to facilitate smooth transition from working life to the "golden years." One potential source of counseling on this sort of information is the Texas Health Information Counseling and Advocacy Program.

Financing Acute and Long-term Care for the Elderly

Although people age 65 and over account for slightly more than 10 percent of the current U.S. population, over one-third of total health expenditures in the U.S. are paid on behalf of the elderly. Furthermore, per capita consumption among the elderly is disproportionately distributed, with persons aged 85 and above consuming 2.5 times more health care than those elderly aged 65 to 69 (Waldo et al., 1989, pp. 111-120).

Members of lower socioeconomic groups will rarely be able to support their own long-term care or that of a parent. The poor face dependence on public support after a lifetime of little retirement saving and health care coverage (Angel and Angel, 1997, p. 15)

Acute Care

Three federal health programs are the predominant sources of financing for senior acute health care services: Medicare, the insurance program for the aged; to a lesser extent, the Medicaid program for the poor; and the health care program of the Department of Veterans Affairs. Medicare consists of two programs: Part A, the hospital insurance component, and Part B, the supplemental medical insurance component. In order to reduce, if not avoid, out-of-pocket costs, approximately two-thirds of the elderly supplement their Medicare coverage with 'medigap' policies that pay the deductible and coinsurance required by Medicare and sometimes cover services not available under Medicare (Wiener and Illston, 1996, pp. 427-430). Because health care coverage provides

a major avenue to health care, individuals, especially minority Americans, who lack health insurance also lack an important supplement to Medicare.

Post-Acute Care

Under the nursing facility Medicaid waiver program, states are granted the authority to design waiver programs that best suit the needs of the population served which otherwise would require care in a nursing home. This waiver program requires recipients to be age 21 or over.

Many states have been encouraged to develop a wider array of service options for the elderly, such as the community-based waiver program. (Equitable Foundation and Children of Aging Parents, 1995, pp. 16-17; Texas Health and Human Services Commission, 1994, p. 25). Texas's waiver program includes case management, homemaker services, home health aide services, personal care services, adult day health, habilitation, and respite care.

Through a variety of waiver programs, Texas offers a range of home and community-based services including personal care facilities (e.g., assisted living) to a specified number of individuals who meet specific medical eligibility criteria. Since 1995, when the community-based alternative waiver program was piloted, the number of enrollees has exploded. The pilot program served 557 clients at a cost of $6.7 million. By 1997, the Legislature authorized 13,100 enrollees to be served on a state-wide basis at a cost of $160 million, and there is a substantial waiting list.

Long-Term Care

The potential for all but the wealthiest individuals to be burdened with catastrophic costs can be greater with long-term care than with most acute care cases (Wiener and Illston, 1996, p. 434). One recent study concluded that various family members provide most long-term care services informally at home and for free (Moses, 1993, p. 41) Furthermore, individuals paid 45 percent of nursing home costs in 1990, according to the American Association for Retired Persons (Texas Health and Human Services Commission, 1994, p. 22).

The other major sources of payment for long-term care include: (1) privately funded long-term care insurance policy, (2) government assistance (Medicaid or limited Medicare), (3) some combination of the above, or (4) accelerated death benefits (Farrell, 1996, p. A-1). The Veterans Administration also covers some long-term care costs. The amount of nursing home expenses covered by the Veterans Administration depends upon Medicaid eligibility and financial need. For those veterans who are living in the community but who need assistance with activities of daily living or are house bound, an additional amount may be added to a monthly pension benefit upon receipt of a doctor's statement.

Those individuals who have sufficient personal savings and income for the foreseeable costs of long-term care need neither Medicaid planning nor long-term care insurance.

(Farrell, 1996, p. A-4) Others have private financing plans, such as private long-term insurance, to help with part or all of the costs of services. Long-term care policies are not currently widespread. The plans can be expensive and the benefits vary significantly. Many policies pay only for nursing home care, excluding home and community-based services (McCollough and Wilson, 1995, p. 48). In Texas, private health insurance paid for only approximately 1 percent of total nursing home costs as of 1990 (Texas Health and Human Services Commission, 1994, p. 22).

Medicaid is by far the largest public funding source of long-term care, paying approximately half of the national nursing home expenses (National Association of Insurance Commissioners, 1996, p. 5). In Texas the percentage is even higher: in 1992, Medicaid supported more than 70 percent of nursing facility residents (Texas Health and Human Services Commission, 1994, p. 24). Unlike Medicare, which provides coverage primarily for acute health care, Medicaid is an entitlement program. The state cannot turn eligible Medicaid recipients away for of lack of funds.

Medicaid reimburses for nursing home care, other institutional care and, on a more limited basis, for home and community-based care. Originally established as a federal-state medical insurance program for low-income persons, Medicaid has gradually shifted to become the primary public funding source for long-term care (McCollough and Wilson, 1995, p. 45). The type of long-term care services reimbursed by Medicaid varies considerably between states. Currently in Texas, to be eligible for Medicaid support for community-based and nursing home long-term care services, an individual is limited to $17,424 in annual income.

For Medicaid, specific eligibility limits apply to married individuals. The Medicare Catastrophic Coverage Act of 1988 permits a spouse who is entering a nursing facility to qualify for public financial assistance and, at the same time, protects the spouse who is still living in the community from utter impoverishment. Under these laws, the couple's assets and income must not exceed certain limits. The couple's assets and income are calculated on the basis of confirmed values as of the beginning of the first, continuous 30-day period of institutionalization. Resources are examined again at the time of Medicaid application.

Accelerated Death Benefits

New products are being developed to provide alternative methods of financing for long-term care costs. One of these products, accelerated death benefits, converts life insurance benefits so that they become payable to the insured before he or she dies, but only after a life event, such as a diagnosis requiring extraordinary medical intervention (Polacheck, 1996, p. 1). Currently, there are three types of these products being marketed in Texas:

1. benefits paid without any contingencies at the time of diagnosis of terminal illness or permanent disability;

2. benefits paid at the time of diagnosis of terminal illness or permanent disability, but with restrictions as to the types of facilities; and

3. benefits paid subject to the terms of a rider attached to the life insurance policy (Angel and Pelley, 1996, p. 1).

The strongest market segment for this type of insurance coverage would be those individuals who have life insurance policies with sufficiently high cash values to cover an extended period of long-term care services (Wiener et al., 1992, p. 51). However, those individuals who do receive these benefits may enjoy greater cash value than those who either cash in the policy or borrow against policy reserves (Wiener et al., 1992, pp. 73-75).

Although growing demand for new insurance products and financing approaches indicates consumer attitudes are changing, it is anticipated that the family will continue to be the primary source of long-term care financing (Angel and Angel, 1997, p. 21). This trend will be true especially for minority populations and single women (Angel and Angel, 1997, pp. 115-116).

Family Relationships and Social Support

Older people wish to stay in their homes and in the community for as long as possible. This option helps preserve independence and can save money on health care costs. Family or friends, often referred to as informal support, can be of significant assistance to older Americans. However, supporting elders in the community does have important implications for family members and friends, who may find themselves cast in the role of unpaid informal caregiver.

Families provide 80 percent to 90 percent of personal and instrumental (explained below) help to older people. The current assumption that modern families no longer take care of their elderly as they did in the past is wrong. Formal services do not encourage families to reduce or withdraw the amount of care they provide, nor does home care substitute for nursing home care. Women, primarily wives, daughters, and daughters-in-law, provide the bulk of long-term care for older people (Kane and Penrod, 1995, pp. 15-16). This has implications for long-term care because of the increase of women working outside the home.

The assistance that older persons need can come from paid, unpaid, or a combination of paid and unpaid providers and sources. On average, a person's long-term care needs are met through some combination. Currently, no system coordinates care and services to ensure that their needs are met as Americans age and experience changes in physical and mental capabilities. Public and private insurance programs address different physical and mental conditions. The bulk of long-term care needs is for chronic conditions for which institutionalization is unnecessary, inappropriate, and not covered by Medicare. "The vast majority of noninstitutionalized frail elderly, therefore, depend on informal helpers, primarily their kin. Even for individuals who are severely disabled, nearly 60 percent of the disabled elderly rely primarily on family caregivers" (Wolf et al., 1996, pp. 115-116).

What Does a Caregiver Do?

Caregivers provide a range of services. Approximately two-thirds assist an older person who cannot perform activities of daily living, often assisting with three or more activities. Most caregivers help with grocery shopping, transportation, housework, meal preparation, or financial management. Half of all caregivers help administer medicines (Family Caregiving Alliance, 1996). Caregivers tend to link older family members to "formal systems, respond in emergencies, provide intermittent and acute care, share their homes, and provide emotional support" (Kane and Penrod, 1995, pp. 16). Pearlin goes on to state:

> Most forms of support that have been identified fall within two general types: instrumental and expressive support. The former refers to the services and resources that help individuals deal with life demands, and the latter pertains to the actions, gestures, and words that engage individuals' thoughts.... Both instrumental and expressive supports are further divided according to whether their sources are formal or informal. Formally provided support is distinguished by its contractual nature; that is, the relationship is usually limited to the provision of support, and the support is typically given in return for previously agreed-upon material considerations. By contrast, informal support is a feature of ongoing relationships whose history and interactions encompass more than the exchange of assistance. Informal support can be both instrumental and expressive, but formal support, at least at its outset, is usually established to provide instrumental assistance (Pearlin et al., 1996, p. 285).

Effects of Caregiving

There are obvious physical and mental consequences of providing care to an older person or family member, but effects on caregivers had not been addressed fully until the 1980s (Kane and Penrod, 1995, p. vii). Stress is a central issue in the discussion of effects on caregivers (Pearlin et al., 1996, p. 290). Primary stressors are "the potential demands and hardships directly involved in the provision of day-to-day care. Primary stressors are also in the form of subjective reactions to caregiving activities, such as a feeling of overload — exhaustion from hard work laced with a sense that there is no connection between the level of intense and relentless effort and the level of accomplishment." Secondary stressors are those that "involve conflicts between the demands of caregiving and the demands of work among caregivers having outside employment"(Pearlin et al., 1996, p. 292).

Caregivers receive their own support from formal sources and from other family members and friends. It has been suggested that this "help and support, perhaps, both shields caregivers from some of the stressors to which they would otherwise be exposed and relieves them of emotional distress they would otherwise experience" (Pearlin et al., 1996, p. 290).

Implications and Areas for Further Study

A caregiver's physical health is affected by the very act of caregiving, but the dollar costs of health and mental health care for caregivers themselves have not been quantified (Kane and Penrod, 1995, p. 9). The care needs of the elderly often exceed the capacity of the family to fulfill. Moreover, the definitive study by the Brookings Institute has shown that most people cannot afford private long-term care insurance to pay for the services of a professional provider (Kane and Penrod, 1995, p. 17). There is a clear perception that many elderly people are institutionalized for social rather than medical reasons. The main reason for this is the inability of informal caregivers to cope with the increasing demands of care.

While government policy is focused towards increasing community care and the retention of the elderly in their homes and neighborhoods, it may be based on the false assumption that there is an infinite, or at least adequate, supply of potential informal caregivers. It is important, therefore, to have a clear indication of the scope and limitations of informal care and an assessment of the formal services that support them. Without developing a more integrated informal and formal care service network, more elders will be institutionalized before their time, creating more financial stress on an already burdened health care system.

Successful Aging and Leisure

A lifetime of healthy habits cannot guarantee independence and self-sufficiency for seniors, but research has found that the longer life expectancy among the general population of developed countries is attributable to better health and living conditions (Angel and Angel, 1997, p. 24). Considerable literature indicates that individuals can slow the biological component of aging by participating in healthy habits such as an exercise program, a healthy diet, weight control, and continued social life and leisure (Fries, 1989, pp. 65-84; Healthwise, Inc., 1992, pp. 255-318; American Association of Retired Persons, 1995, pp. 2-4).

Health and functional capacity are a mix of biological and social factors. Studies have shown that both mental and physical health are impaired by lack of social supports (Crimms et al., 1994, pp. 159-175; Guralnik et al., 1993, pp. 110-117; House et al., 1982, pp. 123-140). However, various cultural groups differ in the quantity and quality of social support that is expected (Angel et al., 1997, pp. 85-86). It is not clear why black and Hispanic older persons are less likely to enter a nursing home and are more apt to live in extended family households (Worobey and Angel, 1990, pp. 370-383; Murtaugh et al., 1990, pp. 957-958). Yet, even if the impetus is economic, these living arrangements can provide an older individual with a responsive social network and increase the likelihood of remaining healthy (Angel et al., 1997, p. 87).

Loneliness brought about by social isolation is a major health risk for the elderly (Lopata, 1970, p. 54). Specifically, elderly persons who lack social ties to family, friends, or church fellowship have been found to be at increased risk of mortality (Seeman et al.,

1987, pp. 721-722). Yet many seniors have not developed the skills to increase social interaction after the death of an intimate companion. Angel, Angel, and Henderson report that the health benefits derived from the social support of just one or a few very close relationships may be sufficient (1997, p. 88). Of course, having only one or a few close intimates leaves one at risk for more loss (Angel et al., 1997, p. 88). "Individuals with limited social support may either experience more stress or may be less well equipped to deal with it than those with more social support" (Angel et al., 1997, p. 89).

"Gerontology has long acknowledged the important role of leisure in the extended vitality and life satisfaction of aging persons" (Cutler and Hendricks, 1990, p. 169). Highly satisfying leisure activities may result in both increased active life expectancy and extension of middle-aged physical and functional viability into the later years. Sufficient evidence suggests that well-being is associated with involvement in leisure activities (Cutler and Hendricks, 1990, p. 176). Of course, personal health problems are the constraint most frequently cited by persons over 60 years of age as causing them to limit or to give up outdoor recreation activities (McGuire et al., 1986, pp. 538-544).

New Directions

The initial challenge of this research project was to explore the considerable body of knowledge surrounding long-term care of the elderly. The literature review formed the foundation on which the rest of the project has been built. Because of the difficulty that many older Texans have had in locating appropriate and affordable levels of care, the subsequent challenge was to condense the literature into a consumer-friendly format which would increase access to and choices among the alternatives Texans clearly prefer — home or community-based long-term care. The preliminary consumer awareness tool is the result of these efforts.

Chapter 3: The Senior Citizen Consumer Guide

Background

Historical Perspective

Because of the reduction in federal funding coupled with increasing demand, the 1982 *Texas Long-Term Care Plan for the Elderly* proposed partnerships among public and private sectors and volunteers to address the needs of elderly Texans. The Plan noted the challenges facing Texas in meeting the health care needs of its aged citizens: a growing population of elderly Texans; greater demand for long-term care services; and the escalating cost of providing services. Among other goals set forth to address these challenges were mechanisms for coordinating long-term care policies and services provided by public, private, and volunteer resources; creating a common database for long-range planning, as well as developing policy and program initiatives; a statewide information and referral network for long-term care services for elderly consumers; and an appropriate long-term care environment for users with as few restrictions as possible (Governor's Long-Term Care Planning Group, 1982, pp. 1-4).

The 1989 Special Task Force on the Future of Long Term Health Care was mandated by the 70th Legislature's House Concurrent Resolution Number 213 to "study the current and future status of long-term health care in Texas and to analyze all current laws and regulations that affect long-term health care" (Special Task Force on the Future of Long Term Health Care, 1989, p. 87). In its report to the 71st Legislature, the Special Task Force made 36 recommendations covering issues pertaining to:

1. quality of life in institutional care;
2. continuum of care services;
3. staffing needs;
4. income eligibility;
5. long-term care rates; and
6. regulatory program revisions.

Specific recommendations included, among other things, increased respite care services, community-based pilot programs under Medicaid waivers, and consumer advocacy and legal services for residents of nursing home facilities. (Special Task Force on the Future of Long Term Health Care Delivery in Texas, 1989, pp. i-iii).

Also reporting to the 71st Legislature, the 1989 Special Task Force on Rural Health Care Delivery in Texas expressed concern for elderly Texans living in rural communities. In comparing urban and rural populations, the Task Force noted that in 1987, 19.6 percent of Texas' total population consisted of rural residents, of whom 23.3 percent were 65 years

and over. Special concerns in rural areas include a greater demand for community health services and a lower tax base, both resulting from the greater number of elderly who generally have fixed incomes (Special Task Force on Rural Health Care Delivery in Texas, 1989, p.5).

In August 1994, the Texas Health and Human Services Commission's (THHSC) Long-Term Care Task Force issued the *Long-Term Care Task Force: Final Report and Recommendations*. Recommendations included:

1. adequate resources and funding to coordinate long-term care for Texans needing the services;

2. development of a model for long-term care delivery which is seamless, integrated, and coordinated;

3. equitable choices with emphasis on community services;

4. a formal, and independent when available, quality assurance system based on customer satisfaction; and

5. long-term care delivery driven by local entities (THHSC, 1994, pp. 1-9).

The conclusions and recommendations of the various committees and task forces on aging and long-term care exhibit common themes, emphasizing:

1. appropriate, high-quality long-term care services that support the elderly individual at home, in the community, or in a nursing home facility, depending on need;

2. adequate funding to provide an array of long-term care services to meet the needs of the elderly population of Texas;

3. a long-term care service delivery system that coordinates information on and services provided to the elderly population of Texas; and

4. consumer/public awareness of long-term care alternatives.

Recent Legislative Action

The 1996 Texas Performance Review recommended an amendment to State law by which the Comptroller of Public Accounts will direct the development of a "comprehensive, statewide senior services directory and information book" (Texas Comptroller of Public Accounts (TCPA), 1996, p.5). To implement the project, an interagency group will be established including the Texas Comptroller of Public Accounts, Texas Department on Aging, Texas Department of Housing and Community Affairs, Texas Department of Human Services, and The University of Texas. Release of the senior service guide is

scheduled for January 1998, in print, CD-ROM and World Wide Web format. The amended legislation authorizes the Texas Health and Human Services Commission and the Texas Department on Aging to allocate needed resources to complete and support the project (TCPA, 1996, p.5).

The proposed legislation, Senate Bill 273, is being considered by the 75th Texas Legislature (1997). The bill directs the TCPA to guide the development of a statewide consumer guide for senior citizens and to be responsible for updating the guide annually. This Legislative session has generated several bills in both the House and Senate that address this issue.

Senior Citizen Consumer Guide

The Senior Citizen Consumer Guide will provide a mechanism for enhancing consumer and public awareness of long-term care alternatives and for coordinating information provided to elders needing to make long-term care decisions. This comprehensive guide will consolidate a vast amount of information related to long-term care and help nondependent consumers to make more informed decisions prior to needing services and supports, either formal or informal (Angel and Moorhead, 1996, p.7). The development of the Senior Citizens Consumer Guide will involve three steps:

1. creation of the Consumer Awareness Tool composed of:

    a. Questionnaire for Long-Term Care Decision Making;
    b. scoring algorithm;
    c. profiles types; and
    d. scripts;

2. identification of specific and related circumstances of long-term care planning to help guide consumers in the best direction; and

3. dissemination of information through traditional print media or newer technologies such as the Internet or other telecommunication channels (Angel and Moorhead, 1996, pp. 7-8).

This policy research project completed the first step, creation of the Consumer Awareness Tool, which has four components.

1. The Questionnaire for Long-Term Care Decision Making determines the user's needs and preferences in securing health and human services, based on his or her current financial and health status. The questionnaire also captures empirical indicators, including factors such as family structure, living arrangements, health insurance, and demographic factors reflecting the expectations, concerns, and preferences of the elderly individual and his or her family (see Appendix A).

2. The Scoring Algorithm assigns the user to one of eight categories. Each category is composed of five areas of concern:

    a. living arrangement and housing support;
    b. health, illness, and functional performance;
    c. economic factors;
    d. health and long-term care insurance; and
    e. family relationships and social support (see Appendix A).

1. Profile Types assign the respondent to one of eight typological profiles according to marital status, financial condition, and health status (see Appendix A).

2. Scripts provide information on specific topics of interest to a wide audience. It is felt that using the script format improves the way in which information on long-term care is presented (see Chapter 4).

The profile types are illustrated in Table 3.1 for married seniors and Table 3.2 for unmarried seniors. Table 3.3 describes each profile type.

Table 3. 1
Profile Types for Married Seniors

	Poor Health	**Good Health**
Financially Secure	**Type I**	**Type II**
Financially Insecure	**Type II**	**Type IV**

Adapted from: Angel, Jacqueline L., and Bee Moorhead. 1996. "Planning for Managed Community Long-Term Care Using the Internet." Paper presented at the Gerontological Society of America Meeting. Washington, D.C. (November 19).

Table 3.2
Profile Types for Unmarried Seniors

	Poor Health	Good Health
Financially Secure	**Type V**	**Type VII**
Financially Insecure	**Type VI**	**Type VIII**

Adapted from: Angel, Jacqueline L., and Bee Moorhead. 1996. "Planning for Managed Community Long-Term Care Using the Internet." Paper presented at the Gerontological Society of America Meeting. Washington, D.C. (November 19).

Table 3.3
Description of Profile Types

Profile Types	Description
Type 1 Married	Financially secure but in poor health. Assistance may include purchase of special equipment to remain at home or formal services such as home health care.
Type 2 Married	Financially insecure and in poor health. Assistance may include informal sources of help or assistance from local Area Agency on Aging.
Type 3 Married	Good health and financially secure. Assistance may include financial planning for long-term care.
Type 4 Married	Good health but financially insecure. Careful planning may be needed to remain at home if incapacitated or lengthy illness.
Type 5 Unmarried	Poor health but financially secure. It is important to discuss with your family how they may provide for you.
Type 6 Unmarried	Poor health and financially insecure. Assistance may include obtaining state-funded meals delivery or homemaker services.
Type 7 Unmarried	Good health and financially secure. Assistance may include obtaining private long-term insurance.
Type 8 Unmarried	Good health but financially insecure. Identify benefits in present locale or discuss living arrangements with family members

Adapted from: Angel, Jacqueline L., and Bee Moorhead. 1996. "Planning for Managed Community Long-Term Care Using the Internet." Paper presented at the Gerontological Society of America Meeting. Washington, D.C. (November 19).

Policy Research Project

We used an adaptation of the focus-group interview methodology to generate information on the usefulness of a Questionnaire for Long-Term Care Decision Making in assisting seniors to make decisions on long-term care. The focus groups allowed us to examine multiple ideas, issues, and questions related to the long-term care decision-making process. We obtained a substantial amount of information in a relatively brief period.

Methodology

Focused Discussion Group

The focus group, defined as an interview style designed to gather a wide range of information from small groups of participants, is used by researchers striving to learn through informal discussions about conscious, semiconscious, and unconscious psychological and socio-cultural characteristics among different groups. This style of focused group discussion attempts to address particular topics of interest or relevance to the group and the researchers. This type of information gathering provides a means for collecting qualitative (narrative) and quantitative (empirical) data. The qualitative data provide the foundation and defining information necessary to support the empirical data obtained from the administration of a Questionnaire for Long-Term Care Decision Making (Berg, 1995, pp. 7-8).

Participants

Participants in the focused discussion group were not a representative sample, but were chosen because they met the specific criteria proposed for the assessment. Additionally, the focused discussion groups were conducted to pilot data collection.

Nine non-Hispanic white adults, five females and four males, were solicited through telephone calls to participate in the focused discussion groups. Informed consent was obtained from each of the participants (see Appendix B). The exercises allowed us to observe how Texas seniors and their families consider options in long-term care and other kinds of senior services and supports. Participants were assigned to two discussion groups. The first discussion group, held on November 12, 1996, consisted of non-dependent, married seniors (65 years and over) with no children or grandchildren, formerly or currently using long-term care services and supports. The second discussion group, held on November 19, 1996, was composed of adult children of married seniors (65 years and over) who were not currently receiving services for seniors.

The limitation of this technique was that minority groups were not represented. Future studies should be conducted using a representative sample.

Materials

The focused discussion group format was selected because it allowed participants to reflect on their expectations for care and family assistance, amplify their preferences associated with a set of options, and clarify their values about given alternatives. The focused discussion group protocol included four basic exercises:

1. mock decision-making;
2. brain storming;
3. clarification and amplification; and
4. a Questionnaire for Long-Term Care Decision-Making simulation (see Appendix A).

The information gathered through the first three exercises was collected in a round-robin fashion with the team members recording the information on a paper easel display. The self-assessment-of-needs questionnaire was administered and the results collected during the discussion group sessions. The questionnaire results were scored after the discussion groups had been conducted. The discussion groups were video-taped and audio-taped in order to transcribe and analyze the information gathered. All participants were asked to sign consent forms prior to beginning in order to inform them of the process and their rights as research participants. (See Appendix B).

Design and Procedure

Focused discussion groups, as a means of information gathering, enable researchers to gain access to large amounts of information in short periods. In summary, the format described above was an informal information gathering exercise to determine the decision-making process of seniors and their families when contemplating long-term care. The focused discussion groups were conducted in a free-flowing and comfortable environment intended to encourage candid discussion among participants. We developed a focused discussion group protocol, but participants were allowed to pursue topics of general interest to them as long as they were related to the topic. The focused discussion group protocol included a benign decision-making exercise and an information-gathering exercise loosely based on Nominal Group Technique and Delphi Technique. We developed and refined these tools as the information-gathering process progressed. Additional information was obtained by allowing the participants to complete a Questionnaire for Long-Term Care Decision-Making prototype, developed and tailored for each group.

Summary of Findings

A preliminary analysis of the data collected from the focused discussion groups and prototype questionnaire identified five predominant themes relating to attitudes about long-term care. These themes were: Housing and Living Arrangements, Financial and Legal Matters, Health Care Facilities and Providers (including social services), Medical

and Long-Term Care Insurance, and Family Support and Relationships. The themes were aligned with the predominant areas of awareness and concerns suggested in the most current literature. For example, Edgman-Levitan and Cleary discuss the importance of how consumers define care and the types of information they desire when making decisions about suitable plans for the future (Edgman-Levitan and Cleary, 1996, pp. 42-56). The following list, obtained from the focus groups, summarize the issues thought to be of greatest concern to older adults:

1. **Housing and Living Arrangements of Seniors:** The comfort, familiarity and safety of the domicile, the nutritional and flavor quality of the meals they receive, and the availability of recreational activities are all central concerns when contemplating long-term care decisions. By and large, older adults do not want to be dependent on family members. The importance of independence and self-determination was continually stressed.

2. **Financial and Legal Matters:** How to pay for basic medical care, housing, transportation, and daily necessities are common concerns.

3. **Health Care Facilities and Providers (including social services):** As a person ages, the urgency for medical care usually increases. Information regarding options is limited; even more scarce is the accessibility of such options to senior citizens. Access to high-quality medical care is extremely important to senior citizens.

4. **Medical and Long-Term Care Insurance:** Possibly the most perplexing of the issues is the topic of insurance and how to pay for necessary medical and long-term care services.

5. **Family Support and Relationships**: Older adults face a number of age-specific dilemmas: retirement, dependency, ill health, social isolation, loss of a spouse, lack of mobility, reduced income, and the inability to care for their familiar household, to list a few. Familial relationships are extremely important in the long-term care decision-making process. Adult children may be central in the decision-making or, conversely, they may not be included at any level of the process. This can be a source of added stress in an already difficult situation.

Death and its consequences emerged as a theme in the focused discussion groups. It does not seem to have a comparable antecedent in the long-term care literature. Though often unpleasant to contemplate, this theme explores the end of life and the difficult experiences it brings such as funeral arrangements and their associated costs.

General Observations

Thus far, we have completed several activities in an attempt to answer two key research questions:

1. Are the questions in the prototype Questionnaire for Long-Term Care Decision Making the ones that participants want to be asked; if not, what are the right questions?

2. Would participants want to use a Questionnaire for Long-Term Care Decision Making in making long-term care decisions for themselves or their family members; if so, why (i.e., what would it lead them to do)?

Using the focused discussion group format and the Questionnaire for Long-Term Care Decision Making simulation, we:

1. tested responses to sample queries;

2. tentatively gauged the response to the Questionnaire for Long-Term Care Decision Making;

3. assessed the awareness of the general public regarding realities of elder long-term care; and

4. introduced ourselves to the techniques of conducting focused discussion groups.

The Development of Scripts

Historically, Texas has encouraged initiatives that would act as statewide information and referral networks. The intent has always been to make the system more coordinated and fully integrated. Thus far, the initiatives in the area of long-term care for the elderly have failed to be fully implemented, leaving a fragmented long-term care infrastructure that is difficult for seniors and their families to navigate.

We determined that topical scripts were needed to link consumers to informational resources they needed as determined by the assessment results. The script format was chosen to provide quick and easy references for users. "Scripts" will be fully explained in Chapter 4. The topics selected for the scripts were based on the six topical areas identified in the literature review. Although not exhaustive, the scripts prepared by the project members demonstrate a variety of formats that can be used in paper or electronic media.

Chapter 4. Script Development

What kind of information do consumers need and want in long-term care decision making? There is little known about this, but we do know that there is a need to inform consumers in a way that is relevant to the long-term care decision making process (Edgman-Levitan and Cleary, 1996, p. 42). The quality of information can be improved by making it more accessible, understandable, and useful. Improved accessibility ideally means making timely and accurate information available to everyone, regardless of where they live.

Equally important, consumers are best served when information is easily understood. This is not always simple because people interpret terms differently. For example, "long-term care" meant insurance to one focus group member, although long-term care is a widely-encompassing concept. Clearly presenting information about long-term care can help build a shared understanding of terms and concepts in an area that can be confusing and complex. In considering health care plans, "educating retirees is especially challenging and requires substantial resources. They need assistance in understanding choices and benefits and seem to be easily confused by the range of choices" (Hoy et al., 1996, p. 16).

This policy research project set out to reach a wide audience through the development of scripts on specific topics in aging. The scripts are one approach to improving dissemination of information about long-term care. Determining whether the pieces of information we have included in the scripts are accessible, understandable, and useful is beyond the scope of this project, however, and will have to be done by other researchers.

The information provided in the scripts must be accurate. To ensure this accuracy, each script was verified by a Texas expert (sometimes more than one) in the given field. The expert reviewers represented a range of backgrounds and expertise such as service providers, practitioners, policy makers, and bureaucrats. The scripts were amended on the basis of their recommendations.

Because consumers show an interest in information that comes from experts *and* from friends, family, or people "like them" (Edgman-Levitan and Cleary, 1996, p. 45), the scripts were developed from information gained from extensive literature review and were tailored to address the issues raised in the focus groups. The combination of expert review and word-of-mouth testimony lends credibility and relevance to what we hope are helpful and valuable sources of information to consumers of long-term care services.

We believe that the scripts are an attractive, easy-to-read, and digestible source of information. They are intended to be both informative and educational, without advocating any particular cause or endorsing any products or services.

After the focus groups were completed, we decided the next step was to develop scripts for a Consumer Awareness Tool to be included in the Senior Citizens' Guide. We intend the scripts to be a helpful tool in the long-term care decision-making process. The scripts

represent the main subject areas people consider when making decisions about long-term care. At least one individual topic from the seven available subject areas was selected for each script. There are more scripts than subject areas. The various topics fall within the categories of health, personal care, and social services, because the conceptual definition of long-term care incorporates a wide array of these service options.

Table 4.1
Subject Areas and Corresponding Script Topics

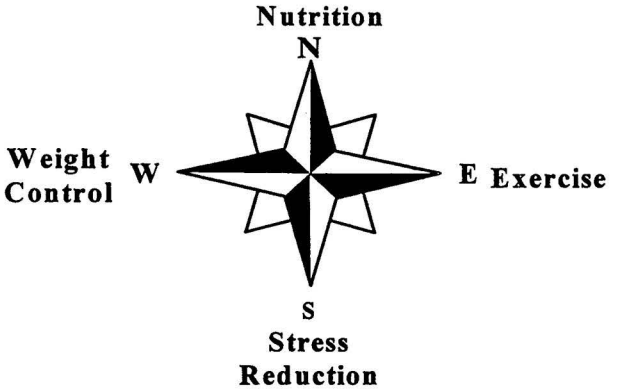
SUBJECT AREAS	SCRIPT TOPIC
Long-Term Care Services	Home Health Care Personal Assistance Services Nursing Facilities
Service Systems	Choosing a Health Plan Planning for Medical Crisis with or without a Doctor Doctor-Patient Relationships
Housing and Living Arrangements	Assisted Living
Financial and Legal	Wills and Trusts Power of Attorney Guardianships Medicaid Planning Medicare Living Wills and Other Advanced Medical Directives
Medical/Long-Term Care Insurance	Private Long-Term Care Insurance
Family Support and Relationships	Caregiving
Successful Aging	Wellness

What Is a Script?

A script is a "mini-guide" on a particular topic in aging: a term, concept, product or service. For this reason, it is difficult to describe the scripts in a general, limited way. For the most part, however, the scripts' elements are consistent with a standard format.

Although they vary in appearance, the scripts have similar components and specific features. Health researchers tell us that what health insurance consumers want is information about how a plan works, what it costs, the covered benefits, the quality of care, and overall satisfaction with care if this information were available (Edgman-Levitan and Cleary, 1996, p. 44). In general, the scripts cover the "what, where, when, how and who" of a specific term or concept in long-term care.

First, the script defines a term. A summary further describes the term, how it works, or relevant facts to help the consumer place it in the overall context of long-term care. This information is conveyed in various ways, depending on the topic itself. Where appropriate, scripts include illustrative text such as pictures, graphics, or diagrams.



This "Wellness Compass" can be found in Appendix R.

This was found to be an interesting and engaging way to capture information and present it visually. Some scripts provide examples to help the consumer identify the topic's relevance. For example, two scripts on Long-Term Care Services provide sample scenarios describing who might need Personal Assistance or Home Health Care Services. The real-life scenarios help the consumer to better identify with the term (see Appendices C and D).

Other scripts have tables containing comparative data that help consumers distinguish between concepts, plans, or services. For example, a table in the script on assisted living describes how an assisted living facility differs from a nursing home (see Table I.1 in Appendix I).

These methods are different ways to present information and answer frequently-asked questions in an attractive and easy-to-understand format. Providing images is also a powerful way to communicate information in an increasingly visual society.

A script's third feature is a "Tips" or "Questions" section that is intended to address concerns and raise issues in the reader's mind. These sections serve as attention-grabbing "triggers" and are a practical component to help the reader. The scripts' fourth component is the "Referral" section, which directs the consumer to additional information. In most

cases, national phone numbers are listed as well as addresses, where appropriate. Some scripts provide checklists for assessing particular services.

The order of the scripts was our choosing. We have not developed an exhaustive list of all the scripts that would be necessary to flesh out a consumer guide; the scripts we produced are intended to be *prototypes*.

Why Scripts Should Be Educational Versus Advocative and also User-Friendly

In charting the infrastructure of long-term care information, we have provided some coordinates without mapping it out entirely. The scripts listed in Table 4.1 are only a start in the process of improving the quality of consumer information by making it more accessible and useful. What type of information consumers find the most useful depends on the type of consumer. Different types of consumers have different informational needs (Edgman-Levitan, 1996, p. 45). "Not everyone has the interest or ability to evaluate detailed information, which is an issue of particular importance with an elderly population. Furthermore, no one has distinguished the informational needs of the general consumer from those of the health care decisionmaker in a family — that is, the person responsible for choosing the health benefits" (Edgman-Levitan, 1996, p. 45).

Case studies in health research suggest effective strategies for improving the content and mode of delivery of consumer information. Because people have different information needs, information should be available at different levels of detail, "with a road map to help people navigate" (Hoy, et al., 1996, p. 27). We believe our project has done this by offering scripts containing basic descriptive information, along with tips and referrals for how to obtain additional information. We recognize that "consumer information is the linchpin of consumer choice" (Hoy, et al., 1996, p. 26).

Summary

We know that the way in which information on long-term care is presented is critical, especially for older people. For this reason, the script format is a straight forward presentation of the topic. Some scripts have eye-catching graphics to illustrate a point and attract the reader. It was necessary to keep the scripts brief without omitting important information. The scripts present basic and topic-related information with some useful detail, but point the consumer in other directions for additional information and resources. This is just one place among many to stop for consumer information; we tried to present the range of issues to be considered in long-term care decision making in a useful format. The gaps in topics will have to be filled by future research to complete the Consumer Awareness Tool. Testing its effectiveness will be another required step in completing the Tool, and eventually, the Texas Senior Citizen Consumer Guide.

Chapter 5. Summary and Recommendations

Texas is facing a burgeoning and ethnically diverse population. It is clear that without adequate planning and preparation, many seniors and their families will have a difficult time finding solutions to meet their long-term care needs. This group will become increasingly important to the state's health services budget, particularly that portion devoted to long-term health care. Many Texans make poor choices about the type and amount of care they require and often select a less-preferred option (e.g., a nursing home) over home and community-based care. As states struggle with dwindling budgets, they will increasingly rely on strategies that redirect existing federal and state dollars to more cost-effective systems. For long-term care, this means educating consumers about appropriate care options while at the same time designing a more efficient system that better suits the needs of individuals and families.

Although there is a vast array of state, federal, and local agencies that provide senior services and supports, the 1996 Texas Performance Review notes that (1) many seniors find it difficult to obtain information, and (2) the information needed to evaluate service options effectively is unavailable (Texas Comptroller of Public Accounts, 1996, p. 2). This policy research project was inspired by the expressed needs and concerns of Texas seniors and their families wanting to make informed decisions regarding options in long-term care. A survey of service providers, government officials, and consumer advocates indicated that "most elderly or disabled people would rather live at home, and do not want to be placed in a nursing home" (Texas Health and Human Services Commission, 1994, p. 108).

The broader goal of the Policy Research Project was to educate and inform Texas citizens about long-term care alternatives. The research project had two objectives. The first objective was to identify the issues and questions that elderly individuals and their families think are important when deciding which services, if any, are suited to their needs. The second objective was to develop the prototype for a consumer awareness tool, designed to help seniors consider long-term care alternatives that are cost-effective and accommodate their preferences. With the wide dissemination of the Consumer Awareness Tool, we hope consumers will be able to consider appropriate services and support options more effectively, and take a more proactive approach to planning their lives, rather than waiting for a crisis to occur.

Approach and Method

We began by educating ourselves about the issues associated with public policy and long-term care. This included the reviewing and analysis of literature on long-term care alternatives, and interviewing consumers and their families in the local community about the ways in which they navigate the system. Using this information, we learned about many of the complexities involved in the long-term care decision-making process.

During the Fall semester 1996, we conducted several discussion group interviews to solicit input and reactions to the concept of a Consumer Awareness Tool. In the discussion groups, interviewees were presented with a representative set of questions designed to help seniors and their families plan for their long-term care needs. Although we wanted to carry out in-depth, state-wide interviews, we determined that further development of the Consumer Awareness Tool was needed. Because of the extent of information that exists concerning senior services, programs, and issues, we concluded that seniors and their families could benefit from basic educational and referral information. Our analysis of both the literature and the discussion group transcripts revealed that we needed to provide consumers with information that (1) is accurate, accessible, and easy to understand, and (2) will help them balance the issues of safety, autonomy, and cost.

From the many concerns of senior citizens in Texas, each student selected certain topics about which scripts were developed. This set of scripts (narratives examining each topic area) succinctly provided essential information. The scripts were prepared in two formats, one for presentation in a conventional written manner such as a guide or booklet, the second in a format such as a World Wide Web-based information system or Internet-based community network (Ellis et al., 1996, p. 101).

Future Research

Although our research provided insights into the conceptual background of the Consumer Awareness Tool, additional research is necessary to determine the usefulness of the instrument. Further research should include state-wide interviews to obtain in-depth information regarding seniors' preferences and their understanding of the long-term care decision-making process.

We recommend that state-wide interviewees be drawn from a carefully-selected sampling frame. It will be important to systematically stratify the entire state by region, and by other factors associated with population needs and planning service areas. Discussion group locations might be randomly selected to ensure adequate coverage of Texas's diverse population—from the densely populated urban areas to the sparsely populated counties of West Texas.

Format of Dissemination

Both conventional print and advanced electronic technologies have been considered as possible delivery modes for the Consumer Awareness Tool. Conventional print media would include service directories, booklets, or newspapers located in government offices, supermarkets, senior citizen centers, churches, pharmacies, and newspaper distribution points. Electronic technology being considered includes automated-telephone systems, touch-screen kiosks at shopping malls or government offices, and the Internet via the World Wide Web. Utilizing such advanced delivery systems will not only save revenue

by cutting down on printing costs, but will allow any Texan with access to a phone line and computer to utilize this tool.

The computer and Internet revolution has touched our senior population, like most other segments of our society. More and more elderly are growing familiar with the World Wide Web and the incredible amount of information available from it (Emmons, 1996, p. C1). Through search engines, topical web sites, and other specialized areas, seniors can access detailed information concerning virtually any aspect of the aging experience, communicate with medical professionals, and maintain contact with peers across vast distances (Baig, 1997, p. 102).

Evaluation of the Senior Citizen Consumer Guide

The next step of the project is to evaluate the usefulness of both the print and Internet versions of the Consumer Awareness Tool. One important consideration is the user's comfort with the mode in which the Tool is presented. For instance, if a senior is asked to evaluate the Consumer Awareness Tool using the Internet, his or her responses may be less positive if he or she is unfamiliar with the mechanics of the Internet.

A brief statewide survey could elicit initial user reaction about attitudes concerning the helpfulness of the Tool. The ultimate evaluation is to determine whether the comprehensive Texas Senior Citizen Consumer Guide will improve long-term care decisions—either in community homes or nursing home settings. The comprehensive guide must be effective. The proposed Senate Bill 273 requires that the interagency work group provide an evaluation of the Texas Senior Citizen Consumer Guide prior to January 15, 1999.

Recommendations for Texas and other States

There are several demographic and economic features about Texas that individually are shared with several states, but which rarely combine to so affect a single state. Texas has by far the largest land mass of the "Lower 48" states, ranging from some of the most highly urbanized areas in the nation (e.g., Dallas, Houston, San Antonio) to some of the most sparsely populated areas of the country (Dortch, 1996, p. 17)

By virtue of its long border with Mexico, Texas has one of the largest Hispanic populations in the nation. Within a few decades, Texas' population is expected to achieve "majority-minority" status, in which the combined nonwhite and "ethnic" populations will exceed the "non-Hispanic white population." Aside from the cultural consequences, the economic impact of this demographic shift will have profound consequences on the level of fiscal support received by Texas' aged population. Because the state's population of working-age citizens forms the main portion of the tax base, as the number of elderly citizens increases as a proportion of the total population, the pressure on the state's economic well-being could be profound (Kelley, 1996, p. A-1).

Yet, in many regards, Texas shares a similar future with other states. A great challenge facing our nation and state is the way the senior care infrastructure will absorb the "baby boomer" generation. When "baby boomers" enter retirement, the solvency of the Social Security system and the financing of Medicare and Medicaid will be stretched to the limit by the added years of life that Americans are expected to enjoy. The emerging demographic trends present serious concerns about the financing and organization of long-term care for the elderly, which will ultimately affect their choices. Furthermore, changes in the size and composition of the American family household have affected the ability of adult children to care for aging relatives (Samuelson, 1997, B7, B11).

In addition to these social forces, political forces are shifting responsibility for programs away from the federal government towards state and local governments ("Devolution: Making It Work," 1997, p. 1). States are struggling to balance these added burdens with the increasing demand for long-term care, while at the same time establishing a cost-effective long-term care infrastructure (Capitman and Sciegaj, 1995, pp. 533-540). Efficient use of shrinking budgets will mean broadening the variety of care programs available to consumers to meet their physical and social care needs, and redirecting federal and state dollars to the most effective delivery systems. Consequently, states are shifting resources toward community-based care (Hudson, 1995, pp. 446-466).

Policy makers are beginning to realize that the current long-term care financing and service delivery system is disjointed and not delivering the consumer-directed and community-based services that individuals prefer and need (Leutz et al, 1992, pp. 42-43). Because Texas does not have a single entry access point for long-term care services, there is a need for a readily available model. Ideally, such a model would present a clear and accurate picture of all available services, helping consumers and their families to understand which services would satisfy their needs. An ideal model would also provide cost and quality-of-service information (Texas Comptroller of Public Accounts, 1996, p. 2).

In Texas, each of the 28 Area Agencies on Aging assembles a provider directory covering services within each service area. The Texas Department on Aging, the Texas Health and Human Services Commission, the Texas Network for Information and Referral, the Texas Department of Human Services, and the Texas Department of Housing and Community Affairs, as well as other agencies, also provide information and/or referrals to seniors on services and programs. However, there is not a state-wide, standardized directory of long-term care resources comparable to those of many states such as Michigan (Texas Comptroller of Public Accounts, 1996, p. 4). Other states, such as Florida and Maine, are using the World Wide Web to disseminate information in a more standardized format to their senior consumers.

In addition, several states have addressed the problem of system fragmentation by implementing a "single entry point" (SEP) method of delivering services. "An SEP can be viewed in several ways. Basically, it is a 'one-stop shop' process providing people with access to long-term care services. However, the concept of 'access' can be extended beyond merely how one enters the system, to how one actually receives services and

follow-up monitoring. Consequently, an SEP—as a process—can operate independently of the actual types of services provided. That is, an SEP is the funneling process through which potential clients of long-term care services can be screened, assessed, advised, and directed to appropriate services, whatever those services are" (State of Hawaii Government Web Page, http://www.hawaii.gov/lrb/ltc/ltccpl.html).

A problem faced by seniors is understanding how to become aware of their service needs, and how to address them. An advantage to the SEP concept is that a senior does not have to sift through various agencies to find the desired information. It can be obtained in "one stop." For instance, New Jersey has recently chosen eight counties to participate in "one-stop" centers to "especially serve the needs of senior citizens...to make it easier for older residents, prime users of social services, to deal with the bureaucracy" (Ragonese, 1997, p. A-6). In its effort to implement an SEP system for its seniors, New Jersey is utilizing a toll-free number in the test counties, where individuals can directly access information and referral specialists to aid them in receiving the information they desire. (One of the ways that our prototype Consumer Awareness Tool could be useful in Texas and other states is helping seniors know what questions to ask of these referral agents.) In conjunction with such efforts, information concerning the new services will be publicized at senior citizens centers, senior nutrition sites, and veterans' organizations.

Conclusion

Our desire to ensure the highest quality of life at the lowest cost will result in many new experiments to better fit the needs and desires of the elderly. Where and how to spend the latter part of life is a very important decision. The proposed development of the Texas Senior Citizen Consumer Guide is one way our state can help make sure we have all the information we need to determine both the cost and the quality of services provided in the home, the community, or in an assisted living or nursing facility.

Designing such a service, as proposed by Senate Bill 273, would be an important step in establishing a collaborative, interagency infrastructure that promotes access to and choices in community-based long-term care services and programs. As part of the Texas Senior Citizen Consumer Guide, the Consumer Awareness Tool could bridge the gap between senior preferences and the available, appropriate services provided by the State.

As state and private organizations are asked to shoulder the social services burden, it will become increasingly important to provide guidance and information to consumers and their families. A well-organized, accurate, and complete information source will ensure that families will have a good understanding of what is available when it is time to make that very important decision about the future. It may also help health care providers and service agencies reach a larger user population with limited staff resources. Moreover, families would have more options on how to allocate their resources to best help their loved ones.

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Appendix A. Questionnaire for Long-Term Care Decision Making

Directions: Read one question at a time, with all its answers, and choose the best answer. If you find that you cannot answer a question, skip it and go on to the next one.

1. What is your date of birth (month, day, year)?

2. What city do you live in or near?

3. Who do you live with?
   - ☐ Currently married, living either with or without your spouse
   - ☐ Widowed, divorced, separated, or never married, living alone
   - ☐ Widowed, divorced, separated, or never married, living with others

4. Are you currently eligible for any of the following government health insurance programs:

   Medicaid?
   - ☐ yes
   - ☐ no
   - ☐ don't know

   Medicare?
   - ☐ yes
   - ☐ no
   - ☐ don't know

   Veteran's Administration?
   - ☐ yes
   - ☐ no
   - ☐ don't know

   State or local government programs, such as Texas Options for Independent Living?
   - ☐ yes
   - ☐ no
   - ☐ don't know

5. Do you currently own a private long-term care insurance policy?
   - ☐ yes
   - ☐ no
   - ☐ don't know

6. Because of a health or physical problem, how much difficulty do you have bathing, including shower, full tub, or sponge bath without help?
   - ☐ none
   - ☐ some
   - ☐ a lot
   - ☐ unable
   - ☐ don't know

7. Because of a health or physical problem, how much difficulty do you have doing ordinary work around the house without help (for example, dishes, dusting, laundry, or doing repairs) ?
   - ☐ none
   - ☐ some
   - ☐ a lot
   - ☐ unable
   - ☐ don't know

8. Because of a health or physical problem, how much difficulty do you have using the telephone without help?
   - ☐ none
   - ☐ some
   - ☐ a lot
   - ☐ unable
   - ☐ don't know

9. Because of a health or physical problem, how much difficulty do you have walking up and down stairs without help?
   - ☐ none
   - ☐ some
   - ☐ a lot
   - ☐ unable
   - ☐ don't know

10. Because of a health or physical problem, how much difficulty do you have getting from a bed to a chair without help?

- ☐ none
- ☐ some
- ☐ a lot
- ☐ unable
- ☐ don't know

11. In the last two weeks, have you had feelings of sadness or being depressed?

- ☐ rarely or none of the time (less than a day)
- ☐ some or a little of the time (1 - 2 days)
- ☐ occasionally or a moderate amount of time (3 - 4 days)
- ☐ most or all of the time (5 - 7 days)
- ☐ not sure

12. Overall, how would you rate your health?

- ☐ excellent
- ☐ very good
- ☐ good
- ☐ fair
- ☐ poor
- ☐ don't know

13. Has a doctor ever told you that you had cancer or a malignant tumor of any type ?

- ☐ yes
- ☐ no
- ☐ don't know

14. Has a doctor ever told you that you had heart disease?

- ☐ yes
- ☐ no
- ☐ don't know

15. Has a doctor ever told you that you had diabetes, sugar in your urine or high blood sugar?

- ☐ yes
- ☐ no
- ☐ don't know

16. Have you ever spoken to your child about your need for assistance some day?

- ☐ yes
- ☐ no
- ☐ don't know

17. Would you be able to rely on at least one of your children, another relative or a close friend for support should you need to do so in the near future?

- ☐ definitely
- ☐ probably
- ☐ unlikely
- ☐ don't know

18. About how much is your personal yearly income for the past year (1996)? Please include income from all sources, such as wages, salaries, Social Security, retirement benefits, help from relatives, rent from property, and so forth.

- ☐ $0 - $4,999
- ☐ $5,000 - $9,999
- ☐ $10,000 - $14,999
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ $50,000 and over
- ☐ don't know

19. About how much is your household income for the past year (1996)? Please include income from all sources, such as wages, salaries, Social Security, retirement benefits, help from relatives, rent from property, and so forth.

- ☐ $0 - $4,999
- ☐ $5,000 - $9,999
- ☐ $10,000 - $14,999
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ $50,000 and over
- ☐ don't know

20. Do you own any of the following? **Please check all that apply.**

- ☐ a home
- ☐ stocks or bonds
- ☐ rental property
- ☐ a savings account
- ☐ none

21. How often does it happen that you do not have enough money to afford the kind of medical care you should have?

- ☐ never
- ☐ once in a while
- ☐ fairly often
- ☐ very often
- ☐ don't know

Scoring the Questionnaire for Long-Term Care Decision-Making

A. Financial:

You are considered to be financially insecure if you answered "yes" to any of the following statements. **Circle any of the following statements that are true.**

- Question #18 is answered as $0-$14,999.
- Question #19 is answered as $0-$29,999.
- Question #20 has nothing at all checked.
- Question #21 is fairly often or very often.

If none of these statements are true/circled, then your financial situation is good.

B. Health:

1. You are considered to be in poor health, experiencing problems with carrying out activities of daily activities (ADL), if you circle at least two of the following statements. **Circle any of the following statements below that are true.**

    - Question #6 is "a lot" or "unable."
    - Question #7 is "a lot" or "unable."
    - Question #8 is "a lot" or "unable."
    - Question #9 is "a lot" or "unable."
    - Question #10 is "a lot" or "unable."

OR

2. You are considered to be in poor health if you suffer from certain chronic conditions and if you circled at least one question in B.1. **Circle any of the following statements that are true.**

    - Question #13 is "yes."
    - Question #14 is "yes."
    - Question #15 is "yes."

OR

3. You are considered to be in poor health if your answer to Question #12 was either "poor" or "fair" self-assessed health.

OR

4. You are considered to be in poor health if your answer to Question #11 was depressed "most or all of the time"

If none of the statements in Section B, 1-4 are true/circled, then you are considered in good to excellent health.

Your profile type is determined by your marital status, as well as your answers to the above questions regarding your financial situation, health, and functioning status. Based on your responses to the quiz, find your type below by indicating your financial and health status.

Married Respondents

Health	Financial Situation	Type
Poor	Good	I
Poor	Poor	II
Good	Good	III
Good	Poor	IV

Unmarried Respondents (divorced, widowed, or separated)

Health	Financial Situation	Type
Poor	Good	V
Poor	Poor	VI
Good	Good	VII
Good	Poor	VIII

Profile Types

Type 1. Married, Poor Health and Financially Secure

Your responses indicate that you may have difficulty taking care of yourself because of a health or physical problem, and that you will probably need assistance with personal activities of daily living, such as bathing and dressing and/or instrumental tasks, such as shopping, handling financial matters, etc.

Remember that your capacity to perform activities of daily living might change in the near future, and that you should answer these questions often to get a better assessment of your current physical and social care needs. **You may want to repeat this test as your health care needs change over time.**

Living Arrangements and Social Support

Most people in this situation rely on their spouse for support. If this is not possible, you might rely on informal sources, such as friends or neighbors. In Texas, there are a number of community resources to help you search for personal care services that can allow you to remain at home. You may want to contact your local Area Agency on Aging or a wide array of volunteer (private and non-profit) organizations such as Austin Groups for the Elderly at 512/451-4611 or the American Association of Retired Persons State Office in Austin at 512/280-9797.

Interventions Can Restore Daily Living Functionality

You may be able to purchase special equipment to help you perform household tasks, such as cooking and cleaning. Many types of special equipment may be used to help you continue living in your own home. Simply installing a microwave oven to simplify meal preparation and to reduce cooking time can help you to maintain your independence while continuing with your day-to-day routine. Similarly, assistive devices can improve independent functioning, depending on the severity of your specific limitation, and your willingness to adapt to the new environment.

Formal Local Support Services

Given your current economic situation, you also might want to consider purchasing formal services, such as from a home health care agency. You may want to also find out what skilled nursing homes are available in your area. The complete list of over 1,157 licensed nursing and 452 personal care facilities available in Texas can be obtained by contacting the Texas Health Care Association at 512/458-1257 or the Texas Department of Human Services, Long-term Care Regulatory Division at 512/834-6770. If you currently have a problem involving a nursing home, contact the State Long-term Care Ombudsman at 512/444-2727. Call 800/252-9240 to reach your local Area Agency on

Aging; to find out about insurance products, call 800/252-3439 (Texas Department of Insurance).

Private long-term care insurance

Although long-term care policies are owned by only a small fraction of the elderly, they may be worth your serious consideration if you are under 75 years, and if you can afford to purchase it. Most older applicants are denied long-term care coverage and as many as 40 percent of those who apply are turned down because of pre-existing conditions such as cancer and heart disease. When an individual with such pre-existing conditions is offered coverage, he or she must pay even higher premiums.

There are other shortcomings to current long-term care insurance. Often the home-care component of such policies does not include personal care or assistance with basic activities of daily living. Current policies typically cover only skilled nursing care performed by licensed registered nurses and health care professionals. Perhaps the most serious problem with long-term care insurance, however, is the financial instability of the insurance companies offering it. Until the industry evolves further and is regulated by the federal government, it is hard to know whether an older person should risk what may be a large portion of his or her savings for a product that may not be delivered when it is needed.

Spousal Caregiver Assistance

Whether you need temporary or long-term care, your spouse will be affected. Certain aspects of the situation may become discouraging to a spouse, no matter how much he or she wants to help or how much satisfaction is derived from helping. For this reason, a spousal caregiver may need to receive information and training prior to initiating a care plan to help cope with the caregiver role. In Texas, information and referral about respite services and other family supports for older adults can be obtained by contacting Family Eldercare, Inc., a non-profit organization located in Austin, Texas, at 512/450-0844.

Type 2. Married, Poor Health and Financially Insecure

Your responses indicate that you may have difficulty taking care of yourself because of a health or physical problem, and that you will need assistance with personal activities of daily living, such as bathing and dressing and/or instrumental tasks, such as shopping, using the telephone, and managing medications. **You may want to repeat this test as your health care needs change over time.**

Living Arrangements and Social Support

Most people in this situation rely on their spouse for support. If this is not possible or should you prefer the privacy of informal care, but from someone else other than your spouse, you may want to consider whether friends, neighbors, and other relatives could assist you.

Formal Local Support Services

Given your current economic situation, you may also want to consider contacting your local Area Agency on Aging. This agency can help you to determine whether it can provide (in some cases for free or a reduced charge depending on your income level) assistance that you may need with services such as transportation, meal delivery, or home health care. Most of the Area Agencies on Aging in Texas provide a case manager who can help you to work out a plan that will enable you to continue living in your own home. The decision to purchase special equipment will depend on the severity of your physical condition, and whether such equipment can help you to perform personal care activities, such as bathing, dressing, etc.

Spousal Caregiver Assistance

Whether you need temporary or long-term care, your spouse will be affected. Certain aspects of the situation may become discouraging to a spouse, no matter how much he or she wants to help or how much satisfaction is derived from helping. For this reason, a spousal caregiver may need to receive information and training prior to initiating a care plan to help cope with the caregiver role. In Texas, information and referral about respite services and other family supports for older adults can be obtained by contacting Family Eldercare, Inc., a non-profit organization located in Austin, Texas, at 512/450-0844.

Benefits Counseling

At this time, you may need to consider contacting a benefits counselor about financing your long-term care. Call the Texas Legal Services Center at 800/622-2520 or the Texas Department on Aging at 800/252-9240 to obtain the phone number of your local Area Agency on Aging. You should also discuss with your spouse and children the expectations they have for providing support to you when you are unable to care for yourself, and for the support they would like to receive from you now and in the near future. There are several options from which you can choose in preparing to meet your future long-term care needs. To discuss various ways for financing your long-term care services, contact the National Institute on Consumer-Directed Home and Community Based Systems at 202/479-6681, or by e-mail at donna.wagner@ncoa.org.

Type 3. Married, Good Health and Financially Secure

Your self-assessments of your physical and mental well-being indicate that you are in good to excellent health, and have few or no problems carrying out basic activities of daily living such as shopping, driving, and attending to your personal hygiene needs. **You may want to repeat this test as your health care needs change over time.**

In addition, your responses indicate that you have enough money to afford basic necessities like food and medical care, and that you usually end up with more than the amount of money you need to cover expenses.

Private long-term care insurance

Although long-term care policies are owned by only a small fraction of the elderly, they may be worth your serious consideration if you are under 75 years, and if you can afford to purchase it. Most older applicants are denied long-term care coverage and as many as 40 percent of those who apply are turned down because of pre-existing conditions such as cancer and heart disease. When an individual with such pre-existing conditions is offered coverage, he or she must pay even higher premiums.

There are other shortcomings to current long-term care insurance. Often the home-care component of such policies does not include personal care or assistance with basic activities of daily living. Current policies typically cover only skilled nursing care performed by licensed registered nurses and health care professionals. Perhaps the most serious problem with long-term care insurance, however, is the financial instability of the insurance companies offering it. Until the industry evolves further and is regulated by the federal government, it is hard to know whether an older person should risk what may be a large portion of his or her savings for a product that may not be delivered when it is needed. Contact the Texas Department of Insurance at 800/252-3439 to find out about insurance products.

Staying Healthy

To help ensure your future self-sufficiency, it is important to maintain an active and healthy lifestyle. As you grow older, it is important to stay involved in meaningful pursuits. You might also want to consider making minor changes in your lifestyle to prevent or delay the onset of many debilitating diseases. Increasing your stamina through physical exercise, and improving flexibility and muscle strength through weight training, are all important components of a general fitness regimen. Always check with your doctor before starting an exercise regime. With a little effort today, you can increase your chances of maintaining your good health for years to come.

Spousal Caregiver Assistance

Whether you need temporary or long-term care, your spouse will be affected. Certain aspects of the situation may become discouraging to a spouse, no matter how much he or she wants to help or how much satisfaction is derived from helping. For this reason, a spousal caregiver may need to receive information and training prior to initiating a care plan to help cope with the caregiver role. In Texas, information and referral about respite services and other family supports for older adults can be obtained by contacting Family Eldercare, Inc., a non-profit organization located in Austin, Texas, at 512/450-0844.

Type 4. Married, Good Health and Financially Insecure

Your self-assessments of your physical and mental well-being indicate that you are in good to excellent health, and have few or no problems carrying out basic activities of daily living such as shopping, driving, and attending to your personal hygiene needs. One

concern that you may have is your ability to cope with a health care crisis, and whether such an event would deplete your savings, or require selling your home. **You may want to repeat this test as your health care needs change over time.**

Family Relationships

While you are healthy, it is important to discuss with your family any concerns you might have about your preferences and needs for long-term care. Whether you are a widow, divorced, or have never married, exploring feelings can reduce or relieve problems experienced by you and the important people in your life. Often children, family, or friends are afraid to ask about your expectations of how you plan to spend your time in later life, in particular what they should do in the event that you are no longer able to take care of yourself.

Staying Healthy

To help ensure your future self-sufficiency, it is important to maintain an active and healthy lifestyle. As you grow older, it is important to stay involved in meaningful pursuits. You might also want to consider making minor changes in your lifestyle to prevent or delay the onset of many debilitating diseases. Increasing your stamina through physical exercise, and improving flexibility and muscle strength through weight training, are all important components of a general fitness regimen. Always check with your doctor before starting an exercise regime. With a little effort today, you can increase your chances of maintaining your good health for years to come.

Spousal Caregiver Assistance

Whether you need temporary or long-term care, your spouse will be affected. Certain aspects of the situation may become discouraging to a spouse, no matter how much he or she wants to help or how much satisfaction is derived from helping. For this reason, a spousal caregiver may need to receive information and training prior to initiating a care plan to help cope with the caregiver role. In Texas, information and referral about respite services and other family supports for older adults can be obtained by contacting Family Eldercare, Inc., a non-profit organization located in Austin, Texas, at 512/450-0844.

Benefits Counseling

Your responses indicate that you may lack enough money to afford basic necessities like food and medical care, and that you usually do not end up with enough money to cover basic living expenses. There are many factors that will determine your financial future, and your ability to pay for your long-term care. Even though you are healthy now, you should begin planning for how you will support yourself in the event that you or your spouse become incapacitated. To discuss various ways for financing your long-term care services, contact the National Institute on Consumer-Directed Home and Community Based Systems at 202/479-6681, or by e-mail at donna.wagner@ncoa.org. You may also need to consider contacting a benefits counselor about financing your long-term care. Call

the Texas Legal Services Center at 800/622-2520 or the Texas Department on Aging at 800/252-9240 to obtain the phone number of your local Area Agency on Aging.

Type 5. Unmarried, Poor Health and Financially Secure

Your responses indicate that you may have difficulty taking care of yourself because of a health or physical problem, and that you will need assistance with personal activities of daily living, such as bathing and dressing and/or instrumental tasks, such as shopping, using the telephone, etc. Depending on whether you live alone or with others will determine the sources of support you may rely on now. **You may want to repeat this test as your health care needs change over time.**

Interventions Can Restore Daily Living Functionality

You may be able to purchase special equipment to help you perform household tasks, such as cooking and cleaning. Many types of special equipment may be used to help you continue living in your own home. Simply installing a microwave oven to simplify meal preparation and to reduce cooking time can help you to maintain your independence while continuing with your day-to-day routine. Similarly, assistive devices can improve independent functioning, depending on the severity of your specific limitation, and your willingness to adapt to the new environment.

Community-based Long-term Care

Since you appear to have enough money to pay for basic necessities and for medical care, you may or may not be eligible to receive government supported services. For instance, the Texas Options Program for Independent Living is designed to address the unmet social needs of frail, elderly Texans age 60 and older who prefer to live independently in the community in spite of limited self-care capacities. The package of services varies with office of the local Area Agency on Aging, but usually includes homemaker service and home-delivered meals, coordinated by a case manager. Whenever necessary, the care plan educates caregivers about ways to manage resources for keeping the frail elder at home in the least restrictive environment. Although your financial capacity seems to fit your current long-term care needs, you might need to revise your financial plan for covering any paid services, should your health diminish. It may also be useful to talk with your family, friends, and neighbors about your future preferences in long-term care arrangements and the potential resources available to you.

Preferences in Living Arrangements

It is important to discuss with your family and friends how they may provide for you when you are no longer able to take care of yourself. It is also important for you to think about your personal preferences: whether to live alone or with someone else, and how to maintain your functional independence.

Private long-term care insurance

Although long-term care policies are owned by only a small fraction of the elderly, they may be worth your serious consideration if you are under 75 years, and if you can afford to purchase it. Most older applicants are denied long-term care coverage and as many as 40 percent of those who apply are turned down because of pre-existing conditions such as cancer and heart disease. When an individual with such pre-existing conditions is offered coverage, he or she must pay even higher premiums.

There are other shortcomings to current long-term care insurance. Often the home-care component of such policies does not include personal care or assistance with basic activities of daily living. Current policies typically cover only skilled nursing care performed by licensed registered nurses and health care professionals. Perhaps the most serious problem with long-term care insurance, however, is the financial instability of the insurance companies offering it. Until the industry evolves further and is regulated by the federal government, it is hard to know whether an older person should risk what may be a large portion of his or her savings for a product that may not be delivered when it is needed. Contact the Texas Department of Insurance at 800/252-3439 to find out about insurance products.

Type 6. Unmarried, Poor Health and Financially Insecure

Your responses indicate that you may have difficulty taking care of yourself because of a health or physical problem, and that you will need assistance with personal activities of daily living, such as bathing and dressing and/or instrumental tasks, such as shopping, using the telephone, etc. **You may want to repeat this test as your health care needs change over time.**

Shared Living Arrangements

If you live alone, and are concerned about your future capacity to care for yourself, you might consider moving in with someone, perhaps a good friend or a close family member. This may improve your financial situation substantially. It might also allow you greater economic security in the future, especially in the event that you suffer a serious illness, and require additional medical or long-term care. Should your health diminish, group homes might be an alternative. In Texas, there are zoning laws that permit group housing (Board and Care facilities) for persons with disabilities requiring personal care. The major distinction between nursing homes and Board and Care homes is that the latter provide no medical care.

Many single seniors are very likely to enter a nursing home. For this reason, it would be prudent to become informed about services offered by nursing homes and other long-term care facilities. The U.S. Department of Justice sponsors a nationwide database that contains recommendations on specific facilities and long-term care providers to consumers. To find out more call, 800/222-2156.

Community-based Long-term Care

Since you appear to lack enough money to pay for basic necessities and for medical care, you may be eligible to receive government supported services. For instance, the Texas Options Program for Independent Living is designed to address the unmet social needs of frail, elderly Texans age 60 and older who prefer to live independently in the community in spite of limited self-care capacities. The package of services varies by each office of local Area Agency on Aging, but usually includes homemaker service and home-delivered meals, coordinated by a case manager. Whenever necessary, the care plan educates caregivers about ways to manage resources for keeping the frail elder at home in the least restrictive environment. Although your financial capacity seems to fit your current long-term care needs, you might need to revise your financial plan for covering any paid services should your health diminish. It may also be useful to talk with your family, friends, and neighbors about your future preferences in long-term care arrangements and the potential resources available to you.

Benefits Counseling

Your responses indicate that you may lack enough money to afford basic necessities like food and medical care, and that you usually do not end up with enough money to cover basic living expenses. There are many factors that will determine your financial future, and your ability to pay for your long-term care. Even though you are healthy now, you should begin planning for how you will support yourself in the event that you or your spouse become incapacitated. To discuss various ways for financing your long-term care services, contact the National Institute on Consumer-Directed Home and Community Based Systems at 202/479-6681, or by e-mail at donna.wagner@ncoa.org. You may also need to consider contacting a benefits counselor about financing your long-term care. Call the Texas Legal Services Center at 800/622-2520 or the Texas Department on Aging at 800/252-9240 to obtain the phone number of your local Area Agency on Aging. You should also discuss with your children the expectations they have for providing support to you when you are unable to care for yourself, and their expectations for the support they would like to receive from you now and in the near future.

Type 7. Unmarried, Good Health and Financially Secure

Your self-assessments of your physical and mental well-being indicate that you are in good to excellent health, and have few or no problems carrying out basic activities of daily living such as shopping, driving, and attending to your personal hygiene needs. **You may want to repeat this test as your health care needs change over time.**

Preferences in Living Arrangements

It is important to discuss with your family and friends how they may provide for you when you are no longer able to take care of yourself. It is also important for you to think about your personal preferences: whether to live alone or with someone else, and how to maintain your functional independence.

Family Relationships

While you are healthy, it is important to discuss with your family any concerns you might have about your preferences and needs for long-term care. Regardless of your marital situation, exploring feelings can reduce or relieve problems experienced by you and the important people in your life. Often children, family, or friends are afraid to ask about your expectations of how you plan to spend your time in later life, in particular what they should do in the event that you are no longer able to take care of yourself.

Staying Healthy

To help ensure your future self-sufficiency, it is important to maintain an active and healthy lifestyle. As you grow older, it is important to stay involved in meaningful pursuits. You might also want to consider making minor changes in your lifestyle to prevent or delay the onset of many debilitating diseases. Increasing your stamina through physical exercise, and improving flexibility and muscle strength through weight training, are all important components of a general fitness regimen. Always check with your doctor before starting an exercise regime. With a little effort today, you can increase your chances of maintaining your good health for years to come.

Private long-term care insurance

Although long-term care policies are owned by only a small fraction of the elderly, they may be worth your serious consideration if you are under 75 years, and if you can afford to purchase it. Most older applicants are denied long-term care coverage and as many as 40 percent of those who apply are turned down because of pre-existing conditions such as cancer and heart disease. When an individual with such pre-existing conditions is offered coverage, he or she must pay even higher premiums.

There are other shortcomings to current long-term care insurance. Often the home-care component of such policies does not include personal care or assistance with basic activities of daily living. Current policies typically cover only skilled nursing care performed by licensed registered nurses and health care professionals. Perhaps the most serious problem with long-term care insurance, however, is the financial instability of the insurance companies offering it. Until the industry evolves further and is regulated by the federal government, it is hard to know whether an older person should risk what may be a large portion of his or her savings for a product that may not be delivered when it is needed. Contact the Texas Department of Insurance at 800/252-3439 to find out about insurance products.

Type 8. Unmarried, Good Health and Financially Insecure

Your self-assessments of your physical and mental well-being indicate that you are in good to excellent health, and have few or no problems carrying out basic activities of daily living such as shopping, driving, and attending to your personal hygiene needs. One concern that you may have is your ability to cope with a health care crisis, and whether

such an event would deplete your savings or require selling your home. **You may want to repeat this test as your health care needs change over time.**

Staying Healthy

To help ensure your future self-sufficiency, it is important to maintain an active and healthy lifestyle. As you grow older, it is important to stay involved in meaningful pursuits. You might also want to consider making minor changes in your lifestyle to prevent or delay the onset of many debilitating diseases. Increasing your stamina through physical exercise, and improving flexibility and muscle strength through weight training, are all important components of a general fitness regimen. Always check with your doctor before starting an exercise regime. With a little effort today, you can increase your chances of maintaining your good health for years to come.

Shared Living Arrangements

If you live alone, and are concerned about your future capacity to care for yourself, you might consider moving in with someone, perhaps a good friend or a close family member. This may improve your financial situation substantially. It might also allow you greater economic security in the future, especially in the event that you suffer a serious illness, and require additional medical or long-term care. Should your health diminish, group homes might be an alternative. In Texas, there are zoning laws that permit group housing (Board and Care facilities) for persons with disabilities requiring personal care. The major distinction between nursing homes and Board and Care homes is that the latter provide no medical care.

Benefits Counseling

As a single senior, you may feel a sense of financial vulnerability about your ability to pay for a catastrophic illness or expensive medications for a serious health problem, especially if you rely solely on Social Security Benefits. In Texas, you can get help with how to finance your long-term care by calling the Texas Health and Human Services Commission Coordination of Information and Referral System at 512 /424-6500; call the Texas Department on Aging at 800/252-9240 to obtain the phone number of your local Area Agency on Aging.

Appendix B. Consent Form

Managed Home and Community Long-term Care in Texas: Planning for the 21st Century

You are invited to participate in an exercise to examine issues surrounding how Texas seniors and their families consider options in long-term care, and other kinds of senior services and supports. You were selected as a possible participant in this exercise because you are an adult child of married, self-sufficient (physically healthy), and senior (a minimum of 65 years of age) parents. You will be one of approximately ten (10) subjects selected to participate in this exercise.

If you decide to participate in the exercise, we request that you read this consent form and the instructions for participating in the group discussion. Completion of the discussion should take approximately ninety (90) minutes. Completing this group discussion will benefit Texans considering long-term care decisions.

Any information that is obtained in connection with this exercise and that can be identified with you will remain confidential and will be disclosed only with your written permission. For example, any information obtained during the discussion will be assigned a code number to de-identify the research material. All information, such as videotapes, assessment guides, and compiled lists will be kept in a locked filing cabinet in the supervising faculty member's office.

Your decision whether or not to participate will not adversely affect your future relations with the Lyndon Baines Johnson School of Public Affairs, The University of Texas at Austin or the Texas State Comptroller's Office. At no time are you under any obligation to participate in this exercise. Your completion of the group discussion will be taken as evidence of your willingness to participate and your consent to have the information used for the purposes of this exercise.

If you have any questions, please feel free to contact Professor Jacqueline Angel at the Lyndon Baines Johnson School of Public Affairs at (512) 471-2956.

You may request to keep a copy of this form.

Thank you for your participation in this exercise.

_____ _____

Signature Of Participant Date

Appendix C. Long-Term Care Services
Home Health Care

What Is Home Health Care?

Home health care consists of a variety of preventive, acute, subacute, rehabilitative, and long-term care services delivered intermittently in the home. Services range from assistance with activities of daily living to high-tech medical treatments. Services are prescribed by a physician and delivered by or under the direction of a health care professional in accordance with a plan of care authorized by a physician. Often home health services relate to a person's acute medical needs and are not provided over an extended period of time. Services may include various levels of nursing care and other professional health services such as occupational therapy, physical therapy, speech/language therapy, respiratory therapy, and medical social work.

Services are designed to assist a person in completing medical treatment regimens, complying with self-administered medication instructions, and participating in other therapeutic activities which aid the person in maintaining health. Services may include help with medications, injections, catheters, and/or rehabilitative therapy for persons who have suffered strokes, fractures, or are recovering from surgery. Medical equipment and supplies that are related to the specific medical interventions provided may be included as part of the service.

In addition to providing care for specific treatments and interventions, skilled health care professionals may provide periodic assessments and monitor a person's health status and well-being, so that treatments can be altered to best meet the individual's needs.

> **Example:** Anna is 78 years old, lives alone in her apartment, and is able to cook and perform personal care. Her daughter visits once a week to help with housekeeping and grocery shopping. Anna has high blood pressure and diabetes, for which she takes several medications. A home health nurse visits once a week to do a physical assessment, monitor Anna's glucose levels, and to provide nutritional counseling.

Who Provides Home Care Services?

Home health services are provided by health care professionals such as nurses (registered or licensed vocational), trained home health aides under the supervision of a registered nurse, occupational therapists, physical therapists, medical social workers, and respiratory therapists. Services are provided through home health agencies that are licensed by the Texas Department of Health as Home and Community Support Services Agencies. Agencies may be "certified" (meet Medicare standards and must be utilized for this payor

source) or "licensed" (meet state standards of care and may be utilized by other payor sources).

How Are Home Health Services Paid For?

Medicare Part A (Hospital Insurance) will pay for home health care visits if services are ordered by a physician, the person is homebound because of illness or injury, and the person needs part-time or intermittent nursing care or physical, speech, or occupational therapy. Routine medical supplies needed by the patient are also covered under the Medicare home health benefit. Services that are not covered include full-time nursing care, drugs and IVs (with some exceptions), homemaker/housekeeping help, and routine/custodial care.

Medicare Part B (Medical Insurance) covers home health visits and management of the plan of care by a physician with a 20 percent co-payment.

Medicaid covers home health visits as an alternative to more costly hospital or nursing home care, and is limited to skilled nursing, physical therapy, and home health aide services. To be eligible for Medicaid home health benefits a person must be considered "homebound." If a person is able to leave their home at will, the person is usually not considered homebound. Services must be prescribed by a physician and delivered in accordance with a physician's plan of care. Some medical supplies and equipment may be covered under the Medicaid home health benefit.

The Texas Department of Human Services provides long-term skilled home health services through a variety of programs to persons who meet financial, medical, and functional criteria.

Private insurance policies may cover basic home health services. Each health plan should be reviewed for specific coverage information.

Who to Contact for Additional Information

Texas Department of Human Services
P.O. Box 149030
Austin, Texas 78714-9030
(800) 252-9240 (to find out your local contact agency)

Texas Department on Aging
1949 IH-35 South
Austin, Texas 78741
(800) 252-9240 (automatically connects to the Area Agency on Aging nearest you).

Texas Association for Home Care, Inc.
3737 Executive Center, Suite #151
Austin, Texas
(800) 880-8893

Medicare Automated Information Service
(800) 638-6833

Tips:

1. Home health care may allow for early discharge from the hospital and prevent or postpone institutionalization. Although long-term care involves much more than just medically-related care, appropriate home health services may be all it takes to allow a person to remain in their home.

2. Home health care can supplement the family's resources and efforts in caring for loved ones at home and can be an important factor in keeping families together.

3. Home health care not only provides needed services but can reduce the isolation for many elderly people living alone in their own homes.

4. Home modifications and adaptive aides increase independence and can reduce the need for and/or enhance some home health services.

5. Personal emergency response systems consist of a small device worn around the neck or on the wrist and allow the wearer to signal for help by pressing a button. They transmit a signal to an emergency monitoring center where staff attempt to determine the nature of the emergency and respond accordingly. These devices can increase a person's independence, security, and peace of mind.

6. In determining which home care provider is best for you, consider how long the provider has been serving the community and what services the provider offers. Ask your physician if she/he knows the reputation of the provider. Friends and family members who have used home health care are also good sources of information.

7. If Medicare or Medicaid will be covering the home health services, make sure the provider is a "licensed and certified" provider.

8. Ask the provider for any written statements that describe its services, fees, patient rights, confidentiality, complaint procedures, hours of service, and emergency arrangements.

9. Ask the provider how they select their employees. Do they perform background checks on their employees?

10. If you have a problem or complaint about a provider, you may contact the Texas Department of Health - Health Facility Licensure Home Health Hotline at 1-800-228-1570.

Appendix C References

The Equitable Foundation and Children of Aging Parents. 1995. *Aging Parents and Common Sense: A Practical Guide for You and Your Parents.* New York, NY. December.

Health Care Financing Administration. April 1996. *Medicare Handbook.* Washington, D.C. (Pamphlet).

National Association for Home Care. http://www.nahc.org

Texas Department of Health, *Texas Medicaid Provider Procedures Manual,* 1997.

Texas Health and Human Services Commission, *Health and Human Services in Texas: A Reference Guide*, May, 1993.

Texas Health and Human Services Commission, State Medicaid Office, *Texas Medicaid in Perspective,* Austin, Texas. May, 1994.

Texas Association for Home Care. http://www.tahc.org

Appendix D. Long-Term Care Services
Personal Assistance Services

What Are Personal Assistance Services?

Personal assistance services provide routine, ongoing care or services to individuals in a residence or independent living environment. Personal assistance services provide individuals with help and supervision in completing activities of daily living such as bathing, dressing, grooming, eating, walking, taking medication, toileting, and other personal care activities. This type of personal care may be provided by unlicensed personnel without nursing supervision and does not require a physician's order. Services may also include some limited activities related to a person's health needs, such as changing bed linens and meal preparation. Personal assistance services are not for the treatment of medical needs and do not include nursing care. Personal assistance services may also be referred to as attendant care services, personal care services, and supportive home care services.

> **Example:** Javier is 82 years old and lives with his wife, Rose, who is 76 years old. Javier had a stroke two years ago and as a result, he needs assistance with his personal care. Rose is able to provide some of that care but it is becoming increasingly difficult due to her arthritis. Javier and Rose are otherwise in good health. A personal assistant comes by daily to assist Javier with his bathing, grooming, and dressing.

Who Provides Personal Assistance Services?

Many elderly do not receive formal, paid home and community-based long-term care services, but rely instead on informal, unpaid support given by family and friends. In fact, this informal care accounts for about 75 percent of the home and community-based long-term care services provided. Where home care in the form of unpaid, informal support is unavailable or inadequate, community care programs may authorize personal assistance services.

In Texas, these services may be administered by state and local units or by private nonprofit or even for-profit agencies. Services may be paid for directly by the authorizing program or by the client through a subsidy or voucher. However, services must be provided by a home and community support service agency licensed by the Texas Department of Health.

How Are Personal Assistance Services Paid For?

The Texas Department of Human Services pays for personal assistance services for those persons meeting financial, medical, and functional criteria through a variety of programs. Some programs serve a limited number of clients and waiting lists for their services may exist. Area Agencies on Aging fund these services through the Texas Department on Aging funds.

Most private insurance policies do not cover personal assistance services but check your health care plan for specific coverage information.

Who to Contact for Additional Information:

Texas Department on Aging
1949 IH-35 South
Austin, Texas 78741
(800) 252-9240 (automatically connects to the Agency on Aging nearest you).

Texas Department of Human Services
P.O. Box 149030
Austin, Texas 78714-9030
(800) 252-9240 (to find out your local contact agency)

Texas Association of Homes and Services for the Aging
2205 Hancock Drive
Austin, Texas 78756
(512) 467-2242

Texas Association for Home Care, Inc.
3737 Executive Center, Suite #151
Austin, Texas
(800) 880-8893

Tips:

1. Personal assistance services can be an important factor in allowing a person to remain in their own home and can prevent the need for institutionalization.

2. Personal assistance services are not only for elderly persons living alone but may be provided to elderly persons living with another caregiver. This service can reduce the burden of the caregiver while allowing the elderly person to remain in the home.

3. Personal assistance services not only provide help with certain care needs but can reduce the isolation for many elderly people living alone in their own homes.

4. Many home modifications or adaptive aides can make daily activities easier to perform. These devices and products can lead to increased independence and/or reduce the need for some personal assistance services. There are many "aides for daily living" available through pharmacies and medical equipment dealers.

5. Personal emergency response systems consist of a small device worn around the neck or on the wrist and allow the wearer to signal for help by pressing a button. They transmit a signal to an emergency monitoring center where staff attempt to determine the nature of the emergency and respond accordingly. These devices can increase a person's independence, security, and peace of mind.

6. Ask the provider for any written statements that describe its services, fees, patient rights, confidentiality, complaint procedures, hours of service, and emergency arrangements.

7. Ask the provider how they select their employees. Do they perform background checks on their employees?

8. If you have a problem or complaint about a provider, you may contact the Texas Department of Health - Health Facility Licensure Home Health Hotline at 800-228-1570.

Appendix D References

The Equitable Foundation and Children of Aging Parents. 1995. *Aging Parents and Common Sense: A Practical Guide for You and Your Parents.* New York, New York. December.

National Association for Home Care. http://www.nahc.org; INTERNET.

Texas Association for Home Care. http://www.tahc.org; INTERNET.

Texas Health and Human Services Commission, *Health and Human Services in Texas: A Reference Guide*. May, 1993.

Texas Health and Human Services Commission, State Medicaid Office, *Texas Medicaid in Perspective,* Austin, Texas. May, 1994.

Appendix E. Long-Term Care Nursing Homes

What Are Nursing Homes?

Nursing homes are long-term care facilities that offer a protective, therapeutic environment for those who need rehabilitation or can no longer live independently because of chronic physical or mental conditions that require round-the-clock care. Nursing homes are licensed facilities that provide 24 hour-per-day skilled nursing care, physical and mental rehabilitation, assistance with activities of daily living, nutritional management, and activities that address social, spiritual, and recreational needs. Meals, laundry, and housekeeping services are also provided. Residents typically have a private or semi-private room with a bath. Nursing homes are sometimes referred to as convalescent homes, rest homes, intermediate or extended care facilities, or skilled nursing facilities.

While all nursing homes provide general medical and social services to residents, they may also specialize in care for certain types of residents, such as those who need physical therapy, Alzheimer's care, or other specific types of care. In general, most nursing homes offer a variety of specialized services. Many specialty services are not part of the care covered by the facility contract or daily rate and therefore cost extra.

The goals of nursing home admission are different for every resident. Some residents will return home after a brief rehabilitative stay. Others may be very ill and may live only a short time. Many may need care for an extended period of time. Whatever the case, good nursing facilities enable residents to capitalize on their strengths and compensate for their weaknesses in an atmosphere as homelike as possible. They involve residents and their families in decisions about their care and the nursing home environment. In addition, a good nursing home should help residents maintain self-esteem, build strength, continue social relationships and interests formed over a lifetime, and even assist in developing new ones.

Who Are the Providers of Nursing Home Services?

Nursing homes are licensed by the Texas Department of Human Services and must meet state and federal government licensing standards. They are monitored by the Texas Department of Human Services, the U.S. Department of Health and Human Services, the U.S. Occupational Safety and Health Administration, state and local fire safety agencies, and a variety of other government agencies. In all, there are about two dozen agencies monitoring licensed facilities on a regular basis.

A board of trustees determines the general policies of the home and implements its mission of care and service to the total person. Trustees are volunteers who often are leaders of the local community.

The administrative staff is responsible for the day-to-day planning and operations of the home. Personnel usually include an administrator or executive director, and admissions, personnel, and financial officers. A director of nursing is usually a registered nurse who manages the daily activities of other registered nurses, licensed vocational nurses, and nursing assistants. Other health care professionals, such as therapists, social services staff, nutritionists, and pastoral care staff provide a variety of services.

Each nursing home has a designated medical director who coordinates with other staff to ensure the adequacy and appropriateness of the medical services provided to the residents. Often, the medical director is the primary physician for many of the residents; however, the resident can use his or her own physician provided the physician agrees to visit the resident at the nursing facility.

How Are Nursing Homes Services Paid For?

Nursing home care, like all good health care, is costly. Before you agree to pay for services, be sure you understand completely all the financial arrangements of the nursing home.

Almost one-third of all Texas nursing home residents pay for costs out of personal resources. Many people enter a nursing home and begin paying for their care out of their own income and savings. Because of the high costs of such care, they deplete their resources.

Traditionally, private insurance has not paid for nursing home care. However, this is beginning to change and some private insurance policies cover nursing home care. The insurance policy should detail any long-term care coverage and a policy-holder should check with the insurance provider to see what services and charges will be covered.

Medicare is a federal health insurance program for people over 65 years of age and people with disabilities. Nursing facility coverage under this program is very limited—up to 100 days per spell of illness. Generally, the first 20 days are fully covered by Medicare, with the resident being responsible for a sizable co-payment for the remaining 80 days. The total daily rate for days 1-100 generally runs $200 to $250. To qualify for Medicare payments in a nursing facility, a person must have recently been in the hospital for at least three days and must be medically unstable at the time of entering a Medicare-certified nursing home.

Medicaid is a joint federal/state program for lower-income people. As the major payor of long-term care, Medicaid will pay for care for those who meet both medical and financial criteria. The financial criteria is adjusted each year, but generally, a person will qualify for assistance from Medicaid if his or her monthly income is about $1300, with total assets of

$2,000 or less. Different criteria are used for a married resident who has a spouse at home. Texas requires Medicaid recipients to contribute all but $30 of their monthly income toward the costs of nursing home care. A nursing home must be Medicaid certified, or at least have a portion of the facility for Medicaid residents. Eligibility is determined by the Texas Department of Human Services according to the state formula.

The Veterans Administration contracts with some nursing homes to care for qualified veterans. In many cases, these are short stays of three to six months, although sometimes the VA will cover the costs for longer periods.

Nursing home costs are generally calculated on a daily rate. These costs vary in Texas based on the facility and level of care that is required by the resident. Those individuals who have higher skilled nursing needs can expect to pay a higher rate than those with less skilled nursing needs. For those nursing home costs that are reimbursed by a third party, the rate is determined by the third party payor, i.e., Medicaid or Medicare. The average nursing home rate for a private-paying individual in Texas is $100.00 per day. However, costs may vary based on the level of care needed, location of the facility, and other services and amenities that are offered by the facility.

Who to Contact for Additional Information:

Texas Department on Aging
1949 IH-35 South
Austin, Texas 78741
(800) 252-9240 (automatically connects to the Agency on Aging nearest you).

Texas Department of Human Services
P.O. Box 149030
Austin, Texas 78714-9030
(800) 252-9240 (to find out your local contact agency)

Texas Association of Homes and Services for the Aging
2205 Hancock Drive
Austin, Texas 78756
(512) 467-2242

Texas Health Care Association
P.O. Box 4554
Austin, Texas 78765
(800) 380-2500

Tips:

1. If you are looking for a nursing home, make sure the facility has a current state license. Ask to see the facility's state inspection report. If you get the run-around or if the report contains any unexplained health, safety, or quality of life deficiencies, consider dropping that facility from your consideration.

2. If Medicaid or Medicare are paying for the care, make sure the facility is a certified Medicare and/or Medicaid provider.

3. Talk with your physician about the level of care and any specific services that are needed, and make sure the facility can meet those needs. Find out what medical, therapeutic, and other specialty services are available.

4. What services are included in the basic daily rate? Ask for a complete list of specific services and benefits not covered in the basic rate.

5. Make a worksheet for evaluating each facility you are considering. Select the criteria you feel are important and "weight" the different criteria based on what is most important to you and what is less important.

6. When evaluating a nursing home, it's important that you get answers to whatever questions you may have, that you not feel intimidated, and that you have a tour of the entire facility. Spend plenty of time at each of the facilities. Make return visits to the facilities that look promising.

7. Talk with everyone from the administrator to the director of admissions, nurses, visitors, volunteers, family members of residents at the facility. Notice the interaction between staff and residents, interaction among the staff, and the activity level of residents. Is family involvement encouraged and, if so, how?

8. When trying to decide on which homes to visit, talk to your physician, friends who have had experiences with local facilities, hospital social workers, and religious organizations. Referrals from someone you know and trust are often your best source.

9. Both the Texas Health Care Association and the Texas Association of Homes and Services for the Aging have checklists for helping select a quality nursing home that best meets your needs. See "Who to Contact for Additional Information" above for the addresses and phone numbers.

10. Keep in mind that in-home and community-based services may be options that can allow a person to remain in their own home or in the community as long as possible. Consider checking out some of these options, such as home health care, personal assistance services, homemaker/chore services, adult day care, and respite care.

11. If you have a problem involving a nursing home, contact the State Long-Term Care Ombudsman at 512/444-2727.

Appendix E References

Health Care Financing Administration. April 1996. *Medicare Handbook.* Washington, D.C. (Pamphlet).

Komisar, Harriet L., Jeanne M. Lambrew, and Judith Feder. *Long-Term Care for the Elderly*, Institute for Health Care Research and Policy, Georgetown University. December, 1996.

Texas Association of Homes and Services for the Aging, *What You Should Know About Housing and Services for Older Adults*, Austin, Texas. (Pamphlet).

Texas Health and Human Services Commission, *Texas Medicaid in Perspective*, Austin, Texas, May, 1994.

Texas Health Care Association, *Choosing the Right Care,* Austin, Texas, 1994. (Pamphlet).

Texas Health Care Association, *Financing Long-Term Care,* Austin, Texas, 1994. (Pamphlet).

Texas Health Care Association, *Medical Issues in Long-Term Care,* Austin, Texas, 1994. (Pamphlet).

Appendix F. How Do I Choose a Primary Care Physician or Health Plan?

Deciding who helps you take care of your health is an important decision and requires serious consideration. You may decide to consider a primary care physician in his or her own private practice. Your physician may be affiliated with an independent group of physicians, or participate in one of several types of "managed care" plans such as a health maintenance organization. Although this information covers how to decide on a health plan, some of the suggestions are applicable to choosing a primary care provider, regardless of where the medical services are provided.

What is important to you ?

Four important factors should be considered in deciding on a health care plan.

1. **Cost:** Who pays for your medical care?
2. **Coverage:** What benefits are offered (covered)?
3. **Convenience:** Is the location convenient and easily accessible?
4. **Choice:** Can you choose a primary care physician or change to another physician if you are not satisfied? Are you comfortable with the hospital(s) the health plan uses? Does it have expertise in the kind of services you might need (i.e., heart, cancer, etc.)?

Will you receive quality health care ?

In assessing the quality of health care you expect to receive, you should seek information regarding:

1. Qualifications of doctors
2. Prevention and early detection
3. Patient satisfaction
4. Improvements in care and service

Where do I find information on a particular health plan?

Consider the following resource for answers to your questions about health plans:

1. Get the copy of benefits contract from your employer benefits office or the plan business office.

2. Contact the health plan's customer services office for answers to your questions.

3. Other agencies or offices can provide information on health plan quality, such as:

    - State Medicaid or Medicare office
    - Consumer protection organizations
    - State insurance board
    - Public health departments

What other things should I consider?

You may have questions or concerns about other factors such as:

1. Waiting time and appointment scheduling

2. Services the plan may not cover

3. Procedure for referrals to specialists and other health professionals

4. Appointments scheduled with same care provider

Adapted from: National Committee for Quality Assurance, (NCQA), 1996, pp. 1-6.

Appendix G. How Do I Plan for a Medical Crisis?

Organizing, maintaining and updating a personal medical file is an important first step in planning for a medical crisis. Important medical information to have readily available includes:

1. Names, addresses and telephone phone numbers of your health care providers, such as physician, dentist, pharmacist, medical specialist.

2. Instructions for the individual you have designated to provide medical information on your behalf, if you are unable.

3. Special instructions, such as a living will, or a durable power of attorney for health care decision making.

4. All prescription and non-prescription (over-the-counter) drugs that you take. List should include:

    - dosage (amount of medication you take and when)
    - name of physician prescribing the drug
    - name, address, and telephone number of pharmacy dispensing the drug

5. Address and telephone numbers of the hospitals that you prefer to use.

6. Medicare number.

7. Medicaid number.

8. Names, addresses, and telephone numbers of your caseworker and/or social worker.

9. Name, policy number, office location of health, Medigap-supplemental health and long-term care insurance policies.

Adapted from: Equitable Foundation and Children of Aging Parents (CAPS), 1995, p. 5-7.

Appendix H. How Do I Communicate with My Physician?

Establishing a relationship with your primary care physician is important. You should be able to talk freely with your physician about your medical concerns, physical condition, treatment plan, and preferences. Some suggestions in establishing a relationship with your primary care physician include:

1. **Get involved.** Discuss your care and treatment plan with your physician and decide with your doctor what treatment is right for you.

2. **Decide what treatment is right for you.** You should decide with your doctor which treatment is the right one for you. Ask questions about your treatment, such as diet, physical activity, medication, and benefits and risk associated with a particular treatment. Tell your doctor about your concerns: medications you are taking; medicine allergies or reactions you may have; and what other physicians you see or medical care you are receiving.

3. **Agree to a treatment plan and stick to it.** Make sure you understand the treatment plan and what results to expect. Ask about possible side effects from taking a medication. Ask about food, drinks, other medicines or activities not allowed while on the treatment. Tell your doctor about any concerns you have regarding your medication and other aspects of treatment.

4. **Look for changes in how you feel.** If you have concern about how you feel once you begin a treatment plan, let your doctor know. Tell your physician about new problems you experience after you start taking medication.

5. **Seek advice and assistance.** You should discuss your medications or other treatment with your pharmacist, as well as your physician. You may also ask your nurse or other health professional when necessary.

6. **Get additional information.** Stay informed about your medical conditions and treatments. Read books, pamphlets, and brochures on topics concerning your health. Contact an agency or association that offers information regarding your particular medical condition. Other resources include computer online services and community health clinics.

Adapted from: Agency for Health Care Policy and Research (AHCPR), 1996, p. 1-7.

For information or answers to questions regarding your medical care in Texas, contact:

Organization	Telephone Number
Bureau of Managed Care Texas Department of Health	(512) 794-6838
Medicaid Eligibility Texas Department of Human Services	(512) 438-3323
State Medicaid Office Texas Health & Human Services Commission	(512) 424-6500
Texas Department of Insurance	(512) 463-6169
Consumers Union Southwest Regional Office	(512) 477-4431
Texas Board of Medical Examiners	(512) 305-7010
Texas Nurse Board	(512) 305-7400
Texas Pharmacy Board	(512) 305-8000

Appendix H References

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Appendix I. Assisted Living

What is Assisted Living?

There is no formal definition of assisted living. It is a concept of providing alternatives to premature institutionalization (i.e., nursing home/institutional care). Fundamentally, assisted living exists in the continuum of long-term care to assist the frail elderly in varying degrees of acuteness with Activities of Daily Living (ADLs).

One definition is any group or residential program (other than a licensed nursing home) that provides personal care for persons with impairments in the performance of ADLs, and has the capacity to meet unscheduled needs for assistance.

Assisted living facilities have many names: residential care, adult congregate living, personal care, catered living, group home for adults, community residences, board and care homes, semi-dependent, and continuing care retirement communities.

Assisted Living in Texas

Assisted living homes are *licensed* as "Personal Care Facilities" by the Texas Department of Human Services. A home with four or fewer residents does not require a license; a home with more than four residents requires a license. Currently, there are 830 licensed personal care facilities in Texas and 4,000 unlicensed facilities. Fifty-one percent of those have 16 beds or less; of that number sixty-one percent have 8 beds or less. So far, most small assisted living facilities in Texas are still "mom-and-pop" operations.

Key Features

- Congregrate housing (private/shared room or apartment in group setting)
- Supportive services (hotel services and personal care) responding to individual needs with respect to types and amounts of services

Assisted living facility in Texas

Who Should Consider Assisted Living?

It depends on care needs. Assisted living can be an alternative for you if you:

- are no longer able to manage at home on your own; or
- are not able to get enough help from family members and others to remain at home safely; or
- are anticipating decline rather than improvement or stability in your physical capacity or health status; and/or
- are kept away from friends and favorite activities by poor health or disability.

For Whom Is Assisted Living Not Appropriate?

If you require skilled or 24-hour nursing care (i.e., involving invasive procedures), assisted living options are not for you. Assisted living is no longer appropriate when you are not able to understand emergency instructions or cannot self-evacuate.

How Is Assisted Living Different from Nursing Homes?

There are two compelling criteria in Personal Care homes that distinguish them from nursing home/institutional care: 1) the resident must have the ability to understand

emergency instructions, and 2) the resident must be capable of self-evacuating. Within Personal Care homes there are two types: A and B homes.

Table I.1
Personal Care Homes

A Home	B Home
resident must be capable of evacuating unassisted (includes people in wheelchairs who can transfer themselves and evacuate in an emergency);	resident is incapacitated to the extent that she or he needs assistance to evacuate;
resident must be capable of following directions for self-preservation under emergency conditions;	resident is incapable of following directions for self-preservation under emergency conditions;
AND	resident requires routine supervision during nighttime sleeping hours (an attendant must be awake and on call for assistance);
resident does not require usual and routine attendance during nighttime sleeping hours.	resident may not be bedfast but may be chairfast needing assistance with transferring upon arising and retiring; but once into chair is able to move independently;
	OR
	resident has needs when self-care is provided an appropriate caregiver or when care is provided by contract with professional personnel to the individual resident.

Source: Texas Department of Human Services Licensing Standards for Personal Care Facilities.

Cost

The mean monthly charge in Austin for a private room is $1,500, but in many assisted living facilities, there are fees for services, so it can cost more. Average private pay would be $2,400.

As compared to nursing homes in general, assisted living rates can be one-third to one-half the rates of nursing homes, with the cost of nursing homes ranging from $3,000 to $4,000 monthly.

'Did You Know...?' Some Texas Facts

- Texas is one of the first two states to allow Medicaid funds to be used for assisted living through its Community-Based Alternatives (CBA) program.
- The Texas Community-Based Alternatives program is funding up to 22,000 residents in a range of assisted living facilities at a rate of $20-$40 per day.
- Nationwide, about 90% of assisted living services are paid for with private funds.
- Texas is one of the top five states with new assisted living construction.

Where do I find more information about licensed facilities?

Texas Department of Human Services

Directory of Personal Care Facilities

Texas Association of Residential Care Homes

Mat Mathews, President
512/276-7000

Where do I find more general information about long-term care options and other community-based care (if assisted living is not for me)?

Texas Department on Aging, Area Agency on Aging

For the phone number of your nearest Area Agency on Aging, call 800-252-9240.

National Association of Area Agencies on Aging Eldercare Locator

(800) 677-1116

Tips on Finding the Right Assisted Living Facility

Remember that assisted living facilities vary greatly in type, cost, services, and assistance provided because they are not yet uniformly regulated.

Questions to Ask and Issues to Consider:

Lifestyle

- What kind of environment does a facility have? Is it attractive and comfortable?
- Does it provide a balance of privacy and safety?
- Is there flexibility for individual preferences regarding meal times and places, bedtimes, transportation, etc.?
- Does the staff seem to respect residents?

Health and Personal Care

- Is there a clear service contract about resident's eligibility if care needs increase? Make sure you are clear about what arrangements will need to be made if the resident declines in physical or cognitive abilities.
- In the context of licensing and the provider's operational capacities, how frail may a resident become and remain in that setting?
- What medical help is available?
- What is the nature of staff training, and the resident/staff ratio?
- Is there help for staying healthy? Do activities and meals support healthful living?
- Can you keep your current health providers?

Affordability

- If you do not like contract provisions, can you modify them?
- What is the cost?
- What services are provided?
- Are different plans or service arrangements offered?

Other considerations

- Make sure you understand the license or status of the facility.
- If you do not like contract provisions, ask if you can modify them.

- Gauge a setting's "personality" for a good fit. Consider what you see, hear, smell, and feel.

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Appendix J. Wills And Trusts

What Is a Will?

A will is a written instrument containing directions for how the property of the person making the will (the "testator") shall be distributed upon his or her death. The will may specify the sources from which taxes, expenses, claims and other charges against the estate are to be paid, and it may also be used to take advantage of estate tax deductions and exclusions. Sometimes the will contains instructions for the guardianship of the testator's minor children, if there is no surviving parent.

A will can be used to place funds in trust for the benefit of minors or anyone else the testator might consider unable to handle property. Such a "testamentary" trust can provide for children's education, or may simply hold the property until a minor becomes an adult. Conditions for a testamentary trust are at the discretion of the person making the will.

The will is usually executed in accordance with the laws of the state where the testator resides. These laws usually require that the will be signed by the testator and at least two witnesses who have no interest in the property passing under it. A signed instrument purporting to be someone's will is not officially recognized until the court having jurisdiction over the instrument declares it to be valid after examining it and the circumstances surrounding its execution. The process by which a court determines whether a will is valid is known as probate.

The person or institution named in the will to take charge of the estate is called a personal representative or executor. The functions of an executor include gathering all the decedent's property, following the instructions of the will, paying taxes, paying claims against the estate and administration expenses, paying bequests under the will, safeguarding the interests of the beneficiaries, and closing the estate. Trusts established by the will are managed by a trustee, which may be either an individual or a bank.

If a person dies intestate (without a will), state law determines how the property is to be divided among the family. The probate court appoints an executor, and in most intestate cases the estate is distributed to the heirs immediately. Minor heirs receive their share upon reaching age 18. The state will also resolve any outstanding guardianship questions. If there are no living relatives, all of the assets will be turned over to the state.

If you die without a will, everything that you own in your name alone will be divided among your spouse, children, or other relatives according to state law. The court will appoint a personal representative to collect and distribute your assets. The personal representative and the attorney for the personal representative are entitled to be paid based on the total value of all property—before deducting mortgages or other liabilities—in your probate estate.

Who Really Needs A Will?

Most Americans die without having wills, but the consequences of dying intestate vary greatly with individual circumstances. Generally, the need for a will grows as one's assets and family ties increase. Wills are especially important for parents with children who are minors, because parents can name a guardian in a will and make arrangements for financial support of children even past the age of 18. Texas law also provides for a separate "Declaration of Appointment of Guardian for Minor Child" in which parents can designate their wishes, in the event of death, for the care of their children.

Couples also have each other to think about. If one spouse dies without a will, state law might force the other to split the assets of the estate with the children, leaving the surviving spouse without enough support. Stepchildren, ex-spouses still living, non-custodial children, and a myriad of other possibilities can add further complications.

A single person with few assets probably doesn't need a will. If such an individual does care about who would get something (such as a car), one option is to change the title or deed to make the item joint property with right of survivorship to a co-owner. Financial accounts can also be jointly held, with or without right of survivorship, and can pass directly to anyone you name. The disadvantage of co-ownership is that it can be difficult to remove the co-owner's name later if circumstances change; usually, the co-owner's interest in the property lasts for life.

There are several categories of wills:

- handwritten wills (known as "holographic wills");
- do-it-yourself typewritten wills, fill-in-the-blanks wills — such as you can buy from a stationery store or take out of a book;
- wills you can generate from a home computer; and
- wills that are professionally prepared and individually designed for you by attorneys.

Any of these kinds of wills can be valid if done properly. If preparing a will without the assistance of an attorney, it is important to study the state probate statutes to find out precisely what the law requires for a will to be considered acceptable in court.

What Is a Trust?

A trust is a means by which a person (often called the "grantor," "settlor," or "trustor") can dedicate a portion of his or her assets to a specified purpose and transfer all decisionmaking power over those assets to a manager or "trustee." The trustee has legal ownership of the transferred property (the "corpus" or "principal" of the trust), subject to the conditions of the trust specified by the grantor.

Trusts can be living (established during the grantor's lifetime) or testamentary (established in a will). A living trust can be revocable (subject to termination or modification at any time by the grantor for any reason) or irrevocable. If irrevocable, the grantor can never end the trust, modify its terms, or withdraw assets. An irrevocable trust is an independent entity under the law.

A grantor may change the terms of a testamentary trust before death, assuming that the grantor has not become incapacitated and unable to make such decisions. In any case, testamentary trusts require that the will creating them be probated. These trusts might also be accountable and have to report to the court.

The trust assets are managed for the benefit of one or more beneficiaries. The grantor can also be trustee and beneficiary, but usually if the grantor is the trustee, there must be other beneficiaries. In some states, the trust can remain empty (unfunded) for quite a while after its creation. In states such as Texas, however, some nominal funding (e.g., $100 in a bank account) is required.

The Miller Trust

The Miller Trust was established in 1993 as a way to help medically needy individuals qualify for Medicaid nursing home assistance. Before the Miller Trust was established, thousands of individuals were denied Medicaid nursing home benefits because their monthly income was only slightly higher than the maximum eligibility amount (currently $1,452 per month). This left them without the care they needed, and without the resources to pay privately for nursing home care, which can range in cost from $1,800 to $3,000 per month.

To be eligible for Medicaid to pay for the cost of care in a nursing facility, an individual must:

- require 24-hour assistance at an intermediate level to a skilled level of care; and
- qualify financially for Medicaid.

In Texas, this means that the person must have no more than $1,452 in income each month and no more than $2,000 in resources. In many cases, however, persons need a nursing facility, but exceed the income threshold. To alleviate some of the hardship of this situation, the state created a new kind of entity called a Miller Trust to keep a potential recipient's income from exceeding the $1,452 limit. (Resources are not affected by a Miller Trust and can still be a basis for Medicaid ineligibility.)

The average cost to establish a Miller Trust in Texas is currently $850 to $1,500. Once the trust is established, all of the individual's retirement and social security checks must be deposited into the trust. The individual is then viewed by the state as having zero income. (In some cases, only a portion of the individual's monthly income may have to be placed in the trust to qualify for Nursing Home Medicaid.)

Trust deposits need only to be made for one month. At the end of this month, the individual should qualify for Nursing Home Medicaid and the application for Medicaid should be submitted. After Medicaid approval, three checks will be drafted out of the trust each month. The first will be a check for $30 which goes to the individual to pay for personal expenses incurred while in the nursing facility. The second check can be written for any medical or dental expenses not covered by Medicaid. The third check goes for the cost of care the individual receives in the nursing home. In effect, this is the remainder of the money left in the trust each month.

If the individual for whom the Miller Trust has been established is married and the individual's spouse still resides in the community, the third check will first go toward the spouse's Monthly Income Standard protected under the Spousal Impoverishment Law. This monthly income standard is currently $1,919 per month. After this final check is drafted out of the account, all other funds go toward the cost of the nursing home care.

The Miller Trust also applies when seeking Nursing Facility Waiver Services. The Nursing Facility Waiver provides home and community based services to individuals who require care. This program is offered through the Texas Department of Human Services and has been designed to be a cost-effective alternative to institutional care.

A Miller Trust is considered irrevocable unless the individual for whom the trust is established recovers to the extent that nursing home care is no longer needed.

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Appendix K. Power of Attorney

A power of attorney is a document in which one person (the "principal") gives authority to another to act on his or her behalf. The designated individual is known as an "attorney-in-fact," although the person need not be a lawyer. The scope of the power can be limited (such as the authority to sell a house) or general. The principal can even grant the power to make gifts of his or her property, but not to make a will.

There are two main reasons to use a power of attorney: to facilitate business or financial transactions, and to enable action on behalf of an individual who is incapable of making his or her own decisions. For business purposes, a detailed and extensive power of attorney is often used to cover every conceivable transaction an attorney-in-fact may have to make.

When using a power of attorney to manage personal affairs, the authority should be specified as much as possible and should be of limited duration. A bank (or anyone else with whom the attorney-in-fact may have to deal) might not accept the power of attorney if it is too general in scope. If the power of attorney involves the transfer of funds, the bank may require that all involved parties approve the arrangement in advance.

What Is a Durable Power of Attorney?

A conventional power of attorney becomes void if the person granting the power is suddenly incapacitated. By designating a "durable" power of attorney, however, an individual can provide for the management of financial affairs and other matters in the event that he or she is rendered unable to act personally. Under such an arrangement, the attorney-in-fact makes decisions that the disabled principal would normally make, such as selling property, cashing certificates of deposit, or writing checks.

A durable power of attorney is often a very broad and detailed document. To be durable, it must contain a clause explicitly stating that the power shall not be affected by the principal's subsequent disability or incapacity, or by the passage of time. Without such a clause, most state laws would probably render the power of attorney inoperative immediately upon the disability of the principal.

Use of the durable power of attorney allows the principal to choose an agent rather than having the court select a guardian. Consequently, it also eliminates the need to establish guardianship or conservatorship over the estate, which is often an expensive and time-consuming process, and enables the attorney-in-fact to make property transactions without prior court approval.

Most experts recommend a separate, statutory health care power of attorney document. This particular instrument is covered in more detail in a separate appendix to this report, "Advance Medical Directives."

Springing Power of Attorney

An alternative to a durable power of attorney is the springing power of attorney, which only becomes effective when the principal becomes incapacitated or upon some other specified occurrence. The springing power of attorney is used if a person wishes to delegate power when incapacitated, but wishes to retain it while still healthy.

A springing power of attorney requires a formal determination of disability before the power of attorney will be considered operative. This can involve a short delay and extra expense. (A springing power of attorney might provide, for example, that two doctors examine the principal and attest to disability.) If there is uncertainty or disagreement over the degree of the principal's disability, however, banks or others might balk at recognizing the authority of the attorney-in-fact. Such disagreements often wind up in court.

Cautionary Notes

It is important to remember that any power of attorney is ultimately an instrument presented to banks and other third parties who can arbitrarily decline to recognize it for their own reasons. The party being asked to accept a power of attorney is in fact doing the principal a favor. If the person or institution has any reason whatsoever to fear "getting in trouble" for honoring the document, it might be rejected. A stock brokerage, for example, does not want to worry about following the instructions of an attorney-in-fact under a customer's power of attorney, only to have the customer file a lawsuit later, arguing that the document should not have been honored for some reason.

Brief, general power of attorney forms usually are not acceptable if the attorney-in-fact is engaging in a transaction involving much money—especially when there are questions about the principal's mental capacity. Moreover, such short instruments are not designed for a "durable" power of attorney.

Banks and other institutions are concerned, too, over reports in recent years of abuses of discretion and "self-dealing" in the principal's property by persons purporting to act under powers of attorney. Institutions do not want to risk claims by disgruntled account owners that their accounts have been spent down by dishonest attorneys-in-fact, using power of attorney documents that were deficient in some respect and should not have been honored.

Consequently, it is prudent to discuss the matter beforehand with the bank or institution that will be asked to honor the power of attorney. Some banks may have their own power of attorney forms and might insist they be used.

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Appendix L. Guardianship

What Is a Guardianship?

When an adult is unable to manage his or her own affairs, a court may appoint a guardian to make personal or property decisions on behalf of that person (or "ward"). A guardian's duty is to protect the ward and his or her estate from abuse, exploitation, and neglect.

All states have guardianship laws to protect citizens who are unable to make personal or property decisions for themselves. Unless a person has made contingency arrangements prior to becoming incapacitated, the state uses these laws to designate someone to take charge of a ward's affairs. Guardianship involves a long, complex proceeding in court, however, and is usually more expensive and time-consuming than voluntary contingency plans such as a durable or springing power of attorney or a living trust.

Why Would Someone Need a Guardianship?

Guardians often make the following type of decisions on behalf of a ward:

- Deciding where the ward should live;
- Making medical decisions for the ward;
- Deciding how the money of the ward will be spent;
- Deciding who can and cannot visit the ward;
- Making sure that the ward has proper food, clothing, medical care, and shelter; and
- Applying for services that the ward may be eligible for and ensuring that those services are administered properly.

How Do You Obtain a Guardianship?

The relationship of the guardian to the ward is much like that of parent to child. Because stripping an adult of independence is a significant matter, the process of obtaining court appointment as a guardian necessarily involves some time and money. The first step is a petition to the court by someone asking to be appointed. In some areas, the court clerk's office has blank forms and instructions.

Next, the court must make an inquiry into the necessity of guardianship. If the court finds that an adult child who is taking care of a parent seeks legal guardianship merely to make

his or her task more convenient, guardianship probably would not be awarded if the parent were to object. As a safeguard, most courts will appoint an attorney to represent the supposedly incapacitated or disabled person.

The court will generally require a hearing, at which medical or mental health professionals must present some kind of evaluation of the disabled person. Often, the petitioner seeking guardianship must make arrangements and pay for the examinations and reports.

Although few people think about it before the need arises, it's best to choose a possible guardian for oneself while in good health. In most states, a person can sign a declaration of guardian that allows him or her—while still in sound physical and mental health—to name a guardian if need arises in the future. To make such a declaration, the person must be competent and over the age of 18. The document must be signed and witnessed by two people other than the designated guardian. The declaration must be notarized, and must have a "self-proving affidavit" briefly stating your intentions.

For further information, the best resource is the local probate court in the county where the proposed ward resides. The Texas Attorney General's Office has an Elder Law section to assist Texas seniors, which can be accessed by Internet on the World Wide Web at http://www.oag.state.tx.us/website/consumer/eldehelp.htm. Adult Protective Services can provide information via its toll-free phone line, 1-800-252-5400. There is also a Legal Hotline for Older Texans: 477-3950 in Austin, or 1-800-622-2520 from elsewhere in Texas.

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Appendix M. Medicaid and Estate Planning

A substantial proportion of people in nursing homes today were not poor before they entered but became impoverished by the cost once they did. Two-thirds of nursing home residents now rely on Medicaid to pay for their care, which for each person typically costs between $30,000 and $50,000 or more annually.

What Is Medicaid?

Medicaid provides medical assistance, including prescription drugs and long-term nursing home care, to financially needy persons regardless of age. By contrast, Medicare covers most senior citizens but is not needs-based. Medicare will not pay for intermediate level nursing care, however, which leaves a large gap in coverage for elders who need only limited assistance. While Medicare only rarely pays for such care for elders, Medicaid will if the individual qualifies. Consequently, while Medicare covers only about 2 percent of all nursing home costs, Medicaid pays more than 42 percent.

Although Medicaid rules require beneficiaries to use up most of their assets paying for nursing facility care before Medicaid begins, there are ways to preserve many of those assets. Each option has some drawbacks, however, and not all of them will be available for everyone. Different methods pertain to unmarried people and to couples; some require advanced planning and probably the assistance of a lawyer or other professional adviser. But in most cases, including Medicaid in strategic care planning can help an elderly person and his or her family reduce the burden of nursing home costs.

Qualifying For Medicaid Benefits

In general, for Medicaid to cover long-term care, one must meet income and asset requirements that vary from state to state. Some clients will be ineligible because their incomes exceed the limits allowed under Medicaid.

In order to qualify for Medicaid benefits for nursing home care, a recipient must:

- Be in a Medicaid approved nursing home under a physician's orders;
- Have medical and nursing home expenses that exceed income; and
- Have no more than $2,000 in non-exempt assets.

The following assets are exempt from treatment as countable resources:

- Personal residence or life estate in a residence;
- One automobile;

- Up to $2,000 in a prepaid irrevocable funeral contract;
- A life insurance policy to cover funeral expenses (available through most funeral homes);
- Up to $1,500 as a burial fund for such things as embalming, flowers, and funeral services;
- Life insurance having a face value of no more than $1,500;
- A burial space for applicant, his spouse, and immediate family members;
- The assets of certain trusts which include the Medicaid recipient as a beneficiary (current regulations involving such trusts are very complex, however, and in some circumstances will require that the assets of the trust be used to repay Medicaid after the death of the Medicaid recipient); and
- The value of income producing property if the annual income after expenses yields a 6 percent return (income from the property must be used for your nursing home care).

Under current Medicaid rules, it is possible to convert non-exempt assets into exempt assets by, for instance, paying cash to put a new roof on one's personal residence. One may also use non-exempt assets to pay bills, including any home mortgage debt.

If a nursing home stay meets the strict requirements for Medicare coverage, the full cost is paid for the first 20 days and there is a sizable copayment for the next 80 days. Although some Medicare supplement policies will cover the copayment, they cease coverage when Medicare stops on the 100th day.

Income which you receive from Social Security, retirement plans, interest, dividends, and rent must be used for the recipient's nursing home care. Medicaid allows a recipient to keep only $30 per month for personal needs, plus an amount equal to any premium on Medicare supplemental insurance and medical expenses not covered by Medicaid (such as eyeglasses and dentures).

Medicaid Planning Tips

Under current Medicaid regulations, any assets not given away within a period of 36 months (called the "lookback period") will be treated as countable resources. This will include any assets, including a home, which is transferred for less than its fair market value. The term used by the Medicaid program for such tranfers is divestment. The period of ineligibility for Medicaid begins on the date the transfer is made. The number of months a person is ineligible is determined by dividing the fair market value of the transferred property by the actual monthly cost of skilled nursing care in the area where

the person resides. Transfers to a spouse will not make one ineligible as long as the spouse does not re-transfer the property to a third party for less than fair market value.

Obviously, if assets are given away for purposes of qualifying for Medicaid, one must be sure that sufficient assets are available to pay the cost of nursing home care during the period of ineligibility. It is also important to realize that simply making a child or other person the joint owner of an asset will not prevent the asset from being treated as a countable resource. In order to prevent the asset from being treated as a countable resource, the Medicaid recipient must retain absolutely no ownership or control over the asset.

Because Medicaid rules often exempt a home of any value from asset eligibility limits, concentrating assets in a home is a good way to protect them. This is useful for both unmarried individuals and for couples, but the rules are different for each and must be carefully followed. Assuming there are no other immediate needs for savings or investments, a person could put those assets into a home by:

- Paying off the outstanding mortgage;
- Making home improvements or certain types of building additions, such as those which have a special medical or health justification;
- Buying a new home or condominium for more money than the present home is worth (for the home to be protected, though, the recipient or spouse must live in it);
- Exempting a child or sibling (if an adult child or brother or sister lives in the home and would qualify the home as an exempt asset, further investments in the home may be desireable);
- Transferring to a non-exempt adult child.

The benefit of transferring a home to a child comes from not having to sell the home to pay nursing facility bills. By transferring the home more than 36 months before applying for Medicaid or enter a nursing facility, the value of the home will not affect Medicaid eligibility at all. If it is transferred within 36 months of entering a nursing facility, eligibility will be delayed for a period equal to the value of the home divided by the average monthly cost of a nursing facility in the state. Thus the crucial importance of planning and knowing the right steps.

Payments to Children for Services

Unmarried individuals are at a disadvantage in trying to pass assets to their children or others. Because there is no spouse through whom assets can be transferred, many Medicaid exemption rules do not apply. One way around the 36-month transfer rule is not to transfer assets at all, but instead to pay a child or other person for services performed. Such services might be personal care or assistance, transportation, housekeeping,

paperwork—almost any reasonable service one would otherwise have to pay someone else to do. Because these are payments rather than transfers, they do not count as transferred assets. However, the Internal Revenue Service and state tax agencies consider these payments as income to the people receiving them, and may require payment of income tax on the amounts received.

Medicaid looks very closely at such arrangements. The services performed (and the payments) must be reasonable and there must be proof they were actually performed. Payment to an adult child or grandchild for regular housecleaning and maintenance, or for regular transportation, for example, might be acceptable if the amounts paid are within range of the amounts which would have to be paid to a private housecleaning service or for a taxi.

Irrevocable Trusts

Trusts (see Appendix J) enable a person to give up the legal right of ownership over assets but decide on the rules by which they are to be managed. One may even continue to receive income produced by the trust. Trusts can offer tax benefits and, as discussed below, protection against Medicaid asset rules.

If an irrevocable trust is established more than 60 months before applying for Medicaid, its assets do not count in determining eligibility for Medicaid. Trust assets will be used in accordance with the rules set up for the trustee. Only irrevocable trusts can protect assets from nursing facility costs.

Other Options If Contemplating a Nursing Home Stay

The prospect of nursing home care can be stressful, and the decision may place a significant financial burden on the patient and his or her family. A number of planning options should be considered prior to making the decision.

- *Purchasing exempt assets and converting non-exempt assets into exempt assets*. As noted above, spending funds on the payment of legitimate debts or making additions and improvements to a residence will reduce non-exempt assets and increase the value of exempt assets. The prepayment of mortgages, land contracts and other debts should be considered.

- *Purchasing prepaid irrevocable funeral contract or funeral insurance*. Most reputable funeral homes can review these planning options.

- *Giving away funds and other non-exempt assets to your children or other loved ones*. If these transfers are made beyond the 36 month lookback period, they will not be counted against the recipient. Even if the transfer takes place within the lookback period, a portion of the value of the asset may not be counted. Obviously, the decision to give away funds and other property involves the consideration of several factors other than Medicaid eligibility.

- Granting a durable power of attorney to a spouse or other responsible person to make divestment transfers and take care of other financial matters. It is important to pick either a person knowledgeable about elder law, or who will seek the advice of a professional. Improper decisions could endanger a recipient's Medicaid eligibility.

Many of these options involve permanent disposition of assets, while the rules governing Medicaid eligibility often change from year to year as well as from state to state. Professional advice may therefore be helpful in sorting through the array of alternatives and the complexity of the laws.

Conclusion

Planning for Medicaid qualification is difficult. Even if nursing home care is imminent, however, there are a number of planning options which should be considered. Early planning, when possible, will provide more options.

The Texas Department of Health is responsible for most of the Texas Medicaid program. To learn about how claims are processed, eligibility for kidney health care, Medicaid and Medicaid Reform Legislation, and other topics, visit their World Wide Web site at http://www.tdh.state.tx.us. The site includes a Frequently Asked Questions page about the program.

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The Texas Attorney General's Office has an Elder Law section to assist Texas seniors, which can be accessed in various ways:

via World Wide Web: http://www.oag.state.tx.us/website/consumer/eldehelp.htm
Adult Protective Services, toll-free 800-252-5400
Legal Hotline for Older Texans
in Austin: 477-3950
statewide: 800-622-2520

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Appendix N. Medicare

What Is Medicare?

Medicare is a national health insurance program for seniors and people with disabilities, regardless of income. Anyone over 65 who is eligible for Social Security or Railroad Retirement Benefits—a program similar to Social Security for railroad employees, their spouses, and survivors—is automatically eligible. People with disabilities who have received Social Security Disability Income for at least 24 months and some people who are receiving regular dialysis or have received a kidney transplant because of kidney failure are also automatically eligible.

U. S. citizens are automatically eligible for Medicare. Permanent legal residents who have been continuously residing in the United States for at least five years are also eligible, but must file an application.

The Medicare program is divided into two sections. Part A is hospital insurance that covers hospital care as well as skilled nursing facility, hospice, and home health care. Part B is medical insurance that covers physicians' fees, therapy services, ambulance services, laboratory tests, supplies, and durable medical equipment, such as a wheelchair.

Under Part B, recipients must pay an annual deductible, after which Medicare generally will pay 80 percent of its approved charge for medical care. Unfortunately, many health care providers charge substantially more than Medicare's approved charge for their services, and the recipient must pay for any charges that are above the approved Medicare rate.

Many health care providers, however, "take assignment," which means that they agree to accept Medicare's approved charge as payment in full. Medicare pays 80 percent of the approved charge, while the recipient pays the remaining 20 percent. Local Medicare carriers have a directory of all doctors and suppliers in the area who always take assignment.

Enrollment in Medicare

Enrollment in Medicare is handled in two ways: either by automatic enrollment, or by application. Persons already getting Social Security or Railroad Retirement benefits upon turning 65 are enrolled automatically in both Part A and Part B. A Medicare card is mailed to the recipient about three months before his or her 65th birthday. Disabled persons who have received Social Security or Railroad Retirement Board disability benefits will automatically get a Medicare card in the mail after receiving benefits for 24 months.

All others must apply for Medicare. This can be done by contacting any Social Security Administration office, which can provide details of when to apply. Delays in enrollment generally result in an increase in the premiums to be paid, however.

Don't put off enrolling. If you wait 12 or more months to sign up, your premiums generally will be higher. Part B premiums go up 10 percent for each 12 months that you could have been enrolled but were not. The increase in the Part A premium (if you have to pay a premium) is 10 percent no matter how late you enroll for coverage.

Under certain circumstances, however, you can delay your Part B enrollment without having to pay higher premiums. If you are age 65 or over and have group health insurance based on your own or your spouse's current employment, or if you are disabled and have group health insurance based on your current employment or the current employment of any family member you have a choice:

- You may enroll at any time while you are covered by the group health plan, or;
- You may enroll during a special eight-month enrollment period that begins the month employment ends or the month you are no longer covered under the employer plan, whichever comes first.

If you do not enroll by the end of the eight month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year.

Even if you continue to work after you turn 65, you should at least sign up for Part A of Medicare. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B at the same time. You would have to pay the monthly Part B premium and the Part B benefits would be of limited value to you as long as the employer plan was the primary payer of your medical bills. Moreover, you would trigger your six-month Medigap open enrollment period.

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Appendix O. Living Wills and Other Advance Medical Directives (AMDs)

"Advance directive" is a broad term that refers to an individual's oral and written instructions about future medical care in the event one becomes unable to speak for oneself. These documents address a variety of complicated medical, legal, and ethical situations that may confront a person near the very end of life. Although there is considerable variation among them, every state recognizes the patient's right to make fundamental choices as to the care and treatment he or she will or will not receive at that time.

In Texas, as in many other states that have addressed these important issues, official forms have been prescribed by statute for living wills, and other forms of advance medical directives. Deviating from these official forms is strongly discouraged because doing so may put its validity in question.

There are two types of advance directives: a living will and a medical power of attorney. Either can be revoked or modified as long as the patient is capable of doing so.

Although many people have heard of the living will, few realize that this is often a very narrow form of advance medical directive. For example, the living will might only speak about "heroic" life prolonging measures, and might only apply when death is otherwise imminent. Such a directive would be of no use to the patient who is stable, but in a coma with no chance of recovery.

What Is a Living Will?

Broadly defined, a living will states the kind of medical care a person wants (or does not want) if he or she become unable to make his or her own decisions. It is called a "living will" because it takes effect while one are still living. Most living wills only affect medical care if the individual has a terminal condition.

Most states have their own living will forms, each somewhat different. The Texas version is called the "Texas Directive to Physicians." The appropriate forms for this legal document are often available at Texas hospitals, as well as in the Texas statutes. The directive has no operative effect unless the individual has a terminal condition and death is imminent.

In order to make a directive legally binding, the individual must sign it in the presence of two witnesses. (It need not be notarized.) These witnesses cannot be:

- related to the individual by blood or marriage;
- entitled to any part of the individual's estate after death;

- the individual's doctor or an employee of the doctor;
- an employee of a health care facility in which the individual is a patient;
- another patient in a health care facility where the individual is a patient; or
- a person who has a claim against the individual's estate after death.

The Health Care Power of Attorney

Although most people are aware of what a will is and why it is useful, few people know about health care powers of attorney. Many seniors will be interested in the health care power of attorney because it can prevent the depletion of their estates for expensive, futile medical treatment.

Health care powers allow the client to select who will make health care decisions in the event of incapacity. Furthermore, it allows the client to specify what types of health care he or she does or does not want. From the standpoint of the health care provider, it can sometimes resolve problems arising from family squabbles over the kind of treatment the client should receive.

A durable power of attorney for health care is a signed, dated, and witnessed instrument naming another person as the authorized agent to make one's medical decisions in the event of incapacitation. This type of power of attorney also establishes whether the individual would like to be connected to life-sustaining equipment in the event of incapacitation. One can also include instructions about any treatment to be avoided.

Health care powers of attorney are especially helpful for clients in nontraditional family relationships, such as unmarried couples. Without the appointment as the statutory agent, a "partner" may be excluded from the decision-making, particularly if the patient's biological family does not want to include the partner.

Like most states, Texas has a specific form for an advance medical directive, appointing a health care proxy, and/or for creating a comprehensive advance directive. Entitled "Texas Durable Power of Attorney for Health Care," the form is relatively simple and must be followed (including modifications to reflect the person's specific conditions and desires) in order for the power to be valid. The proxy can be empowered to deal with temporary incapacity as well as terminal illness.

Whom Should I Appoint as My Agent?

The "agent" may be a family member or close friend that the individual trusts to make important decisions. The designated agent should clearly understand the individual's wishes and be willing to accept the responsibility of making medical decisions. The person appointed as an agent cannot be:

- the individual's doctor or other treating health care provider;
- an employee of the treating health care provider, unless he or she is related to the individual;
- the individual's residential care provider; or
- an employee of the residential care provider, unless he or she is related to the individual.

The scope of an agent's power is usually worded broadly, so that he or she can make any health care decision the principal would normally make. It is important for the principal to give his or her agent clear guidance in making the difficult medical decisions that could arise, especially with regard to religious or ethical limitations to be placed on treatment.

The document should instruct the proxy that in making any decision, he or she is to first try to communicate the proposed decision to you, to ascertain your desires, if possible. If this is not possible, your agent should be instructed to make a choice for you based upon what he or she believes to be in your best interests.

State law sometimes makes it difficult to compel a health care provider to follow the directions of your agent, especially if doing so would violate his or her own conscientious principles. To ease their concerns, medical personnel should be absolved from legal liability when following the instructions of a duly authorized agent. Otherwise a provider might be reluctant to withdraw treatment for fear of a lawsuit by the family later.

How Do I Make My Texas Durable Power of Attorney for Health Care Legal?

A durable power of attorney must be signed in the presence of two witnesses, although it need not be notarized. The witnesses must affirm that the principal is of sound mind, voluntarily signed the document, and understands the durable power of attorney. These witnesses cannot be:

- the designated agent;
- the doctor or residential care provider;
- an employee of the doctor or residential health care provider; or
- a person entitled to any part of the principal's estate upon death, or any other person who has a claim against the estate.

State-specific guides with sample forms are also available to members of the American Association of Retired Persons (AARP), through its office of Legal Counsel for the

Elderly. Many nursing homes or similar institutions have a patient advocate to consult about making an advance medical directive.

The required procedures for signing and witnessing an advance medical directive vary widely. While in Texas the instrument does not need to be notarized, this might not be the case in other states; in fact, the notarized signatures are highly advisable. It may help ensure that the advance medical directive is recognized in other states, if the need arises. There should also be a clause in which the witnesses recite that they know the principal personally and declare that the person appears to be of sound mind and under no duress or undue influence.

Most advance medical directives are worded to become effective upon the principal's incapacity to make health care decisions. The law in Texas states that the individual's physician is the person who determines whether or not the person are incapacitated. Other effective dates or other criteria may be specified, but if it is too complicated, the agent might have trouble establishing his or her authority with the health care providers. It is also possible to direct that the power end at a later date or upon a particular event, such as release from the hospital after surgery.

Powers to be Included in the Advance Medical Directive

The following are basic powers that must be given to an agent if he or she is to have any meaningful health care decision making authority:

- To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical and/or diagnostic procedures, medication, and the use of mechanical or other means to affect any bodily function, including (but not limited to) artificial respiration and cardiopulmonary resuscitation;

- To authorize admission to or discharge from any hospital, nursing home or other facility, even against medical advice;

- To authorize any medication or procedure intended to relieve pain, even though such treatment might lead to bodily damage, drug addiction, or hasten the moment of (but not intentionally cause) death; and

- To consent, refuse, or withdraw consent to life sustaining treatment.

Perhaps the most critical provision in an advance medical directive is the expression of the patient's wishes as to "life-sustaining treatment." If the patient wants his or her doctors to employ maximum life-sustaining or prolonging efforts, an advance medical directive is the place to say so. If that is not what is desired, then the statement in the directive should be as explicit as possible, for example: "I do not want my life to be prolonged, and I do not want life-sustaining treatment to be provided or continued if my Agent believes the burdens of the treatment outweigh the expected benefits. In making this determination, my Agent is to consider the relief of my suffering, the expense

involved and the quality of my continued existence, as well as the length of time by which the proposed treatment is likely to extend my life."

People differ widely on whether "nutrition and hydration" is to be considered "treatment," subject to being terminated. "Nutrition and hydration" refers to the introduction of food and fluids into the body through a nasogastric feeding tube and/or intravenous fluid lines. Under all circumstances, appropriate non-invasive care, such as spoon feeding or moistening the mouth should be expected to continue. If the patient has particular views about nutrition and hydration, these should also be included in the directive, especially if it might be applied in a state where, by law, the withholding or withdrawal of food and water is not permitted unless the patient has given specific written authorization.

Problems to Anticipate

If a patient has made the decision to refuse treatment, medical providers must by law honor it. Before imposing this duty, however, the law requires that they know of the patient's instructions. As a practical matter, it is up to the patient to ensure that everyone expected to follow the advance medical directive has been given a copy of it.

Although hospitals and nursing homes are required by federal law to ask about your advance medical directive, there is no guarantee the actual document will find its way into the right hands when needed. Without some extra effort, the doctor or hospital might, in fact, not know about the advance medical directive. A good strategy is to have several original documents prepared for signing initially, so they can be taken along on trips, and freely distributed in advance.

Practical problems can arise in the event of a medical crisis at home to which emergency personnel respond. If the advance medical directive is not handy, EMS paramedics are not likely to delay CPR while the family rummages through desk drawers looking for it. Moreover, these personnel may be required by law or their own policy to administer life support and stabilize patients for safe transport to a hospital. If this is so, there is little one can do until the patient is at the hospital. Some states are developing procedures that allow emergency medical personnel to refrain from life support efforts under some circumstances.

For those who have no advance medical directive, some states have laws that authorize family members, in a specific order of kinship, to make some or all health care decisions. Even without such statutes, doctors and hospitals routinely rely on family to make decisions, if there are close family members around and if they are in agreement. Problems are likely to arise, however, when the family does not know or cannot agree on what the patient would want in a given situation. This uncertainty can lead to family disharmony and extra unpleasantness at an already stressful time.

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Appendix P. Private Long-Term Care Insurance

The primary methods to pay for long-term care services are: (1) use of personal resources (income and/or savings), (2) qualification for government assistance (Medicaid or limited Medicare coverage), (3) purchase of a long-term care insurance policy before assistance is needed, (4) use of personal resources combined with benefits paid by a long-term care insurance policy, or (5) use of an accelerated death benefit or viatical settlement.

What Is Private Long-Term Care Insurance?

Long-term care insurance is an insurance contract which, in exchange for a premium, covers some or all of your expenses when you need assistance in a nursing facility, in a community-based setting, or at home after a predetermined waiting period (an "elimination period"). Long-term care insurance does not cover acute care in a hospital.

Am I at Risk of Needing Long-Term Care Services?

Because the probability of needing nursing home care increases with age and because more people are expected to live longer lives in the coming decades, people who live to be age 85 and over will face an increasingly higher chance of needing nursing home care. Women are especially likely to need nursing home care.

The chance of anyone needing home health care is even greater than needing nursing home care. Three out of five people over the age of 65 will need some type of long-term care services.

Can I Afford Long-Term Care Services?

Average costs for long-term care services in 1996 are as shown in Table P.1. Costs vary depending on location in the U.S., problems in performing Activities of Daily Living ("ADLs"), or the presence of a cognitive impairment. These costs are increasing faster than inflation.

Table P.1
Average Costs for Long-Term Care Services in 1996

nursing home costs	$38,000
in-home skilled nursing care, visited for the entire year	$12,300
in-home personal care from a home health aide three times a week for a year, with each visit lasting two hours	$ 8,400

Source: National Association of Insurance Commissioners. 1996. *A Shopper's Guide to Long-term Care Insurance.* Kansas City, MO. p. 6.

What Are the Different Types of Policies?

There are three types of long-term care policies sold in Texas:

1. **Nursing Facility Only** coverage typically means all levels of nursing care — skilled, intermediate, and custodial that has been approved by the insurance company.

2. **Home Health Care Only** is required to include adult day care services. Minimum standards are: policies pay home-care benefits for skilled nursing care performed by registered nurses, licensed practical nurses, and occupational, speech, or physical therapists, or the services of home health aides employed by licensed agencies. Such aides have less training and primarily help patients with personal or custodial care. Companies are allowed the option to offer coverage for homemaker services, such as cooking, cleaning, and running errands.

3. **Nursing Facility and Home Health Care Combined** policies pay for services provided in a nursing facility, in the community, or at home.

Are There Other Features I Can Add to the Policy?

1. ***Renewable.*** All policies in Texas must be guaranteed renewable. That means that the insurance company generally cannot refuse to renew the policy or change policy provisions as long as the premiums are paid on time, subject to policy maximums. This does not mean that the premium rate is locked in for a lifetime because Texas permits premiums to be raised for an entire class of policyholders.

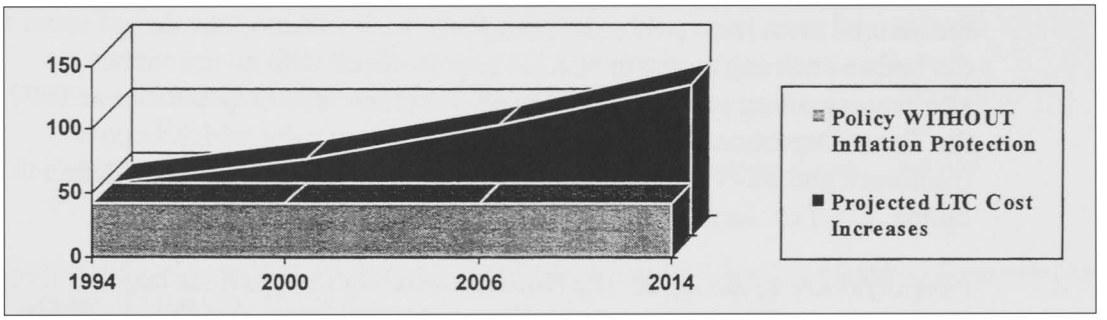
2. ***Waiver of Premium.*** Waiver of premium may allow the policyholder to stop paying premiums once he or she becomes eligible for benefits.

3. ***Return of Premium Option.*** This option permits a refund to the policyholder or the policyholder's estate of any premiums paid minus any benefits the company paid on the policyholder's behalf. For benefits to become payable the insured must have paid premiums for a predetermined number of years or die before attaining a certain age. Be sure to check with an accountant or attorney regarding potential tax consequences. (It is anticipated that in 1997 the Texas Department of Insurance will adopt new rules which impose disclosure and other requirements on long-term care policies that contain this option. [21 Tex. Reg. 11727])

4. ***Nonforfeiture of Benefits.*** The Nonforfeiture Option provides benefit credit to the insured if the insured discontinues premium payments. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy up to the policy limits (21 Tex. Reg. 11740). (In 1997 the Texas Department of Insurance will adopt new rules which will require all companies to offer at least one type of nonforfeiture option [21 Tex. Reg. 11727].)

5. ***Inflation Protection Option.*** A 65-year old who contracts today for a $100 per day benefit will see the purchasing power of that benefit cut in half over the next 20 years even if inflation remains low (3 percent per year). A purchaser who may not need policy coverage for many years may need to carefully consider inflation protection even though it can be expensive, adding as much as 40 percent to the premium. On the other hand, a 75-year-old purchaser may experience only a few years of inflation and thereby opt to self-fund for this risk.

Figure P.1
Projected Long-term Care Cost Increases Versus Policy Without Inflation Protection (Dollars in Thousands)



Source: California Department of Aging. 1996. *Taking Care of Tomorrow: A Consumer's Guide to Long-Term Care.* Sacramento, CA (July), p. 30.

The Texas Department of Insurance requires companies to offer one of three methods of adjusting the daily benefit amount to offset the effects of inflation:

1. Benefit levels increase annually at a rate of not less than 5 percent, compounded annually, throughout the interval of coverage.

2. The insured has the option to increase benefit levels on the anniversary date throughout the interval of coverage, but rejection of the option must be written within 30 days of the anniversary date. Benefit levels increase automatically at a rate of at least 5 percent of the original benefit amount, compounded annually.

3. The policy covers a specific percentage of actual or reasonable charges so inflation does not affect benefits paid (Texas Department of Insurance, Minimum Standards for Benefits for Long-term Care Coverage Under Individual and Group Policies).

There is a substantial difference between simple or compound inflation protection. For example, a 1996 benefit of $80, based on 5 percent increases in 20 years, would become $160 using a simple interest calculation, but would become $212 using a compound interest calculation.

Tips

Affordability of Long-term Care Insurance

Do you have trouble stretching your income to meet the necessities, such as paying for utilities, food or medicine? If so, you should probably not purchase a long-term care insurance policy.

Medicare Does Not Cover Long-term Care

Many people believe that their long-term care services will be paid for by the government, but Medicare pays only for skilled, recuperative care an average of less than a month. Medicare supplemental insurance policies offer little added assistance because they are contingent on Medicare's severely restrictive eligibility criteria.

Tax Laws Have Changed So Benefits Are Not Taxable

Beginning in 1997, the Health Insurance Portability and Accountability Act of 1996 allows companies to offer "tax-qualified" policies in addition to the nonqualified products that have been offered in the past. Consumers should evaluate the differences in these policies carefully. For example, an accountant or attorney may help. Generally, "tax-qualified" policies provide for tax-free benefits and deductible premiums if the premiums exceed 7.5 percent of adjusted gross income. Policies issued before December 31, 1996 will be considered tax-qualified whether or not they meet federal requirements.

Check on Financial Security of the Insurance Company

Check into the rating of your insurance company's financial condition and "claims-paying ability." These companies include AM Best, Duff & Phelps, Moody's and Standard & Poor. (See page Table P.1) AM Best Reports are usually available at public libraries. The other three companies will give ratings over the telephone. However, buying from a company with an "A" or "A+" rating does not guarantee the purchaser will receive benefits in 15 or 20 years. One safeguard is to buy from a carrier that has reinsured its long-term care policies.

Keep Your Policy

If you already own a policy, keep it and buy additional coverage from your insurer if you feel your current policy is inadequate. If you own a policy that is very restrictive, you'll have to weigh the likelihood of collecting benefits against the higher premiums you will probably have to pay for a new, less restrictive policy, as well as the loss of any equity you may have built up.

Dealing with Agents

- Talk to several before you buy.
- Never buy a policy or sign something you do not understand.
- Never buy a policy on an agent's first visit. Have the agent leave a brochure explaining the policy or use the "outline of coverage" to compare policies. Ask the agent to return; invite a trusted friend or relative to be present.
- Never sign a blank application.
- Answer all questions truthfully. An insurer can deny a claim or cancel a policy if an answer is intentionally deceptive and is incomplete or inaccurate.
- Pay premiums for no more than one year at a time. Never pay cash for a policy.

Texas Consumer Protections

Long-term care policies must meet all of the standards set by the Texas Department of Insurance. Policies advertised or marketed as long-term care and nursing home policies which were issued after September 1, 1992 must offer benefits for at least twelve consecutive months.

Definitions. Each policy must include in its definitions of care (1) the level of skill required, (2) the nature of the care and, (3) the setting in which the care must be delivered. If the services or the facilities providing the care do not meet policy benefit definitions, you may not be covered for services received.

Inflation Protection. The Texas Department of Insurance rules require companies to offer inflation protection. You may reject or accept the offer. If the policy holder rejects the protection, it must be in writing.

"Free Look." All long-term care policies must provide a "free look" period of at **least 30 days.** Be sure your policy says what you think it does. *For a full refund, return the policy before the 30 days is up.* Using certified mail is a good idea but not required.

Renewable. Long-term care insurance policies sold in Texas must be "guaranteed renewable" — allowed to continue in force as long as the premiums are paid, subject to the policy maximum. The company by itself may not change policy provisions or refuse to renew.

Mental or Nervous Disorders. Long-term care policies may limit or exclude coverage of some mental or nervous disorders. However, they may not exclude coverage of Alzheimer's disease and related disorders or biologically-caused brain diseases and serious mental illness, including schizophrenia, paranoia and other psychotic disorders, and various manic and depressive disorders.

Pre-existing Conditions. A pre-existing condition is a condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage. In Texas, companies may not deny a claim for losses incurred more than six months from the effective date of coverage.

What Are Accelerated Death Benefits?

"Accelerated benefits" are *life* insurance benefits rather than long-term care insurance benefits. The benefits are also called "living benefits" because the proceeds are paid to the insured to provide care before he or she dies but after some triggering event as specified by the insurance contract. Some companies charge an extra premium for the option to accelerate, and some charge only if this option is exercised.

Even though there are many people who own life insurance policies, the face value of the policy must be sufficiently large to cover long-term care costs in order for the accelerated benefits option to make sense as the sole funding source for long-term care services. This is especially true if the benefits will not be paid out for many years.

In Texas, there are three types of Accelerated Death Benefit products:

1. Accelerated Death Benefits triggered by the diagnosis of terminal illness or permanent disability;

2. Accelerated Death Benefits triggered by the diagnosis of terminal illness or permanent disability with the added contingency that the benefit must be used for specific long-term services (i.e., nursing home care); and

3. A long-term care insurance rider or attachment added to an existing life insurance policy. (These are subject to long-term care insurance regulations.)

What Are Viatical Settlements?

Viatical companies buy life insurance policies from terminally ill policyholders. For example, in exchange for being named the beneficiary on the policy, the company assumes the premium payments and pays the insured a lump sum settlement. The proceeds of the sale may pay for the health care costs and living expenses of the policyholder.

For Additional Information Contact

For general information or counseling:

The Texas Department of Insurance
333 Guadalupe Street (78701)
P. O. Box 149091
Austin, TX 78714-9091
1-800-252-3439
(512) 463-6515

Department on Aging
P. O. Box 12786 (78711)
1949 IH 35 South
Austin, TX 78741
1-800-252-9240
(512) 444-2727

Servicio en espanol
Hearing or speech impaired persons call:
Relay Texas 1-800-735-2989

To report a complaint, contact:

The Texas Department of Insurance
Complaints Resolutions Office
1-800-252-3439 or (512) 463-6515

For publications about long-term care insurance:

The Texas Department of Insurance
1-800-599-7467 or (512) 305-7211

To check on the financial stability or the claims-paying ability of your insurance company:

The Texas Department of Insurance
Consumer Helpline 1-800-252-3439

A. M. Best
1-900-420-0400

Moody's Investor Service
(212) 553-0377

Duff & Phelps
(312) 368-3157

Standard & Poor's
(212) 208-1527

The American Association of Retired Persons is developing a long-term care insurance program. Call 1-800-523-5800 to find out the status of that project.

Questions to Ask When Deciding to Purchase Long-term Care Insurance

CHECK LIST

		Check ✓ Yes	No
1)	What types of care are covered and in what setting (eligible facility)? Some facilities might be:		
	Nursing home only?	☐	☐
	Home and Community Based informal caregivers?	☐	☐
	Home and Community Based adult day care services?	☐	☐
	Home and Community Based therapeutic devices?	☐	☐
	Assisted Living Facility?	☐	☐
	Other?	☐	☐
2)	How much is the daily benefit?		
	Less than $50 per day?	☐	☐
	Between $51 and $60 per day?	☐	☐
	Between $61 and $75 per day?	☐	☐
	Between $76 and $100 per day?	☐	☐
	More than $101 per day?	☐	☐
3)	Does the policy have maximum benefits for each illness or per person, including maximum periods of confinement? Some examples include:		
	Nursing home maximum daily benefit?	☐	☐
	Nursing home lifetime maximum?	☐	☐
	Home and Community-based daily maximum?	☐	☐
	Home and Community-based lifetime maximum?	☐	☐
	Other?	☐	☐
4)	How long is the elimination period?		
	30 days?	☐	☐
	60 days?	☐	☐
	90 days?	☐	☐
	120 days?	☐	☐
	180 days? (This is the Texas maximum.)	☐	☐
5)	How long is the waiting period before pre-existing conditions are covered?)		
	Less than 6 months?	☐	☐
	More than 6 months?	☐	☐

		Check ✓ Yes	No
6)	Does the policy exclude coverage for certain mental and nervous disorders?	☐	☐
7)	What inflation protection is offered?		
	Annual benefit increases?	☐	☐
	Optional benefit increases every 2 to 5 years?	☐	☐
	Simple increases?	☐	☐
	Compound increases?	☐	☐
8)	How much will the premium increase in the future? _____		
	Is this an "attained-age" policy?	☐	☐
9)	Is there a grace period for late payment?	☐	☐
10)	Does the policy have a premium waiver feature?	☐	☐
	Will I have to pay the premium while I am receiving long-term care?	☐	☐
11)	Can the policy be upgraded?	☐	☐
	At the premium I would have paid when I first purchased the policy?	☐	☐
	At my current age?	☐	☐
12)	Are there age limits or specific health conditions that would prohibit me from purchasing this policy?	☐	☐
13)	Do I have a life insurance policy with a cash surrender value?	☐	☐

Source: Texas Department of Insurance, 1993, p. 5; California Department of Aging, 1996, p. 33.

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Appendix Q. Family Relationships and Caregiving

What is a Caregiver?

The term "caregiver" refers to anyone who provides assistance to someone else who needs it. A caregiver provides any or all of a range of help services: physical, household, medical, emotional, etc.

Since 1984, "caregivers" also refers to well-organized interfaith volunteer caregiver (IVCs) programs that provide a menu of services to the elderly and disabled in their homes. The whole purpose is to enable these persons to remain in their homes as long as possible with dignity, independence, and safety. Through a nation-wide grant program, *Faith in Action*, the Robert Wood Johnson Foundation has assisted more than 600 caregiver programs to be established. These caregiver programs provide services that include transportation to appointments, shopping, personal business, social contact and community involvement, and household assistance and respite care through referral to the family eldercare programs. Caregiver programs associated with the Foundation provide their services *free of charge*.

There are two types of caregiving: informal and formal. Informal care is help given by families. Formal care is professionally-rendered. Another way to think about the types of caregiving is to break it down into paid and unpaid sources. A person's long-term care needs are usually met through some combination of paid and unpaid sources.

Families and Caregiving

Families provide 80 to 90 percent of personal and instrumental help to older people. Since 1965 the assumption that modern families no longer take care of their elderly as they did in the past is wrong.

Caregivers tend to be family members who link their older member to the formal system, respond in emergencies, provide intermittent and acute care, share their homes and provide emotional support. About 66 percent of caregivers assist an older person with activities of daily living (ADLs). Of these approximately 19 percent assist with one or more ADL. Fifteen percent assists with two ADLs, and 33 percent assist with three or more ADLs.

Demographics of the Caregivers

Women, primarily wives, daughters, and daughters-in-law provide the bulk of long-term care for older people. Eighty-percent of caregivers are women; 41 percent spend more

than forty hours a week providing care, yet 90 percent of those people work outside the home for pay.

It is estimated that between one-third and one-half of caregivers are employed outside the home. Many caregivers, the "sandwich generation," have competing demands: between 20 and 40 percent of caregivers have children under age 18 to care for in addition to their disabled relative. The average woman can expect to spend 17 years caring for a child and 18 years caring for an elderly parent. On average, caregivers provide personal assistance and household maintenance chores for 12 hours per week per parent. Twenty-eight percent give care for eight hours or less, while 63 percent provide help for 21 hours or more care. Eleven percent provide constant care. Caregivers of non-community-dwelling patients provide an average of 286 hours per month or 66.5 hours per week of care.

Effects of Caregiving on Family Members

There are physical and mental effects of providing care to an older person or family member. Stress is a central issue in the discussion, and there is a growing awareness of the importance of caregivers' own support system. There are many resources designed to help caregivers cope with the demands and issues of caregiving. Caregivers receive their own support from formal sources and other family members and friends.

Is There Assistance Available?

Depending on your community, there are resources and support available to caregivers. You can contact your local Area Agency on Aging for information about referrals to educational programs, support groups, respite care services, and counseling.

Resources

Children of Aging Parents (CAPS) 800-227-7294
National Alliance for Caregiving 303-718-8444

Internet Web Sites:
DHHS/Administration on Aging - http://www.aoa.dhhs.gov/aoa.html
National Federation of IVCs, Kingston, NY - http://www.nfivc.org
National Council on Aging, Washington, DC - http://www.info/@ncoa org

Appendix Q References

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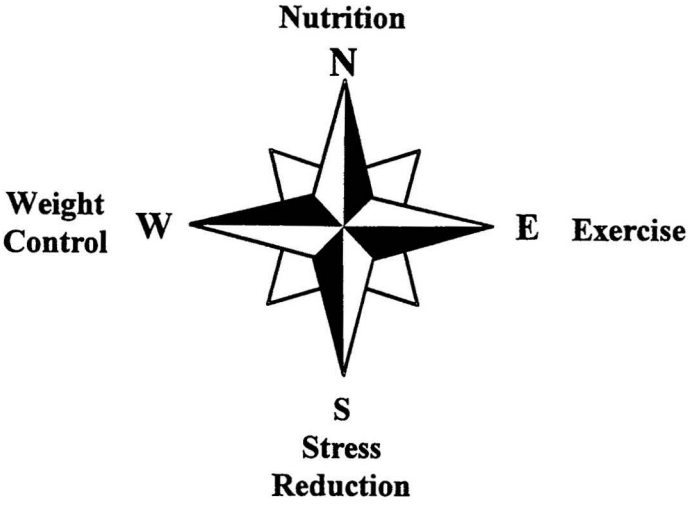
Appendix R. Wellness

You can find the way to vitality and an active lifestyle by way of good health habits. It's not too late to start on that road.

Figure R.1
The Wellness Compass



Exercise

With your physician's approval, moderate amounts of exercise, performed on a regular, weekly basis, can help you feel better and improve the likelihood of a healthy life.

Start your workout by warming up the body. Warm-up consists of slow, rhythmic activities. There are three kinds of exercises:

- Strengthening exercises such as squeezing balls, light weight lifting, and rowing;
- Stretching exercises such as toe-touching which help maintain flexibility (It is recommended to stretch slowly and gently and repeatedly until you can move any body part through its full normal range of motion.);
- Aerobic or endurance exercises such as swimming which must be sustained at least 10 to 12 minutes but no more than 200 minutes per week, spread out over five to seven sessions in order to achieve the maximum desired benefits. (Inactive seniors should start with walking and gradually step up the pace,

increase the distance, and walk often. The goal is to increase your heart rate to the following target values calculated as: [220 - age] x 75% = Beats Per Minute.)

Table R.1
Target Heart Rates During Exercise

Age	Beats Per Minutes
60	120
65	116
70	112
75	109
80	105
85+	101

Source: Fries, James F. 1989. *Aging Well: A Guide for Successful Seniors*. pp. 66-69.

Nutrition

Chances are you can permanently change just one small habit per month. Here are some simple dietary habits to try over the next year for good nutrition:

Eat a variety of foods as recommended by the U.S. Department of Agriculture's *Food Guide Pyramid.* Choose a diet:

- low in fat, saturated fat, and cholesterol and sugar. Fat intake should be less than 30% of your total daily calories. Sugars are "empty calories" — they have no vitamins, minerals, or fiber.

- with some milk, cheese, and yogurt. Drink two cups per day of low-fat milk or eat two servings per day of other dairy products, such as low-fat yogurt or cheese.

- with some meats, poultry, fish, dry beans, eggs, and nuts. Try to include two fish meals per week, and avoid high-fat meats. Two or three times a day you can have two to three ounces of cooked meat. Peas and beans and other high-protein foods can be substituted for meat.

- fresh or fresh-frozen fruits. In addition to vitamins and minerals, fruits are high in fiber which aids digestion. Eat from two to four servings of 1/2 cup each per day.

- fresh or fresh-frozen vegetables. Like fruits, vegetables have lots of vitamins and minerals and fiber. They also have been shown to protect against cancer. From three to five servings per day is recommended.

- whole-grain and enriched breads, cereals, and grain products. Did you know you can eat from six to eleven slices of bread per day? Or three cups of pasta? Or six one-ounce bowls of your favorite ready-to-eat cereal? Sounds like a lot, but complex carbohydrates such as bread and cereal contain large amounts of vitamins, minerals, fiber, and water. Enjoy, but be careful what you're putting on them isn't increasing the fat in your diet!

Drink water. When you first get up in the morning or along with breakfast, drink a big glass of water. Drink at least one 8-ounce glass each day — but six to eight glasses is better. Fruit juices are good substitutes for water, but coffee, tea, and cola drinks can work to increase water loss through urination. You should drink enough water so that at least once each day your urine is nearly colorless, and you should be voiding urine at least three times a day. If you are concerned about overloading your bladder, drink most of your water in the morning and early afternoon, and increase your water intake gradually by a glass per week to give your body a chance to adjust.

Weight Control

Excessive body weight cannot be ignored without serious risk to your health. It stresses the heart, the muscles, and the bones, and increases the likelihood of disease.

- Check with your doctor before starting any diet, especially if you are hoping to lose a lot of weight quickly. Go slowly during the weight reduction phase, because a sudden reduction in calorie intake will lower your metabolism, making it even harder to burn off what you do eat.

- Exercise will increase your basal metabolic rate, making it easier for your body to burn the food you do eat. See the exercise suggestions above.

- Weight maintenance requires a continued low-fat diet and exercise. Weigh yourself regularly. It is easier to make small corrections by adopting one small change per week than to change an entire lifestyle at once.

Stress Reduction

Life-changing events as well as everyday demands — both joyous occasions and those that cause grief — produce physical, mental, and emotional reactions called stress. Leisure activities are positive, life-affirming ways to stay involved and relieve stress.

- *Pets*. Dogs and cats take your mind off of your cares. Owning a pet is a responsibility, but there are measurable benefits too:

  - Dog owners take about twice as many walks as people without dogs;

  - Pet owners have a better survival rate a year after a heart attack or a diagnosis of chest pain (angina); positive interactions with pets can lower your blood pressure; and

  - A grieving pet owner is less likely to become depressed or have deteriorating health than a grieving person who does not own a pet.

  For information on visiting-pet programs or becoming a volunteer with your pet, contact:

  The Delta Society
  P. O. Box 1080
  Renton, WA 98057-9906
  (206) 226-7357

- *Gardening*. Gardening promotes strength and flexibility. For information on creating an accessible, raised-bed garden, contact:

  The Arthritis Foundation
  P. O. Box 7669
  Atlanta, GA 30357-0669

- *Deep breathing*. Shortness of breath is your body's way of telling you to relax. Try sitting back in a chair or lying on your back. Inhale through your nose and exhale through your mouth several times.

- *Holidays*. A holiday can be a particularly stressful time. Remember to continue a healthy diet, exercise, stay involved with family, friends, or social groups, observe those family traditions that you can, and set aside plenty of time for relaxation and sleep.

Who to Contact for More Information

For more information contact your personal physician.

For more information on exercise and nutrition contact the Texas Department on Aging Information and Assistance Service at 1-800-252-9240 (calling this number will automatically ring into the agency in your area).

Appendix R References

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Appendix S. Senate Bill 273.

A BILL TO BE ENTITLED

AN ACT

relating to development of a statewide consumer guide for senior citizens.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter B, Chapter 403, Government Code, is amended by adding Section 403.026 to read as follows:

Sec. 403.026. SENIOR CITIZEN CONSUMER GUIDE; INTERAGENCY WORK GROUP.

(a) The comptroller shall develop and annually update a statewide consumer guide for senior citizens designed to assist senior citizens and their families in making informed choices regarding available senior services. The guide must:

(1) contain a directory of service providers for senior citizens in a format developed by the interagency work group created under Subsection (b) and arranged by geographical area if appropriate;

(2) contain comprehensive information on services available to senior citizens, including long-term care services, housing assistance, meals, personal care, and transportation;

(3) enable a senior citizen or a person assisting a senior citizen to identify and assess each option available for meeting a senior citizen's individual needs; and

(4) prominently display:

(A) the regional toll-free access number of the appropriate area agency on aging; and

(B) the toll-free number of the Texas Department on Aging.

(b) An interagency work group is created to assist the comptroller in developing and updating the guide. The work group is composed of representatives from:

(1) the comptroller's office, appointed by the comptroller;

(2) the Texas Department on Aging, appointed by the executive director of that agency;

(3) the Texas Department of Human Services, appointed by the commissioner of human services;

(4) the Texas Department of Housing and Community Affairs, appointed by the director of that agency; and

(5) the Health and Human Services Commission, appointed by the commissioner of health and human services.

(c) The comptroller may request that other state agencies or universities designate representatives to serve on the work group in addition to the representatives listed in Subsection (b) if the agency or university requested to participate has an employee with specialized expertise or knowledge of a subject matter to be included in the guide.

(d) A member of the work group serves at the will of the appointing entity.

(e) The comptroller shall appoint a member of the work group to serve as presiding officer, and members of the work group shall elect any other necessary officers.

(f) The work group shall meet at the call of the presiding officer.

(g) The appointing entity is responsible for the expenses of a member's service on the work group. A member of the work group receives no additional compensation for serving on the work group.

(h) The work group is not subject to Article 6252-33, Revised Statutes.

(i) The entities listed in Subsections (b)(2)-(5) shall take all action necessary to assist the comptroller in developing and updating the guide, including providing staff with expertise in information and referral services and other necessary information, but may not diminish services required to be provided by other law.

(j) The work group may modify the contents of the guide if the modifications do not detract from the goal of increasing consumer access to senior services.

(k) The comptroller shall make the guide available to:

(1) the public through the Internet; and

(2) each area agency on aging and, on request, to another state agency in electronic format.

(l) In conducting the work needed to develop the statewide consumer guide for senior citizens, the interagency work group shall consult with consumer and provider groups involved in the delivery of long-term care services.

SECTION 2. Subchapter B, Chapter 101, Human Resources Code, is amended by adding Section 101.031 to read as follows:

Sec. 101.031. SENIOR CITIZEN CONSUMER GUIDE; SUPPORT AND DISTRIBUTION.

(a) The board by rule shall require an area agency on aging to submit annually to the comptroller current information on local service providers and resources for senior citizens for inclusion in the senior citizen consumer guide created under Section 403.026, Government Code. Each agency shall provide the information in a format prescribed by the comptroller.

(b) An area agency on aging shall make the guide available to as many senior citizens in the agency's service area as possible.

SECTION 3. Not later than January 10, 1998, each area agency on aging shall submit to the comptroller of public accounts information on local resources for senior citizens in the agency's area for inclusion in the initial senior citizen consumer guide created under Section 403.026, Government Code, as added by this Act.

SECTION 4. Prior to completion of the guide, the comptroller of public accounts shall provide opportunity for review and comment of the guide under development to consumer and provider groups involved in the delivery of long-term care services. Not later than February 14, 1998, the comptroller shall complete development of the senior citizen consumer guide required by Section 403.026, Government Code, as added by this Act, and make the guide available in the manner required by that section.

SECTION 5. Not later than January 15, 1999, the interagency work group created under Subsection (b), Section 403.026, Government Code, as added by this Act, shall prepare and deliver to the clerks of the standing committees of the senate and house of representatives with primary jurisdiction over human services a report concerning the effectiveness of the senior citizen consumer guide required by Section 403.026, Government Code, as added by this Act.

SECTION 6. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several [*sic*] days in each house be suspended, and this rule is hereby suspended, and that this Act take effect and be in force from and after its passage, and it is so enacted.

ISBN: 0-89940-732-3