1995 WHITE HOUSE CONFERENCE ON AGING
Options for Message/Speech

1. **General**
   - Rare opportunity to address nation's seniors. Over 2,000 senior delegates, thousands more by satellite.
   - Historic event: Last WHCoA held in 1981.
   - Dual themes of Conference: intergenerational linkages; diversity of older Americans.
   - Opportunity to recognize WWII generation (50th Anniv end of war)

2. **Health Care**
   - Critical statement on Medicare/aid expected. To be determined. (including Medicare Trust Fund solvency)
   - 30th Anniversary of enactment of Medicare and Medicaid in 1995.
   - Note: Rego options--potential VP topic.

3. **Social Security**
   - Unions, many senior advocates have urged President to emphasize his commitment to protecting and maintaining universality of the Social Security program .
   - Solvency
   - Issue of means-testing
   - Contract for America proposals: rollback taxation of benefits; raise earnings limit.
   - 60th Anniversary of creation of Social Security program.

4. **Accomplishments/Other**
   - Opportunity to highlight Administration accomplishments on behalf of seniors. Along with notable anniversaries of admired federal programs (Medicare, Social Security, Older Americans Act), opportunity to discuss examples of government working for the people it serves.
   - Elevation of Commissioner of Aging to Assistant Secretary of Aging
   - Champion of long-term care, health security, strengthening Medicare (Mommograms), containing spiralling health care costs
   - Establishment of independent Social Security Administration
   - Improving SSA customer service: 800 number, Personal Earnings and Benefits Statement, reduction in pending disability claims.
   - Laundry list of accomplishments being compiled.

M E M O R A N D U M

To: **Melanne Verveer**
Patti Solis

From: **Karen Guss**

Date: **April 12, 1995**

Re: **White House Conference on Aging**

cc: **Jennifer Klein**

Yesterday, I attended a planning meeting for the White House Conference on Aging at which a few issues that may be of interest to you were discussed.

First, the official opening of the Conference will be a two-hour plenary session on the morning of May 3, at which the President, Cabinet Secretaries, and Members of Congress will speak. The session will be carried by satellite to at least 10 locations. The downlink sites include New York, Providence, Pittsburgh, Orlando, San Diego, Los Angeles, Sacramento, Dallas and Little Rock. The seating capacities at the sites range from 400 to 2000 people. People at yesterday's meeting discussed trying to get the Cabinet and others to appear at the satellite sites on May 3 as hosts of the event, with the goal of attracting regional press. I wanted to let you know about this because someone (probably Lee Ann Inadomi) will be contacting one or both of you in an effort to get Mrs. Clinton and/or Mrs. Rodham to host at one of these sites. (As you know, Mrs. Clinton has her own WHCoA event in Washington the following day, May 4, at 8:30 a.m.).

The Conference staff brought up the Older Americans Month proclamation, and asked when it would be signed by the President. (Older Americans Month is in May). Melanne, as you may recall, when Norma Asnes came in a few weeks ago, she told us that she was interested in White House hosting an event honoring older Americans and she reacted enthusiastically to a suggestion made by a representative of the Administration on Aging that the President sign the Older Americans Month proclamation at the event. I'm unaware of the status of Norma's suggestion, but if her suggested event is going to happen and we want the proclamation signed at it, perhaps we should get involved before other plans are made.

Finally, the AARP's radio programs were discussed. These programs reach tens of millions of seniors. It might be worthwhile for the First Lady or someone else connected to the mammography awareness campaign to appear on one of the programs.

Another option could be to tape the remarks made at the kickoff on May 1 and then broadcast them on an AARP program.

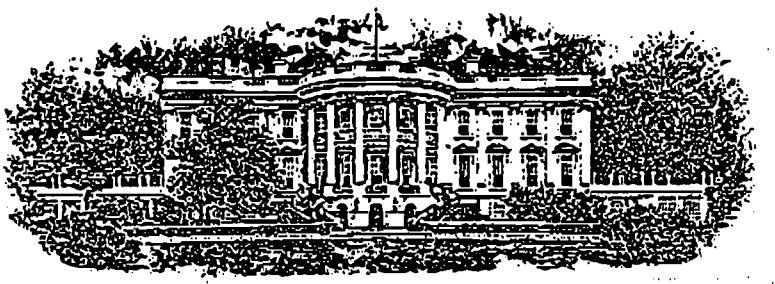
Please call me at (x65603) if you have any questions or would like me to follow up on this memo.

FAX TRANSMITTAL COVER SHEET

TO: Jennifer FROM: Bob Blancato

FAX: 456-2878

OF PAGES 1 + COVER



1995 WHITE HOUSE CONFERENCE ON AGING
501 School Street, SW, 8th Floor
Washington, DC 20024
Phone # (202) 245-7116 • Fax # (202) 245-7857

COMMENTS:

This is final version — at least we hope it is. Thanks for your help.

Assuring Comprehensive Health Care Including Long-term Care
IRDS 2 Access to Quality Care

2.4 Reforming the health care system

WHEREAS the components of the health care system are so interrelated that no part can function well unless the system as a whole functions well;

WHEREAS the cost of health care is rapidly escalating and currently represents over 17% of the Federal budget and over 20% of each older person's annual household income;

WHEREAS 40 million Americans are uninsured, of which 25% are children;

WHEREAS the current health care system does not adequately promote and support preventive care;

WHEREAS Medicare covers less than 50% of all health care expenses of people age 65 and older, provides no outpatient drug coverage, and covers almost none of the cost of long-term care; and

WHEREAS the health care system is an important consideration in reducing the Federal budget deficit;

THEREFORE, BE IT RESOLVED by the 1995 White House Conference on Aging to support system-wide health care reform efforts that adhere to the following principles:

Americans of all ages should have health security, including access to affordable health care and long-term care, choice of providers, and high quality care;

Cost containment is a critical component of meaningful health care reform and must not be separate from the reform process;

Medicare's commitment to its beneficiaries must not be jeopardized by arbitrary cuts. Savings can be achieved in Medicare to help offset the cost of expanded coverage, including long-term care, thus making Medicare more cost effective;

Long-term care which includes home and community based services as well as institutional services. Private long-term care insurance must include specific consumer protections and safeguards;

Reforms that provide for prescription drug coverage for Medicare must be encouraged;

Financial and regulatory incentives must be provided for health promotion and preventive services;

Improved consumer information and education must accompany health system reform to ensure that quality care is not sacrificed.

WHITE HOUSE CONFERENCE ON AGING

Planning/Coordination Meeting
April 17, 2-3:30 (3:00 if possible)p.m.

Agenda

1. Report/Discussion on Outside Groups Strategy
   -Marilyn Yager/Steve Edelstein

2. Pre-Conference Rollout
   -Julia Moffett

3. Media Strategy
   -Julia, Peggy Lewis, Elaine Dalpiaz

4. Program for Opening Plenary/Possible Second Plenary
   -Bob Blancato, Elaine, Others

5. Satellite Sites
   -Mike King, LeeAnn Inadomi

6. Next Steps on Policy

7. Additional Items

Satellite - Will First Lady do May 3

Sacramento
Florida - Orlando
Chicago
Pittsburgh

Mike King
401-5631

MEMORANDUM

On Tuesday, April 11, we reviewed the locations that were hosting satellite downlinks of the WHCoA. Of the 11 locations, 6 were chosen to focus on and to push for WH or Cabinet level participation.

Hunter College, New York City, NY
The Convention Center, Pittsburgh, PA
The Radisson Twin Towers, Orlando, FL
University of Arkansas, Little Rock, AR
California Exposition, Sacramento, CA
John Knox Center, Kansas City, MO

Chicago has been added as another location for the Satellite downlink. While this location is at a disadvantage because of lead-time, they should be able to pull together a substantial event.

The attached information are working documents and are flexible depending on schedules of speakers.

1995 WHITE HOUSE CONFERENCE ON AGING
SATELLITE LOCATIONS

Hundreds of thousands of individuals across the United States will have the opportunity to view the opening plenary session of the 1995 White House Conference on Aging (WHCoA) via satellite. Any facility equipped to receive a Ku-band signal may show this historic event. There is no charge to receive the signal. The satellite coordinates and other technical information can be obtained by calling Tibor Saddler at Advanced Engineering & Planning Corporation, Inc., in Alexandria, VA at (800) 800-2372 or at (703) 838-6885.

The broadcasting of the opening plenary session, as well as the funding for eleven satellite locations, have been made possible through an "in-kind" gift to the WHCoA from five regional Bell operating companies: Pacific Telesis Group, BellSouth, NYNEX, Bell Atlantic, and SBC Communications. The eleven Bell satellite sites, coordinated by Health and Human Services Regional Directors, are listed below.

- **Rhode Island Convention Center, Providence, RI** Contact: Philip Johnston (617) 565-1500
- **The Meadowlands Hilton East, Rutherford, NJ** Contact: Alison E. Green (212) 264-4600
- **Hunter College, New York, NY** Contact: Alison E. Green (212) 264-4600
- **The Convention Center, Pittsburgh, PA** Contact: Lynn Yeakel (215) 596-6492
- **Radisson Twin Towers, Orlando, FL** Contact: Patricia Ford-Roegner (404) 331-2442
- **INFOMART, Dallas, TX** Contact: Patricia Montoya (214) 767-3617
- **University of Arkansas, Little Rock, AR** Contact: Patricia Montoya (214) 767-3617
- **San Diego Convention Center, San Diego, CA** Contact: Grantland Johnson (415) 556-1961
- **California Exposition, Sacramento, CA** Contact: Grantland Johnson (415) 556-1961
- **UCLA, Los Angeles, CA** Contact: Grantland Johnson (415) 556-1961
- **John Knox Center, Kansas City, MO** Contact: Kathleen Steele (816) 426-2821

***

To obtain information about other satellite locations, contact Bryan Preston at (202) 245-0105.

To: Mike King, IGA HHS
From: Alison Greene, Regional Director, REgion II
RE: White House Conference on Aging -Live Downlink May 3rd
Date: April 14, 1995

BROOKDALE CENTER ON AGING SITE OF LIVE WHITE HOUSE CONFERENCE ON AGING OPENING SESSION

1. We have confirmed the site with Hunter College. The Brookdale Center on Aging is nationally acclaimed and its founder, Dr. Rose Dobrof, is on the White House WHCOA policy committee.

2. The site has an 800 seat auditorium with access from the street through a nice promenade with benches outside. There is a holding room and private bath off of the stage. The downlink will be accessed by a van parked on the 25th street side of the building. We are making arrangements with the city of New York to reserve and hold the parking on that side of the street for that day.

3. The event is scheduled to run from 8 am to approximately 12:30 pm. The agenda is flexible and we can adjust to accommodate a WH or Cabinet participant's schedule.

8-8:30 am	Registration, continental breakfast (hosted by NYNEX)
8:45 am	Welcome by Regional Director Alison E. Greene welcome to Brookdale by Rick Moody, Assoc Director
9-11 am	Live telecast of Plenary session
11-11:15	Greetings and remarks by Guest Headline Speaker
11:15-12 noon	Panelists will present brief discussion of the four major conference resolutions Panel to be moderated by Mary Alice Williams(invited) Panelists (as of 4/14) NYS-Ed Kramer, Office of Aging NJ-Commissioner of Social Services Bill Waldman(invited) NYC-Commissioner of Aging Herbert Stupp *We have the facility for a hand held "walk around" mike to take a few questiosn/ comments from the audience.
12 noon to 12:30	Recognition ceremony for NY/NY alternates who have participated in WHCOA with special Certificate.
12:30	End of day.

We have sent out 3,000 invitations(Brookdale's mailing list)
1,000 " by NYS Aging monthly newsletter

We plan to invite another 1500 to 2000 people and are more than confident that we will have a packed (800) auditorium.

We are printing leaflets similar to the flyer attached and will distribute to all area agencies in northern New Jersey and the NY metropolitan area, including Long Island, Westchester, Rockland, Dutchess and Orange counties.

Groups involved and invited (and who are networking with their leadership include, but are not limited to:

AARP
Older Womens League(OWL)
Retired Senior Volunteers Program(RSVP)
Grey Panthers of New York
HANY(Hospital Assoc. of NY-Social workers)
Modern Maturity Magazine (HQ in NYC)
The NY FEB board is contacting all other federal agencies and inviting them to participate
Graduate schools of social work at NYU, Columbia, Yeshiva, and Fordham are also invited
Administrators of all nursing homes and long term care facilities in NYC, Long Island and Westchester
We are invited the relevant leadership from the Archdiocese and from UJA.
Additionally, we are mailing to approximately 250 people on NY Citizens Committee on Aging list of leadership
Elected officials invited include:
Speaker of the Assembly Shelly Silver
Minority State Senate Leader Martin Connor
Manhattan Bor. Pres. Ruth Messinger
Queens Bor.Pres Claire Schulman
Bronx Bor. Pres. Fernando Ferrer
Brooklyn Bor. Pres. Howard Golden
Mayor Rudolph Guiliani and Donna Hanover Guiliani
Assemblyman Steve Saunders
Public Advocate Mark Green

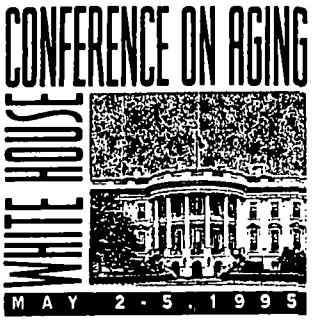
Possible "celebrity" MCs if Mary Alice Williams can't do it are:
Donna Hanover Guiliani
Katie Couric (invited)
Ossie Davis and Ruby Dee
Tony Randall
Beverly Sills
All have connections with this issue and are popular here.

NYNEX has been very generous in underwriting both the downlink, the breakfast and the cost of extra security. They also have a

community bulletin board on NY1 (the prime cable TV channel in NYC) and will run our announcement, we expect local cable coverage.

Thats all for now. We will have more confirmations by Tuesday morning. The delays were unavoidable.

We are printing 5,000 flyers to start.



1995 WHITE HOUSE CONFERENCE ON AGING

LYNN H. YEAKEL
Regional Director, Mid-Atlantic Region
U.S. Department of Health & Human Services

in conjunction with the
ALLEGHENY COUNTY DEPARTMENT OF AGING
cordially invites you to the live telecast of the

PRESIDENT'S ADDRESS TO THE
WHITE HOUSE CONFERENCE on AGING
followed by a Leaders' Luncheon

Wednesday, May 3, 1995
8:30 a.m. - 2:00 p.m.

David L. Lawrence Convention Center
1001 Penn Avenue
Pittsburgh, PA

Registration & Coffee	7:30 a.m. - 8:30 a.m.
Welcome & Introductions	8:30 a.m. - 9:00 a.m.
Live Telecast	9:00 a.m. - 11:00 a.m.
Open Forum Discussion	11:15 a.m. - 12:15 p.m.
Luncheon	12:30 p.m. - 2:00 p.m.

R.S.V.P. by April 26, 1995

CALL 215-596-6492
or
215-596-6923

April 12, 1995

NOTE TO MIKE KING:

re: WHCoA Information - as requested

Lynn Yeakel, Philadelphia Regional Director, asked me to respond to your note concerning the WHCoA events /packet of information that you need in order to make your presentation. Please forgive the informality of the note, but I will not be in the office tomorrow and our LAN is out until next Monday and I wanted to make certain that you received this information ASAP. Following the format of your note:

1. The first group of materials is the mailing list of the groups/individuals invited. It includes the alternate delegates (97) as well as the list from the Pittsburgh Department of Aging (367). I also want to mention that there are several other individuals that we need to invite but I am unable to give you a list at this time. Hopefully, by the beginning of next week we should have this information. From conversations with our AoA Regional Administrator, we will probably only have 1/4 of the alternate delegates attend. Pittsburgh expects that at least 250 would attend from their list. We plan to fill in the balance of the audience with the senior citizen center population from the Pittsburgh area, as well as any others that we decide on next week. We are hopeful that our audience will be in the range of 450 - 500 people.

2. The Pittsburgh mailing list of attendees includes a section of public officials. We plan to include public officials from the other states next week.

3. All the invitations to the attached listings have been mailed out as of today - a total of 464. A copy of our invitation to the alternate delegates is attached. The Allegheny Dept. of Aging Office has mailed out the remaining invitations. I will forward a copy of it as soon as we receive our copy from them.

4. The funding issue has finally been resolved. The Bell representative is underwriting the cost of a breakfast and the Allegheny County Dept. of Aging is having the County Commissioners underwrite the cost of the luncheon, cake, presentations, etc.

5. I have spoken to the Convention Center and the AV personnel and have requested what we will need, e.g. microphones in audience for a Q and A period. The one thing that we would like from the WHCoA is some signs approximately 2x3 to post at the convention center with the WHCoA logo or something similar.

Please let me know if you need any further information.

Nancy Newton
Region III

WHITE HOUSE CONFERENCE ON AGING
ORLANDO DOWNLINK SITE

Radisson Twin Towers
Orange Room
5780 Major Boulevard
Orlando, Florida

Wednesday, May 3, 1995
7:30 am - 1:00 pm

Expected attendance: 600

o INVITEES:

285 WHCoA Alternate Delegates
103 Area Agencies on Aging (AAA) in region
11 Florida AAA's with request to solicit attendees
409 Florida Senior Center directors
8 state agencies on aging

[Florida AARP to send mailing labels for area members]

[Regional political appointees of Housing & Urban Development, Education, Labor, Environmental Protection Agency, Justice, General Services Administration, Small Business Administration, Federal Emergency Management Administration, Agriculture, and Internal Revenue Service have been invited and also were asked to provide names of anyone they would like for us to invite to the session]

We also plan to invite additional senior advocates as their names are made available to us from a number of sources.

o PUBLIC OFFICIALS INVITED:

Gov. Lawton Chiles has been invited, but has not had time to respond. [We understand some governors will be officials delegates to the WHCoA. If Governor Chiles is not a delegate, will he be invited to the Washington conference in some official capacity? Also, if we know that the First Lady or some Cabinet member will be attending the Orlando site, that information would be useful in our follow-up to ascertain his attendance at the downlink site.]

Linda Chapin, Orange County (FL) Commission Chairman has accepted.

We plan to invite U.S. and state senators and representatives from the area.

ORLANDO DOWNLINK SITE

Wish list: Hilliary Rodham Clinton, First Lady*
Janet Reno, Attorney General
Carol Browner, Administrator, EPA

* We understand from the **Atlanta Journal & Constitution** that the First Lady will be in Atlanta on Tuesday, May 2 for a global telecast originating at CNN. Since she will already be in the area, should her schedule permit travel to Orlando, at this point we are quite flexible with the agenda and could easily arrange it prominently feature her. We could also plan additional activities/events/visits in the Orlando area for Ms. Clinton should that be desired.

o 816 letters of invitation have been mailed to date.

o FUNDING:

Need $4859 for food/beverages (must be confirmed with Radisson Hotel by April 19) -- includes coffee at registration, soft drinks during the morning break, and a box lunch for the Alternate Delegates in attendance. Hal Duncan at WHCoA has been apprised of these funding needs.

o LOGISTICS:

The Orange Room at Radisson Twin Towers (Orlando) seats 600 theater-style; 400 at round tables. We plan to have a raised dais with podium and table. Microphone at podium and two on table. Three wireless microphones for audience dialogue.

Hotel is located 20 minutes from Orlando airport and 30 minutes from the city.

City of Orlando is hosting an all-day event for seniors on May 3: "Downtown Orlando Seniors Day." Video of the opening session will be shown at 3:00 pm as part of that event.

1995 WHITE HOUSE CONFERENCE ON AGING

REGIONAL SATELLITE FORUM

WHO: President Clinton and Delegates in Washington D.C. via White House sponsored satellite broadcast. Onsite greetings from Florida's Governor Lawton Chiles (invited) and Orange County Chairman Linda Chapin.

WHAT: Live satellite broadcast of opening session, White House Conference on Aging, followed by dialogue on the issues.

WHEN: May 3, 7:30 a.m. - 1:00 p.m.
Broadcast - 9:00 a.m. - 11:00 a.m.

WHERE: The Orange Room, Radisson Twin Towers
5780 Major Boulevard, Orlando, Florida
Telephone: 407-351-1000
Conference questions: 404-331-2442

REGISTER FREE.....REGISTER NOW.....SPACE MAY BE LIMITED

MAIL REGISTRATION FORM BELOW TO: White House Conference on Aging
U.S. Department of Health and Human Services
Suite 1515, 101 Marietta Tower
Atlanta, Georgia 30323

OR REGISTER BY PHONE - 404-331-2442 - OR FAX - 404-331-1807

- -

YES - I'll be attending the Regional Satellite Forum,
May 3, 1995 at the Radisson Twin Towers, Orlando

Name _____

Mailing Address _____

_____

_____

Phone _____

1995 WHITE HOUSE CONFERENCE ON AGING

REGIONAL SATELLITE FORUM

JOINING PRESIDENT CLINTON AND DELEGATES IN WASHINGTON, D.C.

THE ORANGE ROOM, RADISSON TWIN TOWERS
5780 MAJOR BOULEVARD, ORLANDO, FLORIDA
WEDNESDAY, MAY 3, 1995

7:30	Registration and Coffee	
8:15	Welcome to Regional Alternate Delegates and Participants	Host, Patricia Ford-Roegner Regional Director U.S. Department of Health and Human Services, Atlanta, Georgia
	Official Welcome to Orlando	Linda Chapin Orange County Chairman
	Greetings	Governor Lawton Chiles *
8:55	Introduction of the Satellite Broadcast	Court Lantaff Assistant Vice-President Bell South Corporation Corporate Sponsor
9:00	Opening Session White House Conference on Aging	Opening Address: President Bill Clinton
11:00	Break	
11:15	Dialogue with Alternate Delegates and participants on Conference agenda items identified at regional, state and local pre-Conference events: o Assuring Comprehensive Health Care, Including Long-Term Care o Promoting Economic Security o Maximizing Housing and Support Service Options o Maximizing Options for a Quality Life	
1:00	Adjournment	* invited

1995 WHITE HOUSE CONFERENCE ON AGING

April 12, 1995

Dear Aging Advocate:

As the dates of the 1995 White House Conference on Aging (WHCoA) draw near, we have all been impressed with the tremendous dedication and sense of excitement we have seen at the regional, state and local level events. Together, we are well on the way to making the 1995 WHCoA a huge success.

On behalf of the Clinton Administration, I want to invite you to participate in the WHCoA sanctioned regional satellite forum.

In our region, the WHCoA live satellite coverage of the opening session will be held Wednesday, May 3, 1995, at the Radisson Twin Towers, Orlando, Florida.

After the opening remarks from special guests and the satellite coverage, there will be time to dialogue on the issues with elected officials, business leaders, other advocates and, of course, seniors from the surrounding geographic area.

I hope you can join us for this momentous occasion. I have enclosed a tentative agenda for your information along with a registration form.

Sincerely,

Pat Ford-Roegner

Pat Ford-Roegner, Regional Director
U.S. Department of Health & Human Services
Suite 1515, 101 Marietta Tower
Atlanta, Georgia 30323

Enclosures

1995 WHITE HOUSE CONFERENCE ON AGING

April 7, 1995

Dear Alternate Delegate:

As the dates of the 1995 White House Conference on Aging (WHCoA) draw near, we have all been impressed with the tremendous dedication and sense of excitement we have seen at the regional, state and local level events. Together, we are well on the way to making the 1995 WHCoA a huge success.

On behalf of the Clinton Administration, I want to invite you to participate in the WHCoA sanctioned regional satellite forum.

In our region, the WHCoA live satellite coverage of the opening session will be held Wednesday, May 3, 1995, at the Radisson Twin Towers, Orlando, Florida.

After the opening remarks from special guests and the satellite coverage, there will be time to dialogue on issues of importance to you with other alternate delegates from the eight state region as well as with elected officials, business leaders, advocates and, of course, seniors from the surrounding geographic area.

I hope you can join us for this momentous occasion. I have enclosed a tentative agenda for your information along with a registration form. If you will be attending, please register as soon as possible to assure reserved space.

Thank you for your time and commitment to this important undertaking.

Sincerely,

Pat Ford-Roegner

Pat Ford-Roegner, Regional Director
U.S. Department of Health & Human Services
Suite 1515, 101 Marietta Tower
Atlanta, Georgia 30323

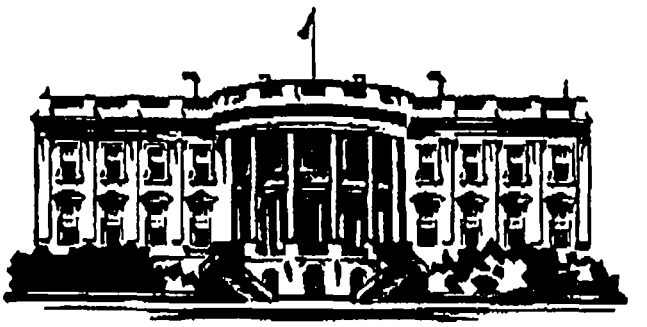
Enclosures

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ▶ 4

To Mike Kurz	From Jean Bowman
Dept./Agency HHS/OIG	Phone # 404-331-2672
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION



1995 White House Conference on Aging

Televideo Conference
University of Arkansas at Little Rock Auditorium

9:00 a.m.	**Registration** Auditorium Lobby
9:30 a.m.	**Welcome** Darrell Smith, President Arkansas Association of Area Agencies on Aging
	Address Carol Rasco, Chief Domestic Policy Advisor The White House
10:00 a.m.	**Opening Session of the White House Conference on Aging**
11:15 a.m.	**Celebration of 30th Anniversary of the Older Americans Act** (cake and coffee in auditorium lobby)
11:30 a.m.	**Segment Two of the White House Conference Opening Session**
12:30 p.m.	**Closing Remarks**
12:40 p.m.	**Adjourn**

Post-it® Fax Note 7671	Date 4-13-95	# of pages ▶ 5
To Don Perkins	From Jean Murray	
Co./Dept.	Co.	
Phone #	Phone #	
Fax # 214-767-3617	Fax #	

Key Political contacts

Governor Jim Guy Tucker
(501) 682-2345

Little Rock Mayor Jim Daly
(501) 371-4516

Arkansas General Assembly
(n invitation will be sent to each member)

They have not been invited

PR for WHCOA TeleVideo Conference

- A flyer has been developed and will be sent to the Governor's Advisory Council on Aging, members of the Silver Haired Legislature, Area Agencies on Aging, aging service providers, and a mailing list of people who have attended related events.
- A press release has been developed and will be distributed by the Department of Human Services to all media outlets in the state (newspapers, TV, radio).
- A letter of invitation will be sent to all members of the General Assembly.

WHITE HOUSE CONFERENCE ON AGING

TeleVideo Conference

In Honor of the 30th Anniversary of the Older Americans Act

Special Guest: Carol Rasco

Chief Domestic Policy Advisor to the President

UALR AUDITORIUM

May 3, 1995

9:30 A.M. TO NOON

Admission: FREE

Paid parking is available in the garage.

Access to the garage is off Fair Park.

To : Michael King@IOS.IGA@OS.DC
Cc :
Bcc :
From : Barbara Gumminger@ORD@KCMO
Subject : WHCoA
Date : Thursday, April 13, 1995 at 2:03:36 pm CDT
Attach :
Certify : N
Encrypt : N

Your request re the White House conf did not come to me so I have just received it. If would help Mike if you copied EA's on these requests so we could begin to gather information when the RD is not in the regional office.

Anyway, your request is difficult to respond to. We are just sending out invitations this week and each federal agency in the KC area, each AAA and State Units on Aging, and each op/staff div are sending out their own invitations to their constituency because of the shortness of time. I know AARP, hospital associations, nursing organizations, etc have all been invited. I can only guess the number of invitations to be issued. That would be approximately 3,000. We anticipate from 700-800 attendees. The site can, however, accommodate 2000 attendees. There is an RSVP so next week at this time we should have better numbers.

The RD has invited all of our alternates (100) plus governors, mayors, congressional staff offices, legislators, state department heads, etc. from our four states, Iowa, Kansas, Missouri, Nebraska.

We have no issues with funding. The site, John Knox Village is free and the contractor has confirmed everything for the downlink. We have received a couple of donations and those have been sent through the Federal Executive Board so we won't have to handle the money. No problems here. We expect all signage and printing costs to be covered. If additional dollars are received, we anticipate issuing vouchers towards the purchase of lunches. We have no technical problems as well. We have done one walk thru with another scheduled for Monday morning.

Our facility is huge with lots of parking, bus drop offs, security, anything you could ask for, our site has. The city has been wonderful to work with. We don't anticipate any problems whatsoever. I am faxing you a layout of Pavilion where the conference is to be held. There will be an exhibit area to one side for private sector organizations such as Visiting Nurses, Hospital Associations, etc. Down the other side will be a "problem table" area. Included here will be medicare/medicaid, ssa, etc. We have 18 exhibits and 15 problem area displays confirmed. These are identified on the layout which will be faxed shortly. There are also 3 restaurants and a large concession area on site.

One of the most interesting things about our site is that the downlink will go directly into the residents living quarters in addition to the main screen in the pavilion. This will provide us with more attendance expansion if the need arises.

We would like to have the First Lady, Vice-President or Mrs. Gore, any Cabinet official. (I might say this is the heart of Bob Dole territory)

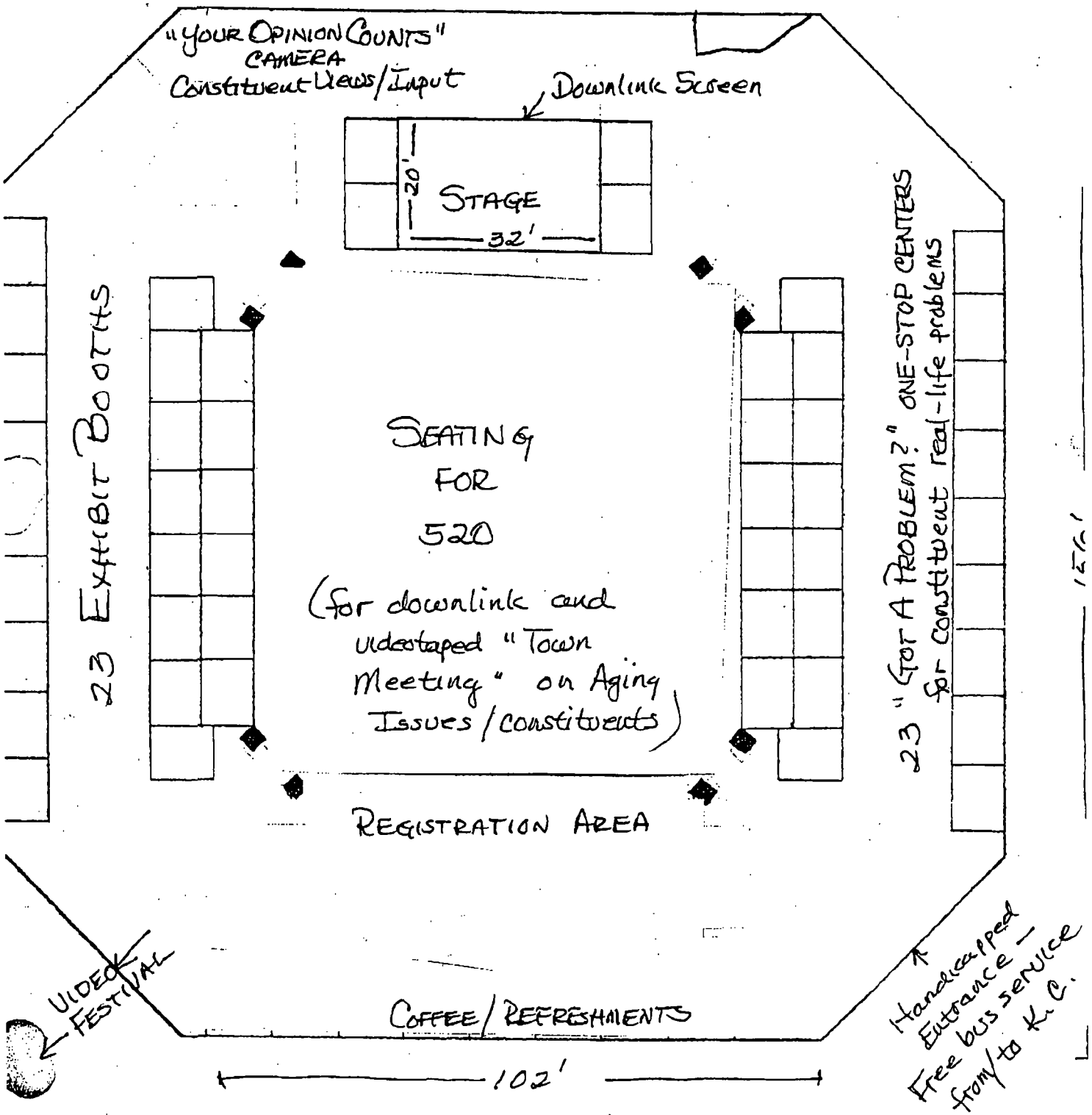
WHITE HOUSE CONFERENCE ON AGING

Kansas City Downlink - May 3, 1995

Draft Agenda

7:00	Registration Opens
7:30	Marching Cobras - Kansas City Girls & Boys Club Inner City Marching Band
7:50	Welcome & Opening Remarks Katie Steele, Regional Director/HHS
8:00	Downlink Broadcast
10:00	Downlink Broadcast Ends Recognition of Alternate Delegates - Presentation of Certificates Recognition of Special Guests
10:15	Break
10:30	Introduction of Cabinet Official Presentation of Key to Kansas City - Mayor Cleaver Cabinet Member Remarks
11:00	"Town Meeting" - Moderator: Local news channel anchor (Session will be videotaped) Overview Presentations (5 minutes each) .Income Security - Regional SSA Commissioner Regional HCFA Administrator .Health - Regional Health Administrator .Housing - University of Kansas Center on Aging .Quality of Life - MU Center on Aging Studies Town Meeting Forum - Constituent Views/Exchange
12 Noon	Luncheon (participant vouchers for lunch)
Afternoon	Exhibits Booths Open Film Festival - "E" Building "Got A Problem" Tables Open (one-stop center tables for constituents with real-life problems with SSA/SSI, Food Stamps, Transportation, Energy Assistance, etc.) Senior Talent Shows - John Knox Village Groups
4:00	Adjournment

(Local media have interest in "actuals", "live feeds" and various interviews during the day)


"YOUR OPINION COUNTS"
CAMERA
Constituent Views/Input
Downlink Screen
20'
STAGE
32'
23 EXHIBIT BOOTHS
SEATING
FOR
520
(for downlink and
videotaped "Town
Meeting" on Aging
Issues/constituents)
23 "GOT A PROBLEM?" ONE-STOP CENTERS
for constituent real-life problems
REGISTRATION AREA
VIDEO FESTIVAL
COFFEE/REFRESHMENTS
102'
Handicapped
Entrance —
Free bus service
from/to K.C.

mm = 8 FT.

SACRAMENTO WHCOA TELESITE

Program Coordinator: Deanna Lea
Sacramento Area Agency on Aging (AAA)

Site: Building C Auditorium
California Expo Center
1600 Exposition Boulevard
Sacramento

Capacity: 1000

Proposed Program:

8:30 a.m.	Welcome by Grantland Johnson, HHS Regional Director
8:40 a.m.	Opening Remarks by Sacramento Mayor Joe Serna (Invited)
9:00 a.m.	Video of Opening Plenary Session
11:00 a.m.	Recognition of WHCOA Alternate Delegates
11:15 a.m.	Panel Discussion by Seniors Representative of Key WHCOA Resolutions
12:30 p.m.	Adjourn

Comments: The Regional Director has sent personal letters of invitation to all WHCOA Alternate Delegates to attend the opening day's televideo of the plenary session on Wednesday, May 3 (see attached). Additionally, the Regional Office has sent out the first press release on this activity (also attached). The Sacramento AAA will be sending out 2000 invitations to its constituents which cover a seven-county service area encompassing Sacramento, Yolo, Placer, Nevada, Sierra, Sutter and Yuba Counties. AARP, Alzheimer's Disease organizations, statewide advocacy groups located in the State Capitol, and other major senior associations will be notifying their own network about the event. Key state and local elected officials are also being invited to participate in discussions dealing with the conference issues and subissues. A preliminary estimate of over 600 will be expected to be in attendance.

# # #

CALIFORNIA

1995 WHITE HOUSE CONFERENCE ON AGING

April 12, 1995

Dear

On behalf of the White House Conference on Aging (WHCOA), I am pleased to invite you to attend the opening ceremony of the 1995 White House Conference on Aging which will be presented by satellite on Wednesday, May 3, 1995 at three separate telesite locations in California. As a distinguished WHCOA alternate delegate, you may wish to participate in this historic event featuring President Clinton's opening remarks.

Senator David Pryor, Chairman of the White House Conference on Aging's Policy Committee, had remarked, "President Clinton stated that his goal was for this WHCOA to reach more people than did the previous three with the use of modern technology. We are proud that the President's goal will be met."

The three telesite locations in California are Sacramento, Los Angeles, and San Diego. Please contact the program coordinator listed on the enclosure at the location most convenient for you for more information and reservations.

I hope you will be able to join your many colleagues who have a deep interest in our nation's aging policy.

Sincerely,

Grantland Johnson

Grantland Johnson
Regional Director
Department of Health & Human Services

Enclosure

FOR IMMEDIATE RELEASE
April 11, 1995

Contact: Frank Clark
(415) 556-3429

Satellite Locations Announced

WHITE HOUSE CONFERENCE ON AGING RIDES INFORMATION SUPER-HIGHWAY

FOUR REGIONAL TELESITES

On May 3rd, 1995 thousands of people across the country will be able to observe and [in some cases] be able to join-in segments of the 1995 White House Conference on Aging (WHCOA). In Arizona and California they can visit any one of four Telesites:

Phoenix Community College	Phoenix, AZ
UCLA Student Union	Los Angeles, CA
California Expo Center	Sacramento, CA
Convention Center	San Diego, CA

Live WHCOA action, featuring President Clinton's opening remarks, will be fed to these western cities from 6:00 to 8:00 AM. TV replay and local participation and commentary will follow from 9:00 to 11:00 AM. In all, 15 cities nationwide will carry portions of the Conference live via satellite links.

Special invitations are being extended to 159 WHCOA Alernate Delegates [129 from California, 30 from Arizona] most of whom are not expected to be called on to attend the May Conference.

Fernando Torres-Gil, Assistant Secretary for Aging, Department of Health and Human Services, who heads the U.S. Administration on Aging said, "the President asked us to explore non-traditional ways of making this year's Conference accessible to a wider national audience. Our goal is to share this historic meeting with thousands of interested citizens beyond the actual 2,259 Delegates who will convene in Washington, D.C. May 2-5."

The 1995 White House Conference on Aging [fourth in history] will take place at the Washington Hilton hotel. Delegates on site will vote on resolutions that will help craft federal aging policy for the 21st Century.

Torres-Gil said the satellite links were secured thanks to "in kind" gifts from five regional phone companies: Pacific Telesis, BellSouth, NYNEX, Bell Atlantic and SBC Communications.

A roster of key contacts in Arizona and California and a list of key WHCOA issues follows.

also publicizing the activity through their own extensive network. Moreover, the County AAA expects to bus in 250 of its clients, while the City AAA expects to bus in at least 200. Based on the interest elicited in the Los Angeles area, there is expected to be over 800 people in attendance.

# # #

LOS ANGELES WHCOA TELESITE

Program Coordinator: Linda Lee
UCLA Center on Aging

Assistant Coordinators: Dan Gersky
Los Angeles City Area Agency on Aging (AAA)

Michael Early
Los Angeles County Area Agency on Aging (AAA)

Site: Ackerman Ballroom
UCLA Student Union
308 Westwood Plaza
Los Angeles

Capacity: 1000

Proposed Program:

8:30 a.m.	Welcome by Frank Cardenas, Regional Administrator, Administration on Aging, Region IX
8:45 a.m.	Opening Remarks by Dean, UCLA Center on Aging
9:00 a.m.	Video of Opening Plenary Session
11:00 a.m.	Proposed Panel Discussion on "Aging Issues Facing Seniors in Los Angeles," moderated by UCLA Center on Aging, with panel members from L.A. County AAA, L.A. City AAA, and the Los Angeles County Board of Supervisors (invited).
1:00 p.m.	Post-WHCOA Action Steps, including publicizing a May 25, 1995 meeting scheduled by the UCLA Center on Aging to present Assistant Secretary of Aging Fernando Torres-Gil, who will provide a summary of the concluded White House Conference.

Comments: The Regional Director has sent personal letters of invitation to all WHCOA Alternate Delegates to attend the opening day's televideo of the plenary session on Wednesday, May 3. Additionally, the Regional Office has sent out a press release advising about this event. This will be followed up by the UCLA Center on Aging sending out a press release targeted to the seniors publications and to the electronic media. UCLA is gearing up to send out 6000 invitations in the next day or so. Both AAAs are Los

Television-Morning

Good Morning America

- Interested in "Big Picture" and celebrities
- Will pitch Bob and Liz Carpenter (member of advisory committee)

CBS This Morning

- Interested in medical and regional angles
- will pitch Norm Abramowitz (Mayor of Tamarac, FL and member of Policy Committee and Dr. Butler (Chair of Advisory Committee)

NBC Today

- Interested in politics, favorable to Democrats
- will pitch Sec. Shalala and Sec. Brown

Fox Morning News

- Interested in heads of associations, politicians
- will pitch Horace Deets of AARP, Connie Morella

CNN Daybreak

- Interested in debate/discussion format
- will pitch panelists from Generations United Conference

C SPAN

Television-Evening

ABC American Agenda

- interested in trends
- will pitch the debunking of aging stereotypes

NBC Nightline

- will pitch, "What is in store for 2025"; Medicare/Social Security; intergenerational panelists (Horace Deets and Marian Wright Edelman, two college students from generations United Panel)

CBS Evening News/Eye on America

will pitch productive Aging such as senior volunteers via Senior Corps Program

Larry King Live

- Secretary Shalala, Hugh Downs

C SPAN

VNRs/Radio Interviews

A total of three VNRs, to take place Wednesday, Thursday, and Friday. Each will be approximately thirty minutes in length and will include highlights from respective days as well as interviews from delegates representing states with largest elder populations.

Fifteen to twenty delegates to be interviewed over the phone by local radio stations in states with largest elder populations. Lynn Filoosh at HHS will handle technical aspects of this project.

Special Focus on Delegates

WHCoA is currently identifying 3-5 delegates from each of the 10 most elder populated states, delegates who have been to previous conferences and "celebrity" delegates. These delegates may be used for the VNRs, radio, television and print media interviews.

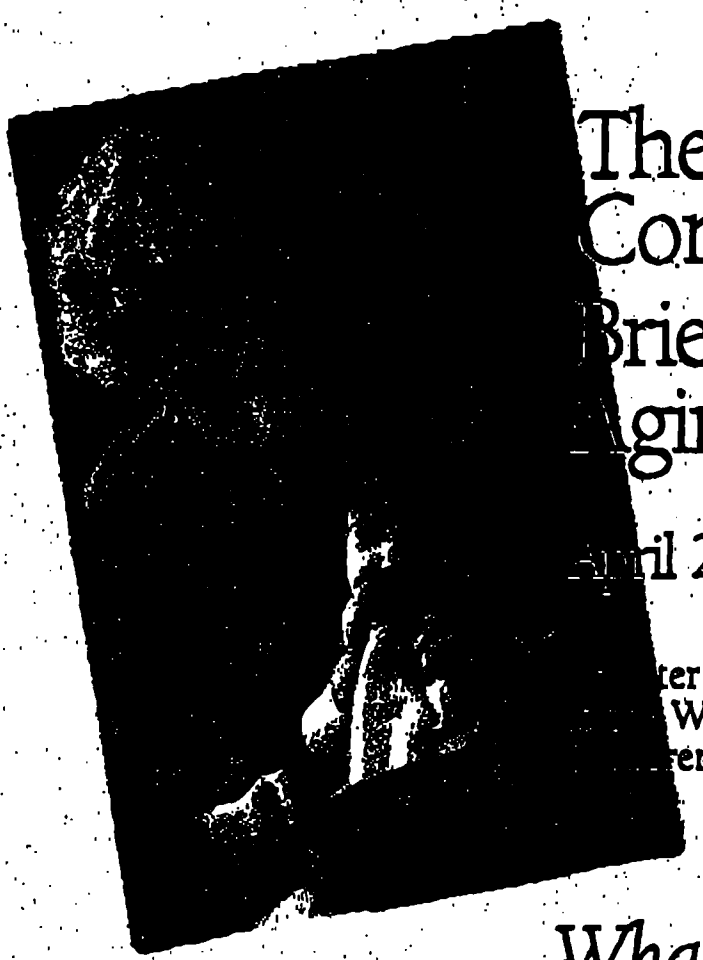
Opinion/Editorial Placement

WHCoA has approached the following to write op ed pieces:

Secretary Shalala -- Wall Street Journal

Fernando Torres-Gil -- LA Times

Hugh Downs -- At-large piece for paper such as Cleveland Plain Dealer, Dallas Morning News, Detroit Free Press, etc.)



The Congressional Briefing on Aging

April 28, 1995

Alternative Forum
to White House
Conference on Aging*

What the White House Conference on Aging Won't Tell You

*The White House Conference on Aging is funded by more than 5.3 million in taxpayers money. The Congressional Briefing on Aging is underwritten by the Seniors Coalition a nonprofit, member-based senior citizens organization.

THE CONGRESSIONAL BRIEFING ON AGING

Guests are invited to participate in Panel discussions with notable authorities on major issues facing America's Senior Citizens. Members of Congress have been invited to serve as Panel Moderators and Special Guest Panelists include:

- Ambassador Max Friedersdorf, Member and Past Chairman of the Federal Council on Aging
- Doug Bandow, Senior Fellow with the Cato Institute
- Dan Mitchell, Resident Scholar at the Heritage Foundation
- Carolyn Weaver, Resident Scholar, American Enterprise Institute for Public Policy Research
- Dr. Robert J. Myers, Former Chief Actuary of SSA and Chairman of the Board of Advisors for The Seniors Coalition
- Stephen J. Entin, Resident Scholar at the Institute for Research on the Economics of Taxation (IRET)
- Grover Norquist, President, Americans For Tax Reform

AGENDA

TAX POLICY
Promoting Better Economic Security by reducing taxes on Senior Citizens
10:00 a.m. to 10:45 a.m.

HEALTHCARE REFORM
Working to deliver better Longterm Care and General Healthcare to Senior Citizens
11:00 a.m. to 11:45 a.m.

MEDICARE AND MEDICAID
Reforming the Medicare System and providing for Medicaid Block Grants
12:00 p.m. to 12:45 p.m.

LUNCHEON BRIEFING
WITH SPECIAL GUESTS*
SPEAKER OF THE HOUSE NEWT GINGRICH AND
HOUSE MAJORITY LEADER DICK ARMEY
1:00 p.m. to 2:00 p.m.

THE POLITICS AND FUTURE OF SOCIAL SECURITY
What Lies Ahead?
2:15 p.m. to 3:00 p.m.

THE QUALITY OF LIFE
Revitalizing the Golden Years
3:15 p.m. to 4:00 p.m.

*Invited

The Seniors Coalition and The Seniors Foundation

Invite You To Attend

The Congressional Briefing On Aging

An Alternative Forum to the White House Conference on Aging*

With Honored Luncheon Guests**

Speaker of The House Newt Gingrich and House Majority Leader Dick Armey

Friday, April 28, 1995

Transportation Committee Room
Rayburn House Office Building Room 2167
10:00 a.m. to 4:00 p.m.

Space is limited. Please reserve quickly to ensure your participation in improving America's Future. RSVP to (202) 466-0590.

*The White House Conference on Aging is funded by more than $9.3 million in taxpayers' money. The Congressional Briefing on Aging is underwritten by The Seniors Coalition, a nonprofit, member-based senior citizens organization.

**Invited

The Seniors Coalition and The Seniors Foundation would like to thank the following organizations for their assistance in providing the background materials included in the briefing books that guests of the Congressional Briefing On Aging will receive:

- American Legislative Exchange Council
- American Enterprise Institute for Public Policy Reform
- Citizens for a Sound Economy
- Institute for Research on the Economics of Taxation
- National Center for Policy Analysis
- National Tax Payers Union
- Americans for Tax Reform
- Urban Institute
- Concord Coalition
- Reason Foundation
- Brookings Institute
- Progress & Freedom Foundation
- Pacific Research Foundation
- Fiscal Associates, Inc.
- Cato Institute
- Institute for Policy Innovation

April 17, 1995

PLANNING MEMO REGARDING ORGANIZATIONAL ACTIVITY AND THE WHITE HOUSE CONFERENCE ON AGING

I. Pre-Conference Meetings with Organizations to Discuss: (Week of April 24th)

A. Issues and Resolutions

Discuss the issues they will be focusing on and their plans and strategies around the resolutions.

B. Broader Message and Accomplishments

1. Broad comments regarding the President's Speech - (assuming we feel confident we can do so)

2. Provide materials regarding the Clinton record on issues of concern to older Americans (assuming materials are prepared).

C. Meetings with Seniors/Health groups will include discussions of external issues likely to be raised in Congress that week in regards to Medicare and Social Security.

D. Ensure that we know each group's total strategy around the Conference.

II. White House Briefing for the President's delegates.

A. Clarify with WHCOA the time and date (needs to be early enough so that participants can do press - preferably AM).

B. Reserve Room/Schedule Briefers (possibly the VPOTUS)

C. Make sure they have materials on the Clinton record and accomplishments.

D. Schedule opportunities for select number of these delegates to do radio/satellite/print to their home communities.

III. Amplification of the President's Speech (Day of activities)

A. Provide copies of the speech to all the organizations involved in the event - ask for statements praising the President's comments.

B. Talk with media affairs about POTUS followup, i.e. possible radio interviews for the President on several key senior stations.

White House Conference on Aging
Preliminary ideas for roll-out plan
Monday, April 17, 1995

Principals

- May propose Presidential interview with AARP Radio Network.
- May propose Presidential interview with clomunist on intergenerational themes (WHCOA suggests Judy Mann or Ellen Goodman).
- An op-ed by the President will appear in a special section of *The Washington Post* on aging, April 26th.
- The President may sign the proclamation for Older Americans Month in a public setting.
- May propose that the President meet with a small group of delegates prior to his address in order to hear first-hand accounts of issues of concern to older Americans.

Cabinet

- White House Briefing Room briefing either Tuesday prior to the event or Wednesday following the event.
- Conference calls with Secretaries Shalala, Cisneros, and Jesse Brown to African-American, Veterans, Business and Health reporters during the week prior to the conference.
- Op-ed by Secretary Shalala being pitched to *Wall Street Journal.*
- Op-ed by Fernando Tores-Gil being pitched for *Los Angeles Times.*
- Op-eds by Hugh Downs will be placed with the *Cleveland Plain Dealer, Dallas Morning News, Detroit Free Press,* and other large regionals.
- Identifying best person to do op-eds for *The Washington Post* and *New york Times.* (might be Members of Congress--Ted kennedy, Barbara Mikulski,...)
- Exploring ideas for a roundtable with aging press and Cabinet members.
- May propose an event/press opportunity/interview with members of the Cabinet and their parents (Shalala, Cisneros, Riley; Shalala and the Vice President's mothers are both delegates)

- Sub-cabinet such as Fernando Torres-Gil, Shirley Chater, and Bruce Vladek will also participate.

- Members of the Cabinet/sub-Cabinet will participate in satellite events in: New York City, Pittsburgh, Orlando, Kansas City, Sacramento, and Little Rock. They will do press in those markets prior to their arrivals on 5/3.

Other Press

- The WHCOA will pitch members of the Cabinet and other representatives for network news programs and morning shows.

- Will explore press opportunities for Senator Pryor, WHCOA Chair..

- Identifying best person to speak at National Press Club on aging issues/preparing for the next century as a scene-setter to the conference.

- Other representatives might include Dr. Robert Butler, Arthur Flemming, Hugh Downs...

- Conference delegates will do press prior to their departure for the conference. Each delegate was sent a "How To Work With Your Local Media" package.

- Many stories focusing on grass-roots aspects of the conference. Intergenrational pieces will also be heavy. Colorful pieces, i.e., delegates who have attended all three WHCOA since 1961, etc.

Outreach

- Will coordinate with White House and HHS Intergovernmental Affairs to make sure they are in touch with their delegates before/after the conference. This will be especially important in the ten cities with satellite events.

- Groups will play a big role. Press conferences, studies, validation, disseminating information to their membership, etc....

Things to keep in mind:

- May is Older Americans Month.

- 30th Anniversary of Medicare + Medicaid

- 60th Anniversary of Social Security

- Legislative Context: Budget hearings

White House Conference on Aging Meeting Agenda
April 6, 1995

I. THE BASICS

Date: May 2-5, 1995
Theme: America Now and Into the 21st Century: Generations Aging Together with Independence, Opportunity and Dignity
Agenda: 1) Assuring Comprehensive Health Care incl. Long Term Care
2) Promoting Economic Security
3) Maximizing Housing and Support Service options
4) Maximizing Options for a Quality of Life
POTUS: Addressing Plenary Session on May 3; other requests pending (Seniors Focus Group, "Senior Speak Out")
Chair: Senator David Pryor
Participants: 2250 delegates from 50 states (chosen by Govs. and Members)
Satellites: Providence, RI; East Rutherford, NJ; Pittsburg, PA; Orlando, FL; Dallas, TX; Little Rock, AR; Los Angeles, CA; San Diego

II. MESSAGE

-Standard "Fighting for Seniors; Protecting"?
-How best to tap into "Future" message?
-Set the groundwork on 4/12--Social Security event

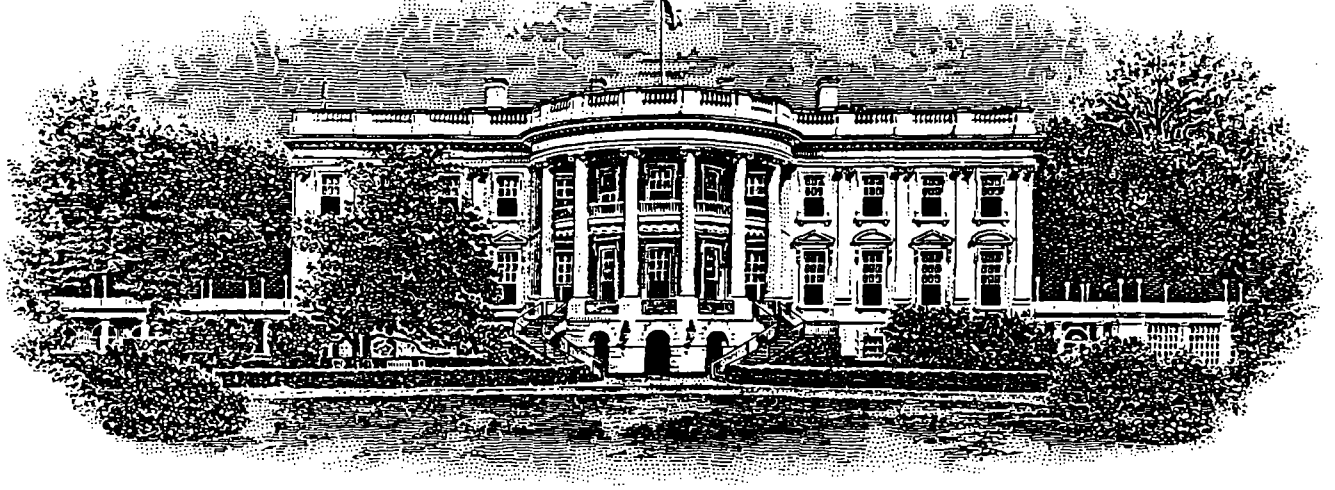
(Important to keep in mind that at the past conferences in 1961, 1971 and 1981, delegates developed and voted on policy recommendations which precipitated landmark legislative initiatives such as Medicare, Medicaid, the Older Americans Act and reforms to Social Security.)

III. POLITICAL CONTEXT

-Late April/early May Senate Finance Hearing on Medicare Trust Fund
Shalala, Rubin, Vladeck invited to testify
-Tie-in to 30th anniversary of House passage of Medicare; the House is throwing a big birthday event

IV. ROLL-OUT

-POTUS Press/Events
-Other Principles
-Cabinet Press/Events
-Intergovernmental Press/Events (All states are hosting WHCOA activities)
-Public Liaison/Aging Groups; Baby Boomers; Generation X
-Congressional Participation/Outreach
-Media Affairs



1995 WHITE HOUSE CONFERENCE ON AGING
FACT SHEET

The fourth White House Conference on Aging (WHCoA) -- and the last of this century -- will be held May 2-5, 1995, in Washington, D.C. President Clinton called for the Conference on February 17, 1994. The WHCoA Policy Committee, a 25-member body appointed by the President and the Congress, set the dates and place at its first meeting on July 27, 1994. Senator David Pryor (D-AR) chairs the Policy Committee.

On January 25, 1995, the Policy Committee approved a theme and final Conference agenda. The theme is "America Now and Into the 21st Century: Generations Aging Together with Independence, Opportunity and Dignity." Four broad issues comprise the agenda: (1) Assuring Comprehensive Health Care Including Long Term Care, (2) Promoting Economic Security, (3) Maximizing Housing and Support Service Options, and (4) Maximizing Options for a Quality Life. In deciding on the theme and final agenda, the Policy Committee considered public comments on theme possibilities and a draft agenda published in the Federal Register October 12, 1994. In addition, reports and recommendations from hundreds of officially recognized WHCoA events throughout the country were considered in developing the final agenda, which was published in the Federal Register February 2, 1995.

Two cross-cutting concerns pervade the agenda and will influence discussions at the Conference. These are: (1) interdependence among generations and among members of extended families, and the responsibility of individuals to plan for changes that will occur throughout their lifespan; and (2) unique contributions and needs of special populations, especially veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities.

Purposes of the WHCoA are to shape resolutions that will influence national aging policy over the next decade and design a strategy for putting policy into action -- for implementing the resolutions the Conference produces.

-over-

The 1995 Conference, authorized by the 1992 Amendments to the Older Americans Act, will have 2,258 delegates. In addition, it will have up to 250 observers, individuals who may attend the Conference but not vote. Delegates are selected by governors, members of Congress, constituent organizations (including national aging organizations and veterans groups), the White House, the HHS Secretary and the WHCoA.

Since President Clinton officially called it on February 17, 1994, the WHCoA has developed a full national program of pre-Conference events and activities. More than 700 events have been held or scheduled, including local, state, regional and mini-conferences. In addition, the WHCoA, in partnership with other organizations, has conducted more than 15 focus groups in a variety of cities throughout the country to gain direct input from individuals, primarily seniors, on their attitudes about aging and their views on what the WHCoA should focus on and strive to accomplish.

President Clinton appointed Robert B. Blancato as executive director of the 1995 WHCoA. Members of the WHCoA Policy Committee are:

David Pryor, U.S. Senate (D-AR), Chair
William S. Cohen, U.S. Senate (R-ME)
Daniel P. Moynihan, U.S. Senate (D-NY)
Barbara A. Mikulski, U.S. Senate (D-MD)
Constance A. Morella, U.S. House of Representatives (R-MD)
Andrew Jacobs, Jr., U.S. House of Representatives (D-IN)
William J. Hughes, U.S. House of Representatives (D-NJ) (retired)
Matthew G. Martinez, U.S. House of Representatives (D-CA)
Donna E. Shalala, Secretary of Health and Human Services
Henry G. Cisneros, Secretary of Housing and Urban Development
Jesse Brown, Secretary of Veterans Affairs
Norman Abramowitz, Mayor of Tamarac, FL
Bea G. Bacon, Central States Coalition on Aging, Olathe, KS
Horace B. Deets, Executive Director, American Association of Retired Persons
James T. DeLaCruz, Coordinator, Quinault Senior Citizens Program, Tahola, WA
Rose Dobrof, Executive Director, Brookdale Center on Aging of Hunter College, New York, NY
Madeleine R. Freeman, Orono, ME
Maralee Lindley, Director, Illinois Department on Aging, Springfield, IL
Thomas H.D. Mahoney, Cambridge, MA
Mary Rose Oakar, President, Healthright, Inc., Cleveland, OH
Herb A. Sanderson, Director, Division of Aging and Adult Services, Arkansas Department of Human Services, Little Rock, AR
Samuel J. Simmons, President and Chief Executive Officer, National Caucus and Center on Black Aged, Inc.
Lawrence T. Smedley, Executive Director, National Council of Senior Citizens
Marta Sotomayor, President, National Hispanic Council on the Aging
Daniel Thursz, President, National Council on the Aging

FEBRUARY 1995

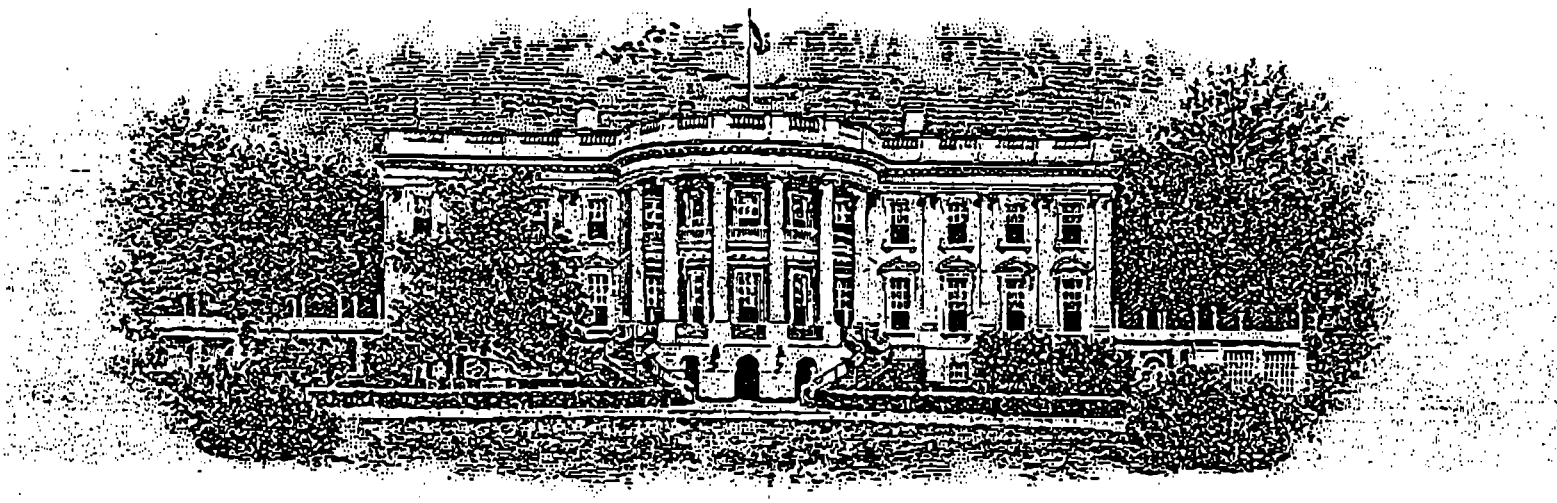
Video Conference
White House Conference on Aging, May 3, 1995

The broadcast is from the Washington Hilton over a video circuit provided by Bell Atlantic. This circuit is routed to the Washington International Teleport. The President's speech and the opening ceremony will be broadcasted to the remote nationwide sites from 9 am until 11 am (EST). Each site must have a Ku-band down-link capability to receive the signal. The satellite coordinates are G-2 Transponder 9V for Vertical.

Listed below are the selected nationwide teleconferencing sites.

Location	Seating Capacity
Rhode Island Convention Center, Providence, RI	500
The Meadowlands Hilton, East Rutherford, NJ	250
Hunter College, New York City, NY	800
David L. Lawrence Convention Center, Pittsburgh, PA	650
Twin Towers Radisson Hotel, Orlando, FL	600
INFOMART, Dallas, TX	500
University of Arkansas, Little Rock, AK	600
John Knox Village, Kansas City, MO	2,000
University of California, Los Angeles, CA	450
California Exposition, Sacramento, CA	1,000
San Diego Convention Center, San Diego, CA	400
TOTAL	7,750

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Jen K

FAX NUMBER:

TELEPHONE NUMBER:

FROM: Chris J.

TELEPHONE NUMBER:

PAGES (INCLUDING COVER):

COMMENTS: We have to give our comments by 9:30 tomorrow (Monday) morning. Pl. review & call me. (Elaine just delivered to my house this afternoon) I have a few -

Assuring Comprehensive Health Care Including Long-term Care
IRDS 2 Access to Quality Care

2.4 Reforming the Health Care System

1 WHEREAS the components of the health care system are so interrelated that no part can function well unless the system as a whole functions well;

2 WHEREAS the cost of health care is rapidly escalating and currently represents over 17% of the Federal budget and up to 25% of each older person's annual expenditures;

3 WHEREAS 40 million Americans are uninsured, including one-quarter of all children;

4 WHEREAS the current health care system does not adequately emphasize preventive care;

5 WHEREAS Medicare covers only 50% of all health care expenses of people age 65 and older and covers almost none of the cost of long-term care; and

6 WHEREAS the Federal budget deficit cannot be eliminated without reforming the health care system,

THEREFORE, BE IT RESOLVED by the White House Conference on Aging to support system-wide reform efforts that adhere to the following principles:

7 Americans of all ages ~~are entitled to~~ should have health security, including access to affordable health care and especially long-term care, while preserving choice of health care providers;

8 Cost containment is a critical component of meaningful health care reform and must not be isolated from the reform process;

9 Medicare's commitment to its beneficiaries must not be jeopardized by arbitrary cuts. Savings can be achieved in Medicare and then reinvested in expanded coverage, to include long-term care, thus making Medicare more cost effective;

10 Long-term care is to be developed with home and community based services as well as institutional services. Private long-term care insurance must include specific consumer protections and safeguards;

11 Health promotion and prevention services must be emphasized; and

12 Improved consumer information and education must accompany health care reform to ensure that quality care is not sacrificed.

March 24, 1995

To: Chris Jennings

From: Elaine Dalpiaz

Subject: **WHCoA Background Papers**

Attached is a list of all of the background papers that will be provided to the delegates three weeks prior to the WHCoA. I have checked the titles of the papers which are attached for your review. The others will follow.

Please note that:

1) These papers represent a continuation of the President's grass roots approach to the 1995 WHCoA. Their purpose is to help spur discussion and were intended to be non-partisan and objective in nature. They have been written by experts with diverse backgrounds and interests, from all across the country.

2) We are still receiving reviews of these papers and will continue to modify them until Wednesday, March 29th. In order to mail them to the delegates on April 10th, we must have the final versions to the printer on Friday, March 31st.

3) In addition to these papers, delegates will be sent background demographic data on each of the four major topic areas, cross-cutting issue papers on special topics such as intergenerational issues, disability issues, minority populations, women, and rural issues, and the draft resolutions. You will receive these materials next week.

ISSUES AND SUBISSUES FOR WHCOA PAPERS

3/24 Status Update

* Means Final Draft Ready For Review

* **Comprehensive Health Care, Including Long-Term Care**
  (still needs some editing per reviewers'comments)

  * ● Promotion and Prevention

  * ● Access to Quality Care

  * ● Continuum of Care Integrating Community and Social Services

  * ● Medicare
    (still needs some editing per reviewers' comments)

  * ● Medicaid
    (still needs some editing per reviewers' comments)

  * ● Older Americans Act

  ● Research and Education

* **Promoting Economic Security**

  * ● Employment

  * ● Social Security

  * ● Other Retirement Income and Resources, Including Pensions

  ● Poverty and Hunger

  ● Tax Policy

  * ● Discrimination

Maximizing Housing and Support Service Options

  ● Range of Options/Availability

  * ● Affordability/Financing/Tax Policies

  ● Linking Support Services to Housing

  ● Consumer Choice/Decision-Making/Promoting Independence

* **Maximizing Options for a Quality Life**
  (second paper on this topic still to come)

* ● Resources for Elders (Community and Social Services/Activities)

* ● Crime, Personal Safety, and Elder Abuse

* ● Spiritual Well-Being, Ethics, Values, and Roles

* ● Image and Roles of Older People

  ● Elders as Resources and Opportunities for Volunteering

  ● Isolation and Loneliness

  ● Legal Issues

Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

COMPREHENSIVE HEALTH CARE, INCLUDING LONG-TERM CARE

I. Overview of Major Issues and Policy Considerations

This year marks the 30th anniversary of the Medicare, Medicaid, and Older Americans Act programs. Together they have helped bring health and economic security to older Americans. Yet, the nation faces a dilemma—brought on in part by the success of these programs. As the life expectancy of the elderly in the U.S. has increased to be among the best in the world and as modern technology has brought new ways of both extending and improving the quality of life, the cost of caring for older people has risen. Health care and long-term care for the elderly are expensive for taxpayers and it is expensive for older people themselves. Strengthening these programs to make them work better for older Americans must be balanced against competing demands such as the need to devote resources to assuring children a healthy and productive start in life.

Public programs—primarily Medicare and Medicaid—cover 63 percent of all health care expenses of people age 65 and over. Yet, they fall short of protecting older Americans against the burden of high health care bills and assuring access to quality health care. The major gap is coverage for long term care. Prescription drugs are the major acute care service not covered by Medicare. Disease prevention and health promotion services are not covered by Medicare, except in limited circumstances. For those with moderate incomes, the costs of private

supplemental insurance and the out-of-pocket cost of deductibles, co-payments and uncovered services remain much higher for older people than for the younger population.

Increasing pressures to reduce spending on Medicare, Medicaid, and other smaller publicly-funded health programs are on the horizon. The size of these programs relative to the rest of the federal budget is already quite high. Because of the rapidly growing costs of care associated with health care spending, these programs are viewed by many as unsustainable in their present forms. Moreover, the pressure not only arises from general concerns about the federal budget overall but also the financing crisis facing Medicare in the near term and the longer term challenges of an aging baby boom generation.

Other critical challenges also command attention. Because our health care system is fragmented, there are major problems with coordination of services and continuity of the care provided. Too often care is driven by who pays rather than by what best meets needs. Consequently, people may be inappropriately kept in the hospital when what they need is long term care. Or, because drugs are not covered by insurance, people forgo taking medications, their health status worsens, and they end up using more expensive services. Such situations lead not only to inefficiencies and higher costs, but also to lower quality care for those who have complex needs.

The complex system of financing and delivering health care also leads to confusion. Few families know where to turn or what options are available when long-term care is needed for older family members or disabled children. Filing

claims and sorting out what is owed after a serious illness are onerous. Medi-Gap supplemental insurance policies can be confusing and costly. As managed care plans increasingly market to older people, the merits and quality of care of these alternative choices are often obscure. Expanding choices, fostering independence, and enabling people to make informed decisions about issues critical to their well-being are major challenges.

Finally, until quite recently research in health care often ignored the needs of older Americans. It was simply not considered a very high priority. Trials of new drugs and tests of new procedures often still do not include elderly subjects even though the elderly are high users of health care.

II. Assessment of Current Situation

Despite popular views that older Americans enjoy high incomes and standards of living, most elderly Americans have modest incomes. For example, over three-fourths of Medicare beneficiaries have incomes below $25,000 and only about 5 percent have incomes above $50,000. Out of these modest incomes, older persons must make substantial payments for health care insurance premiums and out-of-pocket spending. In 1994, it is estimated that such expenses totaled about $2500 per elderly person residing in the community, although those amounts vary substantially across families by age, presence of supplemental insurance, and income. Persons over age 80, for example, devote over 29 percent of their incomes, on average, to health care expenses.

For persons young and old with substantial long term care needs, burdens of

health care spending quickly become catastrophic. The annual cost of a nursing home exceeds $30,000 per year in most parts of the country and even modest amounts of home care services can mount up to $10,000 or $15,000 per year. These expenses are beyond the reach of most Americans if they must fully pay for them out of pocket. Moreover, many seniors who need long term care also have high acute care spending needs as well.

These high expenditures do not come about because of a lack of other sources of support. Rather, it is because the overall costs of care are very high and public and private insurance programs leave a number of gaps in coverage. For example, the elderly represent only about 12 percent of the U.S. population, but account for 36 percent of all health care spending in the U.S. These costs are spread over a number of payers of health care on behalf of older Americans. Medicare accounts for 45 percent of spending on the elderly and Medicaid and other public programs cover another 18 percent. Medicaid is also a critical part of the safety net for millions of low-income children.

Private sources of spending—a little more than a third—include supplemental insurance coverage and beneficiary out-of-pocket payments. About three-quarters of seniors have some form of private supplemental coverage. Generally, they pay for much of the costs of supplemental insurance through private insurance. The exception is older Americans fortunate enough to have good employer-subsidized employee or retiree coverage. But only 38 percent of Medicare beneficiaries have this type of supplemental insurance. Although that number has grown substantially since the 1970s, it may not expand much further as more and more employers have chosen to limit or cut back their retiree health benefits. Furthermore, supplemental

coverage does not eliminate the risks of very high health care burdens when an individual has an expensive acute care episode.

Private insurance for long term care is much less prevalent. Only about 2 million such policies have been sold in the U.S. and many of those are owned by persons under the age of 65. Many persons over age 65 with any type of health problem would find it difficult to purchase private long-term care insurance. Thus, as yet private insurance offers little in the way of protection against long term care needs.

What about the public programs that offer health care services to older Americans? Medicare is the largest and most important program. It covers nearly 98 percent of all persons over 65 residing in the U.S. Eligibility for Medicare is related to eligibility for Social Security benefits, either as workers, dependents or survivors. Once eligible, an individual is covered without charge by Part A, Hospital Insurance. This part of the program is funded by payroll tax contributions and covers hospital, home health and limited skilled nursing home services. Part B, Supplementary Medical Insurance, is voluntary and enrollees in Part B must pay a premium equivalent to a little more than 25 percent of the actuarial costs of the insurance. Most, but not all, Part A beneficiaries sign up for Part B. This part of the program covers physicians services, outpatient care, and laboratory and other ambulatory services. Medicare was intended to be an acute care program and thus it
covers almost no long term care services.

Medicaid, on the other hand, covers a broader range of acute and long term

care services, but to a more limited group of older Americans. It is a joint federal/state program and hence many of the details vary across the United States. Moreover, there are actually several types of older Medicaid beneficiaries who qualify in different ways and may receive different services. Low income seniors become eligible by qualifying for the Supplemental Security Income program. Most of these "categorical" eligibles are automatically enrolled in Medicaid and can receive all acute and long term care services offered. Even for persons with Medicare, this is likely to be an important benefit, filling in acute care services such as prescription drugs and alleviating the older person from having to pay cost sharing under Medicare or Part B premiums.

Another group which becomes eligible are those who have very high medical expenses and hence their incomes net of medical expenses are low enough to qualify them as "medically needy." These beneficiaries are often nursing home residents who rapidly spend down because of the very high costs of nursing home care. They receive help, but only after they have already spent a great deal of their incomes and assets. And, 20 states do not have a medically needy program.

A last group of eligibles are those who are in what is referred to as the Qualified Medicare Beneficiary (QMB) program. These additional enrollees in Medicaid have incomes below 100 percent of poverty (or between 100 and 120 percent of poverty for a less generous, related program). In this case they are not eligible for all Medicaid benefits, but only for relief of the premiums and cost sharing expenses that Medicare requires. This benefit, added in 1989, thus could help to fill in gaps in coverage for those with very low incomes. Participation in the QMB program remains low, however.

Medicaid has become, by default, the major public program for long term care. Since it was designed as a welfare program, individuals must spend most of their own incomes and assets before becoming eligible for any help. In turn, this has led many persons to seek ways to meet these requirements, while protecting or transfering their assets. But even more important is the poor balance between nursing home and home and community based services. One of the major gaps in health care coverage for the elderly is in the lack of home care services. Some states, like New York or Oregon, have been aggressive in offering home care services to their Medicaid beneficiaries, but these states are the exceptions and not the rule. Partly as a result of few public dollars available to support development, capacity in home care has tended to lag. In the last few years, however, there has been a rapid increase in the availability and use of such services, albeit from a very small base.

From the perspective of public costs of these various programs, aggregate spending by Medicare and Medicaid is very high. In 1995, total spending by Medicare on persons age 65 and older will be about $155 billion and on Medicaid for people age 65 and over nearly $46 billion (counting both the federal and state shares). This will constitute 12 percent of the federal budget and 2.5 percent of GDP in the U.S. These two programs are each expected to grow about 10 percent per year for the foreseeable future.

Check

Information on the quality of health care services for older Americans is more difficult to come by. But interestingly, in recent surveys, Medicare beneficiaries report higher levels of satisfaction with their health insurance as compared to beneficiaries of all other types of insurance. Among Medicare

beneficiaries, 52 percent say they are very satisfied, as compared to only 44 percent of those with employer-provided insurance. Moreover, when considering various issues, 89 percent of Medicare beneficiaries report they are very satisfied with the overall quality of their care. The percentages drop off, however, when the question refers either to out-of-pocket costs (72 percent very satisfied) and availability of care (46 percent). Some of the concerns about availability may be capturing some of the increased reluctance by providers to take new Medicare patients. As yet, however, this problem is still an isolated one.

III. Future Directions

What will the future hold? It seems very likely that there will be increasing pressures to reduce spending on health care services for the elderly through the public sector. Indeed, there are already calls for major reductions as part of the budget balancing discussion underway in the U.S. Congress. These items are too large a part of the federal budget to ignore. This means that not only are expansions in areas such as long term care or prescription drugs unlikely in the near future, but also that some of the budget cutting efforts are likely to affect current levels and quality of services offered.

There are few easy ways to slow public spending. Payment levels to providers of health care services are already lower for both Medicare and Medicaid than those found in the private sector. Although most providers still take Medicare patients, major cutbacks in payment levels could reduce access to care over time, or affect the high quality of care that beneficiaries now generally receive. It could also threaten the financial stability of institutions that depend on Medicare revenues,

such as rural hospitals and specialized teaching hospitals. Payment levels under Medicaid are already so low that it would be difficult to cut them any further. Under Medicare, beneficiaries may be asked to pay more for their care in the form of higher cost sharing or premiums.

The movement to managed care that is taking place so rapidly elsewhere in the health care system will have a major impact on America's senior citizens as well. Even if Medicare and Medicaid stick with the largely fee-for-service systems they have in place for older beneficiaries, the private marketplace changes will influence the availability of care for seniors. It is very likely that expansion of managed care will be undertaken as a means for holding down the rate of growth of spending in these programs.

If done well, managed care holds a lot of promise; effective coordination and support of those with high cost illnesses could be a benefit to both patients and taxpayers. Moreover, competition among private plans to package services creatively for senior citizens might lead to some improvements in the coordination of acute and long term care services. But managed care plans have tremendous financial incentives to cover only healthier patients and to cut corners in the provision of quality care. Managed care plans have little experience meeting the special needs of elderly and disabled patients. Studies to date show that managed care costs rather than saves Medicare money—in part because the current method of paying managed care plans can not adjust appropriately for the health status of enrolled beneficiaries. Moreover, reporting requirements about the quality and quantity of care provided by managed care plans are very limited. Nor do beneficiaries have the information they need to make informed choices among

managed care plans.

Fiscal pressures make it important to set priorities. Expansion of home and community based services needs to be weighed against reducing out of pocket costs for acute care such as prescription drug benefits. Improved supplemental coverage and outreach to low-income seniors to participate in the QMB program must be evaluated against more funds for prevention and basic and applied medical research on issues important to the health of older people. The need for improvements in Medicare and Medicaid must be weighed against other national priorities.

Resolving the dilemma of assuring affordable quality care for older people and addressing the federal budget deficit and looming Medicare insolvency requires making careful choices and trade-offs. Accurate information and an informed public debate are critical. The full array of options needs to be developed, analyzed, and carefully considered. They should include new revenues such as increased income or payroll taxes, premiums, and taxes on Social Security or Medicare benefits. Increased revenue options should be analyzed by their fairness and intergenerational equity. Restructuring benefits to provide better coverage for the chronically ill and older people with modest incomes should be weighed against moderately higher Part B premiums or deductibles for all. Tighter provider payment rates for managed care plans, hospitals, and physicians should be considered in the context of acceptable differentials between public program and private insurer provider payment rates, and the need to preserve a high quality health care system for all Americans.

Most importantly, people need information and choices so that they can take

greater responsibility for decisions that affect their independence and well-being. This includes making decisions among physicians or managed care plans and selecting a home care aide or assisted living facility, as well as their role as citizens and voters expressing their views about programs which have a 30 year record of protecting their health and economic security.

Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

PROMOTION & PREVENTION

I. Overview of Major Issues and Policy Considerations

For people of all ages, health promotion is a path to feeling good now and preventing health problems in the future. While each generation experiences unique risks, an integrated intergenerational approach to health promotion and disease prevention can yield universal results.

Older Adults

For older women at high risk for osteoporotic hip fractures, health promotion, in the form of exercise programs, nutrition counseling and medication management, can make the difference between nursing home dependence and independent living.

For retirees coping with arthritis, health promotion, in the form of a chronic disease self-management program, can make the difference between just "getting by" and lives filled with purpose and meaning.

For older people with life-threatening illness, health promotion, in the form of shared medical decision-making and knowledgeable consumers of medical and health care services, can make the difference between wasted medical care that adds no value to life and effective care that adds quality to both living and dying.

Infants, Young Children, Youth, and Young Adults

Illness prevention and health promotion programs (e.g., immunizations) are the foundations of a healthy start in life for infants and young children. For youths and young adults, health promotion and illness prevention contribute substantially to their own healthy aging. Health promotion can encourage avoidance of at-risk behaviors such as alcohol consumption, cigarette smoking, substance use/abuse, obesity, and inactivity that often lead to poor health in later life.

Years of innovative programming in a wide variety of settings have shown that older people have the interest and ability to better control their health and their health care through health promotion. Research shows that the payback is substantial: better health, reduced health care costs, and improved quality of life.

Policies that encourage prevention and health promotion for all generations are substantial investments in the health of our society. For children and younger generations -- who are the older Americans of the future -- such initiatives help ensure that they will enter later years with sound basic health, possibly avoiding some of the conditions that put today's elderly at risk.

However, considering that health promotion can benefit **all** populations, health promotion for older adults continues to be underfunded, under-researched, and unavailable to large segments of the population, especially minority elders and those living in inner cities and rural areas.

Clear, compassionate and enlightened national policies are needed to:

- Shift some of the bias of our health care system from illness care toward

health management, particularly for vulnerable populations, including older adults, infants and children, youths, and young parents..

- Increase universal access to and participation in programs that both improve quality of life and reduce overall costs.
- Strengthen and protect the older adult's role in making medical decisions.
- Encourage all older adults, young adults, and families live the most healthful and fulfilling lives possible.

II. Assessment of the Current Situation

Health Promotion Is Wide-Ranging

Health promotion is planned action to maintain or improve physical, mental and spiritual health. Programs for older adults have been around since the late 1970's. Early programs focused primarily on promoting good health through diet and exercise and other "wellness" activities. As interest grew and more older adults were reached, the definition has expanded to include a much broader range of activities: prevention, early detection, consumer empowerment, chronic disease management, and wellness. For children, youths, and young adults, health promotion activities are in many cases similar or identical to those for older persons. Examples of health promotion programs that work across generations:

Prevention: Flu shots, injury prevention, smoking cessation, proper nutrition and exercise, regular checkups, incontinence counseling.

Detection: Pap tests, mammograms, glaucoma screening, blood pressure screening, nutrition screening and assessment, bone density testing.

Consumer Empowerment:	Medical self-care education; workshops on medical consumerism (creating the knowledgeable consumer) and shared medical decision-making, access to information.
Chronic Disease Management:	Education on managing chronic conditions such as arthritis, hypertension, heart disease, osteoporosis, diabetes, etc.; mental health counseling; medication management seminars, self-help groups and caregiver support.
Wellness:	Fitness (including aerobic exercise and strength training), nutrition programs, stress management, mental wellness programs (coping with loss).

The best practices are those that promote dignity and independence, and build knowledge and skills to help individuals to make informed choices about health issues.

Health Promotion is Widespread

The settings and resources for health promotion for older adults are diverse and varied. Settings include:

Aging Network:	State and Area Agencies on Aging, senior centers, congregate meal sites
Health Network:	Hospitals, HMOs, insurance companies, public health departments
Private Sector:	Employers, unions, private health clubs, non-profit health organizations

Community-based:	Congregations, universities and colleges, recreation departments, community centers, YMCAs, etc.
Voluntary groups:	American Association of Retired Persons, National Council of Senior Citizens, American Red Cross, etc.

While the number of organizations offering health promotion resources to older adults has increased significantly in the last ten years, most older adults, especially elders in rural or inner-city settings, and minority populations, still do not have easy access to good resources or programs.

Health Promotion Leads to Improved Health

Research has shown that health promotion can help to postpone premature deaths (mortality), reduce disease and disability (morbidity), and improve the ability to live independently (functional health status).

Postponed mortality. Breast cancer deaths could be decreased by as much as 30 percent if older women had regular breast examinations and mammograms and received follow-up treatment. Screening for cervical cancer could also reduce premature deaths for older women, yet many older women do not have the recommended regular Pap tests.

Reduced morbidity. The focus of health promotion for many older adults is on postponing or reducing the impact of existing chronic disease. Programs that identify, treat, or manage underlying conditions, such as hypertension in the elderly, can reduce the incidence of disabling strokes. The same lessons hold true for chronic illness with onset earlier in life, such as diabetes.

Improved functional health status. Functional health status is measured by an individual's ability to live independently. Poor functional health usually results from the impact of one or more chronic conditions, injury, or sensory impairment, such as vision or hearing loss. Moderate exercise, quitting smoking, and avoiding obesity can help people stay mobile as they age.

Why Health Promotion Makes Good Economic Sense

While the main goal of health promotion is to promote healthy lives, well-designed programs also reduce the need for clinical services and lower the cost of health care. Health promotion programs reduce health care costs in three ways:

1. *Preventing health problems in the first place.* For example, hip fractures cost the nation over $2 billion each year. Prevention programs aimed at improving bone density, increasing muscle strength, reducing the risk of falls all effectively reduce costs.

2. *Effective management of chronic illness.* For example, evaluation of arthritis self-management courses shows that people who participate in such programs can reduce physician visits by up to forty percent. Diseases that can strike people of any age such as diabetes or kidney dysfunction, can similarly be managed through self-education and nutrition programs.

3. *Active involvement in health care decisions through medical self-care and informed medical decision-making.* For example, retiree self-care programs have shown decreases in hospital stays, doctor visits and health care claims. And, after involvement in informed medical decision-making programs, older men with

enlarged prostates choose surgery 40-60 percent less often.

Health Promotion and an Enhanced Quality of Life

Quality of life is an important issue for all older adults, whether they reside in their family home or in a nursing home. A feeling of control and independence, the ability to participate in desired activities, and a sense of self-worth -- all quality of life measures -- reflect each older person's overall level of health.

The implications for health promotion are apparent: even modest changes or improvement in one's environment and sense of control may result in significant gains in quality of life. In health promotion research, self-reported quality of life is often the measure that shows the greatest gains.

III. Projections for the Future

Four certainties must be kept in mind when planning for the health and well-being of our older population:

1. The Senior Boom. The sheer numbers of older adults in our country and the trend toward an ever-increasing senior boom will mean that the health concerns of this age group will dominate our health care system for years to come.

2. The Chronic Care Boom. As adults grow older, chronic conditions such as arthritis, high blood pressure, osteoporosis, and heart disease become more prevalent. More than four out of five people aged 65+ have at least one chronic condition. Multiple conditions are commonplace, especially among older women.

The health concerns for most older adults, therefore, focus less on cure and more on maintenance, management, and coping.

3. *The Health Care Bust.* Our current health care system is well-equipped to deal with acute care needs, but less equipped to help seniors with their chronic care concerns. In some cases, the health care system makes heroic efforts to sustain people near the end of life, but does relatively little for them when they are coping daily with chronic conditions. A better investment of time and money should be made to improving one's quality of life.

4. *Promoting Health is a Critical Investment in an Aging Society.* Measures taken today to promote child and young adult health will yield enormous dividends in the future. Health promotion and disease prevention should be embraced as strategies to increase the well-being and health of Americans of all ages.

Because well-designed health promotion programs improve health, prevent health problems, reduce health care costs, and help people cope with chronic conditions, they are a good societal investment and should be extended to all Americans.

Clearly, the greatest responsibility for personal health rests with the individual. However, without a sense of empowerment and access to resources, many individuals are unable to take advantage of the benefits of health promotion. The government's role in health promotion includes four main areas:

1. *Dissemination.* Through continued funding of programs such as Title III-F

of the Older Americans Act, health promotion activities can continue to be offered to older adults on a local level. Guidelines for such programs need to be expanded to embrace the broader definition of health promotion, including chronic illness management, medical self-care, medical consumerism, and shared medical decision-making. Special efforts must be made to make health promotion available to all older Americans, especially high-risk and underserved populations, including minority, rural, inner city, and disabled elders. Additionally, coordination between the federal Administrations on Aging and Children, Youth and Families, in conjunction with the Centers for Disease Control and Prevention, and the National Institutes of Health could yield new avenues to promote health and prevention among all ages using existing structures.

Good, sound information about health, health care and medical choices needs to be disseminated. The government's role should include ensuring that all older adults have access to good information about their medical conditions and their options for care.

2. *Research.* The medical research agenda in aging must be expanded to include evaluation of what older adults can do for themselves. Research focused on the effectiveness of health promotion programs should receive the same attention as research on the outcomes of medical procedures. In addition, more basic research is needed to determine what influences older adults and young people to change their health behaviors. Research is also needed to identify risk factors for disability and to determine if interventions known to be effective in younger persons are equally effective in reducing

risk in older people.

3. *Reimbursement.* Restrictions on Medicare and other health insurance plans often prohibit the reimbursement of health improvement programs even after cost-effectiveness has been proven. Regulatory flexibility is needed to allow both experimentation and implementation of programs that both improve health and reduce costs.

4. *Environment.* Clean air and water, crime prevention, safe highways, protected food supplies, safe places to walk, run, or relax are all needed to promote the health of Americans.

Beyond the issues of financing, delivery, and direction of health promotion for older adults lies the greater issue of rediscovering and supporting the potential of age. For younger persons, the greater issue is maximizing potential for a long and healthy life and understanding the role individuals play in their own healthy aging. The goal of health promotion is not solely to save some money here or to prolong a life there. Rather, the purpose of health promotion is to help each person reach his or her potential as an individual and as a member of society during each stage of life.

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

ACCESS TO QUALITY CARE

I. Overview of Major Issues and Policy Considerations

Access to quality care including both community and institutional long-term care must serve as the foundation for any discussion of comprehensive health care for Medicare beneficiaries. This paper discusses issues concerning access to quality care with a focus on the barriers impeding both access and quality. Policies that reduce these barriers and increase the accessibility and the quality of care for the aging population in the United States should be considered.

The traditional barriers to access to care for the elderly include structural barriers such as:

- cost or co-payment problems,
- transportation difficulties,
- appointment scheduling problems, and

attitudinal barriers such as:

- ageism that redirects scarce resources away from the elderly in need,
- ageism that incorrectly attributes health problems to advancing age.

Cost or co-payment problems

At present, approximately 93% of people out of the work force and over age 65 are covered by Medicare, the federal insurance program for hospital (Part A) and physician and related services (Part B) for Social Security beneficiaries. Although this high coverage rate is encouraging for access, Medicare neither covers all health care (custodial long-term care is one glaring omission) nor

provides first dollar coverage for the services it does cover (except in certain HMOs). In 1990, the last year of available figures, it was estimated that the average Medicare enrollee had an out-of-pocket liability of slightly more than $1,000.00 for health care. Others have estimated that older people are now spending a greater proportion of their income on health care than at any time since before the implementation of Medicare. Therefore, while the coverage rates for Medicare should be praised, the costs and co-payments are not and may again be a barrier to access to quality health care.

Transportation difficulties

Problems concerning transportation also can present barriers which may impede access. Admittedly, self-reports of the frequency with which older people forego seeing a doctor because of transportation difficulties were only about 3% in a 1985 study.

Appointment scheduling problems

Difficulties concerning scheduling of appointments and delays in waiting rooms are also considered to be traditional barriers to access. However, given the strong supply of physicians and nurse practitioners in the U.S., only 3% of the elderly reported scheduling problems as a barrier to access in a 1985 study.

Ageism that redirects scarce resources away from the elderly

During times of abundant resources, there is enough for all. However, during times of scarcity or unwillingness among the payers of health care (which seems to be the case for health care during the last decade of the twentieth century), some mechanism for rationing the scarce resources is required. Rationing health care

based on the ability to pay is always decried but unfortunately is nearly always present as well. People willing to pay a premium and/or willing to pay cash are often able to get health care services immediately, with the exception of some transplant organs which are regulated and restricted. Rationing on the basis of age of the recipient has also been proposed and generally decried. But some rationing on the basis of age does exist. Rationing on the basis of the cost of the health service itself has also been proposed. Some procedures—such as bone marrow treatments—are simply very costly at this time, and many third-party insurers attempt to avoid authorizing these procedures. All these forms of rationing—by ability to pay, by age, by cost of the procedure—need to be examined explicitly. Perhaps in an ideal world rationing would not be necessary; in the United States at this time rationing does exist. The challenge is to be explicit and fair in the approach, while maximizing access to quality health care. In this context intergenerational interdependence must be recognized and respected.

Ageism that incorrectly attributes health problems to advancing age

Both older people themselves and health care providers unfortunately can hold the ageist belief that health problems can be due to advancing age. Pathologies cause disease, advancing age does not. Advancing age may restrict the body's normal mechanism to overcome disease and advancing age may restrict the reserve capacity of the person to respond to external or pathological threats, but advancing age does not cause disease or health problems. Diseases cause health problems, and state-of-the-art medical treatments can be brought to bear on diseases in people and patients of any age. Certainly some of the probabilities of a favorable outcome may be reduced in an older person (in all likelihood because of the diminished reserve capacity), but treatment is always an option. Nevertheless,

one in eight—12%—of people over age 70 in Massachusetts reported that sometime during the previous year they did not seek medical care when they really thought they should just because they figured the health problem was really due to their age. When one out of eight fails to make the initial contact because of an attitude that is essentially agist, the best medical care in the world can not be effective.

Let us consider another example of attitudinal barriers to access, namely the case of urinary incontinence (UI). UI affects up to one-third of community living elders and slightly more than half of the institutionalized elderly. Clinical experts have judged that current medical treatments could cure or ameliorate the symptoms of approximately one third of those with UI. But in order to receive these current medical treatments, the patient and the physician must talk about the problem. A recent study undertaken by a team of researchers in Massachusetts suggests that such discussions do not occur often enough. Of 1,140 randomly selected respondents aged 65 years and older in two counties in Massachusetts, approximately one in four reported that they leaked or actually lost control of their urine sometime during the previous 12 months, while one in ten reported that they lose control of their urine at least once a week. The length of time these elders reported they had UI varied; about half (48%) reported they had their problem for a year or less, one-quarter (25%) had UI for about two years, a little less than one-quarter (22%) had UI for three to ten years, and 5% reported they had UI for more than ten years. When asked if they had ever discussed their UI with a doctor or nurse, less than half (47%) reported they ever had. Of the 53% who had discussed UI with their doctor or nurse, most had a discussion with the last six months (62%) but nearly one in five (18%) last talked with their doctor or nurse about UI two or more years ago.

Access to quality health care requires an encounter between patient and doctor, and a discussion about the important health conditions. Encounters occur as evidenced by the fact that nearly nine out of ten people 65 years of age or older report at least one doctor visit during the previous year. However, the Massachusetts data cited previously seem to indicate that the appropriate discussions within the encounter do not always occur.

What role or responsibility does the health care provider share in initiating discussions about sensitive topics such as UI during an encounter? Among primary care physicians, urologists, and gynecologists responding to a survey in the same Massachusetts UI project, almost one-fourth of the physicians (23%) reported that **no** elderly outpatients had volunteered during an encounter in the last month that they had UI. In fact, 97% of these physicians reported that only one in ten or fewer outpatients 65 years of age or older volunteered during the last month that they were having problems with UI. Did these doctors therefore initiate discussions about UI? The proportion of patients with whom physicians reported initiating questions about UI tended to be large among urologists and gynecologists (about three out of four of these doctors reported asking about three-quarters or more of their patients about UI) but distressingly small among primary care physicians (only one third of primary care physicians reported initiating such discussions with three-quarters or more patients, while 41% of these primary care physicians reported initiating such discussions with one in ten patients (including none).

Even if current treatments can cure or alleviate up to one-third of the existing UI problems, patients and physicians need to take steps to initiate appropriate discussions during their health care encounters in order to trigger the treatments.

Additional factors influencing the attitudinal barriers to access

Sociodemographic factors seem to play an additional role in creating these attitudinal barriers to access. Results of one study suggest that characteristics such as age, sex, income, education level, living arrangement, perceived health status, functional level, and morale are all related to perceived barriers to accessing health care. For example, older people with lower self-perceived health status were more likely to attribute their health problems to age and were also more likely to report perceived cost and transportation barriers. Reporting transportation barriers was also found to be associated with being female, living alone, and having less education. What are the underlying mechanisms that might explain these findings?

We live in a society in which stereotypes, perceptions, and fears play an instrumental role in shaping behavior, a society in which information can be a powerful tool for survival. The impact of these factors cannot be ignored when searching for the root causes of barriers to access to care for the aging. The elderly as a group typically have been subject to negative stereotypes. These negative stereotypes not only affect the way that members of society view the elderly, but also affect the way that elderly individuals view themselves and each other. These views in turn shape the behavior of the elderly and affect how their behavior is received by others. The potential influence of negative stereotypes of the elderly on access to quality health care is sobering.

Cultural stereotypes of facilities may also play a role in access to quality care. Consider for example the possible consequences of a negative stereotype of nursing homes. The concept of nursing homes potentially brings to mind the stereotypical image of an immense, institutional facility where people are left to be forgotten and die. If an elderly person is at all influenced by this negative

stereotype, he or she might delay or fail to seek treatment out of fear that he or she might be placed in this perceived negative setting. It would be impossible in this paper to discuss all of the examples of stereotypes which factor into the construction of barriers to access, however, even these few examples demonstrate the potential magnitude of this pervasive problem.

There are many fears associated with aspects of aging, fear of getting older, fear of pain, fear of losing one's mental capacity, fear of dependence, fear of financial loss, as well as more general concepts such as fear of change and fear of the unknown, just to name a few examples. All these fears, combined with negative cultural stereotypes and attitudes, coalesce to create and perpetuate the attitudinal barriers to access to care for the aging. No one is immune to these influences, not doctors, not family members, not even policy makers. The continuing power of these factors is based largely in ignorance. Without sufficient alternative sources of information which contradict extreme stereotypes, individuals have no incentive to test and restructure views and behavior. To refer back to the nursing home stereotype as an example, if an elderly person were to be exposed to alternative information which contradicts the negative nursing home stereotype, the fear of being placed in a nursing home might be lessened, thereby freeing the individual to seek needed treatment. Obviously, information alone is not going to rid society of all the pervasive fears and stereotypes. The solution needs to be multidimensional. However, increased exposure to information is an essential step in combatting the controlling influence of these constructs as barriers to access to care for the aging.

Quality concerns

Assuming that elderly individuals manage to overcome the structural and attitudinal barriers to access and actually obtain medical care, the focus then shifts to the quality of care that these individuals receive once they enter the system. Traditionally, the conventional wisdom has been that the main barriers to quality care for the aging revolve around undercare. As a result, physician and health care providers in general respond to quality problems with a "more is better" mentality. Unfortunately, this approach has created a health care delivery system which is polarized in terms of quality, with problems related to undercare at one end of the spectrum and problems related to overcare at the other end. How do issues of undercare and overcare present barriers to quality?

Undercare. One of the major barriers to quality is a lack of communication and coordination among caregivers concerning the health and treatment status of individuals. This deficit creates a climate in which the needs of aging patients can fall through the cracks of the health care delivery system. A second related factor involves a lack of central access to medical information on patients. Without access to medical records and patient history and status information, care providers are forced either to order and wait for duplicative tests and procedures or to make uninformed decisions concerning the appropriate treatments. Furthermore, collection of patient encounter data for Medicare beneficiaries in managed care organizations is not mandatory. This creates a significant obstacle to monitoring, accessing, and improving the quality of care provided to older adults. A third related factor involving undercare is a lack of focus on effective transitioning of patients between acute and long-term care facilities and from care facilities into the home. This problem results in inconsistency in the quality of care patients receive

and allows for the possibility that progress made in one setting could be negated in another. The emphasis in typical fragmented care seems all too often to be on treatment for the moment, without sufficient coordination of treatments between settings and across time. These barriers to quality brought about by a lack of consolidated information, communication, and coordination appear to be basic problems inherent in a health care system which fosters a highly segmented approach to care.

In addition, as a growing number of older and other Americans obtain health care services through managed care plans, more attention will be needed to the quality and quantity of care provided. Recent preliminary research has revealed severe quality care problems for the elderly enrolled in several HMO's.

Overcare. The barriers to quality care which revolve around undercare present valid hazards for elderly patients. However, it is essential to remember that issues involving overcare require attention as well. Although barriers to quality involving overcare produce different problems than barriers involving undercare, many of the mechanisms at the source of these barriers are the same. For example, the lack of communication and coordination among care givers concerning the health and treatment status of patients also plays an instrumental role in constructing overcare related barriers to quality. One possible ramification of this deficit might be the use of duplicate or incompatible treatment approaches. The lack of central access to patient information also factors into barriers related to overcare by allowing for potential problems such as polypharmacy.

The quality of care that aging patients receive is also affected by the lack of

alternative types and levels of care options currently available. This lack of alternatives can lead to overutilization of inappropriately comprehensive care facilities such as nursing homes and hospitals. Overutilization of these facilities is in no one's best interest because it can result in multiple and or unnecessary treatments for aging patients and can unnecessarily waste scant resources in the process.

Overutilization can also result from family members' unwillingness or inability to provide the support needed to care for their elders. Elderly individuals, facing a lack of family support, may attempt to compensate for this lack of support by unnecessarily utilizing care facilities. These examples convey that overcare barriers to quality require as much attention as undercare barriers when addressing ways to increase quality levels.

Iatrogenic problems. In a discussion of the barriers to quality care there is yet another dimension of overcare that merits attention, namely iatrogenic disease, illness, or conditions. Iatrogenic problems can be defined as illness resulting from diagnostic procedures, treatment measures, and injurious occurrences that are not due to the natural progression of the patient's condition. Examples of potential iatrogenic illness include preventable decubitus ulcers (bed sores), predictable adverse drug reactions, urinary tract infections from catheters, injuries incurred from some falls, and hospital-triggered acute confusion states. The elderly are subject to increased risk of developing iatrogenic problems because their frailty and reduced reserve capacity may make them more susceptible to complications. Iatrogenic illness in a university hospital setting affected 36% of 815 consecutively admitted patients in a general medical service. Factors such as age, drug exposure,

and length of stay were all found to be related to onset of iatrogenic illness. The same underlying factors identified as barriers to quality care create a climate in which iatrogenic illness thrive. Without adequate communication, coordination, and access to information care providers run the risk of over responding to patients needs concerning some aspects of care and neglecting patients needs with regard to other aspects.

Conclusions

These factors combine to place the elderly in a tenuous position. That is, often elderly patients are most in need of quality care due to the complexity and multiplicity of their care needs, yet they are often the least equipped to assert their rights to that care. Add to that a possible lack of family support and you have a sub-population of frail elderly patients with complex care needs left to navigate a confusing health care system alone.

The following are approaches that attempt to get at the root causes of barriers to access to quality care.Approaches to improve access to quality care include:

- automate and coordinate patient records across time and across providers,
- use care managers to facilitate a seamless continuum of care for frail elders,
- educate elders, the general public, and health providers to overcome negative stereotypes of both elders and some care systems for elders.

The key to combatting barriers to access to quality care for the aging successfully seems to revolve around taking measures to create a seamless continuum of care. One of the first problems that needs to be addressed in order

to facilitate creation of this continuum is the lack of central access to information concerning patient history and medical status. Although the technology exists for automated patient records, in general, care facilities are still relying upon hand written patients charts, with their demonstrated inefficiencies. One study found:

- A patient [hospital] medical record is unavailable for 30 percent of all clinical encounters.

The average patient [hospital] record, weighing 1.5 pounds, makes finding specific information difficult and time consuming.

- 70 percent of inpatient medical records are incomplete at time of discharge.

- 11 percent of all laboratory tests are reordered since results are unavailable at time of discharge.

- At any one time, as many as 22 different people within a hospital setting may need access to an individual patient record.

- Physicians spend an estimated 38 percent of their time writing patient charts.

- Nurses spend up to 50 percent of their time writing patient charts.

Elements that will require attention when formulating plans for computerized patient records include: usability, uniformity, reliability, accessibility, confidentiality, cost effectiveness, in addition to consideration of exactly what

information to include.

A second approach to creating a seamless continuum of care could involve developing the role of a care manager into the health care delivery system. Someone must be made responsible for each elderly patient to ensure that all of the patient's needs are being met, to facilitate facility transitions and family involvement, and to coordinate treatment approaches across time. It is a common belief that this type of managed care approach necessitates invoking a capitated method for financing care. However, it is important to note that the traditional fee-for-service (FFS) approach is not inherently incompatible with managed care. It merely dictates that managed care mechanisms such as a care manager/advocate need to be included on the list of services covered by FFS payments.

Third, educational efforts also could play a role in addressing access to quality care for the aging. Steps need to be taken to heighten patient/caregiver awareness of approaches to care, payment options, available resources in the community and in health care settings, and special needs and rights relating to elderly health care. Attempts at furthering the education of care providers is also warranted, with a focus on highlighting the characteristic special needs of the aging population, and on increasing understanding of the potential ramifications of various diagnostic and treatment procedures. Increasing the dissemination of health care information will also serve to undermine the influence of negative stereotypes and fears on access to quality care for the aging.

Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

CONTINUUM OF CARE INTEGRATING COMMUNITY & SOCIAL SERVICES

I. Overview of Major Issues and Policy Considerations

Maintaining Health

Older people are living longer. However, people do not want to live in pain, ill health and dependence on others. They want to be healthy enough to stay in their own homes and remain engaged with their families and communities or enjoying the lifestyle they have chosen for their retirement years.

Most people think of the goals of health care as treatment and cure of disease or repair of injuries. For older persons with chronic illness or disability, a cure or reversal of the effects of illness may not always be possible. Yet it is reasonable to pursue health care goals which will enable older persons to live where they choose, and to conduct their daily lives in their customary manner, with whatever help is needed to support their choices. Good health care can reduce mental and physical illness, pain and disability among older persons, and can reduce the differences in health and life expectancy between different ethnic and economic groups.

Effectively managing medical care in complex cases requires practitioners who are knowledgeable about age-related conditions and care. The appropriate use of prescription drugs, for example, can improve well-being of an older person, but misuse of medication can contribute to declining health, accidents and debilitating

hospitalizations. The diagnosis and treatment of mental health and alcohol problems of the elderly can result in improved health and independence of older persons and reduced health care costs. Improved nutrition and accident prevention can also reduce the need for hospital and long term care. On the other hand, the barriers of cost may prevent older persons from obtaining well-managed care, or from following prescribed courses of medication or diet.

Access to the right kinds of health care may be restricted by a lack of appropriate providers, lack of affordable transportation to care, and how much government and private insurers pay for different kinds of care.

Long Term Care

Long Term care is a set of health, personal care, social services needed by people who have lost some ability to carry out the essential activities of daily living. Long term care can be provided in a variety of locations, including a house or apartment, day center, group residential home, or nursing home. Most long term care is provided by spouses or other family members. A sometimes confusing variety of providers delivers a range of services, doing for older people the tasks they can no longer do for themselves.

One way of describing long term care is passage along a "continuum of care" over time from less intensive, less restrictive service and settings, to more intensive, more thorough care which does most things for the person.

Another concept of long term care is to offer "consumer choice" from a range of service options which could meet the individual needs. Variety, flexibility

and even competition in the array of services available, allows for individually-tailored care arrangements which respond to personal preferences and encourage the use of family and environmental support, such as housing modification and equipment. The goal envisioned in these home and community-based care systems is "aging in place," that is, bringing the service to the individual where they live or spend most of their time.

Most money for long term care is now spent for institutional care and often cannot be used for other arrangements in a continuum of care or for aging in place. Health care funds generally cannot be used for the most essential services needed by older persons, except in institutions. Other public funds support a fragmented and uneven assortment of community and in-home services, and other needy populations compete for the same resources. The fewest services are directed toward family caregivers, and just getting good information and advice at the right time is often difficult for spouses and relatives.

Long term care is confusing and disorganized. It is generally expensive. Its reimbursement has been biased in favor of using nursing homes and other institutions. Long term care, and health care more broadly, can make it possible for older persons and their families to remain in control and responsible for their day-to-day living, but current financing and policy barriers encourage higher cost nursing home care and greater dependence. Older persons also need the knowledge and authority to have greater control over decisions about care and treatment, especially at the end of life.

II. Assessment of the Current Situation

Between 1950 and 1990, death rates for those age 65 to 84 fell by one-third. The over age-85 population is the fastest growing in the nation, and this group is made up of the greatest users of health and long term care. Currently, while women live longer than men, the amount of time they live free of limitations on their daily activities is about the same as for men.

Among the conditions most often associated with disability and hospitalization are heart disease, falls and fractures associated with osteoporosis, stroke and high blood pressure. Between 12 and 22% of older people have mental health problems, such as depression, which affect how they take care of themselves. Nutrition-related conditions affect 85% of the elderly, and contribute to unnecessary hospital use.

At least three out of five persons needing long term care are elderly. Half of the frail elderly in need of long term care are near the poverty threshold (150% of poverty) and are most often widowed women. More than one-fifth of the over age 85 population resides in nursing homes. Two-thirds of the long term care provided in the community is provided free by spouses and other relatives or friends. Among the most disabled elderly, about half use paid help to get along at home and in the community. Studies have shown that family help is not withdrawn when formal (paid) services are provided.

Although surveys repeatedly demonstrate a preference among older persons for home and community care, most public funds (as well as private insurance) are spent on institutional care. The Urban Institute estimates that in 1993, $108 billion

was spent on long term care: $75 billion for nursing home care and $33 billion for home based care. Government spends nearly $10 in nursing homes for every $1 in home and community care.

A recent General Accounting Office (GAO) study of three leading states with case-managed home care programs showed declining public expenditures on nursing home care, and average costs for home care which were consistently lower than institutional care. Yet only a few states have been able to structure long term care to give consumers a choice between home, community-based or institutional care. Nursing homes remain the largest and growing expense in the Medicaid program nationally. Nursing home care also represents the largest out-of-pocket expenses for older citizens. There are still few alternatives.

Resources

The organization and delivery of health care to the elderly has been largely determined by the private health care industry, with the federal Medicare program playing a significant role in paying for universal access to doctor and hospital care. The cost of prescription drugs exceeds an average out-of-pocket expense of $500, which is not paid by Medicare. The high cost of drugs for some individuals can be catastrophic. At the same time the misuse of prescription drugs is said to account for as many as 25% of nursing home admissions.

Long term care is the major uninsured expense for older persons. At an average annual cost in excess of $30,000, nursing home admission can be a catastrophic event for older persons of modest means, especially if a spouse remains in the community with an obligation to pay for most of the care. Of the

$59.9 billion spent on nursing home care in 1991, nursing home residents and their families paid $25.8 billion. Medicaid and Medicare spending for nursing homes amounted to $28.4 billion and $2.7 billion respectively. Private insurance paid $600 million.

Home and community care is also a major expense. Older people paid for about 12% of their home care ($1 billion). Medicare paid $4.4 billion, and Medicaid paid $1.4 billion for home **health** care.

Because most long term care consists of assistance with essential daily tasks, most necessary services are outside the scope of home health care. The most commonly needed services include:

- personal assistance with bathing, toileting, dressing, eating and transferring from bed to wheelchair;
- home modifications and adaptive equipment;
- housekeeping and chores;
- food purchase and preparation;
- arranging for social, physical and intellectual activity to maintain abilities;
- transport to medical care and services;
- monitoring health status and managing medications.

These services can be provided at home, in senior centers or day health programs, in apartment buildings, in group living arrangements, in nursing homes, or using some combination of settings, depending on individual needs.

Individual assessments and care plans are the most reliable way to define the

types, settings and amounts of help each consumer needs and prefers. State and Area Agencies on Aging and some community-based providers offer the assessment and care planning help in most states, at least for some low-income older persons. However, the major funders, Medicare and Medicaid, pay for few of these services outside of nursing homes, so consumer choice is limited by financing policies.

The complexity of identifying and arranging health and long term care services for frail older persons is daunting for public and private paying consumers. Some communities have organized "one-stop-shopping," or "aging resource centers" to provide information and assistance and care management for families and older persons. Such arrangements are not widely available, however, as they are dependent on the limited funding available from the Older Americans Act (less than $1 billion for all services) and special Medicaid waivers managed by states. The absence of information and advice about alternatives makes nursing home care, with its comprehensive range of care, the most convenient form of care for families in crisis; this may overcome cost and other considerations. The predictability of Medicaid for nursing home care, after private funds are expended, also makes nursing homes more attractive in some cases than home care, with its uncertain public funding base.

III. Projections for the Future

Assessment of Resources to Meet Needs

Rising cost and demand are an unavoidable demographic and economic reality. The cost of health care for all age groups is projected to pose a serious threat to our national prosperity. The increased number of older persons will require increased care. Just in the area of long term care, the cost of nursing home

care is expected to rise from a 1993 total of $75 billion to $168.2 billion in the year 2018 in constant (1993) dollars. The Brookings Institution projects that users of nursing homes will increase from 2.2 million to 3.6 million; users of home care from 5.2 million to 7.4 million.

The role of family caregivers other than spouses cannot be expected to remain as high given the necessity for women to be in the paid workforce, the decline in the number of children in each family, and the movement of families away from the communities in which their aging parents reside. The increasing reliance on paid care, and worker shortages, may contribute to a necessary rise in wages and benefits, which means an increase in overall costs of care.

Only a small percentage, perhaps 20%, of the population can be expected to afford lifetime savings or insurance premiums adequate to fully protect the family from the escalating costs of long term care. However, the current public system which requires institutionalization and poverty to qualify for help from Medicaid, exacts a harsh penalty on consumers and their spouses not found in other sectors of health insurance.

Other financing systems have been proposed to enable citizens to insure for the some of the cost of long term care at the level of their ability to pay. Citizens can then expect to pay out-of- pocket (or out of savings) for remaining, uninsured cost of the long term care services they ultimately use, based on how much they can afford, with government subsidies for the rest.

Public costs can be minimized by expanding systems of pre-admission

screening and case management in long term care, to carefully assess needs and to arrange the most consumer-centered, cost-effective services to accommodate different needs and different locations of long term care. The development of innovative services and technology can also reduce costs.

"Assisted Living" is increasingly discussed as a residential care option which costs less than nursing homes. The definition of Assisted Living remains vague - ranging from private apartments with services to maintain independence, to large "group homes" which are fairly institutional in character. Some of the most desirable models, which encourage autonomy and privacy, are priced beyond the means of most older persons. Restrictions on the amount of nursing and personal care provided often result in relatively short lengths of stay before older persons must move. Development of assisted living models which are affordable and encourage "aging in place" holds promise for the future.

Other areas for future service development include: wider availability and lower cost for housing modifications and adaptive equipment for persons with disabilities; more innovative and affordable options for 24-hour care at home; a greater variety of day time programs for disabled older persons; programs to reduce the isolation, loneliness and boredom of homebound older persons; more cost-effective approaches to health monitoring and medication management for homebound older persons, and wider availability of daily home-delivered meals.

The development of innovations in nursing home care, as well as limitations on overuse of institutions, are a necessary strategy for the future. The replacement of aging facilities creates an opportunity for new design concepts that offer greater

privacy, encourage more self-sufficiency and mobility, and maintain mental and physical well-being. At the same time, the use of some nursing homes can be redirected toward more effective and age appropriate rehabilitation in the community.

Most recommendations for the future of health care for the elderly project increases in Medicare expenditure based on the growth of the population, and presume that costs can only be reined in by improving preventive health care, the management of complex health conditions, and restraints on the costliest sectors of the health system.

In long term care, the growth of the population in need of care is the most dramatic change expected on the health horizon. Reform and adequate financing of the system of long term care will include more individualized and cost-effective service arrangements; a flexible array of provider options; care management which is aimed at responding to consumer preference in the most cost-conscious ways; mechanisms for citizens to plan and save for their future care needs; and advice and assistance to families and older persons to organize and purchase care when they need it. Close coordination and planning at the community level will be necessary to assure that there is continuity across the spectrum of services from prevention and primary care, through acute care, and into long term and terminal care.

Autonomy and self-reliance are prominent values in the emerging concepts of health and long term care. Personal responsibility is a prominent theme in the discussion of public policies. Younger citizens can only be expected to save or insure for long term care if there is a simple and financially sound way to do so.

Demands of financing education, the increasing difficulty of home ownership, and the costs of health care for younger families are all barriers to exclusive reliance on private savings and insurance to finance care. Some combination of public and private financing may be the most feasible. Older persons with modest resources also would benefit from cost-sharing arrangements which combine private, public and personal financing of care.

Planning for future health and long term care needs on a national or personal level requires clear goals. Older persons most often express the preference for assistance to remain at home and interdependent with families and community. Older persons express the desire for privacy, self-sufficiency, affordability, simplicity, safety and comfort. Consensus about these goals is a first step toward restructuring the continuumof care services and funding to achieve what citizens want at a price we can all afford into the future.