Martin O. Weddington Papers.

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Version 3
August 20, 2018

The 'notch'

Divisive Social Security issue may be decided this year/**3**

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Martin-
Thanks for taking time to tell me about your involvement with the "Notch" issue. I really enjoyed our visit! Perhaps the story many contain some information you might not already know.

-Doug Hanneman

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March/April, 1991

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Advocates defend equal-rate law

1976 law guards nursing-home residents from discrimination

A Minnesota law that protects nursing-home residents from financial discrimination should not be changed, even to help ease the state's current budget dilemma.

That's what elderly advocates are telling state lawmakers, who are under pressure from Gov. Arne Carlson to cut nursing-home spending despite claims of financial stress by many of the homes' operators.

Advocates argue that the Nursing Home Rate Equalization Law helps preserve private-paying residents' assets, and ensures that those on Medicaid receive equal consideration in nursing-home admissions and care.

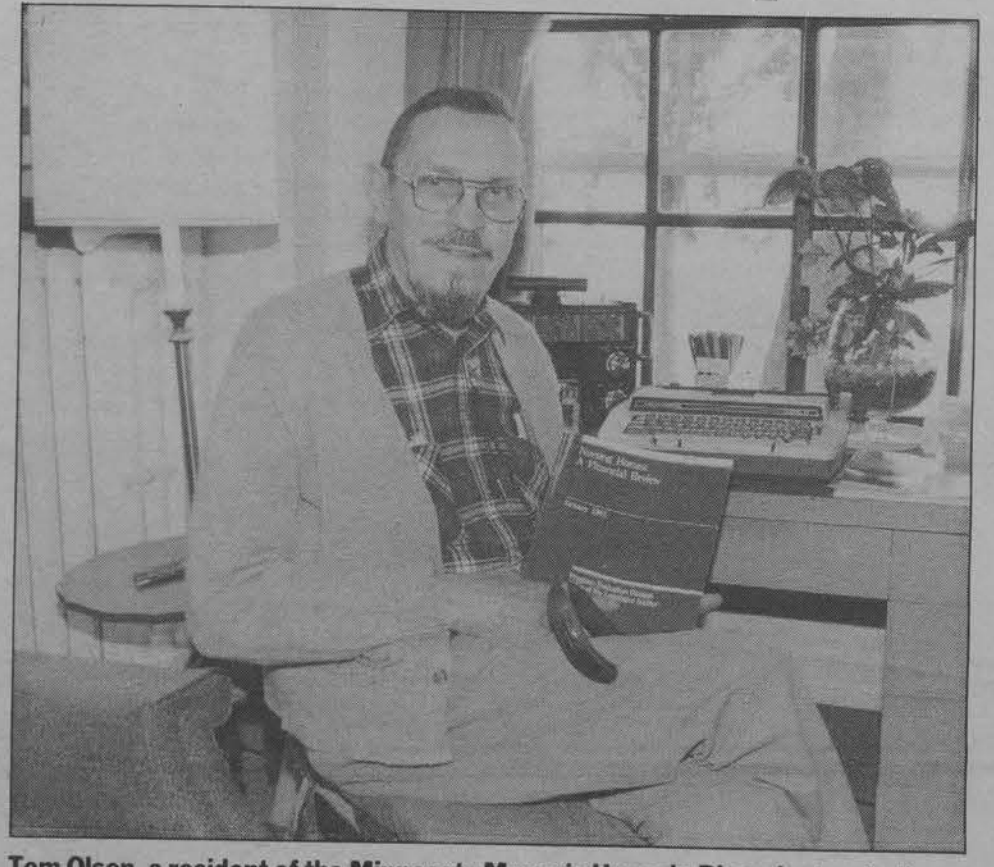
Without it, "certain facilities would bend over backward to admit only those people who can pay on their own," claimed Tom Olsen, a resident of the Minnesota Masonic Home in Bloomington.

Even slight changes in the law could hurt thousands of Minnesotans needing nursing-home care, the advocates argue. "My feeling is that it should be kept the same," said Olsen, who is on the board of directors of the Minnesota Alliance for Health Care Consumers, a nursing-home residents' advocacy group.

Support for the law is also being rallied by the Minnesota Senior Federation, the Minnesota Board on Aging, the American Association of Retired Persons and other consumer groups.

Enacted in 1976, the law forbids homes from charging private-pay residents more than those on Medicaid. North Dakota is the only other state to have a similar law.

Recently, some nursing-home operators and others have suggested changing the law in order to bring additional dollars into the industry.



Tom Olsen, a resident of the Minnesota Masonic Home in Bloomington, believes nursing-home residents would be harmed if state law were changed to allow homes to charge higher rates to private-paying residents.

"It's the only law that has ever worked to eliminate the problem of Medicaid discrimination in nursing homes."

-Jim Varpness

The idea has also attracted the attention of some lawmakers who don't want to see further increases in state payments to nursing homes.

Consumer groups warn that changes would lead to Medicaid discrimination. Threats to the law are already surfacing, they claim.

The first sign is a recent state Legislative Auditor's report, which recommends that the law be analyzed to determine if it saves the state money, or costs more.

Reevaluating the law solely as a public-cost issue alarms Iris Freeman, executive director of the Minnesota Alliance for Health Care Consumers. "Our organization is horrendously troubled by that suggestion," she said.

Yet an even more serious threat, according to the advocates, comes from one of Minnesota's two nursing-home trade groups. Care Providers of Minnesota, which represents 240 of the state's 440 long-term care facilities, has considered asking legislators to eliminate rate equalization during a resident's first 100 days in a home. The plan could be a financial boon for homes, since over 40 percent of residents stay less than 90 days and most are private-pay.

Though Care Providers recently tabled the proposal, the mere discussion of it worries advocates.

"I don't know if you can really have just a little bit of equalization," said Freeman. "It's probably like being a little bit pregnant."

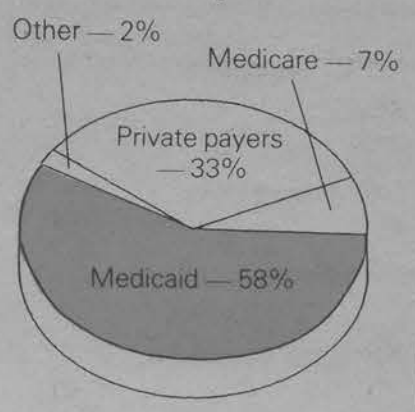
PLEASE SEE **LAW** ON **2**

NURSING-HOME FINANCING AT A GLANCE

Medical Assistance, known as Medicaid in most other states, is a federal-state-county program that pays for medical and health-related services for low-income people including a majority of Minnesota's nursing-home residents.

WHO PAYS

In 1989, Medical Assistance covered 58 percent of Minnesota nursing-home residents, and Medicare, 7 percent. One-third of residents paid for their own care, while others including insurance companies and health maintenance organizations, covered the remaining few.



Source: Minnesota Legislative Auditor's Office

INSIDE

Other stories inside relating to long-term care:

Bush delays calling 1991 Conference on Aging

WASHINGTON WATCH
Federal Policy and Older Minnesotans

The 1991 White House Conference on Aging, a once-a-decade opportunity for Americans to tackle elderly issues in the national spotlight, appears to be on hold.

The decision to call the conference belongs to President Bush, who was given that authority when Congress reauthorized the Older Americans Act in 1987.

But to date, no call has been issued, which has caused some elderly advocates to question whether a White House Conference on Aging will be held this year.

"I really doubt that it can happen in 1991 because it takes so long to plan," said Gerald Bloedow, executive secretary of the Minnesota Board on Aging.

Because of the delay, some observers now believe the conference cannot be held before spring 1992, which would require further amendments to the Older Americans Act.

And with the president continuing to focus his attention on the Middle East, and 1992 being an election year, some advocates speculate that the conference will not even be held. "I would think that a White House Conference on Aging is not even on the back burner now," Bloedow said.

So far, the White House hasn't indicated whether a conference will be called. An admi-

PLEASE SEE **CONFERENCE** ON **2**

Good Age

March/April, 1991
Volume 10, No. 5

EDITORIAL POLICY
Good Age is published six times annually for older residents of the St. Paul area. Good Age strives for accuracy, fairness and balance as a source of news and information about laws and policies affecting older adults, health and social services, consumer issues, recreational activities and education.

OPINION PAGE
Opinions expressed on the "Opinion" page are intended to reflect a broad range of views and are not necessarily the views of Good Age or the Amherst H. Wilder Foundation.

LETTERS
Letters to the editor are welcome. Letters should be brief and legible and must include the writer's signature, home address and telephone number where the writer can be reached during daytime hours. Letters may be edited for reasons of space and clarity.

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LAW: Advocates oppose changes

Continued from page 1

Care Providers shelved the plan in February in order to concentrate its efforts on opposing a proposal by Carlson to cut $15.4 million in state Medicaid payments to nursing homes over the next two years. The group's new strategy may also include working with elderly advocates, said Dean Neumann, the group's public relations coordinator. "At this point, it hasn't been formalized but I think it's likely to happen," Neumann said.

According to Neumann, a reduction in Medicaid funding "would really be in the wrong direction. It really does have an impact on resident care."

Carlson's plan has also been criticized by the state's other nursing-home trade group, Minnesota Association of Homes for the Aging (MAHA). MAHA's communications director Jim Williams said the state would be backing off from its commitment to equalization if payments were reduced.

Equalization works, Williams said, because it "commits the state to pay for the cost of care in return for homes charging the same rates to Medicaid residents as they do to private-pay residents." Without that commitment, homes will be forced to find other revenue sources, he said.

Williams said the governor's budget "turns 180 degrees away" from the recent state Legislative Auditor's report, which claims that 40 percent of the state's nursing homes have been financially stressed in recent years. "The report very clearly states that legislators should not look at cutting funding to nursing homes, but should actually look at increasing it," he said.

Because state Medicaid funding is matched by federal dollars, a $15.4 million cut would actually mean a $61 million loss for nursing homes after private-pay residents' payments are factored in, Williams claimed. "If the state takes a dollar away, it really takes $4 away," he said.

Even in the face of funding cuts, advocates say they won't settle for any change in equalization. "It's the only law that has ever worked to eliminate the problem of Medicaid discrimination in nursing homes," said Jim Varpness, Minnesota's long-term care ombudsman.

Varpness called Medicaid discrimination "one of the top five major complaints of nursing-home residents all over the country." Thanks to equalization, the problem doesn't even exist in Minnesota, he said.

Several forms of Medicaid discrimination are found in other states, Varpness said. The most common type occurs when Medicaid recipients are passed over for nursing-home admission or service in favor of those who can be charged more.

Victims also include private-pay residents who deplete their resources and end up on Medicaid. For them, discrimination may include being tranferred out of a facility, or being denied readmission following hospitalization. Sometimes, private-pay residents are moved to "welfare sections" of homes after using up their funds.

Absence of equalization also forces private-pay residents to deplete their assets quicker, Varpness said. A recent national study estimated a 22 percent difference between rates for Medicaid and private-pay residents.

Grace Nelson, one of equalization's staunchest supporters, believes charging higher rates to private-pay residents is unfair. "Why should an individual be charged more just because he or she has more money?" she asked rhetorically.

Nelson got involved in the issue in 1975 after her mother had spent three months in a nursing home. "She was paying about $7 or $8 a day more than the resident in the next bed who was on Medicaid," recalled the 82-year-old activist, who has held leadership positions in the Minnesota Senior Federation/Metro Region and is on the Minnesota Board on Aging.

To defend equalization, Nelson has testified at legislative hearings and was a court witness when the law was challenged on grounds of price-fixing in the late 1970s. The law was eventually upheld by the U.S. Supreme Court in 1985.

Despite that victory, advocates say the battle over equalization appears far from over. Said Nelson: "This has been a long, long drawn-out fight."

CONFERENCE: Bush delays call

Continued from page 1

nistration spokeswoman would only say the matter "remains under consideration."

Advocates say White House Conferences on Aging are important because they help pave the way for major legislation benefiting older Americans. Previous conferences — which have met every 10 years since 1961 — led to such major initiatives as Medicare and Medicaid, elderly nutrition projects, and the abolition of mandatory retirement.

By most measures, past conferences have been large affairs. The last one, held in 1981, was preceded by thousands of community meetings and dozens of "mini-conferences" held across the country. The conference itself, in Washington, D.C., attracted more than 2,220 delegates including 43 Minnesotans. More than 600 resolutions were adopted relating to Social Security, long-term care, transportation and dozens of other concerns.

Public pressure on Bush to call the 1991 conference began mounting early last year and continued until Iraq's invasion of Kuwait, said Donna Cohen, an acamedic who was commissioned by the Federal Council on Aging to put together a conference plan.

"There was a lot of pressure building up during the summer but things changed Aug. 2," said Cohen, a professor of gerontology at the University of Illinois at Chicago. "The momentum was extraordinary in terms of phone calls and letters."

Members of Congress, including Minnesota Republican Sen. Dave Durenberger and Democratic Rep. Bruce Vento, are among those who have urged Bush to issue the call, and a resolution to that effect was passed last June by the House of Representatives.

Bloedow said a White House Conference on Aging can bring visibility to issues that normally don't get widespread attention. "Until you get answers on the national level, these issues aren't going to be solved. And a conference is a good visible way of doing that," he said.

Health-care access would likely be the major issue if a conference were to be called, Bloedow believes. Americans under age 65 would stand to benefit the most since most older people already are covered by Medicare, he noted. "It would have been a wonderful opportunity to do something intergenerational," he said.

Despite the administration's delay, Cohen remains hopeful that a conference will be called. The mushrooming significance of issues such as long-term care and education's applications in the field of aging make the timing right, according to Cohen. "My view is that this is the best of times to hold a White House Conference on Aging," she said.

White House staff have told Cohen that the question of calling a conference is not a matter of "not wanting to do it. It's an issue of whether it can be called and come off as a relatively small conference," she said.

Several states including California, Illinois and New Jersey have already held mini-conferences on aging, Cohen noted. "We did a lot of grass-roots work and heard a lot of Americans asking questions about our destiny with regard to the young and old. Intergenerational issues have been a theme rather than young versus old."

Ingrid Azvedo, who chairs the Federal Council on Aging, is also confident a conference will be held. She claimed the administration "has been very, very close to calling it" on two previous occasions, the most recent being just prior to the Iraqi invasion of Kuwait.

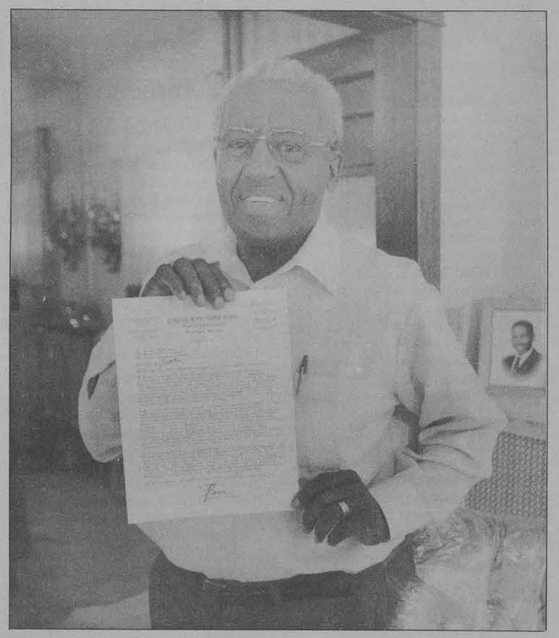
If the president decides to have a conference, she said the call won't come until everything is in place to handle the "thousands of phone calls that will automatically come with the release of the news of the White House Conference."

And if it is held, Azvedo believes measures must be in place to ensure that resolutions are carried out. That didn't happen after the last conference, she said. "We walked away with some wonderful resolutions but none of them were ever enforced."

Part of that problem could be avoided if groups represented at the conference put their self-interests aside, she noted. "I would like to see a united front that really wants to help this population."

Meanwhile, many advocates and policymakers are growing skeptical that a conference will be called. And just in case one isn't, a subcommittee of the House Select Committee on Aging is among those discussing alternatives to the forum.

'Notch' lobby continues battle over benefits



Martin Weddington holds a letter he received from Minnesota Congressman Bruce Vento, who supports legislation to raise benefits for those born in the Social Security "notch" years.

Martin Weddington remembers his disappointment and anger after applying for Social Security retirement benefits 11 years ago.

The source of his ire: a 1977 change in the Social Security benefit calculation formula. Because of the change, Weddington was told his monthly retirement checks would be smaller than those received by older retirees with similar job and earnings histories.

"It was a real shocker," the retired postal worker recalled. "I said to the clerk, 'You mean just because of my birthday I'm going to get benefits that are smaller than those received by people born just one year earlier?'"

Weddington has not been alone in his frustration. More than nine million Social Security beneficiaries born between 1917 and 1921 have been affected by the change. Of those, about six million, including 103,000 Minnesotans, are still alive.

Some have willingly accepted the disparity in benefits, commonly known as the "notch."

Other so-called "notch babies," including Weddington, have asked Congress to rework the benefit formula one more time. Lawmakers didn't intend for their benefits to be this small, they argue.

The issue has been a political hot potato for Congress. Most legislators have kept a low profile on the matter. Yet some, including Minnesota Republican Sen. Dave Durenberger, openly contend that the 1977 formula revision is generally working as Congress intended. A benefit increase to the notch babies, they claim, would only endanger the stability of the Social Security trust funds.

Weddington, 73, maintains that he's not asking for much — just a benefit check that's more on par with those received by older retirees.

Lawmakers sympathetic to the notch babies' cause have introduced dozens of proposals aimed at resolving the issue. Supporters have included the Gray Panthers, the Veterans of Foreign Wars, the Jewish War Veterans, the American Bar Association, and the five-million member National Committee to Preserve Social Security and Medicare.

Opponents complain that some notch groups, particularly the National Committee, have misguided millions of elderly into expecting benefits that aren't rightly theirs. "They've made a business out of the notch," said one critic.

Notch champions claim they only want what's fair. At congressional hearings in 1986, they cited the example of two sisters, one born in 1916 and the other in 1917. Though the two had nearly identical employment and earnings histories (both worked for the same employer during the same 25-year period), the difference between their monthly Social Security checks was $118.

The Social Security Administration says the notch is an issue of misunderstanding. "It's a matter of perception — the cup being half full or half empty," said Mark Faitek, manager of the St. Paul Social Security office. "People born in the notch years are saying that they get less than the people before them and really they're getting more than the people born after them."

Elderly advocacy groups including the American Association of Retired Persons, the National Council of Senior Citizens and the Minnesota Senior Federation have tried to keep the notch at a distance, despite having many members who support notch legislation.

"We have taken some heat for our position," said Peter Wyckoff, executive director of the Minnesota Senior Federation — Metro Region. Wyckoff said his organization has studied several notch proposals but determined that none were fiscally responsible. "In effect, they would perpetuate overpayments made by Social Security," he said.

Both sides agree on one thing: the issue is divisive. Said one elderly activist: "The notch is the abortion issue of senior citizens."

The issue has its roots in 1972 when Congress approved automatic cost-of-living increases for Social Security beneficiaries. But when the increases were enacted, a flaw in the formula caused benefits to soar, pushing the system toward bankruptcy. Without correction, actuaries feared that prospective retirees' monthly benefits would ultimately exceed their preretirement earnings.

To get the system back on firm financial footing, Congress in 1977 revised the formula and enacted a five-year phase-out period that gradually reduced the earnings/benefits ratio for those born after 1916.

By the end of the transition period, replacement rates — the ratio of a worker's preretirement income replaced by Social Security — were designed to level off at an average 42 percent. Those born from 1912 through 1916, commonly referred to as the "windfall babies," were allowed to continue receiving their unintended higher benefits, which average as much as 55 percent of their preretirement earnings.

Because of the changes, people born between 1917 and 1921 generally receive smaller benefit checks than those born during the previous five years who have similar work and earnings histories. Yet they also benefit from generally higher replacement rates than those born in 1922 and later.

Notch lobbyists argue that the 1977 revisions didn't work as Congress intended. The transition formula, they point out, didn't anticipate the double-digit inflation of the late 1970s and early 1980s. As a result, instead of reducing payments by five to ten percent over the five-year period, as lawmakers planned, payments have been as much as 20 percent lower.

A 1988 study by the government's General Accounting Office (GAO) confirms the notch groups' contentions. But it also shows that the 1977 revisions have generally worked as Congress intended by stabilizing replacement rates. And it shows that notch babies with the largest benefit disparities are retirees who tend to have higher incomes and more assets.

Despite the findings, notch lobbyists say their 12-year battle is hotter than ever. This year, instead of dozens of notch proposals before Congress, there is just one. Endorsement for the plan is being solicited from previous notch-reform supporters, including Minnesota Democratic Reps. Bruce Vento and Gerry Sikorski. The plan's House sponsor, Rep. Edward Roybal, D-Calif., says 135 members have already signed on. The Senate sponsor is Terry Sanford, D-N.C.

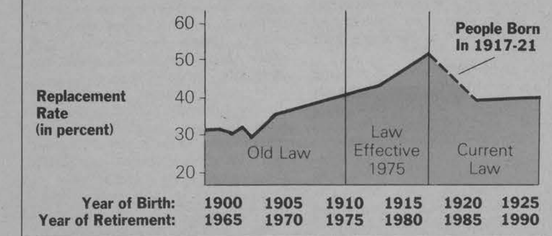
The proposal would extend the transition period by five years to include all beneficiaries born from 1917 through 1927. Those who retired at age 62 would receive an average $200 annual increase in their benefit. For those who retired at 65, the average benefit would increase $500 annually. Unlike previous bills, the proposal doesn't ask for retroactive payments. The plan would cost the Social Security trust funds about $4.5 billion annually during the first four years and less after that.

Notch lobbyists are optimistic about the bill. "Now we can say that everyone who wants to fix the notch has pretty much agreed on the way to do it," said Allen Johnston, director of grassroots action for the National Committee.

Meanwhile, many notch babies have grown tired of waiting for a resolution.

"I've become disillusioned and disappointed," said Weddington, who decided last year to quit sending money to a notch group. He also got rid of most of his literature on the subject, and throws out more when it arrives in the mail. Said Weddington: "It just stirs up the blood."

Social Security Replacement Rates* for Age-65 Retirees with Average Earnings



*A "replacement rate" is the ratio of a worker's preretirement income replaced by Social Security.
Source: Social Security Administration

Long-term care report stresses independence

A report recommending ways the state can help frail older Minnesotans stay in their own homes and out of nursing homes has been submitted to the governor's office.

Among other ideas, the report calls for statewide coordination of long-term care services, support for people tending to ill family members, and more funding for programs that enable older people to stay in their own homes.

The plan, known as the Seniors Agenda for Independent Living, is the work of the Minnesota Board on Aging and the state's Interagency Board for Quality Assurance. It was ordered two years ago by then-Gov. Rudy Perpich.

The 58-page report cites several factors that make aging and independence critical issues in Minnesota in the 1990s. Those factors include a rapidly increasing elderly population, spiraling long-term care costs, and a complex long-term care system that is biased toward institutional care.

Recommendations include better planning and more funding for at-home services

"Along with South Dakota and Nebraska, Minnesota ranks among the top three states in the nation in its reliance on institutional care for frail older persons," the report states. About 8 percent of Minnesotans age 65 and older are in nursing homes, compared to 5 percent nationally. "This bias toward institutional care exists despite the fact that most persons prefer to remain independent in their own homes for as long as possible."

The report predicts Minnesota will need more than 58,000 nursing-home beds — 8,000 more than are now available — if current state policies are not modified. State Medicaid spending for nursing home care will also soar, from approximately $226 million in 1991 to over $713 million in 2010.

Among the plan's 36 recommendations:

- Designation of a coordinating body for long-term care planning and administration in the state,
- Establishment of a system to provide consumers with information on long-term care services,
- Modification of state funding priorities to increase the emphasis on home- and community-based care,
- Changes in state policies to encourage less costly types of care,
- Expanded support for family caregivers through increased funding of respite-care programs and possible modification of tax codes to reward full-time caregivers for their efforts,
- State leadership in promoting and developing national long-term care insurance,
- Incentives for insurance companies to offer long-term care insurance policies that are more affordable and offer a wide range of benefits,
- Modification of Minnesota's tax policies to encourage saving for health, long-term care and social needs,
- Expansion of programs such as adult foster care and congregate-housing arrangements that enable older people to stay out of nursing homes,
- Expansion of transportation programs serving older Minnesotans, and
- Facilitation of a broad-based policy discussion involving consumers, legislators, providers and others on choices and protections for consumers of long-term care services.

Copies of the report are available by calling the Minnesota Board on Aging at 296-3868.

LOCAL NEWS BRIEFS

Help with tax forms available at 22 locations

Older Minnesotans who need help filling out their income tax returns can turn to trained tax counselors at more than 400 sites across the state through Monday, April 15.

Volunteers with the Tax Counseling for the Elderly (TCE) and Volunteer Income Tax Assistance (VITA) programs are staffing 22 sites in the St. Paul area. They also make home visits to taxpayers unable to travel because of physical disabilities. For the location of sites or to arrange a home visit, call the Minnesota Department of Revenue at 296-3781.

Volunteers are able to completely prepare state and federal income and property tax returns or simply check over forms for people who have already filled them out.

When coming to a VITA or TCE site, taxpayers are reminded to bring: copies of their 1989 state and federal tax returns; their 1990 tax booklets; wage and tax statements (W-2); pension statements (W2-P); interest statements (and other 1099 forms); statements documenting Social Security benefits (1099-SSA); and information describing medical expenses or charitable contributions. Renters should also bring form CRP from their landlord and homeowners should bring statements of property taxes payable in 1991.

Alzheimer's patients needed for drug study

A new medication that may be helpful in the treatment of behavior and memory changes in people diagnosed with Alzheimer's disease is undergoing testing at the Minneapolis Veterans Administration Medical Center.

Researchers believe that the new experimental drug, BMY-21502, may help reduce memory loss and thinking problems in Alzheimer's patients. The research study is designed to measure the drug's safety and effectiveness. Similar studies are being conducted at several other sites across the country.

Participants will be needed over the next several months. Applicants must be diagnosed with mild to moderate Alzheimer's and have no other significant medical problems. Veterans as well as nonveterans are eligible. For details, call study coordinator Susan Anton-Johnson at 725-2052.

Social Security check late? Don't worry

The St. Paul office of the Social Security Administration urges people who do not receive their Social Security or Supplemental Security Income (SSI) checks on time to not be alarmed: the check is most likely in the mail.

More than 39 million Social Security checks and 4.6 million SSI payments are made on time each month, though occasionally some checks are delayed.

Social Security checks are usually delivered on the third day of the month, and SSI checks arrive on the first day. People who don't receive their Social Security checks by the sixth of the month or SSI checks by the fourth are urged to give Social Security a call.

A sure way to avoid late checks by mail is to have payments directly deposited into an account at a savings institution. The electronic payment system is now more popular than receiving checks by mail. For more information, call Social Security toll-free at 1-800-234-5772. The best times to call are between 7 and 9 a.m. and 5 and 7 p.m.

Project serving Alzheimer's patients extended by 1 year

A federally funded pilot project that arranges and pays for services for Minnesota families affected by Alzheimer's disease and related memory-loss disorders has been extended by one year, to May 1993.

The extension is expected to bring an estimated additional $3 million in care services to participants in the Minnesota Alzheimer's Disease Demonstration.

The project currently provides over 350 Minnesota families with help such as adult day care, skilled nursing, therapy, housekeeping, Meals on Wheels and companions. The project pays 80 percent of the cost of those services, which are not normally covered by Medicare, up to $626 a month.

The project is a controlled study, meaning that in addition to the 350 families receiving the extra services, another 350 families are monitored but do not receive the services. If deemed effective, the extra services could someday become part of Medicare's regular benefit schedule.

The project is currently operating on a three-year $6 million grant. Services are provided through the Minnesota Alzheimer's Consortium comprised of the Amherst H. Wilder Foundation, Ebenezer Society, Miller-Dwan Medical Center in Duluth, and the Minneapolis/St. Paul Chapter of the Alzheimer's Association. Related studies are being conducted at seven other national sites.

Funding for the extension is contained in the latest federal budget package and was supported by U.S. Sen. Dave Durenberger and U.S. Reps. Bruce Vento, Martin Sabo and James Oberstar, all of Minnesota.

The project is open to residents of Ramsey, Anoka, Dakota, Hennepin, St. Louis and Washington counties. Applicants must have a diagnosis of Alzheimer's disease or a related disorder. For details, call 888-7653.

City's new aging committee wants input from citizens

St. Paul's fledgling Advisory Committee on Aging, which began meeting in January, is exploring ways it can best meet the needs of the city's rapidly growing older population.

Early meetings have included discussions of a mission statement and work plan and identifying issues of concern to the city's older residents.

"We are in the process of working out our organization and setting our priorities," said Marvin Grunke, a retired social services professional who chairs the 15-member panel.

The panel was created in a resolution passed last summer by the City Council. The resolution charges it with researching elderly issues and recommending changes or improvements to Mayor Jim Scheibel.

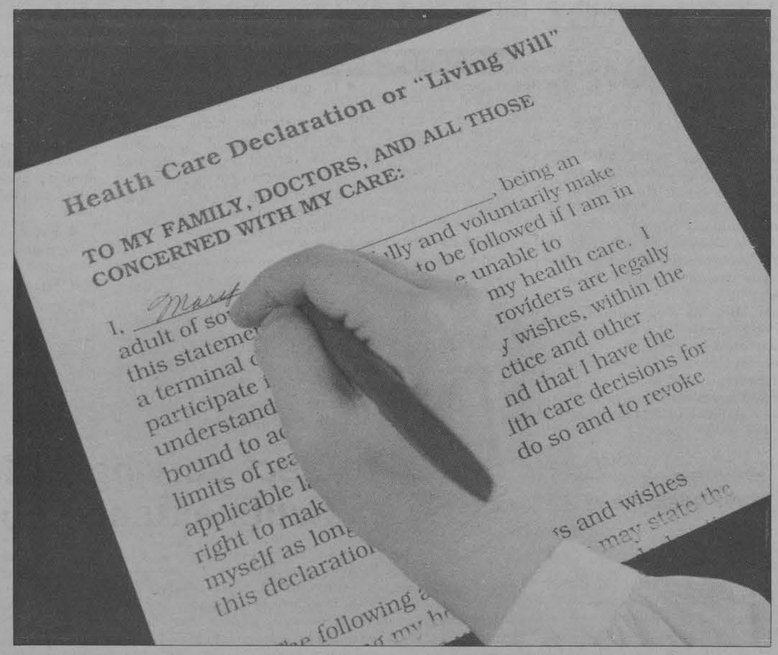
The committee meets from 9:30 to 11:30 a.m. every second and fourth Thursday of the month at St. Paul Public Health, 555 Cedar St.

Early meetings have included presentations by heads of city departments and representatives from social service agencies, and a general discussion of elderly needs. The talks indicate that "there is apparently a need for some sort of information center that can help elderly people find services and other things they don't know are available," Grunke said.

Committee members represent diverse interests including government, business, social services and other areas. "There's a lot of interest and a lot of enthusiasm," said Ellen Black of the city's Department of Community Services who works with the panel.

Black said the committee wants to hear older citizens' concerns. Written comments may be sent to the committee in care of her at St. Paul Public Health, 555 Cedar St., St. Paul, MN 55101.

Focus



Minnesota's living will law, enacted in 1989, permits competent adults to leave written instructions for care and treatment in the event of a terminal illness. The document applies only when patients are no longer able to participate in treatment decisions.

INSIDE:
- **On pages 6 and 7, answers to common questions about living wills, a checklist for completing a living will, and agencies to call for further information.**
- **On page 8, a condensed version of Minnesota's living will form.**

Living Wills

Concerned about the health care you'll receive if you have a terminal illness or injury? Minnesota law allows you to write a living will so that your wishes and instructions for medical treatment are known.

For a moment, imagine the unthinkable: You're in an auto accident that leaves you unconscious with no hope for recovery. Do your doctors and loved ones know how you want to die?

Or imagine you're dying of cancer and your heart stops beating. Do you want doctors to use cardiopulmonary resuscitation to get your heart beating again?

What if you suffer a stroke and lapse into a coma? Do you want tube feedings continued, even if they'll keep you alive for months or even years?

Most people in situations like these leave the weighty decisions to their doctors and loved ones. But often those decisions aren't easy, especially if the patient's wishes aren't known. Disagreement or doubt over what a dying patient would or would not want can lead to guilt feelings, family fights, tough calls for doctors, and even lawsuits.

To spare family members from that anguish, a growing number of Minnesotans are writing living wills. In a living will, you can state your wishes and instructions for treatment in advance of a terminal illness. And those wishes will have legal force, thanks to a 1989 state law.

But for your living will to be legal, you must follow an eight-point form contained in the law. The form, called a health-care declaration, allows you to indicate how much — or how little — medical treatment you want if you become terminally ill and unable to make decisions for yourself. It also gives you the right to name a "proxy," someone who will make decisions about your medical care when you can't. You can change or revoke your living will at any time.

Under the law, a living will only becomes enforceable if you are in "an incurable or irreversible condition" for which treatment "will only preserve to prolong the dying process." That definition applies to many types of incapacitating conditions, including a coma or permanent brain injury that could make it impossible for you to express your wishes.

Not so long ago, people didn't give much thought to these matters. But advances in medical technology are now allowing patients to be kept alive when they might not want to be.

Decisions over withholding or withdrawing life-sustaining treatment are becoming increasingly common. A recent study shows that of the 2.1 million Americans who die this year, 1.7 million will die in a health-care facility. Of those deaths, 70 percent will involve decisions about whether to withhold or withdraw life-support systems.

Minnesota's living will law allows you to make those decisions in advance. Your instructions can be general. For example, you can use statements such as "I do not want medical treatment that will only prolong my dying" or "I would like all available life-sustaining treatment."

You can also be specific. For example, you may write "I do not want to be sedated so that I can't feel pain or am not able to communicate with my loved ones," or "I do not want to be fed through a tube in my stomach if I am no longer able to eat by mouth." You can also leave guidelines for the use of a respirator, kidney dialysis or antibiotics to treat infections such as pneumonia.

The form gives special attention to one type of treatment: artificial feeding of food and water. The law requires that you indicate your feelings and wishes in this area. The form states that without tube feeding, you may die of dehydration or malnutrition rather than from the illness or injury.

In the absence of a living will, decisions regarding the provision of food and water will be made on the basis of "reasonable medical practice." That means doctors will consider the benefits or possible harm of tube feeding as well as the patient's wishes. Then, consent must be obtained from the patient or family before inserting or withdrawing a feeding tube. Because doctors' personal beliefs and hospital and nursing home policies vary on this issue, living will experts advise that you state your wishes.

Finally, the form enables you to express religious beliefs and other personal values that may be pertinent to your care. You can also leave other special instructions, such as adding a provision regarding organ donation or disposition of your remains, or state where you want to die.

Living will experts say that the more you

PLEASE SEE **LIVING WILLS** ON 6

Living wills

Continued from page 5

write, the more your doctors and loved ones will know of your desires.

People who prepare living wills need to think carefully about their options, said Leigh Mathison, a Bloomington attorney who speaks to groups about the law. She said many people are surprised to learn what they can put in a living will. "I think a lot of people expect the health-care declaration form to be a ready-made form that they can just sign, not something they have to think about," she said.

According to Mathison, a living will should be written only after you have taken the time to explore your personal values and learn about the medical options that are available. "When I speak to groups, I try to give a lot of alternatives and ideas about what people might want to say," she said.

With a living will, you can give guidelines to questions such as these:

- If you were terminally ill and suffering great pain, would you want medications to control the pain, even if they hastened your death?
- If there's no hope for recovery, would you want to be hooked up to a respirator?
- Is there any specific treatment you would want to make you more comfortable? If it does not provide comfort, would you want it stopped, even if it resulted in death?
- Do you want to die in a hospital or at home? If your preference is to die at home, would you allow being sent to a hospital if it could provide treatment for your comfort?

Decisions to questions like these can also be made by a proxy appointed by you to carry out your wishes. A proxy has the right to review your medical records and receive information about your condition in order to participate in treatment decisions. You can appoint anyone you wish as proxy.

Mathison believes the naming of a proxy is the most important function of a living will. "Most people are not either able or inclined to be specific in their living wills, so that heightens the importance of a proxy," she said. "And not only should they appoint a proxy, but they should have a discussion of their wishes with that person."

Sam Sigal, a Minneapolis attorney who also speaks publicly on the subject, said most people write living wills to indicate the kinds of treatment they don't want. "It's usually people who don't want to be hooked up to life-support machines when it's been determined that there's no hope that they'll be cured and they're not able to communicate," he said.

National polls indicate that the majority of Americans believe it is preferable to die than to be kept alive by life-support mechanisms. A Gallup Poll taken last November showed that three out of four people surveyed agreed that terminally ill patients have the right to request that treatment be withheld so that they can die. A similar poll conducted earlier in the year by Princeton Research Associates showed that 79 percent of adults support state laws that allow terminally ill patients to refuse life-sustaining treatment, or to order that treatment be stopped once it has begun. And a 1989 New York Times/CBS News Poll found even stronger support for discontinuing tube feedings. Eighty-five percent of those surveyed said they would want tube feeding discontinued if they were comatose and showed no brain activity.

Some living will critics argue that people don't have enough facts to make life-and-death decisions in advance of an illness. "If you don't possibly know what kind of disease you're going to have, how can you indicate what kind of care you will need or want?" said Nancy Koster, vice president of Minnesota Citizens Concerned for Life.

Koster said her organization doesn't dispute a person's right to make his or her own health-care decisions. "There are just a lot of mechanical problems about writing a living will," she said. "Someone else has to translate what is in that written document and then apply that to when you're not competent. We have a lot of problems with that."

Living will supporters maintain that you don't need to know the exact medical circumstances in order to make advance decisions. "If you believe that a person is basically the same throughout life and that their values are fairly consistent, then this shouldn't be a concern," said Evelyn Van Allen, coordinator of the Minnesota Network for Institutional Ethics Committees, a service of the Minnesota Hospital Association.

According to a 1989 report in the Journal of the American Medical Association, fewer than one in ten Americans has a living will. But that number is expected to significantly increase when a new federal law goes into effect later this year.

The law — known as the Patient Self-Determination Act — will require hospitals, nursing homes and other health-care providers that receive money from Medicaid or Medicare to provide patients with written information explaining their medical-care rights under state laws.

It will also require hospitals and other providers to have procedures to ensure they comply with a patient's wishes. "There will be more consistency in the asking of living wills and so forth," Van Allen said. The federal government will also conduct a campaign to educate people about legal right-to-die options.

Van Allen said interest in living wills is already growing as a result of last year's U.S. Supreme Court decision in the case of Nancy Cruzan. Cruzan was a Missouri woman who was left irreverisbly unconscious after a January 1983 car crash. Her parents wanted the hospital and doctors to discontinue her tube feedings, and to allow her to die. But her health-care providers refused to do so because Cruzan had never written down her wishes, nor given authority to her parents to make treatment decisions. In its decision, the court upheld a Missouri law that required "clear and convincing evidence" of a patient's wishes in order to stop Cruzan's life-sustaining care. But it also hinted that a living will would have met the definition of "clear and convincing evidence."

In Minnesota, the decision has prompted many requests for a booklet on living wills prepared by the state's Living Will Coalition. More than 20,000 booklets have been distributed in the two years since the state's living will statute was enacted. Copies are available at senior centers, hospitals, nursing homes and from the coalition's member organizations.

Demand for presentations by attorneys and health-care professionals familiar with the law is also increasing. "A lot of people are giving education programs on the living will," Van Allen said.

What you should know about living wills

QUESTIONS AND ANSWERS

What is a living will?
It's a written statement in which you can state your wishes and instructions about the kind of medical treatment you want or do not want if you have a terminal illness or injury and are not able to make decisions for yourself. You may also name a person to carry out your wishes; this person is called a "proxy."

Who can make a declaration?
Any competent person age 18 or older. Living wills are not only for older people; they are helpful for people of all ages. Accidents and cancer, for example, are the highest causes of death in Minnesota for people between ages 20 and 50; both can result in a terminal condition.

Why should I write a living will?
It helps your family and your doctor. It lets them know the kind of medical treatment that you want or don't want if you can't speak for yourself. A written declaration is legally enforceable. It helps to avoid family disagreements, guilt feelings, and doubts about how to treat you when you are in a terminal condition.

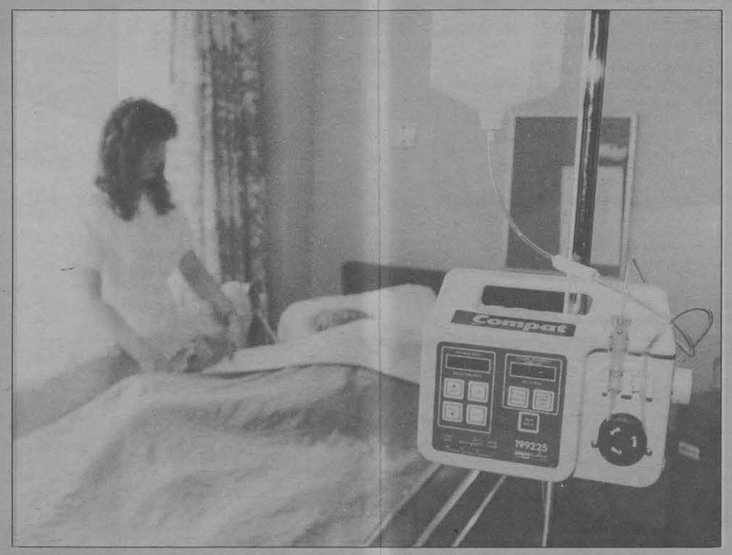
What is a terminal condition?
It's an incurable or irreversible condition for which the administration of medical treatment will only prolong the dying process. This is a broad definition and would apply to many types of incapacitating conditions such as permanently unconscious, and those that are more commonly thought of as terminal conditions.

What are my rights regarding health care decisions?
An earlier law, the Minnesota Patients and Residents Bill of Rights, gives you the right to participate in your medical care decisions, to receive complete information about your medical condition, and to refuse treatment. The Adult Health Care Decisions Act extends this right to a time when you may not be able to make decisions yourself.

Does the law require me to make a living will?
No, that's up to you. In fact, it's against the law to require anyone to write a living will in order to receive health care or health insurance. If you do not want to write a living will and become incapable of making medical care decisions, your doctor will consult your family to make those decisions.

Is the living will declaration only for people who don't want treatment?
No. Although most living wills state the kind of treatment not wanted, you may state that you want all treatment possible, or that you want certain treatment such as artificially administered nutrition or hydration.

How do I go about writing a living will?
First, think carefully about your beliefs related to death and dying. Then talk with your family or close friends and your doctor. You may also want to talk with your minister or priest, or your lawyer.



Questions surrounding the use of pumps and other devices to provide nutrition and hydration during a terminal condition require thoughtful consideration when completing a living will.

Is there a special form to use?
Yes. The law requires all declarations to be substantially the same as the one in the law (see form on page 8).

Do I have to fill out the entire form?
No. But the law says that if you don't state whether or not you want artificially administered sustenance (tube feeding) or that you want your proxy to make decisions about administering, withholding or withdrawing artificial sustenance, such decisions will be made according to reasonable medical practice.

What does reasonable medical practice include?
The law requires administration of food and water by mouth to a patient who accepts it. It also requires care to provide comfort and control pain.

What if I don't know what some of the terms in the form mean, such as the difference between health care and life-sustaining medical treatment?
It's important to talk to your doctor or someone else who can tell you about various kinds of treatment, such as cardiopulmonary resuscitation (CPR). You may either provide general instructions to your doctor and proxy, or you may be more specific.

Should I name a proxy?
The law permits but does not require you to name a proxy to carry out your wishes. You should consider naming a proxy and an alternate. You should ask your proxies whether they are willing to serve.

What do I do after I've written my instructions and/or named a proxy?
You must sign the declaration in the presence of two witnesses or a notary public, none of whom can be named as a proxy. Neither of the witnesses can be persons who stand to gain anything from your estate.

What should I do with the living will after it is signed and witnessed?
Make copies and give them to your doctor (to be placed in your chart), proxy, family, friends, clergy, attorney and others who may be involved in caring for you when you are in a terminal condition. Keep the orginal in a safe, accessible place, not in a safe deposit box.

How do I know that my doctor will carry out my wishes?
Your doctor or any other health care provider, such as a hospital or nursing home, must tell you when you give the declaration to them whether or not they are willing to comply with it. If they are not willing to do so, you have the choice of finding another doctor or provider. However, reasonable medical practice must always be observed, which may require your doctor to override your declaration in some instances.

Can I change or revoke my living will?
Yes, at any time and in any manner by telling your doctor or other health care provider. You should review it periodically to see if there are any changes you want to make.

Suppose I write a living will and later become seriously ill or injured but am still able to communicate my medical care wishes?
Then the declaration would not go into effect. Your declaration will be effective when you have a terminal condition and cannot make your own decisions.

What if I already have a living will, especially one written when in another state?
A living will written before Aug. 1, 1989 or one written in another state must substantially comply with Minnesota law. If in doubt, write a new living will using the Minnesota form.

Adapted from the booklet "Questions and Answers about the Adult Health Care Decisions Act (Living Wills)" by the Minnesota Living Will Coalition.

CHECKLIST

1. Give your living will careful and thoughtful consideration. Ask questions such as "Why am I writing a living will?" and "What are my desires, wishes, values about health care?"
2. Discuss your living will with your doctor and other health care providers, and family and friends. Make sure your wishes are clear to them and determine if they will honor them.
3. Discuss your living will thoroughly with your proxy and specify any limitations.
4. Write out specific instructions. Specify what you want provided, withheld or withdrawn.
5. Distribute your living will to your doctor, family, proxy and others concerned with your health care.
6. Periodically review your living will.

FOR MORE INFORMATION

The following organizations belong to the Minnesota Living Will Coalition. Each can provide copies of the booklet "Questions and Answers About the Adult Health Care Decisions Act (Living Wills)" as well as names of speakers to help explain the law.

- American Association of Retired Persons (AARP)/VOTE — (202) 728-4756
- Minnesota AFL-CIO — 227-7647
- Minnesota Alliance for Health Care Consumers — 866-4660
- Minnesota Association of Homes for the Aging — 331-5571
- Minnesota Board on Aging — 296-2770 or toll-free 1-800-652-9747
- Minnesota Dietetic Association — 646-4997
- Minnesota Hospital Association — 331-5571 or toll-free 1-800-462-5393
- Minnesota Network of Institutional Ethics Committees — 331-5571
- Minnesota Senior Federation — 645-0261 or toll-free 1-800-365-8765
- Minnesota State Bar Association — 333-1183
- University of Minnesota Retirees Association, Inc. — 625-4700

Suggestions for preparing a living will

Though many people talk about preparing a living will, fewer than one in ten of us actually write one. Preparing a health care declaration requires thoughtful consideration of your beliefs and feelings about death and dying, and your wishes about care and treatment if you become terminally ill.

Living wills prepared in Minnesota must substantially follow the form contained in state law. But some people are confused by the form's language and redundancy, said Evelyn Van Allen, coordinator of the Minnesota Network for Institutional Ethics Committees, a service of the Minnesota Hospital Association. "We found that after people got the form, they still had many questions and thought it was complicated," she said. "So they wouldn't complete it."

Van Allen, who gives presentations on the law, said people need not feel intimidated. During her talks, she goes through the form and offers suggestions to help people prepare their own declarations.

The most important thing, says Van Allen, is to use your own words. "I always tell people to think of it as writing a letter to your family and doctor and nurses. I think communication is the most important function of a living will."

Your preparation of a living will should also include a discussion of your wishes with family members, friends, clergy, and, of course, your doctor. This can help prevent any misunderstandings later on. Family disagreements are the major reason why living wills are not honored.

Instructions in a living will should reflect your desires. The opening paragraph of Minnesota's living will form enables you to indicate the circumstances under which you wish the declaration to apply. Other parts of the declaration allow you to indicate the kinds of treatment and care you desire, and those you don't want.

All declarants are required to state their wishes about artificially administered sustenance. You may also indicate that this matter is up to your proxy. Artificially administered sustenance, according to a handout by Van Allen, means that if you cannot take food or fluids by mouth, special nutritional preparations will be given through tubes placed through your nose into the stomach, or surgically placed directly into the stomach or small intestine.

Most people have strong feelings about tube feedings, so it's important to discuss the matter with your doctor and others involved in your care, said Van Allen. If your wishes are not made clear, decisions about your care will be made according to reasonable medical practice, and there's no assurance that your desires will be followed.

The living will form also provides space to express special wishes or instructions, such as leaving your organs or tissues after death. You can also indicate where you wish to be cared for if you become terminally ill. Some people prefer to die in a hospital; others want to die at home.

Van Allen also strongly recommends designating a proxy. This will let everyone know whom you have chosen to make decisions for you. You can name anyone as your proxy, as long as they do not sign as a witness to the declaration.

After having the declaration witnessed and signed, copies should be distributed to everyone who may be involved in your care in the event of a terminal condition. "It's also important to keep a written list of the people you give your copies to in case you later decide to change or retract it," Van Allen said.

Be sure to review your declaration periodically. Van Allen recommends that that be done when you visit your doctor for your regular checkup, or when there's a significant change in your health. "And if someone has a chronic or terminal illness, I suggest that they update their declaration whenever their condition changes," Van Allen said.

FOCUS: LIVING WILLS

Condensed version of living will form

This is a condensed version of the living will form contained in the booklet "Questions and Answers About the Adult Health Care Decisions Act" prepared by the Minnesota Living Will Coalition. The complete form includes an introduction and space for writing preferences and instructions regarding care and treatment. Free single copies of the booklet are available by calling the Minnesota Board on Aging at 296-2770.

To my family, doctors, and all those concerned with my care:

I, _____, being an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my health care. I understand that my health care providers are legally bound to act consistently with my wishes, within the limits of reasonable medical practice and other applicable law. I also understand that I have the right to make medical and health care decisions for myself as long as I am able to do so and to revoke this declaration at any time.

Comments and Instructions:

This declaration sets forth your directions regarding health care. You may give your instructions by filling in the blanks in any or all of the following paragraphs or leave these decisions to the discretion of your doctor or proxy (if any), except that you must complete Paragraph 6. You may attach an additional page or pages if more space is needed. You should discuss this with your doctor, if possible.

1. The following are my feelings and wishes regarding my health care (you may state the circumstances under which this declaration applies):

You may state your wishes regarding your care to apply when you have an incurable or irreversible illness or injury with no hope of recovery.

2. I particularly want to have all appropriate health care that will help in the following ways (you may give instructions for care you do want):

You may wish to specify that you want care to provide comfort and control pain and treatment that may substantially improve your condition.

3. I particularly do not want the following (you may list specific treatment you do not want in certain circumstances):

You may or may not wish to list specific types of treatment here. You may state that you do not want treatment if it will not help you recover and will only prolong the dying process.

4. I particularly want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do want if you have a terminal condition):

You may state that you want certain types of treatment tried for a limited time to determine whether they are beneficial; for example, cardiopulmonary resuscitation (CPR), or mechanical respiration. You may also state that you want all available medical treatment.

5. I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition):

You may list specific treatment you do not want, such as CPR or long-term mechanical respiration, or any other life-prolonging care that is not necessary to provide comfort or relief from pain.

6. I recognize that if I reject artifically administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially administered sustenance should I have a terminal condition (you may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition):

Artifically administered sustenance (tube feeding) may prolong your dying indefinitely in a permanently unconscious or persistent vegetative state. You must state either that you want or do not want artifically administered sustenance, or that you want your proxy or doctor to make that decision for you.

7. Thoughts I feel are relevant to my instructions. (You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care):

In addition to religious beliefs, personal values or preferences regarding the location of your care, you may wish to add a provision regarding organ donation or disposition of your remains.

8. Proxy Designation. (If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.)

You are encouraged to name a proxy to make health care decisions for you when you cannot do so. Your proxy must honor your wishes as expressed in this declaration, or act in your best interests if your wishes are unknown. If you name a proxy here but do not complete Paragraph 6 above as required, your proxy may not be able to make a decision for you regarding artificially administered sustenance.

If I become unable to communicate my instructions, I designate the following person(s) to act on my behalf consistently with my instructions, if any, as stated in this document. Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian or conservator is to be appointed for me, I nominate my proxy named in this document to act as guardian or conservator of my person. (Form provides space for name, phone number, etc.)

If the person I have named above refuses or is unable or unavailable to act on my behalf, or if I revoke that person's authority to act as my proxy, I authorize the following person to do so: (Form provides space for name, phone number, etc.)

I understand that I have the right to revoke the appointment of the persons named to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

This provision ensures that your proxy will be able to make health care decisions for you to the fullest extent permitted by law.

9. Notarization or witnessing. Your declaration should either be notarized or witnessed. (You may sign and date in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a will or by operation of law, and neither or whom is your proxy.)

If you choose to have your declaration notarized, the Notary Public cannot be named as a proxy in your declaration.

Posters strike back at elder abuse, neglect

A series of posters depicting various forms of abuse and neglect facing older people is being distributed statewide by the Minnesota Adult Protection Coalition.

The five posters describe examples of physical abuse, financial exploitation, self-neglect and other forms of maltreatment. Each poster features an illustration and explanation of the problem and the name and phone number of a community agency that can help.

The posters have two main purposes, according to Linda Silver of the coalition's executive committee.

"The first objective is to get people to know there is help available, whether they need it themselves or know of someone else who does," Silver said. The other is to raise public awareness of problems facing older adults and encourage use of preventive services. "The posters have messages that say there are hard things happening to older people and maybe people should care and get involved," Silver explained.

According to the coalition, all adults who have difficulty caring for themselves are susceptible to neglect or abuse. One of every 25 Americans over 65 — or about 20,000 older Minnesotans — is at risk.

Elder maltreatment is a growing social problem. Reports of older Minnesotans being abused and neglected increased almost tenfold during the 1980s. According to the state Department of Human Services, 496 Minnesotans age 18 and older were reported as allegedly abused or neglected in 1981, compared to 4,586 in 1988. Over half of the substantiated reports involved people age 60 or older.

Studies indicate victims of elder abuse are likely to be old, age 75 or older. Women are more likely to be abused than men, mainly due to a longer life expectancy. Victims are generally dependent on their families or others for their care and protection.

Abusers usually experience great stress. The victim's son is the most likely abuser, followed by the victim's daughter.

The poster campaign was developed for the coalition free of charge by McCool and Company, a Minneapolis-based advertising design firm. Since the campaign began last fall, the coalition has spent over $13,000 to print and distribute the posters, which are free for the asking.

Five thousand copies of each poster were printed and over a third have so far been distributed. Requests are coming from churches, pharmacies, clinics, community agencies, government offices and libraries. An informational flyer on the posters can be obtained by calling the coalition at 879-1409.

In addition to the poster campaign, the coalition has initiated a project to alert meter readers and other service personnel to signs of neglect and abuse and to report their concerns to specially trained personnel. Called Gatekeeper, the project involves workers from Northern States Power Co., Minnegasco, People's Natural Gas, and Dakota Electric.

Posters such as this one are being distributed across Minnesota to raise public awareness of elder abuse and neglect. The campaign is being conducted by the Minnesota Adult Protection Coalition.

UPCOMING EVENTS

Lyric Theatre to present 'Simon's Night'

"Simon's Night," a play by Minnesota author Jon Hassler, will be presented by the Lyric Theatre at the Hennepin Center for the Arts, 528 Hennepin Ave., Minneapolis, over four consecutive weekends starting Friday, April 5.

Based on Hassler's novel of the same title (see Henry Hall's review on page 11), "Simon's Night" is the story of a retired English professor who believes his failing memory is a threat and seeks haven in a home for the elderly. There, he encounters quirky residents who have succumbed to proprietress Hattie Norman's notions of what is appropriate behavior for older people.

A publicity release calls "Simon's Night" "not merely a play for and about the elderly. Hassler's script turns from the problems of growing old and reminds us with humor, compassion and honesty that older people are just young people in old bodies."

The play will run Thursdays through Sundays. Tickets are priced from $6 to $12; discounts are available to groups, students and older adults. For curtain times and information on group tickets, call 824-4935. For reserved seating (other than groups), call the Connection at 922-9000.

Programs aid caregivers, widowed and families

Family Service of Greater St. Paul is offering several programs for older adults and their families this spring.

Family education nights will be held from 6 to 7:30 p.m. Thursdays in March. Topics include: "Alternatives to Nursing Homes," March 7; "Caregivers Education," March 14; and "The Paper Chase," March 21.

A support and education group for older women will meet weekly during the day for eight consecutive weeks starting in late April or early May. Topics include communicating and asserting one's needs, introduction to codependent or abusive relationships, and making new friends or starting over after the loss of loved ones.

A caregivers education group for people over 60 will begin meeting Wednesdays from noon to 1:30 p.m. for six consecutive weeks starting in late April or May. Topics include the aging process, community resources, balancing family and caregiver needs, and self-care. People who complete the six-week series are eligible to join "The Elder Connection," an ongoing support group that meets monthly during the day.

Other programs for caregivers include: "Sandwich Generation Caregivers" for people tending to elderly parents or relatives while raising a family; "Feeling Alone" for single adult children involved in caring for frail elderly parents; and "Intergenerational Spouse Caregivers Group" for people of all ages.

All programs will be held at the Family Service office, 166 E. Fourth St., Suite 330, St. Paul. Fees are based on family income and start at $2 per session for families with annual incomes below $10,000; the fee is $3 per session for people with annual incomes between $10,000 and $20,000. Preregistration is required for all programs; call 222-0311.

St. Thomas sets classes for older adults

The Center for Senior Citizens' Education at the University of St. Thomas in St. Paul is offering four courses this spring.

"A Bird's Eye View of the History of China," a nine-part series, will meet at 1 p.m. Thursdays starting March 7. "Peoples of the Book: Jews, Christians and Muslims," a ten-week series, will meet at 10 a.m. Thursdays starting March 7. "Art Appreciation, Antiques and Collectibles," a nine-part series, will meet at 1 p.m. Tuesdays starting March 12. "The Spirit of Scotland," a six-part series, will meet at 10 a.m. Tuesdays starting April 2.

All classes last two hours and will meet in the auditorium of Brady Educational Center on the university's west campus. Fee for each series is $25. For details, call Dr. Mo Selim at 647-5221.

St. Thomas also sponsors Senior Consulting Services, a program that gives older adults an opportunity to consult with professionals from various fields. For more information, call 647-4304.

'Aging: It's Everyone's Future' set for April 27

"Aging: It's Everyone's Future," a half-day program for older adults, their families and others interested in aging-related issues, will be presented from 9 a.m. to 12:30 p.m. Saturday, April 27, at Wilder Residence West, 514 Humboldt Ave. St. Paul. The keynote address, on spirituality and aging, will be given by the Rev. Jim Martin, director of the Wilder Alzheimer's Care Network.

The free program is sponsored by the Amherst H. Wilder Foundation, Services to the Elderly. A continental breakfast will be served. Advance registration is required. For details, call 649-3665.

Peer counselors schedule annual conference

The Peer Counselor Alumni Association will host its annual Quality of Life and Aging Conference on Friday, April 19, at the Roseville Holiday Inn, 2540 N. Cleveland Ave. People trained as peer counselors as well as professionals and others involved in serving the elderly are invited to attend.

The conference will feature speakers and panels consisting of social workers and legal and counseling professionals. The main topic will be transitional changes that occur in the lives of older, frail and disabled people. For conference details, call Peggy Black at 429-3762.

Gerontological Society sets spring conference

The Minnesota Gerontological Society, an organization of older adults, professionals and others interested in the field of aging, will hold its spring conference Thursday, April 11 at the Sheraton Midway Hotel in St. Paul. The theme will be "My, How Things Have Changed! What Are Senior Services Really Like Today?"

The event is being cosponsored by the Minnesota Area Geriatric Education Center. For details, call 222-8233 or 624-3904.

RESOURCES

Arthritis medications explained

Two new brochures about common medications used to treat arthritis are available from the Arthritis Foundation-Minnesota Chapter.

The first brochure describes nonsteroidal anti-inflammatory drugs. These aspirin and aspirin-like medications are used to reduce inflammation that causes the joint pain, stiffness and swelling of arthritis.

The second brochure is about corticosteroids, which are also used to reduce inflammation but are stronger medications similar to a natural body hormone.

Each brochure has sections on what the drugs are, when they are used to treat arthritis, how they work, their side effects, a checklist of things to do and not do when using them, and a list of generic and brand names for the drugs.

To receive a free copy of one or both of the new brochures, call the chapter at 874-1201; if phoning from outside the metro area, call toll-free 1-800-333-1380.

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A newly revised guide to nursing homes and supportive-living facilities for older people in the Twin Cities area is now available from the Metropolitan Council.

The directory, now in its fourth edition, lists nursing homes, supportive-living arrangements, board and care homes, and board and lodging facilities.

Profiles of individual facilities include such information as number of rooms, age of residents, availability of respite beds, financing accepted and services available.

The directory also describes options for financing care, residents' rights and factors to consider in choosing a facility.

To receive a copy, send a request and $3.50 to the Metropolitan Council's Data Center, Mears Park Centre, 230 E. Fifth St., St. Paul, MN 55101.

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A new guide that helps older people ensure that their wishes will be respected if they ever become unable to make financial or personal decisions is now available from the Minnesota Vulnerable Adults Coalition.

Written by Jean Orsello, legal services developer for the Minnesota Board on Aging, the 22-page "Planning for Incapacity" discusses several planning options including informal arrangements with family members, banking tools, durable powers of attorney, trusts and conservatorship planning.

Single copies of the guide are available free by calling the board at 296-2770.

GOOD HEALTH

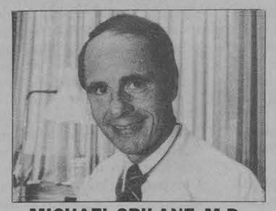
Sleep disturbances are problem for 30 percent of those over 70

A good night's sleep is not a sure thing! About 30 percent of people over age 70 complain of insomnia, and nearly half of these use sleeping medications on a regular basis. The older one is, the more likely that sleep will be a problem.

Major advances have been made over the past decade in medical knowledge of sleep and sleep disturbances. Old ideas have been discarded as many specific causes of insomnia have been discovered. Much of the knowledge has come from sleep laboratories where patients are observed while they sleep. Special techniques are used to monitor physiological activities such as blood pressure, eye movements, muscle contractions, brain waves, heart function and breathing.

Older people tend to sleep less than younger people, but they often remain in bed just as long. Sleep is lighter and more often is interrupted by periods of wakefulness. People with equal amounts of sleep may complain of insomnia or may feel well-rested. Many who complain of insomnia actually obtain adequate physiological rest. Others, whether or not they sense the insomnia, may have sufficent sleep deprivation to produce daytime symptoms of fatigue, headaches and even confusion.

Although insomnia-troubled patients simply state, "I cannot sleep," sleep experts recognize different patterns of disturbance: inability to fall asleep, frequent awakening, inability to return to sleep, and early morning wakening. Different



MICHAEL SPILANE, M.D.

causes can be responsible for each pattern.

Stress, anxiety and depression are frequent causes of insomnia in the elderly. Typically, the complaint is inability to fall asleep, but frequent awakening and early morning wakening may be predominant. Death of a loved one, a relocation, financial concerns, ill health or unresolved anger are common causes.

Some older people experience insomnia because of intermittent nocturnal obstruction of the airway passages. An abrupt lowering of body oxygen leads to awakening. Snoring, snorting and frequent awakening are almost always present. These people most often are obese, but in the elderly the problem may be caused by overrelaxation of the throat muscles.

For unknown reasons, elderly individuals may experience sudden leg movements during sleep. This is termed restless leg or restless muscle syndrome, and is a cause of frequent awakening and insomnia. The degree of sleep disturbance varies with the number and intensity of leg and foot movements.

Medications are another cause of insomnia. "Cold" medications and caffeine are well-recognized stimulants of the nervous system, but many other drugs have similar effects.

Nocturnal symptoms such as shortness of breath, joint pain, and urge to urinate are very real causes of insomnia. A sleep complaint is understandable if a person has been forced to the bathroom five times during the night.

If sleep is taken during the day, there is the risk that it will be taken away from the night. Active elderly who do not nap have more restful nighttime sleep. A complete reversal of sleep patterns, with days switched for nights, may be experienced by people with Alzheimer's disease.

When all is said, there remains a group of insomniac elderly who are not stressed or depressed, do not take problem medications, are active and do not nap, do not have obstructive breathing or restless legs, and do not have disease-related symptoms that keep them awake. Most get adequate sleep yet are distressed by a sense of wakefulness. Medical science has a ways to go.

What can you do if you cannot sleep? This will be the subject of our next column.

Dr. Spilane is an internal medicine staff physician specializing in geriatrics at the Senior Health Center at St. Paul-Ramsey Medical Center.

SENIOR LAW PROJECT

State and federal laws protect nursing-home residents' rights

Q. Do residents of nursing homes have any special rights or protections under the law?

A. Yes. Minnesota has a "bill of rights" for residents of nursing homes. This law also applies to patients or residents of other types of health-care facilities. Nursing-home residents also have additional rights under a new federal law.

Q. What kinds of rights do I have under Minnesota's bill of rights?

A. Some rights are of a personal nature. For example, you have the right to be treated with courtesy and respect, and to be free from mental or physical abuse. You also have the right to privacy in your own room which means that the staff must knock and get permission to enter your room unless there is an emergency.

Other rights relate to the health-care treatment you receive at the facility. In this area, you have the right to receive complete and current information about your medical treatment in language that you can understand. As long as you are competent, you also have the right to refuse treatment or care. In addition, you have the right to fully

participate in the planning or your health care and to have a family member or other representative present at a formal care conference if you so desire.

Q. Are there additional rights under the bill of rights?

A. Yes. The rights mentioned above are just an example of those contained in the bill of rights. To make sure that you are informed of all your rights, the law requires the health-care facility to inform you that you do have legal rights when you are admitted to a facility. You must also receive a written explanation of those rights at that time.

Q. What rights do I have under the new federal law?

A. The new federal law also requires the nursing home to provide you with oral and written information explaining your rights when you enter the facility. This information must be clear and understandable. The federal law expands your rights under Minnesota's bill of rights by stating that this information must be provided in a language that you understand.

The law also gives you the right to see your own medical records within two days of your written request to view them. Under the new federal law, you may see all records that relate to you.

The federal law also contains a provision concerning resident finances. It states that the resident is free to manage his or her own funds or to have another manage them. The nursing home cannot require competent residents to deposit their funds with the facility.

The Senior Law Project provides free legal assistance to low-income older adults age 60 and older. Residents of Ramsey, Dakota and Washington counties may reach the project weekdays between 9 a.m. and noon at 224-7301. Carver and Scott County residents should call 440-1040.

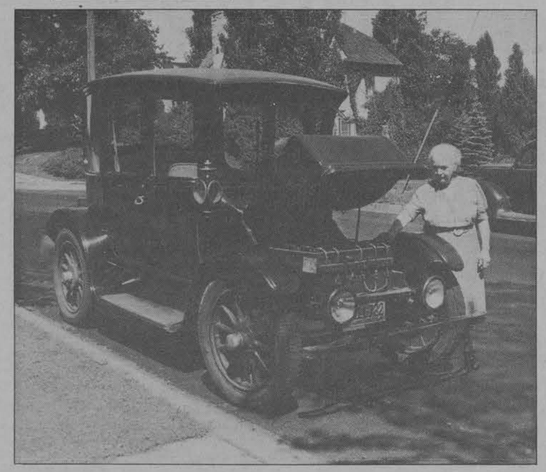
REMEMBER WHEN?

Electric cars were costly but well-built

Remember when dowagers who could afford them whipped around in electric runabouts? These motorcars were made from about the turn of the century to about 1920, though many remained in service through the end of World War II (the first car wrecked in Pittsburgh was reported to be a 1901 Riker Electric).

All electric runabouts were top-notch with respect to coach work and upholstery and cost in the $2,000 range (well over $20,000 in today's dollars). Besides the Riker there were the Baker, the Stanley, the Rauch and Lange, the Studebaker and the Chicago Electric. The photo shown here, taken by the Minneapolis Star Journal, is of a Rauch and Lange in 1941.

A big selling point for all electric runabouts was that



women did not have to struggle with a crank. The fact that none of them could go faster than 20 miles-per-hour or farther than 30 miles per battery charge may have had limited appeal to the men folk.

Story by Henry Hall. Photo courtesy of the Minnesota Historical Society.

ON BOOKS

Hassler's absorbing 'Simon's Night' reveals aging as it is experienced

"Simon's Night," by Jon Hassler, Balantine Books, 1979.

Someone once said, "if you want facts, find a good reporter; if you want truth, find a good novelist." This book is a case in point. The author explores aging as it is experienced, not as a sociological phenomenon. It has been around longer than most books we like to review here, but our excuse is that the author has made it into a play opening at the Hennepin Center for the Arts on Friday, April 5 (see related story on page 9). Book and play are both particularly relevant to older people.

The truth Hessler tells here concerns the rewards in later life that tend not to happen in homes for the elderly.

The hero, Simon Shea, thinking his mind has gone, signs himself into such a place — the Norman Home — and immediately begins a losing battle to adapt. Helping to keep him from adapting is the physician who gives him his preadmission physical. She is an attractive young woman who lives with a Vietnam War veteran she met while he was kicking his various chemical dependencies and she was in training. She tells Simon, "Get out of that place or you will become feeble minded." Simon is a retired English professor who has also been doing book reviews for a St. Paul newspaper for 35 years. His brain was an important tool of his trade.

Simon, however, has been forgetting things. He forgot where he left his car the last time he was in St. Paul and it is still missing when the story begins; and he forgot to turn off the stove, almost burning down his cabin. He is 76 and believes it is time not to have to think about things. For 33 years, he has been

HENRY HALL

living by himself after his wife took off with an artist. A strict Catholic, he cannot see divorce as an option.

While pouring a drink for his doctor and her friend, Simon shares his feeling about memory loss: "It feels like death ... like every alternative in life has been taken away ... every action might lead to some unforeseen disaster. And then — worse — you begin thinking that your inaction might lead to some other disaster. You get to thinking you're forgetting something even when you aren't."

After they have left, and with help of four hefty shots of whisky — Simon bears his soul in the prayer format he devised years ago to help him keep his faith secure. He begins with a psalm and then improvises, clearly revealing how much better he feels now that the doctor and her friend have come into his life. He also reveals the depth of his religious belief (and, one suspects, the author's). Religion thus becomes a premise of the story.

The book could become unbearably ponderous and pontifical except that Hassler uses his deft sense of the absurd to demolish whatever he sees as pretentious or phony. The Norman Home, the local hospital, the bank, shopping malls, funeral parlors, auto repair people and miscellaneous bureaucrats all are subjected to a thorough and delicious slashing.

Even the Catholic Church, a major factor in Simon's thinking and action, gets some rough treatment when Simon goes to confession after a week's extramarital affair. The priest, fresh out of seminary, keeps calling Simon "my son." Without making any effort to determine Simon's marital or family status, he launches into a homily about man's obligation to wife, home and children.

Throughout his life as well as this story, Simon has experienced major revelations. One led him to break off his affair and another led him to decide that the residents of the Norman Home needed goals. It's not unfair to readers to reveal that the latter revelation has a bizarre and absurd outcome. Further detail about the plot is best discovered in the book (currently available) or the play.

The philosophical clincher, 10 pages from the end of the book, is that everyone needs to be taken seriously, if only by a few people. Simon has found a few people who take him seriously and the discovery leaves him hopeful about the future, although neither he nor the reader knows exactly how it all will go.

The play, well worth seeing, comes down in the end about the same as the book. It takes a slightly different route because everything in a play must come out of someone's mouth.

The play is ably cast and professionally performed, and people who appreciate theater will probably enjoy it. People looking for insights into human aging should also read the book. It doesn't matter which comes first.

VOLUNTEER!

Like to bowl? Share the fun with others!

The Greater St. Paul Retired Senior Volunteer Program seeks Ramsey, Dakota and Washington County residents age 60 and older to share their lifetime experiences through volunteer activities. RSVP offers supplemental insurance coverage and limited reimbursement for travel and meal expenses. For more information, call 221-2820.

Bowling Assistant — Spend time on Saturdays helping with a weekly bowling activity at a Como Avenue board-and-care facility. Set up and put away equipment, keep score, and keep the game running smoothly. A chance to utilize knowledge of the game and visit with residents.

Secretarial Assistant — Open and sort mail, assist visitors, and answer phones for a large program that advocates for seniors. Flexible hours. Orientation and training provided.

Legal Referral Volunteer — Interview and assess inquiries from seniors in regard to legal advice. Make referrals to appropriate legal services. Must be a good listener and have patience. Flexible Tuesday and Thursday hours.

Mender — Stitch and repair clothing for residents of board-and-care facilities. Items can be mended at home. Various sites.

Crisis Line Advocates — Provide support, advocacy, and information and referral to battered women in Washington and northern Ramsey counties. Training is provided. Flexible hours.

Elder Friends Co-Coordinator — Assist the coordinator of a program that provides socialization opportunities for frail older people. Position requires approximately 10 hours per week with a one-year commitment.

Swimming Assistant — Experienced swimmers are needed to work on a one-to-one basis with adults who are developmentally disabled. Plenty of instruction is provided while in the water.

Gifts Coordinator — Organize and coordinate a program that acquires, stores and delivers gift items such as lap robes, gowns and slippers for cancer patients. A responsible but very rewarding position.

Shoppers — Get your exercise while shopping for groceries for a service that delivers to older and handicapped individuals' homes. Volunteers are especially needed in the Midway and Roseville areas. Positions are also available for grocery deliverers.

Handy Helpers — Repair, build, install, replace. If you enjoy making minor repairs and doing small building projects, there are places in St. Paul that can use your expertise. A variety of projects await a person with dependable carpentry skills.

Office Worker — Help in the office of a West St. Paul school. Typing, filing, answering phones, and helping with mailings are all a part of this job. Hours are flexible.

Carousel Workers — Sell tickets, souvenirs or even operate the carousel in St. Paul Town Square. Have a good time with children of all ages. Flexible shifts are available evenings or on weekends.

Opinion

DISTORTED IMAGES

Competition spurs a 'medical arms race'

Let's face it. Nobody wants a doctor who doesn't keep up with the latest medical practices. And who wants to stay in a hospital that uses antiquated equipment? When it comes to health care, Americans expect the best.

To stay competitive, many doctors and hospitals are buying sophisticated and expensive medical technologies. The problem is, many of those new technologies aren't even needed.

The result: skyrocketing costs and possibly "even a threat to the quality of patient care," according to a recent report by the Metropolitan Council's Health Planning Board.

Experts estimate that at least 20 percent of the national health bill — $125 billion in 1989 — is wasted on unnecessary, inappropriate or dangerous treatments that have not been proven effective.

1990 was a good year for older Americans

Following the 1989 repeal of the controversial Medicare catastrophic insurance law, many elderly advocates feared Congress might turn a deaf ear to the needs of older Americans. It didn't happen.

Advocates say 1990 was a good year for the elderly. For starters, the Social Security trust fund was taken out of budget deficit calculations. Mammography screenings were added to Medicare. Tighter controls were placed on the sale of "Medigap" insurance policies. The U.S. Supreme Court ruled that employers must spend equally on benefits for workers over 65 as for those under 65. Even proposed cuts in Medicare were later scaled back after elderly activists complained to Congress.

Not a bad year at all.

A new image, but are they serious?

The National Committee to Preserve Social Security and Medicare is trying to clean up its act.

For years, the organization has been accused of using scare tactics to recruit new members and raise money. Today, the group's leaders are more concerned about reputation, evidenced by a new lobbying presence in Washington and toned-down fundraising letters.

Not everyone is convinced by the change, however. "I still caution my people," Rep. Sherwood Boehlert, R-N.Y., told the AARP Bulletin. "Let the buyer beware, so to speak. I do not recommend they contribute to that organization."

GUEST COLUMN

Frail elderly need help at home, not more nursing-home beds

ANN WYNIA

Minnesota must change the way it addresses the problems of vulnerable elderly people. To begin with, the widespread assumption that all elderly people eventually will live in nursing homes must be changed. It is true that between one-fourth and one-third of all seniors spend some time in nursing homes, but only 5 to 8 percent live there at any one time.

Nearly 25 percent of Minnesota's nursing-home residents are there mainly for supervision and minimal assistance. Within about six months of admission, more than half of them have "spent down" their own money and are eligible for Medicaid. From then on, their care costs are a public expense.

If we continue at current rates, Minnesota is going to need at least 8,000 more nursing-home beds by the year 2010. At today's average cost of $27,000 per person per year, state spending for the same level of service will increase from the current $550 million a year to $1.4 billion by 2010.

The most rapidly growing category of elderly people is age 85 and older, and they are also historically the most frail and most in need of health and social services. Their numbers are projected to increase 64 percent between now and the year 2010.

The Minnesota Department of Human Services learned last year how quickly such numbers grow, when 2,000 more nursing-home residents than had been projected became eligible for state-paid Medical Assistance. The amount needed to cover their costs was $54 million, a figure that has become a key factor in the current fiscal year budget.

The money would last longer if it were used differently. For about $3,000 a year, vulnerable elderly people can be supported independently with Alternative Care Grant (ACG) services. For every 100 people served by ACG, there is a corresponding decrease in 58 nursing-home Medicaid enrollments.

State agencies addressing the future needs of older Minnesotans have developed an agenda that proposes expanded access to ACG programs. These programs help people stay in their homes by providing homemaker services, home-health aides, personal-care assistance, family foster care, respite care and adult day care.

In Minnesota, many good public and private programs serve the elderly. However, they are not coordinated and families who need help deciding whether and how to maintain elderly relatives at home can find it difficult to know what is available. In some communities, services are limited; in others, people are not always aware they exist.

What Minnesota needs is a new effort to integrate services and programs into an organized infrastructure of community services for the elderly throughout the state.

The state of Oregon has developed a model from which we can learn. Not only does Oregon spend less than Minnesota on long-term institutional care and more on a well-developed alternative-care system, but it also has reduced the percentage of people over age 65 in nursing homes to 3 percent.

Changing how the state operates is not going to be cost-free. We must understand that an investment in home and community services is a far better contribution than are bricks and mortar for more nursing-home beds.

A crisis is looming, costs are rising, and the consequences of not acting are clear. With experience gained in Oregon, Minnesota knows what to do.

Ann Wynia, St. Paul, is a former Minnesota Human Services Commissioner and a former majority leader of the Minnesota House of Representatives.

FROM THE EDITOR

Is Good Age important to you?

By Doug Hanneman

For the better part of ten years, those of us who work on Good Age have striven to give you a quality newspaper. Many of you have taken the time to tell us how we're doing.

Some readers have told us how much they appreciate Good Age's coverage of legislative issues affecting older Minnesotans — coverage they don't find in other newspapers. Others have told us of dramatic improvements in their lives after requesting services that they first learned about in Good Age. Still others have told us how their lives changed after following advice given in one of our health or legal columns.

We hope that you, too, have personally benefited from the news and information found in these pages. And we hope you'll continue to benefit from what you read here in the months ahead.

But to keep bringing Good Age to you, we'll need your help. Without it, the very existence of Good Age may be in jeopardy.

First, a little history will explain why this appeal is being made.

In Good Age's early days, advertising was the sole source of income. But advertising paid only a portion of the bills. Fortunately, in 1984, the Amherst H. Wilder Foundation stepped into the picture and generously agreed to pick up all of Good Age's costs. This subsidy has continued for seven years.

Today, faced with fiscal constraints familiar to most nonprofit human-service organizations, and with an expanded emphasis on direct services to older adults most at risk of institutionalization, Wilder is no longer able to fully subsidize Good Age's $48,000 annual budget. Beginning July 1, the subsidy to Good Age will be significantly reduced. That's why we're asking for your help.

In the coming weeks, we'll be sending letters of appeal to dozens of local senior centers, senior high-rises, churches, and other organizations serving older adults. Many of these are groups that have received large quantities of Good Age free of charge for many years. Ultimately, Good Age's future will depend on their support.

Our goal is to raise at least $10,000 by finding 100 or more contributors to donate $100 each by June 1. This will ensure the continued publication of Good Age through June 30, 1992. The names of those making contributions will appear as "Friends of Good Age" in each issue during the year.

But to reach this goal, we'll also be needing the support of many caring, generous individuals. Your contributions may be mailed to Good Age at 570 Asbury St., Suite 305, St. Paul, MN 55104. If you have any questions, call Good Age at 649-3661.

As you might know, Good Age is largely a volunteer operation — 14 volunteers over age 65 help make this newspaper possible. You can join them in supporting Good Age's mission by making a contribution. Your generosity will help ensure that Good Age continues to serve you and 25,000 other readers with news and information vital to your daily lives.