Aging and Long-Term Care

4 CE Hours

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Learning objectives

- Describe the causes of the booming elderly population.
- Define the following subgroups: “young-old,” “old,” and “old-old.”
- Discuss some of the pros and cons associated with specific psychosocial interventions in nursing homes.
- Describe three different models of respite care and explain their purpose.
- Discuss the reasons older people frequently turn to primary care physicians for mental health care.
- Summarize the four main barriers to treatment encountered in long-term mental health care.
- Discuss barriers to the delivery of mental health services to older adults and strategies used to address them.
- Identify three key adaptive mechanisms used by older people.

Introduction

The average life span of Americans has increased dramatically, and the population age 85 and over has grown and will continue to grow throughout this century. Old age is a lively and exciting time for many Americans, with the majority of older Americans coping constructively with the many changes that accompany the aging process. But many elders struggle to cope with difficult life situations or mental disorders that negatively affect their ability to participate fully in life. It is estimated that nearly 20 percent of the population aged 55 and older experience mental disorders that are not part of “normal” aging.

The cost of this loss of vitality—to elders, their families, their caregivers, and the country—is staggering. Moreover, ample evidence suggests that older Americans could avoid much of this suffering if prevention and treatment resources were more adequately delivered. A growing body of scientific research has highlighted both the potentially disabling consequences of unrecognized or untreated mental disorders in late life, and important advances in psychotherapy, medications, and other treatments. When interventions are tailored to the age and health status of older individuals, a wide range of treatments becomes available for most mental disorders and mental health problems experienced by older people. This, in turn, can vastly improve the quality of late life. Despite this progress, stigma, missed opportunities to recognize and treat mental health problems in older people, and barriers to care prove that there is still a great deal to do.

Since 1900, the percentage of Americans age 65 and over has tripled. In 1998, this group numbered 34.4 million and represented 12.7 percent of the U.S. population, or about one in every eight people. America’s older adult population will burgeon between the years 2010 and 2030, when the 76 million members of the “baby boom” generation born between 1946-1964 reach 65 years of age. At that time, older people will account for 20 percent of the nation’s population (USDHHS, 1999a). The interplay of mental health and aging issues, pointed out in the early 1970’s by Butler and Lewis and others, may become even more evident in the future (Butler and Lewis, 1973).

Based upon studies that examine the existing mental health needs of older Americans, it is reasonable to anticipate that the upsurge in the number of older adults in this new century will be accompanied by an increased need for mental health and supportive services tailored to this population. The challenges that mental health and aging policymakers and service providers are already facing and may expect to confront in the future can be readily identified. This section focuses on major issues in the field of mental health and aging; discusses efforts to address these issues; and identifies crucial challenges that must be confronted in the years ahead, as well as strategies to meet them.

The following sections provide a discussion of issues related to the mental health needs of older Americans, including a demographic profile of the nation’s elderly population, the mental health problems that tend to be more prevalent among them, mental health and aging dilemmas that concern policy makers as well as service providers, and efforts to give heightened attention to these challenges and to provide programmatic and policy responses.

Older Americans and their characteristics

Older Americans are a diverse segment of the nation’s population. With the extension of longevity, the diversity of older people in communities across the U.S. has become even more apparent. Not only do the values, beliefs, and activities of the old-old appear to differ from those of the young-old, younger cohorts of older Americans also include more people of minority ethnicity and race. These differences foreshadow the variations that can be anticipated within the baby boom generation that will begin to turn 60 years old in 2006.

The following provides a brief description of the characteristics of the older adult population in the United States:

- **Age.** Older adults are often categorized by their age: young-old (65-75), the old (75-85), and the old-old (85+). The older population itself is getting older. People 85 years and older comprise the most rapidly growing segment of the U.S. population. Among those older Americans are centenarians, numbering 55,000 in the year 2010 (U.S. Bureau of the Census, 2010). While the extension of longevity among older Americans is a result of public health and other successes, the incidence of chronic illness and vulnerability to mental health conditions, such as depression and Alzheimer’s disease, tends to rise in the later years of life. In addition, while suicide rates for people 65 and older are higher
than for any other age group, the suicide rate for people 85+ is the highest of all – nearly twice the overall national rate.

- **Gender.** Most older people, and especially the old and old-old, are women. At 65 - 69 years of age, there are 118 women for every 100 men. At age 85+, there are 241 women for every 100 men (USDHHS, 1999b). On average, women live seven years longer than men and are much more likely than older men to be widowed, to live alone, to be institutionalized (Goldstein & Perkins, 1993), and to receive a lower retirement income from all sources. Because they live longer, women are also likely to suffer disproportionately from chronic disabilities and disorders, including mental disorders. However, Caucasian men who are 85+ account for the high suicide rate —65 per 100,000 people -- in the elderly population (CDC, 1999). One subsegment of the older adult population — older gay men and lesbians — have not been a focus of most discussions about aging and mental health. Yet, the challenges faced by gay men and lesbians have become more widely known in recent years. Though there is a dearth of sound research on the mental health needs of gay, lesbian, and bisexual Americans, some have suggested that these individuals may be at increased risk for mental disorders and mental health problems due to exposure to societal stressors, such as prejudice, stigmatization, and anti-gay violence (Dean et al, 2000). Social support— which is an important element of mental health for all older people— may be especially critical for older people who are gay, lesbian, or bisexual (Dean et al, 2000). Furthermore, access to health care may be limited because of concerns about health care providers’ sensitivity to differences in sexual orientation (Solarz, 1999). Further research on the mental health needs of older gay, lesbian, and bisexual Americans is needed.

- **Marital Status.** The emotional and economic well-being of older Americans is strongly linked to their marital status. Between the ages of 65 and 74, 79 percent of men and 55 percent of women were married in 1998. These numbers decrease significantly in the eighth decade of life, with 50 percent of men married and 13 percent of women married at age 85+. Among older Americans age 85 and older, 42 percent of men were widowers and 77 percent of women were widows. While only 4 percent of older men and 5 percent of older women had never married, all older people who were alone because they were widowed, divorced (7 percent), or unmarried were more apt to live alone, to have a lower household income, and to have fewer caregivers available to assist them (Federal Interagency Forum on Aging Related Statistics, 2000).

- **Minority Status.** Minority populations are expected to represent 25 percent of the elderly population in 2030, up from 16 percent in 1998. Between 1998 and 2030, the Caucasian population 65 years and over is expected to increase by 79 percent compared with 226 percent for older minorities, including Hispanics (341 percent), African-Americans (130 percent), American Indians, Native Alaskans, and Aleuts (150 percent), and Asians and Pacific Islanders (323 percent) (USDHHS, 1999b). Minorities face additional stressors such as higher rates of poverty and greater health problems (Sanchez, 1992). Despite this, access to health care is frequently frustrated by limited English proficiency and by the lack of availability of bilingual health care providers. In a number of minority groups, Westernized mental health treatment modalities that tend to be dependent upon verbal inquiry, interaction, and response, do not appear to present a comfortable “fit” with many minority cultural beliefs and practices. Consequently, minority communities have consistently called for assistance from people who are bilingual and bicultural. Where these are not available, there has been a call for mental health services and provided by professionals who have an understanding and appreciation for their cultural values, norms, and beliefs and are culturally competent.

- **Income.** A number of studies have identified poverty as a risk factor associated with mental illness (Bruce & McNamara, 1992; Cohen, 1989; Sanchez, 1992). For those individuals who are poor or who have limited incomes, the lack of adequate financial resources can seriously constrain access to health and mental health services. While the economic status of older Americans has improved, there is wide disparity in the distribution of income, especially among subgroups within the elderly population (Siegel, 1996; U.S. Bureau of the Census, 1996).

- **Living Arrangements.** Living arrangements tie closely to income, and, specifically, being at risk of poverty, health status, and the availability of caregivers (Federal Interagency Forum on Aging Related Statistics, 2000). The majority of nursing home residents have such mental disorders as dementia, depression, or schizophrenia. Moreover, a recent Supreme Court decision, Olmstead v. L.C., requires states to provide community-based services for people with disabilities— including mental disorders—who would otherwise be entitled to institutional services, provided that community placement is appropriate, the affected people do not oppose such a plan, and the placement can be reasonably carried out considering the resources of the state. Thus, mental health services must be designed to fit the needs of people irrespective of their living arrangements.

- **Physical Health.** The majority of older people report that they are in good health compared with others their age (APA Working Group on the Older Adult, 1998). However, most older people have at least one chronic condition and many have multiple conditions, such as arthritis, hypertension, heart disease, cataracts, or diabetes. Between 1994-1995, over 4.4 million (14 percent) had difficulty in carrying out activities of daily living such as bathing or eating, and 6.5 million (21 percent) had difficulty with activities such as shopping, managing money, doing housework, or taking medication, many because of chronic disabling conditions. Although poor physical health is a key risk factor for mental disorders (Kramer et al, 1992), recent studies have established that all too often symptoms of mental disorders escape detection and treatment by health professionals who treat older people for physical ailments. Yet, the prevalence of chronic conditions in the elderly population should be a cause for anticipating possible comorbidity. Understanding the relationships between physical and mental health is a central task in the assessment and treatment of older people by health care professionals (APA Working Group on the Older Adult, 1998). Moreover, potential adverse effects of medications, and specifically of drug interaction effects, are more likely among older people, who tend as a group to use more prescription drugs, and should thus be a point of routine inquiry by health care professionals.

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**Successful aging: Stressors and adaptations**

During the normal process of aging, older people encounter stressors, such as retirement from a career or job, that may trigger both appropriate and distorted emotional responses. However, exposure and adaptation to these stressors varies with each person’s economic resources, gender, ethnicity, level of education, life experiences, and perception of the meaning of the stressor itself. Pearlin and Skaff (1995) view older people as confronted with two main types of stressors: life events and chronic strain, and their conceptualization is used in discussing these events. The life events thought to be the most stressful are those that are unscheduled or undesired rather than those that can be planned for, such as a lack of an occupational role in retirement. As older people confront undesired life events, there is an intricate balance of physical, social, and emotional forces, any one of which can upset or involve the others. The initial event or primary stressor may lead to secondary stressors as those described below:

- **Health-related events.** Health events such as a fall or a heart attack have a more depressive effect than many other types of events (Ensel, 1991; Murrell et al., 1988). For example, an elderly woman falls...
and breaks her hip, which necessitates hospitalization and surgery. Upon her return home, she finds that stress proliferates as she needs help with shopping and the maintenance of her home, experiences economic strain, and is unable to participate in leisure activities. It may be difficult to distinguish the depressive effects of acute health events from the chronic problems that result from these events.

- **Loss of loved ones.** The loss of relatives, friends, or a spouse during the advanced years of life can result in loneliness, an increased sense of vulnerability, increased isolation, and other psychosocial dilemmas. Frequently adding to the emotional toll of bereavement is the need to also make practical decisions—where to live and what to do about the family home and possessions (Butler et al., 1998). Social roles may change, as can connections to friends, family, and community. Some people may gain a new sense of independence and competence (Lopata, 1979; Wortman & Silver, 1992) as they adapt to these losses and changes. However, bereavement is a well-established risk factor for depression (Zisook & Shuchter, 1993; Zisook et al., 1994).

In addition to these unplanned life events, chronic strains may also impact the older adult (Pearlin & Skaff, 1995):

- **Strains related to their community or neighborhood of residence.** Relocation may place an older person in an unfamiliar environment. If the person remains in his old neighborhood, the older person may feel separated from previous support networks because familiar neighbors may no longer be there. A deteriorating or changing neighborhood may be upsetting, and access to transportation, convenience to shopping and medical care, and availability of a senior center or movie theater are all amenities whose absence may constitute ambient stressors. Also, growing frailty may leave people feeling less able to defend themselves against physical dangers.

- **Relationship strains.** These strains may occur in relation to family members. Older people may experience disappointments with regard to their children’s situation in life, especially if it does not coincide with their own values or desires. For example, their children may not be raising their own children in a way that meets with the elder’s approval, or may not be supportive or respectful of the older person. Additionally, assuming caregiving responsibilities for a spouse may lead to secondary stressors, such as family conflicts, financial strains, or the loss of the caregiver’s identity. Finally, financial hardship and chronic health problems may create undesired dependency on others.

- **Strains in the older person’s immediate environment.** These involve the ordinary logistical problems or “hassles” that people face in their daily lives. Studies of the old-old who live independently have focused attention on this class of stressors (Barer, 1993). They include such ordinary activities as getting out of the bathtub, managing the steps on a bus, seeing the fine print in a telephone book, changing a light bulb, or removing trash for pickup. For people of advanced age, these activities may be major obstacles to be overcome each and every day.

Historically, our society has held ambivalent views of aging and of older people. Among these are many persistent myths that have resulted in the devaluation of the potential of older adults. For example, the myth that older adults are set in their ways and incapable of learning, growing, and changing does not take into account the fact that declines in some intellectual abilities generally are not severe enough to cause problems in daily living. More importantly, such a myth disregards determinations by researchers that the aging brain has the capacity to make new connections, absorb new data, and, thus, acquire new skills (Rowe and Kahn, 1998). Furthermore, it disregards recent analyses that suggest that creativity is not lost in old age (Cohen, 2000).

Yet another myth incorrectly suggests that lack of productivity is associated with old age. It miscasts older people as no longer capable of being productive on the job, of being socially active, or of being creative. Instead, older adults are cast as disengaged, declining, and disinterested in life. However, most older people tend to remain actively concerned about their personal and community relationships and many are still employed (APA Working Group on the Older Adult, 1998; Butler et al., 1998; Rowe and Kahn, 1998).

Acknowledging such myths is important in order for communities to support the self-esteem of older people, their ability to live and work successfully, and their ability and motivation to maintain and improve the quality of their lives. Health, mental health, human services, and aging programs will be miscast if old age is perceived to be a time of inevitable isolation, decline, and decay. Thus, mental health and aging professionals must be attentive to their biases and stereotypes in order to effectively serve older people (Roff and Atherton, 1989). Recent research helps to further debunk ageist stereotypes by revealing that older people as a group cope and adapt well and tend to be very resilient. This resilience is comparable to and sometimes exceeds that of their younger counterparts (Foster, 1997). Older people also appear to have the capacity for constructive change, even in the face of mental illness, adversity, and chronic mental health problems (Cohen, 1988).

Whether older people can face stressors, function well, and maintain their well-being appears to depend upon the resources that older people possess and use. Several key adaptive mechanisms used by older people have been identified (Pearlin and Skaff, 1995):

- **Coping.** Coping involves managing situations giving rise to stress, managing the meaning of these situations, and managing the stresses that result from these situations. Older people tend to use “emotion-focused coping,” a strategy that refers to managing the meaning of the situation or controlling the symptoms of stress rather than trying to manage the stressful situation itself (Chiriboga, 1992; Martin et al., 1992). Some of the stressors experienced by older people, such as frailty and chronic health problems, are not easily modified by problem-solving; thus, older people may cope by reshaping the meaning of the situation or restructuring their priorities. For example, an elderly woman who has painful arthritis and cannot tolerate the side effects of the medication is very disappointed that she can no longer play the piano. She may choose to continue to enjoy music and to find satisfaction by coaching students. Older people also cope by universalizing their situation and comparing themselves with others, using family and friends as reference points. This strategy helps them to see that hardships are not aimed solely at themselves, but also impact their peers.

- **Social support.** Social support includes both concrete and emotional assistance provided by families, friends, neighbors, and volunteers or by acceptable private or governmental organizations, including religious organizations and senior centers that have high levels of legitimacy within their community and their peer group. For example, older people may actively participate in church groups, supported by a circle of friends, or may receive concrete support in the form of homemakers or chore services and home-delivered meals when needed. An extensive body of research has shown that social support is an important predictor of good physical and mental health, life satisfaction, and reduced risk of institutionalization among older adults (LaGory & Fitzpatrick, 1992; Forster & Stoller, 1992; Sabin, 1993; and Steinbach, 1992). Social support may also buffer the adverse effects of various stressors common to aging (Feld & George, 1994; Krause & Borawski-Clark, 1994). Researchers point out, however, that the effectiveness of social support depends on the situation, the person, and his or her needs; thus, goodness-of-fit is essential. Unneeded, unwanted, or the wrong type of support may reduce older peoples independence or self-esteem (Pearlin and Skaff, 1995; Rowe and Kahn, 1998).

- **Sense of control.** Many older people maintain a sense of mastery over the circumstances of their lives, and this sense extends into late life as a resource important to well-being (Rodin, 1986). Those working with older people can reinforce this sense of control by respecting their right to make decisions or to initiate, withdraw,
or terminate treatment (APA Working Group on the Older Adult, 1998). A sense of control has also proved to be an effective buffer mitigating the impact of stressors (Cohen & Edwards, 1989; Krause & Stryker, 1984). For example, in Alzheimer’s caregivers, a strong sense of mastery protects the caregiver against the stressors that arise in the daily care of the patient (Skaff, 1991).

In their study of high functioning older people, Rowe and Kahn (1998) found three characteristics that define successful aging:
1. Low risk of disease and disease-related disability.
2. High mental and physical function.
3. Active engagement with life.

And they found that successful aging is most fully represented by the combination of all three of these factors. However, Pearlin and Skaff (1995) point out that the outcome of successful aging must be examined not only in relation to the above three criteria, but with respect to the social, economic, and cultural conditions to which people are exposed, as well as their adaptive mechanisms. This psychosocial perspective assures that we acknowledge the diversity of older people and view each individual as having unique interactions with his or her environment.

Ideally, aging is a dynamic process in which an individual confronts the stressors and challenges of later life not as a passive victim but as an actor drawing on resources developed over a lifetime. Even the impact of losses that may be irreversible, such as those that involve personal health and the deaths of significant others, can be minimized by restructuring personal meaning, with the availability and use of social supports, and a sense of mastery over important circumstances of life (Pearlin & Skaff, 1995).

**THE MENTAL HEALTH OF OLDER AMERICANS**

Most older adults enjoy good mental health, but almost 20 percent of those who are 55 years and older experience specific mental disorders that are not part of “normal” aging. The most common disorders, in order of prevalence, are anxiety disorders, such as phobias and obsessive-compulsive disorder; severe cognitive impairment, including Alzheimer’s disease; and mood disorders, such as depression. Schizophrenia and personality disorders are less common (USDHHS, 1999a). There are suggestions, however, that mental disorders in older adults are underreported.

One study, for example, estimates that 8-20 of older adults in the community and up to 37 percent of those who receive primary care experience symptoms of depression. It is particularly noteworthy that the rate of suicide, frequently a consequence of depression, is highest among older adults (Hoyert et al, 1999). In addition, approximately two-thirds of those in nursing homes suffer from mental disorders, including Alzheimer’s and related dementias (Burns et al, 1993). Older adults with mental illness vary widely with respect to the onset of their disorders.

Some have suffered from serious and persistent mental illness most of their adult life, while others have had periodic episodes of mental illness. A substantial number experience mental health disorders or problems for the first time late in life—problems which are frequently exacerbated by bereavement or other losses that tend to occur in old age.

Yet another variable is severity. Mental disorders can range from problematic to disabling to fatal. Clearly, then, treatment and prevention efforts must take into consideration the range of experiences and needs of older adults with mental disorders in order to provide appropriate care for older people at all points of the mental health continuum. But there are major barriers to overcome. For example, assessment and diagnosis of mental disorders in older people can be particularly difficult (USDHHS, 1999).

Older people with mental disorders may present with different symptoms than younger people—emphasizing somatic complaints rather than psychological troubles (USDHHS, 1999). In addition, it can be hard to determine whether certain symptoms—like sleep disturbances—are indicative of mental disorders or another health problem (Lebowitz et al, 1997). Moreover, there is significant underdiagnosis of mental illness among primary care providers. Treatment also presents a number of challenges. Older people metabolize medications differently due to physiological changes, which may make them more vulnerable to side effects of psychoactive medications. They are also likely to take medications for other disorders, placing them at risk for unintended medication interactions. Older adults with cognitive deficits may also have difficulty managing medications or remembering appointments (USDHHS, 1999).

Psychosocial interventions can be an important component of effective treatment, but lack of transportation may make it difficult for older people to get to counseling appointments or support group meetings. As noted earlier, there is convincing evidence that depression and other mental disorders typically are unrecognized, and thus, older adults fail to receive treatment from primary care providers or other clinicians for these issues. Efforts to prevent mental disorders among older adults have also been inadequate. At this time, there is no national agenda to promote mental health and prevent mental and behavioral disorders (Center for Mental Health Services [CMHS], 2000). Present knowledge about effective prevention techniques is not as extensive as the understanding of the diagnosis and treatment of mental disorders. Preventing mental disorders before they occur—or primary prevention—requires some understanding of their etiology, risk factors, pathogenesis, and course (USDHHS, 1999). As noted in a 1994 Institute of Medicine (IOM) report, the base of knowledge about prevention for some disorders is considerably more advanced than for others (Mrazek & Haggerty, 1994). Among older adults, for example, the largest pool of primary prevention research focuses on depression that develops late in life (USDHHS, 1999). Moreover, there has been a history of disagreement within the mental health community about how to define prevention (Mrazek & Haggerty, 1994). Nonetheless, there has been a growing awareness that certain psychosocial factors can heighten the risk of developing mental disorders or exacerbate them when they occur. Further research is needed on the prevention of mental disorders in older adults. In addition, greater effort must be devoted to translating research advances that are currently in practice.

**Delivery of mental health services to older adults**

While there is strong evidence that older people may be in need of mental health services, older adults have made limited use of these services (Dennmier, 1998). A very small percentage of older adults—less than 3 percent—report seeing mental health professionals for treatment. This rate of utilization is lower than for any other adult age group (Lebowitz et al, 1997). Older Americans account for only 7 percent of all inpatient services, 6 percent of community-based mental health services, and 9 percent of private psychiatric care, despite comprising 13 percent of the U.S. population (Persky, 1998). And, in a study examining community mental health services and older people, 40 percent of community mental health providers identified non-health related services such as transportation and home help services as unmet needs, suggesting that the comprehensive needs of these people are not being met (Estes et al, 1994). Unfortunately, individual and systemic barriers thwart the provision and receipt of adequate care to older people with mental health needs. The following are among the barriers most frequently noted in the literature (Birren et al, 1992; Butler et al, 1998; Estes, 1995; NCOA, 1999; Persky, 1998):
- **Stigma.** Stigma surrounding the receipt of mental health treatment affects older people disproportionately (USDHHS, 1999a), and as a result, older adults and their family members often do not want to be identified with the traditional mental health system. The stigmatization of mental illness has deep, historical roots dating back to Descartes’ conceptualization of the separation of mind and body. During centuries past, the stigma surrounding mental illness was reinforced in both European and American societies by fears about deviant, violent behaviors. While considerable progress has been made to achieve increased scientific understanding of mental disorders, the social meanings attached to mental illness and the treatment of most conditions continue to place the moral identity of the individual at risk of degradation. Today’s older Americans grew up during decades in which institutionalization in asylums, electroshock treatments, and other treatment approaches, understandably, were regarded with fear. Moreover, among older people who tend to be defined in large measure by their pre-retirement work roles and by any ongoing community involvement, the possibility of becoming more vulnerable, falling victim to ageist perspectives, and then being doubly jeopardized and demeaned can only raise the specter of a loss of dignity and of place in society.

- **Denial of problems.** Anxiety, depression, memory loss, and dementia may complicate the ability of older people to recognize that they have a mental health problem for which they should seek help. Older people may also deny mental health problems. Health professionals, family members, and policy makers may internalize society’s negative attitudes toward older people and give superficial attention to or be dismissive of their problems. Moreover, as older people themselves become more dependent, they may fear a loss of control over their lives and, thus, become resistant to the idea that they may need help.

- **Access barriers.** Access to services by older people is thwarted in a number of ways. Affordable, accessible transportation to services may be unavailable. For some older people, the cost of mental health treatment—especially prescription drugs—may be too expensive. Older people who live alone are a particularly hard-to-reach population. They may live in rural areas that do not have adequate mental health services, or they may live near these services but far from family members. They may not be able to come to an office as a result of their physical frailty. The isolation of older adults may require outreach workers to go into the home to build relationships and provide day-to-day monitoring and support. Outreach activities may also involve approaching the family of the elder, but the only “family” may be neighbors or a service coordinator; for example, in a public housing project.

- **Funding issues.** Typically, funding streams for aging and mental health are separate and limited. As in other fields of health and human services, the separation of funding streams can complicate efforts to collaborate and can result in the fragmentation of services. Perhaps of greater concern to most service providers, families, and older people with mental health problems is the fact that current funding for both of these systems is not ample enough to cover the mental health service needs of the elderly population. While Medicare and Medicaid provide insurance coverage for older person’s mental health needs, these benefits are limited.

- **Lack of collaboration and coordination.** The mental health and aging networks are separate and distinct in most state and local communities across the nation. Coordination issues are thus as relevant in mental health and aging as in other fields of health and human services. Although interdisciplinary practice and coordination have long been advocated, there is a continuing need to emphasize their importance and to ensure that they occur. Interdisciplinary collaboration and the coordination of multiple services are especially essential in work with elders who are poor, have limited English proficiency, or have physical health problems.

- **Gaps in services.** While the mental health system has tended to not serve older people in quite the same proportion as children or adults, the Aging Network has tended, in relation to mental health and aging, to serve primarily people with Alzheimer’s disease. Even when community-based service providers have the capacity to respond to the mental health concerns of older adults, they frequently are challenged by the lack of adequate reimbursement and by the lack of a complement of staff needed to provide appropriate, culturally sensitive prevention and treatment services to minority elders and continuing care to those who are chronically mentally ill.

- **Workforce issues.** There are national shortages of health and social service professional and paraprofessional personnel who have expertise in providing geriatric mental health care. Shortages across disciplines are sure to become even more problematic as the population ages and the demand for specialized mental health services increase. One promising trend has been noted. General psychiatrists are seeing a greater proportion of geriatric patients in their practices. A survey of state home health associations found low to moderate availability of home health aides who primarily serve older adults. Despite the fact that many older adults in need of home health services have complex physical and mental problems, few home health workers had any aging-related education (Dawson & Santos, 2000). Thus, there is a critical need for training opportunities for those entering and currently working in the area of mental health and aging. Barriers to education include a lack of trained faculty, lack of training sites, student and faculty resistance, curricula that are too full, and a view of the elderly as a low-priority population.

- **Organized consumer support.** At the state, local, and national levels, there has been recent success in organizing consumer groups that include older people who are consumers of mental health and/or substance abuse services, their families, and advocates, but expansion of these efforts is needed. Although these important service delivery issues and the critical challenges mentioned at the outset of this section continue to remain concerns, there have been strong, though intermittent, efforts to give heightened attention to mental health and aging issues and to develop and provide programmatic and policy responses.

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**Community mental health services**

It is estimated that only 50 percent of older adults who acknowledge mental health problems receive treatment from any health care provider, and only a fraction of those receive specialty mental health services. The specialty mental health services system consists of private mental health providers funded by private insurance and consumers, and publicly and privately owned providers funded by states, counties, and municipalities. Institutional or facility-based mental health services include inpatient care (acute and long-term), residential treatment centers, and therapeutic group homes. Community-based services include outpatient psychotherapy, partial hospitalization/day treatment, crisis services, case management, and home-based and “wraparound” services.

Historically, public and private funding for adult mental health services was targeted toward intensive and costly institutional care. In past few decades, due mainly to court decisions restricting the institutionalization of adults with mental illness, the service priorities have changed in favor of less intense community-based services.

Most mental health funding comes from state and local governments, Medicaid, and private insurance. Publicly funded services are thought to be a “safety net” for those unable to afford private insurance or to pay for services. The federal government augments state and local funding through the Community Mental Health Services Block Grant (CMHDBG). The CMHDBG is a joint federal-state partnership that awards annual formula grants to the states to provide community-
based mental health services to adults with serious mental illness and children with serious emotional disturbance. The Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services administers the CMHSBG. Each state has a state mental health authority whose mission it is to oversee the public mental health system. In order to receive CMHSBG funds, each state must have a comprehensive plan to provide mental health services throughout the state. States vary widely in the organization of their mental health service delivery systems, and in the degree to which these systems interact with providers of other types of services—e.g., primary care, social services, and the aging network.

Access to community-based mental health services is problematic for older people because of several factors, including the growing reliance on managed care; the targeting of mental health services to specialized groups that exclude the elderly; and the emphasis public providers place on serving the severely chronically mentally ill. In addition, community mental health organizations often lack staff trained in addressing non-mental health medical needs, which are especially important for older adults. These organizations also tend not to see treatment of those with cognitive impairments as part of their mission.

Survey findings indicate that while older adults have a tremendous need for services, such as elder case management or psychiatric home care services, only a few states designate older adults as priority clients. In the past, only a minority of the states addressed the mental health needs of the elderly through specialized services for them. However, studies have also shown that the use of specialized geriatric services and staff as well as partnerships between the aging and mental health systems can increase access to services for older people. A greater number of states are now offering elderly specialized services.

### Primary and long-term care

**Primary care.** When faced with a mental health problem, older people frequently first turn to their primary care physician. Over 50 percent of older people who receive mental health care receive it from their primary care physician. Many reasons have been suggested for this pattern: going to a primary care physician does not carry the same stigma that specialty mental health services do; insurance policies encourage use of primary care; and primary care may be more convenient and accessible. While many older people prefer to receive mental health treatment in primary care settings, diagnosis and treatment of older people’s mental disorders in these settings are often inadequate. Many primary care physicians receive inadequate training in mental health. Physicians often attribute psychiatric symptoms either to changes expected with age or concomitant physical disorders and sometimes inappropriate prescribe psychotropic medications. In addition, some physicians’ negative attitudes toward older people appear to undermine their clinical effectiveness.

There are also system barriers to providing mental health care in the primary care setting. It is important to coordinate mental and physical health care, because elders with emotional problems can also have physical health problems. However, frequently, this coordination does not occur. In response to these shortcomings, several models aimed at improving mental health services in primary care have been developed. These models call for either collaboration between mental health and primary care providers, or integration of mental health providers into the primary care setting. In the past, there have been three ongoing multi-site research efforts in the United States that examined services to older people with mental health problems in primary care settings.

**Long-term care.** Various studies indicate a high prevalence of mental illness in nursing homes. Dementia and depression appear to be the most common mental disorders in this setting. However, most residents with mental disorders do not receive adequate treatment. Barriers to good treatment include:

1. A shortage of specialized mental health professionals trained in geriatrics.
2. Lack of knowledge and inadequate training of nursing home staff about mental health issues.
3. Lack of adequate Medicaid and Medicare reimbursement to facilities to cover behavioral and mental health problems.
4. Difficulty obtaining the services of psychiatrists and other mental health professionals due to inadequate reimbursement policies.

Thus, there is a great need to incorporate mental health care into the basic structure of nursing home care and to make professional services available to patients and their families. Psychosocial interventions that can be used in nursing homes include individual, group, program, family-based, and staff interventions. Each intervention focuses on helping the resident and/or the family adapt to the nursing home environment, change resident behaviors, improve quality of life, or enhance staff and resident morale.

### Mental health services in long-term care facilities

There is strong evidence of a high prevalence of mental illness in nursing homes (Lombardo et al, 1996). One study found that up to 88 percent of all nursing home residents exhibit mental health problems, including dementia (Smyer et al, 1994). These individuals exhibit a wide range of symptoms, from delusions and hallucinations to sadness and anger at their loss of privacy and independence (Lombardo et al, 1996). Depression is a major problem in long-term care facilities with estimates ranging from about 12 to 22.4 percent for major depression, and an additional 17 to 30 percent for minor depression (Burrows et al, 1995; Katz et al, 1995).

A number of interventions can be used to address the mental health needs of the residents of nursing homes, but often, they are not available. Thus, many residents do not receive the mental health care they need (Burns et al, 1993; Shea et al, 1995).

Although there is a need to incorporate mental health care as a basic component of nursing home care and to make professional services available to patients and their families, major barriers to obtaining treatment for mental health conditions in nursing homes exist. These have been outlined by Lombardo et al. (1996) in a descriptive summary of key policy issues. They include: (1) A shortage of specialized mental health professionals trained in geriatrics; (2) lack of knowledge among and inadequate training of nursing home staff about mental health issues; (3) lack of adequate Medicaid and Medicare reimbursement to facilities to cover behavioral and mental health problems; and (4) lack of adequate reimbursement to obtain the services of psychiatrists and other mental health professionals.

As continuing care retirement communities, assisted living facilities, and other types of living arrangements become more commonplace, it’s important to ensure that residents of these facilities have access to mental health services. In addition, research is needed to determine types of interventions and services that are most appropriate and effective in these settings.

A wide range of psychosocial interventions is appropriate for use in the nursing home. Smyer & Frysinger (1985) have categorized them as follows:

- **Individual interventions** include interpersonal skill training, psychotherapy, reality orientation, self-care training, or social interaction for the treatment of a specific resident.
- **Group interventions** involve several patients and may use interpersonal skill training, education and discussion, group therapy, or socialization therapy.
• Program interventions are not specific to one person or a group, but rather impact many residents by focusing on the facility’s environment or its quality of life; for example, the therapeutic use of animals, social hours, reality orientation classes, activities programs, environmental stimulation, or intergenerational programs.

• Family-based interventions include in-service training with family members and staff, short-term counseling groups for children of elderly parents, conjoint therapy with elderly couples, and can prepare residents to return to the community. Program interventions achieve specific efforts. Selected examples of interventions practiced in facilities are described below (Lombardo et al, 1996):
  - Mobile psychogeriatric teams. In one innovative model, nursing homes in rural areas were supported through state-funded mobile mental health intervention teams. A mobile psychogeriatric team, consisting of a psychiatrist, a psychiatric nurse, and a clinical social worker, were available, upon request, to 23 nursing and 28 residential care facilities in a rural catchment area. The team provides assessments, treatment services, and medication reviews for individuals with mental illnesses or behavioral disturbances; worked with staff on the development of care plans; and trained staff. The program was prevention-oriented, aimed to avoid development of psychiatric crises, and thus, worked to reduce the likelihood of admissions to acute hospital settings.
  - In-facility mental health department. A mental health department staffed by a psychiatric mental health clinical specialist was established within a facility. The specialist reviewed psychotropic medications to ensure the appropriateness of the drugs, dosages, and times of administration; developed nursing interventions that could be used in addition to or in place of medications; and worked closely with staff to suggest how to address behavioral problems.
  - Preadmission Screening and Resident Review (PASRR) agency collaboration with Health Department. The mental health and public health systems and the aging network collaborated on the implementation of PASRR, instituted by the Omnibus Budget Reconciliation Act of 1987 (OBRA). Some states set up systems to use PASRR Level II screening results to establish treatment plans to improve the mental health care of residents. In one example, the PASRR screening agency sent the Department of Health a list, by residents, of all residents or prospective residents who received Level II screening, were appropriate for admission, and needed mental health services. Surveyors then spot checked records of residents to see whether they received recommended mental health services. If residents were not receiving the services, facilities could cited for deficiencies and required to develop a plan of correction.

• Staff interventions include weekly staff meetings; training or workshops for staff; environmental alternatives to increase social interactions among patients, staff, and family members; or a core group of administrators that focuses on staff relations and attitudes.

What mental health needs are addressed by psychosocial interventions in nursing homes?

Individual and group interventions can be utilized to help residents adapt to the nursing home environment and role changes. For example, residents can be assisted to regain or maintain orientation to their surroundings, or, with withdrawn residents, increasing their social activities. Other similar interventions can decrease specific problems or achieve specific behaviors, such as social interaction. Also, interventions can prepare residents to return to the community. Program interventions offer benefits and can help to improve quality of their lives. In a 10-state study, ethnographic researchers found that quality of life issues, such as dignity, independence, freedom of choice, self-image, and a sense of purpose and privacy, were important to residents (Teitelbaum, 1995). Family-based interventions usually focus on providing accurate information about the aging process and the specific difficulties troubling the resident, enabling family members to better understand their own reactions to the older adult’s impairments and increasing the ability of caregivers to provide optimal care while continuing their own personal development. Finally, the purpose of staff interventions is to improve both staff and resident morale and functioning.

How are these interventions implemented?

Mental health interventions can be implemented in the nursing home setting in a variety of ways. Due to the scarcity of mental health professionals who work directly with residents, consultation and education with staff are often utilized. There may be an arrangement with one or more mental health specialists who monitor and train the staff, consult with attending physicians, and assist staff in conducting assessments and developing individual care plans. Or, there may be a senior nurse with knowledge and skill in mental and behavioral areas who advises staff. While program strategies that include mental health interventions are implemented in some nursing homes, there is a paucity of outcome-oriented research on the effectiveness of such efforts. Selected examples of interventions practiced in facilities are described below (Lombardo et al, 1996):

- Mobile psychogeriatric teams. In one innovative model, nursing homes in rural areas were supported through state-funded mobile mental health intervention teams. A mobile psychogeriatric team, consisting of a psychiatrist, a psychiatric nurse, and a clinical social worker, were available, upon request, to 23 nursing and 28 residential care facilities in a rural catchment area. The team provides assessments, treatment services, and medication reviews for individuals with mental illnesses or behavioral disturbances; worked with staff on the development of care plans; and trained staff. The program was prevention-oriented, aimed to avoid development of psychiatric crises, and thus, worked to reduce the likelihood of admissions to acute hospital settings.

- In-facility mental health department. A mental health department staffed by a psychiatric mental health clinical specialist was established within a facility. The specialist reviewed psychotropic medications to ensure the appropriateness of the drugs, dosages, and times of administration; developed nursing interventions that could be used in addition to or in place of medications; and worked closely with staff to suggest how to address behavioral problems.

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How effective are psychosocial interventions in nursing homes?

While there is no way to reverse the most common causes of dementia, research has shown that depression and anxiety in older people with chronic diseases, including some forms of dementia, usually can be treated successfully with medication and with various forms of psychotherapy and cognitive behavioral therapy (Burns, 1992; Fogel, 1993; Gallagher-Thompson, 1994, Kambholz & Gottlieb, 1990). There are many studies that evaluate the various types of interventions. Examples of outcomes from studies that examined individual, group, program, and staff interventions are described in this section. In a five-year study, Haight et al. (1998) followed 256 newly relocated nursing home residents who received individual interventions. Group members participated in “life review” activities conducted by a therapeutic listener on a one-to-one basis, while those in the control groups received friendly visits. Life review is a form of reminiscence therapy, involving reciprocal acts of telling and listening. The listener helps the older person reframe and integrate life periods and events. Controlling for the effects of adjustment over time, researchers found that at eight weeks, experimental group members were significantly less depressed. At the end of the first year, there was significantly less depression and hopelessness and greater psychological well-being and life satisfaction in the life review groups compared to the control groups. Researchers concluded that over time, life review can alleviate despair in frail elders who have been newly admitted to a nursing home.

In a review of 29 studies that focus on improving the quality of life in nursing homes, Wieland et al., 1995 included a group intervention (Moran & Gatz, 1987) that evaluated the effect of task-oriented versus insight-oriented group therapy conducted in two different groups on locus of control and life satisfaction. Results were compared with a wait-list group. Twelve weekly sessions, each 75 minutes in length, were held with the residents. The task-oriented group improved on locus of control, active coping, striving for social desirability, and sense of well-being, but not on trust. The insight group improved on locus of control and trust. However, trust decreased in the control group. The residents indicated they liked these groups, and there was less than 20 percent attrition in attendance.

A program model that has drawn considerable attention, the Eden Alternative, founded in 1994, provides a more humane habitat for residents of nursing facilities, using the companionship of animals and other humans. For example, birds, dogs, cats, rabbits, and even...
chinchillas are brought into the facility. Rooms and halls are filled with green hanging plants, and residents can plant vegetables and flowers in gardens on the grounds. Children play onsite and mingle with residents for several hours most days as part of a day care program. Three years after the project began in a nursing facility, staff found a 15 percent drop in the death rate compared to a nearby nursing facility that served as a control. Infection rates dropped by about 50 percent. Staff turnover rates plunged by 26 percent, saving the facility the cost of recruiting and training nursing assistants — about $2,000 per individual. The average number of prescriptions per resident fell to 3.01, compared to a national average of 5.60. And, medication costs fell to less than 56 percent of the U.S. average (Lombardo et al., 1996; Thomas, 1994; Vilbig, 1995).

Finally, Smith et al. (1994) describe a Geriatric Mental Health Care Training Project that trained nurses and nursing personnel in rural long-term care facilities to care for residents with psychiatric and behavioral problems. A two-day train-the-trainer program covered six modules focused on mental health topics, including the causes of problem behaviors, management techniques, and the impact of the care providers’ feelings and reactions. Geropsychiatric nurse specialists trained 43 nurse leaders, and then these leaders trained 520 staff in their own facilities. Two-way interactive telecommunications techniques were also used to reach leaders in rural facilities. The nurse trainers viewed the program materials as relevant and user-friendly, while the trainees gave the overall quality of the program, its relevance, and usefulness high marks. There was a significant increase in knowledge on the part of both the trainers and trainees. And, pre- to post-test attitude changes were overwhelmingly positive for the trainees. The leaders/trainers—who had more positive attitudes to begin with—showed a less dramatic pattern. Prior to the training program, many problem behaviors were attributed wrongly to the resident being manipulative rather than to impairments or to feeling threatened. After the training, these attitudes improved.

Supportive services and health promotion

This section describes a number of supportive services and health promotion activities that may help older people with mental disorders and their families. In planning for the delivery of mental health services, it is clear that alternatives to specialty mental health settings must be considered, given the stigmatization of mental health services in the minds of many older adults. Senior centers, congregate meal sites, and other community settings that older people frequent and feel comfortable in may offer promising venues for the delivery of mental health services to seniors. Hence, it is essential that the aging network, the mental health system, and primary health care providers form partnerships to explore how to best marshal their various resources in the service of older people’s mental health. Among the services discussed are:

- **Adult day services** are group programs designed to respond to the needs of functionally and/or cognitively impaired adults. These programs provide older adults with social interaction and health monitoring and also provide respite for caregivers.

- **Health promotion and wellness programs** focus on educating older adults about how to increase control over and improve their mental health, nutrition, or physical exercise. The programs seek to promote mental health and prevent the onset of mental disorders and costly treatment.

- **Mental health outreach programs** offer early identification and interventions to encourage access to services for high-risk older adult populations. They offer assessment and referral to community treatment and support services. These programs strive to keep older people in the community by providing supportive services that help to increase functioning.

- **Support groups and peer counseling programs** provide preventive interventions. Support groups have members who share similar problems and pool resources, gather information, and offer mutual support. Peer counseling programs utilize the skills and life experiences of older people as peers to enable others at risk to be supported and helped. Both of these interventions provide psychosocial support to older people facing life transitions, short-term crises, or chronic stressors.

- **Caregiver programs** offer a range of services for caregivers of frail elders, such as respite care, support groups, care management, counseling, or home modifications. These services can reduce caregiver stress and improve coping skills so that families can continue to provide care.

- **Respite care** refers to a range of services that offer temporary relief to caregivers of frail elders, such as short periods of companionship in the home or short stays in residential settings. Respite programs can prevent or alleviate depression and burnout, delay the need for more costly care, and offer an opportunity for mental health outreach by bringing the family into short-term contact with formal care delivery systems.

Respite care

As mentioned above, respite care refers to a wide range of services intended to give temporary relief to caregivers of frail elders. This relief can be provided in a variety of ways, from use of volunteers providing short periods of companionship in the home to short stays in institutions. The only common element to these services is the intent of providing a rest for caregivers (Montgomery & Kosloski, 1995). Informal care provided by family members is the main source of help for the majority of disabled elders living in the community (USDHHS, 1998). What has been consistently reported across studies are the constraints or restrictions of this informal caregiving on time for leisure, social, or personal activities. Overall, 55 percent of caregivers reported less time for other family members and for vacations, leisure time or hobbies (Tennstedt, 1999; National Alliance for Caregiving and Alzheimer’s Association, 1999; McKinlay et al., 1995). This personal time restriction is greater when the needs for care are greater, as is true in dementia care. Respite care is an intervention that aims to alleviate some of the pressures that can accompany caregiving.

What mental health needs can respite care address?

Respite care is provided to benefit both caregivers and elders. For caregivers, respite programs can prevent or alleviate depression and burnout by allowing timeouts for the caregivers to use in whatever way they choose. This is important for caregivers’ mental health and also enables older people and their families to use community-based rather than institutional services. Research has indicated that the caregiver’s capacities and health may be as important in predicting institutionalization as is the physical condition of the person receiving the care (McFall & Miller, 1992; Pruchno et al., 1990). Thus, a major force driving the development of respite programs result in net savings to society by reducing or delaying the need for more costly forms of care. In addition, by bringing families at risk for mental health problems into contact with formal care delivery systems, respite programs offer an opportunity for mental health outreach. For example, the respite provider, after assessing the family situation, may be able to increase the family’s awareness of needed services available through the aging network—adult day services, meals-on-wheels, or senior center activities—and to link the family with these services, if they are interested.
How is respite care implemented?

Respite care is provided and paid for in numerous ways. Respite care is among the services included in the National Family Caregiver Support Program, established in 2000, under the Older Americans Act. Programs may vary along a continuum from low to high levels of care, and respite episodes may range from a few hours to stays of up to six weeks. Clients may use services as frequently as once or twice a week or as infrequently as once or twice a year.

There are three models of respite care:

- **In-home services.** The most frequently requested and utilized form of respite service is in-home respite care, which can be provided by a volunteer, homemaker, home health aide, or nurse. This type of care can include assistance with housework, physical needs, or sitting with the older person. Most in-home programs provide services for a period of three to four hours, although some offer more extended overnight or weekend services.

- **Out-of-home respite.** This type of respite care can be provided in a group or institutional setting such as a foster home, adult day care center, respite facility, nursing home, or hospital. Institutional respite usually takes the form of holiday or intermittent readmissions, and some facilities require cumbersome medical exams or other assessments. The most common form of out-of-home respite care is in-home respite provided through adult day care programs, which are discussed in a separate section of this report.

- **Comprehensive care models.** In comprehensive respite programs, the family selects from a variety of in-home or out-of-home respite options that offer differing levels of care according to the service that best fits their needs at the time. For example, in one respite program, family members are able to choose from three types of respite for a one-year period: a short nursing home stay, adult day care, or in-home respite from a home health aide or visiting nurse.

Respite care is provided through a range of aging, public mental health, or social service agencies, or private organizations. Eligibility may be determined using income and diagnostic criteria. Some private organizations serve a specific type of client, such as Alzheimer’s patients and their families. An example of how respite services can be organized and delivered includes a joint endeavor between a health care agency and an Area Agency on Aging. These two organizations operate services that provide homecare aides who offer companion, personal care, homemaker, or skilled care services. They also have facilities to provide overnight respite care, including supervision by a healthcare worker and participation in day care activities if the respite stay exceeds one night. Payment varies depending on whether the client is entitled to coverage through Medicaid or a social service agency.

How effective is respite care?

In their beginning efforts to study respite, researchers have examined three outcomes: caregiver satisfaction, caregiver burden/well-being, and institutionalization. While many studies show modest but positive results, evidence regarding the effectiveness of respite care is limited and inconsistent (Zarit et al., 1999). Researchers cite the complexity of the issue as a reason for the mixed findings; for example, variation in the levels, types, and quality of care as well as the characteristics of the elder and caregiver.

The most pervasive finding in the literature is that caregivers like respite programs and find them valuable, especially in-home respite care (Berry et al., 1991; Malone Beach et al., 1992; Montgomery & Kosloski, 1995; Zarit et al., 1999). Families report benefits including relief from tasks, psychological support, stimulation for the elder, and health assessments of the older person that led to changes in medical routines. Concerns caregivers had about respite care centered on increased confusion and dependency of the elder, disruption of home routines, and relinquishing responsibility and control; however, these problems are more frequently associated with out-of-home services, especially in hospital settings. Findings with regard to caregiver burden and well-being are inconsistent. Some studies report no significant changes in either caregiver well-being or caregiver strain (Burdz et al., 1988; Deimling, 1991; Lawton et al., 1989; Knight et al., 1993), while other studies indicate a lessening of objective or subjective burden for the caregiver (Kosloski and Montgomery, 1993; Montgomery & Borgatta, 1985 and 1989). Montgomery & Kosloski (1999) examined the factors that influence caregivers’ utilization of respite care. They report that caregivers become most receptive to respite programs only when they (1) reach the point at which they are providing extensive care; and (2) have identified themselves as caregivers. It is at this point that respite programs can have the greatest impact. Finally, findings with regard to whether respite care prevents or delays institutionalization are mixed. Some studies found that respite had no impact on nursing home placement (Montgomery and Borgatta, 1985 & 1989; Montgomery & Kosloski, 1995); however, another study found the greater the amount of respite use, the less the probability of nursing home placement (Kosloski and Montgomery, 1995).

Assisting older adults with mental health needs requires attention to the body, mind, and spirit. The services described in this section can be a vital part of a holistic support system for older people and their families, but could likely be even more effective if the many systems involved—aging, health, and mental health—collaborated to coordinate care and form partnerships with other community organizations. Finally, there is a need to develop innovative models to deliver mental health outreach and care in alternative settings.

MEDICARE

The Centers for Medicare & Medicaid Services (CMS) is the agency in charge of the Medicare program under the direction of the U.S. Department of Health and Human Services (HHS). The 2010 Affordable Care Act offers many new benefits for reliable, high quality health care at a more affordable cost. This new piece of legislation extends and strengthens the Medicare program and contains the following improvements:

- Over 32.5 million people were able to acquire one or more preventative services at no cost, increasing their option if to identify and treat health problems early.
- Preventive services now cover depression screenings, screenings and counseling for alcohol abuse, obesity and behavioral therapy for cardiovascular disease.
- 3.6 million people in 2011 covered by Medicare received a 50 percent discount on brand-name prescription drugs in the coverage period, called the donut hole in Part D, which amounted to a savings of approximately $600 per person.
- The 2013 plan provides even more help in the prescription drug coverage gap in Part D, with individuals paying only 47.5 percent for covered brand-name drugs.

The goal of the Medicare program, starting in 2013, is to assist individuals to improve their health care to live a more productive life. The program works to provide high quality, affordable health care with added benefits, while individuals already covered by Medicare are guaranteed their existing benefits. Medicare health and prescription drug plans may change coverage benefits and costs each year. Plans...
must be reviewed for the coming year to be sure it will meet the individual’s needs for the following year. If the current Medicare program is adequate, the current plan need not be changed and will continue. Medicare consists of four parts, Part A, Part B, Part C, and Part D. These will be discussed in detail in later sections. Medicare is the official national health care insurance program provided by the U.S. government for the following individuals:

- People 65 and older.
- People under 65 with certain disabilities.
- People of any age with end-stage renal disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant.

Medicare does not provide complete coverage for all health care needs, and individuals should be advised to check the Medicare handbook, which is available in hard copy and online. The program helps to pay for many important health care services, including hospitalizations and physician services. Individuals are eligible for Medicare when they reach age 65, regardless of their income or health status. Medicare is financed by a portion of the payroll taxes paid by workers and their employers and monthly premiums deducted from Social Security checks. In 2013, Medicare was a major part of discussions about the challenge to address and regulate the growth of both federal spending and health care costs in the U.S. The goal of the program is to provide quality health care for all individuals and meeting the health care needs of an increasing elderly population. Changes occurred in 2013 as well as 2014 when the Affordable Health Care plan took full effect. New reports suggest that by modernizing Medicare and Medicaid, health care would be improved and the federal government could save $542 billion over the next decade (United Health Group, 2013).

## Financing Medicare

Medicare is partially financed by payroll taxes imposed by the Federal Insurance Contributions Act (FICA) and the Self-Employment Contributions Act of 1954. In the case of employees, the tax is equal to 2.9 percent (1.45 percent paid by the employer and a matching 1.45 percent paid by the employer) of the wages, salaries, and other compensation in connection with employment. Until December 31, 1993, the tax provided a maximum amount of wages, etc., on which the Medicare tax could be increased each year. Beginning January 1, 1994, the compensation limit was removed. In the case of self-employed individuals, the tax is 2.9 percent of net earnings from self-employment, and the entire amount is paid by the self-employed individual. The percentages above remain in place through 2013.

### Premiums

Most Medicare enrollees do not pay a monthly Part A premium, because they (or a spouse) have had 40 or more quarters in which they paid Federal Insurance Contributions Act taxes. Medicare-eligible people who do not have 40 or more quarters of Medicare-covered employment may purchase Part A for a monthly premium of:

- $243 per month in 2013 for those with 30-39 quarters of Medicare-covered employment.
- $441 per month 2013 for those with less than 30 quarters of Medicare-covered employment and who are not otherwise eligible for premium-free Part A coverage.

All Medicare Part B enrollees pay an insurance premium for this coverage. Part B premiums are approximately $93.50 per month. A new income-based premium schedule has been in effect, wherein Part B premiums are higher for beneficiaries with incomes exceeding $80,000 for individuals; or $170,000 for married couples. Medicare Part B premiums are commonly deducted automatically from beneficiaries’ monthly Social Security checks. Part C and D plans may or may not charge premiums, at the program’s discretion.

To get more information about their Part B premium, individuals should contact Social Security.

### Medicare Part A

Most people age 65 or older who are citizens or permanent residents of the United States are eligible for free Medicare hospital insurance (Part A). Medicare Part A helps cover inpatient care in hospitals. This includes critical access hospitals and skilled nursing facilities, hospice care services, home health care services and inpatient care in a religious nonmedical health care institution. Individuals must meet certain conditions to get these benefits. Individuals are eligible for Part A if:

- They receive or are eligible to receive Social Security benefits.
- They receive or are eligible to receive railroad retirement benefits.
- They receive or are eligible to receive railroad retirement benefits.
- They receive or are eligible to receive railroad retirement benefits.
- They are the dependent parent of someone who worked long enough in a government job and paid Medicare taxes.
- They are the dependent parent of someone who worked long enough in a government job and paid Medicare taxes.
- They are the dependent parent of someone who worked long enough in a government job and paid Medicare taxes.
- They have permanent kidney failure and receive maintenance dialysis or a kidney transplant.
- They have ALS (Amyotrophic Lateral Sclerosis), also known as Lou Gehrig’s disease, which will get Part A and Part B automatically the month the disability benefits begin.
- They have chronic kidney disease and receive maintenance dialysis.
- They have worked long enough in a government job where Medicare taxes were paid and so meet the requirements of the Social Security disability program.

- They are under 65 and disabled after they get disability benefits.
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They are the child or widow(er) age 50 or older, including a divorced widow(er) of someone who worked long enough in a government job to pay Medicare taxes. In this case, they would meet the requirements of the Social Security disability program.

They receive Social Security benefits for 24 months or receive disability benefits from the RRP for 24 months. After the above time limits, these individuals will automatically get Part A and Part B.

They have permanent kidney failure and receive maintenance dialysis or a kidney transplant.

They have ALS (Amyotrophic Lateral Sclerosis), also known as Lou Gehrig’s disease, which will get Part A and Part B automatically the month the disability benefits begin.

They have worked long enough in a government job where Medicare taxes were paid and so meet the requirements of the Social Security disability program.

The following services are covered under Part A:

- Inpatient hospital care.
- Skilled nursing facility care.
- Blood the hospital gets from a blood bank.
- The home health services that are medically necessary, either part-time or intermittent skilled nursing care, physical therapy, speech-language pathology and services, and services involved with the continuing need for occupational therapy.
- A doctor enrolled in Medicare or certain healthcare providers who work with the doctor.
- Home health services may also include medical social services, part-time or intermittent home health aide services, and medical supplies for use at home. The individual must be homebound, which means leaving home is a major effort.
- Individuals may pay 20 percent of the Medicare approved amount for durable medical equipment, which includes oxygen equipment.
and supplies, wheelchairs, walkers, and hospital beds ordered by the doctor or other healthcare provider enrolled in Medicare for use in the home.
- Hospice care upon certification from the doctor that the individual is terminally ill and expected to live six months or less period.
- Hospice will pay for a stay in the facility, room, and board, if the hospice medical team determines that the individual needs short-term inpatient stay for pain and symptom management that can’t be addressed at home.
- Medicare also covers inpatient respite care in been approved Medicare facility so that the caregiver can rest. Individuals can stay up to five days each time they get respite care. The individual may pay 5 percent of the Medicare approved amount for inpatient respite care.
- Medicare will pay for covered services for health problems that are not related to the terminal illness.

Medicare Part B

Part B Medical Insurance helps cover medical services like doctors’ services, outpatient care, and other medical services that Part A does not cover. Part B also covers many preventative services Part B is optional and helps to pay for covered medical services and items that are medically necessary. Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium. If individuals have original Medicare and visits doctors or other health care providers who accept the Medicare assignment, they can contact www.medicare.gov/publications to review coverage and specific cost information or call 1-800-Medicare to have a booklet mailed. If individuals are in a Medicare Advantage Plan, such as an HMO or PPO or have other insurance, Medicare costs may be different. Individuals should contact their plan or benefits administrator directly to find out about the costs and benefits. Some beneficiaries with higher incomes will pay a higher monthly part B premium. If individuals are not eligible for Part free hospital insurance, they can buy Part B medical insurance, without having to buy Part A hospital insurance. Under original Medicare, if the Part B deductible applies, individuals must pay all costs until they meet the yearly Part B deductible before Medicare begins to pay its share. After the deductible is met, individuals typically pays 20 percent of the Medicare approved amount of service. There is no yearly limit for what individuals pay out-of-pocket. There is no cost for preventative services if you get the services from a doctor or qualified health care provider who accepts Medicare assignments.

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<thead>
<tr>
<th>If yearly income in 2011 was:</th>
<th>Part B Premiums by Income</th>
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<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
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<tr>
<td>Above $85,000 up to $107,000</td>
<td>Above $170,000 up to $214,000</td>
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<tr>
<td>Above $107,000 up to $160,000</td>
<td>Above $214,000 up to $320,000</td>
</tr>
<tr>
<td>Above $160,000 up to $214,000</td>
<td>Above $320,000 up to $428,000</td>
</tr>
<tr>
<td>Above $214,000</td>
<td>Above $428,000</td>
</tr>
</tbody>
</table>

Medicare Part B Details

Part B covers the following:
- “Welcome to Medicare” preventative visit.
- Yearly open “Wellness” visit.
- Abdominal aortic aneurysm screening.
- Alcohol misuse counseling, which is new to the 2013 plan. This allows for one screening per year for adults, including pregnant women, who use alcohol but do not meet the medical criteria for alcohol dependency. If the primary care doctor or other primary care practitioner determines individuals are misusing alcohol, they qualify for up to four face-to-face counseling sessions per year if they are competent and able to be alert during counseling. The qualified primary care doctor or care practitioner must provide the counseling in a primary care setting like a doctor’s office.
- Medicare covers ground ambulance transportation to a hospital, critical access hospital, or skilled nursing facility for medically necessary services when transportation in any other vehicle would endanger health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter if the individual needs immediate and rapid ambulance transportation that ground transportation cannot provide. In some cases, Medicare may pay for limited nonemergency ambulance transportation with the written order from the doctor stating that ambulance transportation is necessary due to the medical condition.
- Ambulatory surgical centers for approved surgical procedures.
- Bone mass measurement for bone density.
- Coverage includes drugs for pain relief and system management, medical, nursing, social services, durable medical equipment, and other covered services that Medicare usually does not cover like spiritual and grief counseling.

To get certain durable medical items in some areas of the country, individuals must use specific suppliers called contract suppliers that are part of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding program in their area. If individuals have Original Medicare Part A, it will show on the red, white, and blue Medicare card. If individuals have Part A, “HOSPITAL (PART A)” is printed on the card. If individuals joined a Medicare Health Advantage Plan, they will use the card sent by the individual plan to receive Medicare covered services.
Durable medical equipment, such as oxygen equipment, wheelchairs, walkers, and other medically necessary equipment that a doctor prescribes to use in the home. Other types of durable medical equipment covered by Medicare include arm, leg, back, and neck braces; medical supplies, such as ostomy pouches; surgical dressings; splints; casts; and breast prostheses following a mastectomy. Medicare covers these items ordered by the doctor or other healthcare provider for use in the home. In all areas of the country, covered equipment or supplies and replacement or repair services must be obtained from a Medicare approved supplier for Medicare to pay. Medicare pays for different kinds of durable medical equipment in different ways. Some equipment must be rented; other equipment must be purchased. Medicare will not cover equipment, such as grab bars and humidifiers, that do not have a primary medical purpose, even though one may use them for reasons of safety or comfort.

- Medicare does not cover long-term care, also called custodial care, routine dental or eye care, dentures, cosmetic surgery, acupuncture, hearing aids and exams for fitting them.
- EKG screening.
- Emergency department services.
- Eyeglasses are covered for one pair with standard frames or one set of contact lenses after cataract surgery that implants and intraocular lens.
- Hearing and balance exams.
- Glaucoma tests.
- Hepatitis B shots.
- HIV screening.
- Home health services.
- Kidney dialysis service and supplies.
- Kidney disease education services.
- Laboratory services.
- Medical nutrition therapy services for patients who have diabetes or kidney disease.
- New in 2013 Medicare covers obesity screening and counseling which includes intensive counseling to help with weight loss.
- Mental health care for outpatient services to help with conditions like depression or anxiety, including visits with the psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist, clinical social worker, who may also treat for substance abuse.
- Occupational therapy, which includes evaluation and treatment to help perform activities of daily living like dressing or bathing after an illness or accident as certified by a doctor or other healthcare provider.
- Outpatient hospital services.
- Outpatient medical and surgical services and supplies.

**Medicare Part C**

Medicare Advantage Plans, HMOs and PPOs, are run by private companies approved by Medicare. They give more choices, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called “Part C.” They provide all of Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (prescription drug) coverage. To join a Medicare Advantage Plan, individuals must have both Medicare Part A and Part B and live in the plan’s service area. The plan may have special rules that individuals need to follow, like seeing doctors that belong to the plan or going to certain hospitals to get services. Health care professionals must follow the rules set by Medicare; however, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how the patient gets services. These might include whether patients need a referral from a specialist or if they have to go to a doctor’s facilities or suppliers that belong to the plan for nonemergency or non-urgent care. These rules can change year after year, and the plan must notify enrollees about changes before the start of the next enrollment year.

- Physical therapy.
- Pneumococcal shots.
- Limited prescription drugs (see Part D).
- Prostate cancer screenings.
- Prosthetic/orthotic items.
- Pulmonary rehabilitation for patients with chronic obstructive pulmonary disease (COPD).
- Federally qualified health center services that covers outpatient primary care and preventive services through community-based organizations.
- Flu shots.
- Rural health clinic services.
- Sexually-transmitted infection screening and counseling which is a new addition to Medicare 2013 and covers up to two individual 20- to 30-minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at risk for STI’s. Screening tests are covered once every 12 months or at certain times during pregnancy.
- Speech-language pathology services.
- Tele-health, which includes medical or other health services and consultations provided using an interactive two-way telecommunications system, such as real-time audio and video.
- Tests other than lab tests, such as x-rays, MRIs, CAT scans, EKGs, and other diagnostic tests.
- Tobacco-use cessation counseling for patients who use tobacco and are diagnosed with an illness that is caused or complicated by tobacco use, or patients that take a medicine that is affected by tobacco.
- Urgently needed care to treat a sudden illness or injury that is not a medical emergency.
- Transplants and immunosuppressive drugs.
- Travel healthcare needed when traveling outside the United States--if the patient is in the U.S. when an emergency occurs and the foreign hospital is closer then the nearest U.S. hospital; or if traveling through Canada or between Alaska and another state, when a medical emergency occurs and the Canadian hospital is closer then the nearest U.S. hospital, or the patient lives in the US and the foreign hospital is closer to the patient’s home than the nearest U.S. hospital that can treat the medical condition, regardless of whether an emergency exists.

The booklet Medicare and You, which is the official Medicare handbook, has many guides and checklists individuals can use to keep track of preventative services, which will help them to talk with their care provider about which services are appropriate for them. For questions or complaints about the quality of the Medicare coverage service, call the local Quality Improvement Organization (QIO). Visit www.Medicare.gov/contacts to get the appropriate QIO’s phone number or call 1-800-Medicare.

The individual may also have to pay a monthly premium for extra benefits. Medicare pays a fixed amount of money for one’s care every month to these health plans. In all types of Medicare Advantage Plans, enrollees are always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that original Medicare covers, except hospice care and some care in qualifying clinical research studies. Original Medicare covers hospice care and some costs for clinical research studies even if in a Medicare advantage plan. Individuals in a Medicare plan should review the “Evidence of Coverage” (EOC) and the “Annual Notice of Change (ANOC) the plan sends each fall. EOC gives details about what the plan covers, the costs and more. The ANOC includes any changes in coverage, costs, or service area, which will be effective in January.

There are several different types of Medicare Advantage Plans:

- **Health Maintenance Organizations (HMO).** In most HMOs, patients can only go to the doctors and healthcare providers, including hospitals, within the plan’s network, except in an emergency. Patients may also need to get a referral from a primary care doctor.
• Preferred Provider Organizations (PPO). In a PPO, patients pay
less if they use doctors, hospitals, and other healthcare providers
that belong to the plan. Higher fees are charged if the patient uses
doctors, hospitals, and providers outside of the network.
• Private Fee-For-Service (PFFS). These plans are similar to original
Medicare and individuals can go to any doctor, other health care
provider, or hospital, as long as they agree to treat the person. The plan
determines how much it will pay doctors, other health care providers,
and hospitals, and how much the patient must pay for the care.
• Special Needs Plans (SNP). These plans provide focused and
specialized healthcare for specific groups of people, like those who
have both Medicare and Medicaid, live in a nursing home, or have
certain chronic medical conditions.
• HMO Point of Service (HMOPOS). These HMO plans may
allow patients to get some services out of network for a higher co-
payment or coinsurance.

Important facts about Medicare Advantage Plans

• Every individual has Medicare rights and protections, including
the right to appeal.
• Individuals should check with the plan before they sign up for
services to be sure they are covered and to determine the cost.
• All plan rules must be followed, and it is critical to check with
the plan concerning consumer rights and responsibilities.
• Medical Savings Account (MSA) plans combine a higher
deductible health plan with bank accounts. Medicare deposits
money into the account for the individuals to pay for health care
services during the year.

Medicare Advantage Plans have a yearly cap on how much the
consumer must pay for Part A and Part B services during the year.
This yearly maximum out-of-pocket amount can be different between
Medicare Advantage Plans and can change each year.

Except for end-stage renal disease individuals can join a Medicare
Advantage Plan even if they have pre-existing conditions. The booklet
and website explain the conditions for enrollment by ESRD patients.

To receive more information about Medicare Advantage Plan types,
individuals should call the plan and request a “Summary of Benefits” (SB)
document. Local State Health Insurance Assistance Program (SHIP) can
offer assistance in comparing different Medicare Advantage Plans.

Comparing Part C Medicare Advantage Plans

Individuals should consider a number of factors when they make
decisions about Part C Plans. These include:
• Annual deductibles - Some plans have an annual deductible that
must be met before costs are covered. This information is available
by calling the plan.
• Monthly premium - The amount individuals pay each month for
coverage in addition to the Part B premium.
• Out-of-pocket limits - All Medicare Advantage Plans must limit out-
of-pocket costs for in-network Medicare Part A and Part B services
during the year. Plans must list limits for in-network, out-of-network,
or combined, which includes both in-network and out-of-network,
services. If “non-network” appears the plan doesn’t have networks.
• Primary care visits – amounts paid for an office visit to a primary
care doctor. These amounts will vary depending on whether a primary
care doctor is seen in or out of the plan’s network. Some plans may
show one combined range for both in and out of network services.
• Specialist visit - The amount individuals pay for an office visit
to a specialist. Again, this will vary depending upon whether a
specialist is in or out of the plan’s network.
• Chemotherapy drugs - The amount individuals pay for
chemotherapy.
• Other Part D drugs - The amounts individuals pay for Part B
drugs like injectable or infused drugs given in a doctors office.
• Home health care - The amounts paid each day for home health care.

Medical Part D

The Medicare Prescription Drug, Improvement, and Modernization
Act of 2003 (also known as the MMA), was signed into law on
December 8, 2003. It created a voluntary prescription drug insurance
program through Medicare called “Medicare Prescription Drug
Coverage” or “Medicare Part D” or “Medicare Rx.” The 2010
Affordable Care Act added to the plan, and was fully implemented in
2014. This drug coverage is available to everyone who has Medicare,
regardless of income, health status, or how his or her prescriptions
have been covered. Medicare coverage may help lower prescription
drug costs and help protect against higher costs in the future. It can
give individuals greater access to drugs that can prevent illness or
further complications from pre-existing conditions. Changes in 2013
focused on early detection of diseases and wellness. Private companies
provide the insurance coverage. Individuals choose the drug plan and
pay a monthly premium. If individuals have a limited income, they
may get extra help to cover prescription drugs for little or no cost. The
amount of the monthly premium paid cannot increase because of that
person’s health condition or the number of prescriptions needed. In
addition to a premium, enrollees may also have to pay a deductible and
a portion of the cost of the drugs.
If this individual decides not to enroll in a Medicare drug plan and has no creditable drug coverage when first eligible, there may be a penalty to pay when choosing to join later. Two methods to get Medicare Prescription Drug coverage are:

- Join a Medicare Prescription Drug Plan that adds drug coverage to the Original Medicare Plan, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
- Join a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan that includes Medicare prescription drug coverage as part of the plan. An individual can get all Medicare coverage through these plans, including prescription drugs.

Individuals must have Part A and Part B to join a Medicare Advantage Plan. Medicare Advantage Plans with prescription drug coverage are sometimes called an MA–PD’s

**Enrollment in Part D**

While Medicare Part D is a voluntary benefit, if individuals choose NOT to enroll in a plan when they are first eligible and do not have other drug coverage that is as good as or better than Medicare’s (also known as ‘credible coverage’), they may be charged a penalty if they decide to enroll at a later time. When individuals first becomes eligible for Medicare, they can join during the seven-month period that begins three months before the month they turn 65. If individuals get Medicare due to a disability, they can join during the seven-month period that begins three months before the 25th month of disability benefits and ends three months after the 25th month of disability. There are only certain times during the year that are open enrollment when individuals can join, switch, or drop a Medicare drug plan. If an individual is getting extra help to pay their health care costs, they will not be charged a late enrollment penalty. There are three ways to avoid paying a penalty:

- Join a Medicare drug plan when first eligible.
- Never go 63 days or more without creditable drug coverage, which may be from a former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or other health insurance coverage.
- Inform their current plan about any drug coverage they have had if that information is requested. If the individual does not tell the plan about their creditable prescription drug coverage, they may have to pay a penalty.

Currently the late enrollment penalty is calculated by multiplying 1 percent of the national base beneficiary premium, which was $31.08 in 2012, for every full, uncovered months of eligibility for Part D without enrollment in a Medicare drug plan or other creditable prescription drug coverage. The national base beneficiary premium may increase each year, so the penalty may also increase each year and individuals have to pay the penalty for as long as they have a Medicare drug plan.

Medicare drug plans cover both generic and brand name drugs. Plans have rules about what drugs are covered in different drug categories. Most plans have a formulary, which is a list of drugs covered by the plan. This list must always meet Medicare’s minimum requirements, but in some situations, it can be changed during the year. Two such situations include: If a new generic version of a covered brand-name drug becomes available; or if new information shows a drug to be unsafe. Plans cannot stop or reduce the coverage of a drug an enrollee currently takes. If a formulary change is made that affects specific enrollees, the plan must alert these enrollees at least 60 days before a change takes place. Plans may have the following coverage rules:

- Prior authorization, which states that the consumer or prescriber must contact the drug plan before certain prescriptions can be filled.
- Quantity limits, which dictate how much medication the consumer can get at one time.
- Step therapy, which states that the consumer must try one or more similar, lower-cost drugs for the plan will cover the prescribed drug.

If consumers or prescribers feel that one of these coverage rules should be waived, they can ask for an exception.

**Choosing Medicare prescription drug coverage for the first time**

Like other insurance, Medicare prescription drug coverage will be there when individuals need with drug costs. Even if individuals do not take a lot of prescription drugs now, they still should consider joining a Medicare drug plan. As individuals age, they usually need prescription drugs to stay healthy. Joining as soon as they are eligible means that individuals will pay the lowest possible monthly premium. Every year (from October 15-December 7), enrollees can switch to a different Medicare drug plan if their needs change. The change takes effect on January 1 as long as the enrollee requests the plan change by December 7. Individuals generally must stay enrolled for the calendar year; however, in certain situations they may join, switch, or drop Medicare drug plans. These circumstances include the following:

- If the individual loses other creditable prescription drug coverage.
- Is the individual moves out of the planned service area.
- If the individual lives in an institution like a nursing home.

**The five-star special enrollment period**

It is possible to switch to a Medicare prescription drug plan that has five stars for its overall plan rating from December 8, 2012 through November 30, 2013. The overall plan ratings are available at www.Medicare.gov/find-a-plan. These ratings are updated each fall and can change each year. Individuals can only switch to a five-star Medicare prescription drug plan if one is available in their area.

An individual can join a Medicare drug plan by:

- Enrolling on the plan’s website or on www.Medicare.gov.
- Completing a paper and enrollment form.
- Calling the plan.
- Calling 1-800-MEDICARE.

Only the individual or the individual’s authorized representative may enroll someone in a prescription drug plan. An authorized representative is someone who has the legal right to make health care decisions on a patient’s behalf. In most cases Medicare, drug plan staff are prohibited from calling the consumer to enroll them in a plan.

**Mechanics of Medicare drug plan (Part D)**

After individuals join a Medicare drug plan, the plan will mail membership materials, including a plan member card to use when getting prescriptions filled. When using the card, the enrollee will pay the co-payment, coinsurance, and/or deductible, if any. In Medicare Advantage Plans that include Medicare prescription drug coverage (Part D), patients’ health care and drug usage is coordinated, with an emphasis on preventive care.
Cost of Medicare Part D

Most drug plans charge a monthly premium that varies by plan. The enrollee pays this in addition to the Part B premium, and some drug plans charge no premium. If individuals have limited income and resources, they may get extra help to cover prescription drugs for little or no cost. Individuals costs vary depending on which drugs they take, which Medicare drug plan is chosen, and whether they receive extra help paying Part D costs. Having a variety of plans to choose from gives individuals the chance to pick a plan that best meets their unique needs. It also allows individuals to get the coverage they she want at the best price possible. When belonging to a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that offers Medicare prescription drug coverage, the monthly premium, which is paid to the plan, includes an amount for prescription drug coverage. Some plans charge no premium. It is possible to pick a plan with or without a monthly premium, deductible, or coverage gap.

Medication therapy management program

Individuals in a Medicare drug plan who take medication for different medical conditions may be eligible to get services at no cost, through a Medication Therapy Management (MTM) program. This program helps individual and their doctor make sure that the medications are working effectively to improve their health. A pharmacist or other health professional will give a comprehensive medication review of all the prescriptions, as well as do the following:

- Discuss how patients can get the most benefit from the prescription drugs they are taking.
- Answer questions and concerns such as medical costs and drug reactions.
- Give instructions as to the best way and times to take multiple medications.
- Question patients about any problems they may be having with their prescriptions and over-the-counter medication.

Patients will also receive a written summary of this information to have available when they consult with their health care providers. The summary includes medication action plan that recommends the best use of the medication, with spaces to take notes and write down any further follow-up questions. Patients also get a personal medication list that will include all the medications they are taking and why they are taking them. The drug plan may enroll the consumer in this program if they meet the following criteria:

1. The patient has more than one chronic health condition.
2. The patient takes several different medications.
3. The medications have a combined cost of more than $3,144 per year. This dollar amount can change each year and is estimated based on out-of-pocket costs and the cost the plan pays for the medication each calendar year.

The extra help Medicare program

Individuals with limited income and resources may qualify for help to pay for some health care and prescription drug costs. Individuals may qualify for extra help, also called the low-income subsidy (LIS), if their yearly income and resources are below these limits set in 2012:

- A single person must have income of less than $16,735 and resources of less than $26,120. Resources include:
  - Money in checking or savings accounts
  - Stocks and bonds
  - Mutual funds and individual retirement accounts (IRA)
- A married person living with a spouse and no other dependents may qualify with income of less than $22,695 and resources of less than $34,120.
- A married person living with a spouse and other dependents may qualify with income of less than $26,120 and resources of less than $34,120. Resources include:
  - Money in checking or savings accounts
  - Stocks and bonds
  - Mutual funds and individual retirement accounts (IRA)
- Resources do not include homes, cars, household items, burial plots, or life insurance policies.
- Monthly income of less than $1,277 and resources of less than $2,690 for one person.
- Monthly income of less than $16,755 and resources of less than $26,120 for a single person.
- Monthly income of less than $22,695 and resources of less than $34,120 for a married person living with a spouse and no other dependents.
- Monthly income of less than $26,120 and resources of less than $36,480 for a married person living with a spouse and other dependents.

The eligibility figures may change in 2013, and individuals may qualify even if they have a higher income, still work, live in Alaska or Hawaii, or have dependents still living at home.

Individuals who qualify for extra help may get extra help paying Part B premiums only. Individuals must apply every year for QI benefits and the applications are granted on a first-come, first-served basis.

3. Qualifying Individual (QI) program helps pay Part B premiums only. Individuals must apply every year for QI benefits and the applications are granted on a first-come, first-served basis.

4. Qualified Disabled and Working Individual (QDWI) program helps pay for Part A premiums only. To qualify for this program the individual must have a disability and be working.

The names of these programs and how they work may vary in different states.

Additional resources to assist with paying Medicare healthcare costs

Individuals who have limited income and resources may be able to get help from their state to assist in paying their Medicare costs if they meet certain conditions. There are four kinds of Medicare savings programs:

1. Qualified Medicare Beneficiary (QMB) program helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments.
2. Specified Low–Income Medicare beneficiary (SLM) program helps with Part B premiums only.
3. Qualified Individual (QI) program helps pay Part B premiums only. Individuals must apply every year for QI benefits and the applications are granted on a first-come, first-served basis.
4. Qualified Disabled and Working Individual (QDWI) program helps pay for Part A premiums only. To qualify for this program the individual must have a disability and be working.

The names of these programs and how they work may vary in different states.

How to qualify

To qualify for a Medicare savings program, individuals must have:

- Part A.
- Monthly income of less than $1,277 and resources of less than $6,940 for one person.
- Monthly income of less than $1,723 and resources of less than $10,410 for individuals married and living together.
These amounts may change each year and many states figure income and resources differently. Individuals may qualify in a state, even if income or resources are higher than the amounts listed above. If individuals have income from working, they may qualify for benefits even if their income is higher than the limits above. Resources include money in a checking or savings account, stocks, bonds, mutual funds, and individual retirement accounts (IRA). Resources do not include homes, cars, burial plots, and burial expenses up to the state’s limit, furniture, or other household items. Some states do not have any limits on resources. For more information, individuals can call or visit the State Medical Assistance (Medicaid) office. Information for each state is available at www.medicare.gov/contacts or individuals can call 1-800-MEDICARE, 1-800-633-4227, and say “Medicaid.” TTY users call 1-877-486-2048.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs if the individual has limited income and resources and meets other requirements. Some, referred to as “dual eligibles,” qualify for both Medicare and Medicaid. If someone has Medicare and Medicaid, most health care costs are covered. Medicaid may still cover other costs that Medicare does not cover. People with Medicaid may get coverage for service that Medicare does not fully cover, like nursing home care and personal care services.

How to Qualify

Medicaid programs vary from state to state. They may also have different names like “Medical Assistance” or Medi–Cal. Each state has different income and resource requirements. Individuals can call the phone numbers listed in the last section for more information on qualification.

Understanding coverage gap

Most Medicare drug plans may have a “coverage gap,” which is sometimes called the “donut hole.” A coverage gap means that after individuals pay a certain amount of money covered drugs, they will have to pay all out-of-pocket costs for their drugs during the “gap.” This means that there is a temporary limit on what the drug plan will cover for drugs. The coverage gap begins after the person and their drug plan have spent certain amounts for covered drugs. In 2013, when in the coverage gap, individuals pay 47.5 percent of the plan’s cost for covered generic drugs and 79 percent of the plans cost for covered brand name drugs until they reach the end of the coverage gap. Not everyone will enter the coverage gap. This amount does not include a plan’s monthly premium that enrollees must continue to pay, even during the coverage gap. Some plans offer additional coverage during the gap for generic drugs, but they may charge a higher monthly premium. Check with the plan first to see if your drugs would be covered during the gap. Once individuals reaches the plan’s out-of-pocket limit, they will have “catastrophic coverage.” This means that this individual only pays only a small coinsurance amount (like 5 percent of the drug cost) or a co-payment (like $2.15 or $5.35 for each prescription) for the rest of the calendar year. If enrollees get extra help paying drug costs, they will not have a coverage gap; however, they will probably have to pay a small co-payment or coinsurance amount.

This example shows calendar year costs for covered drugs in a plan that meets 2007 Medicare’s standards.

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<thead>
<tr>
<th>Yearly Deductible</th>
<th>Co-payment/Coinsurance</th>
<th>Coverage Gap</th>
<th>Catastrophic Coverage</th>
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<tr>
<td>Mr. Adair pays the first $325 of his drug costs.</td>
<td>Mr. Adair pays a co-payment or coinsurance amount, and his plan pays its share for each drug until his total drug costs (including his deductible) reach $2,970.</td>
<td>Mr. Adair pays everything until he has spent $2,970 out-of-pocket for covered drugs he is in the gap. (This includes his yearly deductible, coinsurance, and co-pays, while in the coverage gap. This does not include the drug plan’s premium.) Even though he is paying everything, he gets a discount because he belongs to a Medicare drug plan.</td>
<td>Once Mr. Adair has spent $4,750 out-of-pocket for the year, his coverage gap ends. He only pays a small coinsurance (like 5 percent) or a small co-payment (like $2.15 or $5.35) for each prescription until the end of the year.</td>
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Comparing Medicare drug plans

Each Medicare drug plan is different. When choosing a Medicare drug plan for the first time, or switching to a different Medicare drug plan, individuals should compare the plans before choosing one that meets their cost and coverage needs.

Items to compare in drug plans

- **Drug Coverage** - Plans may have rules about what drugs are covered in different categories. Enrollees must check to see if the plan covers their prescription drugs. Medicare drug plans have a list of drugs covered by the plan (formulary) that must always meet Medicare’s requirements. Even if a drug is on the plan’s list, there may be special rules for filling the prescription. The list can change during the year because drug therapies change, and new drugs and medical knowledge become available. If enrollees are affected by the change, the plan will notify him or her at least 60 days before the formulary changes. If there is a formulary change that affects a drug taken, in most cases, it will still be covered until the end of the year.

Enrollees should compare coverage concerning chemotherapy and dialysis drugs and costs for drugs on different levels tiers.

- **Cost** - Enrollees should check to see how much prescription drugs would cost in each plan. If individuals currently has prescription drug coverage, they should compare current costs to those of the Medicare drug plans that are under consideration. Monthly premiums, deductibles, and an enrollee’s share of the cost of the prescriptions (co-payments and/or coinsurance) will vary with each plan and by each drug. If individuals have limited income or resources, they may qualify for extra help to pay drug plan costs.

- **Convenience** - Medicare drug plans must contract with pharmacies in the enrollee’s area. Enrollees should check with the plan to make sure the pharmacy they want to use is in the plan. Some plans also allow the enrollee to get prescriptions through the mail. If enrollees spend part of the year in another state, they should ensure the plan will cover the costs there.
Penalty for late enrollment

If individuals do not join a Medicare drug plan when they first become eligible to join (Initial Enrollment Period), and there is a period of 63 continuous days or more during which the individual does not have creditable prescription drug coverage, they may have to pay a late-enrollment penalty when they do join. This amount changes every year. Individuals will have to pay a penalty as long as they have Medicare prescription drug coverage.

Switching Medicare prescription drug plans

If an individuals currently has Medicare prescription drug coverage, they should review the coverage each year in the fall. They should also consider switching Medicare drug plans if another plan better meets the needs. Generally, plans can be switched only from October 13 - December 7 of each year. Coverage under the new plan will begin January 1 of the following year. It is best to join a plan early in the month after making a decision. In certain circumstances, enrollees may be able to change plans at other times.

Rules about coverage of certain drugs

There are many rules that can vary by plan. There are certain drugs that Medicare drug plans are not required to provide, such as benzodiazepines, barbiturates, and drugs for weight loss or gain. Some plans may choose to cover these drugs as an added benefit. In addition, drug plans are not allowed to cover over-the-counter drugs for erectile dysfunction or drugs for relief of colds. Plans may also exclude certain other drugs from coverage. Although a Medicare drug plan may not have a specific drug on their list of covered drugs (formulary), a drug that is safe and effective for the same purpose will be available for drugs that are covered by law. This may be in the form of a generic drug or therapeutic alternative (other brand-name drug) that has the same benefit as a more expensive brand-name drug. Plans have rules that need to be followed before certain prescriptions can be filled. For instance, some drugs may have more side effects or have restrictions on how long they can be taken. Some drugs cost more than others, even though some less expensive drugs may work just as well. All plans have an exception process. If a doctor believes one needs a drug that is not on the plan’s list or the plan has rules that should be waived, he or she can request an exception. Not all exceptions are granted. Plans have many standard rules meant to ensure that certain drugs are prescribed and used correctly, and only when truly necessary. These rules include:

- Prior authorization - This means before the plan will cover these prescriptions, a doctor must contact the plan. A doctor must show that the drug is medically necessary for it to be covered.
- Quantity limits - This rule determines how many pills a patient can get at a time.
- Step therapy - This means the patient must try one or more similar lower cost drugs before the step-therapy drug is covered.

Tiers or categories on a Medicare drug plan’s drug list

Many Medicare drug plans place drugs into different “tiers.” Drugs in each tier have a different cost. Some plans may have more tiers and some may have fewer. Here is an example:

<table>
<thead>
<tr>
<th>TIER</th>
<th>Individual Pays</th>
<th>What Is Covered</th>
<th>Cost Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lowest Co-pay</td>
<td>Most generic prescription drugs</td>
<td>$5.00</td>
</tr>
<tr>
<td>2</td>
<td>Medium Co-pay</td>
<td>Preferred brand-name prescription drugs</td>
<td>$28.00</td>
</tr>
<tr>
<td>3</td>
<td>Higher Co-pay</td>
<td>Non-preferred brand-name prescription drugs</td>
<td>$53.00</td>
</tr>
<tr>
<td>Specialty Tier</td>
<td>Higher Percentage</td>
<td>Unique, very high-cost drugs</td>
<td>25 percent - 33 percent of drug cost</td>
</tr>
</tbody>
</table>

Not actual costs, but examples of co-payments or coinsurance costs for a 30-day supply. Costs vary by plan and by drug.

Prescription drug coverage helps beneficiaries in four important ways

- Medicare drug coverage helps all beneficiaries pay for prescription drugs, no matter how they paid before. The typical senior who previously lacked drug coverage will end up spending about half of what he or she used to spend on prescription drugs each year, an average annual savings of $1,100.
- Medicare drug coverage offers more and better choices than ever before. Beneficiaries have a number of plans from which to choose, and plan providers are competing for senior business. That means seniors can save more and get the coverage they want.
- The competition to serve seniors has been stronger than expected, lowering costs for seniors and the government. In 2012 the average senior premium seniors paid $2.65 for generic drugs and $6.60 for their brand name prescription drug. In 2014, the federal government will spend less overall on the Medicare drug benefit.
- Medicare is providing extra help to low-income beneficiaries. About one-third of seniors are eligible for prescription drug coverage that includes little or no premiums, low deductibles, and no gaps in coverage. On average, Medicare will pay for more than 95 percent of the costs of prescription drugs for low-income seniors. The days of low-income seniors having to make painful sacrifices to pay for their prescription drugs are coming to an end.

Medicare prescription drug costs

Insurance companies who offer Part D plans and Medicare Advantage plans set their own premium prices. Monthly premium costs vary according to the type of benefits selected. Part D plans also have cost-sharing expenses, like deductibles, co-pays, and coinsurance. Filling prescriptions at a network pharmacy lowers costs. Individuals must show their Medicare or plan member ID card every time so money
spent on drugs will be correctly calculated through the year to meet deductibles. Many large, national chain pharmacies give additional savings cards that lower costs even further. Patients should ask their doctors if there are lower-cost, lower-tier drugs that would be effective. All of these cost-saving measures help to delay the coverage gap. Individuals should also check to see if they can qualify for any of the programs to help pay drug costs through Medicare, Medicaid, or Social Security.

**Client Medicare Rights in 2013**

All people receiving Medicare or Medicaid have rights. They have the right to:
- Be treated with dignity and respect at all times.
- Be protected from discrimination.
- Have personal and health information confidential.
- Receive information in a way that they understand from Medicare health practitioners’ counselors, contractors and providers.
- Have Medicare questions answered.
- Have access to doctors, other health care providers, specialists, and hospitals.
- Learn about treatment choices and plans in clear language that the client can understand and participate in treatment choices.
- Get emergency treatment when and where they need it.
- Discuss decisions about health care payments, coverage of services, and prescription drugs.
- Request a review and/or appeal of certain decisions about health care payment, coverages or services and prescription drugs.
- File complaints and/or grievances about the quality of their health care.

**Challenges in mental health and aging**

Individuals who work with the elderly need to address the following challenges in the near future:
- **Prevention and early intervention.** Existing efforts generally focus on the diagnosis and treatment of illness rather than on the early identification of high-risk individuals and families, preventive measures, and the promotion of optimal health.
- **Public awareness and education.** Stigma discourages older adults and their family members from acknowledging mental health problems. It also discourages the pursuit of treatment. Societal stereotypes and myths can hinder efforts to diagnose and treat mental illness.
- **Workforce issues:** shortages and need for education. There is an insufficient supply of trained professionals and paraprofessionals available to provide mental health services to older people. Training opportunities for those entering and currently working in the field must include multidisciplinary cross-training.
- **Financing mental health services.** Federal, state, and private funding streams are separate, may not be coordinated, and tend to be less than adequate.
- **Collaboration.** The delivery system encompasses a variety of distinct care systems at both the institutional and community levels: medical care, long-term care, mental health services, and aging network services. These systems operate under different principles, and need to be coordinated in order to best serve older people.
- **Access.** Many mental health services for older adults are consistently in short supply. Some older citizens do not recognize their own need for help or do not know how to access the service delivery system. Most older adults could access mental health care through their primary care physician, but many health professionals are not adequately prepared to identify or refer clients in need of mental health treatment.
- **Research.** An expanded mental health and aging research agenda is needed to deepen the understanding of the biological, behavioral, social, and cultural factors that prevent and cause disease, especially for at-risk and underserved populations. Research is needed in the areas of prevention, intervention, health services, and training.
- **Consumer involvement.** Consumer and family participation is essential in the care planning and treatment processes. Partnerships have begun to develop among consumers and family members, advocacy groups, and providers to plan and develop mental health research, systems, and services.
- **Needs of special populations.** To provide competent assistance, mental health professionals who serve special population groups, such as racial and ethnic minorities, must acquire adequate knowledge about the culture and values of these groups, how services can be tailored to meet the needs of these groups, and the types of mental health approaches that are most effective with minority elders.

Addressing these challenges will require the concerted efforts of all those working toward the improved mental health of older people in both the public and private sectors, including social workers, policymakers, practitioners and service providers, researchers, consumers, family members, and other advocates. By taking advantage of the numerous efforts in mental health and aging that have been implemented and using them as a foundation to craft policies, programs, and research that will enhance the mental health of older people and their families, the emerging crisis in geriatric mental health care can be addressed. This provides the opportunity to work in partnership across services systems and disciplines to address the mental health needs of older adults.

**Resources for further information**

**Videos**
Visit www.YouTube.com/cmshhsgov to see videos covering different health care topics on Medicare’s You Tube channel.

**Messages and Tweets**
Follow official Medicare information at @CMSGov and the Children’s Health Insurance Program at @IKNGov.

**Blogs**
Visit http://blog.medicare.gov/feed or http://cms.gov/feed/ for up-to-date news and current information from the website.

**Social Security**
1-800-772-1213 | TTY-1-800-325-0778 | www.socialsecurity.gov

**Medicare Coordinator or Benefits Contractor**
1-800-999-1118 | TTY-1-800-318-8782

**Department of Defense**
Get Information about TRICARE for LIFE and the TRICARE Pharmacy Program.
1-866-773-0404(TFL) | TTY-1-866-773-0405
1-877-363-1303 (Pharmacy) | TTY- 1-877-540-6261
www.tricare.mil/mybenefit

**Department of Veteran Affairs**
1-800-827-1000 | TTY- 1-800-829-4833 |www.va.gov

**Office of Personnel Management**
For Information about the Federal Employee Health Benefits Program for current or retired employees
1-888-767-6738 | TTY- 1-800-878-5707 | www.opm.gov/insure

**Railroad Retirement Board (RRB)**
For individuals with benefits from RRB
1-877-772-5772 | TTY-1-312-751-4701 | www.rrb.gov
Quality Improvement Organization (QIO)

Report complaints about quality of care or if coverage is ending to soon. Visit www.medicare.gov or call 1-800-Medicare to get the phone number of the local QIO.

Caregiver Resources

Visit “Ask Medicare” at www.medicare.gov/caregivers to help caregivers to assist in selecting drug plans, comparing nursing homes, get help with billing and more.

References

Introduction/Background


- www.EliteCME.com


Primary and Long-Term Care


Medicare and Medicaid Financing


Challenges in Mental Health and Aging

1. Between 2010 and 2030, how many of America’s “baby boomers” will reach the age of 65?
   a. 50 million.
   b. 72 million.
   c. 76 million.
   d. 100 million.

2. Women on average live seven years longer than men.
   a. True.
   b. False.

3. According to the Federal Interagency Forum on Aging Related Statistics, 2000 report, what group of elderly people is the poorest with a poverty rate of 47 percent?
   b. Widowed Hispanic men.
   d. Caucasian women over the age of 80.

4. Older people are confronted with what two main types of stressors?
   a. Finances and the loss of loved ones.
   b. Social status and physical pain.
   c. Marital status and living arrangements.
   d. Life events and chronic strain.

5. Which of the following statements is false?
   a. Older people metabolize medications differently due to physiological changes.
   b. Older people with a sleep disturbance will have a mental disorder.
   c. Older adults with cognitive deficits may also have difficulty managing medications or remembering appointments.
   d. Older people with mental disorders may present with different symptoms than younger people.

6. Long Term Care- Various studies indicate a high prevalence of which of the following in nursing homes?
   a. Dementia and depression appear to be the most common mental disorder in these settings.
   b. Schizophrenia is most common.
   c. Eating disorders are most common.
   d. None are common.

7. These Long Term Care studies also show:
   a. Lack of knowledge and adequate training of nursing home staff about mental health.
   b. Adequate knowledge and training about mental health.
   c. Excellent knowledge and training about mental health.
   d. None of the above.

8. The major barriers to obtaining treatment for mental health conditions in nursing homes include:
   a. A shortage of specialized mental health professionals trained in geriatrics.
   b. Lack of adequate Medicaid and Medicare reimbursement to facilities to cover behavior and mental health.
   c. Lack of adequate reimbursement to obtain the services of psychiatrists and other mental health professionals.
   d. All of the above.

9. What mental health needs is addressed by psychosocial interventions in nursing homes?
   a. Individual and group interventions can be utilized to help the resident to adapt to the nursing home environment and to roll changes.
   b. Residents cannot be assisted to regain orientation to their surroundings.
   c. Interventions cannot decrease specific problems or achieve specific.
   d. All of the above.

10. Eden Alternative includes which of the following?
    a. Provides a more humane habitat for residents of nursing facilities.
    b. Uses the companionship of animals and other humans.
    c. Children play onsite and mingle with residents for several hours most days.
    d. All of the above.

11. Geriatric Mental Health Care Training Projects include the following EXCEPT:
    a. Trained nurses and nursing personnel in urban long-term care facilities.
    b. A two-day train-the-trainer training covered six modules focused on mental health topics, including the causes of problem behaviors and management techniques.
    c. Geropsychiatric nurse specialists trained 43 nurse leaders, and then these leaders trained 520 staff.
    d. Two-way interactive telecommunications techniques were also used to reach leaders in rural.

12. Respite care refers to:
    a. A range of services that offer temporary relief to caregivers of frail elders.
    b. Respite programs can prevent or alleviate depression and burnout.
    c. Respite may delay the need for more costly care.
    d. All of the above.

13. The three models of Respite Care are:
    a. In home services, limited care models, out of home services.
    b. In-home services, out-of-home respite, comprehensive care models.
    c. Traveling models, community care, in home care.
    d. None of the above.

14. Medicare is for which of the following groups?
    a. People 65 and older.
    b. People under 65 with certain disabilities.
    c. People of any age with end-stage renal disease (ESRD).
    d. All of the above.

15. The program helps to pay for which of the following EXCEPT:
    a. Many important health care services including hospitalizations.
    b. Physician services.
    c. A new prescription drug benefit.
    d. Long-term care.
16. Medicare Part A helps cover which of the following:
   a. Inpatient care in hospitals.
   b. Prescriptions.
   c. Long-term care.
   d. All of the above.

17. Part B Medical Insurance helps cover the following EXCEPT:
   a. Preventative services.
   b. Outpatient care.
   c. Hospice care.
   d. Other medical services that Part A does not cover.

18. Part C of Medicare includes all of the following EXCEPT:
   b. HMOs and PPOs.
   c. Plans are run by private companies that do not have to be approved by Medicare.
   d. None of the above.

19. Part D of Medicare includes which of the following:
   a. A voluntary prescription drug insurance program through Medicare.
   b. A mandatory drug plan.
   c. A non-Medicare approved drug plan.
   d. None of the above.

20. Additional resources to assist with paying Medicare costs are:
   a. Qualified Medicare Beneficiary (QMB) Program.
   b. Specified low-income Medicare beneficiary (SLM) Program.
   c. Qualified disabled and working individual (QDWI) program.
   d. All of the above.