Activities of Daily Living (ADLs) – Basic self-care tasks: feeding, toileting, bathing, grooming, dressing, mobility and transferring (such as moving from bed to wheelchair). May also refer to Instrumental Activities of Daily Living (IADLs), the complex skills needed to live independently, such as managing finances, driving, cooking and more. 40

Acute Care – Usually given in a hospital, this level of care involves intensive or emergency care for a short period of time while a patient is being treated for a brief severe illness or while recovering from surgery. 176

Adult Day Health Services – Provides caregivers with the opportunity for respite and the ability to continue working while caregiving. For adult participants, provides health services and social opportunities in a safe place outside the home during the day. Services can include health monitoring, medication management, hair salon, showers, meals and activities. 34-36

Advance Directive – A legal document that dictates treatment preferences and the designation of a surrogate decision-maker should a person become unable to make medical decisions on their own behalf. Also called a Living Will. 26-28

Assisted Living – Combines housing and support services to maximize the residents’ self-sufficiency. Services may include housekeeping, linen services, meals, activities, transportation, medication management, respite and more. 31

Caregiver – Anyone – spouse, sibling, adult child – who is responsible for the care of someone who has poor mental health, is physically disabled or whose abilities are impaired by disease, chronic illness or old age. 20-23

Conservator – A person appointed by a court to manage someone else’s financial affairs when that person is no longer able. 26-28

Continuous Care – Inpatient or round-the-clock in-home care provided or arranged by a hospice provider when a patient is facing a medical crisis that requires close medical attention. 164

Dementia – The loss of intellectual functions (thinking, remembering, reasoning) of sufficient severity to interfere with a person’s daily functioning. Dementia is not a disease in itself, but rather a group of symptoms that may accompany certain diseases or conditions. Symptoms may also include changes in personality, mood and behavior. 52-53

Do Not Resuscitate (DNR) Order – A medical order that instructs medical personnel not to use cardiopulmonary resuscitation (CPR) or ventilation if the person is not breathing or has no pulse after suffering cardiac or respiratory arrest. 14-18, 45-46

Durable Power of Attorney – A legal document that allows a person to act on another’s behalf, even when the grantor of the document loses capacity. 26-28

Guardianship – Refers to a situation where a court appoints an individual to be a legal guardian for an elderly person who is deemed to be incapacitated, either partially or fully. The legal guardian is fully
liable for the health and well-being of the person and/or their property, as decided by the court. 26-28

**Healthcare Proxy** – Named in an advance directive, this individual is designated to make healthcare decisions when the patient is unable. The healthcare proxy has a responsibility to abide by the wishes of the patient and should be trustworthy. 26-28

**Hospice Care** – This philosophy and approach provides comfort and care at life’s end, in lieu of heroic life-saving measures. It can include medical, counseling and social services, and is provided in-home, in specialized hospitals or in hospice care centers. 45-46

**Incapacity** – Lack of physical and/or mental ability to manage one’s own personal and/or financial affairs, as decided by the court. 26-28

**Living Will** – See *Advance Directive*. 26-28

**Long-Term Care** – A variety of services that includes medical and non-medical care. It can be provided in a person’s home, retirement community or in assisted living or nursing facilities. 40

**Medicaid** – Government health insurance for low-income seniors, pregnant women, and children. 41-42

**Medicare** – Government health insurance for people age 65 or older and adults with disabilities. Part A is hospital insurance, Part B is coverage for doctors and Part D is prescription drug coverage. Part C is HMO or PPO-style insurance and can combine parts A, B and D or just A and B. 41-42, 54-59

**Memory Care** – A specialized facility or area in an adult day health center, assisted living or nursing facility dedicated to caring for patients with dementia, Alzheimer’s disease or other cognitive impairments. 94, 116

**Mental Capacity and Competence** – The ability, as decided by the court, to perceive, understand and appreciate all relevant facts and to make a rational decision based on those facts; to understand the nature and effect of one’s actions. 26-28

**Non-Skilled Home Care Services** – Assistance with ADLs and IADLs. Services may also include assistance with transportation, shopping or running errands, medication reminders, companionship or respite care. 140

**Nursing Facility** – Provides 24-hour skilled care for residents who generally rely on assistance for ADLs and IADLs. 41-42

**Palliative Care** – A medical specialty that focuses on relieving pain and other debilitating symptoms of serious illness to provide the best possible quality of life for patients and their families. Utilizes an individualized care plan that can be delivered at the same time as other treatments. Palliative care is also part of end-of-life hospice care. 45-46

**Personal Care Services** – Help with the most personal ADLs, including assistance with dressing, bathing, walking, exercising, getting out of bed, toileting and eating. 140

**Person-Centered Care** – A care philosophy that emphasizes relationships and takes into account the person’s interests, experiences and preferences to build an individualized care plan. Focuses on treating patients with respect, dignity and autonomy. 34

**Power of Attorney** – A legal document that allows a person to act on another’s behalf as long as the grantor of the document has capacity. 26-28

**Respite** – A temporary break from the responsibilities taken on by a family caregiver. Respite can be provided by a companion service, adult day health center, home health agency and assisted living or nursing facilities. 20-23

**Skilled Home Healthcare Services** – Skilled services are usually medical-based or clinical services for acute or short-term care at home. They can be provided by a registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist or social worker. A physician’s order is required for skilled services. 140

**Trust** – A legal arrangement and estate planning tool, which typically eliminates probate. 26-28

**Will** – A legal document that communicates how a person wishes personal assets and property to be distributed on or after death. A will is probated. 26-28
Discussing important aging issues with your loved one can be a difficult conversation to approach. According to a national survey, seniors and their adult children rarely discuss aging issues, and many suspect that this trend may even apply to spousal and other caregiver relationships. While we can’t predict the changes we will experience as we grow older, we do know that the most common changes are related to health, driving, living arrangements, the need for assistance, finances and end-of-life issues. Often, by talking about these important life issues early and planning ahead, families will find it easier to cope with the changes, crisis decision-making can be avoided, and personal control can be retained even in difficult situations.

While the majority of those surveyed said they are comfortable discussing age-related issues, the reality is they seldom do. The main reason mentioned: No one is starting the conversation. In general, when a person reaches age 70, or their eldest child reaches age 40 – whichever comes first – it is time to start having conversations about aging and making plans for the future. So, how and where do you start?

**SETTING THE STAGE**

Research and planning are vital when preparing to start a conversation about aging. Before meeting, you may want to consider the following:

- Be alert to natural opportunities to talk about aging issues, and ask questions. This will help you gather information, little by little, that may be helpful in starting a full-fledged discussion later.
- If someone you know has gone through an age-related situation, ask them how they started their conversation.
- Make a checklist of the topics you’d like to discuss. This will help you stay on track and keep you from getting overwhelmed.
- Plan to involve others. Parents may want to talk with all of their children together, or adult children may want their siblings present.
- Get on the same page. If you are going to involve multiple people in the conversation, it is a good idea to establish a common understanding of what needs to be discussed, who will lead the conversation and who will handle which tasks.
- Decide when and where you will start the conversation. This is especially important if you are involving multiple people. Plan to meet in person, if possible. These subjects are more difficult to discuss over the phone. If a face-to-face meeting isn’t possible, be sure to set aside time to talk uninterrupted. Choose a time and place that is comfortable and relaxing. Avoid busy, high-stress times like the holidays, if possible.
STARTING THE CONVERSATION

• Consider using this article as a stimulus for starting the conversation. For example, you might mention, “I read this article and it got me thinking about aging preparations. How prepared are you for the next chapter of your life?”
• You may also want to try starting with a “what if” question, such as, “What if something happened and you were no longer able to live alone? Where would you want to live?”
• When you are ready to begin the discussion, keep distractions to a minimum. Start out slow and easy, tackling one topic at a time. Don’t try to cover everything in one marathon conversation.
• Remember to listen respectfully to everyone involved.
• Be their partner, not their parent. Ask your loved one what they want and listen without interjecting. You may want to jot down notes as they speak. This will help you remember what they want and why they want it, as well as remember any questions or concerns you may have.
• Keep sibling arguments and bickering to the background. Don’t force a parent to take a side. Allowing sibling rivalry and disagreement into the discussion can break down lines of honest communication or stop it altogether.

PLANNING FOR THE FUTURE

When helping your loved one plan for their future, always listen to them respectfully and show them that you want to do your best to honor their wishes and provide support. When approaching sensitive topics, such as living assistance, legal matters and end-of-life planning, begin by asking them what they want. Follow-up by asking, “How can I respect your wishes?” and “If we absolutely can’t make your first choice happen, what are your second and third choices?” In doing this, you will be off to a great start fostering a trusting partnership.

COLLECTING IMPORTANT INFORMATION WITH TACT

As you work your way through each topic, it is important to record your loved one’s plans and wishes and to collect documentation as you go. Giving up control of important paperwork, legal matters, finances and the like may make your loved one feel as though they are giving up pieces of their independence. The tips below can help soothe the situation, as well as help caregivers easily locate important documents, contacts and information during a crisis. Should a crisis occur, you’ll be relieved to have the necessary documentation stored in one easily-accessible, but secure, location.

• Let your loved one have as much power as possible.
• Allow your loved one to keep their documents and maintain their current filing/storage system. But request that they allow the primary family caregiver, or legal designee, to make and store copies securely in a single location.
• Respect their wishes for how to properly store their information. For instance, your loved one may be adamant about storing all documents in a secure location, such as a safety deposit box, instead of in a filing cabinet at home. Respect their peace of mind and do not argue.
• If they seem hesitant, ask them why and how you can help ease their mind. Understanding and compromise are key.

continued
IMPORTANT TOPICS TO DISCUSS

Health Matters
It’s important to develop a plan before health problems arise. Should there be a health crisis, you’ll need to know about your loved one’s:
• Current health conditions, physicians, medications and hospital preference.
• Health insurance. Do they have Medicare or other health insurance coverage? If so, find their policy identification numbers and collect a copy of the policies.
• Living will/advance directive. Do they have one? If so, find out where it is and collect a copy. Who is named as healthcare proxy?
• Legal designations. Is there a durable power of attorney for healthcare who has been given the responsibility to make healthcare decisions?
• Emergency plan. Is there a friend or neighbor who would help in an emergency? Do they have a house key and know how to contact the family?

Living Arrangements and Long-Term Care
It is important to discuss both preventative measures that may help maintain your loved one’s independence, as well as plan for potential future care needs. Some topics to discuss and questions to ask include:
• Driving status. Should they get to a point where they are no longer able to drive safely, how would they prefer to handle this loss? Would they prefer public transit? Would they need to move closer to services and assistance? For more on assessing and discussing driving status, see the next page.
• Need for additional help. Would your loved one prefer to receive assistance in their home or are they receptive to other living arrangements, such as living with family, in an assisted living or residential care community? Are they willing to use in-home and community-based services? What can they afford?

Financial Planning
Making sure finances are in order can bring peace of mind to the entire family and provide protection when life changes occur. Topics to discuss and questions to ask include:
• A general overview of financial resources and expenses. (e.g., savings, investments, life insurance policies, retirement accounts, stocks and bonds).
• Who can sign on their bank accounts? Who will pay bills in the event of an emergency and are they set up to do so?
• Who will be given the responsibility to manage financial issues? Is there a durable power of attorney for financial matters?
• Have they completed any estate planning? Who is their financial advisor?
• Where are their bank and investment accounts located? Collect copies of all important financial documents and contacts.

End-of-Life Issues
These are important issues for families to discuss before the time comes. When your loved one shares their wishes, it means things can be handled the way they prefer, and the family won’t be left guessing about what to do. You’ll need to discuss:
• Their desires for medical care, if terminally ill, as well as their feelings about heroic life-saving measures. Do they have a Do Not Resuscitate (DNR) order? If not, at what point would they want a DNR signed?
• What are their wishes for burial/cremation and funeral arrangements? Do they have burial insurance or a pre-paid burial plan? If so, find out where it is and collect a copy.
• Do they have an up-to-date will or trust? If so, find out where it is and collect a copy. You’ll also want to have a list of their legal advisors’ names and contact information.

Driving Status
Many drivers monitor themselves and gradually limit or stop driving when they feel that certain situations or driving in general is not safe. However, some people fail to recognize declining abilities, while others may resist hanging up the keys, fearing it will reduce their independence, socialization and ability to participate in familiar activities. Moreover, conditions, such as dementia or Alzheimer’s disease, may make some drivers unable to properly evaluate their driving.

The 15 Warning Signs box on the next page can help you identify red flags of unsafe driving. Having someone casually ride along to observe driving habits firsthand may help you better judge your loved one’s driving abilities. Additionally, there are resources available to assess and test driving ability, including www.seniordriving.aaa.com. If you are still concerned and think a change needs to be made, talk about it candidly with them. Start the conversation out of a sincere sense of caring for the person’s well-being and base it on specific things you have observed.

During your conversation about driving, remember that putting a stop to driving may not be your only option. One size does not fit all, and, while ceasing driving may be the only answer in some cases, stopping too early can also impact a person’s overall well-being. Consider these options first:
• Taking a classroom or online refresher course, such as the AARP Driver Safety Program.
• Making equipment adjustments to maximize comfort and control of the vehicle.

• Easing your loved one into using other methods of transportation that will allow them to maintain their independence. Options may include rides from family and friends, public transportation, paratransit services, such as Tulsa Transit’s Lift Program, taxis or other public or private transportation options. For area options, see the Transportation Resources section on page 219. It may be helpful to accompany the person during initial trials of alternate forms of transportation.

If the person is not taking proper action in response to your concern and the impairment is increasingly obvious, it may be necessary to involve the driver’s doctor. Also, if you feel that a medical or vision problem may threaten personal or public safety, contact the Medical Desk at Oklahoma’s Department of Public Safety, P.O. Box 11415, Oklahoma City, OK 73136 or call (405) 425-2424.

Conversations about important life issues may not be easy, but they are vital. These discussions can help a person maintain control at a time in their lives when they may not be able to speak for themselves. They provide important guidance for a family faced with sudden or difficult decisions. And they can help preserve independence, dignity and quality of life. Remember, most people want to have these conversations, they just don’t know where to begin. So, just start talking.

For additional explanations of the legal documents mentioned in this article read, Legal Matters and Older Adults on page 26.
HELPFUL RESOURCES FOR DRIVING CONVERSATIONS AND ASSESSMENT


• Driving Safely While Aging Gracefully available at www.nhtsa.gov.

• For information on driving skills assessment, education for continued safety and planning for post-driving needs, as well as guidance on making adjustments to maximize comfort and control of a vehicle, go to www.seniordriving.aaa.com.

• A variety of driving safety guides are available for free at www.thehartford.com/mature-market-excellence/publications-on-aging.

• For information on making adjustments and adaptations to vehicles, see the Vehicle Adaptive Devices section on page 175.

• For information on local resources, see the Driving Assessments and Resources section on page 193.

15 WARNING SIGNS THAT YOU MAY NEED TO HANG UP YOUR KEYS

1. Feeling uncomfortable, nervous or fearful while driving.
2. Dents and scrapes on the car or on fences, mailboxes, garage doors, curbs, etc.
3. Difficulty staying in the lane of travel.
4. Getting lost.
5. Trouble paying attention to signals, road signs and pavement markings.
6. Slow response to unexpected situations.
7. Medical conditions or medications that may be affecting your ability to handle the car safely.
8. Frequent “close calls” (e.g., almost crashing).
9. Trouble judging gaps in traffic at intersections and on highway entrance/exit ramps.
10. Other drivers honking at you and instances when you are angry at other drivers.
11. Friends or relatives not wanting to ride with you.
12. Difficulty seeing the sides of the road when looking straight ahead.
13. Being easily distracted or having a hard time concentrating while driving.
14. Difficulty turning your neck to check over your shoulder while backing up or changing lanes.
15. Frequent traffic tickets or warnings by traffic or law enforcement officers in the last year or two.

If you notice one or more of these warning signs, you may want to have your driving assessed by a professional or attend a driver refresher class. See the Driving Assessments and Resources section on page 193. You may also want to consult with your doctor if you are having unusual concentration or memory problems, or other physical symptoms that may be affecting your ability to drive.
PACE (Program of All-Inclusive Care for the Elderly) provides community-based care and services to people age 55 or older who need a nursing home level of care, but wish to remain living in the community. Based on medical necessity and the individual’s goals, care and services are approved through the PACE interdisciplinary team. PACE provides coverage for primary and specialty healthcare, prescription drugs, transportation, home care, checkups, hospital visits and nursing home stays when necessary.

Who Can Join PACE?
You can join PACE if:
• You are 55 years old or older;
• You live in the service area of a PACE organization;
• You are certified by the state to need nursing home level of care; and
• Receiving PACE services would allow you to live safely in the community.

PACE Provides Comprehensive and Preventive Care
With PACE, you have a team of healthcare professionals to help you make healthcare decisions. Your team is experienced in caring for people like you. Usually, they care for a small number of people. That way, they get to know you, what your living situation is and your preferences. You and your family participate as the team develops and updates your plan of care and your goals in the program. When you enroll in PACE, you may be required to use a PACE-preferred physician. These physicians are best suited to help you make healthcare decisions. PACE organizations also support family members and other caregivers with training, support groups and respite care.

PACE Provides Services in the Community
PACE organizations provide care and services in the home, the community and at the PACE center. They have contracts with many specialists and other providers in the community to make sure you get the care you need. Many PACE participants get most of their care from staff employed by the PACE organization in the PACE center. PACE centers meet state health and federal safety requirements and include adult day programs, primary care from physicians and nurses, activities and occupational and physical therapy services.

PACE Provides Medical Transportation
PACE organizations provide all medically-necessary transportation to the PACE center for activities or medical appointments. You may also be able to get transportation to some medical appointments in the community.

What You Pay Depends on Your Financial Situation
PACE uses Medicare and Medicaid funds to cover all of your medically-necessary care and services. You can have either Medicare or Medicaid, or both, to join PACE. If you have Medicaid, you will not have to pay a monthly premium for the long-term care portion of the PACE benefit. If you don’t qualify for Medicaid, but you have Medicare, you will be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare Part D drugs. However, in PACE, there is never a deductible or copayment for any drug, service or care approved by the PACE team. You can also pay for PACE privately, if you do not have Medicare or Medicaid.

For listings of PACE programs in northeast Oklahoma, see page 173.
CAREGIVING BASICS and the Stages of Caregiving

Are you …
• Helping with shopping, cooking or running errands?
• Making or receiving telephone calls on behalf of a loved one?
• Providing transportation to medical appointments?
• Assisting with bill paying or medication management?
• Providing personal care, such as bathing, dressing, toileting or feeding?
• Perceiving your loved one as dependent upon you to make decisions for them?
• Seeking and managing paid assistance and other services for your loved one?
• Considering changing your work or living arrangements to allow you more time to care for a loved one?
• Considering long-term care placement?

… then you are a caregiver.

You may not think of yourself as a caregiver. You may see what you’re doing as something natural: taking care of someone you love. If you are helping to care for a loved one, you are a caregiver.

STAGES OF CAREGIVING

Stage 1 – Basic caregiving. This is when you’re “just helping out.” You may be doing things like assisting with banking, paying bills, shopping and providing transportation.

Stage 2 – Self-identifying as a caregiver. Helping is now a necessity. You feel a responsibility to help on a daily basis. This may include assistance with personal grooming or light housekeeping in addition to the assistance provided in stage one.

Stage 3 – Providing personal care. Providing personal hygiene assistance is the hallmark of stage three. The relationship at this point can become uncomfortable between caregiver and loved one. This may be the right time to bring in outside assistance with personal care.

Stage 4 – Needing assistance. Is your caregiving role starting to exhaust and consume you? If so, it is time to consider support services. Education, respite care and in-home services, as well as adult day health services can help.

Stage 5 – Exploring facility placement. This stage comes with the realization that there is a need for more services than can be provided at home. Stage five is about weighing options and learning about what types of facilities meet the needs of your family and your loved one.

Stage 6 – Placement in a facility. The sixth stage involves placement of your loved one in some form of care facility. The caregiver in this stage often takes on the role of advocate or care manager.
As a caregiver, if you live more than one hour away from your loved one, then you are considered a long-distance caregiver.

The struggle to balance your loved one’s desire to be independent with the expectation that they are safe, comfortable and have their needs met is at the core of all caregiving. Achieving this balance can be even more difficult when you live some distance away.

Identify the Need for Help
Watch for signs that your loved one is having difficulty managing daily tasks. Identify what type of help they may need to remain independent at home for as long as possible. When you visit your loved one, watch for the following:

- Is there food in the refrigerator that is safe and healthy to eat? Check expiration dates. Are they eating regular meals?
- Has the condition of the home – inside or outside – changed?
- Are there piles of unopened mail? Have the bills been paid?
- Do they have regular visits from friends or family?
- How is their grooming and personal appearance?
- Are they able to drive safely? See Driving Status on page 17.

Build a List of Support Contacts
If you find that the needs of your loved one outweigh your ability to help from afar, there are nonprofit agencies, government programs and home health providers who can help. Building a list of resources and contact people can help you coordinate care and services for your loved one from a distance.

- Case/care managers – can help navigate home and community-based services that may offer an continued
older adult or person with disabilities the option to remain independent. A case/care manager can be your eyes and ears, help with appointments, arrange services, such as home-delivered meals, adult day health services and transportation, and can keep you informed of changes or needs that your loved one may be experiencing.

- **Family, friends and neighbors** – make a list of their phone numbers and addresses. Ask them to stop by your loved one’s home for regular visits. Check in with them to find out how your loved one is doing.
- **Personal physicians** – keep in contact with your loved one’s doctors. A HIPAA release, signed by the patient, will allow you and their physicians to discuss any concerns about their mental or physical well-being.
- **Community groups** – check with their church or social groups to ensure regular visits, an occasional meal or social activity.
- **Home care services** – you can hire a home health agency to help with bathing, personal care, activities, meal preparation and medication management.

### Important Documents
**Having legal, medical and insurance documents can help a caregiver near or far. These documents may include:**
- Medical history
- HIPAA release
- Insurance policies
- Doctors and specialists with phone numbers and addresses
- List of medications, dosages and corresponding conditions
- Hospital preferences
- Will
- Power of attorney
- Advance directive

For additional explanations of legal documents, read *Legal Matters and Older Adults* on page 26.

### Make the Most of Your Visits
Few long-distance caregivers are able to spend as much time with their loved one as they would like. The key is to use your time effectively:
- Make appointments with your loved one’s physician, lawyer and financial advisor during your visit to participate and encourage any type of planning or decision making.
- Meet with neighbors, friends and other relatives to hear how they think your loved one is doing. Ask if they have observed any behavioral changes, health problems or safety issues.
- Take time to connect with your loved one by talking, listening to music, going for a walk or participating together in activities that you both enjoy.

### Caring for a Loved One in a Long-Term Care Facility
If your loved one lives in an assisted living or nursing care facility, it is important to maintain ongoing communication with the care staff and friends who visit regularly.
- Work with the managing nurse and physician. Agree on a time when you can call to get updates on your loved one’s condition and progress.
- Call family, friends or other regular visitors and ask for their observations.
- When you visit, take time to develop a friendly, personalized relationship with the staff members who have primary responsibility for your loved one’s care. This will help ensure that your loved one is getting proper attention and care.

The struggle to balance your loved one’s desire to be independent with the expectation that they are safe, comfortable and have their needs met is at the core of all caregiving. Achieving this balance can be even more difficult when you live some distance away.
With an aging population and changes in healthcare, such as shorter hospital stays, more and more caregiving is being provided by people who aren’t healthcare professionals. In fact, more than 65 million Americans provide care to a loved one.

Caregiving can be Rewarding and Stressful

If you’re a caregiver, you know that taking care of someone who needs your assistance can be very rewarding. Being there for your family when they need you is a core value for many.

Caregiver stress refers to the emotional and physical strain of caregiving. The body can handle short bursts of stress and strain without compromising overall health. However, prolonged periods of stress can negatively impact the body.

Many caregivers fall into the trap of believing that they have to do everything by themselves. Needing an extra set of hands, time for yourself or someone to talk to, are all normal needs. Take advantage of the many resources and tools available to help you provide care for your loved one.

Signs of Caregiver Stress

As a caregiver, you may be so focused on your loved one that you don’t realize that your own health and well-being are suffering. Watch for these signs of caregiver stress:

- Feeling tired much of the time;
- Feeling overwhelmed and irritable;
- Sleeping too much or too little;
- Gaining or losing a lot of weight; and/or
- Losing interest in activities you used to enjoy.

As a caregiver, you are more likely to experience symptoms of depression or anxiety. In addition, you may not get enough physical activity or maintain a balanced diet, which only increases your risk of medical problems, such as heart disease and diabetes.

Strategies for Dealing with Caregiver Stress

The emotional and physical demands involved with caregiving can strain even the most resilient person. That’s why it’s so important to take advantage of available help and support. These strategies have helped others manage their caregiver stress:

- **Accept help.** Prepare a list of ways that others can help you, and let the helper choose what they would like to do. For instance, one person might want to provide a meal, where as someone else might want to play cards with your loved one.
- **Focus on what you are able to provide.** Don’t give in to guilt. Feeling guilty is normal, but understand that no one is a perfect caregiver. You’re doing the best you can at any given time. You don’t have to feel guilty about asking for help.
- **Get connected.** Find out which organizations in your community offer classes on caregiving. Local hospitals and health organizations may have classes specifically about the disease your loved one is facing.
- **Join a support group.** A support group can be a great source for encouragement and advice from others in similar situations. It can also be a good place to make new friends.
- **Seek social support.** Make an effort to stay emotionally connected with family and friends. Set aside time each week for socializing, even if it’s just a walk with a friend. Whenever possible, make plans that get you out of the house.
- **Set personal health goals.** For example, set a goal to find time to be physically active on most days of the week, or set a goal for getting a good night’s sleep. It’s also crucial to maintain a healthy diet.
- **See your doctor.** Get recommended immunizations and screenings. Make sure to tell your doctor that you’re a caregiver. Don’t hesitate to mention any concerns or symptoms you have.

*Source: Mayo Clinic*
A hospital stay can be stressful and intimidating. As a family member, you are focused on your loved one’s medical treatment and so is the hospital staff. But planning for when your loved one leaves the hospital is equally important. How the hospital discharge and transition home (or to another facility) occurs is critical to the health and well-being of your loved one and to their continued independence and quality of life.

What is Discharge Planning?
Medicare defines discharge planning as “a process used to decide what a patient needs for a smooth move from one level of care to another.” Ideally, discharge planning is done by a team that includes the patient, family caregiver(s), the physician and the hospital discharge planner (nurse or social worker).

How Oklahoma’s CARE Act Helps You
In 2014, Oklahoma became the first state in the nation to advocate on behalf of caregivers and their loved ones by passing the Caregiver Advise, Record, Enable Act, more commonly known as the CARE Act. This piece of legislation requires hospitals to:

• Record the name of the family caregiver when a loved one is admitted into a hospital;
• Notify the family caregiver if the loved one is to be discharged to another facility or back home; and
• Consult and train the family caregiver for the medical tasks that they may need to perform at home, such as medication management, injections, wound care and transfers.
How Caregivers Can Help Guide the Process
As the caregiver, you are an essential part of the discharge planning process. The better you understand the process, the better you will be able to advocate for the patient and for yourself. Meeting with the discharge planner early in the process should help ensure a smooth transition out of the hospital. Also, you may find it helpful in the long-run if, while your loved one is in the hospital, you keep a notebook with all the names and contact information of the people who are involved with their hospital care and discharge plan. This notebook is also a good place to keep all care instructions and referral information. Your Discharge Planning Checklist, published by the Centers for Medicare and Medicaid Services, is a useful tool for this process and is available online at www.medicare.gov or by calling (800) MEDICARE (633-4227).

What if You do Not Agree with the Discharge Date?
If you do not agree with your loved one’s date of discharge, you may appeal the discharge. Talk first with the physician and the discharge planner to express your concerns and request a review of the decision. If that does not work, contact Medicare, Medicaid or your insurance company to institute a formal appeal. Until a decision is rendered, the hospital cannot force you to take your loved one home or pay for continuing care. If your appeal is denied, however, you will be required to pay for the additional hospital care.

Finally, remember that hospital discharge planning is short term – it is not an exact forecast of the future for your loved one. Peace of mind comes from knowing what home and community-based services are available to you and your loved one, now and in the future.

Sources and Additional Information
You can find additional discharge planning information, including “A Family Caregiver’s Guide to Hospital Discharge Planning” by the National Alliance for Caregiving and the United Hospital Fund of New York, at www.caregiving.org/resources/care-recipient-health. For more Caregiver Support resources, see page 188.

The Discharge Plan Should Include:

- An evaluation of the patient, by qualified personnel, to determine post-hospital care needs;
- A discussion with the patient and their caregiver(s) about the post-hospitalization care plan and access to family and other supports;
- A determination of Medicare or insurance eligibility for the recommended discharge services;
- A plan for homecoming or transfer to another care facility, e.g., rehabilitation center, skilled nursing, assisted living or nursing home;
- Referrals to in-home or community-based services, (e.g., home healthcare, adult day health services or care management);
- A discussion surrounding any possible problems or changes that could occur at home and a list of necessary equipment rentals or home modifications;
- A review of all medications taken prior to admission and all the medications prescribed to be taken post-discharge to ensure no duplications, omissions or harmful side effects;
- A complete written medication list with dosage instructions;
- Teaching and practicing of specific patient care procedures;
- Establishing the dates and times of follow-up appointments;
- A 24-hour phone number for the caregiver to call and speak with a healthcare professional regarding any health or care-related concerns; and
- A plan for transportation home from the hospital.
Almost everyone would prefer to have a say in who is given the authority to manage their affairs when the time comes that they can no longer make those decisions on their own. Likewise, most people want to decide for themselves how their estate and personal items will be distributed upon their death.

Pre-planning ensures your affairs are handled in the manner you desire and is one of the greatest gifts you can give to your family and friends. Crucial planning documents include an advance directive for healthcare, durable power of attorney (DPOA), will, and depending upon your circumstances, possibly a trust.

**Advance Directive for Healthcare**

The advance directive for healthcare is a written, legal document that allows individuals, 18 years of age or older and of sound mind, to inform physicians and others of his/her wishes to:

- Provide, decline or withdraw life-sustaining medical care;
- Appoint a healthcare proxy to make medical decisions for you if you are unable to do so;
- Donate specified organs or the entire body for transplantation or research.

The advance directive is only used if your attending physician and another doctor both determine you are no longer able to make medical decisions. Oklahoma law presumes you desire life-sustaining treatment unless you have clearly expressed otherwise. Once your advance directive has been completed, copies should be given to your family, physician, attorney, healthcare proxy and alternate healthcare proxy. If you live in an assisted living facility or nursing home, a copy should be included in your resident file. Make sure your physician is willing to comply with your wishes; if your physician is not willing to comply, he or she must promptly inform you of that fact and take all reasonable steps to arrange for your care by another physician.

Your advance directive should be reviewed every few years, and especially after a major, life-changing event. If you recently moved to Oklahoma, you should review any previously executed end-of-life documents from your former state and execute an Oklahoma Advance Directive for Health Care.
The advance directive can be revoked at any time and in any manner that indicates your intention to revoke. Inform all those who received a copy that it has been revoked and request they destroy their copy. Inform your physician that your advance directive has been revoked and ask him or her to make the revocation part of your medical record. Completing a new advance directive automatically revokes the old one.

The Oklahoma Advance Directive for Health Care was revised in 2006. While a previously executed advance directive will remain in effect until revoked by you, it is recommended that you consider executing a new advance directive because of the additional options available in the revised form.

An Oklahoma Advance Directive for Health Care can be downloaded free from these websites:
• www.okbar.org
• www.senior-law.org

**Durable Power of Attorney (DPOA)**

A power of attorney gives another person the authority to make decisions (financial, business or healthcare) on your behalf. There are two types of power of attorney – durable and non-durable. Both allow the person the exact same authority while you, the creator, are well and of sound mind and body. The difference between the two types of power of attorney comes into play when you are not well and are unable to act or make decisions for yourself. If you become incapacitated and cannot act or make decisions for yourself, the durable power of attorney remains active, but the non-durable power of attorney becomes inactive.

Powers of attorney can be effective immediately or upon a certain event, and very restrictive or very broad. Typically, a person would name a trusted family member or friend as their power of attorney. It is important that the person named is trustworthy and conscientious, as he or she could potentially use the powers to the disadvantage of the person creating the DPOA. The DPOA can be changed or terminated at any time, provided the creator is not incapacitated, and automatically terminates at the death of the creator. If you change or terminate your DPOA, it is important to notify all relevant parties. The DPOA is an inexpensive alternative to a court-supervised guardianship or conservatorship, which is necessary when a person becomes incapacitated without pre-planning. While there is a uniform statutory form for a power of attorney (durable) at 15 O.S. § 1001-1020, it is strongly advised to consult an attorney to draft a DPOA.

As mentioned above, if you have not pre-planned by crafting a DPOA and you become unable to care for yourself or your finances, you may be subject to a guardianship proceeding. A guardianship is designed to protect incapacitated adults. A court case must be instituted for a guardian to be appointed, during which the court must make a determination of incapacity, or a lack of physical or mental ability to care for oneself or manage one’s affairs leading to significant resulting consequences.

continued
If a determination of incapacity is found, the court will appoint a guardian to take care of the person or their property – usually the child, spouse, sibling or other relative of the individual found to be incapacitated (now known as the ward) or an attorney, public guardian or bank.

The court will tailor the powers of the guardian to the need of the ward. In Oklahoma, there are three types of guardianships:

**General Guardianship** – gives the guardian almost complete power over the ward’s property and/or person. Exceptions relate to withholding or withdrawal of life-sustaining treatment (unless the ward has an advance directive for healthcare) and certain non-life-sustaining medical treatments. This is granted when the court determines that the ward is completely incapacitated.

**Limited Guardianship** – gives the guardian only the powers specified by the court over the ward’s property and/or person. The ward keeps power to manage the areas not taken away by the court. This is granted when the court determines that the ward is only partially incapacitated.

**Special Guardianship** – used to appoint a temporary guardian in an emergency. Usually the special guardianship is very limited and will not last longer than 30 days.

Guardians must file reports with the court as required. The court may be petitioned to change or dissolve a guardianship.

**Will**
A will is a legal document that communicates how a person wishes personal assets and property to be distributed after their death. You must be 18 years of age or older and of sound mind to effectuate a will. When a person dies without a valid will, their property is distributed, not according to their wishes, but according to state laws. These laws only allow distribution of property to family, as strictly outlined by the law. When you plan ahead and create a valid will, you may, upon your death, give your property to anyone you please. A will can be easily changed or revoked.

A will that is entirely handwritten, dated and signed in the creator’s own handwriting and contains no typed or printed portion is valid in Oklahoma. However, it is recommended that you utilize an attorney to draft your will.

**Trust**
A trust is a written document that manages your property for your benefit while you are living and, upon your death, distributes your property according to your wishes. Using a trust generally allows for easier and quicker distribution of your property and avoids probate. The downside to a trust is that creation of a trust is generally more expensive than that of a will, and if all property fails to be transferred to the trust, your estate may still need to be probated. It is recommended you consult with an attorney to create your trust.
INDEPENDENT LIVING EVALUATION CHECKLIST

Community Name: ________________________________________________

Contact Name: ________________________________________________

Address: ______________________________________________________

Telephone: ___________________ Email: __________________________

Date Visited: ___________ Circle: First Visit Second Visit Third Visit

Day of the Week: ___________ Circle: Morning Afternoon Evening

Floor Plans and Accommodations

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the floor plan logical and easy to follow?</td>
<td></td>
</tr>
<tr>
<td>Is the property ADA compliant?</td>
<td></td>
</tr>
</tbody>
</table>

What different sizes and types of living units are available? Are the available units an appropriate size for the resident’s needs? What is the square footage?

Do living units have kitchens or kitchenettes?

Are all living units private?

Do the living units have grab bars and call buttons?

Circle the utilities that are included:

Electric  Gas  Water  Trash/Sewer  Other

Circle the in-home amenities that are available. Is there an extra cost?

Phone  TV  Cable  Internet  Other

Are living units furnished or unfurnished?

Is there a parking fee for residents or visitors? Does the community have parking options, such as carports and garages? Is there an extra cost?

What kind of security is provided? Key or code access, gated entry, security patrols, etc.?

Is smoking allowed? Where?

Does the community provide EMSA/TotalCare ambulance service membership? Is there an extra cost?

Is there an emergency generator or alternative power source?

continued
### Services and Amenities

<table>
<thead>
<tr>
<th>YES</th>
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<tr>
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<tr>
<td>What special services are available (housekeeping, linen/laundry services, etc.)?</td>
<td></td>
</tr>
<tr>
<td>Are a variety of planned activities available? Is there an extra cost?</td>
<td></td>
</tr>
<tr>
<td>Are transportation services available? Is there an extra cost or any restrictions?</td>
<td></td>
</tr>
<tr>
<td>Circle meals that are served daily. Is there an extra cost?</td>
<td></td>
</tr>
<tr>
<td>Breakfast    Lunch    Dinner    Snacks</td>
<td></td>
</tr>
<tr>
<td>Can residents have pets? Are there any restrictions?</td>
<td></td>
</tr>
<tr>
<td>Does the community offer worship services? How often? What religions and denominations are served?</td>
<td></td>
</tr>
</tbody>
</table>

### Financial Obligations and Processes

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td>Is a contract available that details all leasing fees and services?</td>
<td></td>
</tr>
<tr>
<td>Is the contract easy to read? Do you understand it?</td>
<td></td>
</tr>
<tr>
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<td></td>
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<td>Under what conditions would a resident be asked to leave the community?</td>
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### Things to Pay Attention to During Your Visit

<table>
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<td>Are the common areas clean? Does it smell clean?</td>
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<tr>
<td>If residents are around to talk to, ask them what they think about the community.</td>
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</tbody>
</table>

### Notes

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The Difference Between Residential Care Assisted Living and an Assisted Living Community

Understanding the differences between assisted living and residential care communities can be confusing. Although the differences are few, they are distinct.

Both are licensed as Residential Care Facilities for the Elderly (RCFE).

Most facilities that market themselves as assisted living facilities are large communities where the resident has his or her own apartment and private bathroom. They tend to have a strong activity program and there is often a registered nurse or licensed practical nurse on staff to oversee resident care.

First introduced over 25 years ago, today assisted living is the fastest growing long-term care option for seniors. Assisted living communities, with their wide range of services, provide a housing solution for older adults who can live independently, but also may require some limited assistance. Large communities often do well serving residents with fixed routines and scheduled needs—regular times for bathing and getting dressed, scheduled meals and activities, etc. For many seniors, assisted living provides just the level of care they need to flourish in their new phase of life.

Residential care facilities, or “Board and Care Homes,” are small RCFEs, which usually have four to 10 beds. Residents may have their own room, but may also share a room, and often have to share a bathroom. These homes tend to be quiet, more homelike and are usually located in suburban neighborhoods. Medical care cannot be provided in a residential care facility.

The smaller home-like space of residential settings may benefit residents who could become overwhelmed by long hallways or confusing layouts. For those who can’t always initiate their own activities, residential settings reduce the chance for isolation. Residential homes can personalize activities for individuals, rather than aim to please large groups.

Residential settings can customize service delivery for each resident, each day. And because there are several residential homes in the area, you can usually find homes that cater to residents who share similar health needs, interests, backgrounds and more.

The licensing regulations and oversight are typically the same for both types of assisted living options.

Cost of Assisted Living or Residential Care Homes

Assisted living and residential care home costs vary depending on the following factors:
- Type of residence
- Size of apartment (studio, one or two-bedroom apartment)
- Bedroom and bathroom accommodations in residential care home
- Types of services needed
- Geographical location of the community

Many communities charge a basic rate that covers general services, with an additional fee for special services. Most assisted living communities charge a month-to-month rate.

Typically, base rates only cover room and board and a service of daily meals, determined by the assisted living community. Sometimes there are entrance fees, deposits and laundry and housekeeping fees. But because fees and services vary by community, it’s important to find out about their individual costs and availability.
# ASSISTED LIVING COMMUNITY EVALUATION CHECKLIST

Community Name: ___________________________________________________________

Contact Name: ______________________________________________________________

Address: __________________________________________________________________

Telephone: ____________________________ Email: ______________________________

Date Visited: ___________ Circle: First Visit Second Visit Third Visit

Day of the Week: __________ Circle: Morning Afternoon Evening

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<td></td>
</tr>
<tr>
<td>Do any living units have kitchens or kitchenettes?</td>
<td></td>
</tr>
<tr>
<td>Circle the utilities that are included: Electric Gas Water Trash/Sewer Other</td>
<td></td>
</tr>
<tr>
<td>Circle the in-home amenities that are available. Is there an extra cost? Phone TV Cable Internet Other</td>
<td></td>
</tr>
<tr>
<td>Circle common areas in the facility: Living Room Den Library Snack Area Game Room Other</td>
<td></td>
</tr>
<tr>
<td>Are living units furnished or unfurnished?</td>
<td></td>
</tr>
<tr>
<td>Can residents and visitors come and go at will?</td>
<td></td>
</tr>
<tr>
<td>Is there a parking fee for residents or visitors? Does the community have parking options, such as carports and garages? Is there an extra cost?</td>
<td></td>
</tr>
<tr>
<td>What kind of security is provided? Key or code access, gated entry, security patrols, etc.?</td>
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</tr>
<tr>
<td>Is smoking allowed? Where?</td>
<td></td>
</tr>
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<td>Is there an emergency generator or alternate power source?</td>
<td></td>
</tr>
</tbody>
</table>

## Healthcare Options

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a written care plan for each resident? What role does the resident have in developing the care plan?</td>
<td></td>
</tr>
<tr>
<td>How is the appropriate level of care determined? What services are included for each level?</td>
<td></td>
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<tr>
<td>Can residents choose their own doctors, therapists and pharmacies?</td>
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<tr>
<td>Does the facility provide EMSA/TotalCare ambulance service membership? Is there an extra cost?</td>
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</table>
### Memory Care

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Does the community offer memory care with specially-trained staff?</td>
<td></td>
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<tr>
<td>Are rooms private or shared? Is there a special memory care unit?</td>
<td></td>
</tr>
<tr>
<td>Do they have separate activities for individuals with dementia?</td>
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</tr>
<tr>
<td>What is the community’s philosophy on dementia care? Is it person-centered?</td>
<td></td>
</tr>
<tr>
<td>How do they keep residents safe? What is the community’s elopement rate?</td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
<tr>
<td>If residents are around to talk to, ask them what they think about the community and staff.</td>
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</table>
More than 65.7 million Americans (29 percent of the population) are caregivers to someone who is ill, disabled or aged. Most family caregivers perform a daily juggling act as they balance caregiving with their other responsibilities.

As more families find themselves caring for an older adult — whether it be a spouse, parent, other relative or even a friend — many are discovering the important role that adult day health services can play in helping them manage their caregiving responsibilities.

Adult day health centers offer a coordinated program of professional and compassionate services for adults in a community-based group setting. Programs are designed to provide health and social services to adults who need supervised care in a safe place outside the home during the day. They also give caregivers a much-needed break, allowing them to attend to personal needs, run errands, rest and relax, or to continue working.

A well-run adult day health program focuses on enriching the participants’ lives by building on their individual skills, knowledge, abilities and strengths. Besides social and recreational services, some adult day health centers provide transportation to and from the center; social services, including counseling and support groups for caregivers; health support services, such as health monitoring; medication management; physical, speech and occupational therapies; specialized Alzheimer’s/dementia care; and assistance with personal care, such as assisted showers, hair care and foot care.

Most socially-based adult day health centers offer lively conversation and reminiscing, exercise and fitness activities, arts and crafts, music, games and regular home-like activities, such as cooking, gardening, woodworking and tinkering, in a safe and stimulating daytime home-away-from-home environment. The socialization, friendships and meaningful activities give many participants a new lease on life and something to look forward to each day.

Adult day health programs are also an affordable alternative to in-home care, enabling families to access a full range of services for a fraction of the cost. Additionally, many centers offer financial assistance through various private and government programs.

How Do You Know if the Time is Right for Adult Day Health Services?

The questions below will help you determine if adult day health services is the right choice for you and your loved one. If you answer “yes” to even one, you may want to start considering adult day health services as an option.

1. Has your loved one recently been discharged from a hospital or skilled rehabilitation center?
2. Are you worried about their safety when you aren’t around?
3. Are you having to leave your loved one alone when you need to work or run errands?
4. Do you find yourself taking time off from work to care for them?
5. Would you feel better if you knew they could eat nutritious meals, get exercise and assistance, and enjoy social activities during the day?
6. Has your relationship with your loved one become strained because the amount of care needed has increased or you spend too much time with each other?
7. Does your loved one have health issues, forget to take medications or have care needs that they cannot manage alone?
8. Are they isolated without the company of other people?
9. Would you like help caring for a loved one?

As a caregiver, it’s very important to care for yourself so that you can effectively (and happily) care for someone else. For information about programs near you, please refer to the Adult Day Health Services section that begins on page 136.
Adult day health services provide older adults with the opportunity to retain their independence and quality of life in a community-based group setting, while their family caregivers benefit from a much-needed break and can continue to work or attend to personal matters. For many individuals and families, daytime care is a welcome alternative to nursing home or other residential care. A well-managed program focuses on enriching the participants’ lives by building upon individual interests and providing opportunities for socialization and friendships.

Consider taking the following steps in selecting the program that is right for your family.

**Step 1: Determine Your Needs**
Make a list of the features and services that are important to you and your loved one.

<table>
<thead>
<tr>
<th>Specific services that may be important:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance with eating, walking, transferring, toletting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing services – breathing treatments, insulin injections, medication management, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, speech or occupational therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health monitoring – blood pressure, blood sugar, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care – bathing, shaving, hair care, incontinence care, etc.</td>
<td></td>
<td></td>
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</tbody>
</table>

**Step 2: Beginning the Search**
To begin your search, review the list of Tulsa-area providers beginning on page 136, or a statewide list at www.ok.gov/health/pub/_WRAPPER/ltc.html. Once you have a list of adult day health centers in your area, it is recommended that you visit each center’s website or call and request a flyer or brochure. The next step in your search will be to compile questions to ask when you visit each center. Here are some suggested questions to get you started:

<table>
<thead>
<tr>
<th>Who is the owner or sponsoring agency of the center?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the center a nonprofit or for-profit organization?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many years has the center been in operation?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is the center licensed by the Oklahoma State Department of Health?  
Is the center nationally accredited by CARF (Commission on the Accreditation of Rehabilitation Facilities)?

What are the days and hours of operation?

Is transportation assistance available?

Are special services available (e.g., nursing care, medication management and physical, occupational or speech therapy)?

What is the cost (hourly or daily rates)? Are there additional charges?

Is financial assistance available?

Are there any restrictions to enrollment (e.g., age, health conditions, limited mobility, memory loss, incontinence)?

Do they offer personal care (e.g., assisted showers, shaving, hair care, foot care and incontinence care)?

Does the center offer different levels of care?

What are the staff credentials? What is the staff-to-participant ratio?

Are meals provided? Can they accommodate special dietary needs?

What kind of activities do they offer? Are there group or individual programs?

Step 3: Pay a Visit

Make an appointment to meet with the staff and tour the centers on your list. Spend some time in the center to get a feel for the people and the program.

Did you feel welcome?

Did someone spend time finding out what you and your loved one want and need?

Did someone clearly explain what services and activities the center provides?

Did they present information about staffing, program procedures and costs?

Is the center clean, pleasant and odor-free?

Is the center ADA compliant?

Is the furniture sturdy and comfortable?

Is there a quiet place within the program area?

Did you see cheerful faces on staff and participants?

Do they have volunteers that help?

Are participants involved in planning activities or making other suggestions?

What kind of security features are in place?

Step 4: Check References

Talk to two or three people who have used the centers you are considering. Ask for their opinion.

Step 5: What to Expect

It’s important to remember that a change in routine can be challenging for you and your loved one. It may take several days or longer to adjust to the new routine and setting. Knowing what to expect is important for both of you. During this transition, if you run into any difficulty or have concerns, ask staff for their suggestions and support. Keep in mind that this transition period is temporary; your loved one will soon enjoy and look forward to their days at the center.
HOME HEALTH AGENCY
EVALUATION CHECKLIST

Home healthcare services cover a wide range of health and other supportive services delivered in a person’s home. This evaluation checklist is designed to help you ask the necessary questions in order to choose the best provider for your needs.

Agency Name: ________________________________
Contact Name: ________________________________
Address: ______________________________________
Telephone: __________________________ Email:_________________________

### Understanding Services

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you receive a written care plan before service begins?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will the agency work directly with you or your loved one, family members and healthcare providers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency refer their clients to dietitians, counselors, therapists or other specialists, if needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any limits on the types of tasks performed? What are they?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the times of service? Does the agency offer 24-hour care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What procedures are in place for emergencies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will the agency or home health aide deliver services in the event of bad weather or power outage?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency provide a list of the rights and responsibilities (patient’s bill of rights) of all parties involved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Must you identify a primary family caregiver? If so, what are their responsibilities?</td>
<td></td>
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</tr>
</tbody>
</table>

### Quality of Care

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the agency hire and train caregivers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the caregivers licensed and insured?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency provide continuing education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How closely does the agency’s supervisor evaluate the quality of the care provided?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency have a quality improvement program?</td>
<td></td>
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</tbody>
</table>

continued
### Licensing, Staffing and History

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the agency accredited by a state or nationally-recognized group, such as JCAHO?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the agency and staff bonded?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long has the agency been in business? How many clients do they have?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency conduct a state and national background check on all staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency drug test staff members? Under what circumstances and by which methods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can the agency provide references from hospitals, doctors, discharge planners or former clients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency have a psychiatric nurse on staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you comfortable with the staff? Are they positive and friendly?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many people will be providing care? Is there consistency with who will provide care?</td>
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</tbody>
</table>

### Financial Obligations and Processes

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the agency provide literature explaining all services and fees, as well as detailed explanations of all the costs associated with home healthcare?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency have a minimum service hour requirement? What is it?</td>
<td></td>
<td></td>
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<tr>
<td>How does the agency handle expenses and billing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will agency fees be covered by health insurance, Medicare or Medicaid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What resources does the agency provide for financial assistance, if needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the agency offer a payment plan?</td>
<td></td>
<td></td>
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<tr>
<td>If you’re considering a home health aide, what is the hourly rate?</td>
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</tbody>
</table>

### For additional information about the home health agencies you are considering:

Visit Home Health Compare at www.medicare.gov. The website includes agency contact information, agency’s initial date of Medicare certification, type of ownership (nonprofit, for-profit or government), services offered, as well as information about each home health agency’s quality of care and reviews from patients who have used the agency.

### Notes

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</table>
Prior to 1981, nursing homes and other institutional settings were the only option for people with limited incomes who needed Medicaid’s help with long-term care. Now, there are home and community-based service waiver programs that allow states to waive certain Medicaid rules and offer in-home care services as an alternative to nursing home or other institutional care.

The ADvantage Program

In Oklahoma, the ADvantage waiver program offers a variety of in-home and community-based services for people age 65 or older with chronic illnesses, and for adults age 21 or older with physical disabilities. To qualify, you must meet Medicaid waiver health and financial requirements.

Currently, the monthly income limit is $2,199 per individual with no more than $2,000 in assets (not including the value of your home and car). You also must need nursing home level of care to qualify for the program. Nursing home level of care means that without the services the waiver provides, you would be at risk for going to a nursing home. Oklahoma’s Department of Human Services (OKDHS) determines if you meet these criteria and are eligible for the program.

Although the ADvantage program doesn’t provide 24-hour care, for many people, simply having help with daily tasks, like preparing meals, doing laundry, grocery shopping or bathing, may be all they need to stay at home.

All services provided by the ADvantage program are based on the individual’s needs. Along with case management, services may include:

- Personal care assistance with daily activities, such as bathing, housekeeping, meals and shopping
- Home-delivered meals
- Durable medical equipment, such as grab bars, shower chairs, hand-held showers and extended toilet seats
- Diabetic supplies and incontinence products
- Prescription drugs
- Home modifications, including installation of ramps or widening a bathroom doorway
- Adult day health services
- ADvantage assisted living facility (not yet available in the Tulsa area)
- Nursing services
- Physical, occupational, speech and respiratory therapies
- Respite care
- Hospice care

How the Program Works

To apply for Oklahoma’s ADvantage program, call your local OKDHS office or the toll-free ADvantage line at (800) 435-4711. You can also call LIFE’s SeniorLine at (918) 664-9000 for help applying for ADvantage.

You will be sent a packet of forms requesting your financial information that must be returned within 10 days. An OKDHS nurse will also schedule a home visit to assess the level of care you need. OKDHS has up to 45 days to determine if you meet the financial and level-of-care criteria.

Once you are approved for the ADvantage program, the first thing you will do is choose an ADvantage-certified agency as your case management provider. You will also choose an ADvantage-certified agency for any nursing or personal care services you may receive. If you don’t have a preference, an agency will be assigned to you. If you choose, you can hire and supervise your own worker to provide your personal care services.

Your case manager will meet with you in your home. A team approach, comprised of your case manager, a nurse, other service providers and any friends or family you wish to include, is used to develop your personal care plan. Your team will meet with you to discuss your goals and create a plan of services. Your case manager arranges and coordinates your services, and contacts you at least monthly, to make sure services remain in place as long as needed. Your plan can be changed as your needs change. You can stay on the ADvantage program as long as your needs can be safely met at home and you continue to meet the program’s level-of-care and financial requirements.
WHAT IS LONG-TERM CARE?

Long-term care consists of a variety of services and supports to meet health and personal care needs over an extended period of time. Most long-term care is non-skilled personal care assistance, such as help performing Activities of Daily Living (ADLs), which are eating, bathing, dressing, grooming, using the toilet, mobility and transferring (to or from a bed or chair).

Who Needs Long-Term Care?

Long-term care is needed when you have a chronic illness or disability and you need assistance with ADLs. Your illness or disability could include a cognitive impairment or problem with memory loss, confusion or disorientation, such as Alzheimer’s disease.

While most people who need long-term care are age 65 or older, a person can need long-term care services at any age. In fact, nearly 40 percent of those currently receiving long-term care are between the ages of 18 and 64. About 70 percent of people over age 65 require some type of long-term care services during their later years.

Cost of Long-Term Care

Long-term care is expensive. On average, an Oklahoma nursing home costs from $51,000 up to $68,000 per year, depending on the location and whether you have a private or semi-private room. Care in an assisted living facility averages almost $37,000 per year. Average rates are $22 an hour for home health aides employed by sampled licensed home health agencies. Adult day health services is the least expensive long-term care option at an average cost of $70 a day. For more information on adult day health services, see the article on page 34 and the listing of providers on page 136.

Who Pays for Long-Term Care?

Most people end up paying for most or all of their long-term care out of their own income or assets. Medicare does not cover the cost of long-term care, especially non-skilled assistance with ADLs, which are a major focus of long-term care. It will, however, cover the cost of skilled services or recuperative care for a short period of time after a hospitalization.

Medicaid is the joint federal and state program that pays for nursing home care for those who meet the financial and functional criteria. Other federal programs, such as the Older Americans Act and Veterans Administration, pay for some long-term care services, but only for specific populations and in specific circumstances.

Most forms of employer-sponsored or private health insurance, including Health Maintenance Organizations (HMOs) or managed care, follow the same general rules as Medicare. If they do cover long-term care, it is typically only for skilled, short-term, medically-necessary care after a hospitalization.

There are, however, an increasing number of private payment options that help to cover the costs of long-term care services. These include long-term care insurance, trusts, annuities and reverse mortgages.

It is important to understand the differences among the public programs and private financing options for long-term care services. Each public program and private financing source has its own rules for what services it covers, eligibility requirements, co-pays and premiums.

The U.S. Department of Health and Human Services developed the National Clearinghouse for Long-Term Care Information website to provide information and resources to help you and your family plan for future long-term care needs. The website has a variety of user-friendly tools, including a savings calculator, so that you can see what it might cost you if you needed long-term care and how much you’d have to begin saving today in order to have enough to pay for your own care needs. For more information, visit the website at www.longtermcare.gov.
Finding And Paying For Nursing Home Care

It's important to remember that a nursing home is a home – a home that also provides meals, healthcare services, personal care, recreation and other services to seniors and adults with disabilities who need daily assistance and care. Deciding which nursing home is best for a loved one can be stressful. Most families don't know where to begin. The following information can help make this important decision less difficult.

Beginning Your Search for Nursing Home Care

- Talk with your loved one who will be living in the nursing home. What are their preferences? Including them as much as possible in the conversation and decision is important and can help them better adjust to what is a necessary, but often difficult, change in their life.
- Talk with other family members. Ask for their help in finding and selecting a nursing home. Sharing the information-gathering and decision-making with other family members can reduce associated stress and increase everyone’s comfort with the final decision.
- Ask people you trust, like your family, friends, neighbors or clergy, if they have had personal experience with nursing homes. They may be able to recommend a nursing home to you.
- Ask your loved one’s doctor if he or she provides care at any local nursing homes. If so, ask which nursing homes he or she visits so your loved one may continue to see their doctor while in the nursing home.
- Narrow your options down to three to six nursing homes to visit. If possible, take another family member or friend with you and use the Nursing Home Evaluation Checklist on page 43 to help you remember which questions to ask, and to use later for comparison. Remember to include the person who will be living in the nursing home in this process as much as possible. During your visit, be sure to talk casually with the staff (especially the nursing assistants, as they provide direct care), residents and their family members, if you can. This will help you get a feel for the community’s culture. You should also ask to see the facility’s inspection notice from the State Health Department. This information is public record. For a more detailed checklist, visit www.medicare.gov/nursinghomecompare/checklist.pdf.
- Compare the nursing homes on your list using the Five-Star Quality Rating System at www.medicare.gov/nursinghomecompare. This quality system was created to help consumers, their families and caregivers compare nursing homes more easily and help identify areas about which you may want to ask questions. Nursing home ratings are taken from health inspection results, nursing home staffing data and quality measures.
- Use the Focus on Excellence Ratings System at www.oknursinghomerratings.com to view ratings on nine measures of quality and overall rankings for participating Oklahoma nursing homes.
- Remember, selecting a nursing home is not an irrevocable decision. You can always choose to move to another facility and although moving is difficult, an extra move may be better for you than choosing to stay at a facility that isn't right for you.
- Family involvement doesn’t end when a loved one enters a nursing home. The family simply takes on a new role – making sure others are providing good care and advocating on your loved one’s behalf.

Nursing Home Care is Not the Only Option

Oklahoma’s Medicaid ADvantage program provides in-home and community-based services to qualifying individuals to help delay or altogether avoid the need for nursing home placement. For more information, see Helping Seniors Remain at Home with the ADvantage Program on page 39.

Paying for Nursing Home Care

Most people know nursing home care is expensive, but few realize how expensive. On average, a year in an Oklahoma nursing home can cost more than $50,000 and as much as $83,000 in other parts of the country. Payment options for nursing home care include:

- **Private Pay:** About one-third of nursing home residents pay for their nursing home care out of their own personal income and savings. Of course, an extended nursing home stay can rapidly deplete one’s savings. On average, people exhaust their personal resources after only six months and must then turn...
to Medicaid for assistance. That's why it's important to contact the Department of Human Services when a person is first admitted to the nursing home – even before Medicaid assistance is needed. Getting correct Medicaid guidance early on helps families understand how to best use individual resources to pay for long-term care and how to protect as many assets as possible for the spouse remaining in the home (community spouse).

- **Long-Term Care Insurance:** This premium-based private insurance can help cover the cost of nursing homes and other long-term care.

- **Medicare:** In certain situations, Medicare will pay for short-term skilled nursing home care. Medicare does not pay the largest part of long-term care services or personal care – such as help with bathing – or for supervision, often called custodial care.

- **Veterans Administration:** Some veterans may be eligible for assistance with nursing home costs or care at a VA nursing home. For more information, contact the Veterans Administration at (800) 827-1000 or visit www.va.gov.

- **Medicaid:** Medicaid helps people pay for nursing home care once they have exhausted their personal resources. To receive Medicaid benefits, the individual must require nursing home level of care and meet the program's income and resource guidelines as outlined below. Medicaid recipients are expected to use their income to pay a share of the cost of the care (minus the cost of health insurance premiums and $50 a month for personal care expenses, and minus any income they are allowed to contribute to their spouse). Medicaid then pays the difference between the recipient's share and the Medicaid-approved payment rate to the nursing home.

### 2015 Oklahoma Medicaid Qualifications

To qualify for Medicaid, an Oklahoma resident must:

- Require nursing home level of care.
- Have an individual monthly income equal to or less than $2,199. Individuals with a monthly income of more than $2,199, but less than $4,365 may still be eligible through use of a Medicaid Income Pension Trust Fund. For more information on a Medicaid Income Pension Trust Fund, contact your local Oklahoma Department of Human Services (OKDHS) office.
- Have individual resources less than $2,000. Single or unmarried individuals with resources above the limit must “spend down” their assets by paying for their own care until they qualify for Medicaid assistance.

### Medicaid Spousal Impoverishment Guidelines

It's important to note that the spouse of a nursing home resident is protected from impoverishment by federal law. The spousal impoverishment provisions help ensure that the community spouse still at home will have the money needed to pay for living expenses by protecting a certain amount of the couple's resources, and, if needed, at least a portion of the nursing home resident's income.

### Resource Eligibility for Married Couples

When a couple applies for Medicaid, an assessment is made of their resources or assets. The couple's resources, regardless of ownership, are combined as the couple's “countable resources.”

The couple's home, household goods, automobiles and burial funds are not included in calculating the couple's combined or countable resources. Countable assets may include savings, checking accounts, certificates of deposit, trusts, stocks, bonds, mineral rights, other property, and certain life insurance and burial policies. Additionally, there are strict regulations that govern the transfer of assets to family members or others and doing so can result in disqualification for Medicaid assistance.

If the couple's combined or countable resources are below $25,000, the community spouse retains the full amount. For assets above $25,000, the following division of assets guidelines apply.

### Division of Assets Guidelines

Generally speaking, division of assets guidelines state that a maximum Protected Resource Amount (PRA) of $119,200 is subtracted from the couple's combined countable resources and retained by the community spouse if the couple had double that amount, $238,400, when one of them entered the nursing home. The remaining half of the assets, as well as any excess assets over $238,400, can then be spent on the couple, and may be used to pay for the needed nursing home care until the resident qualifies for Medicaid.

### Spousal Income Protection

The community spouse may retain up to $2,981 a month in income, which may include a portion of the nursing home resident’s income. The amount of income the community spouse may keep depends on the amount of income received by each person and the cost of monthly health insurance premiums.

For more information on Medicaid coverage for nursing home care or to complete an application, contact your local OKDHS office. To locate your local OKDHS office, see the Medicaid Information section beginning on page 205.
NURSING HOME EVALUATION CHECKLIST

Nursing Home Name: ________________________________________________________________

Contact Name: ___________________________________________________________________

Address:  ________________________________________________________________________

Telephone: ____________________    Email: __________________________________________

Date Visited: ___________  Circle:  First Visit  Second Visit  Third Visit

Day of the Week: ___________ Circle:  Morning  Afternoon  Evening

<table>
<thead>
<tr>
<th>Floor Plans and Safety Accommodations</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the floor plan logical and easy to follow?</td>
<td></td>
<td></td>
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<tr>
<td>Do the hallways have handrails? Do rooms/bathrooms have grab bars and call buttons?</td>
<td></td>
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<tr>
<td>Are there safety locks on the doors and windows? Are there security/fire safety systems?</td>
<td></td>
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<tr>
<td>Is there an emergency generator or alternate power source?</td>
<td></td>
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<tr>
<td>Circle the in-home amenities that are available. Is there an extra cost? Phone TV Cable Internet Other</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Healthcare Services</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Is special care available, such as for individuals with dementia? Is the staff specially trained?</td>
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<tr>
<td>Is transportation available for visits to the resident’s personal physician and special medical services, such as dialysis?</td>
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<tr>
<td>Is physical therapy available for as long as the resident needs it?</td>
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<tr>
<td>Does the facility provide EMSA/TotalCare ambulance services membership? Is there an extra cost?</td>
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<table>
<thead>
<tr>
<th>Quality of Care and Life</th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>What is the facility’s philosophy of care? Do they focus on person-centered care?</td>
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<tr>
<td>Are care planning meetings held at times easy for residents/family to attend?</td>
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<tr>
<td>Does the nursing home have an active family council?</td>
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<tr>
<td>Do residents have the same caregivers on a daily basis?</td>
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continued
| Does the staff knock before entering a resident’s room? |   |   |
| Are the doors shut when a resident is being dressed or bathed? |   |   |
| Is there fresh water available in the rooms? |   |   |
| Are residents offered choices of food? Are snacks offered throughout the day? |   |   |
| Do residents receive assistance eating or drinking, as needed? |   |   |
| Does the nursing home meet cultural, religious or language needs? |   |   |
| Are residents participating in activities and exercise? |   |   |
| What is the visitation policy? |   |   |
| Are transportation services provided? Is there an extra cost or any restrictions? |   |   |
| Does the nursing home have outdoor areas for residents and staff? |   |   |

**Licensing, Staffing and History**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Is the nursing home Medicaid-certified?</td>
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<tr>
<td>Has the facility’s license ever been revoked? If so, when and why?</td>
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</tr>
<tr>
<td>Are background checks conducted on all staff members?</td>
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<tr>
<td>Does the nursing home have its own doctor(s) on staff?</td>
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<tr>
<td>How many licensed nurses are on duty at each shift? RNs: LPNs:</td>
<td></td>
</tr>
<tr>
<td>What is the resident-to-staff ratio? Resident-to-nurse? Resident-to-aide?</td>
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<tr>
<td>Is the nursing home accepting new residents? If not, is there a waiting list for admission?</td>
<td></td>
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</table>

**Financial Obligations and Processes**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Is a contract available that details all fees, services, and admission and discharge policies?</td>
<td></td>
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<tr>
<td>Is the contract easy to read? Do you understand it?</td>
<td></td>
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<tr>
<td>What levels of care are addressed in the contract?</td>
<td></td>
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<tr>
<td>How does the facility bill for services and utilities?</td>
<td></td>
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<tr>
<td>How are rate increases and late payments handled?</td>
<td></td>
</tr>
<tr>
<td>Under what conditions would a resident be asked to leave the facility?</td>
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**Things to Pay Attention to During Your Visit**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Is the facility clean? Does it smell clean?</td>
<td></td>
</tr>
<tr>
<td>Are residents’ rights posted?</td>
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</tr>
<tr>
<td>Is there a resident notification area? Is there an up-to-date activity and meals calendar posted?</td>
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</tr>
<tr>
<td>If residents are around to talk to, ask them what they think about the facility and staff.</td>
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</table>
The word “hospice” frightens many people. Often, this fear comes from the misconception that accepting hospice care means giving up hope. Fortunately, this is far from the truth. Hospice services can be a tremendous source of help and comfort and are focused on improving the quality of a patient’s life.

**What is Hospice?**

Hospice care is considered to be the model for quality, compassionate care for people facing a life-limiting illness with a prognosis of six months or less. It involves a team-oriented approach to providing expert medical care, pain management and emotional and spiritual support tailored to the person’s needs and wishes. Support is provided to the person’s loved ones as well.

The focus of hospice relies on the belief that each of us has the right to die pain-free and with dignity, and that our loved ones will receive the necessary support to allow us to do so. Hospice focuses on care, not curing.

**How Does Hospice Work?**

Generally, hospice is recommended when the patient is expected to live six months or less. A referral to a hospice provider from the individual’s physician is required to begin care. Except for restrictions set by an insurance provider, the selection of a hospice service provider is a personal choice.

*continued*
Once the referral is received, hospice staff will visit the individual to assess their overall needs and wishes. At this time, hospice staff will also set up an interdisciplinary care team that includes the individual and the primary caregiver, as well as physicians, nurses, hospice aides, social workers, chaplains, various therapists and trained volunteers.

The care team should work together to create a care plan specifically tailored to meet the needs and desires of the individual and the family. Among its major responsibilities, the hospice care team:

- Manages the person’s pain and symptoms – referred to as palliative care;
- Provides emotional support;
- Provides needed medications, medical supplies and equipment related to managing the life-limiting illness;
- Inquires about end-of-life care, advanced directives and a Do Not Resuscitate (DNR) order;
- Coaches loved ones on how to care for the person;
- Delivers special services, like speech, occupational and physical therapy, as needed;
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home or the caregiver needs respite; and
- Provides grief support to surviving loved ones and friends.

As you consider beginning hospice care, it is also a good idea to consider the person’s end-of-life wishes and to choose a funeral, burial or cremation provider. You’ll also need to include this information in your hospice care plan. For a list of funeral, burial and cremation providers serving the Tulsa area, see page 180.

**What is a Do Not Resuscitate (DNR) Order?**

A DNR is a medical order that instructs medical personnel not to resuscitate in the event a patient stops breathing or their heart stops. The DNR request is usually made by the patient or healthcare power of attorney and allows the medical teams to respect the patient’s wishes. Advanced directives or DNR forms can be changed at any time by the patient or healthcare proxy by simply communicating with his or her physician or hospice staff.

**What is Palliative Care?**

It is a medical specialty that focuses on the relief of pain, stress and other debilitating symptoms of a serious illness. The individualized plan can be delivered at the same time as other treatments. The goal is to relieve suffering and provide the best possible quality of life for patients and their families.

**Where are Hospice Services Provided?**

Hospice services most often are provided in the patient’s own home, but can also be in a long-term care or assisted living facility, a family member’s home, hospital or special end-of-life care facility. For a list of hospice care agencies, see page 164.

**How is Hospice Paid for?**

In Oklahoma, besides private pay, hospice care can also be paid by Medicare (Part A), the Veterans Administration, most private health insurance plans or the ADvantage program.
HOSPICE CARE AGENCY EVALUATION CHECKLIST

Hospice Name: _______________________________________________________

Contact Name: _______________________________________________________

Address: __________________________________________________________________________

Telephone: __________________________ Email: __________________________

Is the hospice licensed by the state? | YES | NO
--- | --- | ---
Is the hospice Medicare-certified? | YES | NO
Is the hospice accredited by a state or nationally-recognized group, such as JCAHO, ACHC or CHAP? | YES | NO
Is the hospice a member of the Oklahoma Hospice and Palliative Care Association (OHPCA), the National Hospice and Palliative Care Organization (NHPCO) or the National Association for Home Care and Hospice? | YES | NO
How many years has the hospice been in business? | YES | NO
What are the geographic service boundaries? | YES | NO
Are you allowed to retain your personal physician? | YES | NO
Circle medical equipment that is typically provided to a patient: Electric hospital bed | YES | NO
Alternating pressure mattress | YES | NO
Bedside commode | YES | NO
Does the hospice require you to have a primary caregiver as a condition of admission? | YES | NO
What responsibilities are expected of the primary caregiver? | YES | NO
What special programs, in addition to routine hospice care, are available? | YES | NO
Are you required to sign a Do Not Resuscitate (DNR) form or an advance directive before being admitted? | YES | NO
Are you required to designate your chosen funeral, burial or cremation provider before being admitted? | YES | NO
How quickly can the hospice start services? | YES | NO

Sources: Oklahoma Hospice and Palliative Care Association (OHPCA), www.okhospice.org and National Hospice and Palliative Care Organization (NHPCO), www.nhpco.org.
As many as one in five older adults experience mental health disorders that are not a normal part of aging – the most common of which are depression and anxiety. In most cases, these mental health challenges respond well to treatment. Sadly, far too often, older adults do not seek or receive the help they need. Left undiagnosed and untreated, mental illness can have serious implications for older adults and their loved ones. That’s why it’s important to understand these 10 facts about mental health and aging.

1. Mental health problems are not a normal part of aging.
   - While older adults may experience many losses, deep sadness that lingers may signal clinical depression. Similarly, an anxiety disorder is different from normal worries.
   - One in four American adults has a diagnosable mental disorder during any one year.
   - About six percent of older adults have a diagnosable depressive illness.

2. Mental health is as important as physical health.
   - Good mental health contributes greatly to an overall feeling of well-being.
   - Research shows mental illness can slow healing from physical illnesses.
   - Untreated mental health disorders in older adults can lead to diminished functioning, substance abuse, poor quality of life and shortened life expectancy.

3. Healthy older adults can continue to thrive, grow and enjoy life!
   - Reading, walking and socializing are just a few of the activities that many individuals enjoy at any age. Exercising the mind and body and maintaining social connections are good for one’s mental health, too.
Mental health problems are a risk for older adults, regardless of history.

- While some adults go through life managing a chronic mental illness, mental health problems also can appear later in life.
- Sometimes mental health deteriorates in response to a stroke, Parkinson’s disease, cancer, arthritis, diabetes and even some medications.
- Older adults without a history of substance abuse may abuse medications, alcohol or other drugs.

Suicide is a risk among older adults.

- Older adults have the highest suicide rates in the country. Those age 85 and older have the highest suicide rate; those age 75 to 84 have the second highest.
- Older adults’ suicide attempts are more lethal. For those 65 and older, there is one suicide for every four attempts compared to one suicide for every 20 attempts for all other age groups.

It is important to consult with a healthcare professional if you have:

- Sadness that has lasted longer than two weeks.
- Consistent worries about issues, such as money, family and health.
- Consistent trouble sleeping or concentrating.
- Frequent trouble remembering things or feeling confused in familiar places.
- Consuming more than one alcoholic drink a day or taking more medication than prescribed.

Older adults can be helped with the same success as younger people.

- Research shows that 80 percent of older adults recover from depression after receiving treatment that includes both psychotherapy and anti-depressant medication.

Our health system is not adequately helping older adults with mental disorders.

- Medicare Part B now covers 80 percent of mental health treatments (the same as any other physical health problem). However, research estimates that up to 63 percent of older adults with a mental disorder do not receive the services they need.
- Seventy-five percent of older adults who commit suicide have visited their primary care physician within a month of their suicide.
- In addition, due to stigma, seniors are less likely to seek services for mental health challenges than they are to see a medical doctor for a physical ailment.

Misdiagnosis and avoidance are common.

- Primary care physicians fail to diagnose depression at least 50 percent of the time.
- Only half of older adults who discuss specific mental health problems with a physician receive any treatment.

Older adults have specific mental healthcare needs.

- Changes in body chemistry, family, friendships and living situations all can have an impact on mental health and need to be considered in treatment.
- If older adults take many medications for illnesses, drug interactions and side effects can affect mood and behavior.
- Sometimes helping solve basic problems, like transportation, can lower stress, improve community connections and improve outlook and mood.

Adapted from Ten Facts About Mental Health and Aging. Reprinted with permission from Older Women’s League (OWL); (800) 825-3695; www.owl-national.org
Many older adults suffer from feelings of loneliness and/or depression. Loneliness includes feelings of being alone or without companionship, social isolation or sadness. Loneliness also includes a desire to have close and meaningful relationships in your life with people who show mutual care and understanding.

It should not be surprising that changes brought on by retirement, the death of a spouse or loved one, living alone, a lack of family and social support, and social isolation can trigger feelings of loneliness. Research shows that loneliness can have a negative impact on one's health, including feeling depressed. While depression is not a normal part of aging, it is common for older adults to sometimes struggle with feelings of depression and loneliness.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 15 out of every 100 adults over the age of 65 suffer from depression. The National Institute of Mental Health (NIMH) reports the risk of depression in older adults increases in conjunction with other illnesses and when the ability to function becomes limited. Rates of depression also tend to rise when some type of home healthcare is required. Some signs of depression include:
- Feeling sad or blue for an extended period of time
- Feeling tired or without energy for an extended period of time
- Having difficulty concentrating, remembering things or making decisions
- Loss of interest in doing activities that one previously enjoyed
- Experiencing weight loss or gain
- Having feelings of guilt or worthlessness

Experiencing one or more of these symptoms does not necessarily mean that you are experiencing depression. You may just be feeling lonely. The best thing to do if you have any of the above symptoms is to make an appointment with your primary care physician or a psychiatrist and discuss your mood. There may be a medical reason or a medication you are taking that can explain how you are feeling. Some individuals may benefit from medication and/or professional counseling to help them through a difficult time. Your primary care physician may be able to determine what type of treatment, if any, is best for you.

Whether you are depressed or just feeling lonely, here are some tips to help you manage your feelings:
- Try to think about what is positive in your life. One way to do this is to make a list of things for which you are grateful and read it to yourself when you are feeling sad.
- Make sure you are eating right. It is recommended that you eat three nutritious meals a day and have nutritious snacks. Avoid eating junk food or food with high sugar or fat content.
• Make sure you get six to eight hours of sleep a night. We all feel better when we have had a good night’s sleep.
• Exercise according to your doctor’s advice.
• Do something you enjoy every day. It can be as involved as gardening or taking a cooking class, or as simple as enjoying a walk, reading, listening to music or taking a leisurely bubble bath. Whatever you choose, taking time for you is a great way to invest in your positive mental health.
• Be social. Consider getting involved with activities and classes at your local senior center.
• Make and nurture friendships. Try to schedule some type of social activity at least one day each week. If your friends are not available, reach out to someone else that may be feeling lonely and invite them to do something.
• Let friends and loved ones know how you are feeling and ask for support.

If you or a loved one is in need of counseling, see the Mental and Behavioral Health and Counseling Services section beginning on page 227.

Occasionally older adults experience feelings of worthlessness, serious depression or even wish they were no longer living. If you or someone you love is experiencing these feelings, call The National Suicide Prevention Hotline at (800) 273- TALK (8255) for help 24-hours a day.

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**How Lonely Are You?**

*from: AARP The Magazine | September 24, 2010*

**Instructions:** The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described, using the numbers below. There are no right or wrong answers. 1=Never, 2=Rarely, 3=Sometimes, 4=Always

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you feel unhappy doing many things alone?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel you have no one to talk to?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel you cannot tolerate being alone?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel as if no one understands you?</td>
<td></td>
</tr>
<tr>
<td>How often do you find yourself waiting for people to call or write?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel completely alone?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel unable to reach out and communicate with those around you?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel starved for company?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel it is difficult for you to make friends?</td>
<td></td>
</tr>
<tr>
<td>How often do you feel shut out and excluded by others?</td>
<td></td>
</tr>
</tbody>
</table>

**Scoring:** A total score is computed by adding up the responses to each question. The average loneliness score on the measure is 20. A score of 25 or higher reflects a high level of loneliness. A score of 30 or higher reflects a very high level of loneliness.

_UCLA Loneliness Scale © Dr. Daniel Russell_
Memory often changes with age, but memory loss that disrupts daily life is not a typical part of aging. Such memory loss may be a symptom of any number of types of dementia. A general umbrella term, dementia describes a group of symptoms that affect intellectual and social abilities, such as memory and/or cognitive ability, severely enough to interfere with daily functioning. Some causes of dementia are treatable and even reversible.

Who Gets Dementia?
Dementia is considered a late-life disease because it tends to develop mostly in older adults. More than 11 percent of people age 65 or older have some form of dementia, and 82 percent of people with Alzheimer’s are age 75 or older.

What Causes Dementia?
Because dementia is the set of symptoms, not the root disease, it can be caused by:

- Diseases that cause degeneration or loss of nerve cells in the brain, such as Alzheimer's, Parkinson's and Huntington's.
- Diseases that affect blood vessels, such as a stroke, which can cause a disorder known as multi-infarct dementia.
- Toxic reactions, like excessive alcohol or drug use.
- Nutritional deficiencies, like vitamin B12 (which can be reversed if caught early) and folate deficiency.
- Infections that affect the brain and spinal cord, such as AIDS Dementia Complex and Creutzfeldt-Jakob disease.
- Certain types of hydrocephalus, an accumulation of fluid in the brain that can result from developmental abnormalities, infection, injury or brain tumors.
- Head injury – either a single severe head injury or chronic smaller injuries.
- Kidney, liver and lung diseases can also lead to dementia.

What are the Symptoms and Progression of Dementia?
Dementia gradually progresses. In the later stages, the person may not know what day of the week, month or year it is, they may not know where they are and might not be able to identify the people around them.

Dementia symptoms vary depending on the cause, but common signs and symptoms include:

- Memory loss
- Difficulty communicating
- Inability to learn or remember new information
- Difficulty with planning and organizing
- Difficulty with coordination and motor functions
- Personality changes
- Inability to reason
- Inappropriate behavior
- Paranoia
- Agitation
- Hallucinations

When to See a Doctor
Don’t delay seeing a doctor if you or a loved one experience memory loss or other dementia symptoms. Often, symptoms can be attributed to a treatable medical condition, such as urinary tract infections or even be a side effect of certain medications. Also, there are medications that can treat symptoms and help slow the progression of dementia, especially when treatment begins early.

Sources: www.mayoclinic.com and www.alz.org
Warning Signs of Alzheimer’s Disease

Just one of 70 different types of dementia, Alzheimer’s disease accounts for 50 to 80 percent of dementia cases and is incurable. Warning signs of Alzheimer’s disease include:

• **Memory changes that disrupt daily life.** Especially in the early stages, common signs include forgetting recently-learned information, forgetting important dates or events, asking for the same information over and over, or relying heavily on family members or memory aids.

• **Challenges in planning, problem-solving and concentration.** Some people may experience changes in their ability to develop and follow a plan or work with numbers. Following familiar recipes, keeping track of monthly bills and maintaining concentration may become difficult.

• **Difficulty completing familiar tasks.** Having trouble driving to a familiar location or remembering the rules of a favorite game are both common red flags.

• **Confusion about time or place.** Alzheimer’s can cause people to lose track of dates, seasons and the passage of time. They may have trouble understanding something if it is not happening immediately and they may forget where they are or how they got there.

• **Trouble understanding visual images and spatial relationships.** For some, visual comprehension issues may develop. They may begin to have difficulty judging distance or direction when driving, catching a ball or even picking something up. In terms of perception, they may pass a mirror and mistake their own image for another, thinking it is someone else.

• **Problems with words in speaking or writing.** People with Alzheimer’s disease may have trouble following or joining a conversation. They may stop in the middle of a conversation and have no idea how to continue, or they may repeat themselves. They may struggle with vocabulary, have problems finding the right word or call things by the wrong name (e.g., calling a “watch” a “hand clock”).

• **Misplacing things and losing the ability to retrace steps.** A person with Alzheimer’s disease may put things in unusual places, or lose things and be unable to retrace their steps to find them. They may even accuse others of stealing. This may occur more frequently over time.

• **Decreased or poor judgment.** People with Alzheimer’s disease may experience changes in judgment or the ability to make decisions. They may use poor judgment when dealing with finances, such as giving large amounts of money to telemarketers. They may pay less attention to bathing or grooming.

• **Withdrawal from work or social activities.** Someone who has dementia may start to remove themselves from hobbies, social activities, work projects or sports. They may have trouble keeping up with a favorite sports team or remembering how to complete a favorite hobby. They may also avoid being social because of the changes they have experienced.

• **Changes in mood and personality.** People with Alzheimer’s disease may become confused, suspicious, depressed, fearful or anxious. They may become easily upset.

If you or someone you care about is experiencing any of the warning signs, please see a doctor to find the cause and explore which treatments might help you. Early diagnosis can give you a chance to obtain treatment and plan for your future.

Adapted from: 10 Warning Signs of Alzheimer’s Disease © 2015 Alzheimer’s Association
Medicare is a Health Insurance Program for:
- People age 65 or older
- People under 65 who have certain disabilities
- People of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant)

There are Four Parts to Medicare:
- Part A – Hospital Insurance
- Part B – Medical Insurance
- Part C – Medicare Advantage Plans
- Part D – Prescription Drug Coverage

What is Medicare Part A?
Medicare Part A is your hospital insurance. It helps cover your hospital inpatient care (including critical access hospitals and inpatient rehabilitation facilities), and inpatient stays in a skilled nursing facility (not custodial or long-term care). It also helps cover some hospice care services and some home healthcare services. You must meet certain conditions to receive these benefits.

How Much Does Part A Cost?
Most people don’t pay a monthly premium for Part A because they or a spouse paid Medicare taxes while working. If you (or your spouse) did not pay Medicare taxes while you worked and you are age 65 or older, you may be able to buy Part A. To confirm whether or not you have Part A coverage, look on your red, white and blue Medicare card for “Hospital (Part A).”

Hospital Deductible for 2015:
The Medicare beneficiary pays:
- $1,260 deductible for a hospital stay of 1-60 days
- $315 per day for days 61-90
- $630 per day for days 91-150
- All costs after 150 days

Skilled Nursing Coinsurance for 2015:
The Medicare beneficiary pays:
- $0 coinsurance for the first 20 days
- $157.50 per day for days 21-100
- All costs after 100 days

When Can I Sign Up for Part A?
Many people automatically get Part A. If you get benefits from Social Security or the Railroad Retirement Board (RRB), you automatically get Part A starting the first day of the month you turn age 65. If you are under age 65 and disabled, you automatically get Part A after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. You will get your Medicare card in the mail about two months before your 65th birthday or your 25th month of disability.

Some people need to sign up for Part A. If you aren’t getting Social Security or RRB benefits when you turn age 65 (for instance, because you are still working), you should still sign up for Part A. You should contact Social Security three months before you turn age 65. If you worked for a railroad, contact the RRB to sign up.

What is Medicare Part B?
Medicare Part B (medical insurance) is optional and helps cover medically-necessary services like your doctors’ services and outpatient care. It also covers some other medical services that Part A doesn’t cover, such as some of the services of physical, occupational and speech therapists, some home healthcare and preventive services.

How Much Does Part B Cost?
Most people will pay the standard monthly Part B premium of $104.90 for 2015. In some cases, your monthly premium amount may be higher if you didn’t
sign up for Part B when you were first eligible. Also, some people pay a higher premium based on their modified adjusted gross income. If you are single and your annual adjusted gross income is more than $85,000 or if you are married with an annual adjusted gross income of more than $170,000, your Part B premium may be higher than the standard premium. The 2015 annual deductible is $147. After you meet the deductible, you will pay 20 percent of the Medicare-approved amount for most Part B covered services. To confirm whether or not you have Part B coverage, look on your red, white and blue Medicare card for “Medical (Part B).”

When Can I Sign Up for Part B?

Many people automatically get Part B. If you get benefits from Social Security or the RRB, you automatically get Part B starting the first day of the month you turn age 65. If you are under age 65 and disabled, you automatically get Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. You will get your Medicare card in the mail about two months before your 65th birthday or your 25th month of disability. If you don’t want Part B, follow the instructions that come with the card and send the card back. If you keep the card, you keep Part B and will pay Part B premiums.

Note: If you are not already getting benefits, you should call Social Security at (800) 772-1213 three months before your 65th birthday, even if you plan to continue working.

Some people need to sign up for Part B. If you didn’t sign up for Part B when you were first eligible at age 65, you may be able to sign up during one of these times:

- **General Enrollment Period** – Between January 1 and March 31 each year. Your coverage will begin on July 1. The cost of your Part B will go up 10 percent for each full 12-month period you could have had Part B but didn’t sign up for it. You may have to pay a late enrollment penalty as long as you have Part B, unless you qualify for a Special Enrollment Period.

- **Special Enrollment Period** – If you didn’t take Part B when you were first eligible because you or your spouse were working and you had group health coverage based on that work, you can sign up for Part B during a Special Enrollment Period. People who sign up for Part B during a Special Enrollment Period continued

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**Medicare Coverage Options**

With Medicare, you can choose how you get your health and prescription drug coverage. Your costs vary depending on your plan, coverage and the services you use.

<table>
<thead>
<tr>
<th>Original Medicare Plan</th>
<th>Medicare Advantage Plan (like an HMO or PPO)</th>
</tr>
</thead>
</table>
| Part A: Hospital Insurance | Part C  
( Includes both Part A: Hospital Insurance and Part B: Medical Insurance) |
| Part B: Medical Insurance | Part C  
( Includes both Part A: Hospital Insurance and Part B: Medical Insurance) |
| Medicare provides this coverage | Private insurance companies approved by Medicare provide this coverage |
| You have your choice of doctors | In most plans, you must see plan doctors |
| Generally, you pay deductibles and coinsurance | Costs, extra benefits and rules vary by plan |
| You pay a monthly premium for Part B | You usually pay a monthly premium in addition to your Part B premium |
| You can join a Medicare Part D prescription drug plan to add drug coverage | If you want drug coverage, you must get it through your plan (in most cases) |
| You can buy a Medigap (Medicare Supplement Insurance) policy — sold by private insurance companies — to help fill the gaps in Part A and Part B coverage | You don’t need a Medigap policy |

(918) 664-9000 The Basics of Medicare • LIFE’s Vintage Guide 55
Period can do so without a penalty. You can sign up:
- Any time you are still covered by the group health plan
- During the eight months following the month when the group health plan coverage ends, or when the employment ends (whichever is first).

### Medicare Part C

#### What is Medicare Part C?
Medicare Advantage Plans are part of the Medicare Program and are sometimes called “Part C.” These are health plan options that are approved by Medicare and offered by private companies. Medicare Advantage Plans provide all of your Part A and Part B coverage. This means they must cover at least all of the services that Original Medicare covers. They generally offer extra benefits and many include Medicare prescription drug coverage. The plan may have special rules that you need to follow, such as seeing doctors that belong to the plan or going to certain hospitals for services.

#### How Much Does Part C Cost?
If you join a Medicare Advantage Plan, you still pay the Medicare Part B premium and you may also pay an additional premium for the Medicare Advantage Plan. Each Medicare Advantage Plan can charge different out-of-pocket costs. These are usually copayments, but can also be coinsurance and deductibles. It’s important to call any plan before joining to find out the plan’s rules, what your costs will be and to make sure the plan meets your needs.

#### When Can I Join, Switch or Drop a Medicare Advantage Plan?
To join a Medicare Advantage Plan, you must have both Medicare Part A and Part B and live in the plan’s service area. You can join, switch or drop a Medicare Advantage Plan at these times:
- When you first become eligible for Medicare (three months before you turn age 65 to three months after the month you turn age 65).
- If you get Medicare due to a disability, you can join during the three months before to three months after your 25th month of disability.
- Between October 15 and December 7 each year. Your coverage will begin on January 1 of the following year.
- You can dis-enroll from a Medicare Advantage Plan and return to Original Medicare between January 1 and February 14 of each year. During this period, you can also join a Medicare prescription drug plan.

### Medicare Part D

#### What is Medicare Part D?
Medicare offers outpatient prescription drug coverage (Medicare Part D) for everyone with Medicare. To get Medicare drug coverage, you must join a plan run by an insurance company or another company approved by Medicare. Once you choose a Medicare drug plan, you may join by completing a paper application, calling the plan or enrolling online. If you want Medicare drug coverage, you need to choose a plan that works with your health coverage.

You can get your Medicare prescription drug coverage either through Medicare Prescription Drug Plans, which add drug coverage to Original Medicare or through Medicare Advantage Plans that include Medicare prescription drug coverage.

#### What if I Already Have Other Prescription Drug Coverage?
If you have another source of drug coverage, such as through an employer or union, you should check with your current provider to determine how your coverage compares to Medicare Part D. Unless your other drug coverage is considered “creditable” coverage, meaning that it is at least as good as Medicare prescription drug coverage, it’s important for you to join a Medicare prescription drug plan when you are first eligible. Postponing enrollment may mean higher premiums due to a penalty that you will have to pay as long as you have Medicare prescription drug coverage.

#### How Much Does Part D Cost?
Most people will pay a monthly premium for Medicare prescription drug coverage.
Additionally, you will pay a share of the cost of your prescriptions, including a deductible, co-payments and/or coinsurance. Your costs will vary depending on the drugs you use, the plan you choose and whether you go to a pharmacy in your plan’s network. If you have limited income and limited resources, Medicare Part D’s Extra Help or Low-Income Subsidy program can help you receive full or partial financial assistance to pay for premiums, deductibles and copayments.
When Can I Join, Switch or Drop a Medicare Part D Plan?

You can join, switch or drop a Medicare Part D prescription drug plan at these times:
• When you first become eligible for Medicare.
• Between October 15 and December 7 each year. Your coverage will begin on January 1 of the following year.
• In certain situations, including if you involuntarily lose your creditable prescription drug coverage, you may get a Special Enrollment Period. You can sign up for Part D and won’t have to pay a late enrollment penalty as long as you join a Medicare drug plan within 63 days of losing your creditable coverage.
• If you are eligible for and receive the extra financial help for Part D costs, you have a continuous Special Enrollment Period and can change your Medicare drug plan at any time.

Note: Between January 1 and February 14 each year, you can join a Part D plan if, during this period, you disenrolled from a Medicare Advantage Plan and returned to Original Medicare. Your coverage will begin the first of the month after the plan receives the enrollment form.

How Do I Qualify for the Extra Help?

You automatically qualify for the Medicare Part D extra financial help if you have Medicare and Medicaid, Medicare and Supplemental Security Income (SSI) without Medicaid, or if the state helps pay your Medicare premiums. If you don’t automatically qualify, you may qualify for the Extra Help if you meet certain income and resource guidelines that may change each year. For 2015, the income limit for a single person is $1,471 in monthly income and $13,640 in assets. The amount for a married couple is $1,991 in joint monthly income and $27,250 in joint assets.


For help understanding Medicare benefits, comparing, selecting and enrolling in a Medicare drug plan and applying for the Extra Help with drug plan costs, call the Medicare Assistance Program at LIFE Senior Services - (918) 664-9000 or toll-free at (866) 664-9009. You may also contact Medicare at (800)-MEDICARE (633-4227) or visit Medicare’s website at www.medicare.gov.

Medicare Savings Programs

If you have Medicare and your monthly income and financial resources meet one of the standards given below, the state of Oklahoma may help pay your Medicare Part A and/or Part B premiums, deductibles and copayments. The three programs available to help with these costs are known as Medicare Savings Programs. They are: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI). If you qualify for QMB, SLMB or QI, you automatically qualify for Extra Help paying the costs of Medicare prescription drug coverage. The benefits provided by each program and the 2015 eligibility guidelines for each can be found in the chart below:

<table>
<thead>
<tr>
<th>PROGRAM BENEFITS</th>
<th>ELIGIBILITY GUIDELINES</th>
</tr>
</thead>
</table>
| **Qualified Medicare Beneficiary (QMB)** | Single: monthly income less than $981 and assets less than $7,280  
MARried: monthly income less than $1,328 and assets less than $10,930 |
| Pays Medicare Part A and Part B monthly premiums  
Pays other Medicare cost-sharing (like deductibles, coinsurance and copayments) |
| **Specified Low-Income Medicare Beneficiary (SLMB)** | Single: monthly income less than $1,177 and assets less than $7,280  
MARried: monthly income less than $1,593 and assets less than $10,930 |
| Pays Medicare Part B monthly premium |
| **Qualifying Individual (QI)** | Single: monthly income less than $1,325 and assets less than $7,280  
MARried: monthly income less than $1,793 and assets less than $10,930 |
| Pays Medicare Part B monthly premium |
The Affordable Care Act is making prescription drug coverage (Part D) for people with Medicare more affordable. It does this by gradually closing the Part D coverage gap (also known as the “donut hole”). For many people enrolled in Medicare Part D, the gap occurs after they and their plan spend a certain amount of money for covered drugs, but before they reach “catastrophic coverage” in which they are only responsible for a small percentage of their drug costs. Prior to the Affordable Care Act, an individual in the coverage gap had to pay the full costs of their prescription drugs, but now people are experiencing lower drug costs as the gap closes. Provisions to close the gap include a discount under the Medicare Coverage Gap Discount Program and an increase in coverage for all other covered Part D drugs.

What is the Coverage Gap, and How Will I Know if I’ve Reached it?

Most Medicare prescription drug plans (Part D) have a coverage gap. This means that after you and your drug plan have spent a certain amount of money for covered drugs, there is a temporary limit on the plan’s coverage. While in the gap, you have to pay a greater share of the costs of your prescription drugs (up to a limit of $4,700 in out-of-pocket costs in 2015). Every month that you fill a prescription, your drug plan will mail you an Explanation of Benefits (EOB) notice, which tells you how much you have spent on covered drugs and if you’ve reached the coverage gap.

How Does the Medicare Coverage Gap Discount Program Work?

Drug manufacturers must sign agreements with Medicare to participate in the Medicare Coverage Gap Discount Program. The agreement specifies that all of the manufacturers’ applicable drugs will automatically be discounted at the point-of-sale for coverage gap claims. (Note: Applicable drugs generally are covered brand-name Part D drugs, including insulin and Part D vaccines.)

This discount applies if you buy your prescriptions at a pharmacy or order them through the mail. The discount doesn’t include the cost of the pharmacy dispensing fee. The full cost of the drug will count as out-of-pocket spending for the purposes of reaching catastrophic coverage.

For example, let’s assume you’ve reached the coverage gap and need to fill a prescription for an applicable drug. The price for the drug is $60 and the dispensing fee is $2. Once the discount is applied (55 percent in 2015) the cost of the drug is $27. After the $2 dispensing fee is added to the $27 discounted amount, your cost for the prescription will be $29. The amount you spend on drugs while in the coverage gap, plus most of the discount you receive, will count toward the amount you need to get out of the gap and qualify for catastrophic coverage.

Who is Eligible for the Savings While in the Coverage Gap?

People who meet all of the following criteria are eligible for discounts under the Medicare Coverage Gap Discount Program:

- They are currently enrolled in a Medicare Prescription Drug Plan or a Medicare Advantage Plan (HMO or PPO) that includes prescription drug coverage.
- They are not entitled to Extra Help, an income-related subsidy through the federal government that
helps people with limited income and resources pay their Medicare prescription drug costs.

- They’ve reached the coverage gap.

Once I’ve Entered the Coverage Gap, Will All Medicare-Covered Brand-Name Prescription Drugs be Discounted?

If a drug company has signed an agreement to participate in the Discount Program, all of the covered Part D brand-name drugs they make are discounted during the coverage gap for that calendar year. This includes prescription drugs on the plan’s formulary (list of covered drugs) and those covered through an appeal. Manufacturers that produce more than 99 percent of the brand-name drugs used by people with Medicare participate in this program.

Will I Get Additional Savings Once I Reach the Coverage Gap if I Have an Enhanced Medicare Drug Plan That Already Includes Coverage in the Gap?

Yes, you may get a discount after your plan’s coverage has been applied to the price of the drug. The 55 percent discount for brand-name drugs will apply to the remaining amount that you owe. For example, if you’re in a drug plan that offers a 60 percent discount on brand-name drugs (after you have spent a certain amount) and you fill a $100 brand-name prescription, the cost of your prescription after your plan’s savings is $40. Once the 55 percent discount is applied to the $40 amount, you will pay $18 for the prescription (plus any dispensing fee), but the full $40 will count as out-of-pocket spending.

What Happens if I Fill a Prescription and Only Part of the Amount is in the Coverage Gap?

The discount will only apply to the portion of your claim that’s in the coverage gap. For example, if you fill a prescription for a brand-name drug that costs $100, and only $50 of that cost is in the coverage gap, the discount will only apply to that $50.

How Will I Know if my Prescription Will be Covered at a Discount and What Should I Do if it Isn’t?

Contact your drug plan or ask your pharmacist if the prescription drugs you take are covered at a discount during the coverage gap. Your brand-name drug will be covered under Part D and discounted if it’s made by a drug company that’s participating in the Medicare Coverage Gap Discount Program and you reach the coverage gap. If your brand-name drug is made by a drug company that has chosen not to participate in the Discount Program, the drug won’t be covered under Medicare Part D. If your drug isn’t covered, talk to your doctor or other healthcare provider to find out if there’s another drug that you can take.

What if I Don’t Get a Discount, and I Think I Should Have?

If you think that you have reached the coverage gap and you don’t get a discount when you pay for your brand-name prescription, you should review your next EOB notice. If the discount doesn’t appear on the EOB, you should work with your drug plan to make sure that your prescription records are correct and up-to-date. If your drug plan doesn’t agree that you are owed a discount, you can appeal by calling (800) MEDICARE (633-4227).

What if I Have Other Insurance?

You can only get the discount if Medicare Part D is the primary payer (pays first) for your prescription drugs. If your other insurance coverage pays second, they will pay after the discount has been provided.

How Has Medicare Increased its Coverage for all Other Part D Drugs?

Medicare has increased its standard coverage by paying a certain percent (35 percent in 2015) of the cost for all other non-brand generic Part D drugs during the coverage gap, including the dispensing fee. If you reach the gap in 2015, you will pay 65 percent of the cost and that amount, including the dispensing fee, will count toward getting you out of the coverage gap. Part D coverage will increase each year and the amount you pay will decrease each year until 2020, when you will only pay 25 percent of the cost.

What Additional Discounts and Savings Will People with Medicare Have Over Time in the Coverage Gap?

- In 2016, people with Medicare will pay 45 percent for covered brand-name drugs and 58 percent for all other covered drugs.
- Over the next several years, the benefits will increase for all covered drugs so that people with Medicare will pay less in the coverage gap.
- By 2020, the coverage gap will close and people will pay only 25 percent for covered brand-name and generic drugs from the time they meet the deductible (if applicable) until they reach the out-of-pocket limit.