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# Senior Tidings

Crawford County Council on Aging, Inc.



October 2009

## Council on Aging...notes



### Medication Drop off

Bucyrus Community Hospital is sponsoring a drive through medication drop off for **unused** medication on October 13th at 2-6 pm. This will help the community to dispose of old outdated medication or unused medication, instead of using the trash or water system.

access our website, please notify us so your name can be taken off our mailing list, to help reduce the cost of postage.

### Newsletter Donations

Donations for the Council on Aging newsletter, *Senior Tidings*, are always appreciated. The number of newsletters printed monthly has greatly increased over the past year. The mailing cost for each home is estimated to be **\$5.00 per year**. All donations should be sent to the Council on Aging, 200 S. Spring St., Bucyrus 44820. Thank you for your support!

### Prices are changing for newsletter postage

The newsletter mailing may look a little different this month due to adding more tabs as closures. We are no longer allowed to use staples per new rules of the Post Office. Please keep in mind, the newsletter can also be viewed via website at <http://crawfordcountyaging.com>. If you

## Health & Nutrition....



### Gallstones....

People over the age of 60 are more susceptible to developing gallstones, tiny pebble-like substances that form in the gallbladder and can block passageways between the liver, gallbladder and small intestine.

Stones can form when a person has

too much cholesterol in their bile (a liquid that helps digest fats), according to the National Institutes of Health. As it ages, the body secretes more cholesterol into the digestive fluid.

Some people with gallstones don't show any signs of having gallstones,

however, you should head to the doctor if you experience these common symptoms:

- Pain in the right upper or middle upper abdomen that lasts for 30 minutes or more
- Jaundice (yellowing of eyes and skin)
- Pain in the back between shoulder blades or below the right shoulder
- Nausea or vomiting
- Clay-colored stool

You can get more information about gallstones and how to treat them from the U.S. National Library of Medicine.

Source: Medicare Rights Center, Vol. 8, Issue 38: September 2009.

## Drinking Problems and Older Adults

Can drinking problems begin later in life? How do you talk to an older person about his or her drinking? Get answers to these and other questions from *Older Adults and Alcohol: You Can Get Help*, a new booklet from NIH.

This colorful 20-page publication is filled with personal stories, checklists, practical tips and resources. Learn how alcohol interacts with medications, how heavy drinking affects health and how family, friends and caregivers might help if they're concerned about someone's drinking.

To download or order free copies of *Older Adults and Alcohol*, visit [www.nia.nih.gov/HealthInformation/Publications/AlcoholBooklet](http://www.nia.nih.gov/HealthInformation/Publications/AlcoholBooklet), or call NIH's National Institute on Aging Information Center toll-free at 1-800-222-2225.

### Wise Choices

#### Get Help for a Drinking Problem

- Find a support group for older adults with alcohol problems.
- Talk to your doctor. Ask about medicines that

might help.

- Visit a trained counselor who understands how alcohol problems affect older adults.
- Choose individual, group or family therapy, depending on what works for you.
- Join a 12-step program like Alcoholics Anonymous, which provides support for people who want to quit drinking.

Source: NIH, *News In Health*, National Institute of Health, Department of Health and Human Services, [newsinhealth.nih.gov](http://newsinhealth.nih.gov), September 2009.

**Forgetful??...**Have you ever gone to the kitchen and couldn't remember why you went there? Forgotten a relative's name? Lost your keys?

Everyone forgets things, but you might need to see a doctor if memory loss is disrupting your daily life, if you're forgetting things more frequently or if you suffer from confusion (like getting lost in a familiar place).

You can also try some of these strategies to avoid memory loss:

- **Use your brain.** Doing things like puzzles, driving a new route, reading, gardening or taking up a new hobby can stimulate brain cells and give your brain a work-out.
- **Rein in cholesterol and high blood pressure.** Studies have shown that vascular diseases might worsen or help cause Alzheimer's disease.
- **Socialize.** Getting together with friends and family helps stave off depression, stress and loneliness which are associated with a higher risk of memory loss.
- **Everything in its place.** It will be easier to find things if you stay organized. Designate a special spot for essentials like keys and your wallet. Write down tasks and appointments, and keep these lists up-to-date. Try saying

these things out loud as you write to help keep them fresh in your mind.

- **Minimize distractions.** Don't try to multi-task or do too many things at once. Focus on what you're trying to remember, you're more likely to recall it later.

You can get more advice on avoiding memory loss from the Mayo Clinic and the U.S. Food and Drug Administration.

Source: *Dear Marci*, Medicare Rights Center, Vol. 8, Issue 37: September 14, 2009.



## Medicare....

### Original Medicare or a Medicare Private Health Plan?

Are you overwhelmed by your Medicare coverage options? Do you want to be sure you choose the "Right" plan? Every year from November 15 to March 31 you can change how you receive your Medicare benefits, through Original Medicare or through one of the private health plans (also known as "Medicare Advantage" plan). It is important to understand your options because after March 31, you will probably be locked into your new plan for the rest of the year.

Original Medicare is the traditional fee-for-service coverage offered directly through the federal government. Under Original Medicare, the government pays directly for the health care services you receive. You can see any doctor who takes Medicare (and most do) anywhere in the country, and you can go directly to the doctor or hospital when you think you need care. You do not need to get special permission (prior authorization) or a referral.

Medicare does not cover the full cost of your care. You pay monthly premium fees, and you pay coinsurance (a percentage of the charge) for each service you receive. However, in Original Medicare, there are limits on how much doctors and hospitals

can charge you.

To fill gaps in Original Medicare coverage, most people have additional insurance, called *supplemental insurance*. You can get supplemental insurance from an employer (often as a retiree plan) or you can buy it from an insurance company in the form of a Medigap Policy that specifically fills gaps in Medicare. If you have low income, you may qualify for "Medicare Saving Programs" (MSP) that can help pay for the out-of-pocket costs. If you have Original Medicare and want Medicare prescription drug coverage (Part D), you must get a stand alone Medicare private drug plan (PDP). Whether you should take Part D depends on whether you have drug coverage now (for example, from a current or former employer) and the quality of that coverage.

While most people keep Original Medicare, some people choose to get their Medicare benefits through a Medicare private health plan instead. These private health plans contract with Medicare and are paid a fixed amount to provide Medicare benefits. They are generally (HMO), Preferred Provider Organizations (PPO), and Private Fee-For-Service (PFFS) plans. You may also see Medicare Advantage plans called Special Needs Plans (SNP), Provider Sponsored Organizations (PSO) and Medicare Medical Savings Accounts (MSAs).

You still have Medicare if you join a Medicare private health plan. These plans must provide all Part A (inpatient) and Part B (outpatient) services, but can do so with different rules, costs and restrictions that can affect how and when you can get care. In most cases, you must still pay your Part B monthly premium (and your Part A premium, if you have one), but these plans often charge a premium in addition to the Medicare Part B premium, and generally charge a fixed amount called a "co-payment" whenever you receive a service. If you want Medicare Part D prescription drug coverage, in most cases you must get it as part of your health plan's benefits package. If they choose to do so, private plans can provide addi-

tional benefits that Original Medicare does not cover, such as general checkups, routine vision or dental care.

Private health plans generally have a network of providers that you must use in order to be covered, so it is important to make sure that the plan's network includes the doctors, hospitals and pharmacies you prefer to use at a cost you can afford. You should always check with a plan directly to find out how coverage works, and you should remember that private health plans can change their rules, provider networks and costs every year. So even if you are happy with the coverage you have now, review how your plan will be changing to make sure it will still cover your health needs at a cost you can afford next year. Remember that each private health plan's rules, costs and coverage restrictions can affect how, where and when you can get care.

If you have health coverage from your union or current or former employer when you become eligible for Medicare, you coverage may automatically convert into a Medicare private health plan. You have the choice to stay with this plan, choose Original Medicare, or switch to another Medicare private health plan. Be aware that if you switch to Original Medicare or another Medicare private health plan instead, the employer or union could terminate or reduce your health benefits, the health benefits of your dependents, and any other benefits you get from your company. Talk to your plan before switching to find out how your health benefits and other benefits will be affected.

Source: *Medicare Interactive*, October 2009.

### Rules for the H1N1 Vaccine & Seasonal Flu Coverage & Reimbursement

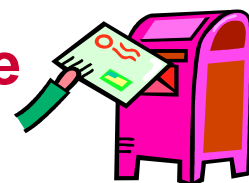
Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. Though Medicare typically pays for one vaccination per year, if more than one vac-

ination per year is medically necessary (i.e., the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. The Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza (H1N1) vaccination, then Medicare will pay for both.

Please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only for the vaccine's administration (not for the vaccine itself).

Source: CMS SHIP, Centers for Medicare & Medicaid, & Senior Health Information Program, [SHIP@cms.hhs.gov](mailto:SHIP@cms.hhs.gov).

## Marci's Medicare Answers....



Dear Marci,



**I have struggled my whole life with dental problems, and now I need dentures. Does Medicare cover dental care?**

—Joyce

Dear Joyce,

Unfortunately, Medicare will never pay for dentures. Medicare also does not cover dental care that you need primarily for the health of your teeth. For example, Medicare will not cover routine checkups, cleanings or pay for you to get fillings. However, Medicare will cover some dental services if they are required to protect your general health, or if you need dental care for another Medicare-covered health service to be successful. Medicare will also pay for some dental-related hospitalizations.

Some Medicare private health plans offer routine dental coverage as part of their benefits package. If you are in a private health plan (such as an HMO or PPO), call your plan to find out what dental services, if any, it covers. If you are considering joining a Medicare private health plan, make sure it covers the doctors and hospitals you prefer to use and the medications you take at a cost you can afford.

—Marci

Dear Marci,



**What does the term “Benefit Period” mean in Part A of Original Medicare?**

—LaVonne

Dear LaVonne,

A benefits period (sometimes called “spell of illness”) is the way Original Medicare measures your use of inpatient services in a hospital. A benefit period begins the day you enter a hospital and ends after you have been out of the hospital for at least 60 days in a row. You pay different amounts depending on where you are in the benefit period.

In a hospital benefit period, you pay a deductible and then Original Medicare will cover you in full for days 1 to 60 of your hospital stay. You pay daily coinsurance for days 61-90. Once you have used up your 90 days of hospital coverage in a benefit period, Medicare pays for up to 60 additional hospital days in your lifetime with a high daily coinsurance.

If you go into the hospital and are discharged and out for less than 60 days and then readmitted, you are still in the same benefit period. For example, if you go into the hospital on May 1st and go home on May 15th (14 days in the hospital), but you need to go back into the hospital on June 30th (after 46 days out of the hospital), you are still in the same benefit period. You do not have to pay another hospital deductible and, since you will be

on day 15 of your hospital benefit, you will not have to pay any coinsurance. If you had been out of the hospital for more than 60 days, a new benefit period would begin, and you would have to pay the hospital deductible for a new admission. There is no limit to the number of benefit periods you can have.

—Marci

Dear Marci,



**My doctor wrote me a prescription for an oxygen tank, but I’m worried I won’t be able to afford it. How can I keep my durable medical equipment costs low with Original Medicare?**

—Kurt (Cheektowaga, New York)

Dear Kurt,

There are different types of durable medical equipment (DME) suppliers under Original Medicare. The one you choose affects how much your costs will be.

You will save the most money if you go to a supplier who is enrolled and “participating” in Medicare. They must bill Medicare and accept the Medicare-approved amount as payment in full (which is called taking assignment). You must first meet your Part B deductible, and you or your supplemental insurance will be responsible for the 20 percent coinsurance.

You may have to pay the full cost yourself if you choose a supplier who is not enrolled in Medicare.

—Marci

Dear Marci,



**Can I rent the durable medical equipment my doctor prescribed, or am I required to purchase the item?**

—Michelle (Richmond, Virginia)

Dear Michelle,

Under Original Medicare, the type of durable medical equipment (DME) you need determines whether you buy or rent the equipment.

Generally, equipment that is made to order or that costs under \$150 must be purchased immediately. However, once you've met your Part B deductible, Medicare will pay 80 percent of its approved amount, and you or your supplemental insurance will pay the balance.

Other items, usually more expensive equipment, such as manual wheelchairs or equipment that needs frequent servicing, such as ventilators or nebulizers, must be rented for a set period of time before you own them. For equipment rented after Jan. 1 2006, you own the equipment after you have rented it for 13 months. The exception is oxygen equipment, which you rent for the entire period you use it.

Your supplier will know whether the DME you need must be rented.

Finally, there are some items, such as motorized wheelchairs, which you have the option to buy or rent.

—Marci

Dear Marci,



**My husband was recently admitted to the hospital with a broken hip. He can leave the hospital soon. But I am unwell myself and I'm worried I won't be able to take care of him properly. Will Medicare pay for him to stay in a nursing home until he is able enough to take care of himself?**

—Brooke, (Austin, Texas)

Dear Brooke,

Medicare will pay for a limited number of days in a "skilled nursing facility" (SNF) only if your loved one had been admitted to a hospital as an in-

patient for three days in a row within 30 days of admission to the SNF, requires daily skilled nursing or therapy services, and receives the care in a Medicare-certified SNF.

A SNF is a Medicare-approved facility that provides short-term post-hospital extended care services at a lower level of care than provided in a hospital. If you do not meet the Medicare SNF requirements, you may qualify for Medicare to pay for some home health care.

—Marci

Source: **Marci's Medicare Answers** is a service of the Medicare Rights Center ([www.medicarerights.org](http://www.medicarerights.org)), the nation's largest independent source of information and assistance for people with Medicare; Vol. 8, Issue 24 (June 2009), 37 & 38 (September 2009), & October 2009. To speak with a counselor, call (800) 333-4114. To subscribe to "Dear Marci," MRC's free educational e-newsletter, simply e-mail [dear-marci@medicarerights.org](mailto:dear-marci@medicarerights.org).

## Coverage of Outpatient Prescription Drugs....



### Getting Coverage of Outpatient Prescription Drugs At The Hospital Pharmacy

In September, Mr. Y went to the emergency room because he thought he was having a heart attack. It turned out to be a bad case of heartburn, and Mr. Y was able to go home the same day. However, while he was in the hospital, he needed to take a dose of Prednisone, which he takes regularly to manage his arthritis. Because in his hurry he had not brought his prescription with him, Mr. Y was told that he would need to buy his pill at the hospital pharmacy. Mr. Y bought one pill of Prednisone at the hospital pharmacy for \$30.75. That was more than he would normally pay through his Medicare Part D prescription drug plan for a full month's prescription at his regular pharmacy.

Mr. Y paid for his Prednisone pill, but did not understand why it was so expensive. He called the Medicare Rights Center's national hotline for help. The hotline counselor explained that because Mr. Y was admitted as an outpatient, Part B covered the medical care that he received in the emergency room. However, any drugs he took on his own (self-administered) to treat conditions *unrelated* to the hospital visit, like the Prednisone for his arthritis, would need to be covered under Part D. Because the hospital pharmacy was not in Mr. Y's Part D plan's pharmacy network, he was charged the hospital's full price for the medication rather than the low Part D co-payment he was used to paying at his own pharmacy.

However, the counselor told Mr. Y that he could still argue that his Part D plan should pay for the drug. In an emergency, Part D plans will cover you to get your prescription at an out-of-network pharmacy if you can show that you could not reasonably obtain the medication from a network pharmacy and you do not routinely use out-of-network pharmacies. Nonetheless, it should be noted, a Part D plan is only required to reimburse you for the amount the plan usually pays, so you may be responsible for the difference between what the plan pays and what the out-of-network pharmacy charges. This means that if you buy a drug from an out-of-network pharmacy, you will most likely receive a reimbursement from a Part D plan that is less than what you paid out of pocket for the drug.

Since Mr. Y was in the hospital when he needed his drug, he could not be reasonably expected to go to a network pharmacy, and Mr. Y does not normally fill his prescriptions at out-of-network pharmacies. The hotline counselor suggested that Mr. Y submit his receipt for reimbursement with a letter explaining the situation. The counselor warned that the plan could still charge Mr. Y more for using an out-of-network pharmacy (the difference between the hospital's price and the plan's allowance for the drug) but that he would likely receive at least some compensation. Mr. Y received a reim-

bursement, but it was significantly less than what he paid at the hospital for the drug.

Source: *Medicare Watch*, a biweekly electronic newsletter of the Medicare Rights Center, Vol. 12, No. 12: June 16, 2009.

## Personal Health Records



You may have health information in lots of places, at home, or in doctor or hospital records. Personal health records (PHRs) are confidential, easy-to-use electronic tools that can help you manage

your health information. PHRs may be an easier way for you to keep all your health information, like doctor or hospital visits, allergies, shots, or a list of your medicines, in one place.

Having a PHR can help you provide more complete information to your health care providers or family members. With all your health information in one place, you may be able to avoid unnecessary procedures or tests and to provide critical information about your health in a medical emergency. A PHR may help you save time and money, and improve the quality of care you get.

PHRs have other great features to help you manage your health information.

You can add personal information like the following:

- Allergies to food
- Health conditions
- Over-the-counter or herbal medications you are taking
- A list of your doctors
- Emergency contacts

In addition to keeping all your information in one place, some PHRs may also make it easier for you to do the following:

- Order prescription refills online
- Schedule appointments with doctors
- Get helpful information on things that matter to you, like diabetes or high blood pressure.

With a PHR, you control your information, since you will have a unique user ID and password, only you will be able to view your record. Most companies that provide PHRs offer a secure site to protect and keep your information safe.

Health plans and most health care providers who offer PHRs must give you a Notice of Privacy Practices, which tells you how they keep your personal information private and safe. If you don't get a privacy notice, ask the health plan or provider for a copy or check your PHRs web site.

With a PHR, you may be able to get to your information anywhere and anytime you have access to the Internet. Some PHRs simply provide a way for you to enter your own information. Other PHRs provide more services, such as making it possible for your pharmacy or doctor's office to add information electronically. Some PHRs may charge a fee for their services. Talk to your doctor or someone from health plan to learn more about your PHR options.

Here are some questions to ask when choosing a PHR:

- Is there a monthly or annual fee to use the PHR?
- What kind of information can I store in the PHR?
- What are the PHR's privacy and security policies?
- Can I give access to my doctors or family members?
- Can I refill prescriptions or make appointments through the PHR?
- Can the PHR generate reports of my health information?
- Does the PHR offer educational health informa-

tion?

### **To Learn More:**

- Visit [www.medicare.gov/phr](http://www.medicare.gov/phr)
- Talk to your doctor or health plan and see if they can help you find or use a PHR.

Source: CMS, *Center for Medicare & Medicaid Services*, CMS Publication NO. 11397, January 2009.



## **How to Select a Home Care Provider....**

It is a fact of life that, as we age, we tend to lose the ability to take care of ourselves like we used to, and find we need some help. It may be as simple as having someone help with bathing, dressing and feeding, or it may be more involved such as skilled care after a hospital stay. In many cases, this care can be provided in our homes by friends and family. But often, we may not have loved ones who are available or capable of providing the assistance we need. In these cases, home care agencies can help.

In an AARP survey, 89 percent of Americans age 50 and older said if they needed to receive assistance with daily activities, they'd prefer to receive it in their own homes.

The first step to selecting a home care agency for yourself or a loved one is to determine the agencies and types of assistance available in your community. Thousands of Ohioans currently receive care through hundreds of home care providers across the state. The Ohio Council for Home Care and Hospice (OCHCH) provides a searchable database of home care agencies of all types on its Web site. Assistance also is accessible over the phone at (614) 885-0434. Information available includes agency types, services provided, payment sources accepted and counties served. Your local health department or area agency on aging also may be able to point you to agencies in your area.

Once you know what agencies are in your area and

what services are provided, you or your loved one may need, you will want to know if an agency is Medicare-certified. If a home care agency is certified, then you know it has met minimum federal requirements for patient care and financial management, and therefore can provide Medicare and some Medicaid home health services. The Ohio Department of Health provides information on these agencies. Keep in mind, however, that if an agency is not Medicare-certified, that does not mean it provides poor care, just that they have chosen not to participate in Medicare. In many cases, these agencies adhere to their own standards, which can be higher or lower than those for Medicare certification.

Another way to determine an agency's standards for care is to look at accreditation. Ohio currently does not require home care agencies to be licensed, but nonprofit professional organizations conduct voluntary accreditation processes that signify that the agency has met national industry standards that are approved by the Center for Medicare and Medicaid Services (CMS). Ask the agency for information about their accreditation and the standards they meet.

Next, pay attention to what the agency has to say about itself. Most agencies provide literature explaining their services, eligibility requirements, fees and funding sources. An annual report can provide helpful information about the agency in one document. Many providers also supply patients with a detailed "Patient's Bills of Rights" that outlines the rights and responsibilities of the providers, patients and caregivers alike.

Other information you should know about agencies you are considering is harder to come by, but no less important. For example, you will want to know how long the agency has been serving the community and its overall reputation in the community. You will also want to know how an agency selects and trains its employees and whether it protects its workers with written personnel policies, benefits packages and malpractice insurance.

Does it conduct a criminal records check on new employees? Some of this information may be available from the agency or at your local library, but some is only available via word-of-mouth.

Once you have an idea of the agencies you like, OCHCH suggest you talk to the agency and get the answers to these questions:

- Are the agency's nurses or therapist required to evaluate the patient's home care needs? If so, what does this entail? Are the patient's physicians and family members consulted?
- Is the patient's course of treatment documented, detailing the specific tasks to be carried out by each professional caregiver? Is a copy of this plan given to the patient and her family member, and updated as changes occur?
- Does the agency assign supervisors to oversee the quality of care patients are receiving in their home? If so, how often do these individuals make visits? Whom can you call with questions or complaints? How are problems followed up and resolved?
- Does the agency take time to educate family members on the type of care that is being provided?
- What are the agency's financial procedures? Does it provide written statements that explain all the costs and payment plan options associated with home care?
- What procedures are in place to handle emergencies? Are the agency's caregiver available 24 hours a day, seven days a week?
- How does the provider ensure patient confidentiality?

Source: *Boomerang*, ODA, September 2009.



## Don't Be a Victim....

**Seniors Can Stop the Thieves...** Each year, nearly 25 million Americans are victims of consumer fraud. Senior citizens are more at risk of telemarketing scams than any other age group. Fraudulent telemarketers direct 56 to 80 percent of their calls at older adults.

Evidence indicates that offenders believe older people have more assets and are more susceptible to excitement tactics or appeals to altruism. They have told police their ideal "mark" is an elderly person, who lives alone, with no contact with family members. They know that senior citizens will not give money or personal information to just any stranger. These experienced criminals have made a science of gaining the trust of older adults.

Scam artists are experts at establishing rapport and stealing seniors' money. Some scams include:

- Claims that you've won a prize, but must pay to receive it;
- Great deals that need immediate payment and there's no time for written information;
- Requests for donations for mysterious charities;
- Offers to "repair" your credit in exchange for an up-front fee or to help you recoup money you've lost in another fraudulent scheme; and
- Call from the supposed police, FBI or bank officials asking for "help" and your personal information.

According to an AARP survey, 90 percent of survey respondents report awareness of consumer fraud; yet two-thirds said it is hard to spot fraud when it is happening.

The survey also showed that senior citizens find it difficult to end telephone calls, even when they say they are not interested in continuing the conversation. Scam artists count on the politeness of senior citizens. Remember, you are not being rude if you:

- Ask to receive the great deal or prize offer in writing so you can read it carefully before making a commitment.

- Refuse to give out personal information over the phone or Internet (unless you initiated the contact); or
- Refuse to pay for an offer in advance.

Legitimate telemarketers appreciate dealing with an educated consumer. If the caller gets frustrated or rude at your unwillingness to provide information, take it as a warning sign.

Criminals also believe that senior citizens will not report the crime to law enforcement officials because they will be ashamed of being victimized and will worry that concerned family members will take control of their finances.

Recognizing scammers is important to protect yourself. Reporting them to the appropriate law enforcement authorities is critical to protecting others. When you report a scammer, you can help the police prosecute them and stop the scammer from stealing from someone else. Report scams to your local police department and the state Attorney General at 1-800-282-0515, so they can prosecute fraudulent telemarketers who try to steal your money.

Source: *Aging Issue*, Ohio Department of Aging, Barbara E. Riley, Director, September 2009.

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