

Parenting our Parents...

Russell Gainer, LCSW

GainWel, Creative Home Counseling

4950 San Pedro, San Antonio, TX 78212

210-744-4372

Who is Aging?

- # Since 1900, Americans have gained 28 years of life expectancy. The most rapidly growing age group in the United States consists of those 85 and over. - Robert Butler
- # Today there are over 70,000 centenarians; by 2006 there will be 100,000 and by 2025 there will be two million.

Changes in Health Status

- # In the next five years we will see a 14% increase in amount of medical care needed.
- # Today, there are 100 million people with degenerative diseases: cancer, cardiovascular disease and arthritis. This number will double early in this century.

The Need for Elder Care

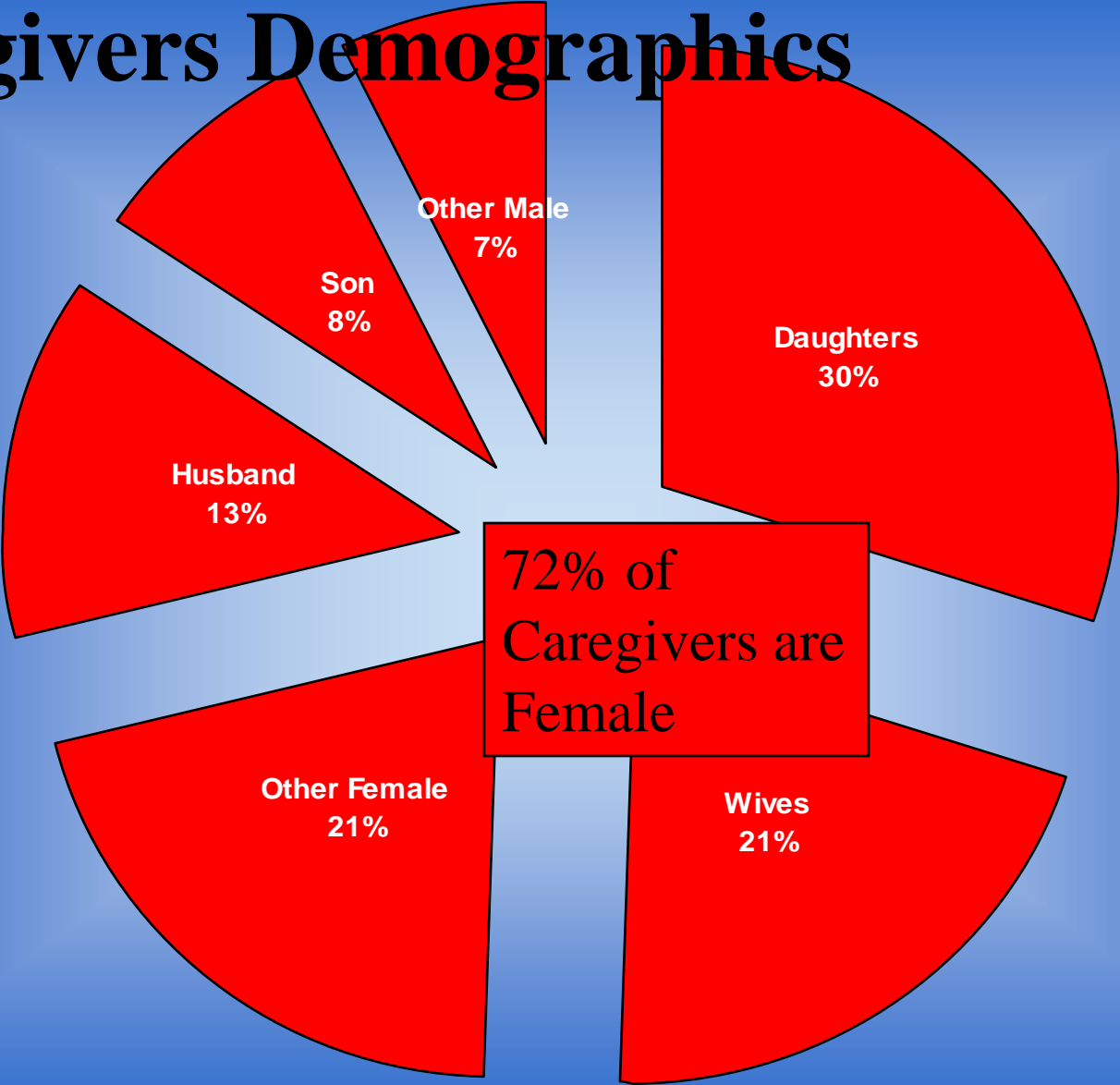
- # People are living longer with more chronic needs
- # Chronic care needs are NOT covered by Medicare
- # Approximately 1 person in every 5 U.S. households (22 million total) is responsible for the care of an elderly person {Source: American Demographic Magazine}

Who are the Caregivers?

Quick Facts...

- # Informal caregivers are individuals who provide unpaid assistance to elderly loved ones.
- # Informal caregivers tend to be female, about 57 years of age, and live in the same household as the care recipient
- # Between 30 to 55 percent of informal caregivers of loved ones are employed.

Caregivers Demographics



72% of
Caregivers are
Female

Effects of Care giving on Careers

- 40% of employed caregivers had to take time off without pay
- Average of 17 days of work missed per year due to caring for a disabled elder
- Going in Late, Leaving Early, Leaves of Absence
- Taking Less Demanding Jobs, Turning Down Promotions
- Giving Up Jobs Entirely

Families Face Major Care Issues

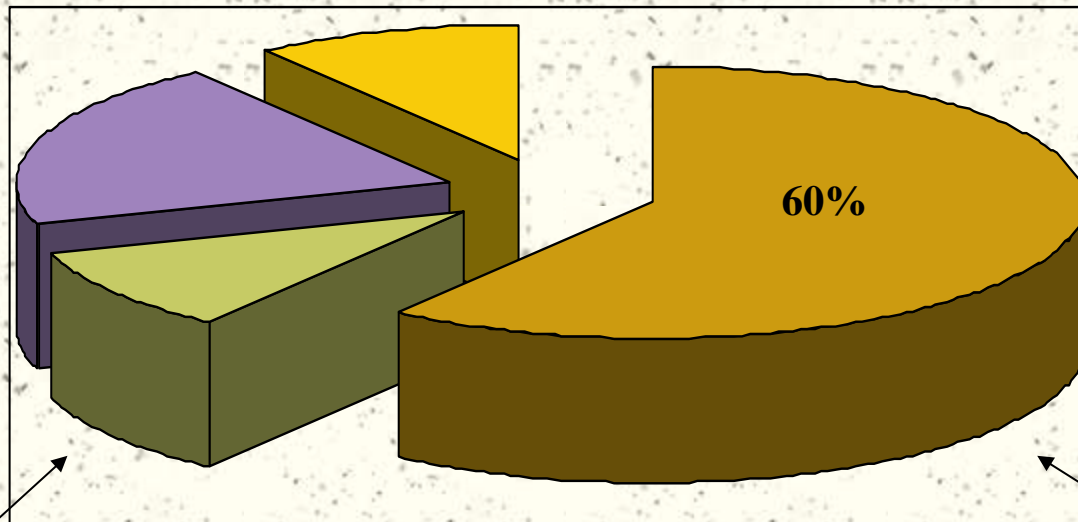
- # Live at a distance
- # Overwhelmed by multiple, conflicting demands
- # Lack skill and knowledge to provide or oversee care
- # Unfamiliar with the health care system

Types of Crisis Situations

- # Unsafe behaviors or living conditions, hygiene
- # Erratic spending patterns
- # Changes in cognitive functioning (memory)
- # Exploitation or Neglect
- # Physical debilitation: Frailty, Stroke, Broken Hip
- # New Diagnosis: Cancer, Heart problems, Diabetes
- # Hospitalization

What happens after discharge?

% Of Total Age 65+ Hospital Discharges in 2000



- To Home, Self-funded Care**
- To Home, Medicare-funded Care**
- To SNF, Hosp, other facility**
- Death, other**

Who Will Need Long Term Care?

- # 60% of people who reach age 65 may need LTC at some point in their lives.
- # 40% of those receiving LTC services are adults between ages 18 and 64.
- # About 10% will stay there five years or longer.

Rose - Multiple Medical Problems



Situation

- Chronic crippling arthritis
- Severe eating and digestive dysfunctions
- Circulatory problems
- Chronic and severe depression
- Admitted to hospital after falling out of bed and fracturing hip
- Suffering from anxiety, confusion, and disorientation
- Family members live on the West Coast and are exceedingly concerned but are not able to be present
- Patient and family are against nursing home placement

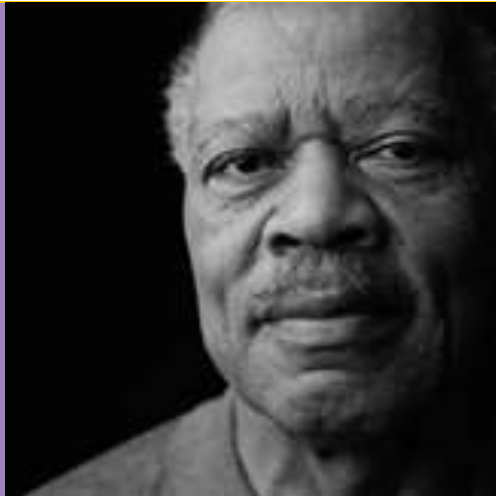
Intervention

- GCM made a visit to patient's home prior to discharge to assess safety and determine additional requirements (hospital bed, commode)
- 24-hour home health aide and nursing care were assigned to the case
- GCM oversaw all aspects of care and ensured that family and patient were kept in the loop and consulted for care changes
- GCM became the family surrogate – arranged for, accompanied to doctors' visits, therapies, mediate issues/concerns among family members

Outcome

- Patient remained at home under our care for 8 months until physical and mental state of patient deteriorated and efficacy of home stay was exceeded
- GCM helped patient and family ultimately research and select nursing home:
 - GCM assisted with completing applications
 - GCM packed up apartment
 - GCM assisted patient in making transition
 - GCM arranged for sale of contents & house

John G. - Early Stage Dementia



Situation

- Lives alone in a small home
- Admitted to hospital for a chronic episode
- Suffers from memory loss
- Has had no contact with his only son for 5 years
- Anxious about going home after discharge
- Does NOT fit into Medicare Certified Homecare services requirements

Intervention

- GCM conducted thorough patient consultation and review of physicians, medications, and anxieties about returning home
- GCM made a visit to patients home prior to discharge to assess safety and determine additional needs
- Made contact with son (who was unwilling to participate)
- Set up an oversight visit every 4-6 weeks
- Developed informal network for checks and care within the patients immediate community (senior center, grocery store to deliver food, mailperson, building super, local news kiosk, drugstore, cleaners)
- GCM accompanied Mr. G to dentist and doctor visits

Outcome

- Coordination, visits, informal system of checks and care, and the addition of a home care worker enabled Mr. G. to continue living at home for 2 years.

Case Example

- # Ms. T is 73 yrs old and lives alone since the death of her husband. She has been independent until a neighbor found her wandering the neighborhood. It was discovered she had not been taking any medications, had not bathed in weeks, and appears to have a poor diet. Her son lives in Michigan with his family.

Decision Making

- ✓ Who will manage the day to day decisions for Mom/Dad?
- ✓ Where does the "authority" to intervene come from?

Legal Considerations

- # Parent's decision making capacity
 - Civil commitment to psychiatric facility needed? Danger to self or others?
 - Agent under MPOA cannot authorize admission to inpatient psychiatric facility
- # Emergency and/or Permanent action needed?
- # Guardianship needed?
 - Guardian cannot authorize admission to inpatient psychiatric facility

Basic Documents

- ❑ Financial Power of Attorney
- ❑ Advance Directives
 - ❑ Medical Power of Attorney
 - ❑ Directive to Physicians (Living Will)
- ❑ Living Trust
- ❑ Declaration of Guardian in the Event of Later Need

Legal Considerations: (Statutory Durable Power of Attorney

(for Financial Matters)

Permits competent persons to appoint an agent to act for them with regard to financial matters if they become unable to make such decisions for themselves because of disability or incapacity. [Provided by Texas law]

Legal Considerations: Advance Directives

(for Medical Matters)

- # Directive to Physicians and Family or Surrogates
- # Medical Power of Attorney
- # Out-of-Hospital Do-Not-Resuscitate (DNR) Order
- # Mental Health Treatment Declaration

Vocabulary

- # **ADL's** - Activities of Daily Living, referring to bathing, dressing, toileting, eating, getting in/out of bed & chairs
- # **Skilled Care** - focused on rehabilitation, or "fixing" something that is wrong. Is paid for through most insurance (Medicare, Secure Horizons, BCBS, TriCare...)
- # **Custodial Care** - focused on maintenance. Primarily to help meet the patients' ADL's. Is paid Privately, or through Long Term Care Insurance, or by Medicaid.

Placement Options

Levels of Care based on ADL's

Locations:

■ Independent

- Retirement Community (\$2000/mo and up +)
- Own Home with caregivers (\$2,800/mo and up +)

■ Need assistance

- Assisted Living (\$3,700-\$5,000/mo)
- Personal Care Home (\$3,500-\$6,000/mo)
- Nursing Facility (\$4,500-\$7,000/mo)

Planning

- # Get an outsiders point-of-view
- # Encourage completion of Durable POA's and Advance Directives
- # Financial Planner
- # Seek the advice of an Elder Law Attorney
- # Consider using a Geriatric Care Manager (GCM)

Where to go for help?

- ✓ **Financial Planner:** Reviews assets and assists in developing a planned approach to health care and retirement coverage
- ✓ **Elder Law Attorney:** Specializes in the review of legal arrangements, Trusts, and develops documents and directives
- ✓ **Geriatric Care Manager:** Specializes in assisting older people and their families to attain the highest quality of life given their circumstances

Geriatric Care Manager

- # Professional, unbiased assessment
- # Evaluates the situation: medical needs, cognitive capacity, physical abilities, living arrangements and environment
- # Develops a *planned* approach to meet needs
- # Coordinates with other professionals & institutions
- # Community resource broker