June 2013 | Vol. 11, No. 6

CASE IN POINT

Leading the Care Coordination Team with Knowledge, News and Learning

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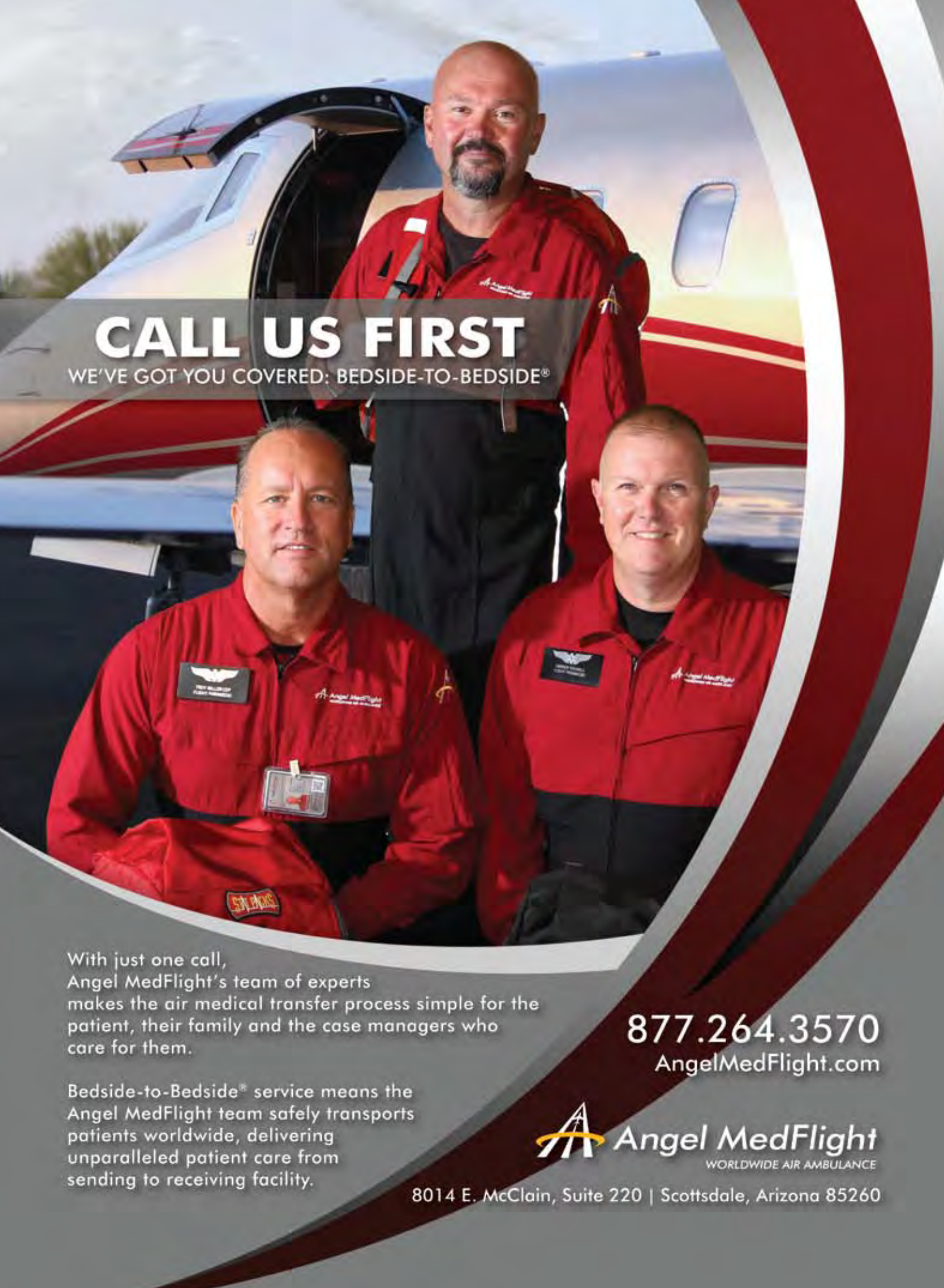

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a division of Access Intelligence

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Vol. 11, No. 6, June 2013
Case In Point (ISSN #1542-6971) is published monthly by Access Intelligence, LLC. Subscription rates: $199 per year.
For subscription inquiries or change of address, contact: Client Services, clientservices@accessintel.com. Tel: 888-707-5814, Fax: 301.309.3847.

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The Coming Crush: Baby Boomers and Chronic Disease

Welcome to the June 2013 issue of ***Case In Point***. In this issue we focus on the baby boomer generation. In 2011, the first of the baby boomers reached what used to be known as retirement age. And for the next 18 years, boomers will be turning 65 at a rate of about 8,000 a day. As this unique cohort grows older, it will likely transform the institutions of aging – just as it has done to other aspects of American life.

A study in the ***Journal of the American Medical Association*** noted that members of the baby boomer generation are in worse health than their parents were at the same stage of life, with obesity and lack of exercise taking a toll. Medicine has improved significantly during baby boomers' lifetime, progressively increasing life expectancy. Yet with significant health issues the cost of this aging population is stressing state and federal economies like no other generation.

The articles in this issue highlight the important role case managers play in helping boomers change behaviors and engage them so they are active participants in their care.

Inside, a group of leading case managers, physicians and other clinicians provide critical insight on long-term care, patient engagement, end-of-life issues, the changing face of technology and much more.

Another vital point of consideration – given that most case managers are part of the baby boomer generation – is how we are going to replace ourselves. Mentoring younger professionals into case management is something that each professional will need to be mindful of and take seriously if our practice is going to continue to flourish.

I hope that you are enjoying everything that your subscription to ***Case In Point*** offers. As busy professionals we realize your time is valuable, so in addition to gaining knowledge from the information in this issue, I hope you take advantage of the continuing education that accompanies each issue. As a subscriber, you have the ability to gain four pre-approved contact hours toward renewal of your professional license or national certification by completing the posttest and program evaluations through the online learning portal.

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I look forward to hearing from you, the work you are doing and the tools and resources you need to improve your practice. Understanding this information assists the editorial team in ensuring this publication and our other tools and resources meet your educational needs.

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LONG-TERM CARE

Depression Ups Stroke Risk in Middle-Aged Women

The conclusion of a twelve-year study found a strong link between mental health and stroke outcomes among middle-aged women, according to new research published in ***Stroke: Journal of the American Heart Association***. The Australian study, which tracked approximately 10,500 women who began the study between the ages of 47 and 52, found that women suffering from depression experienced a 2.4 times increased risk of stroke compared to nondepressed women. A previous study of slightly older women found a 30 percent higher risk of stroke among those who experienced depression, yet this is believed to be the first study to track the effects of mental health on younger middle-aged women. To establish as direct a link between depression and stroke as possible, researchers factored out multiple stroke risk factors, including age, socioeconomic status, lifestyle habits, and physical conditions like high blood pressure, heart disease and diabetes. Even when eliminating key risk factors, researchers found that depressed women were 1.9 times more likely to experience a stroke. The study took place at the University of Queensland in Australia. CIP

WORKERS' COMPENSATION

Healthy Lifestyle Impedes the Harms of On-the-Job Stress

While job stress can lead to physical ailments like heart disease, a new study shows that a healthy lifestyle can significantly reduce the risk of poor health outcomes in the face of workplace worry. English researchers from University College of London scoured the health data of more than 102,000 men and women across five European countries, rating each individual's lifestyle in one of three categories – healthy, moderately unhealthy or unhealthy – based on the variables of exercise, alcohol consumption, smoking and obesity. Overall, approximately 16 percent of participants reported job stress. When factoring in lifestyle habits, researchers discovered that stressed individuals leading a healthy lifestyle saw a drastic reduction in the incidence of coronary artery disease (CAD). The stressed-but-healthy group members were victims of CAD at a rate that was half than the stressed-and-unhealthy group of workers – 15 per 1,000 healthy workers were affected by CAD vs. 31.2 per 1,000 for the unhealthy group. The study appeared in the ***Canadian Medical Association Journal***. CIP

CLINICAL

Rising Obesity Rates Linked to Glut of Sleep Apnea Cases

A small study from the University of Wisconsin-Madison suggests that the sharp increase in obesity prevalence is having a tremendous impact on the quality of sleep of millions of Americans who suffer from disrupted nighttime breathing, a condition known clinically as sleep apnea. In addition to gender and physiological variables like a narrow upper airway, obesity is considered one of the leading causes of sleep apnea, which can contribute to heart problems and other health challenges. Overall, the study tracked more than 1,500 people, some in the seven-year period from 1988 and 1994 and others from 2007 to 2010. Researchers found a definitive increase in the cases of sleep apnea, which rose somewhere between 14 and 55 percent from the first portion of the study to the second. Dr. Paul Peppard, the study's author, estimates that obesity has caused approximately 80-90 percent of the total increase in symptoms that are associated with sleep apnea. When extrapolating the data across the U.S. population, the researchers estimate that obesity is the cause of some 4 to 5 million new cases of sleep apnea. The study appeared in the ***American Journal of Epidemiology***. CIP

HEALTHCARE DELIVERY

For Same Services, Hospitals' Billing Fluctuates Wildly Depending on Location

An unprecedented release of hospital-billing data reveals that a patient's location can have a tremendous effect on the price of the healthcare services they receive, according to information that the federal government published online last week. As part of an effort to improve the transparency of the healthcare marketplace, the Centers for Medicare and Medicaid Services released a wide-ranging data set comparing the prices for treatments of 100 common ailments as they are priced in more than 3,400 hospitals across the country. As the data shows, wide variation exists between what different hospitals might charge for the same services. For example, a joint replacement costs $5,300 at a hospital in Ada, Okla., and $223,000 at a facility in Monterey Park, Calif. Overall, the review of hospital-billing data portrays massive differences in regions across the country, and it shows that hospitals within the same geographic region have divergent prices as well. In Denver, Colo., services for heart failure range from a low of $21,000 to a high of $46,000. Rates for the same services fluctuate from $9,000 to $51,000 in Jackson, Miss. CIP

ACUTE CARE

Admissions Through the ED Rise Over the Past Decade

The entry point of hospital admissions is shifting dramatically, according to a new study from Rand Corp. that tracks total admissions between 2003 and 2009. Over that time, hospital admissions from the emergency department (ED) increased by 17 percent. During the same time, admissions from outpatient settings, including doctors' offices, decreased by 10 percent, says the report, ***The Evolving Role of Emergency Departments in the United States***. Uninsured and indigent populations are most likely to use the ED as an entry point to the healthcare system, according to the report, which shows that physicians who work in the ED provide about two-thirds of all acute care to the uninsured. Meanwhile, more than half – 55 percent – of services provided in the ED are uncompensated. Overall, total inpatient admissions grew at a slower rate than the net increase in population. The rising use of the ED may reveal a growing pattern in physician practices across the nation – namely, that "office-based physicians increasingly rely on EDs to evaluate complex patients with potentially serious problems, rather than managing these patients themselves." CIP

Numerical Analysis of Baby Boomers' Health

In this edition of By the Numbers we explore the numbers behind the ranks of the rapidly increasing over-65 population, including the key trends in health and wellness.

72 MILLION

The number of Americans who will be over the age of 65 by 2030, marking a more than 100 percent increase in this population in 20 years. The 72 million seniors will account for approximately 20 percent of the U.S. population.

19 MILLION

The U.S. Census Bureau projects that the population age 85 and over could grow from 5.5 million in 2010 to 19 million by 2050.

$15,709

After adjustment for inflation, healthcare costs increased significantly among older Americans from $9,850 in 1992 to $15,709 in 2008.

43% Use of hospice in the last month of life increased from 19 percent of decedents in 1999, to 43 percent in 2009. Use of ICU/CCU services grew from 22 percent of decedents in 1999 to 27 percent in 2009.

24% Among older Americans, 49 percent of deaths occurred in hospitals in 1989, declining to 32 percent in 2009. The percent dying at home increased from 15 in 1989, to 24 percent in 2009.

58% Projections indicate that by 2050 the composition of the older population will be 58 percent non-Hispanic White, 20 percent Hispanic, 12 percent Black, and 9 percent Asian.

19.2 Life expectancies at both age 65 and age 85 have increased. Under current mortality conditions, people who survive to age 65 can expect to live an average of 19.2 more years, nearly five years longer than people age 65 in 1960. In 2009, the life expectancy of people who survive to age 85 was seven years for women and 5.9 years for men.

1,156

In 2009, the leading cause of death among people age 65 and over was heart disease (1,156 deaths per 100,000 people), followed by cancer (982 per 100,000), chronic lower respiratory diseases (291 per 100,000), stroke (264 per 100,000), Alzheimer's disease (184 per 100,000), diabetes (121 per 100,000), and influenza and pneumonia (104 per 100,000).

57% The most common chronic condition among seniors is hypertension, affecting 57 percent of women and 54 percent of men. Arthritis affects 56 percent of women and 45 percent of men, while heart disease afflicts 37 percent of men and 26 percent of women.

21% Overall, the prevalence of diabetes reported by persons age 65 and over increased from 13 percent in 1997-1998 to nearly 21 percent in 2009-2010.

16% Older women were more likely to report clinically relevant depressive symptoms than were older men. In 2008, 16 percent of women age 65 and over reported depressive symptoms compared with 11 percent of men.

41% In 2009, about 41 percent of people age 65 and over enrolled in Medicare reported a functional limitation. Twelve percent had difficulty performing one or more instrumental activities of daily living (IADLs) but had no activities of daily living (ADL) limitations. Approximately 25 percent had difficulty with at least one ADL and 4 percent were in a facility.

Source: Older Americans 2012: Key Indicators of Well-Being, Federal Interagency Forum on Aging-Related Statistics

New Drug Approvals: A Case Manager's Guide

COMPILED BY RICHARD SCOTT

The latest FDA drug approvals have direct application to case managers and the patients they monitor. For the treatment of COPD, prostate cancer and more, these drugs are new tools for your mission of coordinating patient care effectively and cost-efficiently.

XOFIGO

Company: Bayer HealthCare Pharmaceuticals Inc.
Date of Approval: May 15, 2013
Indication: Prostate Cancer

The FDA approved Xofigo (radium Ra 223 dichloride) to treat men with symptomatic late-stage castration-resistant prostate cancer that has spread to bones but not to other organs. It is intended for men whose cancer has spread after receiving medical or surgical therapy to lower testosterone.

Prostate cancer forms in a gland in the male reproductive system found below the bladder and in front of the rectum. According to the National Cancer Institute, an estimated 238,590 men will be diagnosed with prostate cancer and 29,720 will die from the disease in 2013.

The most common side effects reported during clinical trials in men receiving Xofigo were nausea, diarrhea, vomiting and swelling of the leg, ankle or foot. The most common abnormalities detected during blood testing included low levels of red blood cells (anemia), lymphocytes (lymphocytopenia), white blood cells (leukopenia), platelets (thrombocytopenia) and infection-fighting white blood cells (neutropenia).

BREO ELLIPTA

Company: GlaxoSmithKline plc and Theravance Inc.
Date of Approval: May 10, 2013
Indication: COPD

The FDA approved Breo Ellipta (fluticasone furoate and vilanterol inhalation powder) for the long-term, once-daily, maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema. It is also approved to reduce exacerbations of COPD in patients with a history of exacerbations.

Breo Ellipta works by decreasing inflammation in the lungs and helping the muscles around the airways of the lungs stay relaxed to increase airflow and reduce exacerbations in patients with COPD.

Breo Ellipta may cause serious side effects, including increased risks of pneumonia and bone fractures. The most common side effects include inflammation of the nasal passage (nasopharyngitis), upper respiratory tract infection, headache, and oral candidiasis (thrush).

NYMALIZE

Company: Arbor Pharmaceuticals
Date of Approval: May 10, 2013
Indication: Subarachnoid Hemorrhage

The FDA approved its New Drug Application (NDA) for Nymalize (nimodipine) oral solution. Nymalize was previously granted Orphan designation which provides seven years of market exclusivity. Nymalize is the first and only nimodipine oral solution indicated for the improvement of neurological outcome in adult patients with subarachnoid hemorrhage (SAH).

Nymalize (nimodipine) oral solution is indicated for the improvement of neurological outcome by reducing the incidence and severity of ischemic deficits in adult patients with SAH from ruptured intracranial berry aneurysms regardless of their post-ictus neurological condition (i.e., Hunt and Hess Grades I-V).

Most common adverse reactions (incidence ≥ 1% and ≥1% placebo) were hypotension, headache, nausea and bradycardia.

LIPTRUZET

Company: Merck
Date of Approval: May 3, 2013
Indication: Heterozygous Familial Hypercholesterolemia

The FDA approved Liptruzet (ezetimibe and atorvastatin) tablets for the treatment of elevated low-density lipoprotein (LDL) cholesterol in patients with primary or mixed hyperlipidemia as adjunctive therapy to diet when diet alone is not enough.

Liptruzet contains ezetimibe, an efficacious LDL cholesterol lowering therapy, and atorvastatin, currently one of the most widely prescribed statins in the U.S. Once-daily Liptruzet treats two sources of cholesterol by inhibiting both the absorption of cholesterol in the digestive tract – through ezetimibe – and the production of cholesterol in the liver – through atorvastatin.

PROCYSBI

Company: Raptor Pharmaceutical Corp.
Date of Approval: April 30, 2013
Indication: Nephropathic Cystinosis

The FDA approved Procysbi (cysteamine bitartrate) for the management of nephropathic cystinosis in children and adults. Procysbi was granted orphan product designation because it is intended to treat a rare disease or condition.

Cystinosis is a rare genetic condition that affects an estimated 500 patients in the United States and about 3,000 patients worldwide. Fatal if not treated in early childhood, cystinosis causes a protein building block called cystine to build up in every cell of the body. The build-up of cystine causes kidney problems, which can cause the body to lose too much sugar, proteins and salts through the urine. Cystinosis may lead to slow body growth and small stature, weak bones and developing and worsening kidney failure. There are three types of cystinosis, the most severe being nephropathic cystinosis, which severely damages the kidneys.

The most common side effects in patients treated with cysteamine products include nausea, bad breath, abdominal pain, constipation, indigestion or upset stomach, headache, drowsiness and dizziness. Other uncommon but serious side effects include ulcers or bleeding of the stomach or intestine, altered mental state, seizures, severe skin rashes and allergic reactions.

Further drug information, including safety information, warnings, contraindications and other facts about general use, is available online at www.fda.gov/drugs. CIP

Health Navigators: Preparing to Educate Consumers on the New State-Based Marketplaces

BY STEVEN DASHIELL

With the sheer amount of information accompanying the release of the first-ever state-based insurance exchanges, the Centers for Medicare & Medicaid Services (CMS) has recently made available additional funding for the support of its Navigator program.

The aim of the program is to help individuals navigate the new information and options available to those who qualify for healthcare under the expanded Medicaid system. Though straightforward in its aim, the navigator program itself requires some explanation of its goals and methodology.

DEFINING THE MARKETPLACE

Individuals who wish to purchase one of the new health insurance plans under the ACA will have to do so through the "marketplace." Previously referred to as "exchanges," the marketplace is an online site where people can view the details, options and costs of various healthcare plans.

However, current studies show that many eligible individuals still know very little about the insurance marketplaces that will be in place before year's end. Many of these individuals who lack knowledge about the marketplace nonetheless feel that Obamacare can greatly help them and their families. A big challenge, however, is the knowledge gap and lack of consumer education, as many purchasing coverage would be buying health insurance for the first time.[1]

ENTER THE NAVIGATOR

The Navigator program is one of the ACA's directives aimed at decreasing this knowledge gap between the marketplace and consumer. The goal of the Navigator program is to provide educated guides (the Navigators) who will provide impartial and accurate information to consumers. Unlike agents or brokers, Navigators do not offer advice or push to sell plans – they exist to disseminate information and help consumers use the new marketplaces.

Navigators will help consumers prepare their electronic and paper applications as they enroll in coverage through the marketplace, while also raising awareness of the marketplace by providing outreach and education to those who may be curious or need more information. Navigators may also refer consumers to health insurance ombudsmen and consumer assistance programs.

The program calls for the creation of three types of health insurance assistants, including the Navigator position described above. The additional two assistants are similar to the Navigator, with a few subtle differences:

- **In-person assistance personnel.** Also known as non-Navigator assistance personnel, these individuals perform the same general functions as Navigators. However, in a state-based marketplace, in-person assistance personnel may also serve as part of an optional transitional program that can be set up by a state before its marketplace is self-sustaining. Unlike Navigators, who are funded through state and federal grant programs, in-person assistance personnel can only be funded through separate grants or contracts administered by the state.
- **Certified application counselors.** Certified application counselors can perform many of the same functions as Navigators and in-person assistance personnel. They do not receive federal grant money through the marketplace, but can get federal funding through other grant programs or Medicaid.

BECOMING A NAVIGATOR

The ACA requires that all Navigators (or other personnel) meet several requirements to be eligible for the role. All Navigators must meet educational standards through a comprehensive training program. By the end of the training, Navigators must demonstrate the ability to assist consumers in the marketplace, and must demonstrate the ability to help an individual who requests general assistance.

Up to 30 hours of training are required, along with a passing score on an exam at the end of the course.

The second requirement for becoming a Navigator is a strict adherence to nonbias and impartiality. Applicants for the Navigator program must submit to the marketplace a written proclamation that the Navigator and its staff do not have conflicts of interest that would affect their ability to help consumers in an impartial fashion. Applicants must also submit a plan to remain free of potential conflicts of interests during their term.

Health insurance agents and brokers, who may often receive benefits for selling particular types of insurance, are not prohibited from working as Navigators in the marketplace. In order to perform the role, however, they must meet three disclosure requirements:

- Navigators must disclose to each consumer any line of insurance business that the Navigator intends to sell while serving in the role. This insurance cannot be health insurance.
- Navigators must disclose any existing and former relationship between the Navigator, its staff and any issuer of health insurance or stop loss insurance in the last five years to each consumer and/or their partner or spouse.
- Navigators must disclose to each consumer any existing or anticipated financial, business or contractual relationships with one or more issuers of health insurance or stop loss insurance.

More information on the marketplace and Navigator program is expected to be released as states set up their marketplaces and make them operational prior to January 1, 2014. Individuals or companies interested in serving as Navigators should look into the decisions and progress their state has made on operating the marketplace. CIP

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1. Ranney, Dave, Shields, Mike. "Knowledge gap: The ACA marketplace is coming but who knows?" Kansas Health Institute. May 13, 2012.

Aetna's Behavioral Health Unit Targets Complex Cases in the Workplace

BY STEVEN DASHIELL

Employee short-term disability negatively impacts employer and employee alike, incurring costs, stunting productivity and leaving employees in the difficult position of playing "catch up" within the work environment. Many who are on short-term disability are there not because of physical injury at the workplace, but due to behavioral health conditions such as anxiety or depression.

Chronic in nature, these conditions have proven difficult to treat, resulting in employees spending a range of days on disability leave. Aetna's Disability and Absence Management Services team has recently suggested that employees on disability leave may become healthier and return to work faster if managed by a disability Behavioral Health Unit (BHU).

According to Aetna's proprietary data, those who have their claims managed by the BHU average 11 fewer days on short-term disability compared to an industry benchmark, resulting in an average cost avoidance of $1,177 per claim. For employees, the BHU helps them improve their physical and mental health so that they may return to work sooner.

WHAT IS THE BEHAVIORAL HEALTH UNIT?

Aetna's Behavioral Health Unit is made up of licensed mental health clinicians and psychiatric registered nurses who communicate with employees, employers, mental health providers and medical providers. The BHU currently enlists 52 licensed clinicians and provides telephonic clinical case management.

"The unit was designed to address the high volume and complexity of psychiatric and psychological disabilities," says Adele Spallone, clinical services head for Aetna Disability and Absence Management. "Claims accepted by this unit have a mental health diagnosis or psychiatric component that may impact the member's health recovery and ability to return to work ... In general, the cases involve multiple providers, frequent interventions, medication management and complex return-to-work issues."

While Aetna's BHU is not the only behavioral health management team out there, the company maintains that it is the "best-in-class" model available. The BHU unit has been in existence for more than 15 years and utilizes a best practice model that incorporates clinical reviews performed by experienced, licensed behavioral health clinicians on all disability claims filed with a primary psychiatric disabling condition.

"I often receive feedback from external brokers that we have been 'pioneers' in the industry and continue to have a service offering for our members and customers that has not yet been equally replicated," says Spallone. "Much of our success continues to be attributed to the fact that we maintain a case management philosophy with return-to-work as a goal."

"WE MAINTAIN A CASE MANAGEMENT PHILOSOPHY WITH RETURN-TO-WORK AS A GOAL."

DATA AND OUTCOMES

Aetna's claims appear strong when viewed against the backdrop – and challenge – of treating behavioral health issues. Up to one in four primary care patients suffer from depression, yet one-third of these patients go undiagnosed, according to the Agency for Healthcare Research and Quality. Among the 8.9 million adults with a mental illness, 37.6 percent of them do not receive any treatment, data from the Substance Abuse and Mental Health Services Administration shows. Overall, those with mental illness receive medical care less frequently, have reduced adherence to treatment therapies for chronic disease, and are at higher risk for adverse health outcomes.

Nonetheless, the BHU has seen positive outcomes. The core of the BHU's claim management strategy is the belief that work is therapeutic, according to Spallone, and that it is in the best interest of the employees to return to work as soon as work capacity has been assessed and proactive return-to-work strategies can be coordinated with their employer.

Employers are invested in the well-being of their employees, but frequent work absences as a result of disability can call into question the effort involved in maintaining an employee. Aetna's BHU has a focused disability claim strategy that intervenes once a disability claim is filed, setting the stage for expectations around the disability and event.

"We are able to proactively assist treating physicians to address referrals to specialty behavioral health providers, we can connect claimants to EAP programs, and we can proactively build a strategy for a timely and safe return to work," says Spallone.

THE CHALLENGES OF BEHAVIORAL HEALTH

Aetna's BHU recognizes that working in the behavioral health field comes with a number of challenges. When a team is in charge of managing behavioral health disability claims, the following challenges must be recognized:

- Lack of "objective" clinical data.
- Incomplete or missing job descriptions.
- Nonspecialty providers treating for behavioral health disorders.
- Stigma.
- Co-morbid conditions.
- Workplace unable to make accommodations or modifications.
- Psychosocial factors.

By gathering the right behavioral health specialists into one unit, the BHU ensured that they had clinicians who understood the psychiatric and psychological complexities of those with behavioral health issues while working together with their physicians to determine the best approach to hastening recovery and returning the employee to work sooner.

"The unit focuses on functional deficits related to specific job duties vs. diagnosis or distress and conceptualizes cases across cognitive, emotional and behavioral realms," says Spallone.

As the outcomes show, the integrated approach is leading to stronger care. CIP

Are Baby Boomers Ignoring Their Aging Future?

The price, duration of long-term care casts a pall across the nation

BY ANGIL TARACH-RITCHEY, RN, GCM

A year ago CNN published an article titled ***Caregiving for Loved Ones the 'New Normal' for Boomers***. An estimated 55 to 60 million Americans provide care to a disabled adult. Statistics vary according to reporting years but we can assume the numbers are growing.

What follows is a basic review of current and future statistics. In January 2011 the first baby boomers began crossing the 65-year-old threshold at 10,000 a day. Every single day 10,000 baby boomers will turn 65 through the year 2029. According to the U.S. Census Bureau, baby boomers were born during the demographic birth boom between 1946 and 1964. Sixty-six million children were born in the U.S. during that period. This doesn't take into account foreigners who were born during that time period who are now citizens or have current resident status in the U.S. Now we're talking about an estimated 70 million individuals who will be 65 years and older by 2030.

If we take a look at the current and future statistics we can easily see the need to do something more than talk about the impending "elder boom" crisis. In 2010 over 5.5 million persons – one in nine – were sixty-five years or older. One in five will be sixty-five years or older by the year 2035 – nearly double the current senior population.

If we understand that nearly seven out of 10 of us will need some type of care after the age of 65 because we are unable to perform at least two activities of daily living or because we have cognitive impairment, can we afford to let the information go without real action?

IMPROVING GERIATRIC CARE

Our current system is failing our elder population. We have a shortage of geriatric specialists, nurses and professional caregivers. We have not focused on geriatric training, which still isn't mandatory in medical school and is barely touched on in nursing schools across the country. Professional caregivers in long-term care do not have a standard or required training program that provides the knowledge and background necessary to meet the physical, psychological, social and spiritual needs of geriatric patients and residents. Social workers and discharge planners are so overloaded with the constant movement of patients in and out of hospitals and rehabilitation facilities they don't have the time to educate patients and families, or provide the resources for success following discharge. That is evidenced by hospital readmission rates in geriatric patients, which is currently on Medicare's radar and the systems that serve those patients.

Medicare and Medicaid are continuously cutting benefits and programs in an effort to continue providing healthcare into the future, and there are limited resources for custodial care or complicated medical care. In the past, if you were a veteran with an honorable discharge you would be eligible for benefits that would provide for your care needs, but even the programs and benefits through the VA have been cut over the last couple of years due to the expanding need of aging and newly disabled veterans. Long-term care insurance is quickly becoming unaffordable as companies are increasing prices. Pensions are becoming a thing of the past and retirement savings programs have been victim to our recent economic downturn.

> "OUR CURRENT SYSTEM IS FAILING OUR ELDER POPULATION. WE HAVE A SHORTAGE OF GERIATRIC SPECIALISTS, NURSES AND PROFESSIONAL CAREGIVERS."

Genworth Financial provides a detailed report on the costs of long-term care, which should be a wake-up call for us all. Currently the average yearly cost for a semiprivate bed in a skilled nursing facility totals more than $83,000. How many Americans can afford to pay that out-of-pocket cost? If you sat with nine friends around a table and you know seven of them will need care in the future, will you and six of your friends be able to pay for a year of skilled care at that price? What about two, three, four or five years? Now take that same semiprivate bed in the year 2033, just 20 years from now when baby boomers will really stretch our system, and the cost skyrockets to an estimated $210,000 a year. Current statistics show that 3 percent or less of the American population makes over $200,000 per year, so what are the 97 percent of the others supposed to do? Even if you have planned well for your care and have made the kind of income that would allow you to pay those yearly costs, how many years could you afford to cover for yourself or your spouse?

Since we know skilled nursing care is not the only type of care available, the minimal amount of care in 20 years in a day program will average over $45,000 a year. Assisted living will average $90,000, and home care, both home health and private duty, will average more than $110,000 a year.

The average American hears the population numbers. Many fear that Social Security, Medicare and Medicaid are on the brink of collapse. If they have spent any time caring for a loved one, they have gotten a taste of our healthcare system in all of its excellence and faults. But few know the realities of care and the associated costs now, let alone in the future.

In a 2008 report from the Families and Work Institute, titled ***The Elder Care Study: Everyday Realities and Wishes for Change,*** in which they interviewed working family caregivers, 54.6 million employees had provided some type of care to a family member over the age of 65 in the previous five years, who either found it too difficult for their loved ones to perform a task or impossible. That was nearly one in two employees in 2008. What percentage can we expect in 2030?

As shocking as that is, what is even more eye-opening is that participants found it too difficult and too depressing to imagine themselves being in the place of their loved ones. Workers expressed what they did not want to

happen to them in their elder years. Rather than understanding that if we act to create our aging future we could prevent the three most-expressed wishes, which were: 1) Not to be a burden to others, especially their children; 2) Not to burden themselves or others with unaffordable expenses; 3) Not to end up in a nursing home.

It is highly likely that the participants of The Elder Care Study will at least experience two out of three of their fears as they relate to the future costs of care and the current lack of resources. This can be compared to New Orleans and Hurricane Katrina. For years the government and people of New Orleans knew their town could not withstand a major hurricane. It wasn't a matter of whether or not a major hurricane would come, but when. Yet individuals and bureaucracies failed to act on that knowledge to reinforce the levees or create another protective system, and their worst fears were realized.

We have one advantage when it comes to the elder boom compared to the devastation of Hurricane Katrina; that is the timing. We know the exact years until all the baby boomers will reach their 65th birthday. We know the average percentage of seniors that will need care. We know the improvements we need to make in educating healthcare professionals. We know that we are still in the window of time to act so we can reduce the impending crisis. But the fear remains that we won't act. Many baby boomers are ignoring it, hoping it will all go away.

We have about five years to create our aging future. We can't rely on the government, or the other guy to do something. Our system cannot possibly support the aging population and unless we understand the urgency and quit ignoring the problem we will be waiting for someone to rescue us. Do you think the survivors and those who ignored action wished they would have acted when they had the time?

As healthcare professionals, we know the realities of our current system and the crisis ahead. It's time we loudly and passionately educate, advocate and act to create a beautiful, positive, supportive and compassionate future for us all. We need to forge together and lead the country to create a system that values seniors, allows us to remain at home, promotes activity and good health, encourages and even demands volunteerism from those capable of giving some form of service, allows us to release the fear of losing it all to care costs, and gives us all something to look forward to rather than dread. We need to stop being so fragmented and start putting our education, experience, skills and resources together with one goal in mind: to create a satisfying, comfortable and caring future together in community.

Baby boomers, it's time to wake up to the reality of what is ahead. Let's turn the fear into creativity, advocacy and action and we will all look back as we enjoy our elder years, glad we acted rather than wishing we had. CIP

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Booming Toward Preventive Health in Our Daily Lives

BY SCOTT ZIMMERMAN

Prevention is a word we associate with taking action prior to things happening to ensure they don't occur. We take preventive steps in all aspects of our daily life – we wear seatbelts to prevent injuries while driving, we lock our doors to keep burglars out, and we put sunscreen on to prevent sunburns. These turn out to be nearly subconscious actions in our routines that help to prevent negative outcomes.

When it comes to preventive healthcare, 95 percent of the baby boomer generation said they feel preventive care is important, but only 32 percent of the aging population is receiving the preventive care measures that are recommended for them, according to our research. It is time for everyone, especially this part of our population, which has been labeled as the largest and richest generation yet, to start taking responsibility for taking care of themselves while they are aging.

According to a recent TeleVox Healthy World Report, ***A Call for Change: How Adopting a Preventive Lifestyle Can Ensure a Healthy Future for More Americans***, baby boomers understand that preventive healthcare is necessary. However, one of the leading factors contributing to the low levels of preventive care use remains the fact that Americans do not know what is covered by their insurance policies. Three-quarters of U.S. adults say that out-of-pocket costs are the number-one reason they decide whether or not to seek preventive care. Furthermore, only 23 percent of baby boomers report understanding what their insurance plan covers in terms of preventive care.

THE POWER OF PREVENTION

Under the Affordable Care Act, many preventive services are provided to those who are insured at no cost. Thus, consumers should take the time to research what preventive measures they could be getting through their insurance coverage at no cost. Often this coverage includes crucial screenings, and these are a good first step toward a preventive lifestyle. Preventive screenings can range from a yearly wellness exam with a primary care doctor to mammograms, prostate and other cancer screenings. These can help prevent, or detect early, conditions that can alter your life if not discovered in early stages.

For those still not convinced of the value of preventive screenings, consider this: According to a recent study from the CDC, if all adults age 50 and older were screened for colorectal cancer, as many as 60 percent of deaths from the disease could be prevented. This is a baffling number, as it indicates that we are aware of the problem, yet continue to do nothing about it. And while not all cancer can be prevented, early detection is often the best tactic we have because catching the disease early greatly increases the likelihood of positive outcomes. Yet, the baby boomer generation is still falling behind in this area. In fact, according to A Call for Change, only 33 percent of baby boomer women have received a mammogram, and only 24 percent of boomer men have received a prostate exam in the last two years.

> "ONLY 33 PERCENT OF BABY BOOMER WOMEN HAVE RECEIVED A MAMMOGRAM."

One of the reasons the baby boomer generation may not be taking advantage of preventive healthcare is related to the avenue in which information is relayed to the patient. Communication of patient information, like so many other tasks, is greatly impacted by advancements in technology. Baby boomers, while regular users of technology, still value face-to-face discussions. Proper discussion should start during in-person visits and then be supplemented with ongoing engagement using technology between visits. Eighty-two percent of boomers report that communication from a healthcare professional via text message, email or voicemail is as helpful, if not more helpful than in-person or phone conversations. It is important for healthcare providers to open all available lines of communication to reach the baby boomer population. Taking these numbers into consideration, more doctors engaging patients via high-tech methods can help improve overall communication between healthcare providers and their patients.

An additional aspect to this issue is the fact that Americans are living longer. Technology and medical advancements have resulted in current generations outliving their predecessors. But this doesn't mean that Americans are living healthier lifestyles. And unhealthy lifestyles, along with a failure to take advantage of preventive care, are forcing Americans to dig deeper into their pockets. According to the CDC, Americans are spending close to $177 billion a year on diabetes and $147 billion a year on obesity-related issues. As baby boomers continue to age, these costs will continue to add up. Taking advantage of the preventive measures that are available could cut down on many of these expenses, as preventing a condition is much more cost-effective than treating it after the fact.

Now is the time for Americans to act. The baby boomer generation has the ability to positively influence a shift to a healthier lifestyle for themselves and pass along the knowledge and habits to future generations. By providing the baby boomer generation with more information regarding insurance benefits and preventive care, healthcare specialists increase the likelihood of healthy lifestyle choices and positive outcomes. It boils down to this: Taking preventive action is a necessary part of living a healthy life. It does require some time spent focusing on healthy behaviors and lifestyle changes, but it's time that Americans can't afford to waste. Eating smart, exercising regularly, participating in regular dialogue with healthcare providers, getting the recommended yearly preventive screenings, and understanding how those screening results are impacted by and in turn impact health behaviors – all are important components in living a healthier lifestyle CIP

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Examining the History of Medicare and Long-Term Care Planning

BY KELLI HANSEN, RN, BSN, CMCN, LNC

As we age, our potential for needing long-term care services increases with the rising occurrences of co-morbidities amassed by the diminishing nutritional dietary habits of our society. So why do we have Medicare and what exactly does it cover in regards to our long-term care needs? Let's start by reviewing the history behind our Medicare and Medicaid programs.

HISTORY OF MEDICARE

Our first national healthcare bill specifically aimed toward coverage of senior citizens and the disabled was first introduced to Congress as "Post-Hospital Care for the Aged" in 1949 by the Vice President Hubert H. Humphrey. It received insufficient support and did not come to pass until Lyndon Johnson occupied the presidential office. However, in the duration before it was signed into law, a bill was passed in 1952 under the Truman administration for guaranteed hospital care for everyone on Social Security. This now paved the way for Medicare to be enacted.

The intent of the Medicare bill was to ensure that senior citizens and the disabled did not suffer from untreated illnesses. The bill evolved and changed over 12 years until July 30, 1965, when the Medicare and Medicaid programs were first initiated into law by President Lyndon B. Johnson. Other presidents before him had endeavored to establish a national health insurance but failed. Prior to the establishment of the Medicare bill, only 50 percent of America's seniors had insurance for hospital care in 1964. During this period, many seniors went untreated for illness and faded away into poverty in our society.

The Medicare bill was established to give hope against this rising issue. By 1965, with the signing of the Medicare bill, access to healthcare for seniors increased by one-third and the rate of poverty decreased significantly. Medicare has made modifications to the bill since it was enacted in 1972 and now includes Americans with disabilities and those suffering with end-stage renal disease.

The Medicare Modernization Act was signed into law by President George W. Bush on December 8, 2003, adding an outpatient prescription drug benefit to the Medicare benefits already in place.

Over more recent years, Medicare has extended the life of the Medicare Trust Fund to 2025, launched a concentrated effort to reduce Medicare fraud, waste and abuse, and restore $2 billion to the Trust Fund. Additionally, preventive benefits have been added to Medicare coverage to help prevent and discover diseases at early stages for less problematic treatment.

MEDICARE COVERAGE FOR LONG-TERM CARE

According to the U.S. Department of Health and Human Services, 70 percent of people will need some form of long-term care services at some point in their lives. It is also a fact that Medicare does not pay for the majority of at-home long-term care services. Medicare only covers medically necessary care and focuses on acute care for medical conditions and treatments, such as physician visits, medications and hospital stays. It also focuses on short-term services for conditions that are expected to improve.

The key word is "short-term." Medicare was never meant to cover long-term services. Medicare pays for healthcare for individuals age 65 and older, individuals under age 65 with certain disabilities, and other individuals of all ages with end-stage renal disease. Medicare does not pay the major part of long-term care services or personal care for daily activities, such as bathing and dressing or supervision needed for an individual with dementia. Medicare does help pay for short stays at skilled nursing facilities, hospice care or home healthcare if the individual meets the criteria. In order to qualify for skilled nursing facility coverage, an individual must have had a recent hospital stay of at least three days; the person may be admitted to a Medicare-certified nursing facility within 30 days of a prior hospital stay and they must require medically necessary skilled care, such as skills of a nurse, physical therapist, or other types of therapy for a recoverable condition.

An example of a stay such as this would be for recovery and rehabilitation related to an acute stroke rather than an individual who had a stroke years prior but didn't fully recover all of their strength. Medicare covers 100 percent of costs in a skilled nursing facility up to 20 days. For days 21 through 100, an individual pays their own expenses up to $140 per day (current rate in 2013) and Medicare then pays any balance owed. Beginning day 101 and beyond, an individual is fully responsible for all further expenses.

Medicare covers hospice care if an individual has a terminal illness with a physician indicating that the individual has less than a six-month life expectancy. Other coverage includes medications to control symptoms of the illness and for pain relief. If additional information is sought for the specifics of hospice coverage along with detailed Medicare information on all coverage, this can be obtained from the CMS website, via the Medicare & You 2013 guide.

If services are requested in an individual's home, Medicare will pay services for a limited time when a physician certifies that the services are medically necessary to treat an illness or injury. Several examples of such services include intermittent skilled nursing care for recovery related to surgery with completion of wound care dressing, and rehabilitation type services such as physical therapy, speech therapy and occu-

pational ther-apy. Medicare will cover durable medical equipment as well, such as wheelchairs and walkers. An individual is responsible for 20 percent of the Medicare approved amount.

In summary, the Medicare bill was put into action as a means to assist in paying for short-term services to prevent seniors and disabled individuals from refusing to obtain treatment for an acute illness or injury and to assist with the soaring costs and financial burdens of obtaining such care. As stated previously, the Centers for Medicare and Medicaid Services states specifically on their long-term care website that such coverage does not cover all the costs associated with care needed for long-term care services. It is crucial for individuals and their families to plan ahead and wisely choose additional insurance coverage to offset the immense strain that long-term care services can inflict on a senior or disabled individual and their families.

"IT IS CRUCIAL FOR INDIVIDUALS AND THEIR FAMILIES TO PLAN AHEAD AND WISELY CHOOSE ADDITIONAL INSURANCE COVERAGE."

LONG-TERM OPTIONS BEYOND MEDICARE

According to Bill Stubbs, CLU, with Stubbs & Associates, there is no "magic" age when an individual should start considering additional insurance purchases for future long-term care financial planning. One option for additional financial coverage is purchasing a Medicare supplement policy also known as Medigap insurance, which is sold by private companies to support paying healthcare costs that the original Medicare does not cover, such as copayments, deductibles and coinsurance. For additional detailed information on Medigap policies, information can be found on the Medicare website. The challenge with Medigap insurance is that it generally does not cover long-term care services, private-duty nursing, vision or dental care, or necessary items sometimes needed as we age, such as hearing aids and eyeglasses. One option to resolve this dilemma is to consider purchasing a long-term care insurance policy.

According to the interview with Bill Stubbs, there are several types of long-term care insurance. The traditional type of long-term care insurance allows for a monthly or annual premium to be paid. This type of policy reimburses for long-term care services, such as skilled nursing home, assisted living care, and home healthcare or custodial services, if benefit eligibility criteria is met. If the policy benefits are never accessed, then the individual loses money in the end. A second type is an endorsement policy added on to modern life insurance or annuity plans. These types of policies are penalty-free for withdrawal from the pre-death benefits within the policy for services that are necessary.

A third type of policy is also associated with life insurance or annuity. According to Stubbs, this type of policy is becoming more commonplace given the options it provides. For every one dollar an individual pays in to the policy, they receive three to five dollars of long-term care service benefits back when they need the reimbursement. If the individual never needs to utilize this pre-death benefit, or only partially utilizes the value of this "portfolio" insurance, then they can request all the premium money back or a portion that has not been utilized; if all the benefits are not accessed or utilized to full capacity, the remaining financial benefit dollar amount is directed to the beneficiary at the time of death of the individual policyholder.

Those considering long-term care insurance policies need to ask questions before agreeing to purchase a policy. Consumers need to be aware that, like any insurance policy, qualifiers must be met in order to receive certain types of benefits. Paying premiums alone does not entitle a policyholder to receive all the benefits. Many policies have elimination periods in which they must wait to receive benefits for a certain period of time once they are eligible, and many also have maximum benefit periods. Long-term care insurance policies are at times complex for consumers to understand and are not necessarily the solution for everyone, but they can facilitate an easing of the financial burdens upon seniors and their caregivers.

SUMMARY

The cost of healthcare is on the rise and our population is aging. Seniors and their families need to develop a long-term financial plan to cover their potential healthcare costs for long-term care services. These plans will prevent an enormous financial burden on themselves and their caregivers. Whatever options are decided, education about the coverage options and qualifications are necessary before the services are needed.

Ongoing community education and interaction is a necessity between seniors and their caregivers, healthcare providers (including patient advocates), and insurance companies in order to ease rising financial anxiety, struggles with growing older, and worries over not having additional long-term care services in place. CIP

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On the Precipice of an Age Crush, Coaching Boomers to Better Health

BY WILLIAM APPELGATE, PHD

Healthcare is at a profound inflection point. Virtually all healthcare professionals are contending with an industry in the midst of truly tectonic shifts in the healthcare landscape. These forces include the inexorable transition from "volume to value" and all that entails, including new organizational structures (e.g., accountable care organizations and patient-centered medical homes) and reimbursement models. New strategies in the effective delivery of care are critical, and will focus more on holistic and proactive care versus episodic "sick care."

Fundamental to that objective is activating the patient as an often untapped resource in their care, especially when chronic conditions are at play in their lives. This issue of ***Case In Point***, dedicated to the impact that the baby boomer generation will have on the healthcare system, is especially timely. The demographics and psychology of this group and their outsized demand threaten to overwhelm and overburden the current healthcare system.

BOOMERS: OUTPACING OTHERS FOR SERVICES

The first boomers started turning 65 as of January 2011, but the consequences of that birthday are only beginning to factor into the healthcare equation. That will change. Boomers now account for more than 35 percent of adult Americans, while their appetite for services, and especially healthcare services, will far outpace their population. Stanford economist John Shoven may have accurately calculated that today's 65 year old has the same mortality and health as a 54 year old had in 1947, but it is hard to reconcile that statistic against the tidal wave of impending chronic disease heading toward us.

Overall, the numbers are staggering – six out of 10 boomers will have a chronic disease; one in four will be burdened with diabetes; one in three will be impacted by obesity; and more than half will be diagnosed with high blood pressure. Add to that the fact that more than 35 million will have comorbid chronic conditions and the scale of the problem comes sharply into focus.

> "THIRTY TO 50 PERCENT OF PATIENTS LEAVE THEIR PROVIDER VISITS WITHOUT UNDERSTANDING THEIR TREATMENT PLAN."

The case for keeping the "well" baby boomers on a path toward health is another challenge upon which the healthcare system has seldom focused, but must now exploit as a golden opportunity. How do we mitigate the predictable trend toward increasing health risks and decreasing health status as baby boomers age?

One answer is utilizing an approach focusing on factors that support human health and well-being, rather than on factors that cause disease. Quite the opposite of pathogenesis, this approach, termed "salutogenesis," considers each individual more or less healthy while being more or less ill, along a continuum. Our health behaviors and environment shape major portions of our health risks and health status. If we can maintain (zero trend) health or build it in the baby boomer population, dramatic cost-containment and savings will result along with the resulting higher order well-being that is desired by all.

So what is the role of the care manager, case manager, nurse, primary care physician and home care specialist in this new dynamic? The opportunity to collaborate with and engage the patient to become accountable for their health becomes a fundamental component of the care plan. The focus on coaching and communicating is equal in value to prescribing and educating. Succinctly summarized by Dr. Carla Stebbins of Des Moines University, "You can be the most clinically-gifted person on the planet, but if you don't know how to communicate that to a person – where they can own it and base change on it – then you're not going to be as effective."

Statistics back this up. Independent studies have found that:

- Thirty to 50 percent of patients leave their provider visits without understanding their treatment plan.
- Hospitalized patients retain only 10 percent of their discharge teaching instructions.

Quoteworthy

"Given that the healthcare system is overburdened and clinician time is limited, some experts regard patient self-management as the only arena where there is available capacity within the U.S. healthcare system for improving quality of care and reducing cost." -Rand, 2007

Quoteworthy

"To live a long and healthy life, develop a chronic disease and learn how to take good care of it." – Sir William Osler

- On average, a patient has 23 seconds to describe their concerns before they are interrupted by the healthcare provider.

A recent study from the Agency for Healthcare Research and Quality estimated that 95 percent of all diabetes care is self-care. The Iowa Chronic Care Consortium has been on the forefront of population health initiatives, and our experience shows that this self-care percentage holds true across the spectrum of chronic conditions. In order to effectively reach in to build patient self-care skills, health coaching becomes a critical and powerful component for empowering the patient as an expert in their own health.

Specific to baby boomers, the data shows that this population is more educated and more affluent. While they may have more chronic conditions, they nonetheless define themselves as healthy and physically active. Boomers have an increased likelihood of simultaneously caring for both children and aging parents, and the CDC reports that they have an increased frequency of major life events (e.g,. death, marriage, change in job).

While they are highly adept at using the internet to research health information and understand their conditions, the challenge of inspiring genuine accountability and building self-management skills remains. The key is partnering with boomers by emphasizing their role in terms of empowerment and control.

Health coaching is a fundamental approach to delivering patient-centered care. While this can be deceptively challenging for the care team, there are fundamental health coach practices that should complement the care team's clinical expertise. The following list takes an in-depth look at these fundamental practices.

Engaging with the patient through multiple techniques. Health coaching combined with motivational interviewing and other coaching sciences is a primary engagement skill, and one that requires training, ongoing practice and reinforcement.

Making compassionate, patient-centered care a priority. The emphasis and attention needs to remain on the patient, their holistic needs, and not simply focused on the chronic condition.

Making the patient central to the therapy plan and goal setting. Successfully prompting health behavior change and patient empowerment requires the provider to recognize the patient as a capable and resourceful part of the plan.

Customized education and skills training. Boomers are particularly receptive to rich, detailed information, but be aware of cultural, socioeconomic and health literacy variation.

Team-based care. Expands the support for the patient and family, and facilitates the care manager exploring options in using different team members for comprehensive care, including registered dietitians, social workers, pharmacists, behavioral health professionals and others.

Consistent, responsive follow-up. Effective patient engagement pivots on driving accountability to the patient level, attentive reinforcement from the patient care team, along with workflow systems and practices to support efficient follow-up.

Physicians, dietitians, nurses and care managers have been carefully trained to "do, teach and tell" with the noble goal being to "fix" the patient. Many of these professionals are exceptionally talented in this approach of delivering healthcare. However, a profound challenge exists, and the impending chronic health needs of the boomer generation will only magnify this challenge. When we, as healthcare professionals, see the end of our work as teaching or telling a patient the best steps to care, we may have fallen short of the critical target – growing the patient's ability and confidence in long-lasting behavior change. The labeled "noncompliant" patient is often someone who needs further exploration in discovering their own motivation for change.

The bigger truth centers more on truly activating the patient. The health coach, whether in the role of care manager, nurse or home health specialist, must engage and activate the best in patient health behaviors. The application of health coach skills, combined with clinical expertise, is the surest way to address the dual challenges of an evolving accountable patient-centric healthcare industry and the impending impact of the boomer generation and their chronic disease burden. The future of our nation's economic health depends on it. CIP

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As Senior Care Moves Home, the Need Arises for More Caregivers and Quality Training Standards

BY JULIE NORTHCUTT

As America's population ages and technology advances, more seniors are choosing to "age-in-place" in their own home. Caregiverlist.com, a publisher of online hiring tools for senior care companies, released the 2013 Caregiverlist Employment Index, reporting a 40 percent growth in the number of senior home care agencies since 2008. Even during the "Great Recession," this segment of healthcare grew exponentially.

This rapid growth in senior home care presents new challenges: where will we find enough quality workers to deliver part-time, full-time and live-in care, and what training requirements should be implemented to maintain quality care in the home?

According to the Bureau of Labor Statistics, employment of personal care aides is expected to grow by 70 percent in this decade and home health aides by 69 percent, making them the first and second fastest-growing occupations.

The Caregiverlist Employment Index has compiled the only data for caregiver pay rates, industry size and growth, top cities for senior care employment and types of senior care positions available. The largest challenge in the industry is finding quality caregivers and implementing training standards. As more hospitals are monitoring the discharges of senior patients to include tracking of quality home care, or even requiring in-home care upon discharge, this need becomes yet more paramount.

OVERCOMING STAFFING ISSUES

While senior caregivers are paid more than minimum wage and receive benefits, there are times when senior care companies are unable to provide services because of the inability to staff an adequately trained professional caregiver. In addition, some positions require caregivers with unique skills and abilities for in-home care services.

The staffing challenges also involve the unique dynamic of caregiving for a senior, which involves the occurrence of natural client turnover because seniors are going to eventually recover from their medical condition and no longer need care, or pass away. Many times quality caregivers will take time off after a senior home care assignment ends. In addition, unique requirements for care in the home are also a factor. While a senior home care agency may have a caregiver available, perhaps the senior has a dog or cat in their home and the caregiver is allergic to pets and will decline the assignment. Customized training may be required for hospice care or memory-loss care. All of these dynamics make hiring and training caregivers for professional jobs an added challenge.

Live-in senior care has also grown, and while live-in caregivers do not actually move in with the senior, they still must be able to stay overnight in a senior's home. Because of this, not all caregivers are able to accept a live-in senior care assignment if they have children or a spouse whom they are unable to leave overnight.

"CUSTOMIZED TRAINING MAY BE REQUIRED."

Another trend impacting the senior home care industry is an increase in hospitals requiring senior home care around-the-clock for the first few days or even the first week after discharge. This is to avoid rehospitalization of the senior within 30 days and the penalties that come along with this, a new requirement added to the Affordable Care Act to increase quality hospital care and decrease Medicare costs.

More senior caregivers are needed nationwide. Solutions proposed are recruiting more early retirees to become companion senior caregivers. Seniors with memory loss often only need companion caregiving services initially. Educating retirees about these jobs which deliver fulfillment along with a paycheck may be one way to attract more workers to the industry.

Certified nursing aides and certified home health aides receive training based on the certification requirements in their state. More states are now proposing and passing legislation to require mandatory training that meets a set standard of requirements for professional senior caregivers in the home. The training requirements are usually proposed by industry trade groups. California has two bills in committee that would require mandatory training, with one bill presented by professional senior care companies and the other bill supported by the Service Employees International Union (SEIU).

Illinois passed legislation requiring eight hours of training for professional senior caregivers and licensing for senior home care agencies in 2008. Currently, 33 states have either licensing or training requirements for senior home care agencies.

The Nursing Home Reform Act, adopted by Congress as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA), was designed to improve the quality of care in long-term healthcare facilities and to define training and evaluation standards for nursing assistants who work in long-term care facilities. Each state is responsible for following this federal law and can create their own additions to the minimum training requirements. Because of this, an individual who has obtained a nursing aide certificate in one state may transfer it to another state. Similar national standards may be needed for senior home care in order to make it easier for companies to employ quality caregivers.

Here are highlights from the Caregiverlist.com Senior Care Employment Index:

Senior Care Industry Size. There are nearly 11,000 senior care agencies in the United States; 1,000 new agencies opened in 2012 alone. Each agency is hiring three to six new senior caregivers on a weekly basis and more than 4,000 caregivers and

certified nursing aides (CNAs) are hired monthly from Caregiverlist.com by subscribing senior care companies.

Senior Caregiver Industry Growth Since 2008*:

- 40 percent growth in senior care agencies across the United States.
- Nearly 4,000 senior home care agencies have opened.
- 10 new franchise corporations began selling territories to new franchisees.
- 1,258 senior home care franchise locations opened.
- More than 2,000 independently owned/corporate locations opened.
- More than 10,474 senior home care agencies are in operation nationwide.

2012 Professional Senior Caregiver Pay Rates: Compiled from Caregiverlist.com's 2012 job applicants, nearly 19,000 caregivers reported a national average of $10 for an hourly rate and $120 for a daily caregiver rate. Even with states increasing the minimum wage in 2013, the average senior caregiver pay of $10 an hour is 38 percent more than the national minimum wage.

Top 20 U.S. City/Metro Areas for Senior Care Employment:

1) Phoenix, Ariz.
2) Chicago, Ill.
3) San Diego, Calif.
4) Los Angeles/Orange County, Calif.
5) San Francisco, Calif.
6) Washington, D.C.
7) Baltimore, Md.
8) Houston, Texas
9) Dallas, Texas
10) Pittsburgh, Pa.
11) Philadelphia, Pa./Cherry Hill, N.J.
12) Seattle, Wash.
13) Portland, Ore.
14) Boston, Mass.
15) St. Louis, Mo.
16) Atlanta, Ga.
17) New York City
18) Miami, Fla.
19) Orland, Fla.
20) Tampa/Sarasota, Fla.

Senior Caregiver Positions Available and Training Required to Secure These Positions:

- Companion Caregiver: No training required other than a caring personality and personal experience is an added bonus.
- Certified Caregiver: Must complete 10-hour basic caregiver training to become certified caregivers.
- Certified Home Health Aide: State-specific (NJ, FL and CA) requirements of formal trainings and standardized testing needed for caregivers to become certified in the home as a health aide.
- Certified Nursing Aide (CNA): Must take state-approved CNA course and pass state CNA exam (Caregiverlist.com has CNA school directory plus admission requirements and costs plus sample and practice CNA test). All Medicare and Medicaid certified nursing homes and hospitals must have a minimum number of CNA's on staff to help with patient care and safety.

The future of senior caregiving is going to continue to exponentially grow, as the number of seniors in America will increase by 75 per-

continued on page 30

Pioneering: Building Your Brand for Patient Engagement

BY KELLEY CONNORS, MPH

Patient engagement is on the minds of healthcare leaders today who care about the Affordable Care Act and its driver, healthcare reform. While many healthcare leaders embrace the engagement as a concept, challenges loom large in an industry characterized by opposing financial incentives that have, heretofore, kept patients passive, and suffering from preventable and progressive conditions that lead to rising healthcare costs.

According to Susan Dentzer, editor of ***Health Affairs***, "Research shows that more informed and empowered patients, who participate with their providers in making wise care decisions, have better health outcomes – and there's some evidence that they even have lower healthcare costs. And, if there were a blockbuster in this case, the "drug" is actually a concept – patient activation and engagement – that should have formed the heart of health care all along."

While its timing as a critical success factor is unarguably late, it's now the perfect storm as the ACA becomes law (unbeknownst to consumers) and our U.S. economy struggles under the weight of "sickness" and "pay for procedure" incentives that have made our healthcare system one of the most inefficient on the planet. Despite our high cost of care, including hospital readmissions rates, lack of primary care physicians, and unpaid and uninsured caregivers, we as Americans still expect a positive healthcare experience.

So, as we collectively move forward to a new world where patients are informed and empowered participants in healthcare, evaluate the "3 P's" in the design and implementation of your patient engagement strategies: planning, partnerships and personalization.

STRATEGIC PLANNING: MEETING PATIENTS' NEEDS

The goal of strategic planning for patient engagement initiatives is to identify your unmet patient needs, and both the "passion" and "pain" points or insights that drive engagement and, ultimately, behavior change for better health outcomes.

"We know today that key patient needs are not being met," Dr. Laura Esserman, director of the University of California at San Francisco's Carol Franc Buck Breast Care Center, said recently at the Health Technology Forum Innovation Conference Friday in San Francisco.

The process for strategic planning includes exploring unmet needs and mapping a new pathway to meet those needs. The mapping process helps pave the way for a greater understanding of how your organization or brand can come serve a broader array of patients. Your planning inquiry should explore impact and relationship between concomitant health conditions, characterization of daily well-being routines, understanding of self-efficacy and confidence in adopting new health behaviors, specific barriers to behavior change and medication compliance, and aspirations and motivations for health and well-being.

The process must also be based on a holistic appreciation and understanding of the continuum of care from a public health and a personal health perspective. This requires looking at the patient journey from both inside and outside the healthcare system to reveal how, when and why patients come to interact with a healthcare provider or service organization.

No matter what your end process, it's critical that you look at the patient, not just as a puzzle piece, but as a driver of healthcare – a real person who lives, works and plays 24/7, inside and outside the healthcare system. For example, consider this profile of a baby boomer. More than a boomer profile indicates, she's a consumer of allergy medications, but she's taking time off work as a caregiver for her elderly parents, one with dementia and the other with Parkinson's disease living in an assisted living facility. She is a breast cancer survivor and at risk for osteoporosis. She's looking to feel stronger and gain energy. What are her pain and passion points? What does she value most? How will you engage her so her health and well-being can improve? How will your staff interact with her to facilitate success?

PATIENT POWER THROUGH SOCIAL MEDIA

Patient power is critical and a significant output from the strategic planning process described earlier. Patients can participate in the improvement of their health outcomes by telling their story, engaging with other patients with similar interests and concerns in online communities, and becoming role models for other patients. Importantly, story sharing is empowering and validates their experience as an active patient. How can your brand or organization facilitate patient story-sharing to engage other patients like them?

Amy Tenderich, founder and editor in chief of DiabetesMine.com, a popular patient resource and community for those living with diabetes, said that little has changed since she was first diagnosed with the disease in 2003.

"I was presented with the myth of the healthcare team," Tenderich recalled. She said her care was not well coordinated and that she felt "lost" as a patient, which led her to create DiabetesMine. Today, Amy's blog has been coined "The New York Times of Diabetes" and she won the LillyforLife Achievement Award for Diabetes journalism from Eli Lilly & Company.

The simple act of story-sharing increases self-confidence of the patient and reinforces that they have the power to improve their health outcomes.

PARTNERSHIPS FOR HEALTHCARE 2.0

Once patient needs are identified, providers and innovators must seek solutions. Most industry leaders believe that while not easy, patient engagement requires technology and a reinvention of the healthcare business model as an essential component to improve health outcomes.

Given that patients have limited access to a reduced number of primary care doctors, healthcare leaders like Dr. Eric Topol, author of ***Creative Destruction of Medicine***, and Clay Christenson, author of ***Innovator's Prescription***, support healthcare 2.0 solutions like HealthPartners in Minneapolis, as they inspire healthcare leaders to be more

responsive to patients and market demands.

Online healthcare for common conditions typically cared for by primary care providers has the potential to help meet the "triple aim" of better health, better healthcare, and lower costs – and to lead to more satisfying customer and patient experiences. Patrick Courneya of HealthPartners in Minneapolis and colleagues report on the experience of HealthPartners' online clinic, called "virtuwell." Launched in 2010, virtuwell provides 24-hour online access, diagnosis and treatment (including prescriptions) by nurse practitioners for about 40 simple conditions, such as sinus infections, urinary tract infections and pink eye. The authors note that virtuwell is the first online service to be authorized for coverage under Medicare.

PERSONALIZATION THROUGH DIGITAL HEALTH TECHNOLOGY

With the maturation of social and digital technology that empowers consumers with knowledge and tools that improve the consumer experience, it's clear that the genie is out of the bottle and her name is "personalization." Personalization means academic, irrelevant and dry "healthcare" content is no longer enough to educate and motivate patients for behavior change. Health "apps" like those produced by technology companies who understand the user experience and patient behavior change deliver a personal experience for every user.

For example, Healthrageous has dynamic personalization technology, which allows a digital health coach to continuously deliver relevant and timely support. The digital coach takes into account an individual's goals, behaviors, health status, and personal preferences for when, where and how they want to engage.

While not every brand or organization may need to invest in an "app," online health coaches can drive engagement for health conditions where lifestyle change means more engagement and fewer doctor visits or trips to the emergency room.

CONCLUSION

The Institute for Healthcare Improvement describes engagement as "actions that people take for their health and to benefit from care." Engagement's close cousin is patient activation – understanding one's own role in the care process and having the knowledge, skills and confidence to take on that role.

More holistic definitions broaden these concepts further, describing patients and families working with providers all across healthcare, in such areas as patient-centered outcomes research.

However your team defines success with patient engagement, research shows that patients rated lowest in terms of their involvement with their care have substantially higher health costs than those rated more highly, at least in the short and medium term.

How will you build brand value through patient engagement as healthcare reform unfolds? CIP

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Going Mobile: How Medical Technology Is Evolving as Boomers Age

BY TIM SMOKOFF

I've fallen and I can't get up." You remember that line, right? Well, that was yesterday's technology. As 76 million baby boomers age, this younger, more mobile population is living a healthy independent life and outgrowing the utility of traditional home-based "panic buttons" that provide no coverage if you step off your front step. Boomers expect more.

Healthcare organizations and caregivers are taking advantage of advancements in new technology to expand their offerings and the populations they serve. Specifically, the proliferation of mobile technologies has given rise to a new generation of dedicated, always connected, health-related innovations ranging from automated panic buttons to telehealth-at-home.

Here's a look at three recent health-related trends that are already making an impact on the healthcare industry and its expansion beyond current standards – a shift that is occurring to meet the demand for better quality care in the era of aging demographics and healthcare reform.

CARE ANYWHERE

The convergence of patient-centric devices, the "measured self" (body sensors which can measure a person's vital signs both inside and outside a hospital), and mobility are driving the move to a "care anywhere" approach to healthcare and case management. As the boomer population ages, the concept of "care anywhere" is becoming increasingly important for adults looking to maintain their independent lives while managing their chronic health conditions. The conversation has shifted for these individuals and those who care for them from security to healthy aging – whether it is staying at home longer, being connected to care teams between visits or ensuring compliance with post-acute care treatment plans.

The traditional home-based panic buttons work to notify a monitoring call center if a user falls within the confines of the home. For today's more mobile, active adults, a whole new category has emerged – mobile personal emergency response systems (mPERS)

that take the safety and security of current PERS offerings on the go. With the combination of wireless and sensor technologies, mPERS have transformed into a comprehensive personal health gateway. Now users can wear a single, integrated device that not only senses a fall and automatically notifies a call center, but also captures data from a variety of health-monitoring devices and sensors – all while the user is at home or away.

The goal of these new mPERS systems is to help today's active adults address their individualized healthcare and security needs comprehensively – everything from personal safety, such as fall detection, to management of chronic conditions. The innovations in wireless technologies and activity sensors coupled with biometric monitoring means that patients now have the freedom to proactively monitor their health wherever they are. With mobile solutions now available, they no longer have to stay tethered to the home to ensure they can communicate with emergency responders. In addition, case managers appreciate having visibility to patient progress between office visits.

mPERS not only promote independent living for active adults but also lower healthcare costs by reducing hospital readmissions, improving outcomes and increasing patient and health provider satisfaction. For instance, the next generation of mPERS helps a care provider monitor a patient between visits, receiving alerts if a patient's monitoring device indicates that he or she is not adhering to the treatment plan. The care team can then proactively reach out to the patient to reinforce the importance of following the treatment plan.

mPERS still automatically connect people in distress to medical assistance, not only in their home but anywhere due to the ubiquitous mobile coverage now available. Equally important, the system tracks a person's location – even outside the home, where 40 percent of falls occur – and can notify neighbors or relatives of when, and where, a loved one has suffered a mishap. This transforms the whole emergency response experience by keeping everyone connected, informed and engaged in near real-time.

THE IMPACT OF ACCOUNTABLE CARE AND MANAGED CARE

Accountable care organizations (ACOs) and the shift toward better managed care are driving adoption of advanced technology in order to control costs. Healthcare organizations are now incentivized to proactively track patient care over time, rather than the reactive, episodic approach that has been at the heart of our health system for decades.

Now case managers are using remote vital signs monitoring made possible through mobile health devices to conduct predictive analyses on patients in order to intervene before a medical crisis reaches its apex. This can include measurements of weight, blood pressure, glucose, asthma and other vital measures that will help case managers better understand a patient's condition wherever they are.

"BOOMERS EXPECT MORE."

Chronic disease monitoring is also available through these systems to detect patterns that can indicate a significant event is approaching, so the case manager can check in with the patient. With 90 percent of those age 65 and above having more than one chronic condition, effective remote monitoring of these conditions is imperative not only for patients' better health, but also for controlling health system costs as steps are taken to prevent acute care.

These remote monitoring devices can also help with patient adherence to treatment plans, especially when it comes to prescriptions. Forty percent of those 65 and above take five or more prescriptions daily. The more complex the medication profile is for a patient, the more important it is to have the ability to monitor their adherence to prescription plans and track key medical indicators. Proactive intervention spurred by nonadherence alerts can ultimately mean the difference between life and death.

Advances in measurement technologies are helping case managers today stay engaged with their patients. Three-dimensional movement sensors, augmented by electronic gyroscopes and magnetometers are now able to detect if a fall has occurred and the severity of the fall, reducing the frequency of false alerts that can be generated through traditional PERS devices.

If a suspect activity is detected, the event is analyzed in the cloud for features, such as acceleration impact peak, rotation angle, and vertical and horizontal movement components, along with more than 100 other features. They are then compared to standard models of falls in order to determine whether a call needs to be initiated to the care center and a case manager notified.

ENGAGING THE PATIENT

Developments in mobile technology are also going "social," making it easier to engage the individual as well as enlist the support of their extended care team, including friends, family and peer groups. Not to be confused with the myriad of health and wellness game-type apps, a new class of mobile applications combine the science of behavior change, objective and subjective health measurements, and the individual's social circle – who provide support, encouragement and promote accountability – for lasting behavior change.

Typically, chronic condition management involves just the physician and the patient, and relies heavily on the individual's initiative and determination to adhere to a treatment plan. The patient leaves the physician's office with a plan to exercise, eat differently, monitor their blood pressure and check back with the physician – and the patient follows the plan until their motivation wanes. This program fails to include the primary influencers in the individual's life – their friends, family and peer groups.

A key component to sustainable change is including these influencers in the activities specified by the physician and the ability to provide immediate feedback. The new social and mobile applications provide a medium in which the patient and their caregivers jointly set goals, create a plan to meet those goals, measure their progress against the goals, and learn to self-manage and engage their social network to participate with them, adding a dose of fun to drive ongoing participation. Plans can be created to address a specific condition and couched in a friendly way. That is,

continued on page 30

Where Are Your Papers? A Movement to Prepare Seniors, and Caregivers, for End-of-Life Issues

BY CYNTHIA J. FINCH, LMSW, CCM, CMCE

As the world changes, so does the neighborhood. And just what is the neighborhood? It's more than just the folks that live across the street. More than just the friendly faces at the grocery store. It is all those factions that are a part of your life when things are going downhill and you don't want to admit that your loved ones are declining.

These are the thoughts I have had for some time now. As an African American healthcare professional, working in the arena of end-of life-care, I realized that I had to take quick action to educate my neighbors about end-of-life issues. Especially since so many of them are a product of the baby boomer generation.

To that end, in 2010 I started talking to everybody I knew about getting their end-of-life situations in order, in case the unexpected happened. Initially they would say, "Oh, Cynthia, we're too young to think about those things. Stop talking like that. You're scaring me."

It turns out I was having my intended effect – I meant for it to shake them up and knock their socks off. I talked to anyone that would listen to me about organizing their personal affairs. My efforts were to prevent their loved one from having to search high and low in their house to locate things to handle their personal affairs, in the event of a death in the family.

As I talked to my neighborhood, I realized that African Americans were far less likely to discuss their affairs with their children or others significant members of their family. Many die and the family would find that there's no insurance money to bury them or their finances are not in order.

DO YOU KNOW?

One of the most frequent statement made when someone dies is, "Do you know where their papers are?"

In an effort to educate the neighbors in my community I began to hold workshops, set up tables at churches, provide education at health fairs or any place I could to tell people about getting someone to be their healthcare agent or healthcare power of attorney (POA). This effort, which began as a simple "moment" discussion, has turned into a movement.

By 2015 my goal is to have 10,000 people in my community with a plan that lays out their wishes in the event they are unable to make decision for themselves. In most state there are rules and procedures for completing a living will, designating someone to be your power of attorney for healthcare and putting someone in place to carry out your plans when you die.

"THE OLDER GENERATION WANTS TO MAINTAIN THEIR INDEPENDENCE AS LONG AS POSSIBLE."

A PERSONAL ACCOUNT

My mother is 84 years old. As her health declines and she becomes more and more dependent on others to assist her, I know that my family one day will have to face making decisions for her. At every holiday family gathering I bring out a book on power of attorney. This book contains power of attorney forms for healthcare. Just this simple effort has allowed my family to have an open discussion about end-of-life issues. My mother once said "I pray that I will just sleep away." That was a comforting statement for me and I said, "I hope I just sleep away too one day." The older generation wants to maintain their independence as long as possible.

Therefore, my movement, "Where Are Your Papers," is a method to create a proactive approach to having your affairs in order. It is a way to get families, your neighbor and community to have a discussion about end of life. Community outreach is a way to include everyone in the process. It does not single out one person and it is not a threatening thought.

"The future depends on what we do in the present."
–Mahatma Gandhi

Here are some steps to take to make sure someone knows where their papers are.

1. Get a box and label it with all your important papers. Tell someone where it can be found in your house.
2. Have a family meeting to discuss end-of-life issues about everyone in the family. That way no one feels pointed out.
3. Appoint someone to be your healthcare power of attorney. This allows the appointed person to make sure your healthcare decisions are carried out.
4. Complete a living will. This is to ensure that your healthcare wishes are followed.
5. Make out a will. In some states a will written in your own handwriting will hold up in court. Some feel more secure by having an attorney to make out a will.

Each year, National Health Care Decisions Day is celebrated. It is a movement that encourages people to plan ahead, be involved in their own lives and direct their future by making decisions in advance.

Join our movement, "Where Are Your Papers." It will make for a happier ending. CIP

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Caught in the Middle: The Precarious Position of the Sandwich Generation

A firsthand account describes the life journey of a family's care experience

BY BARBARA HUETTIG BIEHNER, FACHE

Never in my wildest dream could I have imagined I would be faced with caring for my parents while still raising my college-aged daughter and working my way through unknown territory in healthcare. Why is this a surprise? Because I am a former healthcare executive with over 25 years of experience in management and I should know enough about healthcare to take care of them. But I didn't have any idea what to do.

I now realize that no one prepares you for this time in life, this new responsibility – even with well-educated parents who have carefully planned out their retirement. They took out long-term care insurance years ago and retired in a comfortable financial position. But I think they honestly believed they would be able to stay in their house forever, with a safety umbrella overhead covering them. So here is the story.

TRAVERSING NEW TERRAIN

Let's start from the beginning – when life changed for all of us.

Dad had a knee replacement in May of 2010. This marked the first time he had ever been in the hospital in his entire life. At the time he was 84 years old. Our first surprise was that he was treated for diabetes upon admission, perhaps more of a precaution but something both my mother and I were surprised to learn about. We also thought he was having both knees replaced but were told that they had planned to do only one due to his health issues. What health issues?

In any event the surgery went well. When he awoke from the surgery he was confused and disoriented. I spent the night with him because he was agitated and wanted to get up and go home. While we could expect some of this confusion post-surgery, with anesthesia and medication effects, it was far more extreme than anticipated. It was the weekend at the time, and extra monitoring was not available due to limited staffing, so I stayed. He was transferred to rehab in a few days where he stayed for over a month. He had limited interest and no initiative to work on rehabilitating his knee.

Now looking back both my mom and I would say – he was never the same after this hospitalization. We have since read articles about the impact hospitalization can have on the elderly and that it can speed up the decline of Alzheimer's patients. But Dad did not have Alzheimer's. Little did we know then – he had something related.

For months after his hospitalization and inpatient rehabilitation, we noticed Dad was not himself. His motivation to continue his rehab at home was nonexistent. He did not initiate any activity or interactions. His personal hygiene was not important. This really shocked us. My father was a brilliant business man with great pride in himself.

Other aspects, such as social skills, remained intact. So most outsiders did not notice any change in his behavior. His visits to the doctor were uneventful as he told his physician of 30-plus years that he was "fine." No one suspected anything. Little did we know, he was compensating for his condition. But I could tell he was not the same. While everyone attributed his situation to "advancing age," I knew there was more to it.

They carried on as they had for years. Spending several months at their vacation home. Traveling back and forth – with more and more assistance needed. He could no longer walk long distances. From sitting around, his leg muscles had atrophied. He refused to do any exercises, except when he was at therapy. He preferred to sit on the couch, watch TV and nap on and off all day. Is this really my father? Avid tennis player and golfer in former years, now a couch potato?

He had not driven since the surgery. So Mom took him to his appointments. He used a walker, as a cane was not enough support. He began to have incontinence problems and started going to see a urologist. One time he could not make it back to the car after the office visit, and he fell on the sidewalk. According to my mom he went down gently, but it was one of many falls to come. Mom is tiny – Dad is a big man. Mom cannot pick him up; with his new knee and weak muscles he cannot get himself up.

As his medical power of attorney and only daughter, I took it upon myself to join him at one of his doctor visits. Sure enough, he expressed to his physician that he was "great for an old guy." I interjected that he was not doing as well as he described and told him about his fall and other issues. This marked the first time his physician knew there were any problems. My dad was irate – he told me to mind my own business, that his doctor did not need to know those things. Fortunately Dr. S. told my dad he was interested in what I had to say. So, from that visit we found out he had a urinary tract infection (UTI). And Dad was tested for sleep apnea. Those tests revealed he stopped breathing once every minute. Long story short, he does not like the equipment and does not use it, but the lack of oxygen is not helping his mental capacity.

Rolling forward a few months, Dad had ongoing issues with UTIs (chronic) and limited mobility. But he insisted he was going to drive soon. (To this day he insists he will drive soon.) Mom cared for him as her primary focus in life – their social outings were limited and became more difficult. He could not manage the stairs in their two-story home so he moved into a bedroom on the first floor. Mom slept upstairs. His world was getting smaller. When at their vacation home his movement was from bedroom to dining and den. His incontinence continued to progress, and began wearing Depends, first at night then all of the time. Is he really aware of what is happening to him? This strong-willed, suc-

cessful man is now in a diaper and peeing on himself. He was getting annoyed and agitated when Mom asked him to take a shower or change clothes – or do anything.

TAKING A TOLL ON ALL PARTIES

During this time, I used up about five years of sick time to help my parents. Traveling to where ever they were, helping out with whatever the issue (crisis) was at the time. Dad was obviously not getting better. His physician had noticed a decline but no treatment was prescribed. (I am not writing this to say something negative about my parents' physician. He has cared for them for decades and has their best interest at heart.) What we now understood was that Dad did not tell his doctor what was going on – and his social skills and intelligence kept everyone from noticing his decline mentally. Only the physical deterioration was obvious. I was starting to believe Dad did not realize that there were any problems and he was going to get better once his knee was better. But the knee was fine, had been fine for over a year – his weakness in his legs and his instability had nothing to do with the new knee.

What we suspected was dementia. What we learned is that bladder infections (UTIs) can cause mental disorientation in patients with dementia. They exacerbated his condition, leading to symptoms like being forgetful, disoriented, confused, unable to carry on a conversation, always sleepy. But no diagnosis was confirmed. Just old age.

Dad continued to have falls. Mom called the local rescue squad on a regular basis to come pick him up each time. In the meantime, Mom was losing more and more weight and having some health issues as well. So then I began to worry. Dad was declining mentally and physically and it was going to kill my mom. At this point I think she was somewhat in denial as she had always taken care of Dad. But a hurricane, 20 inches of snow and long power outages in the northeast finally convinced her that living in their home was not going to work long term. One time, I had to ask the police to check on them because they had no power, phone, cell phone, for days at a time. We had to do something.

I began to communicate my two brothers, who were also concerned about Mom and Dad. They both were willing and eager to help. The challenge was what to do. Geographically we were as far apart as we could be – California, North Carolina and Massachusetts. With Mom and Dad also in the northeast but five hours away at a minimum from any of us, no one could check on them regularly. And with busy careers and families, no one could care for them. What to do? I had spent five years of accumulated sick and vacation time in about a year to help them. My time was running out, as I am sure was my employer's patience.

> "WE BEGAN TO WORRY WHEN MEDICARE WOULD DECIDE HE WAS NOT MAKING ANY MORE PROGRESS AND WOULD DISCHARGE HIM. WE NEEDED TO MOVE HIM SOONER RATHER THAN LATER."

It was decision time. With all of us siblings working, no one would be willing nor able to move to live closer to Mom and Dad. So the decision was made to bring them down to warmer weather – to me. So I began to look at retirement communities. Found the perfect one, with all levels of care available and beautiful accommodations. It is a nonprofit community focused on serving the elderly. My daughter and I were ready to move in ourselves. I shared all of the research with my siblings via email and phone calls.

In the meantime back at their home, Dad falls again and is hospitalized for another UTI. Clueless to his physical and mental condition and not appreciating that his needs are getting greater, Dad believed he was fine and he did not need any care. After a short stay, they move him to rehab. He made little progress on gaining strength and was confused about where he was.

It was time to intervene. I had been talking with Mom about moving down close to me and we discussed the concept of an assisted living community. It made sense to be in one, starting in "independent living" but having all levels of care available when needed. She realized it was time to sell the old homestead and move on. Meanwhile, Dad was still insisting he was going back home and would soon be able to drive and go fishing. He would never leave his home. But when asked, he was not sure where he was or what day it was. We began to worry when Medicare would decide he was not making any more progress and would discharge him. We needed to move him sooner rather than later. Our decision was to get him into rehab in North Carolina. So the transition began.

With help from my daughter and a friend, we transported Dad down to North Carolina to the rehab portion of the retirement community, Davis Healthcare, in Wilmington, N.C. He was clueless as to where we were going and why. Mind you, we explained it to him over a dozen times during the 11 hour trip. He also kept insisting it was his turn to drive – but he did not know where we were or where we were going. The road trip was successful as we delivered Dad to rehab that same day. Mom stayed back in New Jersey to start getting the house ready to sell.

As with all other interactions, I continued to email my brothers to keep them up to date on what was going on. As the medical power of attorney it was my responsibility to keep everyone informed, but the burden of the decisions and moves was mine. While I welcome the opportunity to help my parents it became overwhelming with the other responsibilities I had in my life.

FINALLY, A DIAGNOSIS

Dad was been in rehab for five weeks and Mom started the process to move down to N.C. My daughter and I cared for "Grampy," daily visits, bringing treats, keeping a log of visitors, laundry, etc. Often he asked for Mom – confused as to where she was, as well as where he was, among other things. His therapy treatments went well. He received speech, occupational and physical therapy related to his physical strength as well as his safety and coping skills. When the sessions were over he was back to his room to sleep and read the same pages of the book he started a month ago. Why wasn't

he improving mentally? In consulting a friend who was a neuropsychologist we finally had the diagnosis we were expecting.

We learned Dad has dementia – frontotemporal dementia. Until we brought him to N.C. and had the neuropsychological evaluation, as well as a mental health assessment from the resident gerontologist, no one has diagnosed him with this debilitating condition. His problem solving, sequencing and reasoning skills have become nonexistent. He became a safety risk to himself and to Mom. His social skills could no longer compensate for his limited capabilities. A wheelchair became the only safe way for him to get around as he continued to be unstable on his feet and utilized poor judgment about his ability to walk. Dad basically needed custodial care and Mom could not do it on her own. To maintain his dignity and spirit, we have decided the best way to care for Dad in the short term is to have a controlled environment but continue to have some independence. We did not believe he was a good candidate for assisted living (not enough oversight) nor skilled care (he is too functional for this right now) – so living with Mom and having in-home care is the best, but not optimal, option.

As for the aforementioned agitation – the physician explained to us that men do not show depression in the ways we expect someone to. They show it through their irritability. So we realized he was also depressed. We discovered he had made investments in some risky oil futures, some of which could be scams. Nothing we could do about this now, but I began to wonder how far back the signs were for the changes in his judgment.

Our journey has just begun. It will require additional caregivers and resources. Mom and I began taking it one day at a time; we were making arrangements for his discharge back to Mom's care, supplemend, of course, with home care and family assistance (primarily me). We began reading and researching. One thing we read repeatedly was that it is often harder on the caregivers than on the patient. Little did we know.

"IT ALLOWS A CAREGIVER TO KEEP ALL OF THE ESSENTIAL INFORMATION AND DOCUMENTS VITAL TO THE CARE OF THEIR LOVED ONE(S) IN ONE SECURE LOCATION."

Reality hit that I will now take on the task of overseeing their care and living arrangements for the foreseeable future. I lost a lot of sleep, wondering if we were doing the right thing – and what is next. Reality hit hard again as we were told Dad needed so much care on a daily basis that he could not live with Mom in the independent living portion of the community. So their lifelong dream of remaining in their home together became just that, a dream. Dad was moved to the assisted living building and Mom moved to an apartment across the campus. This was not what we planned. But we knew we did not have a choice and we did not know how Dad's condition would progress. Their home was put on the market and sold – their 60 years together in their own home, 35 in their current home all placed in boxed or given away to charities. Gone.

In the meantime I began to look for ways to simplify and organize my world. I knew I had to be organized with their personal and medical information along with my own. And that I had to be a better communicator with my siblings. I was very fortunate to be introduced to a couple in a similar situation. They had been caring for their parents for several years and experienced much of what I was just a neophyte in learning. They shared with me their journey and the tools they developed to help them as caregivers.

In order to coordinate all of the care and communication, they introduced me to a web-based application that they developed. It allows a caregiver to keep all of the essential information and documents vital to the care of their loved one(s) in one secure location. This way I have all of their documents, medical information, caregiver resources, medication management and basic information that I need in one place. It also means that I have the tools and resources necessary to manage their care in a confidential manner. And my brothers have access to the information and can be remotely involved and remain up to speed on our parents. The company is called Monarcares (www.monarcares.com). I encourage caregivers and family members alike to consider something like this to manage their responsibilities in the simplest and safest manner.

So what is next? Simply put, taking it one day at a time. I am taking patient advocate training so I can help others in the same situation. Hopefully it will help me care for my parents as well. My parents are fairly settled in their respective places. Dad is bored and we worry about his limited physical and mental activities. He falls often and is pretty much restricted to his wheelchair. He plans on driving and playing golf again soon. Mom is lonely and spends most of her days sitting in Dad's room while he naps. She has joined a few activities such as a knitting group and volunteers within the complex. I try to find things we can do together like going to baseball games at the local university where I work along with other events going on in the community. I have neglected to mention that I also have a 17-year-old high school student and a 22 year old about to graduate from college. Now I understand what it means to be in the sandwich generation.

I feel guilty that I moved my parents from their home and away from friends (the few that are left) to bring them to a place that they barely knew. But I know I did the right thing. CIP

After successful completion of her first career as a healthcare executive, **Barbara Huettig Biehner, FACHE**, serves as an executive in residence at the University of North Carolina Wilmington's Cameron School of Business where she teaches management as well as career preparation courses. Contact: biehnerb@uncw.edu

Become Your Own Best Caretaker: Exert Your Personal Power to Thrive

BY LORI CAMPBELL

In the past, when disease was not physically evident at the time of a person's death, "old age" was an assumed diagnosis. Today, physicians are no longer allowed to list "old age" as a cause of death – instead, they are required to list the immediate causes of death and the conditions leading up to it. Aging is not a disease or a disability; people of all ages encounter disease and disability. According to the National Council on Aging's Center for Healthy Aging, "Chronic disease, illness, and disability are not inevitable consequences of aging, but in fact can be prevented or delayed."

Despite medical advances, our youth-obsessed Western culture still expects young people to thrive while older adults are expected to merely survive. Isn't it ironic that our medical advances allow people to live longer lives, yet they are not celebrated or supported as active and valuable members of society in old age? And so it is – what we expect is what we get. People come into their later years believing in negative stereotypes associated with old age, and as a result they live out those ingrained beliefs.

All too often, healthy older adults are socialized into a passive, dependent lifestyle, which requires them to live on someone else's terms rather than their own (and makes them easier to "manage"). Young and old have fallen into the trap of thinking late life is a time to be "taken care of." Caretakers fall to this logic, too, believing their job is to "take care of" rather than "walk alongside" and empower older adults. While this philosophy might have been borne from good, protective intentions, it has gradually undermined the real possibility for older people to practice autonomy and independence in late life.

Older people still need, want and are capable of living a vibrant, healthy, purpose-fueled life. The reality is that the quality of life for young and old alike greatly relies on positive perceptions. I know 90 year olds who are thriving and 40 year olds who are merely surviving. The potential to thrive is independent of age – it's dependent on thought.

SEEKING A NEW WAY

I created the movement of AgePotential, a mission to shift our culture's perception of aging. AgePotential promotes the development of new expectations, leading to a culture of people who expect and plan to live happy, healthy and fulfilled lives regardless of chronological age. AgePotential is a catalyst for societal change in our perceptions and treatment of the elderly.

The AgePotential movement must begin within each person individually exerting the power within themselves to thrive at every age. The first step to exerting your personal power to thrive is to address your belief system around aging, because we cannot achieve our full potential without consciously realigning our beliefs and letting go of the stereotypes. This can be difficult to do and easy to overlook, because these stereotypes are most often held unconsciously.

For the most part, beliefs around aging are steeped in myth rather than truth. One of the most pervasive myths is that we are victims of our genes. We know from Bruce Lipton's research in the science of epigenetics as well as the findings of Dr. Dean Ornish's research at the Preventive Medical Research Institute that our genes are our predisposition – not our fate. We all have both healthy "good" genes and diseased "bad" genes. What activates a gene in either direction (toward either disease or prevention) is how "healthy" or life-enhancing our thoughts, beliefs, perceptions, emotions and lifestyle choices are. Our thoughts motivate our actions, and our actions motivate our results. Our thoughts truly are the catalyst for our life experience.

We unknowingly give away our power when we resign ourselves to the belief that the power to age well lies outside of us – in our genes, doctors, medications or circumstances. The real power lies within. Your inner perceptions and expectations of yourself are the number-one influential factor in your health and aging journey. Think of it this way: Your quality of life is dictated by 10 percent genes and 90 percent lifestyle and mindset.

REDEFINING AGING

To help move beyond assumption and misconception, I'd like to discuss the three distinct ways of measuring aging: chronological age is measured by the calendar; psychological age is measured by how old you feel; and biological age is measured by the state of health of your cells, tissues, organs and telomeres. The majority of us are fixated on our chronological age – the only measure of age that we can't possibly change. The power to affect our potential to thrive lies in their psychological and biological age – both of which we can change by changing our thoughts, which will result in changing our actions.

Beliefs, perceptions and attitudes about our lives have proven to affect health and well-being down to a cellular level, known as the science of egigenetics. Epigenetic research shows that we are capable of changing the readout of our genes, the control above the gene.

A study cited in the ***International Journal of Neuroscience*** states that meditation lowers biological age over time despite the continuous process of chronological age. On average, meditators have the biological age of a person five to 12 years younger. It is therefore not surprising that some researchers conclude, "meditation reverses aging."

Another marker of biological age is telomere length. Telomeres are the protective end caps of our DNA chromosomes.

Long telomeres are ideal, and indicate a lower biological age. According to Dr. Elissa Epel and other researchers at the University of California, the rate of telomere shortening is affected directly by psychological influences, such as emotions and stress. Researchers liken it to our cells "eavesdropping" on our thoughts and emotions. Every cell in your body is aware of how you think and feel about yourself. Most people are aware of how important diet and exercise is to their health, but are unaware of how equally important it is to be mindful of thoughts, beliefs, perception and emotions. The ability to live healthy, passionate and purposeful lives is not dictated by age but rather by awareness, intention and action.

Now more than ever, boomers and subsequent generations want their second-half of life to be as vibrant and healthy as their first-half of life. Healthcare professionals are for the most part surrounded by illness, disease and dependence; however, this does not have to be your aging experience. As healthcare providers you are naturally tuned into caring for others who are "sick." Without intentional reflection and redirection of your thoughts it would be easy to "think" and "believe," at least subconsciously, that disease and disability are a natural progression of life. The research clearly states the body-mind -spirit can maintain health and vitality into old age. Disease and disability are not inevitable, and we are not victims of the aging process.

My challenge to you is to begin being your own best caretaker by nurturing a proactive, mindful approach to your health and aging journey. Go on a radical philosophical diet – I am not referring to food, but rather thought. Abstain from using your age as an excuse or a limitation in how you perceive yourself and your potential. Remember: your thoughts and perceptions drive your action, and your action drives your reality. Make an effort to continually heighten your awareness, and remember that what you see around you is not the ultimate reality. Pay attention to your self-talk and what your body is telling you. Do you tell yourself that you have a purpose? Do you allow yourself to engage in your passions? Do you believe you are worthy and valuable? If you answer "no" to any of these questions, it is time to reinvest in your psychological health. Exert the power of control you have over your mind and body; your health and quality of life depends on it.

Because of our mind-body connection, our bodies follow our minds' lead. Neuroscience tells us what we put our thought-energy on will become our reality. What is your mind telling your body? Are your thoughts and beliefs rooted in myth or truth? What are your expectations for yourself – to thrive or merely survive? Take the time to realign your mind, and your body will follow. CIP

Lori Campbell is a gerontologist, author and speaker with expertise in wellness and aging who helps people master the art of aging. She is the author of ***Awaken Your AgePotential***. Contact: lori@agepotential.com

A Beautiful Choice: Living, and Dying, With Dignity

BY RANDI REDMOND OSTER

The fact is Medicare spends nearly 30 percent of its budget on beneficiaries in their final year of life, with approximately half of Medicare dollars spent on patients who die within two months. Yet, given a moment of hope from the medical community, it's hard to say no to treatment. But sometimes less care is truly more.

I brought my 79-year-old father to the emergency room because to me it looked like he'd had a stroke. After 11 hours of waiting in the ER and undergoing a CT scan, an attendant brought him up to a room. The diagnosis was a brain tumor called a glioblastoma. It is like tree roots growing throughout the brain. All I wanted was for my father to be fine. He and my mom lived with us and took care of the kids while I worked more than 50 hours a week for a large company and while my husband worked as a hospital administrator. I was the major breadwinner of the family and felt the pressure of the "sandwich generation." I tried to balance corporate demands, children's demands and elder care, while keeping my husband happy. Sometimes, my life felt like a house of cards and a feather could take it down.

With my father sitting in his hospital bed, he told me he just wanted the facts about his prognosis and asked me to help him get them. My mom just held his hand and tried to hide her tears, as I stared at them both in a daze. My cell phone rang and brought me back to my work reality. It was my manager. I told her I was in the hospital with my dad. She, too, had been through medical emergencies and in unemotional corporate speak, she told me the best advice ever:

"Randi, the doctors will only answer the questions you ask. They will not give you more information than you request. Don't be afraid to ask the hard questions." Before she hung up she told me to take care of my dad and that she'd handle the work stuff. I felt so appreciative of her support. Now I just had my family to manage, at least for a day.

As I hung up the phone, a young female resident surgeon was meeting with my father, telling him the doctor told her to tell him they scheduled brain surgery for the next day. The caliber of her education meant to me that she knew surgery was the best next step; otherwise wouldn't we be discussing other options?

All day my dad kept saying he wanted a "minimally invasive approach" and did not want chemo and radiation. He kept saying this to anyone who'd listen but no one seemed to actually be listening, not even me. Lying in bed, he looked up at me almost as his last resort and asked again, "Can you please find out what the surgery entails?"

> "THE DIAGNOSIS WAS A BRAIN TUMOR CALLED A GLIOBLASTOMA."

IN A FLASH, ROLES REVERSED

My parents, who just yesterday seemed perfectly fine, were in the middle of a medical crisis. Nothing really prepared me for it. I was their "little girl." Our roles reversed in that instant. Still in shock about the quick turn of my dad's health, I held back my tears. "Sure," I said.

I grabbed another tissue and stepped out into the hall. I shut my dad's hospital room door and braced myself against the wall for support. The doctor's imposing frame next to my petite build was not ideal for level conversation, something I had learned was critical during negotiations. I always looked for chairs to sit in to level the height disparity. But there were none in the narrow hall. The doctor had no choice but to look down on me. Instead of gaining control by acting calmly, showing poise, and introducing myself to the doctor, I skipped that step. Instead, my own pushy New York ways combined with my boss's suggestion to ask the hard questions made me just blurt out, "How long will he live without surgery and how long with surgery?" I could not believe I was asking such a cold question. I felt a lump in my throat, and touched the wall with both hands behind my back.

The doctor smiled, as if he was proud he knew the answer and said, "Simple. Eight weeks without surgery and eight months with surgery." He continued with the fine print speech. "There is a very good chance with brain surgery he could experience some paralysis on one side of his body. He might have trouble speaking. He probably won't see colors. Also, he'd still need chemo and radiation. He'd be home with the family so you could provide care at home, take him for treatments, and help him with pain from surgery."

That is exactly what my dad wanted to avoid. Why would they have scheduled this surgery without listening to him?

Asking the hard question first really told me the critical information: eight weeks vs. eight months. "So," I said, "without surgery he could go home, have no additional pain, meet with his friends and family and slowly deteriorate. He will eventually fall asleep and not wake up. With surgery, he could be a vegetable, but maybe not. But he definitely will have pain and need after care, starting tomorrow?"

"Yes, but don't forget he'll also have time for one last cruise," the doctor said, sounding like a salesman. ***One last cruise*** reverberated in my head. My father should go through all of this pain for one last cruise? In the couple of minutes the doctor spent with my dad, he clearly did not know him. After the Navy, my dad never wanted to go on a ship again.

As I was leaving the next day, a resident pulled me aside in the hall. "I got to know your dad last night," he said. "He's a remarkable man and brave to make the choice he did." He hesitated and whispered, "You know, the doctors get $15,000 for the surgery and then it's $3,000 a day for after care. They don't tell you that."

We took my dad home. At the beginning, he was fully mobile. I invited his friends and relatives to the house and we spent the weekends laughing over old photo albums. He had time and brain capacity to impart all his life wisdom to me.

"Come here," he said.

"You seem fine. Can it wait?" My terseness was in direct proportion to my pressure for meeting the work deadlines.

"Randi, get me a piece of paper and a pen." He said this firmly and I stopped touching all the electronics and grabbed the paper.

"Write this down: 'Your life is more than your job.'" I wrote, as instructed, in big letters across the paper.

"Now, give me the paper," he said.

I handed him the paper and watched him scratch out his signature. It was clear the brain tumor was progressing because he struggled to write his name – Eugene V. Redmond. He handed me the paper, with his chicken-scratched signature, and we just looked at the paper and hugged.

As the days progressed, he lost movement in his legs. He needed assistance peeing. I know he was ashamed to have me hold the plastic jar for him, my strong capable father. By week seven, he was "shadowing." He needed care 24/7. Between my husband, my mom and me we all did shifts. We kept him home until we were unable to care for him but visited the hospice every day.

On the fifth day, he was close to the end without pain. My mom and I decided not to leave his side. We sat in the room reading magazines and chatting, sometimes our reminiscing even made us laugh. I looked over at my dad and saw a slight smile. Suddenly, I had this feeling as my mom and I continued leafing through magazines. Nothing changed in my father's breathing, nothing changed in his position, nothing changed in his facial expression, but I felt drawn to him. I walked over to him as he lay on the bed. "Mom, come here," I said.

"Why?" she asked.

"Just come here, now," I gently urged, wanting her to stay calm.

She put down the magazine, and got up from the chair and walked around the bed to see my father's face.

"Kiss him and tell him you love him." I gave her clear instructions.

"Now? Why?" she said.

"Just do it," I encouraged.

I kissed him first on his forehead and then my mom leaned down and kissed his cheek and said, "I love you."

He took one last inhale. At that moment, he stopped breathing.

"What happened?" she asked, seeming a little confused.

I took my dad's hand and my mom's and just felt the moment and let my father lovingly pass. Deep down I do not believe my knowing the exact timing of when to say our final goodbye was a coincidence. I was overwhelmed with gratitude. Eugene Victor Redmond, my father, lived and died, with no pain and dignity. CIP

Randi Redmond Oster is a writer, electrical engineer and sandwiched-mom. Today she is a leading speaker on healthcare reform. Her passion stems from her personal experience caring for her son's chronic disease – Crohn's. After spending a month advocating for her son in the hospital, Oster experienced first-hand the need for loved ones to understand the system prior to a crisis. Contact: www.randiredmondoster.com

continued from page 18

cent in the next decade. There will be a lot of large companies expanding through acquisitions of smaller, locally managed agencies, along with hospitals getting involved to help senior care remain local. The bottom line is clear: we need more senior caregivers to meet the rapidly increasing need, and innovative programs will need to be developed to deliver quality caregiver training. CIP

Source: From Caregiverlist.com subscribers and senior care franchise corporations.

In 2008, **Julie Northcutt** launched Caregiverlist.com, the premiere service connecting seniors and professional caregivers with the most reliable senior care options. Caregiverlist.com not only provides the most reliable senior care options, but also the highest quality ratings of long-term care communities and outstanding careers nationwide. Contact: julie@caregiverlist.com

continued from page 21

instead of an individual embarking on a hypertension program, it could be referred to as "100 Days to Lower Blood Pressure." Particularly for boomers, the benefits of these social applications go beyond treatment adherence; they also provide an avenue to maintain social connections, which are essential to healthy aging.

When coupled with current information from health monitoring devices that communicate readings on measurements, such as weight and blood pressure, these social applications provide the extended care team with valuable insight to the individual's progress between office visits. The data, which can be uploaded from a variety of health-monitoring devices, is fed through a utility service to the patient's electronic medical record and then to the social platform where it can be shared with the extended care team. With this near real-time data, individuals can track their own progress, care providers can monitor for compliance, and they can course-correct if needed, even before the next office visit.

ALL ABOUT CONVERGENCE

Recent innovation in healthcare is all about the convergence of elements in support of healthy aging: safety, technology, user experience, engagement and feedback. This convergence is enabling individuals and those around them to play an increasingly active role in the management of their own health. Ultimately, healthy aging relies on the individual to adopt and maintain healthy behaviors, supported by their care team and augmented by mobile health technology, advancing quality care, anywhere. CIP

Tim Smokoff is the CEO of Numera, enabling its partners to expand their own version of "Care Anywhere" through custom-branded solutions that support healthy aging, chronic conditions and post-acute care. Contact: tsmokoff@numera.com

A Song of Strength: 'Heroines Choir' Faces Down Breast Cancer

How an arts movement delivers strength to cancer 'victors'

BY ALICE BILLMAN

Across America, countless friends, family, co-workers and mothers are shattered by their breast cancer experience. Some, close to me, lost the battle. I felt an urgency to use the powerful tool of the arts to return these women to a sense of complete beings.

Using my nonprofit agency, Heroes Unite, which for the past 13 years has been dedicated to empowerment through the arts, a new project was inspired: The Heroines Choir.

Heroines, by definition, are women of courage. I choose not to call them survivors. They are women who have confronted their mortality and gained a new perspective on living steeped in appreciation borne of heroic perseverance. With that in mind, I prefer to call them victors.

TRANSFORMING LIVES

I have successfully used arts programming to enrich the lives of at-risk youth, HIV patients, terminally ill children and domestic abuse victims for more than 15 years. While the measurable outcomes speak for themselves, it is the individual stories that make you realize that everyone holds the power within themselves to heal and improve their quality of life.

It is no secret that singing is inspiring. There are countless research studies dedicated to justify its benefits. But if you just whistle a happy tune, those million dollar studies prove what you already feel in your heart and know in your spirit – something simple yet profound.

The women who have joined The Heroines Choir can all testify to how this project is fulfilling its mission to heal, empower and inspire. In our inaugural year of 2012 we performed for over 30,000 people at three events. With our pink satin capes, big smiles and fun-filled repertoire, we poke fun at ourselves and rejoice in our transformational ability to defy death and claim victory. The funny thing is, these women are not professional singers. Most could barely match a note.

But with patience, love and lots of helpful materials, they are trained under the guidance of our choir director, Candi Tandy (also a victor), to retain choreography, lyrics, timing and notes they never thought they could hit. Many of the women get to realize their childhood dreams of being on stage, while building confidence, harnessing a camaraderie of spirit, and strengthening bodies and minds. This is the glory and benefit of participating in chorale.

Overall, our goals extend beyond the cancer community. This is a concentrated self-empowerment program. Each heroine, with a chosen cause behind her, can experience immediate and powerful results.

"THOSE MILLION-DOLLAR STUDIES PROVE WHAT YOU ALREADY FEEL IN YOUR HEART AND KNOW IN YOUR SPIRIT."

A SENSE OF COMMUNITY SUPPORT

Every program Heroes Unite sponsors relies on the same philosophy of helping others to help themselves. A key aspect of our mission is to impact public perception about arts and healing. Just the words "breast cancer" induce a sense of morbidity. Going to support groups to recruit women was so depressing for me. I understand that the opportunity to vent and gain information on how to navigate the medical industry is important, but often I found women stuck in a mental cycle of victimization. The Heroines Choir is a different type of support group in that we are all proactive. Our efforts to learn, share and give back all induce joy, which heals.

We meet twice monthly and commence all practices with a half an hour of Chi Gung exercises and meditation as an additional component of our alternative therapy. There's nothing like increased oxygenation coupled with improved self-esteem and the joy of creative expression to turn one's health and life around. Not only for breast cancer victors, but for anyone.

The Heroines Choir also serves a third function. With our eye-catching capes, infectious smiles and positive repertoire we become spokespersons for awareness, arts empowerment and powerful holistic therapy. Wherever we sing, we shine the light of true humanitarianism. Our marketability to participate in live arts and cultural performances is a natural fit and our impact is always positive and memorable.

With more and more patients seeking alternative modalities to treat disease, the medical industry is slowly recognizing and incorporating these proven methods.

The Heroines Choir's long-term goal is to be sponsored by a national medical group that supports alternative therapies and the arts as viable modalities for healing. Eventually creating subdivisions within cities around the country, we will develop a national repertoire to share at conferences on alternative therapies, women's empowerment, art therapy and myriad related topics with our songs of passion, joy and victory. We are currently recruiting and welcome heroines and their supporters throughout the year.

We are currently seeking support for our steering committee to accomplish goals like hosting our first luncheon, entitled "Alternative Therapies for Breast Cancer," where we will feature lectures on thermography and Chi Gung by respected leaders in their field. We will entertain with a Chi Gung/Tai Chi demonstration and, of course, the heroines will sing songs of joy and inspiration. We hope to see you there. (For further information, visit www.HeroesUnite.org and click on "Heroines.") CIP

Alice Billman is a seasoned professional in the realms of theater, direction, administration, production, grant writing and program development. Web: www.heroinesmiami.org | Contact: heroinesmiami@gmail.com

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