Age Like You Mean It!℠
Planning for the Second Half of Life.

RESOURCE BOOKLET

ELDER LAW & LIFE CARE planning center

a practice with purpose

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Online Resources

National Adult Protective Services Association http://www.napsa-now.org/

The National Adult Protective Services Association (NAPSA) is a national non-profit 501 (c) (3) organization with members in all fifty states. The goal of NAPSA is to provide Adult Protective Services (APS) programs a forum for sharing information, solving problems, and improving the quality of services for victims of elder and vulnerable adult mistreatment. Its mission is to strengthen the capacity of APS at the national, state, and local levels, to effectively and efficiently recognize, report, and respond to the needs of elders and adults with disabilities who are the victims of abuse, neglect, or exploitation, and to prevent such abuse whenever possible.

National Center on Elder Abuse https://ncea.acl.gov/

The National Center on Elder Abuse is dedicated to educating the public about elder abuse, neglect, and exploitation and its tragic consequences. NCEA is an internationally recognized resource for policy leaders, practitioners, prevention specialists, researchers, advocates, families, and concerned citizens.

Elder Justice Coalition http://www.elderjusticecoalition.com/

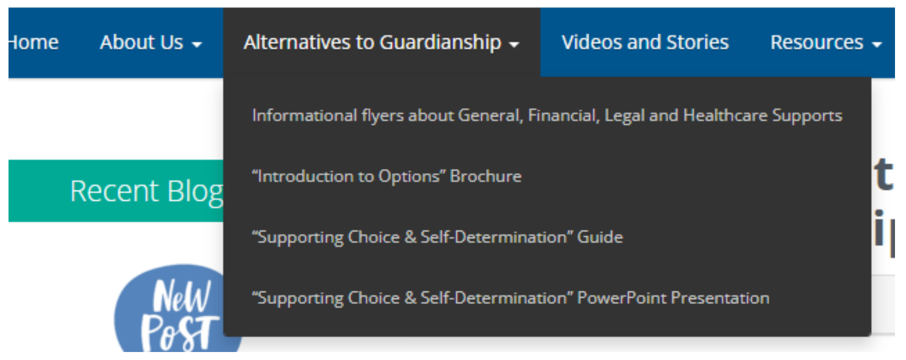
The Elder Justice Coalition, through national and grassroots advocacy, educational briefings, media outreach, research, and information dissemination seeks to:

- Increase public awareness of the tragedy of elder abuse, neglect and exploitation at the local, state, and national levels.
- Increase awareness, support, and funding for the Elder Justice Act in the Senate and House of Representatives as a comprehensive approach to addressing elder justice issues.
- Monitor and appropriately influence other relevant legislation and regulations that pertain to the prevention of elder abuse, neglect and financial exploitation.

US Department of Justice – Elder Justice Initiative https://www.justice.gov/elderjustice

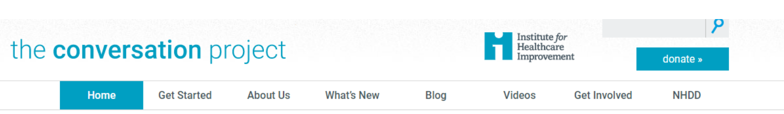
Together our mission is to combat elder abuse and financial exploitation, encourage reporting abuse, and educate the public to make America safer for all.

Rethinking Guardianship



Rethinking Guardianship

Alternatives to Guardianship



The Conversation Project

https://theconversationproject.org/wp-content/uploads/2020/12/DementiaGuide.pdf

Helping people share their wishes for care through the end of life.

Brunswick County Resources

- **Department of Social Services** (910)253-2077
- **Area Agency of Aging** (910)395-4553
- **Brunswick Senior Resource Center** (910) 754-2300
- **Hospice - Lower Cape Fear** (910)754-5356
- **Brunswick County Sheriff's Office "Are You Okay?"** (910)253-2749 (I.M.P.A.C.T. UNIT)
- **Brunswick County Sheriff's Office General** (910)253-2777
- **Brunswick County Sheriff's Financial Exploitation Office** (910)253-2505 – General Information
- **1-877-5-NO-SCAM**

Other Resources

- **http://www.aarp.org/family/caregiving**
- **http://www.acl.gov/aging-and-disability-in-america**
- **http://www.caregiver.com**
- **http://www.caregiver.org/caregiver/jsp/home.jsp**

The Elder Law & Life Care Planning Center www.APracticeWithPurpose.com
(910) 755-Plan (7526)

New Hanover County

Elder Law & Life Care Planning Center Local Resource Guide

Local Support Systems

According to the National Institute on Aging, many caregivers find building a local support system is a key way for them to get help. That local support system might include family members and friends, faith groups, and caregiver support groups.

Dementia Alliance of North Carolina

Phone: 919-832-3732

The Dementia Alliance provide support and resources all around the state of North Carolina.

New Hanover County Senior Resource Center

Phone: 910-798-6400
List of locations online at src.nhcgov.com/

New Hanover County Senior Resource Centerprovide services which promote wellness, encourage independence, and enhance quality of life for all older persons.

NCCARE360

Website: https://nccare360.org/

NCCARE360 is the first statewide network that unites health care and human services organizations with a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina. NCCARE360 helps providers electronically connect those with identified needs to community resources and allow for feedback and follow up. This solution ensures accountability for services delivered, provides a "no wrong door" approach, closes the loop on every referral made, and reports outcomes of that connection. NCCARE360 is available in all 100 counties across North Carolina.

Other Support Sources and Resources:

NIA Alzheimer's and related Dementias Education and Referral (ADEAR) Center

Email: adear@nia.nih.gov
Phone: 800-438-4380
Website: www.nia.nih.gov/alzheimers

The ADEAR Center offers information on diagnosis, treatment, patient care, caregiver needs, longterm care, and research and clinical trials related to Alzheimer's disease. Staff can refer you to local and national resources, or you can search for information on the website. The Center is a service of the National Institute on Aging (NIA), part of the Federal Government's National Institutes of Health. They have information to help you understand Alzheimer's disease. You can also get hints on other subjects, including:

- Talking with the doctor.
- Financial and legal planning.
- Medicines.
- Comfort care at the end of life.
- Paying for care.

Alzheimer's Association

Phone: 800-272-3900
Website: www.alz.org

The Alzheimer's Association offers information, a help line, and support services to people with Alzheimer's and their caregivers. Local chapters across the country offer support groups, including many that help with early stage Alzheimer's disease. Call or go online to find out where to get help in your area. The Association also funds Alzheimer's research.

Alzheimer's Foundation of America

Phone: 866-232-8484
Website: www.alzfdn.org

The Alzheimer's Foundation of America provides information about how to care for people with Alzheimer's, as well as a list of services for people with the disease. It also offers information for caregivers and their families through member organizations. Services include a toll-free hotline, publications, and other educational materials.

Other Support Sources and Resources:

Eldercare Locator
Phone: 1-800-677-1116
Website: https://eldercare.acl.gov

Caregivers often need information about community resources, such as home care, adult day care, and nursing homes. Contact the Eldercare Locator to find these resources in your area. The Eldercare Locator is a service of the Administration on Aging. The Federal Government funds this service.

National Institute on Aging Information Center
Email: niaic@nia.nih.gov
Phone: 1-800-222-2225
Website: www.nia.nih.gov/health

The NIA Information Center offers free publications about aging. Many of these publications are in both English and Spanish. They can be viewed, printed, and ordered online.

Project C.A.R.E
Phone: 910-408-6365
https://www.ncdhhs.gov/assistance/adult-services/project-care

Project C.A.R.E. (Caregiver Alternatives to Running on Empty) is the only state funded, dementia specific support program for individuals who directly care for loved ones with Alzheimer's disease or related dementias. Project C.A.R.E. is a coordinated delivery system that is responsive to the needs, values and preferences of unpaid family caregivers.

GoGo Grandparent
Phone: 855-464-6872
This service allows adults without a smartphone to use rideshare services like Lyft or Uber. 24/7 operators add reliability and extra eyes. They can also help keep emergency contacts in the loop.

EatWell
https://www.eatwellset.com/

Tips and tools for taking care of loved ones with dementia. They have customized color and pattern adaptive dishes to help people living with dementia eat more successfully.

Direct Services: Groups That Help with Everyday Care in the Home
Here is a list of services that can help you care for the person with Alzheimer's at home. Find out if these services are offered in your area. Also, contact Medicare to see if they cover the cost of these services. You can reach Medicare at 1-800-633-4227.

Home Health Care Services
Home health care services send a home health aide to your home to help you care for a person with Alzheimer's. These aides provide care and/or company for the person. They may come for a few hours or stay for 24 hours. Some home health aides are better trained and supervised than others.
What to know about costs:

- Home health services charge by the hour.
- Medicare covers some home health service costs.
- Most insurance plans do not cover these costs.
- You must pay all costs not covered by Medicare, Medicaid, or insurance.

How to find them:

1. Ask your doctor or other healthcare professional about good home health care services in your area.
2. Search for "home health care" in your area.

Here are some questions you might ask before signing a home health care agreement:

- Is your service licensed and accredited?
- What is the cost of your services?
- What is included and not included in your services?

Note: The Center is not affiliated with these services mentioned here and we have not done any independent investigation on these companies. Consumers must investigate and vet all service providers.

REPORT THAT FRAUD!

Where to file complaints – and what will happen then

Your Money **Scam Alert**
By Sid Kirchheimer
AARP, 2017

GUESS WHAT the most frequent Google search related to scams is. According to Google, it's simply "How do I report a scam?" The answer, of course, isn't simple.

Fraudsters can't be stopped unless their schemes are reported.

For scams perpetrated by shady contractors and front-door solicitors, contact local police and your state attorney general or district attorney. For other scams, here's a guide to which federal watchdog agency should get your complaints. Depending on your scam, there may be several.

FEDERAL TRADE COMMISSION
Ftc.gov/complaint

This is the agency for reporting identity theft, abusive debt collectors and most types of fraud. After filing a complaint, you'll get a reference number to use when contacting the agency for future updates. The FTC received more than 3 million complaints in 2015, and it does not routinely respond back to you or resolve your individual case. Rather, your complaints will be entered into a database that the FTC and some 2,000 civil and criminal enforcement agencies use to track scam patterns and build cases against specific con artists. Fraud complaints should also be filed with your state's attorney general and even local law enforcement authorities.

NATIONAL DO NOT CALL REGISTRY
Donotcall.gov

For reporting unsolicited sales calls. Start by putting your phone number on this registry. Once yours has been there at least 31 days, you can report unwanted calls. Your information will be pooled with other data to help catch violators. Note that calls from legitimate charities, survey firms, debt collectors and political candidates or parties are not covered by the Do Not call rules.

CONSUMER FINANCIAL PROTECTION BUREAU
Consumerfinance.gov/complaint
855-411-2372

For complaints about shady business practices and financial products, including loans, bank services, credit reporting, ID theft, debt collection and payment cards. The CFPB forwards complaints to the company, which has 15 days to respond. Cases are supposed to be resolved within 60 days. You can check the status of your case via the CFPB website. For credit cards and bank-issued ATM and debit cards that are used fraudulently, lost or stolen, contact the issuer.

INTERNET CRIME COMPLAINT CENTER
ic3.gov/complaint

For reporting internet-based scams, including online auctions; investment and sales fraud; internet extortion, hacking and phishing; and scam.

Another tax scam: IRS imposters

January 29, 2015
by
Amy Hebert
Consumer Education Specialist, FTC

Tax identity theft is the theme of the week, but it's not the only tax scam we're talking about. Complaints to the FTC about IRS imposter scams have shot up over the last year — by almost 50,000 complaints.

Here's what happens: You get a call from a scammer pretending to be with the IRS, saying you'll be arrested if you don't pay taxes you owe right now. You're told to wire it or put it on a prepaid debit card. They might threaten to deport you or say you'll lose your driver's license. Some even know your Social Security number, and they fake caller ID so you think it really is the IRS calling.

But it's all a lie. If you send the money, it's gone.

IRS Imposter Scams Infographic

When you have a tax problem, the IRS will first contact you by mail. The IRS won't ask you to wire money, pay with a prepaid debit card, or share your credit card information over the phone.

If you get a call like this, file a complaint with the Treasury Inspector General for Tax Administration at tigta.gov. You also can file a complaint with the FTC at ftc.gov/complaint. If you're concerned there's a real problem, call the IRS directly at 800-829-1040.

Want to help your friends and family? Share this infographic and get more information at ftc.gov/taxidtheft.

IRS IMPOSTER SCAMS

The Internal Revenue Service (IRS) is the government agency that collects federal taxes.

Scammers pretend to be IRS officials to get you to send them money.

How the scam works

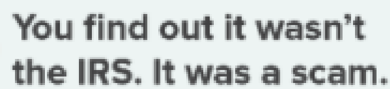
You get a call.

- Your caller ID might show it's the IRS calling.
- The caller might give a badge number and know the last four digits of your Social Security number.

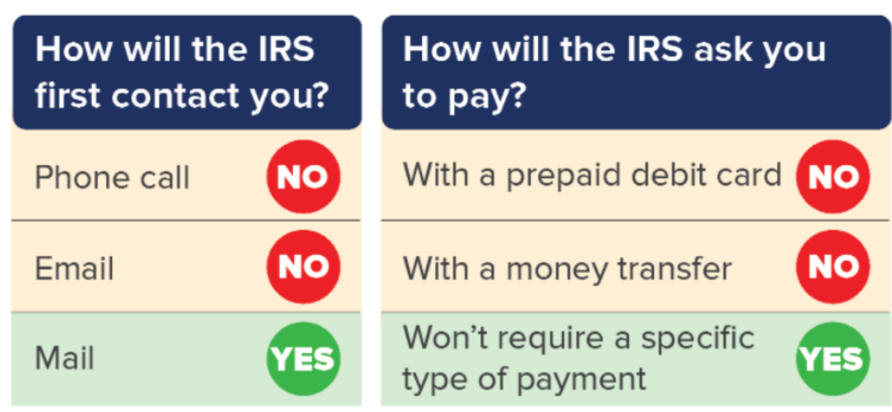
You are told:

- "You owe money."
- "You better pay now or you'll be arrested."
- "Put money on a prepaid debit card or wire it to us."

If you pay...



You find out it wasn't the IRS. It was a scam. → **The money is gone.**



Warning signs

How will the IRS first contact you?		How will the IRS ask you to pay?	
Phone call	NO	With a prepaid debit card	NO
Email	NO	With a money transfer	NO
Mail	YES	Won't require a specific type of payment	YES

Got a call?

Don't give the caller information
such as your financial or other personal information.

Write down details
such as the number and name of the caller.

Hang up

Contact the IRS directly
If you think you may owe back taxes, call the IRS at **800-829-1040** or visit **irs.gov/balancedue**.

Report the call
File a complaint with:

- the Treasury Inspector General for Tax Administration (TIGTA) at **tigta.gov** or **800-366-4484**.
- the FTC at **ftc.gov/complaint** or **877-FTC-HELP**.

Warn friends and family
Tell people you know that these calls are scams.

ftc.gov/imposters

Federal Trade Commission
January 2020

PROTECTING CONSUMERS

Attorney General Roy Cooper works to protect North Carolina consumers from scams and frauds. Cooper and his Consumer Protection Division have helped hundreds of thousands of consumers like you get more than $95 million of your money back, and have helped win $250 million in savings on your utility rates.

Scam Warnings

Read our alerts to find out about the latest scams, or sign up to have our alerts delivered to you by email. You can also get advice on how to avoid common problems from Attorney General Cooper's consumer columns, and read our consumer tips.

Identity Theft

Consumers can now get a free security freeze to keep thieves from using your credit plus a free credit report every year.

If you're a victim of identity theft, we can help you get started fixing the damage.

Telemarketing

Signing up for the Do Not Call Registry gives you the right to decide who calls you at home. If you've joined the list but still get calls from telemarketers, let us know. We've taken action against dozens of companies, for unlawful telemarketing, winning more than $1 million from violators.

Some telemarketers are criminals out to steal your money. Cooper's consumer protection team shuts down telemarketing fraud rings and helps victims get their money back when possible.

Home Loans

Buying a home is probably the most important purchase you'll ever make. We investigate and prosecute mortgage fraud and offer advice on avoiding unfair loans. We're also helping North Carolinians prevent unnecessary home foreclosures.

Contact us for help: If you think you've been the victim of a scam, or if you want to learn to be a smarter consumer, call Attorney General Roy Cooper's consumer hotline toll free within North Carolina at 1-877-5-NO-SCAM or (919) 716-6000. You can also file a consumer complaint online.

AVOID CONSUMER SCAMS

Scammers are always coming up with new tricks and twists to steal your hard-earned money.

To protect yourself from consumer frauds and scams, remember:

- Never share your Social Security Number, bank account or credit card information with someone you don't know who calls you or emails you.
- Walk away from high-pressure sellers who tell you that you must make a decision right away.
- Don't sign any contract or other paperwork until you've had a chance to read and understand it.
- Never pay money upfront to get a loan or win a lottery or sweepstakes.
- Don't respond to letters or emails that ask you to help transfer money into your bank account or wire money out of the country.
- Don't cash checks you get in the mail along with a letter or call that tells you you've won an unexpected prize. The checks are most likely fake.
- Check out a company with Attorney General Roy Cooper's Consumer Protection Division at 1-877-5-NO-SCAM before you do business with them.

You can learn to avoid the latest frauds and scams by reading our consumer alerts and columns. You can also sign up up to have alerts emailed to you.

You can also read more consumer tips and learn how to file a complaint if you're the victim of a scam or bad deal.

STOP TELEMARKETERS

Stop unwanted phone calls by signing up for the Do Not Call Registry. It's fast, free and effective. Telemarketers must stop calling your home phone or cell phone numbers in most cases if you add your numbers to the Do Not Call list.

How To Join the Do Not Call Registry

Call toll free (888) 382-1222 to add your numbers or join by email at www.donotcall.gov.

What If Telemarketers Keep Calling?

Stop telemarketers who keep calling you by filing a complaint with Attorney General Roy Cooper. If a telemarketer who shouldn't call does anyway, they'll hear from us.

We've taken action against dozens of companies that have broken Do Not Call laws, winning more than $1 million from violators.

Telemarketing Fraud

Some telemarketers aren't just a bother, they're criminals out to steal your money and your personal information. If you or someone you know has been scammed by phone, let us know. We work to shut down telemarketing fraud rings, and sometimes we can get your money back.

You can also read about common telemarketing scams and learn how to avoid them.

CONSUMER

How We Help Consumers

If you've been tricked or scammed, we want to help.

Attorney General Roy Cooper's Consumer Protection experts protect North Carolina consumers. We fight unfair business practices like scams and frauds. We've helped hundreds of thousands of consumers like you get more than $95 million of your money back, and have helped win $250 million in savings on your utility rates.

File a Complaint

You can file a complaint with us and we'll work to resolve it. We respond to 20,000 consumer complaints each year. If we find a pattern of illegal business practices, we can enforce the law on behalf of all North Carolina consumers. While we can't represent you in a private legal case, we may be able to help if you didn't get what you paid for or were tricked into a bad deal.

Get Tips

We want to help you avoid problems from the start. Watch the video **Standing Up, Fighting Back** to learn about frauds and scams. Before you file a complaint, read our consumer information. We explain the law and give consumers tips on many topics, like how to stop telemarketing calls, get a fair loan or buy a new car.

Contact Us

If you think you've been the victim of a scam, or if you want to learn to be a smarter consumer, call Attorney General Roy Cooper's consumer hotline toll free within North Carolina at 1-877-5-NO-SCAM (1-877-566-7226) or (919) 716-6000.

CABLE TV

Under a law passed by the General Assembly, the Attorney General's Consumer Protection Division has been charged with handling certain kinds of consumer complaints against cable television companies. Local governments will continue to handle some cable complaints.

Before filing a cable complaint with us, please review the two sections below:

Contact your cable company first.
Before filing a complaint, please contact your cable company or video provider first and give it the opportunity to resolve your problem. Often, the company can resolve your complaint quickly and it may be unnecessary to file a complaint.

Find out where to file your complaint - with local government or the Attorney General's Office.
If you first contacted your cable company and it did not resolve your problem, you may file a complaint with your local government or with the Attorney General's Consumer Protection Division, depending on the type of franchise your company has.

Our office handles complaints only against companies with a **State-issued franchise**. If your cable company has a State-issued franchise, you can file a complaint with our Consumer Protection Division.

- If your cable company has a **local franchise**, you should file your complaint with your local government - usually your town, city or county.

- To determine what type of franchise your cable company has, ask the company or review your cable bill. If your cable company has a State-issued franchise, your bill should say that complaints should be filed with the Attorney General's Office. If it doesn't, your company likely has a local franchise and you should contact your city or county manager's office.

- If you have asked your cable company and reviewed your cable bill and still cannot find out whether your company has a local or State-issued franchise, contact your local government or us and we will help you determine where your complaint should be filed.

Tips/FAQ

Before filing a complaint with us, be sure to call your service provider to try to resolve your issue and to determine that your provider has a State-issued franchise. In addition, please review these tips and frequently asked questions. The tips may help you avoid or solve problems from the start, and there are some issues that should be directed to the Federal Communications Commission (FCC), the federal agency responsible for regulating cable and video services.

What can I do to protect my children from sex and violence on television?

Parental Controls: We encourage you to be aware of and take control over the programs your children watch. You have several options for blocking unwanted material.

- First, if your cable service has a set-top box, the box probably contains a parental control feature on it that you can use to restrict access to certain channels or programs by using special codes. Alternatively, you may also ask your cable or video company about other ways to block certain channels. If you have any questions about how to use these devices or need to upgrade your equipment to include a parental control device, contact your cable company. Each company has different equipment and the company can best explain how to properly use it.

- Second, if your television is fairly new and has a screen 13 inches or larger, it probably has a "V-chip." Instructions on how to use the V-chip should be included in the operating instructions for your television set. You can use the V-chip to block programs based on ratings developed by the television industry and approved by the Federal Communications Commission.

These ratings, also called “TV Parental Guidelines” are designed to identify some programs containing violence and sexual content. Not all programs are rated, however. Sports, news, commercials, promotions, and unedited movies with a Motion Picture Association of America rating that are aired on premium cable channels such as HBO are not required to have the ratings. Here are the different ratings used:

- TV-Y – This program is designed to be appropriate for all children.
- TV-Y7 - This program is designed for children age 7 and above. Some programs with extra levels of “fantasy” violence may be designated TV-Y7-FV.
- TV-G - This program is designed to be suitable for children of all ages.
- TV-PG - This program contains some material that parents may find unsuitable for younger children. The program contains moderate violence (V), some sexual situations (S), infrequent coarse language (L), or some suggestive dialogue (D).
- TV-14 - This program contains some material that parents may find unsuitable for children under age 14. This program contains intense violence (V), intense sexual situations (S), strong coarse language (L), or intensely suggestive dialogue (D).
- TV-MA - This program is specifically designed to be viewed by adults and therefore may be unsuitable for children under age 17. This program contains graphic violence (V), explicit sexual activity (S), or crude indecent language (L).

Get more information about parental controls from the FCC.

Obscene and Indecent Programming: Generally, cable and video companies are free to decide what channels are available to their customers. We do not have the authority to tell a company to get rid of certain channels or programs.

However, federal law places restrictions on the airing of “obscene” and “indecent” programs. Generally, companies cannot air “obscene” material at any time. “Indecent” material can only be aired during certain hours, generally late at night.

Unresolved complaints about obscene or indecent programming should be directed to the FCC. Get more information on obscene and indecent programming, and learn how to file an indecency complaint with the FCC.

What if I think my cable service is too expensive?

We are sympathetic with your concerns, but the Attorney General's Consumer Protection Division does not have the authority to regulate the rates your cable or video company charges.

If your cable company has a local franchise, you may contact your local franchising authority, usually your city or county, for information regarding how it regulates your company's rates. Generally, the local franchising authority is responsible, at least in some circumstances, for regulating rates for "basic cable service," the introductory level of cable service a consumer can buy. This package usually includes local television stations and some public, educational and government access channels.

Generally, the local franchising authority does not have the ability to regulate the rates a cable company charges for programs which are beyond the basic service tier. Get more information about the regulation of cable television rates from the FCC.

What if I don't like my line-up of channels? What if my cable company does not carry a channel that I want?

You may request a certain channel at any time by contacting your cable or video company. Companies usually take these requests into account, along with other business concerns, when they consider adding new channels to the line-up.

However, for the most part, the company is free to decide what channels it carries and on what tier a channel is offered.
We do not have the authority to tell companies what channels it must provide or how it should package its channels.
Get more information about the availability of channels from the FCC. You can also file a complaint with the FCC.

What if I don't like my public access channels or want my cable company to carry different public access channels?
Public access channels, called PEG channels because they are for public, educational or governmental use, are the responsibility of local governments.

Cable companies operating under a local franchise must follow the PEG channel requirements of the local franchise agreement. These requirements will vary from place to place, depending on what the agreement says.

Cable companies operating under a state-issued franchise must follow the PEG channel requirements of the new law. Generally, cities and counties can request PEG channels from the company. The city or county is allowed a minimum number of channels, depending on how large its population is.
If you have any unresolved complaints about PEG channels, you should contact your city or county.

What if the cable company has damaged my yard or property?

Generally, cable companies must comply with any right-of-way regulations the city has. If you have any questions about whether a right-of-way regulation exists in your city or what the regulation says, you may contact your city government.

If a cable or video company with a State-issued franchise has damaged your yard or property, please contact the company first and give it the opportunity to fix the problem. If the company does not fix the problem, you may file a complaint with us. Include photographs of the damage if you can.

What can I do if a company with a State-issued franchise refuses to provide me with a cable or video service?

Under the new law, cable and video companies with State-issued franchises are generally not required to provide service in particular areas. Our office does not have the authority to tell companies where they must provide service.

A cable or video company may not deny service to any group of potential residential subscribers within its franchise area due to race or income. If you believe that you have been the subject of this type of discrimination, please file a complaint with us.

Can you help me get broadband, high-speed Internet service in my area?

Our office does not have the ability to order a company to provide broadband service in a certain area. If you want broadband service and it is not available in your area, contact your nearest cable or telephone company and request it. The more the companies hear from interested consumers, the more they will consider making the service available.

STOP JUNK MAIL

Sick of sorting through piles of junk mail to find bills you need to pay or that magazine or letter you want to read? There are some simple steps you can take to limit the amount of junk mail clogging your mail box. Limiting certain kinds of junk mail can also reduce your risk of identity theft.

Here's how to cut down on junk mail.

Opt out of credit card offers. Those pre-approved credit card offers you get are tempting to identity thieves. If you throw them away without shredding them, all a criminal has to do is fill one out in your name and change the address. Call 1-888-567-8688 (1-888-5OPT-OUT) or opt out online to stop the flood of credit card offers. You'll be asked to provide some personal information such as name, address and Social Security Number, but that information will be used only to process your request.

Ask the credit bureaus not to share your information for sales pitches. You can write to all three credit bureaus and tell them not to share your information for promotional purposes. Include your full name, address, Social Security Number and date of birth in your letter, and send it to:

Equifax
P.O. Box 74024
Atlanta, GA 30374
Experian
901 West Bond
Lincoln, NE 68521
Attn: Consumer Services Department
TransUnion
Name Removal Option
P.O. Box 505
Woodland, PA 19094

Tell companies you don't want their junk mail. Register with the Direct Marketing Association (which represents many but not all companies that solicit through the mail) and tell them you don't want to get junk mail. This will stop mailings from any company participating in the DMA's Mail Preference Service for five years. You can register with the DMA online at no charge, or download a registration form and register by mail.

Mail Preference Service
Direct Marketing Association
P.O. Box 643
Carmel, NY 10512

Note: If you register by mail you will need to include a check for $1 (along with your name and address) to cover processing of your request.

- **Block explicit mail.** To stop unwanted sexually explicit advertising from being sent to you or your child, you can file what's called a prohibitory order with the U.S. Postal Service. You'll need to fill out the Application for Listing and-or Prohibitory Order form available via the U.S. Postal Service Web site. You can fill out the same form to report a piece of explicit mail that you or your child received.

- **Stop unwanted sales calls, too.** Sign up for the Do Not Call Registry to cut down on unwelcome telemarketing calls. You can add your home and mobile telephone numbers to the National Do Not Call Registry online or by calling 1-888-382-1222 within North Carolina from the number you wish to register.

Craigslist scam advertises false rental deals

If you're looking for a home to rent, watch out for phony online listings. Rental fraudsters find information on properties that have been listed for sale elsewhere, create fake rental listings on websites like Craigslist, and then pose as the owners when potential tenants reply.

A Winston-Salem-area consumer recently reported paying $1,000 to an online scammer who advertised a rent-to-own home deal on Craigslist. The consumer replied to the ad, signed a contract and made a payment, only to learn that the scammer didn't really own the property.

When browsing for homes for rent or sale online, look out for these warning signs:

- The advertised price is significantly lower than similar properties in the area.
- The listing says the owners will be gone for years and want someone to care for their home.
- You're told you can only look in the windows of the property, not go inside.
- You're asked to pay money upfront by wire transfer or prepaid debit card, and you may be asked to send the money overseas
- You're told that keys are with the property owner and will be sent once the contract is signed and the deposit paid.

To protect yourself from a rental scam:

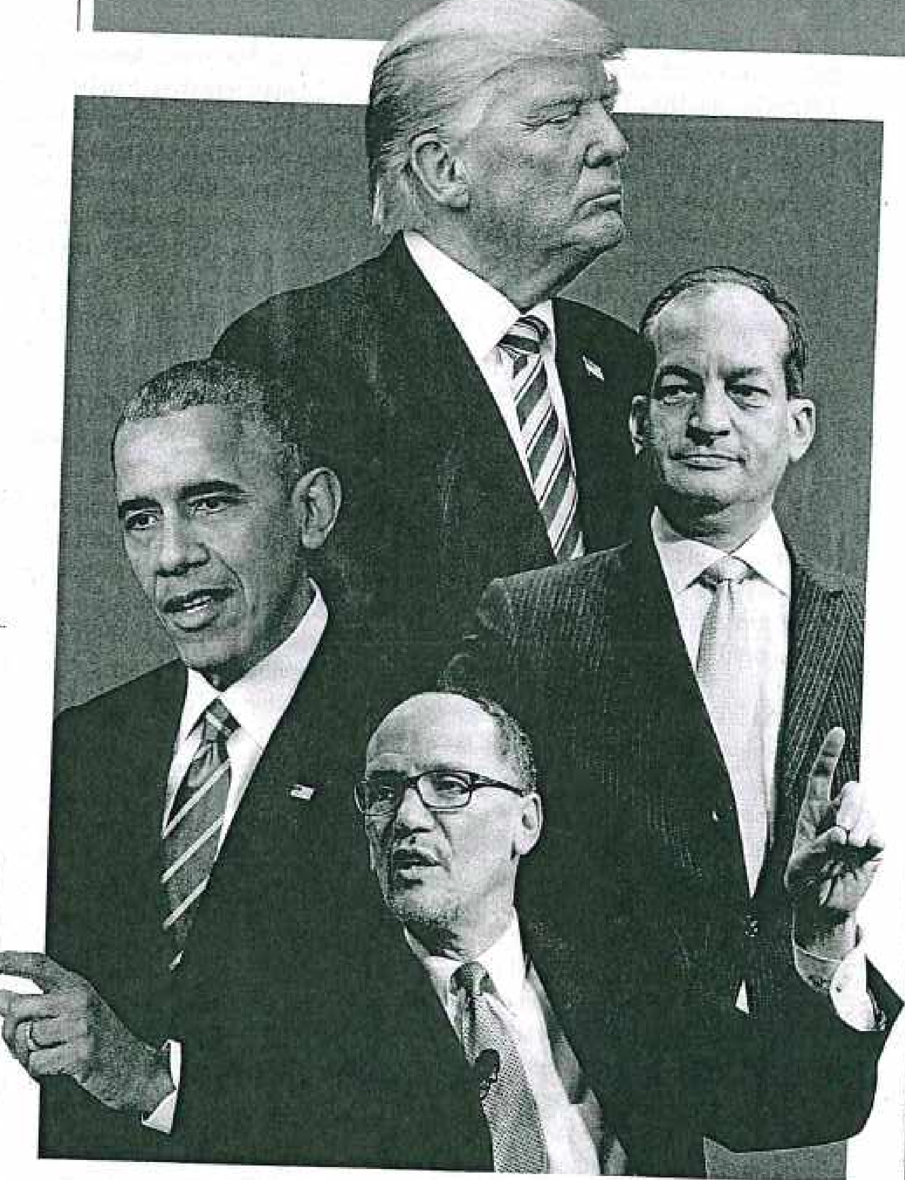
- Search the property's address online. If the property is listed for rent or sale with a real estate agent, contact the realtor directly.
- Walk away from the transaction if you're asked to pay a deposit before you've reviewed and signed a lease.
- Use secure payment methods like certified bank checks or credit cards.

If you spot a scam, report it to the Attorney General's Consumer Protection Division by calling 1-877-5-NO-SCAM or filing a complaint online at www.ncdoj.gov.

The New Financial Rule You Need to Know About

The so-called fiduciary rule makes it harder for brokers to take advantage of you.

BY MEGAN LEONHARDT



A new financial reg proposed by the Obama administration is now being rolled out by President Trump's Labor Department.

BIG CHANGES are in store for your retirement savings, now that a new federal rule has gone into effect. After nearly a decade of back and forth between the financial industry and consumer advocates, the Labor Department has rolled out the first phase of the so-called fiduciary rule, which requires financial advisers to act in your best interests.

If you thought your financial adviser was already required to do that, you're not alone. Almost half of Americans believe that by law all financial advisers must act in their clients' best interests, according to a Personal Capital survey.

It's true for many financial planners who charge fees rather than commissions. But until now, it hadn't been the case for everyone. Going forward, anyone who handles retirement assets and doles out advice—whether they call themselves brokers, financial advisers, financial planners, or wealth managers—must adhere to new "impartial conduct standards." Those standards also require advisers to charge reasonable rates and bar them from lying to or misleading you about the products they're recommending (such as mutual funds, ETFs, or annuities).

The new fiduciary rule applies only to advisers

CLOCKWISE FROM TOP: PHOTOGRAPHS BY ALEX WONG/GETTY; BLOOMBERG/GETTY; GETTY; MARK WILSON/GETTY

working with retirement assets—for most people, that's a 401(k) or a Roth or traditional IRA. Taxable brokerage accounts are not affected.

The new rule has the greatest impact on advisers registered as brokers. In the past, these folks followed a less stringent "suitability" standard that allowed them to recommend options that would cost you more—and pay them more—even if cheaper or better options were available to you.

Given all the uncertainty surrounding this rule—until recently, it wasn't even clear the Trump administration would implement this Obama-era regulation—it's time to cut through the clutter. Here's what you need to know:

THIS IS ONLY PHASE ONE

The fiduciary rule will be rolled out in stages. While new obligations to clients are in effect, the rule's remaining provisions—including one that would allow investors to bring class actions—are slated to roll out Jan. 1. (There's also a Labor Department review to determine if the second part of the rule is necessary.)

The phased rollout means there won't be much federal enforcement at this point. The Labor Department has said it won't penalize those who don't follow the new standards until they're completely finalized. Yet investors can still bring claims through the industry's arbitration process, for instance by filing a case with the Financial Industry Regulatory Authority, says Fred Reish, a partner with Drinker Biddle specializing in fiduciary issues.

EXPECT TO GET INUNDATED WITH ADS

Some firms believe an industrywide fiduciary standard for retirement accounts could be a big business opportunity. For years, fee-only financial planners (who had been required to act in their clients' best interests all along) have sold themselves as "true" fiduciaries. But now advisers at places like Merrill Lynch, Wells Fargo, and other big firms can say the same thing. In fact, they're already taking out ads doing that.

YOU MAY BE ASKED TO RESTRUCTURE YOUR ACCOUNT

Several big firms, such as Merrill Lynch and LPL Financial, have already announced they may need to transition some clients from a commission account to an advisory account—where you'll pay a quarterly or annual fee for advice, rather than having your adviser get paid a commission on funds you buy.

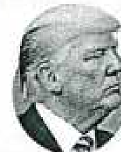
Those companies say fee-based accounts will help them comply with the new rule, because advisers may face conflicts of interest if they're getting paid a higher commission to place you in one fund over another.

If you already have an adviser and a commission-based account, it's worth calculating whether you trade enough or seek enough financial advice to justify switching to a fee-based account. If you buy only a few shares a year, paying a small commission on trades is likely to be cheaper than an annual ongoing fee. That's particularly true if you don't need a lot of financial hand-holding.

"There's a strong incentive for firms to move investors into fee accounts because they're easier to supervise, and the fees are a more steady income stream," says Barbara Roper, director of investor protection at the Consumer Federation of America. If your costs are rising, and you're not getting many new services,

In Their Own Words

Though the Trump administration is implementing the Obama fiduciary rule, its support of the reg remains unclear.



"[The final rule] may significantly alter the manner in which Americans can receive financial advice and may not be consistent with the policies of my administration."

—PRESIDENT DONALD TRUMP

"It's a very simple principle: You want to give financial advice? You've got to put your client's interests first. You can't have a conflict of interest."

—FORMER PRESIDENT BARACK OBAMA

"Trust in Americans' ability to decide what is best for them and their families leads us to the conclusion that we should seek public comment on how to revise this rule."

—LABOR SECRETARY ALEXANDER ACOSTA

"This is a huge win for the middle class. In far too many places and on far too many issues, the rules no longer work for working people."

—FORMER LABOR SECRETARY TOM PEREZ

or you're getting services that you don't want, "it's not a problem with the rule, it's a problem with the adviser or the firm," Roper says. So you may want to shop around.

YOU'LL SEE WHAT YOU'RE PAYING FOR

Under the new rule, there's a push for firms to be more transparent. That means your statement may look different, particularly if you've been using a commission-based adviser. You may have been paying higher fund fees, for instance, even if you didn't see those fees directly. New statements may show a clearer breakdown of the costs for your funds and for advice.

Don't panic if you suddenly see new fees, experts say. "You're hopefully going to get something that should be clearer than your cell phone bill," says Paul Ellenbogen, Morningstar's director of global regulatory solutions.

YOU'LL BE PITCHED NEW PRODUCTS

Expect your advisers to offer you a bunch of financial products such as new annuities and fund classes. This is generally a positive thing, says Roper: "The product innovation in response to the rule is one of the most significant benefits."

Newly launched annuities, for instance, offer shorter surrender periods (the waiting period before investors can withdraw funds) and lower embedded costs than their predecessors, she says.

Your adviser may also pitch you new fund classes (such as "clean shares") that do away with steep commissions. Fund companies have reshaped their offerings to get rid of a lot of the conflicts of interest that were embedded in older adviser-sold fund classes.

DON'T SIGN ANYTHING TOO QUICKLY

The fiduciary rule won't actually bar commission-based products. In fact, a carve-out that is slated to go into effect next January will allow advisers to sell certain specialized products using a commission structure, even if there's a conflict. The Best Interest Contract Exemption (or BICE) requires advisers to disclose their conflicts, and you'll need to sign a contract acknowledging you've received and understood the disclosure.

In all likelihood, these contracts will be long (some of the early ones were 72 pages) and full of legalese and jargon. Not sure what you're reading? Decline to sign, or get outside legal advice before you do.

YOU STILL MUST ASK HARD QUESTIONS

"It will still be crucial to ask advisers, 'Does your advisory agreement require you to be a fiduciary for all my investments, or just the money in my IRA?'" says Michael Kitces, director of wealth management at Pinnacle Advisory Group.

Ask your advisers how they are getting paid—and how much their cut will be. For instance, "'[I'm] looking at this bill, and I want to know what I'm paying to whom for what,'" Ellenbogen says.

Also watch how your advisers are communicating the changes. Many firms have already sent out notifications. "If you haven't heard anything, you may want to start asking why," says attorney Marcia Wagner.

YOU MAY WANT TO MAKE A CHANGE

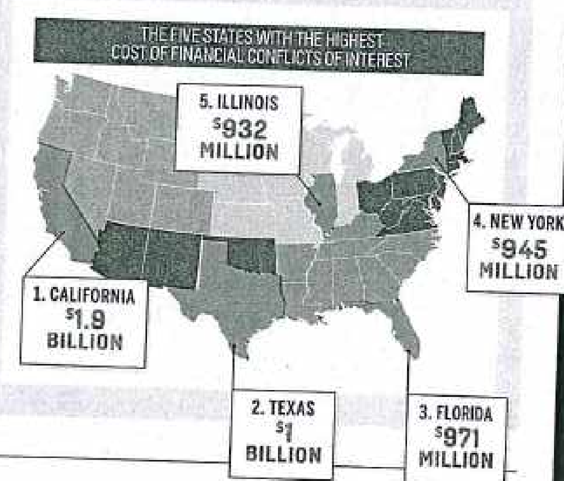
If you are sensing problems—if you're not happy with your new fee-for-service arrangement, for instance, or you're getting fuzzy answers to your questions—it may be time to leave your adviser. "If you don't understand something, ask your adviser to explain it. If he or she can't or won't, then that speaks volumes," Wagner says.

If you are interested in finding a new adviser, check out groups like the Garrett Planning Network, which consists of financial planners who already act as fiduciaries and charge a transparent fee.

And because no association or designation is a fail-safe, do some background research as well by looking up an adviser's record on BrokerCheck before you commit. ■

The Cost of Conflicts

Advisers not acting in their client's best interest has real consequences. Investors lose billions each year to higher fees and lower returns.



SOURCE: Economic Policy Institute

Division of Aging and Adult Services

North Carolina is Aging!

- The state's total population has exceeded 10 million!
- North Carolina ranks 9th nationally, both in total population and in the number of people 65 and older.
- By 2028, one in five North Carolinians will be 65 and older. By 2031, there will be more people 65 and older than children 0-17.
- The state has more people 60 and older than under 18 years.
- In 2019, 82 counties in the state had more people 60 and older than under 18 years. By 2025, this number is expected to increase to 89 counties and by 2038 to 95 counties.
- In 2019, an estimated 44,306 people 60 and older migrated from other states and abroad to North Carolina.
- In the next two decades, our 65 and older population will increase from 1.7 to 2.7 million, a projected growth of 56%. The projected growth among the age groups 65-74 (29%), 75-84 (87%) and 85+ (116%) indicates that as the baby boomers continue to age, there will be an increased proportion of older adults in the state creating challenges for long-term services and supports.

NC Population Change 2019-2039

	2019		2039		% Change 2019-2039
Age	#	%	#	%	
Total	10,487,088		12,706,544		21%
0-17	2,309,948	22%	2,579,712	20%	12%
18-44	3,720,591	36%	4,395,245	35%	18%
45-59	2,074,591	20%	2,326,862	18%	12%
60+	2,382,240	23%	3,404,725	27%	43%
65+	1,735,619	17%	2,705,349	21%	56%
85+	190,083	2%	410,591	3%	116%

Source: NC Office of State Budget and Management, Standard Population Estimates, Vintage 2019 & Projections Vintage 2039

Race and Ethnicity, 2019

Race/Ethnicity, age 65 and older	NC	US
White	79.8%	82.9%
Black or African American	16.7%	9.2%
American Indian and Alaska Native	0.9%	0.6%
Asian	1.4%	4.4%
Some other race	0.5%	1.8%
Two or more races	0.7%	1.1%
Hispanic or Latino origin (of any race)	2.0%	8.2%

*As a % population 65 and older

Source: US Census. 2015-2019 American Community Survey (ACS), 5-year estimates

Social and Economic Characteristics of population, 2019

Characteristics, age 65 and older	NC	US
Living alone	26.4%	26.%
Veterans	18.3%	17.9%
Speak English less than "very well"	2.3%	8.7%
Have a disability	35.1%	34.5%
Have less than high school education	16.5%	15.6%
Have high school, GED/Alternative education	30.8%	31.2%
In labor force	16.7%	18.0%
Income below poverty level	9.1%	9.3%
Income between 100%-199% of poverty level	21.4%	18.8%
Median household income	$41,750	$45,837

*As a % of population 65 and older Source: US Census. 2015-2019 American Community Survey, 5-year estimates

- 42% of housing units with people 65 and older are single person households.
- Of the estimated 92,766 grandparents responsible for grandchildren under 18, 42% are age 60 and older.

Health Profile

- According to the Alzheimer's Association, North Carolina currently (2019) has 170,000 adults 65 and older with **Alzheimer's disease** and this number is projected to rise to 210,000 by 2025, an increase of 24%. Alzheimer's disease is the fourth leading cause of death among people age 65 and older.
- Of the **people 65 and older**, according to the Behavioral Risk Factor Surveillance System (BRFSS) survey, 2019:
  - 81% had at least one chronic disease, 54% of them had 2 or more chronic diseases;
  - 71% had an adult flu shot/spray in the past 12 months and 76% had a pneumonia shot ever;
  - Only 9% self-reported that their health is poor and 72% reported exercising in the past 30 days.

Rank	Leading causes of death, age 65 and older, 2019	Number of deaths	% of Total deaths
1	Diseases of the heart	15,493	**22%**
2	Cancer	14,334	**21%**
3	Chronic lower respiratory diseases	4,499	6%
4	Alzheimer's disease	4,455	6%
5	Cerebrovascular disease	4,441	6%
6	Diabetes mellitus	2,118	3%

Source: North Carolina State Center for Health Statistics

Type of disability, age 65 and older, 2019	% with a disability
Ambulatory	**22%**
Independent living	14%
Hearing	15%
Cognitive	9%
Self-care	8%
Vision	7%

Source: US Census, 2015-2019 ACS, 5-year estimates

- **Coronavirus disease 2019 (COVID-19)**: Older adults due to age, comorbidities and likely weaker immune systems are at a higher risk of illnesses, hospitalizations, or dying if diagnosed with COVID-19. Of the total deaths due to COVID-19 (December 6, 2020), 23% of deaths occurred among people 65-74 years and 60% of deaths in 75 and older. Daily updates on cases, hospitalizations, deaths are available at https://covid19.ncdhhs.gov/dashboard

Given the potential social and economic impact of this unprecedented growth in the aging population, it is critical that NC focus efforts to improve those social determinants of health shown to have a direct positive effect on the health and well-being of individuals that promote aging within the community and postpone or avoid the necessity for long-term care.

The Dementia Diagnosis
What Should We Do Next?

Most patients and their family members are not entirely surprised when a diagnosis of dementia is made by a physician. The patient and the family member have probably been noticing subtle changes for some time. However, when these suspicions are confirmed by an actual diagnosis, the patient and their family members need to carefully assess their situation and confirm that appropriate planning is done to ensure the best care without creating a financial crisis. When the diagnosis of dementia is made early in the disease process, the patient can take part in the planning process allowing the family to map out the type of care to be utilized at the various stages of the illness.

Most people prefer to receive care in their own homes. Typically, family members are the initial caregivers for their loved ones. As care needs increase, family members can quickly become overwhelmed. Initially the family may decide to hire caregivers to help with the care in the home setting. Families need to understand the differences between nurse registries and home health agencies when contracting for care.
When hiring a home health agency, the contract is between the agency and the client and the home health aides and nurses are employees of the agency. Nurse registries act to match a patient with an independent home health aide or nurse. Once the match is made, the contract is between the client and the aide or nurse individually. It is critical that the client understand who will be responsible in the event of theft or negligence or if the worker becomes injured on the property. Families need to understand the amount of supervision of the worker that the company provides. If

the company does not supervise the worker and the patient has dementia, the family must closely watch the situation to ensure that services are properly provided. Different companies have different contractual provisions and protocols for services. Some companies provide dementia training to the staff that will be dedicated to providing services to dementia patients in order to provide higher levels of service. At the Center, our team is familiar with the contract types and we are able to advise families about the choices available. Some people prefer to avoid the company altogether by hiring unlicensed individuals as caregivers. In addition to risks inherent in hiring someone who has not met the background checks of an agency or registry, families need to understand their legal obligations concerning payroll and unemployment taxes in these situations. I know of an individual who was blackmailed when she discharged a private caregiver (not one hired through an agency) that she was paying "under the table."

Some families are surprised to learn that when a person needs 24-hour care, that home care is the most expensive option for obtaining that care. Generally, it will cost in excess of $100,000 per year to have around the clock home care. So families need to consider what funding sources they have to pay such costs. If the patient has a long term care insurance policy, it should be carefully reviewed to determine what will trigger the policy, and what are the daily and lifetime policy limitations. For patients who are veterans or their spouses, veterans' benefits should be analyzed.

When an early diagnosis is made, the patient will have an opportunity to consider changes to the estate planning documents in place. If a patient can pay the cost of care from income indefinitely, then the typical revocable living trust planning is appropriate. However, if a family cannot pay for care from income without impoverishing the spouse or seriously jeopardizing future care by principal depletion, the documents need to revised in order to allow maximum flexibility for planning to utilize government benefits such as Veterans' benefits or Medicaid.

Many families wait until a person with a diagnosis is brought to an Elder Law and Life Care Planning attorney to ensure that person's voice can be heard through their estate planning documents, such as the financial and health care powers of attorney. While we always tell our clients it is never too late to do planning for long term care, in this one instance of getting estate planning documents in place that accurately reflect one's voice, one's wishes, it will be too late if the person does not possess the requisite mental capacity to execute those estate planning documents. If no estate plan was put into place prior to the diagnosis or if changes need to be made, be sure to consult with us as early in the diagnosis process as possible to see what can be done.

Drugs with ACB Score of 1

Generic Name	Brand Name
Alimemazine	Theralen™
Alverine	Spasmonal™
Alprazolam	Xanax™
Aripiprazole	Abilify™
Asenapine	Saphris™
Atenolol	Tenormin™
Bupropion	Wellbutrin™, Zyban™
Captopril	Capoten™
Cetirizine	Zyrtec™
Chlorthalidone	Diuril™, Hygroton™
Cimetidine	Tagamet™
Clidinium	Librax™
Clorazepate	Tranxene™
Codeine	Contin™
Colchicine	Colcrys™
Desloratadine	Clarinex™
Diazepam	Valium™
Digoxin	Lanoxin™
Dipyridamole	Persantine™
Disopyramide	Norpace™
Fentanyl	Duragesic™, Actiq™
Furosemide	Lasix™
Fluvoxamine	Luvox™
Haloperidol	Haldol™
Hydralazine	Apresoline™
Hydrocortisone	Cortef™, Cortaid™
Iloperidone	Fanapt™
Isosorbide	Isordil™, Ismo™
Levocetirizine	Xyzal™
Loperamide	Immodium™, others
Loratadine	Claritin™
Metoprolol	Lopressor™, Toprol™
Morphine	MS Contin™, Avinza™
Nifedipine	Procardia™, Adalat™
Paliperidone	Invega™
Prednisone	Deltasone™, Sterapred™
Quinidine	Quinaglute™
Ranitidine	Zantac™
Risperidone	Risperdal™
Theophylline	Theodur™, Uniphyl™
Trazodone	Desyrel™
Triamterene	Dyrenium™
Venlafaxine	Effexor™
Warfarin	Coumadin™

Drugs with ACB Score of 2

Generic Name	Brand Name
Amantadine	Symmetrel™
Belladonna	Multiple
Carbamazepine	Tegretol™
Cyclobenzaprine	Flexeril™
Cyproheptadine	Periactin™
Loxapine	Loxitane™
Meperidine	Demerol™
Methotrimeprazine	Levoprome™
Molindone	Moban™
Nefopam	Nefogesic™
Oxcarbazepine	Trileptal™
Pimozide	Orap™

Categorical Scoring:

- Possible anticholinergics include those listed with a score of 1; Definite anticholinergics include those listed with a score of 2 or 3

Numerical Scoring:

- Add the score contributed to each selected medication in each scoring category
- Add the number of possible or definite Anticholinergic medications

Notes:

- Each definite anticholinergic may increase the risk of cognitive impairment by 46% over 6 years. [3]
- For each on point increase in the ACB total score, a decline in MMSE score of 0.33 points over 2 years has been suggested. [4]
- Additionally, each one point increase in the ACB total score has been correlated with a 26% increase in the risk of death. [4]

Aging Brain Care

www.agingbraincare.org

Drugs with ACB Score of 3

Generic Name	Brand Name
Amitriptyline	Elavil™
Amoxapine	Asendin™
Atropine	Sal-Tropine™
Benztropine	Cogentin™
Brompheniramine	Dimetapp™
Carbinoxamine	Histex™, Carbihist™
Chlorpheniramine	Chlor-Trimeton™
Chlorpromazine	Thorazine™
Clemastine	Tavist™
Clomipramine	Anafranil™
Clozapine	Clozaril™
Darifenacin	Enablex™
Desipramine	Norpramin™
Dicyclomine	Bentyl™
Dimenhydrinate	Dramamine™, others
Diphenhydramine	Benadryl™, others
Doxepin	Sinequan™
Doxylamine	Unisom™, others
Fesoterodine	Toviaz™
Flavoxate	Urispas™
Hydroxyzine	Atarax™, Vistaril™
Hyoscyamine	Anaspaz™, Levsin™
Imipramine	Tofranil™
Meclizine	Antivert™
Methocarbamol	Robaxin™
Nortriptyline	Pamelor™
Olanzapine	Zyprexa™
Orphenadrine	Norflex™
Oxybutynin	Ditropan™
Paroxetine	Paxil™
Perphenazine	Trilafon™
Promethazine	Phenergan™
Propantheline	Pro-Banthine™
Propiverine	Detrunorm™
Quetiapine	Seroquel™
Scopolamine	Transderm Scop™
Solifenacin	Vesicare™
Thioridazine	Mellaril™
Tolterodine	Detrol™
Trifluoperazine	Stelazine™
Trihexyphenidyl	Artane™
Trimipramine	Surmontil™
Trospium	Sanctura™

Medications Reviewed in 2012 Update

Medications Added with Score of 1:
Aripiprazole (Abilify™)
Asenapine (Saphris™)
Cetirizine (Zyrtec™)
Clidinium (Librax™)
Desloratadine (Clarinex™)
Iloperidone (Fanapt™)
Levocetirizine (Xyzal™)
Loratadine (Claritin™)
Paliperidone (Invega™)
Venlafaxine (Effexor™)

Medications Added with Score of 2:
Nefopam (Nefogesic™)

Medications Added with Score of 3:
Doxylamine (Unisom™, others)
Fesoterodine (Toviaz™)
Propiverine (Detrunorm™)
Solifenacin (Vesicare™)
Trospium (Sanctura™)

Medications Reviewed But NOT Added:
Fexofenadine (Allegra™)
Gabapentin (Neurontin™)
Topiramate (Topamax™)
Levetiracetam (Keppra™)
Tamoxifen (Nolvadex™)
Nizatidine (Axid™)
Duloxetine (Cymbalta™)

Criteria for Categorization:
Score of 1: Evidence from in vitro data that chemical entity has antagonist activity at muscarinic receptor.

Score of 2: Evidence from literature, prescriber's information, or expert opinion of clinical anticholinergic effect.

Score of 3: Evidence from literature, expert opinion, or prescribers information that medication may cause delirium.

Complete References:

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4. Fox C, Richardson K, Maidment I, et al. Anticholinergic medication use and cognitive impairment in the older population: the Medical Research Council Cognitive Function and Ageing Study. Journal of the American Geriatric Society. 2011; 59(8): 1477-1483.
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To request permission for use, contact us at acb@agingbraincare.org.

Aging Brain Care

ANTICHOLINERGIC COGNITIVE BURDEN SCALE

2012 Update

Developed by the Aging Brain Program of the Indiana University Center for Aging Research

Original Investigation

Association Between Anticholinergic Medication Use and Cognition, Brain Metabolism, and Brain Atrophy in Cognitively Normal Older Adults

Shannon L. Risacher, PhD; Brenna C. McDonald, PsyD, MBA; Eileen F. Tallman, BS; John D. West, MS; Martin R. Farlow, MD; Fredrick W. Unverzagt, PhD; Sujuan Gao, PhD; Malaz Boustani, MD, MPH; Paul K. Crane, MD, MPH; Ronald C. Petersen, MD, PhD; Clifford R. Jack Jr, MD; William J. Jagust, MD; Paul S. Aisen, MD; Michael W. Weiner, MD; Andrew J. Saykin, PsyD; for the Alzheimer's Disease Neuroimaging Initiative

IMPORTANCE The use of anticholinergic (AC) medication is linked to cognitive impairment and an increased risk of dementia. To our knowledge, this is the first study to investigate the association between AC medication use and neuroimaging biomarkers of brain metabolism and atrophy as a proxy for understanding the underlying biology of the clinical effects of AC medications.

OBJECTIVE To assess the association between AC medication use and cognition, glucose metabolism, and brain atrophy in cognitively normal older adults from the Alzheimer's Disease Neuroimaging Initiative (ADNI) and the Indiana Memory and Aging Study (IMAS).

DESIGN, SETTING, AND PARTICIPANTS The ADNI and IMAS are longitudinal studies with cognitive, neuroimaging, and other data collected at regular intervals in clinical and academic research settings. For the participants in the ADNI, visits are repeated 3, 6, and 12 months after the baseline visit and then annually. For the participants in the IMAS, visits are repeated every 18 months after the baseline visit (402 cognitively normal older adults in the ADNI and 49 cognitively normal older adults in the IMAS were included in the present analysis). Participants were either taking (hereafter referred to as the AC^+ participants [52 from the ADNI and 8 from the IMAS]) or not taking (hereafter referred to as the AC^- participants [350 from the ADNI and 41 from the IMAS]) at least 1 medication with medium or high AC activity. Data analysis for this study was performed in November 2015.

MAIN OUTCOMES AND MEASURES Cognitive scores, mean fludeoxyglucose F 18 standardized uptake value ratio (participants from the ADNI only), and brain atrophy measures from structural magnetic resonance imaging were compared between AC^+ participants and AC^- participants after adjusting for potential confounders. The total AC burden score was calculated and was related to target measures. The association of AC use and longitudinal clinical decline (mean [SD] follow-up period, 32.1 [24.7] months [range, 6-108 months]) was examined using Cox regression.

RESULTS The 52 AC^+ participants (mean [SD] age, 73.3 [6.6] years) from the ADNI showed lower mean scores on Weschler Memory Scale–Revised Logical Memory Immediate Recall (raw mean scores: 13.27 for AC^+ participants and 14.16 for AC^- participants; *P* = .04) and the Trail Making Test Part B (raw mean scores: 97.85 seconds for AC^+ participants and 82.61 seconds for AC^- participants; *P* = .04) and a lower executive function composite score (raw mean scores: 0.58 for AC^+ participants and 0.78 for AC^- participants; *P* = .04) than the 350 AC^- participants (mean [SD] age, 73.3 [5.8] years) from the ADNI. Reduced total cortical volume and temporal lobe cortical thickness and greater lateral ventricle and inferior lateral ventricle volumes were seen in the AC^+ participants relative to the AC^- participants.

CONCLUSIONS AND RELEVANCE The use of AC medication was associated with increased brain atrophy and dysfunction and clinical decline. Thus, use of AC medication among older adults should likely be discouraged if alternative therapies are available.

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Anticholinergic (AC) medications have been linked to impaired cognition[1-16] primarily in nondemented older adults[10,17] and an increased risk for cognitive impairment and dementia in older adults.[1,3,4,18-20] The biological basis for the cognitive effects of AC medications is unknown. However, given the importance of the cholinergic system in cognition, researchers speculate that direct impairment of cholinergic neurons may underlie these effects. In fact, previous studies[21,22] using scopolamine hydrobromide, a cholinergic antagonist, have shown transient cognitive impairment in young and older adults. A recent study[23] suggested that administration of AC medications modulates the association between brain volume and cognition. However, to our knowledge, no studies have examined the effects of regular AC medication use on neuroimaging measures of brain structure and function in cognitively normal (CN) older adults.

The goal of the present study was to assess AC medication use in CN older adults from the Alzheimer's Disease Neuroimaging Initiative (ADNI). In particular, we sought to evaluate whether cognitive performance, brain glucose hypometabolism, structural brain atrophy, and clinical progression to mild cognitive impairment (MCI) and/or Alzheimer disease (AD) were associated with the use of AC medication. We also completed a similar analysis in an independent cohort of CN older adults from the Indiana Memory and Aging Study (IMAS). We hypothesized that participants taking AC medications (hereafter referred to as AC$^+$ participants) would show poorer cognition, reduced glucose metabolism, brain atrophy, and increased clinical decline relative to those not taking AC medications (hereafter referred to as AC$^-$ participants) and that these effects would be greatest in those with the highest total AC burden score.

Key Points

Question Is use of anticholinergic medication associated with poorer cognition, brain hypometabolism, brain atrophy, and/or increased risk of clinical decline in cognitively normal older adults?

Findings In this longitudinal study of 2 cohorts of cognitively normal older adults, use of medications with medium or high anticholinergic activity was associated with poorer memory and executive function, brain hypometabolism, brain atrophy, and increased risk of clinical conversion to cognitive impairment. This finding was greatest for those taking drugs with the most anticholinergic activity.

Meaning Use of medication with significant anticholinergic activity should likely be discouraged in older adults if alternative therapies are available.

Methods

Alzheimer's Disease Neuroimaging Initiative

Data used in the preparation of this article were obtained from the ADNI (http://adni.loni.usc.edu; for more information, see the eAppendix in the Supplement, http://www.adni-info.org, and previous reports[24-29]). Written informed consent was obtained according to the Declaration of Helsinki.[30]

Indiana Memory and Aging Study

The IMAS includes CN participants, participants with subjective cognitive decline, participants with MCI, and participants with AD, but only data from CN participants and participants with subjective cognitive decline were used for this analysis. Participants provided written informed consent according to the Declaration of Helsinki,[30] and the procedures were approved by the Indiana University Committee for the Protection of Human Subjects.

AC Medications

Medication logs from the ADNI and the IMAS were manually curated to identify medications with low, medium, or high AC effects as defined by the Anticholinergic Cognitive Burden (ACB) scale and other reports.[18,31-33] See eTable 1 in the Supplement for all medications identified. To be defined as an AC$^+$ participant, participants had to have been taking the medication at the baseline visit for a minimum of 1 month. The total AC burden score was also calculated using the ACB scale, which uses the literature to guide an expert-based determination of the adverse cognitive AC activities (low effect = 1, medium effect = 2, and high effect = 3). The total AC burden score was the sum of ACB scores of all applicable medications taken by a participant.[4,6,8] See eTable 2 in the Supplement for medications included in calculating the total AC burden score.

Participants

A total of 402 CN participants from ADNI 1, ADNI Grand Opportunity, and ADNI 2, including 301 CN participants without significant memory concerns and 101 CN participants with significant memory concerns, were included in the present analysis. A diagnosis was made as previously described[34,35] and as in the ADNI 2 manual (http://www.adni-info.org/Scientists/doc/ADNI2_Procedures_Manual_20130624.pdf). Participants were divided by AC medication use into those taking 1 or more medications with medium or high AC activity (AC$^+$ participants) and those not taking any such medications (AC$^-$ participants), resulting in 52 AC$^+$ participants and 350 AC$^-$ participants. There was no significant difference in the rates of AC use between CN participants with significant memory concerns and those without, nor was there a significant effect of diagnosis (with or without significant memory concerns) or of the interaction between diagnosis and AC use on clinical progression.

The CN participants with or without subjective cognitive decline from the IMAS were also evaluated as an independent replication sample. Participants were CN if they had normal cognition relative to demographically adjusted norms and no significant self- or informant-based cognitive complaints. Participants had subjective cognitive decline if they had normal cognition and self- and/or informant-based complaints. From the IMAS, there were 8 AC$^+$ participants and 41 AC$^-$ participants.

Cognitive Testing

The ADNI participants underwent a comprehensive cognitive and clinical battery. We assessed the effect of AC use on executive function (Trail Making Test Part B [TMT-B], a composite executive function score[36]) and memory (Weschler

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Memory Scale-Revised Logical Memory Immediate and Delayed, a composite memory score[37]).

Participants from the IMAS received a battery of neuropsychological tests and cognitive concern questionnaires, most of which have been previously described.[38] After preadjusting for age, sex, and education, combined *z* scores (relative to the complete IMAS CN group) were generated for 3 domains: executive function, memory, and general cognition. We then assessed the effect of AC use on the *z* scores of these 3 domains.

Fluorodeoxyglucose F 18 Positron Emission Tomography

Preprocessed fluorodeoxyglucose F 18-positron emission tomographic (FDG-PET) scans (coregistered, averaged, standardized image and voxel size, and uniform resolution) were downloaded from the ADNI Laboratory of Neuroimaging (LONI) site (http://adni.loni.usc.edu) and processed as previously described.[25,34] Mean standardized uptake value ratios (SUVRs) were extracted from 2 regions of interest, including a bilateral hippocampal region of interest[39] and an overall cortical region of interest representing regions where CN participants show greater glucose metabolism than participants with AD from the full ADNI 1 cohort. Seventy-three participants were excluded from FDG-PET analyses for missing data. The IMAS participants did not undergo FDG PET.

Structural Magnetic Resonance Imaging

Baseline structural 3-T magnetic resonance imaging (MRI) scans were downloaded from LONI for ADNI 2 participants; ADNI 1 participants were excluded because their scans were collected on 1.5-T scanners using a different protocol. Scans were corrected prior to downloading as previously described.[24] After downloading, we processed the scans using FreeSurfer version 5.1[34,35] to extract target measures of atrophy selected for known relevance in cognitive function and AD (temporal lobe, ventricle volume, and total cortex). If 2 MRI scans were available, the values from both scans were averaged. A total of 116 ADNI participants were excluded from this analysis owing to missing data. The IMAS participants underwent structural magnetization-prepared rapid acquisition gradient-echo scans on a Siemens 3T Tim Trio using the ADNI sequence. Similar to ADNI, scans were processed using FreeSurfer version 5.1 to extract the same atrophy measures. Two participants were excluded owing to missing data.

Confounding Effects of Medical History and Medication Use

Because the observed effects may potentially be caused by overall morbidity in AC$^+$ participants, we evaluated the effect of the total number of medications, the total number of common comorbid conditions, and the presence or absence of each comorbid condition. The comorbid conditions tested included transient ischemic attack, myocardial infarction, cardiac surgery, hypertension, hyperlipidemia, diabetes, sleep apnea, other vascular disorders, insomnia, depression, anxiety, attention-deficit/hyperactivity disorder, and other psychiatric disorders. First, we determined whether there was a difference between AC$^+$ participants and AC$^-$ participants regarding medical history and medication use (**Table**). Next, we determined whether these variables were associated with the outcome variables. Finally, we included those variables that were either different between AC$^+$ participants and AC$^-$ participants or associated with an outcome in the general linear model assessing the effect of AC medication use on cognitive and imaging measures. Only those that were significant within the final general linear model were included (covariates reported in the Results). Furthermore, we randomly selected samples matched on medical history variables (52 AC$^-$ participants and 52 AC$^+$ participants) and ran similar analyses.

Statistical Analysis

In the ADNI, cross-sectional measures of cognitive performance, glucose metabolism, and brain atrophy were compared between AC$^+$ participants and AC$^-$ participants using a general linear model preadjusted for age, sex, and Aβ positivity (yes/no; defined using previously established cutoffs on either cerebrospinal fluid sample [Aβ1-42 < 192 mg/mL][40] or cortical florbetapir F-18 SUVR [SUVR≥1.1],[41] years of education [included in analyses of cognitive variables only], and total intracranial volume [included in analyses of MRI variables only] using the residuals of a linear regression model). After checking normality, we determined that the TMT-B score, the FDG SUVR in the cortical region of interest, and the inferior lateral ventricle and lateral ventricle volumes were skewed. Using log transformations, we normalized the TMT-B scores and FDG SUVR in the overall cortical region-of-interest variables, while the ventricular volumes were normalized using a square root transformation. These transformed variables were used in the statistical analyses to test the effect of AC medication use. All other variables were normally distributed, so untransformed values are reported. The statistical threshold for significance was set at $P < .05$.

Associations between the total AC burden score and cognitive performance, glucose metabolism, and brain atrophy measures were evaluated using Spearman correlation models. Target cognitive and imaging variables were preadjusted for age, sex, Aβ positivity, education, medical history variables (see Results), and total intracranial volume as appropriate.

Finally, a Cox regression model was used to determine whether AC medication use was associated with clinical progression from CN to MCI and/or AD in the ADNI cohort (mean [SD] follow-up period, 32.1 [24.7] months [range, 6-108 months]), covaried for age, sex, medical history variables (see Results), and Aβ positivity. We also looked at the interaction of AC medication use and Aβ positivity on clinical progression.

Cognitive performance and brain atrophy measures were compared between AC$^+$ participants and AC$^-$ participants in the IMAS to replicate the results observed in the ADNI. All measures showed a normal distribution. A general linear model was used to assess the effect of AC medication use in the IMAS, covaried for age, sex, education, and total intracranial volume as appropriate. Associations between the total AC burden score and cognitive performance and brain atrophy measures were also evaluated using Spearman correlation models. No medical history variables were found to be significant covariates in the IMAS.

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Table. Demographic Characteristics and Medical Histories of 402 Participants From the ADNI

Characteristic	Participants, No.		P Value
	AC⁻ (n = 350)	AC⁺ (n = 52)	
Age, mean (SD), y	73.3 (5.8)	73.3 (6.6)	.96
Sex			
Male	171	18	.06
Female	179	34	
Education, mean (SD), y	16.4 (2.6)	16.1 (2.7)	.40
Handedness			
Right	318	50	.20
Left	32	2	
APOE ε4 positive, % of participants	28.0	25.0	.65
Non-Hispanic white, % of participants	84.6	94.2	.06
Medications, mean (SD), Total No.	4.2 (2.8)	6.7 (3.1)	<.001
Comorbid conditions, mean (SD), Total No.	1.8 (1.3)	2.2 (1.5)	.03
Transient ischemic attack			
No	341	51	.78
Yes	9	1	
Myocardial infarction			
No	325	51	.15
Yes	25	1	
Cardiac surgery			
No	330	50	.58
Yes	20	2	
Hypertension			
No	193	24	.23
Yes	157	28	
Hyperlipidemia			
No	181	29	.59
Yes	169	23	
Diabetes			
No	324	49	.67
Yes	26	3	
Sleep apnea			
No	334	49	.70
Yes	16	3	
Other vascular conditions (eg, atrial fibrillation)			
No	327	47	.42
Yes	23	5	
Anxiety			
No	342	47	.01
Yes	8	5	
Depression			
No	306	37	.002
Yes	44	15	
Insomnia			
No	338	46	.01
Yes	12	6	
ADD or ADHD			
No	348	52	.59
Yes	2	0	
Other psychiatric condition (eg, posttraumatic stress disorder)			
No	348	52	.56
Yes	2	0	
Concussion			
No	331	48	.51
Yes	19	4	

Abbreviations: AC⁺, participant taking anticholinergic medication with medium or high anticholinergic activity; AC⁻, participant not taking anticholinergic medication; ADD, attention-deficit disorder; ADHD, attention-deficit/hyperactivity disorder; ADNI, Alzheimer's Disease Neuroimaging Initiative.

Results

Cognitive Performance

No significant differences in age, sex, education, ethnicity/race, or *APOE* ε4 genotype were observed between AC⁺ participants and AC⁻ participants in either sample (Table; see eTable 3 in the Supplement for the demographic characteristics of the IMAS participants). Of the medical variables examined, only the total number of medications, the total number of comorbid conditions, anxiety, and depression were different between AC⁺ participants and AC⁻ participants ($P < .05$). Significant effects of AC

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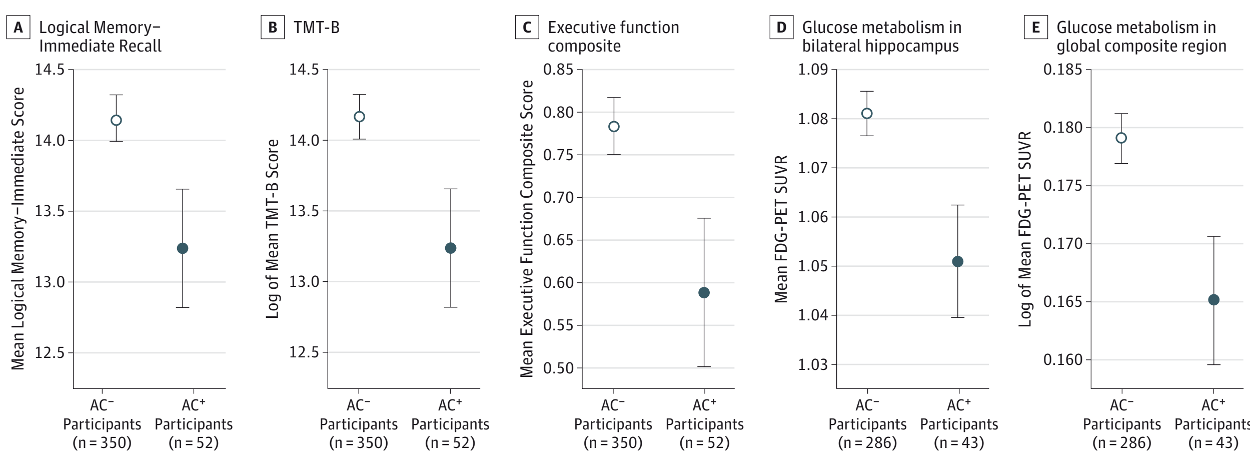
Figure 1. Association of Anticholinergic (AC) Medication Use With Cognition and Glucose Metabolism Among Participants From the Alzheimer's Disease Neuroimaging Initiative (ADNI)



Cognitively normal older adults taking 1 or more medications with medium or high AC activity (referred to as AC⁺ participants [n = 52]) showed poorer cognition than those not taking these medications (referred to as AC⁻ participants [n = 350]), including a lower score on the Weschler Memory Scale–Revised Logical Memory Immediate Recall (*P* = .04 [A]), the Trail Making Test Part B (TMT-B) (*P* = .04 [B]), and an executive function composite (*P* = .04, with transient ischemic attack, myocardial infarction, and diabetes as additional covariates [C]). Glucose hypometabolism, as measured by the fluorodeoxyglucose F 18–positron emission tomographic (FDG-PET) standardized uptake value ratio (SUVR), was also observed in the bilateral hippocampus (*P* = .02, with anxiety as an additional covariate [D]) and in a global cortical region of interest of AC⁺ participants (n = 43) relative to AC⁻ participants (n = 286), generated from an analysis of cognitively normal participants who show greater glucose metabolism than participants with AD from the full ADNI 1 cohort (*P* = .03, with other vascular conditions and concussion as additional covariates [E]). Error bars indicate SD.

medication use on the mean Logical Memory–Immediate score (raw mean scores: 13.27 for AC⁺ participants and 14.16 for AC⁻ participants; *P* = .04 [**Figure 1**A]), the mean TMT-B score (raw mean scores: 97.85 seconds for AC⁺ participants and 82.61 seconds for AC⁻ participants; *P* = .04 [Figure 1B], with transient ischemic attack as an additional covariate), and the mean composite executive function score (raw mean scores: 0.58 for AC⁺ participants and 0.78 for AC⁻ participants; *P* = .04 [Figure 1C], with transient ischemic attack, myocardial infarction, and diabetes as additional covariates) were found, with AC⁺ participants showing lower scores than AC⁻ participants. The mean Logical Memory–Delayed Memory score (raw mean scores: 12.40 for AC⁺ participants and 13.24 for AC⁻ participants; *P* = .07) and the mean memory composite score (raw mean scores: 0.85 for AC⁺ participants and 0.93 for AC⁻ participants; *P* = .11 [data not shown]) trended toward significance, with AC⁺ participants showing lower scores than AC⁻ participants. In the IMAS, the general mean cognition *z* score was significantly reduced for the AC⁺ participants relative to the AC⁻ participants (raw mean scores: −1.27 for AC⁺ participants and −0.34 for AC⁻ participants; *P* = .03 [eFigure 1 in the Supplement]).

FDG Positron Emission Tomography

Differences in glucose metabolism between AC⁺ participants and AC⁻ participants were observed, with the AC⁺ participants showing reduced glucose metabolism in the hippocampus (raw mean values: 1.06 for the AC⁺ participants and 1.08 for AC⁻ participants; *P* = .02 [Figure 1D], with anxiety as an additional covariate) and the global FDG-PET region of interest (raw mean values: 1.48 for AC⁺ participants and 1.52 for AC⁻ participants; *P* = .03 [Figure 1E], with concussion and other vascular diseases as additional covariates) relative to AC⁻ participants.

Structural MRI

A significant effect of AC medication use on brain structure was also observed. The AC⁺ participants demonstrated reduced total cortical volume (raw mean values: 406134.21 mm^3 for AC⁺ participants and 423107.01 mm^3 for AC⁻ participants; *P* = .02 [**Figure 2**A]) and larger lateral ventricle (raw mean values: 17880.19 mm^3 for AC⁺ participants and 15620.22 mm^3 for AC⁻ participants; *P* = .01 [Figure 2B]) and inferior lateral ventricle volumes (raw mean values: 757.25 mm^3 for AC⁺ participants and 571.49 mm^3 for AC⁻ participants; *P* < .001 [Figure 2C]) relative to the AC⁻ participants. Regional effects were also observed in the temporal lobe, with AC⁺ participants showing a reduced temporal lobe cortical thickness (raw mean values: 2.80 mm for AC⁺ participants and 2.84 mm for AC⁻ participants; *P* = .02 [Figure 2D], with concussion as an additional covariate) and a reduced medial temporal lobe (MTL) cortical thickness (raw mean values: 3.10 mm for AC⁺ participants and 3.15 mm for AC⁻ participants; *P* = .02 [Figure 2E], with concussion and cardiac surgery as additional covariates) relative to AC⁻ participants. In the IMAS, the AC⁺ participants had a reduced MTL cortical thickness (raw mean values: 2.91 mm for AC⁺ participants and 3.10 mm for AC⁻ participants; *P* = .01 [eFigure 2A in the Supplement]) and showed a trend toward thinner bilateral temporal lobe cortices (raw mean values: 2.69 mm for AC⁺ participants and 2.81 mm for AC⁻ participants; *P* = .05 [eFigure 2B in the Supplement]) compared with the AC⁻ participants.

Association of Total AC Burden Score With Cognition and Brain Atrophy

Significant associations of the total AC burden score with cognition and brain atrophy were observed. Specifically, a higher total AC burden score was associated with a poorer TMT-B per-

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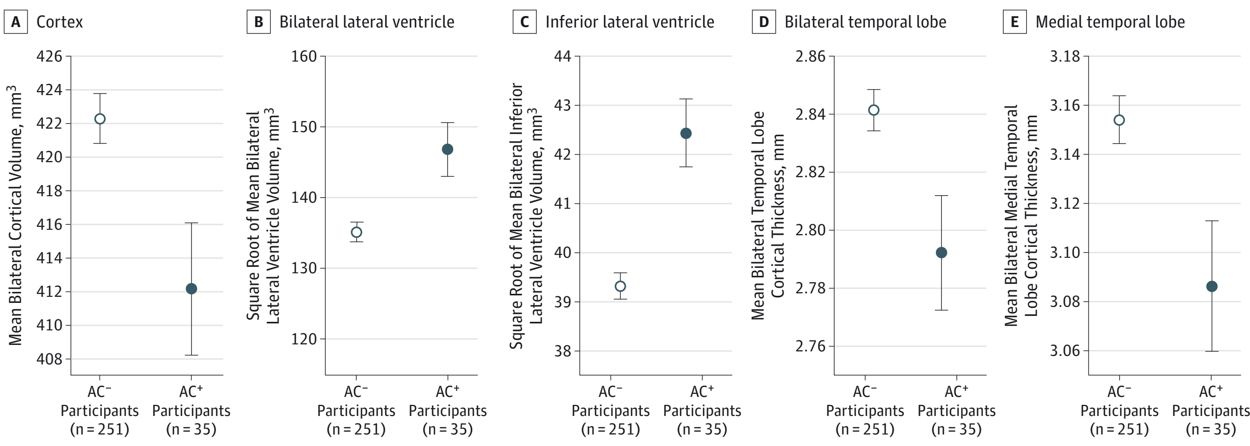
Figure 2. Effect of Anticholinergic (AC) Medication Use on Brain Atrophy Measures



Cognitively normal older adults taking 1 or more medications with medium or high anticholinergic activity (referred to as AC+ participants [n = 35]) showed more brain atrophy than participants not taking these medications (referred to as AC− participants [n = 251]). Reduced total cortex volume ($P = .02$ [A]), increased bilateral lateral ventricle volume ($P = .01$ [B]), and increased inferior lateral ventricle volume ($P < .001$ [C]) were observed in AC+ participants relative to AC− participants. Furthermore, reduced bilateral temporal lobe ($P = .02$, with concussion as an additional covariate [D]) and medial temporal lobe ($P = .02$, with concussion and cardiac surgery as additional covariates [E]) cortical thicknesses were also observed. Error bars indicate SD.

formance ($r = 0.137$; $P = .01$ [**Figure 3**A], with transient ischemic attack and total number of medications additional as covariates) and greater inferior lateral ventricle ($r = 0.126$; $P = .03$ [Figure 3B]) and lateral ventricle volumes ($r = 0.154$; $P = .01$ [Figure 3C]). The inferior lateral ventricle volume remained significantly associated with the total AC burden score after excluding participants with a total AC burden score of 0 ($r = 0.331$; $P < .001$ [Figure 3E]). The TMT-B score ($r = 0.146$; $P = .06$ [Figure 3D]) and the lateral ventricle volume ($r = 0.152$; $P = .10$ [Figure 3F]) showed nonsignificant trend associations with the total AC burden score after excluding those participants with a total AC burden score of 0.

In the IMAS, the pattern of results was similar, although mostly nonsignificant trends were observed owing to attenuated power. Specifically, a higher total AC burden score was associated with reduced general cognition and atrophy (eFigure 3 in the Supplement). A trend for a negative association between the total AC burden score and general cognition across all participants ($r = −0.239$; $P = .10$ [eFigure 3A in the Supplement]) was observed, which was significant after excluding those with a total AC burden score of 0 ($r = −0.625$; $P = .004$ [eFigure 3C in the Supplement]). A negative association was observed between the total AC burden score and MTL cortical thickness ($r = −0.313$; $P = .03$ [eFigure 3B in the Supplement]), which only trended toward significant after excluding those with a total AC burden score of 0 ($r = −0.428$; $P = .07$ [eFigure 3D in the Supplement]).

Association of AC Use With Future Progression

A significant association between AC medication use and future progression of ADNI participants to MCI and/or AD was observed ($P = .01$; hazard ratio, 2.47 [**Figure 4**A]; with total number of medications, cardiac surgery, total number of comorbid conditions, and other psychiatric conditions as additional covariates). After evaluating the interaction between AC medication use and Aβ positivity, we observed that AC+ participants who are Aβ positive showed the highest risk of conversion relative to AC− participants who are Aβ negative ($P < .001$; hazard ratio, 7.73 [Figure 4B]; with cardiac surgery and other psychiatric conditions as additional covariates) or those who are positive for either AC medication use or Aβ ($P = .001$; hazard ratio, 4.24 [Figure 4B]).

Matched Sample

In the matched sample, the AC+ participants showed reduced total cortex volumes (raw mean values: 406134.21 mm^3 for AC+ participants and 417770.60 mm^3 for AC− participants; $P = .01$), increased inferior lateral ventricle volumes (raw mean values: 757.25 mm^3 for AC+ participants and 583.62 mm^3 for AC− participants; $P = .02$), and an increased likelihood for clinical conversion ($P = .01$; hazard ratio, 3.87 [data not shown]) compared with the AC− participants. The AC+ participants also showed a trend toward poorer Logical Memory–Immediate performance (raw mean values: 13.27 for AC+ participants and 14.42 for AC− participants; $P = .08$) and increased lateral ventricle volumes (raw mean values: 17880.19 mm^3 for AC+ participants and 15164.28 mm^3 for AC− participants; $P = .10$ [data not shown]) compared with the AC− participants.

Discussion

Use of medications with medium or high AC effects in the ADNI cohort was associated with poorer cognition (particularly in immediate memory recall and executive function), reduced glucose metabolism, whole-brain and temporal lobe atrophy, and clinical decline. The effect appeared additive because an increased burden of AC medications was associated with poorer executive function and increased brain atrophy. Similar effects were seen in an independent cohort of

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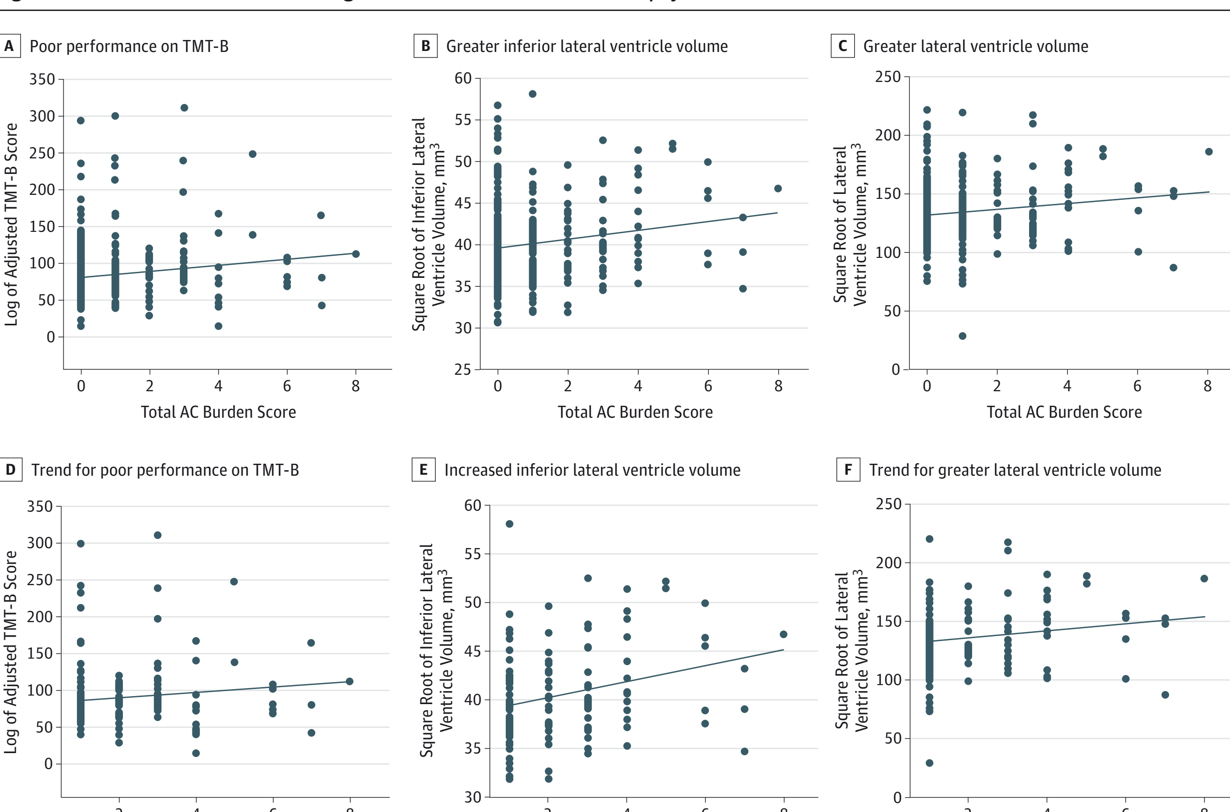
Figure 3. Association of Total Anticholinergic (AC) Burden Score and Brain Atrophy



The total AC burden score was significantly associated with both cognition and brain atrophy. Specifically, a higher total AC burden score was associated with poorer performance on the Trail Making Test Part B (TMT-B) (r = 0.137; P = .01, with transient ischemic attack and total number of medications as additional covariates [A]) and greater inferior lateral ventricle (r = 0.126; P = .03 [B]) and lateral ventricle volumes (r = 0.145; P = .01 [C]). Inferior lateral ventricle volume was still significantly associated with the total AC burden score after excluding participants with a total AC burden score of 0 (r = 0.331; P < .001 [E]). The TMT-B score (r = 0.146; P = .06 [D]) and lateral ventricle volume showed nonsignificant trend associations with the total AC burden score after excluding those with a total AC burden score of 0 (r = 0.152; P = .10 [F]).

older adults. These results suggest that medications with AC properties may be detrimental to brain structure and function, as well as cognition.

The observed findings support previous reports[1-16] regarding the association between AC medication use and cognitive impairments, with a significant effect of AC medication use on executive and immediate, rather than delayed, memory. We also found that the increased clinical progression from CN to MCI and/or AD was associated with AC medication use.

This study is one of the first, to our knowledge, to examine in vivo brain structural and functional differences between CN participants taking medications with medium or high AC activity and CN participants not taking these medications. We observed that AC^+ participants had reduced brain glucose metabolism and increased brain atrophy compared with AC^- participants. Furthermore, those with the highest total AC burden scores showed the most atrophy.

The increased brain atrophy and decreased brain function that we observed may be linked to the central effects of AC medications on cholinergic pathways within the brain. Cholinergic pathways, especially those extending from the basal forebrain, are important for cognition.[42] Studies have suggested that AC medications may affect cognition by altering cholinergic inputs, with a study[23] showing that AC medication administration leads to an uncoupling between brain structure and cognition in older adults. The process by which AC medications might lead to neurodegeneration is less clear. Cholinergic receptor antagonists have been shown to induce cell death,[43] while increased cholinergic neurotransmission reduces neurodegeneration in an AD mouse model.[44] Decreased cholinergic activity due to AC medications may induce synaptic loss and neurodegeneration in regions with significant cholinergic innervation, namely the MTL and cortex.[45]

In mice, lesioning or damaging cholinergic neurons in the basal forebrain has been shown to cause degeneration of the septal-hippocampal and basalo-cortical projections and neurons in the hippocampus and cortex.[46] Another possibility is that participants taking AC medications may be more sensitive to neuronal damage in response to stress. This hypothesis centers around the interaction of cholinergic systems and stress because MTL cholinergic neurons have been shown to regulate the hypothalamic-pituitary-adrenal axis.[47] Reduced cholinergic ac-

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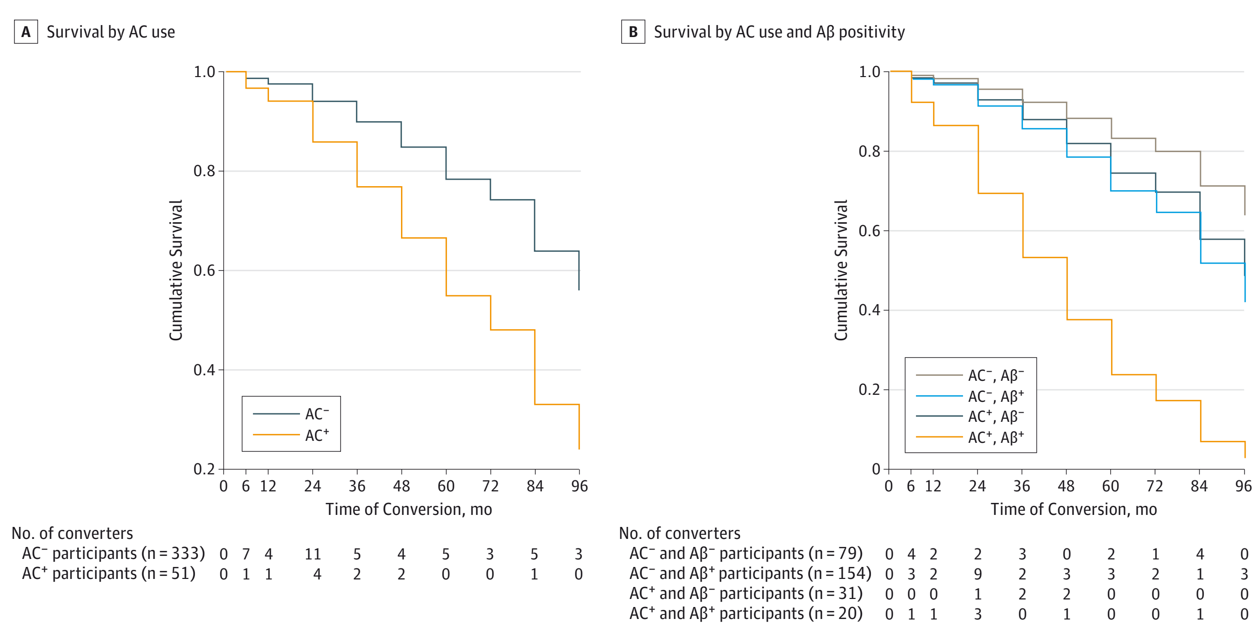
Figure 4. Effect of Anticholinergic (AC) Medication Use on Clinical Conversion



A, A significant association between AC use and future progression of Alzheimer's Disease Neuroimaging Initiative participants to mild cognitive impairment and/or Alzheimer disease was observed (P = .01; hazard ratio [HR], 2.47; with total number of medications, cardiac surgery, total number of comorbid conditions, and other psychiatric conditions as additional covariates). B, When evaluating the interaction between AC use and Aβ positivity, we found that participants taking 1 or more medications with medium or high AC activity who are positive for Aβ on florbetapir F-18–positron emission tomographic (PET) scans or cerebrospinal fluid (CSF) samples (referred to as AC⁺ and Aβ⁺ participants) showed a higher risk of conversion relative to participants not taking these medications who are negative for Aβ on florbetapir F-18–PET scans or CSF samples (referred to as AC⁻ and Aβ⁻ participants) (P < .001; HR, 7.73; with cardiac surgery and other psychiatric conditions as additional covariates) and participants who are positive for either AC use or Aβ (P = .001; HR, 4.24).

tivity has been linked to increased plasma corticosterone levels, which in turn are linked to increased hippocampal cell death.[47] Furthermore, chronic stress has been associated with increased Aβ levels, tau hyperphosphorylation and aggregation, and neurodegeneration in mouse models through dysregulation of the hypothalamic-pituitary-adrenal axis.[48]

Overall, the findings in this study provide a potential biological basis for the reduced cognition associated with the use AC medications through the functional and structural changes in the brain. However, future longitudinal studies with imaging and other brain biomarkers, as well as in animal models, are needed to more fully understand the mechanism underlying the effect of AC medications on the brain.

There are a few notable limitations to this study. First, the information on medication use was based on self-report rather than directly ascertained through medical/prescription records. Self-report could be inaccurate because participants may forget to report specific medication use. However, given the normal cognitive status of the participants at baseline, it is unlikely that they would have reported taking medications that they were, in fact, not taking. Thus, the observed effect is potentially underestimated because some AC⁻ participants may in fact have been taking an AC medication. Future studies using medical/pharmacy records, along with imaging and biomarker measures, would help to confirm the findings of the present study.

A second limitation is the relatively small sample size of AC⁺ participants. Future studies using larger samples are warranted. A third limitation is the inability to determine the causality of the findings because the results may be due to poor health rather than AC medication use.[49] We did include common comorbid health conditions (eg, vascular and psychiatric conditions), total number of medications, and total number of comorbid conditions as covariates. However, the only way to determine true causality would be by use of a well-controlled prospective longitudinal study.

Another limitation may be the variability in the duration of AC medication use among participants. Furthermore, a participant who had taken an AC medication for many years but ceased shortly before the baseline visit would not be captured as an AC⁺ participant. Future studies with a better-controlled medication history assessment (ie, using medical/pharmacy records and patient self-report) are warranted, as well as studies on the effect of the duration of AC medication use on the target outcomes. Finally, only structural MRI and FDG PET were assessed in the present report. Future studies examining changes on more advanced imaging measures (ie, diffusion tensor imaging and resting-state or task-based functional MRI) would provide additional evidence about the selective effect of AC medications on the brain structure and function in specific circuits.

Conclusions

In summary, we observed that CN older adults taking medications with medium or high AC activity showed poorer cognition, reduced cerebral glucose metabolism, increased

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brain atrophy, and increased clinical decline compared with those not taking these medications and that these symptoms were greatest in CN older adults with the highest total AC burden scores. These findings highlight the importance of considering the cognitive adverse effects of AC medications before using them to treat older adults at risk for cognitive decline in a clinical setting, as well as in therapeutic trials.

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The 2019 Beers Criteria: What You Need to Know

Linda Brookes, MSc

February 22, 2019

The Beers Criteria[1] may well be one of the best-kept secrets in geriatrics. While widely cited in prescribing guidelines for older adults, some geriatricians, at least anecdotally, report that many primary care physicians either don't know about them or don't use them, even though 90% of older adults take at least one prescription drug.[2] And about one third of these older patients have been prescribed at least one drug on the Beers Criteria warning list.[3]

The Beers Criteria do more than guide decisions about what drugs to use in older patients. They also tell us what *not* to do—that is, what drugs are potentially good candidates for deprescribing.[4]

Issued by the American Geriatrics Society (AGS), the latest version of the Beers Criteria was released in January 2019. These updated criteria, which apply to all clinical settings except hospice and palliative care, list 30 individual medications or medication classes to be avoided. The criteria list more than 40 additional drugs or drug classes that should be used with caution or avoided altogether in certain diseases or conditions.

Medscape spoke with Michael A. Steinman, MD, co-chair of the AGS committee, about these updates and their implications.

What's Changed?

The 2019 update drops 25 medications or medication classes included in earlier versions because they are no longer available in the United States or because concerns with the drugs are not limited to the older population alone.

Otherwise, the new recommendations do not differ extensively from those of 2015.[5] "That reflects the stability of our recommendations and a maturity in the evidence for many of the drugs," Steinman contended. He did caution, however, that "the literature isn't as robust as we would like for some of these medications."

The rationale for each recommendation, the quality of supporting evidence, and the graded strength of the recommendation are clearly noted. For example, the criteria list 15 first-generation antihistamines as drugs to avoid, noting, among other reasons, that they are highly anticholinergic and that clearance is reduced with advanced age. While the quality of evidence is determined to be moderate, the Beers committee grades the recommendation as strong. Another example: proton-pump inhibitors. These drugs are associated with a risk for *Clostridium difficile* infection as well as bone loss; evidence is high. But the strong recommendation to avoid is more nuanced, noting that scheduled use for more than 8 weeks should be avoided except for certain high-risk patients.

However, the Beers Criteria are not intended to be taken as gospel. In an accompanying editorial,[6] Steinman and his AGS panel co-chair Donna Fick, PhD, RN, caution against strict adherence to the criteria without considering individual patient circumstances.

In practice, the quality of the evidence is probably not the primary driver of clinician decision-making, Steinman believes. "It's a question of doing the best with the evidence that is out there. The vast majority of recommendations in most guidelines do not have a strong evidence base to support them."

Keeping the Focus Where It Belongs

The Beers Criteria do not include medications that could be a problem for patients of all ages, instead keeping their focus on those that create special concerns in the elderly. "We wanted to emphasize that the harms and benefits of drugs can change as people age," Steinman stressed. "Clinicians may not fully appreciate the additional risks that come with age as well as the changing opportunity for benefit."

The Beers authors stress that the criteria should not be used to excessively restrict access to these medications.

He outlined some of the challenges faced in deciding which drugs to retain in the updated criteria, noting that "some medications were removed not because their benefits and risks have changed, but because these drugs were only rarely used. We wanted to declutter the criteria and ensure that people weren't overwhelmed." Instead, the focus is on more frequently prescribed drugs —though "how you determine that is not always easy," he admitted.

What's Missing in the 2019 Update

Statins. A widely used drug class that some might have expected to see in the Beers Criteria is absent. Studies of statins for primary prevention of cardiovascular disease have reached different conclusions about benefit in people over 65, and major guidelines in North America and Europe differ in their recommendations for the use of statins in older adults.[7] Recent reviews found little or no benefit in the very elderly,[8,9] and the latest US cholesterol management guidelines advise that statins may have limited benefit in adults aged ≥ 75 years with physical or cognitive functional decline, comorbidities, or frailty.[10] "Concerns have been raised about the role of statins, particularly in primary prevention for older adults, but we did not find any very clear evidence for an unambiguous recommendation," Steinman said. Further clarification is expected in 2020, when the STAREE (Statins in Reducing Events in the Elderly) trial of atorvastatin versus placebo in individuals aged ≥ 70 years is completed.

Drugs approved in other countries. Also absent from the Beers Criteria are medications not approved in the United States. But that does not mean that they are not useful for clinicians in other countries. "It's a matter of applying common sense," according to Steinman. "For example, a blanket recommendation to avoid benzodiazepines would also apply to benzodiazepines not available here. The principles are the same, even though the specific medications might differ from country to country," he maintained.

The Beers Criteria Should Not Be Overused

The Beers authors stress that the criteria should not be used to excessively restrict access to these medications through policies such as prior authorization and/or health plan coverage policies.[6,11] The American Medical Association (AMA) recently voiced concern that payers may use the Beers Criteria inappropriately to rate quality of care delivered by a physician and determine coverage, potentially financially penalizing physicians. In a 2018 resolution, the AMA emphasized that the Beers Criteria "should not be applied in a punitive or onerous manner to physicians and must recognize that deviations from the quality measure may be appropriate."

Steinman agreed. "We certainly don't want the criteria to be used to restrict access for people and penalize them." There will still be individual patients who can appropriately be prescribed drugs that warrant caution.

Access to the Beers Criteria

The 2019 AGS Beers Criteria document is available free to AGS members and to subscribers of the *Journal of the American Geriatrics Society,* but nonmembers must pay ($42.00 currently) to download a printable version. The AGS and Steinman declined to comment on why the paper is not available free of charge to everyone. The 2019 criteria can also be accessed for a fee via the AGS iGeriatrics smartphone app ($9.99/year for all subscribers). The AGS has entered into a 15-year license agreement with Clinical Support Information Systems to incorporate the Beers Criteria into medication review solution software.

A summary of the Beers Criteria for patients is available free on the website of the AGS's Health in Aging Foundation, along with tip sheets in English and Spanish and what patients can do if they find that they are taking a medication on the list. The AGS believes that the criteria provide a useful tool for initiating conversations between patients and healthcare providers about the effectiveness, adverse effects, cost, adherence, and goals of care for patients' entire medication regimens.

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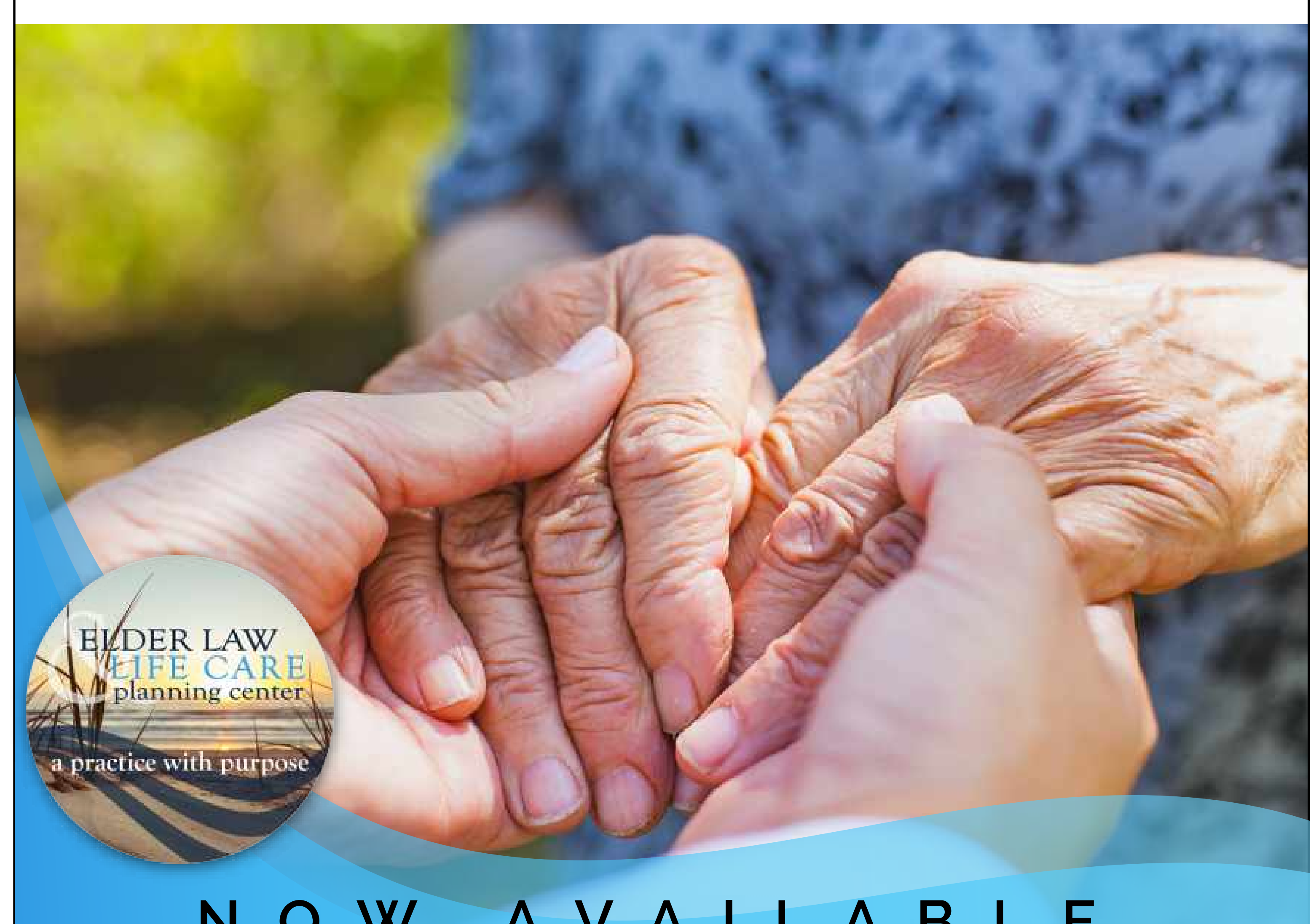

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Helayne Levy Payne
Helayne Levy Payne, M.A., J.D., LL.M. in Elder Law CDP, CADDCT

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You're *Not* Alone

Living With Alzheimer's Disease - Local Resource Guide

Local Support Systems

According to the National Institute on Aging, many caregivers find building a local support system is a key way for them to get help. That local support system might include family members and friends, faith groups, and caregiver support groups.

Brunswick Senior Resources, Inc.

Phone: 1-910-754-2300
List of locations online at www.bsrinc.org

Brunswick Senior Resources, Inc. and The Cape Fear Area Agency on Aging provides information, resources, case assistance, educational programs, and free support groups in the community throughout the year. The full list of area support groups are here: http://capefearcog.org/wp-content/uploads/2019/11/Support-Groups-11-2019.pdf

New Hanover County Senior Resource Center

Phone: 1-910-798-6400
List of locations online at src.nhcgov.com/

New Hanover County Senior Resource Centerprovide services which promote wellness, encourage independence, and enhance quality of life for all older persons.

Dementia Alliance of North Carolina

Phone: 1-800-228-8738

The Dementia Alliance provide support and resources all around the state of North Carolina.

Project Life Saver

A rescue program for individuals with "Wandering Syndrome," A symptom common to many brain related disorders. New Hanover and Brunswick Counties are the only local sheriff's offices offering this FREE resource.

Brunswick Contact Information:

Phone: 910-253-2749
Mailing Address: P.O. Box 9, Boliva, NC 28422
Address: 70 Stamp Act Drive, Boliva, NC 28422
Website: http://www.brunswicksheriff.com/community-programs/project-lifesaver

New Hanover Contact Information:

Phone: 910-798-4200
Address: 3950 Juvenile Center Rd., Castle Hayne, NC 28429
Website: https://www.newhanoversheriff.com/Forms-Permits-Resources/

Cape Fear Council of Governments Family Caregiver Support Program

Phone: 910-395-4553
Website: https://capefearcog.org/area-agency-on-aging/family-caregiver-support-program/

The NFCSP offers a range of services to support family caregivers. Specific services vary by county but generally include:

- Information to caregivers about available services,
- Assistance to caregivers in gaining access to the services,
- Individual counseling, organization of support groups, and training to assist caregivers in the areas of health, nutrition, and financial literacy, and in making decisions and solving problems about their caregiving roles
- Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- Supplemental services, on a limited basis

These services can work in conjunction with other State and Community-Based Services to provide a coordinated set of supports. Studies have shown that these services can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care.

Other Support Sources and Resources:

Eldercare Locator
Phone: 1-800-677-1116
Website: https://eldercare.acl.gov

Caregivers often need information about community resources, such as home care, adult day care, and nursing homes. Contact the Eldercare Locator to find these resources in your area. The Eldercare Locator is a service of the Administration on Aging. The Federal Government funds this service.

National Institute on Aging Information Center
Email: niaic@nia.nih.gov
Phone: 1-800-222-2225
Website: www.nia.nih.gov/health

The NIA Information Center offers free publications about aging. Many of these publications are in both English and Spanish. They can be viewed, printed, and ordered online.

Project C.A.R.E
Phone: 844-728-0191
https://www.ncdhhs.gov/assistance/adult-services/project-care

Project C.A.R.E. (Caregiver Alternatives to Running on Empty) is the only state funded, dementia specific support program for individuals who directly care for loved ones with Alzheimer's disease or related dementias. Project C.A.R.E. is a coordinated delivery system that is responsive to the needs, values and preferences of unpaid family caregivers.

GoGo Grandparent
Phone: 855-464-6872
This service allows adults without a smartphone to use rideshare services like Lyft or Uber. 24/7 operators add reliability and extra eyes. They can also help keep emergency contacts in the loop.

EatWell
https://www.eatwellset.com/

Tips and tools for taking care of loved ones with dementia. They have customized color and pattern adaptive dishes to help people living with dementia eat more successfully.

Direct Services: Groups That Help with Everyday Care in the Home
Here is a list of services that can help you care for the person with Alzheimer's at home. Find out if these services are offered in your area. Also, contact Medicare to see if they cover the cost of these services. You can reach Medicare at 1-800-633-4227.

Home Health Care Services
Home health care services send a home health aide to your home to help you care for a person with Alzheimer's. These aides provide care and/or company for the person. They may come for a few hours or stay for 24 hours. Some home health aides are better trained and supervised than others.
What to know about costs:

- Home health services charge by the hour.
- Medicare covers some home health service costs.
- Most insurance plans do not cover these costs.
- You must pay all costs not covered by Medicare, Medicaid, or insurance.

How to find them:

1. Ask your doctor or other healthcare professional about good home health care services in your area.
2. Search for "home health care" in your area.

Here are some questions you might ask before signing a home health care agreement:

- Is your service licensed and accredited?
- What is the cost of your services?
- What is included and not included in your services?

Note: The Center is not affiliated with these services mentioned here and we have not done any independent investigation on these companies. Consumers must investigate and vet all service providers.

Other Support Sources and Resources:

NIA Alzheimer's and related Dementias Education and Referral (ADEAR) Center

Email: adear@nia.nih.gov
Phone: 1-800-438-4380
Website: www.nia.nih.gov/alzheimers

The ADEAR Center offers information on diagno- sis, treatment, patient care, caregiver needs, long-term care, and research and clinical trials related to Alzheimer's disease. Staff can refer you to local and national resources, or you can search for information on the website. The Center is a service of the National Institute on Aging (NIA), part of the Federal Govern- ment's National Institutes of Health. They have infor- mation to help you understand Alzheimer's disease. You can also get hints on other subjects, including:

- Talking with the doctor.
- Financial and legal planning.
- Medicines.
- Comfort care at the end of life.
- Paying for care.

Alzheimer's Association

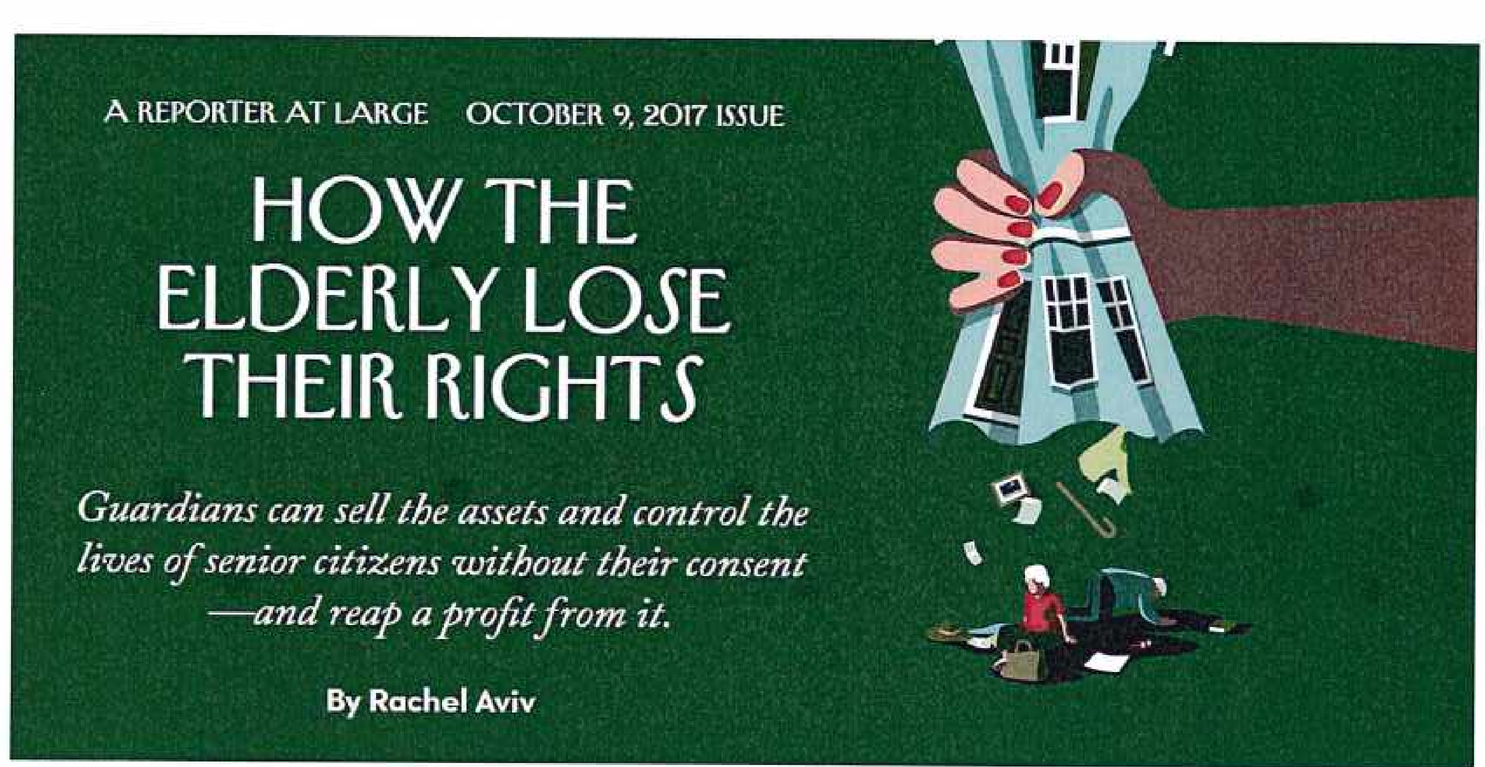
Phone: 1-800-272-3900
Website: www.alz.org

The Alzheimer's Association offers information, a help line, and support services to people with Alzheimer's and their caregivers. Local chapters across the country offer support groups, including many that help with early stage Alzheimer's disease. Call or go online to find out where to get help in your area. The Association also funds Alzheimer's research.

Alzheimer's Foundation of America

Phone: 1-866-232-8484
Website: www.alzfdn.org

The Alzheimer's Foundation of America provides information about how to care for people with Alzheimer's, as well as a list of services for people with the disease. It also offers information for caregivers and their families through member organizations. Services include a toll-free hotline, publications, and other educational materials.



After a stranger became their guardian, Rudy and Rennie North were moved to a nursing home and their property was sold.
Illustration by Anna Parini

THE NEW YORKER

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HOW THE ELDERLY LOSE THEIR RIGHTS

Guardians can sell the assets and control the lives of senior citizens without their consent—and reap a profit from it.

By Rachel Aviv

For years, Rudy North woke up at 9 A.M. and read the Las Vegas *Review-Journal* while eating a piece of toast. Then he read a novel—he liked James Patterson and Clive Cussler—or, if he was feeling more ambitious, Freud. On scraps of paper and legal notepads, he jotted down thoughts sparked by his reading. "Deep below the rational part of our brain is an underground ocean where strange things swim," he wrote on one notepad. On another, "Life: the longer it cooks, the better it tastes."

Rennie, his wife of fifty-seven years, was slower to rise. She was recovering from lymphoma and suffered from neuropathy so severe that her legs felt like sausages. Each morning, she spent nearly an hour in the bathroom applying makeup and lotions, the same brands she'd used for forty years. She always emerged wearing pale-pink lipstick. Rudy, who was prone to grandiosity, liked to refer to her as "my amour."

On the Friday before Labor Day, 2013, the Norths had just finished their toast when a nurse, who visited five times a week to help Rennie bathe and dress, came to their house, in Sun City Aliante, an "active adult" community in Las Vegas. They had moved there in 2005, when Rudy, a retired consultant for broadcasters, was sixty-eight and Rennie was sixty-six. They took pride in their view of the golf course, though neither of them played golf.

Rudy chatted with the nurse in the kitchen for twenty minutes, joking about marriage and laundry, until there was a knock at the door. A stocky woman with shiny black hair introduced herself as April Parks, the owner of the company A Private Professional Guardian. She was accompanied by three colleagues, who didn't give their names. Parks told the Norths that she had an order from the Clark County Family Court to

"remove" them from their home. She would be taking them to an assisted-living facility. "Go and gather your things," she said.

Rennie began crying. "This is my home," she said.

One of Parks's colleagues said that if the Norths didn't comply he would call the police. Rudy remembers thinking, You're going to put my wife and me in jail for this? But he felt too confused to argue.

Parks drove a Pontiac G-6 convertible with a license plate that read "CRTGRDN," for "court guardian." In the past twelve years, she had been a guardian for some four hundred wards of the court. Owing to age or disability, they had been deemed incompetent, a legal term that describes those who are unable to make reasoned choices about their lives or their property. As their guardian, Parks had the authority to manage their assets, and to choose where they lived, whom they associated with, and what medical treatment they received. They lost nearly all their civil rights.

Without realizing it, the Norths had become temporary wards of the court. Parks had filed an emergency ex-parte petition, which provides an exception to the rule that both parties must be notified of any argument before a judge. She had alleged that the Norths posed a "substantial risk for mismanagement of medications, financial loss and physical harm." She submitted a brief letter from a physician's assistant, whom Rennie had seen once, stating that "the patient's husband can no longer effectively take care of the patient at home as his dementia is progressing." She also submitted a letter from one of Rudy's doctors, who described him as "confused and agitated."

Rudy and Rennie had not undergone any cognitive assessments. They had never received a diagnosis of dementia. In addition to Freud, Rudy was working his way through Nietzsche and Plato. Rennie read romance novels.

Parks told the Norths that if they didn't come willingly an ambulance would take them to the facility, a place she described as a "respite." Still crying, Rennie put cosmetics and some clothes into a suitcase. She packed so quickly that she forgot her cell phone and Rudy's hearing aid. After thirty-five minutes, Parks's assistant led the Norths to her car. When a neighbor asked what was happening, Rudy told him, "We'll just be gone for a

 little bit." He was too proud to draw attention to their predicament. "Just think of it as a mini-vacation," he told Rennie.

After the Norths left, Parks walked through the house with Cindy Breck, the owner of Caring Transitions, a company that relocates seniors and sells their belongings at estate sales. Breck and Parks had a routine. "We open drawers," Parks said at a deposition. "We look in closets. We pull out boxes, anything that would store—that would keep paperwork, would keep valuables." She took a pocket watch, birth certificates, insurance policies, and several collectible coins.

The Norths' daughter, Julie Belshe, came to visit later that afternoon. A fifty-three-year-old mother of three sons, she and her husband run a small business designing and constructing pools. She lived ten miles away and visited her parents nearly every day, often taking them to her youngest son's football games. She was her parents' only living child; her brother and sister had died.

She knocked on the front door several times and then tried to push the door open, but it was locked. She was surprised to see the kitchen window closed; her parents always left it slightly open. She drove to the Sun City Aliante clubhouse, where her parents sometimes drank coffee. When she couldn't find them there, she thought that perhaps they had gone on an errand together—the farthest they usually drove was to Costco. But, when she returned to the house, it was still empty.

That weekend, she called her parents several times. She also called two hospitals to see if they had been in an accident. She called their landlord, too, and he agreed to visit the house. He reported that there were no signs of them. She told her husband, "I think someone kidnapped my parents."

On the Tuesday after Labor Day, she drove to the house again and found a note taped to the door: "In case of emergency, contact guardian April Parks." Belshe dialled the number. Parks, who had a brisk, girlish way of speaking, told Belshe that her parents had been taken to Lakeview Terrace, an assisted-living facility in Boulder City, nine miles from the Arizona border. She assured Belshe that the staff there would take care of all their needs.

"You can't just walk into somebody's home and take them!" Belshe told her.

Parks responded calmly, "It's legal. It's legal."

Guardianship derives from the state's *parens patriae* power, its duty to act as a parent for those considered too vulnerable to care for themselves. "The King shall have the custody of the lands of natural fools, taking the profits of them without waste or destruction, and shall find them their necessaries," reads the English statute *De Prerogative Regis*, from 1324. The law was imported to the colonies—guardianship is still controlled by state, not federal, law—and has remained largely intact for the past eight hundred years. It establishes a relationship between ward and guardian that is rooted in trust.

In the United States, a million and a half adults are under the care of guardians, either family members or professionals, who control some two hundred and seventy-three billion dollars in assets, according to an auditor for the guardianship fraud program in Palm Beach County. Little is known about the outcome of these arrangements, because states do not keep complete figures on guardianship cases—statutes vary widely—and, in most jurisdictions, the court records are sealed. A Government Accountability report from 2010 said, "We could not locate a single Web site, federal agency, state or local entity, or any other organization that compiles comprehensive information on this issue." A study published this year by the American Bar Association found that "an unknown number of adults languish under guardianship" when they no longer need it, or never did. The authors wrote that "guardianship is generally "permanent, leaving no way out—'until death do us part.' "

When the Norths were removed from their home, they joined nearly nine thousand adult wards in the Las Vegas Valley. In the past twenty years, the city has promoted itself as a retirement paradise. Attracted by the state's low taxes and a dry, sunny climate, elderly people leave their families behind to resettle in newly constructed senior communities. "The whole town sparkled, pulling older people in with the prospect of the American Dream at a reasonable price," a former real-estate agent named Terry Williams told me. Roughly thirty per cent of the people who move to Las Vegas are senior citizens, and the number of Nevadans older than eighty-five has risen by nearly eighty per cent in the past decade.

In Nevada, as in many states, anyone can become a guardian by taking a course, as long as he or she has not been convicted of a felony or recently declared bankruptcy.

Elizabeth Brickfield, a Las Vegas lawyer who has worked in guardianship law for twenty years, said that about fifteen years ago, as the state's elderly population swelled, "all these private guardians started arriving, and the docket exploded. The court became a factory."

Pamela Teaster, the director of the Center for Gerontology at Virginia Tech and one of the few scholars in the country who study guardianship, told me that, though most guardians assume their duties for good reasons, the guardianship system is "a morass, a total mess." She said, "It is unconscionable that we don't have any data, when you think about the vast power given to a guardian. It is one of society's most drastic interventions."

After talking to Parks, Belshe drove forty miles to Lakeview Terrace, a complex of stucco buildings designed to look like a hacienda. She found her parents in a small room with a kitchenette and a window overlooking the parking lot. Rennie was in a wheelchair beside the bed, and Rudy was curled up on a love seat in the fetal position. There was no phone in the room. Medical-alert buttons were strung around their necks. "They were like two lost children," Belshe said.

She asked her parents who Parks was and where she could find the court order, but, she said, "they were overwhelmed and humiliated, and they didn't know what was going on." They had no idea how or why Parks had targeted them as wards. Belshe was struck by their passive acceptance. "It was like they had Stockholm syndrome or something," she told me.

Belshe acknowledged that her parents needed a few hours of help each day, but she had never questioned their ability to live alone. "They always kept their house really nice and clean, like a museum," she said. Although Rudy's medical records showed that he occasionally had "staring spells," all his medical-progress notes from 2013 described him as alert and oriented. He did most of the couple's cooking and shopping, because Rennie, though lucid, was in so much pain that she rarely left the house. Belshe sometimes worried that her father inadvertently encouraged her mother to be docile: "She's a very smart woman, though she sometimes acts like she's not. I have to tell her, 'That's not cute, Mom.' "

 When Belshe called Parks to ask for the court order, Parks told her that she was part of the "sandwich generation," and that it would be too overwhelming for her to continue to care for her children and her parents at the same time. Parks billed her wards' estates for each hour that she spent on their case; the court placed no limits on guardians' fees, as long as they appeared "reasonable." Later, when Belshe called again to express her anger, Parks charged the Norths twenty-four dollars for the eight-minute conversation. "I could not understand what the purpose of the call was other than she wanted me to know they had rights," Parks wrote in a detailed invoice. "I terminated the phone call as she was very hostile and angry."

A month after removing the Norths from their house, Parks petitioned to make the guardianship permanent. She was represented by an attorney who was paid four hundred dollars an hour by the Norths' estate. A hearing was held at Clark County Family Court.

The Clark County guardianship commissioner, a lawyer named Jon Norheim, has presided over nearly all the guardianship cases in the county since 2005. He works under the supervision of a judge, but his orders have the weight of a formal ruling. Norheim awarded a guardianship to Parks, on average, nearly once a week. She had up to a hundred wards at a time. "I love April Parks," he said at one hearing, describing her and two other professional guardians, who frequently appeared in his courtroom, as "wonderful, good-hearted, social-worker types."

Norheim's court perpetuated a cold, unsentimental view of family relations: the ingredients for a good life seemed to have little to do with one's children and siblings. He often dismissed the objections of relatives, telling them that his only concern was the best interest of the wards, which he seemed to view in a social vacuum. When siblings fought over who would be guardian, Norheim typically ordered a neutral professional to assume control, even when this isolated the wards from their families.

Rudy had assured Belshe that he would protest the guardianship, but, like most wards in the country, Rudy and Rennie were not represented by counsel. As Rudy stood before the commissioner, he convinced himself that guardianship offered him and Rennie a lifetime of care without being a burden to anyone they loved. He told Norheim, "The issue really is her longevity—what suits her." Belshe, who sat in the courtroom, said, "I was shaking my head. No, no, no—don't do that!" Rennie was silent.

Norheim ordered that the Norths become permanent wards of the court. "Chances are, I'll probably never see you folks again; you'll work everything out," he said, laughing. "I very rarely see people after the initial time in court." The hearing lasted ten minutes.

The following month, Even Tide Life Transitions, a company that Parks often hired, sold most of the Norths' belongings. "The general condition of this inventory is good," an appraiser wrote. Two lithographs by Renoir were priced at thirty-eight hundred dollars, and a glass cocktail table ("Client states that it is a Brancusi design") was twelve hundred and fifty dollars. The Norths also had several pastel drawings by their son, Randy, who died in a motorcycle accident at the age of thirty-two, as well as Kachina dolls, a Bose radio, a Dyson vacuum cleaner, a Peruvian tapestry, a motion-step exerciser, a LeRoy Neiman sketch of a bar in Dublin, and two dozen pairs of Clarke shoes. According to Parks's calculations, the Norths had roughly fifty thousand dollars. Parks transferred their savings, held at the Bank of America, to an account in her name.

Rennie repeatedly asked for her son's drawings, and for the family photographs on her refrigerator. Rudy pined for his car, a midnight-blue 2010 Chrysler, which came to symbolize the life he had lost. He missed the routine interactions that driving had allowed him. "Everybody at the pharmacy was my buddy," he said. Now he and Rennie felt like exiles. Rudy said, "They kept telling me, 'Oh, you don't have to worry: your car is fine, and this and that.' " A month later, he said, "they finally told me, 'Actually, we sold your car.' I said, 'What in the hell did you sell it for?' " It was bought for less than eight thousand dollars, a price that Rudy considered insulting.

Rudy lingered in the dining room after eating breakfast each morning, chatting with other residents of Lakeview Terrace. He soon discovered that ten other wards of April Parks lived there. His next-door neighbor, Adolfo Gonzalez, a short, bald seventy-one-year-old who had worked as a maître d' at the MGM Grand Las Vegas, had become Parks's ward at a hearing that lasted a minute and thirty-one seconds.

Gonzalez, who had roughly three hundred and fifty thousand dollars in assets, urged Rudy not to accept the nurse's medications. "If you take the pills, they'll make sure you don't make it to court," he said. Gonzalez had been prescribed the antipsychotic medications Risperdal and Depakote, which he hid in the side of his mouth without swallowing. He wanted to remain vigilant. He often spoke of a Salvador Dali painting

that had been lost when Parks took over his life. Once, she charged him two hundred and ten dollars for a visit in which, according to her invoice, he expressed that "he feels like a prisoner."

Rudy was so distressed by his conversations with Gonzalez that he asked to see a psychologist. "I thought maybe he'd give me some sort of objective learning as to what I was going through," he said. "I wanted to ask basic questions, like What the hell is going on?" Rudy didn't find the session illuminating, but he felt a little boost to his self-esteem when the psychologist asked that he return for a second appointment. "I guess he found me terribly charming," he told me.

Rudy liked to fantasize about an alternative life as a psychoanalyst, and he tried to befriend the wards who seemed especially hopeless. "Loneliness is a physical pain that hurts all over," he wrote in his notebook. He bought a pharmaceutical encyclopedia and advised the other wards about medications they'd been prescribed. He also ran for president of the residents, promising that under his leadership the kitchen would no longer advertise canned food as homemade. (He lost—he's not sure if anyone besides Rennie voted for him—but he did win a seat on the residents' council.)

He was particularly concerned about a ward of Parks's named Marlene Homer, a seventy-year-old woman who had been a professor. "Now she was almost hiding behind the pillars," Rudy said. "She was so obsequious. She was, like, 'Run me over. Run me over.' " She'd become a ward in 2012, after Parks told the court, "She has admitted to strange thoughts, depression, and doing things she can't explain." On a certificate submitted to the court, an internist had checked a box indicating that Homer was "unable to attend the guardianship court hearing because______," but he didn't fill in a reason.

The Norths could guess which residents were Parks's wards by the way they were dressed. Gonzalez wore the same shirt to dinner nearly every day. "Forgive me," he told the others at his table. When a friend tried to take him shopping, Parks prevented the excursion because she didn't know the friend. Rennie had also tried to get more clothes. "I reminded ward that she has plenty of clothing in her closet," Parks wrote. "I let her know that they are on a tight budget." The Norths' estate was charged a hundred and eighty dollars for the conversation.

Another resident, Barbara Neely, a fifty-five-year-old with schizophrenia, repeatedly asked Parks to buy her outfits for job interviews. She was applying for a position with the Department of Education. After Neely's third week at Lakeview Terrace, Parks's assistant sent Parks a text. "Can you see Barbara Neely anytime this week?" she wrote. "She has questions on the guardianship and how she can get out of it." Parks responded, "I can and she can't." Neely had been in the process of selling her house, for a hundred and sixty-eight thousand dollars, when Parks became her guardian and took charge of the sale.

The rationale for the guardianship of Norbert Wilkening, who lived on the bottom floor of the facility, in the memory-care ward, for people with dementia ("the snake pit," Rudy called it), was also murky. Parks's office manager, who advertised himself as a "Qualified Dementia Care Specialist"—a credential acquired through video training sessions—had given Wilkening a "Mini-Mental State Examination," a list of eleven questions and tasks, including naming as many animals as possible in a minute. Wilkening had failed. His daughter, Amy, told me, "I didn't see anything that was happening to him other than a regular getting-older process, but when I was informed by all these people that he had all these problems I was, like, Well, maybe I'm just in denial. I'm not a professional." She said that Parks was "so highly touted. By herself, by the social workers, by the judge, by everyone that knew her."

At a hearing, when Amy complained to Norheim that Parks didn't have time for her father, he replied, "Yeah, she's an industry at this point."

As Belshe spoke to more wards and their families, she began to realize that Lakeview Terrace was not the only place where wards were lodged, and that Parks was not the only guardian removing people from their homes for what appeared to be superficial reasons. Hundreds of cases followed the same pattern. It had become routine for guardians in Clark County to petition for temporary guardianship on an ex-parte basis. They told the court that they had to intervene immediately because the ward faced a medical emergency that was only vaguely described: he or she was demented or disoriented, and at risk of exploitation or abuse. The guardians attached a brief physician's certificate that contained minimal details and often stated that the ward was too incapacitated to attend a court hearing. Debra Bookout, an attorney at the Legal Aid Center of Southern Nevada, told me, "When a hospital or rehab facility

needs to free up a bed, or when the patient is not paying his bills, some doctors get sloppy, and they will sign anything." A recent study conducted by Hunter College found that a quarter of guardianship petitions in New York were brought by nursing homes and hospitals, sometimes as a means of collecting on overdue bills.

It often took several days for relatives to realize what had happened. When they tried to contest the guardianship or become guardians themselves, they were dismissed as unsuitable, and disparaged in court records as being neglectful, or as drug addicts, gamblers, and exploiters. (Belshe was described by Parks as a "reported addict" who "has no contact with the proposed ward," an allegation that Belshe didn't see until it was too late to challenge.) Family who lived out of state were disqualified from serving as guardians, because the law prohibited the appointment of anyone who didn't live in Nevada.

Once the court approved the guardianship, the wards were often removed from their homes, which were eventually sold. Terry Williams, whose father's estate was taken over by strangers even though he'd named her the executor of his will, has spent years combing through guardianship, probate, and real-estate records in Clark County. "I kept researching, because I was so fascinated that these people could literally take over the lives and assets of people under color of law, in less than ten minutes, and nobody was asking questions," she told me. "These people spent their lives accumulating wealth and, in a blink of an eye, it was someone else's."

Williams has reviewed hundreds of cases involving Jared Shafer, who is considered the godfather of guardians in Nevada. In the records room of the courthouse, she was afraid to say Shafer's name out loud. In the course of his thirty-five-year career, Shafer has assumed control of more than three thousand wards and estates and trained a generation of guardians. In 1979, he became the county's public administrator, handling the estates of people who had no relatives in Nevada, as well as the public guardian, serving wards when no family members or private guardians were available. In 2003, he left government and founded his own private guardianship and fiduciary business; he transferred the number of his government-issued phone to himself.

Williams took records from Shafer's and other guardians' cases to the Las Vegas police department several times. She tried to explain, she said, that "this is a racketeering operation that is fee-based. There's no brown paper bag handed off in an alley. The

payoff is the right to bill the estate." The department repeatedly told her that it was a civil issue, and refused to take a report. In 2006, she submitted a typed statement, listing twenty-three statutes that she thought had been violated, but an officer wrote in the top right corner, "NOT A POLICE MATTER." Adam Woodrum, an estate lawyer in Las Vegas, told me that he's worked with several wards and their families who have brought their complaints to the police. "They can't even get their foot in the door," he said.

Acting as her own attorney, Williams filed a racketeering suit in federal court against Shafer and the lawyers who represented him. At a hearing before the United States District Court of Central California in 2009, she told the judge, "They are trumping up ways and means to deem people incompetent and take their assets." The case was dismissed. "The scheme is ingenious," she told me. "How do you come up with a crime that literally none of the victims can articulate without sounding like they're nuts? The same insane allegations keep surfacing from people who don't know each other."

In 2002, in a petition to the Clark County District Court, a fifty-seven-year-old man complained that his mother had lost her constitutional rights because her kitchen was understocked and a few bills hadn't been paid. The house they shared was then placed on the market. The son wrote, "If the only showing necessary to sell the home right out from under someone is that their 'estate' would benefit, then no house in Clark County is safe, nor any homeowner." Under the guise of benevolent paternalism, guardians seemed to be creating a kind of capitalist dystopia: people's quality of life was being destroyed in order to maximize their capital.

When Concetta Mormon, a wealthy woman who owned a Montessori school, became Shafer's ward because she had aphasia, Shafer sold the school midyear, even though students were enrolled. At a hearing after the sale, Mormon's daughter, Victoria Cloutier, constantly spoke out of turn. The judge, Robert Lueck, ordered that she be handcuffed and placed in a holding cell while the hearing continued. Two hours later, when Cloutier was allowed to return for the conclusion, the judge told her that she had thirty days in which to vacate her mother's house. If she didn't leave, she would be evicted and her belongings would be taken to Goodwill.

The opinions of wards were also disregarded. In 2010, Guadalupe Olvera, a ninety-year-old veteran of the Second World War, repeatedly asked that his daughter and not Shafer be appointed his guardian. "The ward is not to go to court," Shafer instructed

his assistants. When Olvera was finally permitted to attend a hearing, nearly a year after becoming a ward, he expressed his desire to live with his daughter in California, rather than under Shafer's care. "Why is everybody against that?" he asked Norheim. "I don't need that man." Although Nevada's guardianship law requires that courts favor relatives over professionals, Norheim continued the guardianship, saying, "The priority ship sailed."

When Olvera's daughter eventually defied the court's orders and took her father to live at her seaside home in Northern California, Norheim's supervisor, Judge Charles Hoskin, issued an arrest warrant for her "immediate arrest and incarceration" without bail. The warrant was for contempt of court, but Norheim said at least five times from the bench that she had "kidnapped" Olvera. At a hearing, Norheim acknowledged that he wasn't able to send an officer across state lines to arrest the daughter. Shafer said, "Maybe I can."

Shafer held so much sway in the courtroom that, in 2013, when an attorney complained that the bank account of a ward named Kristina Berger had "no money left and no records to explain where it went," Shafer told Norheim, "Close the courtroom." Norheim immediately complied. A dozen people in attendance were forced to leave.

One of Shafer's former bookkeepers, Lisa Clifton, who was hired in 2012, told me that Shafer used to brag about his political connections, saying, "I wrote the laws." In 1995, he persuaded the Nevada Senate Committee on Government Affairs to write a bill that allowed the county to receive interest on money that the public guardian invested. "This is what I want you to put in the statute, and I will tell you that you will get a rousing hand from a couple of judges who practice our probate," he said. At another hearing, he asked the committee to write an amendment permitting public guardians to take control of people's property in five days, without a court order. "This bill is not 'Big Brother' if you trust the person who is doing the job," he said. (After a senator expressed concern that the law allowed "intervention into somebody's life without establishing some sort of reason why you are doing it," the committee declined to recommend it.)

Clifton observed that Shafer almost always took a cynical view of family members: they were never motivated by love or duty, only by avarice. " 'They just want the money'—that was his answer to everything," she told me. "And I'm thinking to myself,

Well, when family members die they pass it down to their children. Isn't that just the normal progression of things?"

After a few months on the job, Clifton was asked to work as a guardian, substituting for an absent employee, though she had never been trained. Her first assignment was to supervise a visit with a man named Alvin Passer, who was dying in the memory-care unit of a nursing home. His partner of eight years, Olive Manoli, was permitted a brief visit to say goodbye. Her visits had been restricted by Shafer—his lawyer told the court that Passer became "agitated and sexually aggressive" in her presence—and she hadn't seen Passer in months. In a futile attempt to persuade the court to allow her to be with him, Manoli had submitted a collection of love letters, as well as notes from ten people describing her desire to care for Passer for the rest of his life. "I was absolutely appalled," Clifton said. "She was this very sweet lady, and I said, 'Go in there and spend as much time with him as you want.' Tears were rolling down her cheeks."

The family seemed to have suffered a form of court-sanctioned gaslighting. Passer's daughter, Joyce, a psychiatric nurse who specialized in geriatrics, had been abruptly removed as her father's co-guardian, because she appeared "unwilling or (more likely) unable to conduct herself rationally in the Ward's best interests," according to motions filed by one of Shafer's attorneys.

She and Manoli had begged Norheim not to appoint Shafer as guardian. "Sir, he's abusive," their lawyer said in court.

"He's as good as we got, and I trust him completely," Norheim responded.

Joyce Passer was so confused by the situation that, she said, "I thought I was crazy." Then she received a call from a blocked number. It was Terry Williams, who did not reveal her identity. She had put together a list of a half-dozen family members who she felt were "ready to receive some kind of verbal support." She told Passer, "Look, you are not nuts. This is real. Everything you are thinking is true. This has been going on for years."

During Rennie North's first year at Lakeview Terrace, she gained sixty pounds. Parks had switched the Norths' insurance, for reasons she never explained, and Rennie began seeing new doctors, who prescribed Valium, Prozac, the sedative

Temazepam, Oxycodone, and Fentanyl. The doses steadily increased. Rudy, who had hip pain, was prescribed Oxycodone and Valium. When he sat down to read, the sentences floated past his eyes or appeared in duplicate. "Ward seemed very tired and his eyes were glassy," Parks wrote in an invoice.

Belshe found it increasingly hard to communicate with her parents, who napped for much of the day. "They were being overmedicated to the point where they weren't really there," she said. The Norths' grandsons, who used to see them every week, rarely visited. "It was degrading for them to see us so degraded," Rudy said. Parks noticed that Rennie was acting helpless, and urged her to "try harder to be more motivated and not be so dependent on others." Rudy and Rennie began going to Sunday church services at the facility, even though they were Jewish. Rudy was heartened by what he heard in the pastor's message: "Don't give up. God will help you get out of here." He began telling people, "We are living the life of Job."

At the end of 2014, Lakeview Terrace hired a new director, Julie Liebo, who resisted Parks's orders that medical information about wards be kept from their families. Liebo told me, "The families were devastated that they couldn't know if the residents were in surgery or hear anything about their health. They didn't understand why they'd been taken out of the picture. They'd ask, 'Can you just tell me if she's alive?' " Liebo tried to comply with the rules, because she didn't want to violate medical-privacy laws; as guardian, Parks was entitled to choose what was disclosed. Once, though, Liebo took pity on the sister of an eighty-year-old ward named Dorothy Smith, who was mourning a dog that Parks had given away, and told her that Smith was stable. Liebo said that Parks, who was by then the secretary of the Nevada Guardianship Association, called her immediately. "She threatened my license and said she could have me arrested," Liebo told me.

After Liebo arrived, Parks began removing wards from Lakeview Terrace with less than a day's notice. A woman named Linda Phillips, who had dementia, was told that she was going to the beauty salon. She never returned. Marlene Homer, the ward whose ailments were depression and "strange thoughts," was taken away in a van, screaming. Liebo had asked the state ombudsman to come to the facility and stop the removals, but nothing could be done. "We stood there completely helpless," Liebo said. "We had

 no idea where they were going." Liebo said that other wards asked her if they would be next.

Liebo alerted the compliance officer for the Clark County Family Court that Parks was removing residents "without any concern for them and their choice to stay here." She also reported her complaints to the police, the Department of Health Services, the Bureau of Health Care, and Nevada Adult Protective Services. She said each agency told her that it didn't have the authority or the jurisdiction to intervene.

At the beginning of 2015, Parks told the Norths that they would be leaving Lakeview Terrace. "Finances are low and the move is out of our control," Parks wrote. It was all arranged so quickly that, Rudy said, "we didn't have time to say goodbye to people we'd been eating with for seventeen months." Parks arranged for Caring Transitions to move them to the Wentworth, a less expensive assisted-living facility. Liebo said that, the night before the move, Rudy began "shouting about the Holocaust, that this was like being in Nazi Germany." Liebo didn't think the reference was entirely misguided. "He reverted to a point where he had no rights as a human being," she said. "He was no longer the caregiver, the man, the husband—all of the things that gave his life meaning." Liebo also didn't understand why Belshe had been marginalized. "She seemed like she had a great relationship with her parents," she said.

Belshe showed up at 9 A.M. to help her parents with the move, but when she arrived Parks's assistant, Heidi Kramer, told her that her parents had already left. Belshe "emotionally crashed," as Liebo put it. She yelled that her parents didn't even wake up until nine or later—what was the rush? In an invoice, Kramer wrote that Belshe "began to yell and scream, her behavior was out of control, she was taking pictures and yelling, 'April Parks is a thief.' " Kramer called the police. Liebo remembers that an officer "looked at Julie Belshe and told her she had no rights, and she didn't."

Belshe cried as she drove to the Wentworth, in Las Vegas. When she arrived, Parks was there, and refused to let her see her parents. Parks wrote, "I told her that she was too distraught to see her parents, and that she needed to leave." Belshe wouldn't, so Parks asked the receptionist to call the police. When the police arrived, Belshe told them, "I just want to hug my parents and make sure they're O.K." An officer handed her a citation for trespassing, saying that if she returned to the facility she would be arrested.

Parks wrote that the Norths were "very happy with the new room and thanked us several times," but Rudy remembers feeling as if he had "ended up in the sewer." Their room was smaller than the one at Lakeview Terrace, and the residents at the Wentworth seemed older and sicker. "There were people sitting in their chairs, half-asleep," Rudy said. "Their tongues hung out."

Rennie spent nearly all her time in her wheelchair or in bed, her eyes half-closed. Her face had become bloated. One night, she was so agitated that the nurses gave her Haldol, a drug commonly used to treat schizophrenia. When Rudy asked her questions, Rennie said "What?" in a soft, remote voice.

Shortly after her parents' move, Belshe called an editor of the Vegas *Voice*, a newspaper distributed to all the mailboxes in senior communities in Las Vegas. In recent months, the paper had published three columns warning readers about Clark County guardians, writing that they "have been lining their pockets at the expense of unwitting seniors for a very long time."

At Belshe's urging, the paper's political editor, Rana Goodman, visited the Norths, and published an article in the *Voice*, describing Rudy as "the most articulate, soft spoken person I have met in a very long time." She called Clark County's guardianship system a "(legal) elder abuse racket" and urged readers to sign a petition demanding that the Nevada legislature reform the laws. More than three thousand people signed.

Two months later, the *Review-Journal* ran an investigation, titled "Clark County's Private Guardians May Protect—Or Just Steal and Abuse," which described complaints against Shafer going back to the early eighties, when two of his employees were arrested for stealing from the estates of dead people.

In May, 2015, a month after the article appeared, when the Norths went to court to discuss their finances local journalists were in the courtroom and Norheim seemed chastened. "I have grave concerns about this case," he said. He noted that Parks had sold the Norths' belongings without proper approval from his court. Parks had been doing this routinely for years, and, according to her, the court had always accepted her accounting and her fees. Her lawyer, Aileen Cohen, said, "Everything was done for the wards' benefit, to support the wards."

Norheim announced that he was suspending Parks as the Norths' guardian—the first time she had been removed from a case for misconduct.

"This is important," Rudy, who was wearing a double-breasted suit, said in court. "This is hope. I am coming here and I have hope." He quoted the Bible, Thomas Jefferson, and Euripides, until Belshe finally touched his elbow and said, "Just sit down, Dad."

When Rudy apologized for being "overzealous," Norheim told him, "This is your life. This is your liberty. You have every right to be here. You have every right to be involved in this project."

After the hearing, Parks texted her husband, "I am finished."

Last March, Parks and her lawyer, along with her office manager and her husband, were indicted for perjury and theft, among other charges. The indictment was narrowly focussed on their double billings and their sloppy accounting, but, in a detailed summary of the investigation, Jaclyn O'Malley, who led the probe for the Nevada Attorney General's Office, made passing references to the "collusion of hospital social workers and medical staff" who profited from their connection to Parks. At Parks's grand-jury trial, her assistant testified that she and Parks went to hospitals and attorneys' offices for the purpose of "building relationships to generate more client leads." Parks secured a contract with six medical facilities whose staff agreed to refer patients to her—an arrangement that benefitted the facilities, since Parks controlled the decisions of a large pool of their potential consumers. Parks often gave doctors blank certificates and told them exactly what to write in order for their patients to become her wards.

Parks and other private guardians appeared to gravitate toward patients who had considerable assets. O'Malley described a 2010 case in which Parks, after receiving a tip from a social worker, began "cold-calling" rehabilitation centers, searching for a seventy-nine-year-old woman, Patricia Smoak, who had nearly seven hundred thousand dollars and no children. Parks finally found her, but Smoak's physician wouldn't sign a certificate of incapacity. "The doctor is not playing ball," Parks wrote to her lawyer. She quickly found a different doctor to sign the certificate, and Norheim approved the guardianship. (Both Parks and Norheim declined to speak with me.)

 Steve Miller, a former member of the Las Vegas City Council, said he assumed that Shafer would be the next indictment after Parks, who is scheduled to go to trial next spring. "All of the disreputable guardians were taking clues from the Shafer example," he said. But, as the months passed, "I started to think that this has run its course locally. Only federal intervention is going to give us peace of mind."

Richard Black, who, after his father-in-law was placed into guardianship, became the director of a grassroots national organization, Americans Against Abusive Probate Guardianship, said that he considered the Parks indictment "irrefutably shallow. It sent a strong message of: We're not going to go after the real leaders of this, only the easy people, the ones who were arrogant and stupid enough to get caught." He works with victims in dozens of what he calls "hot spots," places where guardianship abuse is prevalent, often because they attract retirees: Palm Beach, Sarasota, Naples, Albuquerque, San Antonio. He said that the problems in Clark County are not unusual. "The only thing that is unique is that Clark County is one of the few jurisdictions that doesn't seal its records, so we can see what is going on."

Approximately ten per cent of people older than sixty-five are thought to be victims of "elder abuse"—a construct that has yet to enter public consciousness, as child abuse has—but such cases are seldom prosecuted. People who are frail or dying don't make good witnesses—a fact that Shafer once emphasized at a 1990 U.S. congressional hearing on crimes against the elderly, in which he appeared as an expert at preventing exploitation. "Seniors do not like to testify," he said, adding that they were either incapable or "mesmerized by the person ripping them off." He said, "The exploitation of seniors is becoming a real cottage industry right now. This is a good business. Seniors are unable to fend for themselves."

In the past two years, Nevada has worked to reform its guardianship system through a commission, appointed by the Nevada Supreme Court, to study failures in oversight. In 2018, the Nevada legislature will enact a new law that entitles all wards to be represented by lawyers in court. But the state seems reluctant to reckon with the roots of the problem, as well as with its legacy: a generation of ill and elderly people who were deprived of their autonomy, and also of their families, in the final years of their lives. Last spring, a man bought a storage unit in Henderson, Nevada, and discovered twenty-seven urns—the remains of Clark County wards who had never been buried.

In the wake of Parks's indictment, no judges have lost their jobs. Norheim was transferred from guardianship court to dependency court, where he now oversees cases involving abused and neglected children. Shafer is still listed in the Clark County court system as a trustee and as an administrator in several open cases. He did not respond to multiple e-mails and messages left with his bookkeeper, who answered his office phone but would not say whether he was still in practice. He did appear at one of the public meetings for the commission appointed to analyze flaws in the guardianship system. "What started all of this was me," he said. Then he criticized local media coverage of the issue and said that a television reporter, whom he'd talked to briefly, didn't know the facts. "The system works," Shafer went on. "It's not the guardians you have to be aware of, it's more family members." He wore a blue polo shirt, untucked, and his head was shaved. He looked aged, his arms dotted with sun spots, but he spoke confidently and casually. "The only person you folks should be thinking about when you change things is the ward. It's their money, it's their life, it's their time. The family members don't count."

Belshe is resigned to the fact that she will be supporting her parents for the rest of their lives. Parks spent all the Norths' money on fees—the hourly wages for her, her assistants, her lawyers, and the various contractors she hired—as well as on their monthly bills, which doubled under her guardianship. Belshe guesses that Parks—or whichever doctor or social worker referred her to the Norths—had assumed that her parents were wealthier than they actually were. Rudy often talked vaguely about deals he had once made in China. "He exaggerates, so he won't feel emasculated," Belshe said. "He wasn't such a big businessman, but he was a great dad."

The Norths now live in what used to be Belshe's home office; it has a window onto the living room which Belshe has covered with a tarp. Although the room is tiny, the Norths can fit most of their remaining belongings into it: a small lamp with teardrop crystals, a deflated love seat, and two paintings by their son. Belshe rescued the art work, in 2013, after Caring Transitions placed the Norths' belongings in trash bags at the edge of their driveway. "My brother's paintings were folded and smelled," she said.

The Norths' bed takes up most of the room, and operates as their little planet. They rarely stray far from it. They lie in bed playing cards or sit against the headboard, reading or watching TV. Rudy's notebooks are increasingly focussed on mortality

—"Death may be pleasurable"—and money. "Money monsters do well in this society," he wrote. "All great fortunes began with a crime." He creates lists of all the possessions he has lost, some of which he may be imagining: over time, Rennie's wardrobe has become increasingly elaborate and refined, as have their sets of China. He alternates between feeling that his belongings are nothing—a distraction from the pursuit of meaning—and everything. "It's an erasure," he said. "They erase you from the face of the earth." He told me a few times that he was a distant cousin of Leon Trotsky, "intellect of the revolution," as he called him, and I wondered whether his newfound pride was connected to his conflicted feelings about the value of material objects.

A few months after the Norths were freed, Rudy talked on the phone with Adolfo Gonzalez, his neighbor from Lakeview Terrace, who, after a doctor found him competent, had also been discharged. He now lived in a house near the airport, and had been reunited with several of his pets. The two men congratulated each other. "We survived!" Rudy said. "We never thought we'd see each other on the other side." Three other wards from Lakeview Terrace had died.

Rennie has lost nearly all the weight she gained at Lakeview Terrace, mostly because Belshe and her husband won't let her lounge in her wheelchair or eat starchy foods. Now she uses a walker, which she makes self-deprecating jokes about. "This is fun—I can teach you!" she told me.

In July, Rennie slipped in the bathroom and spent a night in the hospital. Belshe didn't want anyone to know about her mother's fall, because, she said, "this is the kind of thing that gets you into guardianship." She told me, "I feel like these people are just waiting in the bushes."

Two days after the fall, Rennie was feeling better—she'd had thirteen stitches—but she was still agitated by a dream she had in the hospital. She wasn't even sure if she'd been asleep; she remembers talking, and her eyes were open.

"You were loopedy-doopy," Scott Belshe, Julie's husband, told her. They were sitting on the couch in their living room.

"It was real," Rennie said.

"You dreamed it," Scott told her.

"Maybe I was hallucinating," she said. "I don't know—I was scared." She said that strangers were making decisions about her fate. She felt as if she were frozen: she couldn't influence what was happening. "I didn't know what to do," she told Scott. "I think I yelled for help. *Help me.*" The worst part, she said, was that she couldn't find her family. "Honest to God, I thought you guys left me all alone." ♦

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Rachel Aviv joined The New Yorker as a staff writer in 2013. Read more »

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MEDICAID PLANNING & TRUST GUIDE

Medicaid Planning

The Facts...

- Assets in a revocable living trust are not protected and must be used to pay for the costs of long-term care.
- If you are married, your home is exempt and cannot be taken when applying for Medicaid. If you are single or widowed, your home is exempt up to $595,000. If you transfer your home to your children, not only will it result in immediate ineligibility for Medicaid, but it could also:
    - Trigger a gift tax,
    - Result in the loss of any property tax exemption, and,
    - Result in your child's spouse (the in-laws) inheriting your home.
- Giving your assets away means losing control. It's not safe even if you "trust" who you give it to. If that person divorces, goes bankrupt or is sued, all of the money you transferred is at risk. There are asset protection trusts that permit you to keep 100% control of your assets without the risk of losing them if long-term care is needed.
- You do not have to wait 60 months to qualify for Medicaid. Eligibility is calculated on a case-by-case basis. It is possible to have cash and other assets and still qualify immediately. Get professional advice and learn the facts.
- It is never too late to protect your assets even if you are already in a nursing home. In fact, you can qualify for Medicaid sooner if you are already in a nursing home, than if you aren't.
- A nursing home or hospital that offers to file a Medicaid application for you has no obligation (and often can't) advise you on how to protect your assets. Only a qualified Medicaid planning attorney will be looking out for your interests.
- Applying for Medicaid prior to qualification could result in being disqualified for a longer period of time than you otherwise would have been.
- Make sure the attorney you hire is experienced in Medicaid planning. Would you go to your regular doctor for a heart problem?
- Consider long-term care insurance. An annual premium for a couple is usually less expensive than one month of nursing home care and with proper planning; it may also enable you to stay home if you become ill. There are also asset based long-term care policies without the risk of premiums that rise every year.

Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526) or ClientServices@APracticeWithPurpose.com.

Who needs Estate Planning?

The Facts...

Estate planning isn't about how much money you have, it's about protecting what you have for you, during your lifetime and for those you love after you're gone. It ensures what you have gets to the people you love, the way you want, when you want.

If you were to die today, are you comfortable everything will be taken care of the way you wanted? Estate planning is legally ensuring things will be handled the way you want by providing sufficient instructions.

Estate planning really is for ***everyone***. It doesn't matter if you have $40,000, $400,000, or $4,000,000. You still have to plan for the future. Whether it's to protect your spouse or to ensure your children don't blow through your assets if you unexpectedly die or become disabled (Terri Schiavo case).

Estate planning can only be done by attorneys, and it can be as simple as a Will, Health Care Documents, Living Will and Power of Attorney. It can also include a revocable, probate-avoidance trust, asset protection trusts, multi-generational tax-saving trusts, tax-saving charitable trusts, private family foundations, and many other fact-specific strategies.

Keeping your Estate Plan Current...

Once completed, your estate plan should be reviewed and kept current with life events such as the birth, death, marriage, divorce or diagnosis of anyone included in your plan. In addition, you should review your plan if there is a significant increase or decrease in your finances or if the laws related to your estate plan change.

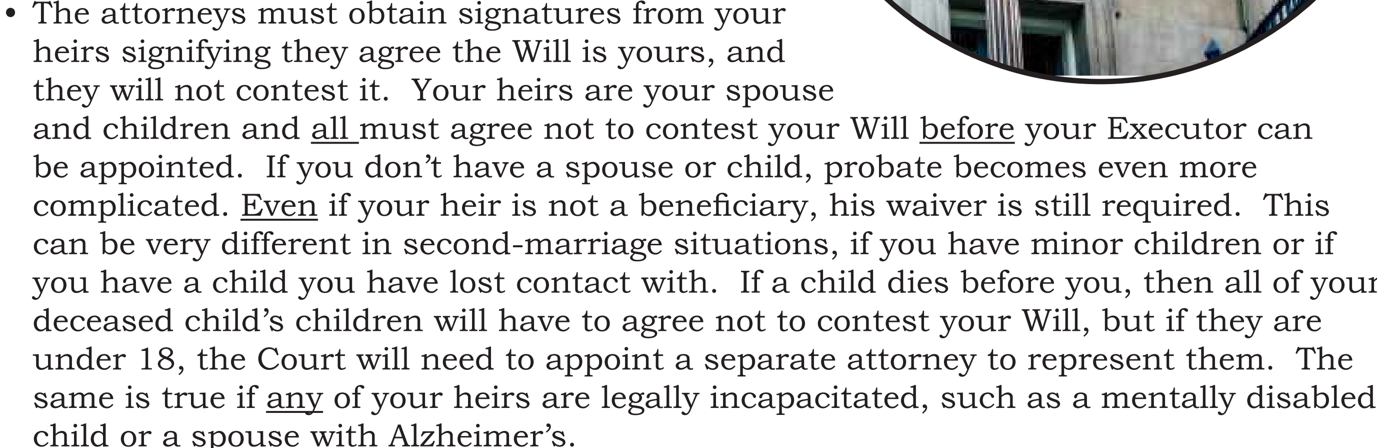
Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526)
or ClientServices@APracticeWithPurpose.com.

Do you need to avoid probate?

The Facts...

What is probate?

It is the legal process of presenting your Will to the Court after your death to authenticate it, and appoint your Executor. Your Executor must be appointed by the Court in order to collect and distribute your assets as stated in your Will. However, because it is a legal process, there are many steps that must be followed before your Executor can be appointed.



- The attorneys must obtain signatures from your heirs signifying they agree the Will is yours, and they will not contest it. Your heirs are your spouse and children and all must agree not to contest your Will before your Executor can be appointed. If you don't have a spouse or child, probate becomes even more complicated. Even if your heir is not a beneficiary, his waiver is still required. This can be very different in second-marriage situations, if you have minor children or if you have a child you have lost contact with. If a child dies before you, then all of your deceased child's children will have to agree not to contest your Will, but if they are under 18, the Court will need to appoint a separate attorney to represent them. The same is true if any of your heirs are legally incapacitated, such as a mentally disabled child or a spouse with Alzheimer's.
- The Executor will have to submit a family tree, filing fees, a petition, a death certificate and affidavits from the individuals who witnessed your Will. Upon receipt of all of the appropriate information (and if no heirs contest it), the Court will appoint the Executor.
- After your Executor is appointed, estate administration begins. It is a period of time the law permits the Executor to accumulate the assets and report to the Court how he or she intends to distribute them. This period is a minimum of 6-9 months, after the Executor is appointed. However, in many cases, it can take a year or more. If you die without a will, the process is similar, but the State decides who gets your assets, not you.
- Unfortunately, probate is unpredictable. That's why many people choose to avoid it, but if all of your heirs agree and your assets are centralized, it can go smoothly.

Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526) or ClientServices@APracticeWithPurpose.com.

Medicare and Medicaid

The Facts...

Eligibility

Medicare is a health-care benefit provided by the federal government to individuals over age 65, or under age 65 and disabled. Medicare covers doctor visits, tests and care provided in a hospital and limited benefits in a nursing home (see below).

Medicaid is health insurance for the poor. To qualify, you must not exceed certain income and asset limits. If your income or assets exceed the qualifying limits, you will not be eligible. There is no age restriction to qualify.

Qualification

To qualify for Medicare, you must be over 65, and eligible for Social Security benefits. You may also qualify if you are under age 65 and have been disabled for two years. An application at the Social Security office will get your benefits started.

To qualify for Medicaid, you must submit a multiple-page application and provide detailed proof of all your financial transactions (banking, CDs, stocks, bonds, income, expenses, annuities, etc.) for the previous 60 months.

Nursing Home Costs

Medicare will only pay for 20 days in a nursing home (in limited circumstances, it can pay the partial cost of 80 additional days) while Medicaid will pay the entire cost of a nursing home.

The laws around Medicaid qualification are extensive, and there are many exceptions. Often, hospitals and nursing homes will offer to do an application for you at no cost. Be careful, they do not represent you, but rather, the institution for which they work. Even with the best of intentions, they often do not have the legal knowledge necessary to determine whether or not your qualification is accurate. This is where a legal professional can really be of value and oftentimes, be able to get you benefits much sooner.

Elder Law Estate Planning Attorneys

An Elder Law Estate Planning attorney practices "estate planning on steroids," the level needed to meet the second half of life head-on.

The Facts...

Would you have your regular doctor do your heart surgery? Sounds like a stupid question right? However, the same could be said for choosing the right attorney for your estate planning. Unfortunately, the legal profession does not have specialties like the Medical profession. You have to guess whether your attorney is qualified to guide you on your estate planning and elder law options.

It seems every brochure or letter you receive from your bank, financial advisor, or brokerage firm asks if you have done your "estate plan." The fact is, your bank, financial advisor or brokerage firm can only help you with the **financial** planning aspects of your estate. You need a qualified Elder Law Estate Planning attorney to draft the legal documents that create an estate plan for you. A qualified Elder Law Estate Planning attorney will work with your financial advisor and accountant to create the best plan for you.

Many attorneys attend a short seminar to learn a certain area of law and then immediately add it to their existing law practice. The intricacies around estate, Medicaid and tax planning are extensive. Not only does the attorney need a thorough knowledge of probate law, estate administration, trust, asset protection and Medicaid laws, they must also have an extensive knowledge of income tax, estate tax, gift tax, generation-skipping tax and excise tax laws. All of these areas intertwine and have a significant impact on your estate plan.

While general attorneys may have some knowledge of the law and be able to guide you through certain parts of the estate or Medicaid planning processes, they will not be aware of the many exceptions and details an attorney whose practice concentrates **only** on elder law and estate planning will know.

An attorney, who does traffic court one day, divorce on another, business law on the third day, estate planning on the fourth day, and sues for personal injury on the fifth, will not have the experience and knowledge of the loopholes as an attorney who practices exclusively in elder law estate planning. If you're looking for a divorce, find an attorney who focuses on divorce. If you want elder law estate planning, utilize an attorney who focuses on elder law estate planning.

Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526) or ClientServices@aPracticeWithPurpose.com.

Planning for those with disabilities or special needs...

The Facts...

In the past, families would disinherit disabled family members and leave assets to someone else who agreed to “take care” of them. If assets are left to a disabled beneficiary, it could disqualify them from state or federal programs under which they are receiving benefits. In 1993 Congress enacted new laws that entitled disabled individuals to derive the same estate planning benefits as non-disabled individuals **without** affecting their eligibility for state or federal benefits. The law made provision for Supplemental Needs Trusts, which enable you to leave any amount of money to a loved one who has special needs without affecting their eligibility for the state or federal benefits they receive.

The law further provides the trust proceeds must be used to provide luxuries for the disabled individual he or she would not otherwise receive under the state and federal programs. Luxuries can include trips, computers, power wheel chairs, prosthetics, or other comforts not generally provided by the government.

A Supplemental Needs Trust can be created by an individual with their own funds or be created by someone other than the disabled individual, typically a parent or relative.

There are different rights and restrictions to each of these trusts, but both ensure **immediate** qualification for federal and state benefits (i.e. Medicaid) and provide luxuries to the disabled beneficiary they otherwise, most likely, would be unable to have.

When do I need Guardianship for my Special Needs Child?

As a parent of a special needs child, you are the child’s “natural guardian” and can make all decisions regarding the child. However, your rights as guardian do not allow you to have access or control of your child’s assets (i.e., proceeds from a lawsuit or gifts from a family member). In addition, when your child reaches the age of 18, you lose your rights as the natural guardian to make healthcare and other life decisions for them. To maintain these rights, you must commence a guardianship proceeding or the State will assume legal authority over your disabled loved one. There are less restrictive alternatives to guardianship if your child possesses the requisite level of capacity for supportive decision-making. To avoid losing your authority, you should contact a qualified Elder Law and Special Needs attorney to discuss your options at least six months prior to your child’s 18th birthday.

Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526) or ClientServices@aPracticeWithPurpose.com.

Revocable Living Trusts (RLTs)

The Facts...

A trust is a contract between the Grantor (the person who creates the trust), the Trustee (one who controls the trust) and the beneficiaries (those entitled to benefit from the trust). You, as Grantor, determine how the trust will be operated by the Trustee and who benefits, how and when. You can create a trust that permits you to be Trustee and give yourself the right to receive full benefits from it. This type of trust is typically referred to as a Revocable Living Trust and is often used as a substitute to your Will. It permits you to keep total control and access to all your assets during your lifetime, and provides for the distribution of your assets to your beneficiaries at your death. We often refer to a revocable living trust as your "Book of Instructions." A well-established advantage to Revocable Living Trusts is the avoidance of probate, which is required if you use a will to distribute your assets after death. Other advantages of Revocable Trusts, when property drafted, can include:

- Asset protection for your spouse after your death.
- Special needs planning for disabled beneficiaries.
- Asset management and protection for children who are not proficient with handling money.
- Protection of assets from a spouse's subsequent remarriage after your death.
- Disability planning in the event you become disabled prior to death.
- Asset protection for your child if his or her marriage should fail to ensure your assets are not part of a divorce settlement.
- Keeping your affairs private (as opposed to open for public review in probate).
- No court intervention required (handled entirely by the Trustee you name in accordance with your detailed instructions).
- Plan for proper management of your business in your absence.

Very few revocable living trusts provide these benefits. Only a qualified estate planning attorney will know how to incorporate these protections into your plan. While a Revocable Living Trust has many advantages, it does not protect your assets from a nursing home, lawsuits, divorce bankruptcy or other creditors.

Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526) or ClientServices@aPracticeWithPurpose.com.

Irrevocable Trusts

The Facts...

A trust is a contract between the Grantor (the person who creates the trust), the Trustee (one who controls the trust) and the beneficiaries (those entitled to benefit from the trust). You, as Grantor, determine how the trust will be operated by the Trustee and who benefits, how and when.

While a Revocable Trust permits you to maintain full control (as Trustee) and have access to all your assets (as beneficiary), an Irrevocable Trust, once created, may prohibit your right to control the trust (as Trustee) or have access to your assets, but you get to decide to what extent.

It is a common misconception that irrevocable trusts, once created, cannot be changed. While that is true of many irrevocable trusts created to avoid taxes (tax reduction or avoidance trusts), it is not true of all irrevocable trusts. An irrevocable trust is a trust you create for the benefit of yourself or others and once created, you, as Grantor, must give up your right to something.

Debtor/Creditor law provides that whatever you can get, your creditors can get. You can have known creditors (i.e., bank/credit card debt) or unknown potential creditors (unforeseen lawsuits, nursing home, and divorce). A typical income-only irrevocable trust permits you to receive the income on your assets, but you must give up your right to your principal. In some irrevocable trusts, you can retain the right to change who gets your assets during your life and after your death, and maintain 100% control of your assets until your mental disability or death (asset protection trusts).

Tax reduction/avoidance trusts are much more restrictive than asset protection trusts. Typically, you cannot retain any right to control or access any of the assets in an irrevocable tax reduction/avoidance trust. There are many irrevocable trusts available that are quite flexible and grantor-friendly. You should consult a qualified Elder Law attorney to get counseled on all your options before creating an irrevocable trust.

Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526) or ClientServices@aPracticeWithPurpose.com.

Charitable Planning

The Facts...

Charitable giving techniques are typically used for those who have accumulated wealth that is subject to estate tax after death. The estate tax rates are as high as 50% and those who have worked hard to create and accumulate assets will opt to utilize charitable giving techniques to minimize taxation while creating a lasting legacy without necessarily depriving family from benefitting from your assets. Charitable planning is also utilized to minimize income taxes (which can exceed 40%), and you can retain full control of your assets.

Charitable planning can also be effective when selling your business. When properly utilized, you can avoid paying income taxes on the sale of your business when sold.

Utilizing a charitable giving plan enables the donor to direct the use of his or her assets that would otherwise go to the IRS. Your assets can pass to your family, charities, or the IRS, but you must choose two out of the three. If you don't, the IRS wins by default.

There are many ways to do charitable planning, including Charitable Remainder Trusts and Charitable Lead Trusts.

Charitable Remainder Trusts enable you to:

- Transfer highly appreciated assets,
- Liquidate them with no tax consequence,
- Receive a charitable tax deduction against your current income, and
- Still receive the benefits from your assets for the balance of your life

At death, the remainder goes to the charity of your choice.

Charitable Lead Trusts:

- Provide income to a charity for a term of years, and at the end of the term, the remainder is paid to your family.
- A Charitable Lead Trust is primarily a gift-discounting technique that permits you to gift $1 of assets to your family members, and the IRS will view it as less than $1 (typically 30% - 60% less). This enables you to gift more than you otherwise would be able to.
- Other charitable strategies include:
  - Private Family Foundations.
  - Donor Advised Funds.
  - Special Funds as part of a Local Community Foundation.

Contact the Elder Law & Life Care Planning Center today at 910.755.PLAN (7526) or ClientServices@aPracticeWithPurpose.com.

Last Will and Testament

The Facts...

If you own assets in your name alone, they may pass from you to the people you love, as long as you leave a Will. Without a Will, your assets pass according to the State's rules, also known as intestacy. The State may not pass your assets to the people you care about. You should be sure.

Also, you should know that...

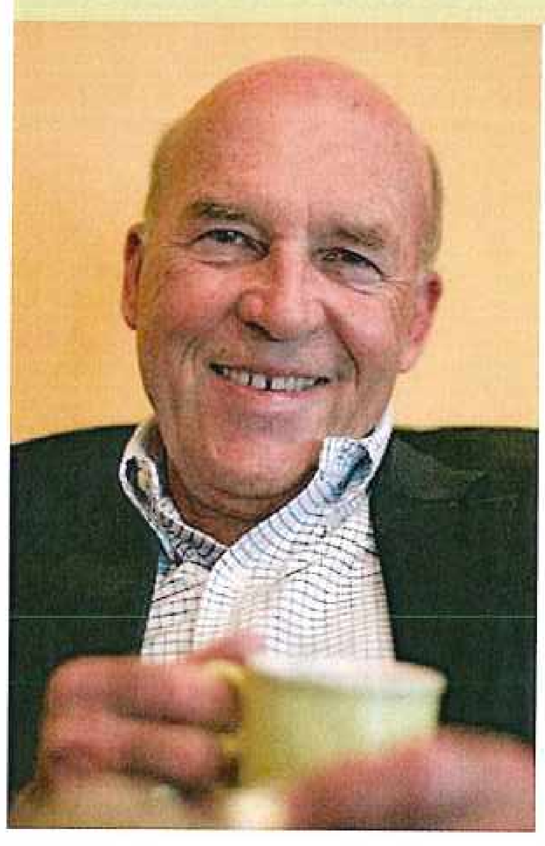
- Assets will pass through your Will to your loved ones if the Will is written properly.
- You can protect the ones you love by creating a trust in your Will which can protect that person from creditors.
- You can protect you.
- It is important that you give your family the tools to help you if you cannot help yourself, your children from divorce, or you may protect your children who are not good with money, or those who have other problems, such as addiction or mental illness.
- You can protect disabled beneficiaries by creating a Supplemental Needs Trust for them, which preserves assets for the family, while keeping their eligibility for public benefits.
- Your Will must go through probate - using the courts to divide your property.

Power of Attorney

The Facts... If you become sick or disabled, either temporarily or permanently, who will make decisions for you?

- A Power of Attorney is the most important document in your estate plan. It is the one document that stands between you and guardianship.
- Without a Power of Attorney, your family may have to file what is known as a Guardianship Proceeding, unnecessarily involving the court and at great expense to the estate.
- A Power of Attorney allows you to appoint someone you trust to handle your affairs if you cannot do so.
- If you cannot pay bills, get records or make other decisions, your family will be prevented from helping you get treatment, pay doctors or for Medicare.
- It is important that you give your family the tools to help you if you cannot help yourself.
- Without a "powerful" Power of Attorney, your family may have no choice but to spend your money for costly long-term care expenses.
- With a carefully crafted Power of Attorney, by an elder law firm, you can be positioned to protect assets from the costs of long-term care.

Senior Health Insurance Information Program



Phone 1-800-351-4664 | TTY 1-800-735-2942 | E-mail shiip@iid.iowa.gov

MEDICARE

Here's information to help you understand Medicare coverage options, so you can make informed choices based upon your health, your budget or both. When you're ready, our trained counselors can work with you one-on-one to help you make The Right Call.

What does Medicare cover? Medicare has two parts.

Hospital Insurance (Part A) Medicare Part A helps pay for four kinds of medically necessary care:

- inpatient hospital care
- inpatient care in a skilled nursing facility following a hospital stay
- home health care
- hospice care

Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A. If you have a specific question regarding Medicare Part A coverage or claims, call 1-800-MEDICARE (1-800-633-4227). The Medicare and You Handbook also has Part A benefit information.

RESOURCES (Click to Download)

Medicare Preventive Benefits

Medicare-Covered Preventive Wellness Visits

Getting Ready To Retire

2019 Medicare Deductibles, Coinsurance and Premiums

Medicare and the Health

Insurance Marketplace

Checklist for New Medicare Beneficiaries

Medicare & Other Insurance for People with Disabilities

Medicare and Iowa Medicaid Managed Care

Medicare What You Need to Know

Medicare_Medical Insurance Record Tracking Form

Dental and Vision Insurers Approved by the Iowa Insurance Division

New Medicare Cards with New Numbers -- Are you Ready?

Your Guide to Medicare's Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program (October 2017)

Medicare's National Mail-Order Program for Diabetic Testing Supplies (May 2016)

Medicare's National Mail-Order Program for Diabetic Testing Supplies (May 2016)

Medicare and VA Healthcare

MyMedicare.gov

Medical Insurance (Part B) Medicare Part B helps pay for:

- doctor's services
- outpatient hospital care
- durable medical equipment
- diagnostic tests
- many other health services and supplies that are not covered by Medicare Part A.

Part B has premiums, deductibles, and coinsurance amounts that you must pay yourself or through coverage by another insurance plan. If you have a specific question regarding Medicare Part B coverage or claims, call 1-800-MEDICARE (1-800-633-4227). The Medicare and You Handbook also has Part B benefit information.

Who can receive Medicare benefits? Medicare is a health insurance program for:

- People 65 years of age and older.
- The disabled—those under age 65 who have received Social Security or Railroad Retiree disability benefits for 24 consecutive months. Call SHIIP at 800-351-4664 for the Medicare and Other Insurance for People with Disabilities factsheet.
- Those with a diagnosis of ALS or Lou Gehrig's Disease.
- People with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant).

To be eligible for Medicare, a person must be a US citizen and resident of the U.S. or an alien living in the U.S. for five years who has been lawfully admitted for permanent residence.

I am turning 65 but will continue to work. Should I sign up for Medicare Part B?

You may be able to delay enrollment in Medicare Part B without penalty if you or your spouse continue to be **actively employed**

and are covered by employer's group health plan. In this situation you can enroll in Medicare Part B during a special eight-month enrollment period when you retire (whether you keep employer-sponsored retiree insurance coverage or not). The Social Security Administration determines when you are eligible to enroll in Medicare. Call their toll-free number, 800-772-1213, with your specific questions. Ask Social Security to send information about your situation in writing. Keep this information on file.

If you're 65 or older, you or your spouse are employed and the employer has 20 or more employees, you must be offered the same health insurance benefits under the same conditions offered to younger workers and spouses. [Note: If you're eligible for Medicare because of a disability, there must be at least 100 employees.] The employer cannot provide a Medicare supplement insurance policy instead of regular group coverage.

Employers with fewer than 20 employees (100 if disabled) are not required to offer health insurance coverage to employees over age 65. However, the employer may choose to do so.

Call SHIIP at 1-800-351-4664 or e-mail us at shiip@iid.iowa.gov, for answers to other questions regarding Medicare and health insurance when you are employed past age 65

I am 62 years old. Can I sign up for Medicare since I am now receiving my Social Security benefits?

No, you will be eligible for Medicare when you are 65. Since you are currently receiving Social Security benefits the Social Security office will automatically enroll you in Medicare and send you a Medicare card shortly before you turn 65.

I lost my Medicare Card. How do I get a new one?

Contact the Social Security Administration at 1-800-772-1213 to ask for a new card. Medicare cards can also be replaced online by visiting Social Security.

I recently moved. How do I change my address with Social Security and Medicare?

Call the Social Security Administration at 1-800-772-1213 to make your address change. If you are a Railroad Retiree, call 1-800-808-0772. You can also go to www.ssa.gov .

Some people on Medicare have limited finances. Are there any programs to help them with health care costs?

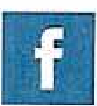
Title XIX or Medicaid is a public assistance program that pays for certain health care costs for qualified people. It is funded by both federal and state governments. In Iowa it is administered by the Department of Human Services (DHS). Eligibility is based on income and resource limits. Call SHIIP (800-351-4664) for the telephone number of the DHS office.

The following Medicare Savings Programs are especially important to Medicare beneficiaries. Eligibility is based on income and resource limits.

Qualified Medicare Beneficiary (QMB) — Pays the Medicare Part B premium and Parts A & B deductibles and co-payments.

Specified Low-income Medicare Beneficiary(SLMB) — Pays the Medicare Part B premium only.

For more information about Medicare Savings Programs call SHIIP at 1-800-351-4664 (TTY 800-735-2942).



Last Updated: 12/07/2018 (JLR)

Medicare Basics

Seniors' Health Insurance Information Program

North Carolina Department of Insurance

Mike Causey, Commissioner

1-855-408-1212 • www.ncshiip.com

What is SHIIP?

Seniors' Health Insurance Information Program (SHIIP) is a consumer information division of the North Carolina Department of Insurance that assists people with Medicare, Medicare Part D, Medicare supplements, Medicare Advantage, and long-term care insurance questions. We also help citizens recognize and prevent Medicare billing errors and possible fraud and abuse through our NC Senior Medicare Patrol (NCSMP) Program.

How does SHIIP work?

SHIIP provides education and assistance to North Carolinians in three ways:

- by operating a nationwide toll-free consumer information phone line Monday through Friday from 8 a.m. until 5 p.m.
- by training volunteers to counsel Medicare beneficiaries within their community about Medicare, Medicare Part D, Medicare supplements, Medicare Advantage and long-term care insurance, and
- by creating educational materials for consumers' use including the Medicare Supplement Comparison Guide and featuring a Medicare Supplement Premium Comparison Database on our Web site (www.ncshiip.com).

When was SHIIP established?

The program was founded in 1986 by the Department of Insurance in direct response to the growing concerns about health insurance for the more than one million Medicare beneficiaries in North Carolina. Numerous insurance companies sell Medicare supplements, Medicare Advantage, long-term care insurance and other medical insurance products to people in North Carolina. Because there are so many companies, and because the Medicare system is so complex, SHIIP was founded to provide people who are eligible for Medicare with an objective information service.

How do North Carolinians contact SHIIP?

You can contact SHIIP by dialing the nationwide toll-free consumer number, **1-855-408-1212**, visiting the SHIIP Web site, **www.ncshiip.com**, or e-mailing **ncshiip@ncdoi.gov**. Trained SHIIP Volunteer Counselors are available in all 100 counties of North Carolina and are coordinated through an existing human service agency such as the Council on Aging, senior centers or the Cooperative Extension offices. If your problem is too complex to handle over the phone, you will need to contact your local SHIIP Coordinator for a one-on-one appointment with a SHIIP Volunteer Counselor.

Can I get more information about SHIIP?

Yes! Contact SHIIP nationwide at **1-855-408-1212** or **(919) 807-6900**, visit **www.ncshiip.com** or e-mail **ncshiip@ncdoi.gov** for further information and ask for more details on the Seniors' Health Insurance Information Program and how it can help you.

In ______________________________ County, contact ____ at

____, phone number: ______________________________.

2017 **Medicare Part A:** Hospital Insurance – Covered Services Per Benefit Period

A **benefit period** begins on the first day you receive services as an **inpatient** in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 consecutive days.

Services	Benefit	Medicare Pays [1]	You Pay [1]
INPATIENT HOSPITALIZATION (admitted) Semi-private room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but **$1,316** deductible	**$1,316** deductible
	61st to 90th day	All but **$329** per day	**$329** per day
	91st to 150th day [2]	All but **$658** per day	**$658** per day
	Beyond 150 days	Nothing	All costs
POST-HOSPITAL SKILLED NURSING FACILITY CARE You must have been an inpatient in a hospital for at least 3 days, enter a Medicare-approved facility generally within 30 days after hospital discharge, and meet other program requirements.[3]	First 20 days	100% of approved amount	Nothing
	21st to 100th day	All but **$164.50** per day	Up to **$164.50** per day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE (also see Part B) Medically necessary skilled care, home health aide services, medical supplies, etc. after a 3-day inpatient hospital stay for visits 1-100.	100% part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for Durable Medical Equipment.	Nothing for services; 20% of approved amount for Durable Medical Equipment.
HOSPICE CARE Full scope of pain relief and support services available to the terminally ill.	As long as doctor certifies need.	All but limited costs for outpatient prescription medications and inpatient respite care.	Limited cost sharing for outpatient prescription medications and inpatient respite care.
BLOOD	Blood	All but first three pints per calendar year	For first three pints [4]

1 These figures are for 2017 and are subject to change each year.

2 Lifetime reserve days may be used only once.

3 Neither Medicare nor Medicare Supplement (Medigap) insurance will pay for most nursing home care.

4 To the extent the blood deductible is met under one part of Medicare during the calendar year it does not have to be met under the other part.

NOTE: The Medicare Part A premium is **$0** for eligible beneficiaries. For those who are ineligible, the Medicare Part A premium is **$413** per month for those who worked fewer than 30 quarters, or **$227** per month for those who worked between 30 and 40 quarters.

2017 **Medicare Part B:** Medical Insurance – Covered Services Per Calendar Year

Services	Benefit	Medicare Pays	You Pay [5]
MEDICAL EXPENSE Physicians' services, outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, ambulance services, outpatient mental health services, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $183 deductible)	**$183** deductible[6] 20% of approved amount and charges above approved amount[7]
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Generally 100% of approved amount.	Nothing
HOME HEALTH CARE (also see Part A) Medically necessary skilled care, home health aide services, medical supplies, etc. after a 3-day inpatient hospital stay beginning with visit 101 or beginning day one if there is no previous hospital stay.	100% part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount	Nothing
		80% of approved amount for Durable Medical Equipment	**$183** deductible[6] 20% of approved amount for Durable Medical Equipment
OUTPATIENT HOSPITAL TREATMENT Reasonable and necessary services for the diagnosis or treatment of an illness or injury. (for inpatient see Part A)	Unlimited if medically necessary	80% of approved amount (after **$183** deductible)	**$183** deductible[6] 20% of approved amount
BLOOD	Blood	80% of approved amount (after **$183** deductible and starting with the 4th pint)	**$183** deductible[6] First 3 pints plus 20% of approved amount for additional pints[8]

[5] These figures are for 2017 and are subject to change each year.

[6] Once you have paid **$183** for covered services, the Part B deductible does not apply to any other covered service(s) you receive for the rest of the calendar year.

[7] The amount by which a physician's charge can exceed the Medicare approved amount is limited by law.

[8] To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

90

The monthly Part B premium for 2017 is $134.

(Premiums will be higher for individuals with annual incomes of **$85,000** or more and married couples with annual incomes of **$170,000** or more.)

Standardized Medicare Supplement Plan Comparison Chart

Benefits	Supplement Plans									
	A	B	C	D	F*	G	K	L	M	N
Part A Coinsurance and Hospital Costs**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓[1]
Parts A/B Blood Deductibles (first 3 pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess[2]					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Out-of-Pocket Limit***	N/A	N/A	N/A	N/A	N/A	N/A	$4,969	$2,560	N/A	N/A

* Plan F also offers a high-deductible plan (F Prime) with the same benefits, but it does not pay until you have met the annual deductible of **$2,200**.

** Part A Hospital coinsurance costs after Medicare benefits are used up. Days 61-90: **$329** per day of each benefit period. Days 91-150: **$658** per "lifetime reserve day" for each benefit period (up to 60 days throughout your lifetime). Beyond 150 days: 100% up to 365 days.

*** After you meet your out-of-pocket yearly limit and your yearly Part B deductible, the plan pays 100% of covered services for the rest of the calendar year.

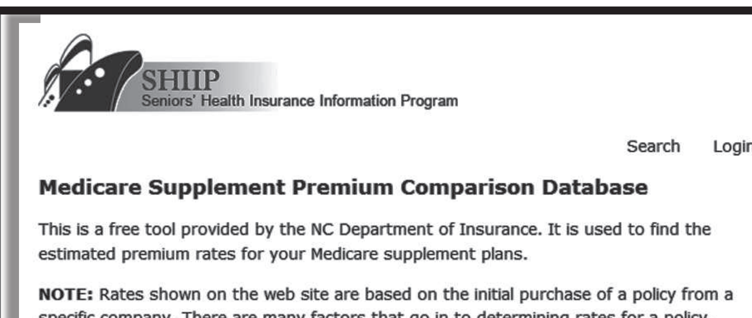
[1] Plan N pays 100% of the Part B coinsurance except for a copayment of up to $20 for some office visits and a copayment of up to $50 for emergency room visits that don't result in inpatient admission.

[2] If you have Original Medicare and the amount a provider is legally permitted to charge is higher than the Medicare approved amount, the difference is called Excess Charge.

Part A Deductible for 2017 is $1,316 | Skilled Nursing Coinsurance (days 21-100) is $164.50/day | Part B Deductible for 2017 is $183

Online Medicare Supplement **Premium Comparison Database**

SHIIP's interactive Web site tool allows individuals to compare Medicare supplement plans at the touch of their fingers. To the right you will see a snapshot of how the page appears. By simply entering your age, gender, the Medicare supplement plan you want to compare and whether or not you use tobacco products, the computer will generate a list of the companies offering that plan along with their estimated premiums. By clicking on the company name, you will be directed to other important aspects of the product. This site has the most up to date information of plans available in North Carolina. It is located at **www.ncdoi.com/medisupp/search_new.asp.**



Medicare Part C: Medicare Advantage Plans

Medicare Advantage Plans are health care options provided under Medicare Part C of the Medicare program. These plans are approved by Medicare but sold and serviced by private companies. There are several plan options available under Medicare Advantage such as managed care plans that involve a provider network (HMOs and PPOs) to those that are specially designed for people with certain chronic diseases and other specialized health needs (SNPs) and some that may or may not have a provider network (PFFS) requirement. Some Medicare Advantage plans include Medicare prescription drug coverage.

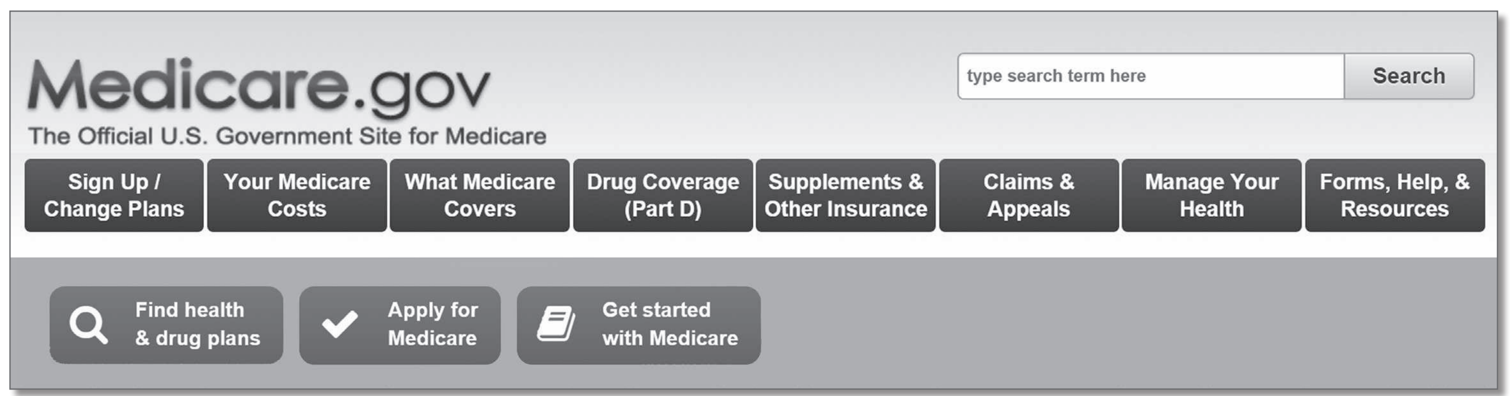
To enroll in any Medicare Advantage plan option you must have both Medicare Part A and Medicare Part B. Once you enroll into a Medicare Advantage plan, you will not use your Original Medicare (red, white and blue) card as your Medicare Advantage plan will replace Original Medicare. Instead the Medicare Advantage plan will provide you with a member ID card to use when visiting your medical provider. Please note, you will continue to pay the Medicare Part B premium, and you might also have to pay an additional monthly premium charged by the Medicare Advantage plan.

It is important to remember to check with your healthcare providers before making any change to your Medicare coverage to make sure they will accept the Medicare Advantage plan you are considering.

Medicare Part D: Prescription Drug Plans Benefit

The Medicare Prescription Drug Plans, also called PDPs, are provided by private companies that sell plans approved by Medicare. You can identify an approved plan by the MedicareRx logo. All people who are new to Medicare have a seven month window to enroll in a Medicare Part D drug plan – three months before, the month of, and three months after their Medicare becomes effective. Remember, the month you enroll will affect the month your PDP is effective.

All people with Medicare are eligible to enroll in a PDP, regardless of income or assets; however, unless they are new to Medicare or are entitled to a Special Enrollment Period, they must enroll during the Open Enrollment Period (OEP) which is October 15 through December 7 each year. For assistance in understanding and enrolling in a Medicare PDP, you may visit the Medicare Web site at **www.medicare.gov** or contact SHIIP at **1-855-408-1212**.



NOTE: If you do not enroll in a Medicare PDP when you first become eligible, and you do not have creditable drug coverage in place, in most cases you will pay a penalty for life when you do enroll in a PDP during the OEP.

There is assistance available for people with Medicare who have limited incomes and resources. If they qualify, they can receive assistance with **premiums, deductibles and co-payments** for their prescriptions. If someone has a monthly income below **$1,508** as an individual or **$2,030** as a married couple living together and assets lower than **$13,820** as an individual or **$27,600** as a married couple living together (includes $1,500/person funeral or burial expense), they can visit their local Social Security office, call Social Security toll free at **1-800-772-1213**, visit **www.socialsecurity.gov**, or request an extra help assistance application by contacting SHIIP. People who qualify for any level of Medicaid automatically qualify for LIS and do not need to apply.

NOTE: If you applied for Extra Help and have a letter stating that you do not qualify for assistance, you are still eligible to enroll in a PDP during your 7 month Initial Enrollment Period or during the annual Open Enrollment Period (Oct. 15 – Dec. 7) and will be responsible for paying the premiums, deductibles and co-payments.

Medicare **Preventive Benefits**

(Refer to your Medicare & You Handbook for a complete list of Preventive Benefits)

Covered Services	Who is Covered	What You Pay
One-Time Welcome to Medicare Preventive Visit and Yearly Wellness Visit One-time "Welcome to Medicare"preventive visit within twelve months of the day your Medicare Part B becomes effective. After you have had Part B for longer than 12 months you can get a "yearly wellness visit" to develop or update a prevention plan based on your current health and risk factors.	All people with Medicare	You pay nothing for the "Welcome to Medicare" preventive visit or the yearly "Wellness" visit if the doctor accepts assignment. The Part B deductible does not apply; however, if your doctor performs additional tests or services during the same visit that aren't covered under these preventive benefits, you may have to pay coinsurance, and the Part B deductible may apply.
Colorectal Cancer Screening Fecal Occult Blood Test – Once every 12 months. Flexible Sigmoidoscopy – Once every 48 months. Screening Colonoscopy – Once every 10 years, but not within 48 months of a screening sigmoidoscopy if you are not at high risk for colon cancer. Once every 24 months if you are high risk for colon cancer. Barium Enema – Once every 48 months (or every 24 months if you are high risk) when used instead of sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older or at high risk for colorectal cancer, but there is no minimum age for having a screening colonoscopy.	Fecal Occult Blood Test – You pay nothing. Flexible Sigmoidoscopy and Screening Colonoscopy – You pay nothing if your doctor accepts assignment. However, if a screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and you may have to pay a copayment; in which case, the Part B deductible does not apply. Barium Enema – You pay 20% of the Medicare-approved amount for the doctor's services. The Part B deductible does not apply. If done in a hospital outpatient setting, you pay a copayment.
Breast Cancer Screening (Mammogram) Once every 12 months for screening mammogram. Diagnostic mammogram covered when medically necessary.	All women with Medicare age 40 and older. Women can get one baseline mammogram between ages 35 and 39.	Screening Mammogram – You pay nothing for the test if the doctor accepts assignment. Diagnostic Mammogram – You pay 20% of the Medicare-approved amount.
Cervical and Vaginal Cancer Screening Pap test and pelvic exam to check for cervical and vaginal cancers once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer or if you are of childbearing age and have had an abnormal Pap in the past three years.	All women with Medicare.	You pay nothing for the lab Pap test, nothing for the Pap test specimen collection and nothing for the pelvic exam if the doctor accepts assignment.
Prostate Cancer Screening Digital Rectal Exam – Once every 12 months. Prostate Specific Antigen (PSA) Test – Once every 12 months.	All men with Medicare over age 50.	Digital Rectal Exam – 20% of the Medicare-approved amount after the annual Part B deductible. If done in a hospital outpatient setting, you pay a copayment. PSA Test – You pay nothing for the test. The Part B deductible does not apply.

Covered Services	Who is Covered	What You Pay
Cardiovascular Screening Screening blood tests for early detection of cardiovascular (heart) disease. Medicare covers screening tests for cholesterol, lipid and triglyceride levels every 5 years.	All people with Medicare.	You pay nothing for the test. The Part B deductible does not apply. You will pay 20% of the Medicare-approved amount for the doctor's visit.
Diabetes Screening, Supplies and Self-Management Training Coverage for glucose monitors, test strips, lancets and self-management training	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the annual Part B deductible.
Coverage for medical nutrition therapy services for beneficiaries with diabetes or kidney disease, including diagnostic therapy and counseling services furnished by a registered dietitian or nutrition professional.	Certain people with Medicare who have diabetes, kidney disease (not on dialysis) or had a kidney transplant within the last 3 years. Your doctor needs to refer you for this service.	20% of the Medicare-approved amount after the annual Part B deductible.
Up to two screening (Fasting Blood Glucose) tests a year for Medicare beneficiaries at risk for getting diabetes	People with Medicare who are at risk for diabetes.	You pay nothing if your doctor or health care provider accepts assignment.
Shots (Flu, Pneumococcal, Hepatitis B) Flu Shot – Once a year in the fall or winter. Pneumococcal (Pneumonia) Shot – One shot in a lifetime if your doctor deems necessary. Hepatitis B Shot (one series, three shots) – If you are at medium to high risk for hepatitis.	All people with Medicare.	Flu Shot – You pay nothing. The Part B deductible does not apply. Pneumococcal and Hepatitis B Shots – You pay nothing if your doctor accepts assignment. The Part B deductible does not apply.
Glaucoma Screening Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this test in your state.	People at high risk for glaucoma, including people with diabetes or a family history of glaucoma, African Americans age 50 and older, or Hispanic Americans age 65 or older.	20% of the Medicare-approved amount after the annual Part B deductible.
HIV (Human Immunodeficiency Virus) Screening Once every 12 months, or up to 3 times during a pregnancy.	All people with Medicare.	You pay nothing for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor's visit.
Bone Mass Measurements Once every 24 months for beneficiaries at risk for osteoporosis (more often if medically necessary).	Certain people with Medicare who are at risk for losing bone mass. Discuss with your doctor.	You pay nothing if your doctor accepts assignment.

Your **Medicare Coverage Choices** at a Glance

When you become eligible for Medicare, you will be able to choose between:

1. Parts A & B (Original Medicare), Part D (Prescription Drug Benefit), and potentially Medicare Supplement Insurance
2. Part C (Medicare Advantage Plan)

When comparing coverage, it's important to look at the two core options first: Original Medicare and Medicare Advantage. Note that Medicare Advantage plans come in many types (the most common are HMOs and PPOs) and must cover the same benefits as Parts A & B of Original Medicare.*

It's also important to consider the potential to add a Medicare Supplement (or Medigap) policy to your Original Medicare to help cover all or some of the costs of Parts A & B. Remember, you cannot have *both* a Medicare Supplement policy *and* a Medicare Advantage Plan. If you need help comparing Original Medicare and Medicare Advantage Plans, use these steps to help you decide.

Original Medicare
(Parts A & B)

Part A
Hospital Insurance

Part B
Medical Insurance

Do you need to add supplemental coverage?

Medicare Supplement Insurance
(also called Medigap plans)

Do you need to add drug coverage?

Part D
Prescription Drug Coverage
(PDP Plan)

OR

Medicare Advantage Plan**
(Part C)

Combines Hospital & Medical
(Managed Care plans offered by private insurance companies)

Available with or without Prescription Coverage.***

*** If you enroll in Part C, you are still in the Medicare program and are responsible for payment of Part B premiums.**

****You must have enrolled in both Medicare Part A and Part B with SSA to sign up for Medicare Advantage (Part C).**

***** Most Medicare Advantage Plans cover prescriptions drugs. You may be able to add drug coverage in some plan types if not already included.**

Leading the Way in Special Needs and Elder Law

The Top 6 Reasons to Hire an Elder Law Attorney

Seniors face complex legal concerns that are often different from what they faced when they were younger. Actions taken may have unintended legal effects. As a senior or someone who's helping make decisions for a senior, it's important that you work with an attorney who is an expert in Elder Law.

What Is Elder Law?
Elder Law encompasses many different fields of law. An Elder Law attorney specializes in how to best use their knowledge to fit the needs of seniors. Some of these fields include:

- Preservation/transfer of assets seeking to avoid spousal impoverishment when a spouse enters a nursing home
- Medicaid
- Medicare claims and appeals
- Social security and disability claims and appeals
- Supplemental and long-term health insurance issues
- Disability planning, including use of durable powers of attorney, living trusts, "living wills," for financial management and health care decisions, and other means of delegating management and decision-making to another in case of incompetency or incapacity
- Conservatorships and guardianships
- Estate planning, including planning for the management of one's estate during life and its disposition on death through the use of trusts, wills, and other planning documents
- Probate
- Administration and management of trusts and estates
- Long-term care placements in nursing home and life care communities
- Nursing home issues including questions of patients' rights and nursing home quality
- Elder abuse and fraud recovery cases
- Housing issues, including discrimination and home equity conversions
- Age discrimination in employment
- Retirement, including public and private retirement benefits, survivor benefits, and pension benefits
- Health law
- Mental health law

Most Elder Law attorneys do not specialize in every one of these areas, so when an attorney says he or she practices Elder Law, find out which of these matters he or

she handles. You will want to hire the attorney who regularly handles matters in the area of concern in your particular case and who will know enough about the other fields to question whether the action being taken might be affected by laws in any of the other areas of law. For example, if you are going to rewrite your will and your spouse is ill, the estate planner needs to know enough about Medicaid to know whether it is an issue with regard to your spouse's inheritance.

Why Hire an Elder Law Attorney?
Rather than being defined by technical legal distinctions, Elder Law is defined by the client to be served.

An Elder Law attorney:

1. Focuses his or her practice on the legal needs of seniors.

2. Works with a variety of legal tools and techniques that specifically meet the goals and objectives of the older client.

3. Uses a holistic approach to legal advice, taking into consideration the key issues facing seniors: housing, financial well-being, health and long-term care, and autonomy/quality of life.

4. Brings to his or her practice a knowledge of the issues facing seniors that allows them and their staff to ignore the myths relating to aging and the competence of seniors.

5. Will take into account and empathize with some of the physical and mental difficulties that often accompany the aging process. Their understanding of the real-life problems of people as they age allows them to determine more easily the difference between the physical versus the mental disability of a client.

6. Is tied into a formal or informal system of social workers, psychologists, and other elder care professionals who may be of assistance to you.

How to Find an Elder Law Attorney
Members of the National Academy of Elder Law Attorneys (NAELA) are attorneys who are experienced and trained in working with the legal problems of aging Americans and individuals of all ages with disabilities. Established in 1987, NAELA is a non-profit association that assists lawyers, bar organizations and others. The mission of NAELA is to establish NAELA members as the premier providers of legal advocacy, guidance and services to enhance the lives of people with special needs and people as they age. NAELA currently has members across the United States, Canada, Australia and the United Kingdom. For more information, visit NAELA.org.

The clients served by Elder Law attorneys can be among society's most vulnerable people, often seeking help when they are most in need of wise counsel and advice.

Because of this, NAELA members believe that Elder Law attorneys should aspire to a higher level of professional practice standards and so they developed Aspirational Standards to define them. Every member pledges to uphold the Aspirational Standards as a requirement of membership.

Hiring an Elder Law attorney will give you peace of mind that the legal advice you seek will come from an expert in the legal needs of people as they age.

To locate an Elder Law attorneys and for more information about the National Academy of Elder Law Attorneys, go to www.NAELA.org.

This information is provided as a public service and is not intended as legal advice. Such advice should be obtained from a qualified Elder Law attorney.

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This article describes, compares, and analyzes the roles and functions of guardianship and several decision-making interventions previously identified as potential alternatives to guardianship. An analytical framework, comprised of capacity, risk, complexity, and support, is developed to assess performance expectations and identify limitations of four types of decision-making interventions. Using case examples to illustrate how the framework applies to practice, the capacity of different types of interventions to address needs and to substitute or divert older adults from guardianship is examined. The article concludes with propositions introduced to guide future research.

Key Words: Financial management, Alternatives to guardianship, Alternatives to conservatorship, Protective services

Rethinking Alternatives to Guardianship[1]

Kathleen H. Wilber, PhD,[2] and Sandra L. Reynolds, BA[3]

Over the last decade, a variety of financial and health-related decision-making interventions have been identified as potential alternatives to legal guardianship. Guardianship, called conservatorship in some states, refers to court appointment of surrogate decision makers for persons judged not competent to make their own decisions. The search for alternatives (Hommel & Wood, 1990; Kapp & Detzel, 1992; Stiegel, 1992; Wilber, 1991) is driven, largely, by the restrictive and paternalistic nature of guardianship as an intervention. Underlying this search is the assumption that less restrictive approaches will balance the need for protection with the need for self-determination by processes that Schmidt (1990) distinguishes as diversion (delaying or preventing the need for court appointment of a surrogate decision maker) and substitution (acting in place of guardianship). Because financial and medical decision-making interventions are important components of guardianship, they are viewed as means to help older persons avoid guardianship.

Societal aging and increasingly complex institutional transactions suggest a growing role for services that provide older persons assistance with money management, benefits advocacy, estate planning, and medical decision making. For example, current estimates are that between 1.5 and 3 million persons age 65 and older need help managing their finances (National Center for Health Statistics, 1987; Stone & Murtaugh, 1990). Of these, a conservatively estimated 500,000 who are without relatives or friends to assist them must look to social services or to the private sector for help (American Association of Retired Persons, 1992). Despite a high level of need among low and moderate-income older adults, financial management and health-related decision-making interventions represent what Estes, Swan and Associates (1993) refer to as a "no-care zone" or underdeveloped social service in many communities (Wilber & Buturain, 1992).

Although financial management and health-related decision-making services have the potential to affect the lives of dependent persons significantly, these areas have received little attention from researchers. Studies that have been conducted have focused primarily on the process and problems of legal guardianship. Identified problems with guardianship include lack of due process in court proceedings, poor performance and abuse by guardians, the high economic costs of guardianship, the immutable nature of the decision, and lack of oversight by the courts (Alexander, 1990; Associated Press, 1987; Bulcroft, 1992; Iris, 1988, 1990; Kapp, 1981, 1992; Keith & Wacker, 1993; Steinberg, 1985; Stiegel, 1992). Although efforts have been underway during the last decade to reform guardianship policies and practices, implementation has been uneven. In addition, despite reforms, guardianship remains the intervention of last resort because, without requiring consent, it transfers an adult's authority to make personal and estate-related decisions to a surrogate.

The search for interventions that prevent or substitute for guardianship placement is a recent area of interest, initiated by conceptually grouping a broad array of services together as "alternatives to guardianship" much the same way that community based long-term care services have been considered "alternatives to institutionalization." Although such an

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approach is an important first step to differentiating service areas, it tends to overshadow the distinct roles, capabilities, and functions of financial management and health-related decisional options.

The purpose of this article is to describe, analyze, and conceptualize financial and medical decision-making interventions for older adults. We do this by developing a theoretical framework to differentiate the roles and functions of four types of service options within the context of current institutional arrangements, policies, and practices. Although our primary emphasis is on financial decision making, we also discuss health-related decision-making approaches. We begin by presenting a typology of decision-making interventions through which we examine current institutional arrangements, distinguish the benefits and liabilities associated with different types of interventions, and differentiate the roles of various services. This typology is followed by the development of an analytical framework comprised of capacity, risk, complexity, and support. The framework is applied to a case study to illustrate which alternatives are most appropriate under different conditions. The article concludes with the presentation of several propositions regarding the substitution and diversion parameters of different decision-making alternatives.

Typology of Decision-Making Options

In Chart 1, decision-making approaches are categorized according to the locus of decisional responsibilities as: (1) services that *support* the older person as decision maker; (2) services in which the older person *shares* decisional responsibility with another party; (3) services where the older person *delegates* current and/or future decisional authority to another party; and (4) services in which a *surrogate* decision maker is appointed for the older person. Chart 1 also identifies service options available within each category.

Supportive decision-making approaches, shown in Cell 1, presume that the older adult has decisional authority to direct transactions but requires help executing decisions (Collopy, 1988; Smyer, 1993). Supportive options, therefore, require decisional capacity for execution, can be terminated by the older person at any time, and become invalid if the person loses capacity. Supportive financial management arrangements include formal bill-paying services (BPS) provided by social service agencies and certified financial planners (CFP); powers-of-attorney (POA) assigned to a family member, friend, bank officer, or attorney; and personal trusts, if language is not included that allows the trust to continue after incapacity. In addition to basic bill paying assistance, BPS includes client education and counseling, benefits advocacy, insurance billing, budgeting, and credit management. Private fiduciaries (e.g., CFP) provide similar services augmented by investment counseling and estate planning. Although BPS offered by social service providers have not been shown to substitute for guardianship (Wilber, 1991), potential benefits include protection against financial exploitation and consumer fraud and reduced risks of utility shut-off, damaged credit, and eviction or foreclosure. BPS provides some measure of safety, as most programs have reasonable oversight mechanisms, such as external audit procedures (Kapp, 1992; Wilber & Buturain, 1993).

POA arrangements grant specific or general powers to an agent to act on behalf of the older adult. Benefits are client control, privacy, and ease of execution and cancellation. Limitations are that POAs lack oversight mechanisms such as bonding, notice, and legal advice, unless a corporate agent is involved; POAs do not survive incapacity.

> Case *Example:* Mrs. S., 76, suffered from hemiplegia and mild cognitive impairment resulting from a stroke. Although she was able to make decisions for herself, she was unable to write and had difficulty organizing and paying her mounting bills, including a number of medical claims from an extended hospital stay. The case management agency that coordinated her home health, housekeeping, and personal care services referred her to a non-profit daily money management (DMM) service that assisted her with her banking, budgeting, bill paying, and medical claim

Chart 1. Typology of Financial Management and Health-Related Decision-Making Services

Supportive Cell 1	**Shared** Cell 2
• Elder retains decisional authority • Elder delegates executional authority Examples: Powers of Attorney (POA) Bill Paying Services (BPS) Trusts (can be supportive)	• Elder shares and negotiates both decisional and executional authority Examples: Joint Accounts Joint Tenancy Trusts (can be shared)
Delegated Cell 3	**Surrogate** Cell 4
• Elder exercises decisional authority prior to incapacity with advance directives Examples: Living Wills Durable Powers of Attorney (DPA) Durable Powers of Attorney for Health Care (DPAHC) Trusts (usually delegated)	• Decisional and executional authority transferred by formal mechanisms Examples: Family Consent Laws Representative Payee (rep payee) Limited Guardianship Plenary Guardianship

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forms. Because DMM is not designed to serve persons who lack decisional capacity, her money manager also helped her execute health and financial advance directives so that her preferences would continue to guide decisions in the event that she became mentally incapacitated.

Shared decision making, shown in Cell 2, involves joint or negotiated responsibility between the older person and another party. Shared decision making includes joint accounts and joint tenancy arrangements in which an elderly person with income or assets other than federal transfer payments (e.g., Social Security, Supplemental Security Income, Veterans Administration Pension, etc.) establishes joint accounts or holds property with another person, presumably a trusted family member or friend. Although these arrangements require capacity when they are executed, joint accounts and joint tenancy (with rights of survivorship, as most are) survive both incapacity and death. While joint accounts can provide authority for a designated party to access funds to assist the older person in bill paying and investing, no oversight is provided; nor is there any obligation for the joint tenant to perform services.

Because older adults with capacity are frequently co-trustees of their own estate, sharing decision-making powers with another fiduciary, trusts are included as a shared financial management service. Trusts involve the drawing of documents that set forth the instructions of the grantor for the management of assets and income. Revocable Trusts, which are the most widely used, can be changed or rescinded by the grantor at any time prior to incapacity or death. Because most are written to anticipate future incapacity, trusts also are included in Cell 3.

Case Example: Shortly after Mr. McD., 80, placed his bank accounts and his home in joint tenancy with one of his two sons, he suffered a massive infection from a ruptured gall bladder. Rushed into surgery, he spent 3 months in the hospital in a semiconscious state. Although he eventually recovered fully and resumed control of his property and assets, during his hospitalization his son was able to manage all of his financial affairs. Had he not recovered, however, upon his death the property would transfer to the joint tenant, suggesting that survivorship issues need to be considered in this type of arrangement.

Delegated decision making (Cell 3) relies on planning tools such as a durable power-of-attorney (DPA), a durable power-of-attorney for health care (DPAHC), and trusts to ensure that financial and health care preferences of the person will survive incapacity. Under DPA and DPAHC arrangements, the older adult selects a responsible party to make decisions in identified areas. Both the DPA and DPAHC are relatively easy documents to enact, yet they confer considerable authority to the agent. In part, because they convey authority to address complex decisional areas, DPA and DPAHC advance directives are believed to offer a viable means to divert adults from guardianship (Alexander, 1990). Authority is not absolute, however, as the agent may be challenged if family conflict or competing interests lead to problems. Because the presence of the DPAHC does not always relieve the medical service provider from the threat of legal action by a family embroiled in conflict, some nursing homes and hospitals may be unwilling to follow DPAHC directives, for fear of costly litigation (Kapp & Detzel, 1992; Moody, 1992). As with joint tenancy arrangements, advance directives lack oversight protection while conveying decisional authority to another.

Trusts are included in Cell 3 as well, because most are written with language that specifies continuation of the terms, under a designated fiduciary, after the grantor no longer has the cognitive capacity to make reasoned decisions. A trust allows the older adult to designate a trustee to manage assets and to stipulate the circumstances under which the trustee assumes control. The trust also describes the manner in which the assets are to be managed after the death or incapacity of the grantor. A major benefit of trusts is their versatility, in that they can be written to address almost any need or concern of the grantor or beneficiaries including complex investment and estate management issues. Disadvantages include the costs and complexity of arranging a trust including drawing up the document, which generally must be done by an attorney, and ongoing trustee's fees, typically 1–2% of the value of the assets per year for a corporate fiduciary. The benefits of using a corporate trustee (typically, bank trust departments or law firms) include regular methods of accountability and the use of a neutral party in situations where competing interests create conflict. A family member or friend can also be named as the trustee, thereby keeping ongoing fees to a minimum. In addition to durable powers-of-attorney and trusts, adults may also nominate a guardian prior to incapacity. Courts generally try to honor these preferences unless there is a compelling reason (e.g., exploitation, neglect) not to do so.

Case Example: Mr. B., 68, was rushed to the hospital after suffering a massive heart attack. Some months earlier he had executed a DPA and a DPAHC identifying the oldest of his three daughters as his agent. Because Mr. B. had previously notified his family and his physician about the advance directive and had addressed family members' concerns about his wishes for a "do not resuscitate" order, his daughter was accepted by significant others and medical personnel as his legitimate decision maker. Although Mr. B. never recovered consciousness, his daughter managed his finances and participated in making decisions about his medical care during his hospitalization and the 6 months he spent in a skilled nursing facility prior to his death. Had Mr. B. been less explicit about his decisions, family or physician disagreement may have undermined the execution of his wishes.

Surrogate decision-making authority (Cell 4) is transferred formally from an adult to another by state statute (family consent laws), government stipulation (representative payee), or court order (guardianship). Currently 25 states have provisions for family consent laws, which determine the order in which family members may act as health care decision

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makers (e.g., spouse, adult children, other relatives) (Sabatino, 1991). Although family consent laws have provisions that ensure that a responsible party is available in most instances, they do not address the suitability of family members or the preferences of the older person. A representative payee (rep payee) is a person or entity specifically designated by the Social Security Administration or other government agency to receive federal transfer payments, such as Social Security or Veterans Administration Pension payments. Rep payee services are authorized based on an assessment by a physician or other health care professional that the beneficiary is unable to manage finances because of a long-term or permanent dementing illness or mental disorder (Hortum, 1989).

Plenary guardianship is a legal process that grants the guardian authority to act in virtually all areas of the ward's life (Schmidt, Miller, Bell, & New, 1981). Most often, a guardian is appointed after the observance of certain court procedures (i.e., petition, investigation, and hearing), if a person of authority, usually a physician, determines that an individual lacks capacity to make decisions and if a responsible party is available to serve as guardian (Kapp, 1990). To address both financial and personal risk, most states separate guardianship into decisional power of the person (e.g., living arrangements, physical well-being, and medical treatment) and the estate (e.g., managing property, assets, and income). A guardian can be appointed for one or both areas. The majority of states' statutes also acknowledge that capacity is situation-specific through provisions for limited guardianship, which tailor surrogate decision-making authority to the individual needs of the ward by granting powers to the guardian only in areas specifically stipulated by the court (Kapp, 1992). Advantages of guardianship are that it serves as a vehicle to protect dependent adults and to conserve assets by transferring decisional control to a surrogate. The authority to grant custodial and economic control of an adult to a proxy represents a highly problematical solution, however, because it rescinds basic civil rights and autonomous decision making. Some of these disadvantages are mitigated by limited guardianships that protect dependent persons without excessive restrictions. Disadvantages of limited guardianship include resistance by some courts to tailor guardianship because of the potential time involved and the concern that the intervention will be insufficient.

Case Example: Mr. S., 71, a resident of a single room occupancy (SRO) hotel, received a modest Social Security benefit and Supplemental Security Income. When Mr. S. failed to pay his rent for the third month in a row, his building manager contacted a case manager at the local senior center for assistance. In talking with Mr. S., the case manager learned that he had been signing his checks over to "a friend." He did not know the friend's name or where he lived. A medical workup suggested that Mr. S. was physically healthy but suffered from moderate cognitive impairment as a result of a dementing illness. In addition to home-delivered meals and a shopping assistance program, the case manager arranged for a local volunteer program to serve as a rep payee for Mr. S. After paying all the bills each month, the rep payee provided Mr. S. with the remaining money to spend as he wished. This arrangement worked well until Mr. S. was hospitalized with congestive heart failure resulting from a damaged heart valve. Although his condition required treatment decisions, Mr. S. appeared to lack capacity to make an informed medical decision or to execute a DPAHC. Using the state's family consent law, his closest relative, a niece, agreed to make health-related decisions on his behalf. Had Mr. S. resided in a state without health care consent legislation, guardianship might have been necessary.

A Framework for Analyzing Alternatives to Guardianship

With the exception of the criterion of least restrictive appropriate alternative (Stiegel, 1992), the literature offers little guidance for determining the specific financial service or combination of services most suitable to the needs of a particular older person. Guidelines have been suggested, however, for determining the appropriateness of guardianship, including assessment of the older person's capacity and potential risk (Heller, 1989; Nathanson, 1990). To assess the suitability of decisional interventions to address various executional and decisional needs and the potential for substitution between interventions, we incorporate capacity and risk standards into a framework that also includes the complexity of decisional issues and the availability and efficacy of informal assistance. The relationship of different decisional interventions to capacity, risk, and complexity is shown in Table 1. The following case example is used to illustrate how different characteristics of the person and his/her situation affect decisional interventions.

Case Example: Scenario No. 1. Mrs. F., 83, recently widowed, owned her own home and a small rental home. She had a savings account of approximately $35,000 and a modest stock portfolio. In addition to a small return on her investments, her income included rent from her second home and Social Security benefits. Although she was mentally and physically able to manage her finances, she had never done the bookkeeping and had no interest in learning how to review bank statements, balance her checkbook, and make investment decisions. After several weeks, she noticed that a large number of bills and checks had accumulated including several past due statements. Confronting piles of bills on the kitchen counter, she was unsure about how much she owed or what was entailed in maintaining her investments.

In assessing the appropriateness of financial and medical decision-making interventions for Mrs. F., her competence or decisional capacity is a critical factor.

Competence/Capacity

Competence, or the cognitive capacity to make decisions is both a legal term and a construct (AARP, 1992; Kapp, 1992). Legally, individuals are presumed competent unless a court of law has rendered a

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Table 1. Characteristics of Financial and Health-Related Services Available to Older Persons

Service	Capacity: Required for Execution	Capacity: Survives Incapacity	Appropriateness to Address Risk to the Older Person: Personal Risk: High, Medium, Low	Appropriateness to Address Risk to the Older Person: Financial Risk: High, Medium, Low	Appropriateness to Address Risk to the Older Person: Oversight or Recourse	Complexity: Ability to Address Complex Financial or Medical Issues
Power of attorney	Yes	No	Low	Medium	Oversight by family; legal action	Medium
Bill-paying services	Yes	Not usually	Low	Medium	Agency audit; legal action	Low
Joint accounts/ Joint tenancy	Yes	Yes	Low	Meidum	Virtually none; legal action	Low
Durable power of attorney	Yes	Yes	Low	High	Oversight by family; legal action	Medium
Durable power of attorney for health care	Yes	Yes	Medium	Low	Oversight by family; legal action	Medium
Representative payee	No	Yes	Medium	Medium	Virtually none by Fed. Govt. Agency	Low
Personal trusts	Yes	Yes, if drawn properly	Medium	High	Internal audit, banking commissioner, legal action	High
Limited guardianship	No	Yes	High	High	Court: legal action	High
Plenary guardianship	No	Yes	High	High	Court: legal action	High

Note. These criteria assume the availability of an appropriate social support network.

formal judgment of incompetence. Conceptually, competence refers to clinical judgment about the extent to which an individual has a reasonable understanding of the nature and consequences of available choices and can reach a reasoned decision, regardless of the actual choice made (Kapp, 1990). As with competence, individuals are presumed to have capacity unless there is clear evidence to the contrary. Although there is considerable variation among state statutes as well as within the literature on the definition of competence and capacity, and they are often used interchangeably, we follow Kapp (1990) in using competence to refer to legal judgments and capacity to mean clinical assessments. Decisions about capacity made in a court of law generally are a prelude to a finding of incompetence and the appointment of a proxy decision maker. Such decisions rely, to a certain extent, on clinical judgments as to whether clients possess capacity; but judges, not clinicians, rule on whether the client is legally competent (Kapp, 1990).

In the legal sense, competence is viewed as a threshold concept — one either has it or does not. In a clinical sense, however, capacity may be intermittent, decision-specific (e.g., capacity to make informed medical decisions versus ability to conduct financial transactions), complete or limited (Buchanan & Brock, 1986). Because a clinical determination of the extent and consequences of mental impairment is inexact, Buchanan and Brock suggest that standards of capacity represent value choices rather than scientific ones. (A comprehensive discussion of the determinants of competence and capacity is beyond the scope of this article. For competing perspectives see Buchanan & Brock, 1986, and Culver & Gert, 1990.)

Despite its vagueness, assessing whether or not an individual has capacity to make decisions is an important consideration for determining which services are appropriate and which are not. As the first panel of Table 1 indicates, decision-making service options can be separated into those that assume capacity when they are transacted, those that initially assume capacity yet survive incapacity, and those granted based on incapacity. Substitution between services that differ on the presumption of capacity is problematical for two reasons. First, from a practical perspective, transactions by persons who lack capacity may be invalid. Second, there is an inherent contradiction in substituting a service that assumes decisional authority for one that is designed for persons who lack the capacity to make reasoned choices.

While the first column under capacity, "Required for execution," groups service arrangements according to whether or not the older person must have decisional capacity to establish the intervention, the second column identifies approaches that survive incapacity. For example, decisional capacity is required to execute trusts and durable powers-of-attorney, as well as arrangements for shared decision-making such as joint tenancy and joint accounts. Unlike supportive arrangements, however, these tools continue to be legally binding after the person loses capacity. (Trusts must contain specific language stipulating survival past incapacity of the grantor). Therefore, when considering the capacity component of the framework, delegated approaches overlap with surrogate approaches, including legal guardianship, as a means to address the needs of persons who lack capacity.

Case Commentary: Because Mrs. F. has capacity, she may decide to use BPS from a daily money management (DMM) social service program if one is available in her community and she meets the income guidelines. While some DMM BPS accept clients with mod-

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erate, or even high, income through a sliding fee schedule, many are designed to serve persons who lack the resources to purchase fiduciary services from the private sector, and few are equipped to manage investments or complex estate planning. Some serve higher income clients by providing routine money management while contracting out investment counseling. In addition to assisting Mrs. F. with day-to-day financial matters, BPS could empower her by showing her how to manage her finances, avoid financial exploitation, and use financial management planning tools.

Although it would probably be more costly, Mrs. F. could employ a bank or other private professional to manage her finances, provide investment counseling, and assist her with estate planning. Or, she could rely on informal assistance from a trusted friend or neighbor.

Assessing and Addressing Risk to the Older Person

Case Example: Scenario No. 2. Mrs. F. turned to her tenant for help. Prior to Mr. F.'s death, the tenant had provided assistance with home repairs, grocery shopping services, and gardening in exchange for rent reduction. Several months after Mr. F.'s death, the tenant began to take responsibility for paying Mrs. F.'s bills and doing her banking. Eventually, she assigned him POA and included him on her bank account as a joint tenant. According to a concerned neighbor, the tenant pressed her to negotiate a purchase agreement on her rental property that was considerably below its market value and even suggested that she deed the property to him based on "the considerable rent that he had paid."

Risk, presented in the middle panel of Table 1, is the second component used to delineate service appropriateness. Whereas decisional ability resides within the person, risk involves the degree of danger present in the contextual situation (Culver & Gert, 1990; Heller, 1989). Questions about risk address the extent to which the older person's behavior, in the context of environmental factors, threatens or supports his/her well-being. In the following discussion, we consider two related areas of competing values used to address risk: (a) decisional freedom versus protection; and (b) privacy versus oversight.

Assessing risk involves balancing the right to self-determination with the need for protection and requires providers to confront the dilemma of when their responsibility to protect a vulnerable incapacitated person from serious harm overrides the older person's right to self-determination (Culver & Gert, 1990). Although a determination of incapacity should be the sine qua non of legal guardianship and other interventions that remove choice, decisional incapacity is a necessary but not sufficient determinant for appointment of a surrogate. The second is the extent to which risk threatens the well-being of an older person who lacks capacity.

Risk can be divided into threats to the person's health, personal safety, or financial well-being. For example, an aged person who lacks capacity to assess dangerous situations but who stays within a supportive housing environment is not likely to require intervention as long as the situation remains stable. Conversely, an older adult who lives independently, lacks capacity, refuses assistance, and endangers herself by wandering at night, walking in traffic, or neglecting important health and hygiene care is a candidate for intervention. In the area of financial risk, a person with marginal capacity to manage finances may not require formal financial management assistance if adequate family support and assistance is available. (Informal support, the fourth area of the framework, is discussed more extensively below.) Conversely, intervention is suggested when an older person lacks capacity and is at imminent risk of being defrauded.

In situations where risk is questionable, a "lesser of two evils" philosophy can be applied. This approach suggests that the severity of an intervention should be considered in light of the potential consequences if a less restrictive intervention or no intervention at all is pursued. A guiding principle when weighing which intervention to pursue for a person who lacks capacity is that the anticipated direct benefits of the intervention should outweigh the potential costs to the older adult. When the situation is ambiguous, concern for freedom overshadows safety. (For a comprehensive discussion of weighing the costs and benefits of competing interests see Rein, 1992.)

The degree of risk that various financial management and health-related decision-making interventions are geared to address is depicted as high, medium, and low in Table 1, middle panel, column 1 (personal risk) and Table 1, middle panel, column 2 (financial risk). When intervention is necessary, it is important to consider which interventions are most likely to reduce risk appropriately. For example, if protective placement is found to be necessary because the person is in imminent danger, does the intervention provide the designated decision maker with the authority to make a protective placement? If not, what other interventions would be more appropriate?

A corollary to the costs and benefits of intervention is the trade-off between privacy and oversight. (Oversight mechanisms of various interventions are depicted in Table 1, middle panel, column 3.) To some extent, older persons who delegate decisional authority to agents through trusts or DPAs do so to protect their financial and personal privacy. In exchange for privacy and the autonomy of selecting the surrogate, older people lose oversight and public accountability. Although the extent of financial abuse by agents and trustees is unknown because of the difficulty of obtaining information on private arrangements, it appears to be a problem of some magnitude (Quinn, personal communication, August 5, 1993; Schmidt, in press; Stiegel, in press). Risk is high because of the private nature of the relationships and the lack of redress. Unless a corporate fiduciary is involved, legal action through the courts and bonding of the agent are the only methods of recourse for malfeasance by private agents. When corporate surrogates are used, institutional methods of oversight and accountability generally are adequate. In contrast to private arrangements,

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surrogate decision-making mechanisms such as guardianship and rep payee services have public mechanisms to ensure accountability of the surrogate. It should be noted, however, that the effectiveness of oversight has been questioned in these programs as well (Associated Press, 1987; U.S. Congress, 1981).

Case Commentary: In Case Scenario No. 2, Mrs. F. has chosen to rely on a POA and joint tenancy, approaches that entail virtually no oversight. Although this appears to put her at risk for financial exploitation, she has the decisional capacity to make her own choices. Given Mrs. F.'s relationship with a third party, referral to a supportive financial management service such as BPS at this juncture is unlikely to result in a successful intervention unless Mrs. F. is seeking to change her financial management arrangements. Although BPS providers support and execute clients' decisions and offer advice on financial matters, they have neither legal nor ethical authority to control clients or assume responsibility for their decisions. Nor do they have the authority to resolve complex financial problems such as competing interests between family members or competing claims by third parties. BPS providers have little authority to intervene in instances of potential financial exploitation or in situations where a person with capacity jeopardizes her own safety. Assuming that she maintained capacity and remained unwilling to change the arrangement with her tenant, there is little in the way of financial management remedies, short of advising her of potential problems and offering to be available if needed, that could be pursued.

Complexity

Case Example: Scenario No. 3. Two years after the death of her husband, Mrs. F. had a massive stroke which impaired both her cognitive and physical functioning. After a prolonged period of recovery, findings from a comprehensive assessment were that she had moderate to severe irreversible dementia. Clearly much of what happens after this depends on the steps she had taken to plan for incapacity. If she had not planned in any way and there were no appropriate family members available to assist her, her options would be limited. In addition, if her tenant had managed her affairs in his own interest instead of hers, her assets may have been diminished.

The question of which service is most appropriate prior to incapacity and after a person loses capacity is related to the extent to which the management of the estate involves complex financial and real estate transactions. Whereas capacity resides with the person and risk addresses the interaction with the environment, complexity refers to the ability of decisional intervention to manage a variety of resources and assets. For example, financial management needs may range from modest federal transfer payments used to maintain basic necessities to complex investments, real estate transactions, and estate management needs. Using a ranking of high, medium and low, the third panel of Table 1 identifies financial management services designed to handle complicated, moderately complex, or limited financial management or medical issues. For example, rep payee is ranked low because it allows a surrogate to collect federal transfer payments (Social Security, Veterans Pensions, etc.) and disburse funds, but confers no authority over other areas (i.e., checking accounts, other income, real estate, or investments). Similarly, joint tenancy allows flexibility to both tenants on the property concerned, which typically consist of bank accounts (less frequently real estate, depending on the type of joint tenancy), but is silent on any property not placed in joint tenancy. In contrast, advance directives such as DPA or trust accounts usually grant an agent authority to manage complex investments, while providing for current and future estate and money management.

With advances in medical technology and increasing institutional complexity, medical decision making adds an additional component to complexity. Concerns have been raised that guardianship is used inappropriately because the interests of third parties (i.e., hospitals, nursing homes, heirs, etc.) take priority over the interests of incapacitated patients. In response, legislation such as the Patient Self Determination Act has been passed in an effort to encourage the use of advance directives for health care decisions. The effectiveness of this legislation, however, has not yet been determined.

Case Commentary: Because Mrs. F. lacks capacity at this juncture, BPS, shared powers, or advance directives are inappropriate. Options that assume incapacity such as rep payee do not confer authority needed to manage her affairs in most areas. Family consent laws would cover her medical decision making but she would still need a surrogate to manage her finances. In this situation, few options appear to be available except for limited or plenary guardianship placement.

Availability of an Adequate Support System

Case Example: Scenario No. 4. If Mrs. F. had failed to plan by executing a trust or advance directive and if she retained property and financial assets, in addition to her Social Security income, it is unlikely that any combination of financial or health-related decision-making services initiated at this time could substitute for guardianship. The exception would be if she had had an adequate informal support system. For example, if the tenant had managed her affairs in her interests and if his authority included health care decision-making the current arrangement may be adequate.

The ability of family or close friends to provide informal decisional support for those with questionable capacity is often overlooked as a possible alternative to formal approaches. Research on guardianship and family caregiving has tended to ignore the informal financial assistance provided by friends and family. While formal interventions involve weighing the trade-offs of freedom versus safety to determine whether protective intervention is warranted, decisional power is not always a zero sum game. In the context of family decision making, Kapp (1991) suggests that conceptualizing safety and freedom as opposites is a mistake because it limits financial decision-making choices to an either/or situation. In

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practice, decision making among older persons and their families or significant others may be enhanced when authority is shared (Jecker, 1990), or when those with marginal or fluctuating capacity are assisted informally by others. Close family members, in particular, may be able to guide their relative to a reasoned decision because they are likely to understand the historical context of decisions, the older person's previous preferences, and how best to convey information. Assuming that the older person benefits from the arrangement, adequate informal support may eliminate the need for formalized surrogate interventions. The dilemma is ensuring that the interests of the individual are served by informal as well as the formal arrangements, as noted in the earlier discussion of privacy.

Informal family decision making may provide an effective method for some elderly persons, but it assumes certain ideal conditions, including geographic proximity to significant others willing and able to fulfill such roles, and the absence of competing interests, family conflicts, or uncomfortable relationships between those involved (Buchanan & Brock, 1986). Additional problems with "influenced" decision making include the possibility that third parties will serve their own interests rather than the interests of the older person, and the erosion of the elderly person's autonomy and self-determination that is likely to occur over time. For some older adults, however, sharing or relinquishing significant areas of authority is the solution of choice. Research on decision making between caregiving dyads of mothers and daughters suggests that both favor child-directed decisions, partly due to the mothers' surprisingly strong belief in the propriety of "paternalism" directed from child to parent (Cicirelli, 1992). Such findings, however, may be specific to the cohort of women who participated in the study. Research on decisional autonomy in health care among different cultures and cohorts (Wetle, 1991) suggests that attitudes are related to such characteristics as ethnicity and age/cohort differences.

As the preceding discussion has attempted to show, the choice of which financial service or service mix is most appropriate is driven by characteristics of the older person (capacity), the situation (risk), and the mix of assets and income (complexity). In addition to examining each alternative separately, it is important to recognize that some interventions can be used in concert (e.g., DPAHC and rep payee) to balance the person's desire for autonomy and self-determination, the family's and community's concerns about safety, and corporate/provider concerns about the need for an authorized decision maker.

Discussion

By delineating potential roles and areas of responsibilities for each type of service, the analytical framework illustrates how interactions between characteristics of the older person and the environment govern which service mix is appropriate and which is not. In addition, because only those services that share functions will provide viable substitutions, we suggest the following propositions:

- Financial services that demand capacity (BPS, POA) will not substitute for services designed for older persons who lack capacity (rep payee, limited or plenary guardianship).
- Financial services that survive incapacity (DPA, joint accounts, trusts) will not divert older persons from guardianship if the individual's personal well-being is imminently threatened unless they contain provisions to address risk.
- Limited financial services targeted to older adults who lack capacity (rep payee) will not substitute for guardianship if the individual's personal well-being is imminently threatened.
- Limited financial services targeted to older people who lack capacity (rep payee) will not substitute for guardianship if the individual's financial asset mix exceeds the authority of the "substitute" to act.
- Financial services that survive incapacity (DPA, joint accounts) or those targeted to older adults who lack capacity (rep payee, DPA) will not substitute or divert older persons from guardianship if the individual's financial well-being is threatened by the payee/agent.

The viability of alternatives also must be addressed in light of institutional requirements, such as the reluctance of many institutions to accept a POA to convey real estate without the security of a court appointment. Other instances include banks who are unwilling to accept POAs that are not on their own forms. This represents at most a minor delay for the mentally competent elderly person who is asking an agent or BPS provider to assist with supportive decision making, but it is unmanageable for an agent acting under a DPA for a client who has now become incapable of signing the bank's papers.

Although the framework illustrates why BPS and other approaches that assume capacity are not viable substitutes for guardianship, it does not offer a rationale for why there has been widespread optimism about the viability of these less restrictive approaches to serve as alternatives. Experience suggests, however, that service providers look to guardianship as a default bill-paying service because they lack other available options. Confronted with the choice of a restrictive intervention or no intervention, providers and even friends and family often prefer to err on the side of safety by referring marginal older adults to guardianship. For example, in Los Angeles County, 80–90% of referrals are "nonhandled" by the Office of the Public Guardian (OPG) because they are inappropriate. Steinberg (1985) found that a high percentage of inappropriate referrals were based on the need for money management. These observations lead to two final propositions:

- While supportive interventions do not substitute for appropriate guardianship, they can reduce the number of inappropriate referrals to the guardianship system and inappropriate use of guardianship as a bill-paying service.

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- Supportive interventions, initiated while the individual has capacity, may delay somewhat the need for guardianship for older adults with marginal capacity, particularly when family or providers are willing to err on the side of autonomy rather than safety.

The study of substitution of decisional interventions is still in its infancy. So far, the debate has focused primarily on alternatives to guardianship, in part, as a response to values of self-determination and autonomy. In addition, guardianship has been the standard policy response to incapacity and risk, in older adults and the developmentally disabled. It is instructive to remember that policy decisions tend to define options and create incentives for certain choices over others (Buchanan & Brock, 1986). Policies have developed that support the concept of guardianship and, consequently, research has developed to evaluate such policies. While this emphasis is natural, it overlooks the fact that the same policies de-emphasize the rest of the repertoire of financial and health-related decisional interventions.

The focus on less restrictive alternatives, while important, also diverts attention from other pressing problems that fall under the general area of financial services for older persons. In addition to testing the propositions proposed earlier, important areas of future research include assessing unmet needs for financial assistance and evaluating various strategies and programs for how those needs can be addressed, examining how financial service support affects quality of life, and clarifying the dimensions of financial exploitation and evaluating potential interventions.

Excessive reliance on initiatives to reduce guardianship diverts decision makers from considering appropriate types and levels of other financial management and health-related decision-making services. While we agree that guardianship should only be imposed in the highly circumscribed instances of incapacity, high risk, complexity, and lack of informal solutions, those who assume that guardianship is always the least desirable alternative, simply because it is the most restrictive, overlook the possibility that for some, it is the only viable option. Only in a broader context can guardianship and other service options be evaluated in terms of their ability to address the problems of functionally and cognitively dependent older adults.

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- **Experian** – **Online Form**
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  (Note: the links above will take you to the websites for the three credit bureaus. These sites are separate from **www.ncdoj.gov**.)

Be prepared to provide detailed information about yourself, including:

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- Your Address
- Your Date of Birth
- Your Social Security Number

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- Your home addresses for the last five years
- Your Social Security number and date of birth
- Two proofs of residence (examples: a copy of your driver's license, utility bill, insurance statement, bank statement)
- Police or DMV report if you're a victim of identity theft

Note: The credit bureaus already have your name and other personal information in their files. You will be providing it to verify your identity.

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English

When you freeze your credit, the company will send you confirmation of the placement of the freeze along with information on how to remove the freeze, including any authentication information you will need, such as a PIN (Personal Identification Number) or password. The information should be sent to you no later than five business days after placing the freeze. Make sure to keep this authentication information in a safe place.

Protected Consumer Security Freezes

You can freeze the credit reports of **children and incapacitated adults**.

Lifting or Removing Your Freeze

You can request that a freeze be lifted for a specified period of time or removed by making the request to the credit bureaus and providing proper identification. The credit bureaus must lift or remove a freeze one hour after receiving the request when the consumer makes the request by telephone or online. If the request is made by mail, the credit bureaus must lift or remove the freeze within 3 days after receiving such a request. Learn more about **Lifting your Security Freeze**.

Main Campus
114 West Edenton Street
Raleigh, NC 27603

p: (919) 716-6400
f: (919) 716-6750

State Crime Laboratory
121 East Tryon Road
Raleigh, NC 27603

p: (919) 582-8700
f: (919) 662-4475

Triad Regional
State Crime Laboratory
2306 West Meadowview Road
Suite 110
Greensboro, NC 27047

p: (336) 315-4900
f: (336) 315-4956

Western Regional
State Crime Laboratory

NC Justice Academy
Salemburg Campus:
PO Box 99
Salemburg, NC 28385

p: (910) 525-4151
f: (910) 525-5439

NC Justice Academy
Edneyville Campus:
PO Box 600
Edneyville, NC 28727

p: (828) 685-3600
f: (828) 685-9933

Sheriffs' Training & Standards
PO Box 629
Raleigh, NC 27602

p: (919) 779-8213
f: (919) 662-4515

Criminal Justice
Training & Standards
PO Drawer 149
Raleigh, NC 27602

English

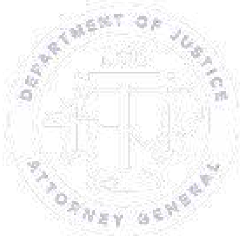
State Crime Laboratory

300 Saint Pauls Road
Hendersonville, NC 28727

p: (828) 654-0525
f: (828) 654-9682

p: (919) 661-5980

f: (919) 779-8210



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English

Jimmo Corrective Action Plan Completed

medicareadvocacy.org/jimmo-corrective-action-plan-completed/

Jimmo Corrective Action Plan Completed

CMS Adds Resources Regarding Medicare Coverage To Help People Who Need Skilled Maintenance Nursing or Therapy

As ordered by the federal judge in *Jimmo v. Sebelius*, the Centers for Medicare and Medicaid Services (CMS) published a new webpage containing important information about the *Jimmo* Settlement on its CMS.gov website. The *Jimmo* webpage is the final step in a court-ordered Corrective Action Plan, designed to reinforce the fact that Medicare *does* cover skilled nursing and skilled therapy services needed to maintain a patient's function or to prevent or slow decline. Improvement or progress is not necessary as long as *skilled* care is required. The *Jimmo* standards apply to home health care, nursing home care, outpatient therapies, and, to a certain extent, for care in Inpatient Rehabilitation Facilities/Hospitals.

The *Jimmo* webpage and other elements of the Corrective Action Plan should help ensure that the *Jimmo* Settlement is implemented correctly and that it opens doors to Medicare coverage and necessary care for beneficiaries who require maintenance care, including people with long-term, progressive, or debilitating conditions. As required by the Court, CMS also provided additional training for Medicare decision-makers.

Judith A. Stein, Executive Director of the Center for Medicare Advocacy, which is lead counsel for the nationwide class of Medicare beneficiaries said, "People living with MS, Parkinson's, Alzheimer's, paralysis and other long-term conditions have waited long enough for this relief. We hope that the new CMS education and information, which can be found at CMS.gov and printed out with the CMS logo, will help convince providers that Medicare really is available for people who need this critical maintenance care."

"After years of fighting over this standard in court, we are hopeful that Medicare has finally acknowledged that beneficiaries with long-standing and chronic problems are entitled to maintenance skilled care to prevent or slow decline in their overall condition," said Michael Benvenuto, of Vermont Legal Aid, co-counsel for the *Jimmo* plaintiffs.

The new webpage contains an "*Important Message About the Jimmo Settlement*," in which court-approved language emphasizes that the Settlement "may reflect a change in practice" for providers and Medicare decision-makers who erroneously believed that the Medicare program covers nursing and therapy services only when a beneficiary is expected to improve. Indeed, the new education and *Jimmo* webpage are important because many health care providers still operate under this misconception, leading beneficiaries to be wrongly denied needed services such as physical and occupational therapy.

This was the case, for example, for Mrs. B, who was denied necessary on-going physical therapy, needed to maintain her condition after spinal surgery. While she had begun to walk again independently after nursing home care, and out-patient PT, when the PT ended because it was "maintenance only," Mrs. B declined and was no longer able to ambulate independently.

One of the "Frequently Asked Questions" posted on the *Jimmo* CMS.gov page clarifies that this should not happen: "The Medicare program does not require a patient to decline before covering medically necessary skilled nursing or skilled therapy."

1Section 483.25(a) of Title 42 of the Code of Federal Regulations

The *Jimmo* webpage contains fifteen such "Frequently Asked Questions," which dispel other mistaken beliefs. One answer, confirms: "Skilled services would be covered where such skilled services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided."

Judge Christina Reiss of the U.S. District Court in Vermont ordered the corrective action plan in February 2017 after finding that CMS was in breach of the original *Jimmo* settlement agreement, which was reached in 2013. In addition to the webpage, the Corrective Action Plan required CMS to offer additional training about coverage for skilled maintenance care for Medicare's contractors and adjudicators who decide whether coverage will be granted.

Under the original *Jimmo* Settlement, CMS revised several chapters of its policy manuals (including those for Skilled Nursing Facility, Home Health, Outpatient Therapy and Inpatient Rehabilitation Facility). CMS also held an educational campaign to clarify that improvement is not required for coverage of skilled care. Lawyers for the *Jimmo* plaintiff class requested further action from the court when it became clear that too many people were still being wrongfully denied Medicare coverage – in part because many health care providers had not been adequately educated, and in part because many providers were still skeptical that Medicare would alter its coverage practices. The new webpage offers CMS's official imprimatur on the correct legal standard that improvement is not required when there is a need for skilled care.

For more information about Medicare coverage for maintenance care and CMS's new *Jimmo* webpage, register for the Center for Medicare Advocacy's free webinar, to be held September 27, 2017 at 3:00pm EDT/12pm PDT.

Contact:
Matthew Shepard, Communications Director
MShepard@MedicareAdvocacy.org, (860) 456-7790

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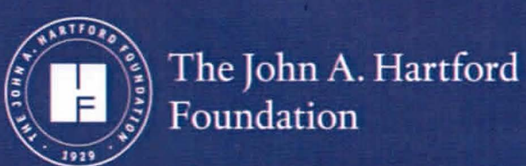
The Center for Medicare Advocacy, Inc., *established in 1986, is a national nonprofit, nonpartisan law organization that provides education, advocacy and legal assistance to help older people and people with disabilities obtain fair access to Medicare and quality health care. The Center is headquartered in Washington, DC and Connecticut, with attorneys throughout the country.*

1 Section 483.25(a) of Title 42 of the Code of Federal Regulations



Checklist

Expedited Appeals in Traditional Medicare For Home Health Services In Light of *Jimmo v. Sebelius*

You do not have to improve to qualify for Medicare coverage!

No Improvement Standard

Restoration potential is not necessary. Medicare coverage "does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition." CMS Transmittal 179, Pub 100-02, 1/14/2014; Medicare Benefit Policy Manual, Chapter 7, Sections 20.1.2, 40.1.1, 40.2.2E; See also, 42 CFR § 409.32(c).

Notice of Medicare Non-Coverage

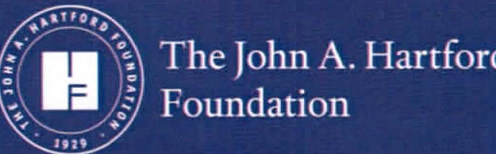
- ✓ Your home health agency must give you the Notice of Medicare Non-Coverage two days before your covered services end.
- ✓ This notice must show the date your skilled nursing and/or therapy is scheduled to end and provide information about how to file an expedited appeal with the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO).

Redetermination by the QIO

- ✓ You must file the appeal by noon the day after you received the notice.
- ✓ After receiving notice about the appeal from the QIO, the home health agency must provide you with a Detailed Explanation of Non-Coverage.
- ✓ The QIO must make a determination within 72 hours of receiving your request.
- ✓ Take this time to request your medical records and ask the physician who ordered your care to submit a written statement explaining why you continue to need intermittent skilled nursing or therapy services.

Reconsideration by the QIC

- ✓ If the QIO decides against you, you must request an expedited reconsideration from the Qualified Independent Contractor (QIC) by noon the following day.
- ✓ The QIC must make a decision within 72 hours of your request.
- ✓ You have the right to extend this period up to 14 days to gather support for your case and prepare your argument.



Check List

Expedited Appeals in Traditional Medicare For Home Health Services In Light of *Jimmo v. Sebelius*

Administrative Law Judge Hearing

- ✓ If the QIC decides against you, you must request a hearing before an administrative law judge (ALJ) within 60 days of receiving the QIC's decision.
- ✓ ALJ hearings are not expedited. For beneficiary-initiated appeals, the ALJ should make a decision within 90 days of receiving the request for a hearing.
- ✓ You must submit your evidence with the request for hearing, by the date specified in the request for hearing, or, if a hearing has been scheduled, within 10 days of receiving the notice of hearing.

Medicare Appeals Council

- ✓ If the ALJ decides against you, you must request a review by the Medicare Appeals Council within 60 days of receiving the ALJ's decision.
- ✓ For beneficiary-initiated appeals, the Appeals Council should make a decision within 90 days of receiving the request for a hearing.

Federal District Court

- ✓ If the Appeals Council decides against you, follow the directions in the denial to file for judicial review in federal district court.
- ✓ You must file within 60 days of receiving the Appeals Council's decision.
- ✓ You must meet the amount in controversy requirement. The amount in controversy is adjusted annually.

Remember

- A home health agency's decision to terminate your Medicare-covered care based on an erroneous "Improvement Standard" is a violation of your rights under Medicare.
- An expedited appeal only addresses the decision to terminate Medicare-covered services. If you wish to continue receiving uncovered care from the home health agency, an Advanced Beneficiary Notice of Non-Coverage (ABN) must be issued. A standard appeal should be pursued for any services you continue to receive.
- If you do not win your appeal or decide not to take further action, you will be responsible for the cost of your care after the termination date on the Notice of Medicare Non-Coverage.

For additional information, see the Center for Medicare Advocacy's Improvement Standard Homepage.

FACT SHEET

A CONSUMER GUIDE TO CHOOSING A NURSING HOME

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) knows that placing a loved one in a nursing home is one of the most difficult tasks a family member ever faces. But when it becomes necessary, prospective residents and their families should have the best information possible to make this decision. There are many resources that can help. The purpose of this guide is to help you navigate those resources, understand the information, and make an informed choice. Once your loved one is in a nursing home, the Consumer Voice can help you get good care there.

FIRST, EXPLORE ALTERNATIVES

If at all possible, plan ahead for future long-term care needs. If an individual and those close to them can discuss preferences related to long-term care and plan ahead of time, decisions and arrangements are much easier when the need for long-term care arises.

Before you look for a nursing home, be sure your loved one's condition and support system has been thoroughly evaluated. When properly diagnosed and treated, some conditions may improve significantly. Also, some people with serious medical conditions can remain at home with the proper support system. Talk with your loved one to find out about her/his wishes. Even if s/he has dementia and/or difficulty communicating, the prospective resident should be at the forefront of the decision-making process as much as possible. Since most people prefer to stay in their own home, it is important to investigate alternatives to nursing home care (e.g. home care, day care, assisted living).

Sources of information about
available services are the Eldercare Locator, telephone number: 1.800.677.1116 or website: www.eldercare.acl.gov and the Administration on Aging:
https://www.acl.gov/node/549

If nursing home care is needed, decide whether long-term care or short-stay rehabilitation is needed.

DO YOUR HOMEWORK

As you begin to evaluate facilities, it's a good idea to do some preliminary research before you visit any nursing homes. Once you have gathered information, visits to the facilities you are considering will provide you with very important insights. (See "Visits to Nursing Homes" section, page 7.) Some issues to consider when evaluating facilities include quality of care and life, bed availability, provision of services that the resident will need, cost, and location in an area where friends and family of the resident can visit often. Ask nursing home residents, residents' families, citizen advocacy groups, your physician, the hospital discharge planner and clergy members for their opinions about various facilities. This guide will highlight some important sources of information to use in your evaluation, including:

- Long-Term Care Ombudsmen
- State or Local-Level Citizen Advocacy Groups
- Cost Information
- Nursing Home Compare website
- State Nursing Home Inspection Reports
- Complaint Information
- Visits to Nursing Homes

EXPERTS TO CONSULT: THE PROSPECTIVE RESIDENT, LONG-TERM CARE OMBUDSMAN AND CITIZEN ADVOCATES

First, consult with experts. The best expert on what will be a good place to live is the prospective resident. Ask him or her about whether s/he wants to live near a particular family member or friend, in his or her hometown, if s/he prefers a large or small facility, etc. Then, a state or local ombudsman program and/or citizen advocacy group can assist you in piecing together the different sources of information to make an informed decision about nursing home care. An ombudsman is a state or county government-funded advocate for residents of nursing homes, board and care homes, and assisted living facilities who will be familiar with the facilities in your area and often with the staff and residents who reside in them. **Ombudsmen assist residents and others by:**

- Educating consumers and long-term care providers about residents' rights and good care practices
- Investigating complaints and advocating for residents rights and quality care in long-term care facilities; and
- Providing information to the public on long-term care facilities and policy issues

S/he can help you find and interpret information from state inspection reports and the resident characteristics or quality measures that can be found on the Nursing Home Compare website: www.medicare.gov/NHCompare/home.asp. To find your Long-Term Care Ombudsman, go to the Consumer Voice website:
www.theconsumervoice.org/get_help or call the Consumer Voice at 202.332.2275 for ombudsman contact information. Many states and/or communities have active Citizen Advocacy Groups that are knowledgeable about nursing homes and can be very helpful in evaluating advice and information you receive. To find a local or state citizen advocacy group go to the Consumer Voice web-site: www.theconsumervoice.org/get_help.

COST INFORMATION

Most nursing homes participate in the Medicare and/or Medicaid programs, which reimburse them for part or all of the care that some residents receive. Medicare pays for post-hospital rehabilitation care and hospice care services for short periods of time. Medicaid pays for nursing home care for longer periods for those who are financially eligible.

Most nursing home residents, even if they pay privately when they enter a home, eventually run out of money because of the high costs. They then apply to have the cost of their care paid for by Medicaid. Unless you are certain the resident can pay indefinitely with private funds, choose a facility that accepts Medicaid payment. Find out what your state's Medicaid eligibility rules are. Note that spouses may keep some assets and have a regular income even if their partner is on Medicaid. For additional information about the rights of residents paying for care through Medicaid, contact the long-term care ombudsman program and/or a local consumer advocacy group.

'NURSING HOME COMPARE' WEBSITE (IF YOU DON'T HAVE INTERNET ACCESS, ASK THE OMBUDSMAN FOR THIS INFORMATION.)

Nursing home data is provided by the federal government through 'Nursing Home Compare': www.medicare.gov/NHCompare/home.asp. On this site, you can search for nursing homes by state, county, city, or zip code. Once you have selected a nursing facility or facilities, you are given the option of viewing several different types of information including facility characteristic, inspection, staffing level, and quality measure information. Below are consumer tips on how– and how not–to use each of these sources of information.

FACILITY OVERVIEW

On 'Nursing Home Compare' the "About Homes" section gives an overview of basic characteristics of each facility. Data in this section includes the type of ownership (for-profit, non-profit, church-related, etc.), type of payment accepted (Medicare, Medicaid, or both), the size of the facility, and whether or not the facility is part of a chain. All of this information can be helpful in getting a preliminary picture of what the facility is like.

STATE NURSING HOME INSPECTION REPORTS

'Nursing Home Compare' provides inspection reports for each facility. State inspection or "survey" reports contain information about any deficiencies found when inspectors complete their annual inspection of the facility. Inspections take place at least every 9 to 15 months. You can also obtain state inspection reports from the state survey agency, the facility itself, or the long-term care ombudsman. Each facility is required by law to make the latest state inspection report available for examination in a place readily accessible to residents. To look at a summary of state inspection information on 'Nursing Home Compare', click on the tab labeled "Inspections".

Tips:

- Check the date of the inspection results posted on the website to be sure that they are dated within the last 9-15 months. If the date is earlier than that, there has likely been a more recent inspection. (The date of the Inspection is listed right above the deficiency summary.)
- View previous inspection results (by clicking on the button labeled "View Previous Inspection Results" located above the list of deficiencies) to see what the pattern of quality has been over a three year period.
- Compare the number of deficiencies cited to the state average.
- If a facility has received a deficiency citation in a particular area, be sure to ask questions about this area when you visit the facility.
- Obtain actual inspection reports at the facility itself or from the long-term care ombudsman program if you don't have access to the web.

Cautions:

- Beware of choosing a facility with a very high number of deficiencies compared to other facilities in the area and the state average.
- Don't assume that a "deficiency free" rating necessarily means that there are no problems with care at a particular facility.

COMPLAINT INFORMATION

You should also delve deeper by gathering information about the number and kind of complaints that have been filed against a facility. Verified or "substantiated" complaint information is included along with the nursing home inspection results on the 'Nursing Home Compare' website. Consumers can also obtain information about complaints filed against a particular facility (substantiated or unsubstantiated) by contacting the state survey and inspection agency, the long-term care ombudsman program, or through a website called Member of the Family at: www.memberofthefamily.net.

STAFFING INFORMATION

'Nursing Home Compare' also provides information about the hours of nursing care provided at each facility. Staffing levels are a critically important factor to consider in evaluating the quality of care given at a facility. The information provided on nurse staffing levels includes national and state staffing averages, and the daily average for individual nursing homes.

Tips:

- Pay attention to the number of Certified Nursing Assistant (CNA) staffing hours. CNAs provide 90% of the hands-on resident care.
- Look for facilities with high levels of RN staffing. Studies show that RN involvement in care is important for quality.
- Visit the facility and ask staff and families about the actual numbers of staff available to directly care for residents on each shift.

Cautions:

- The staffing hours reported on 'Nursing Home Compare' include not only direct care from nurses and nursing assistants but also administrative nursing time. This makes it difficult for consumers to know how much direct care residents are receiving.
- The staff hour data used for 'Nursing Home Compare' is self-reported by the facility and is not audited for accuracy.

QUALITY MEASURES

'Nursing Home Compare' also provides information on "Quality Measures." To see this, select the nursing home using the search criteria from the home-page and then click on the tab labeled "Quality." Nursing homes have many opportunities to improve care and their scores on the measures. Ask the facility if they are participating in the training provided by their state's Quality Improvement Organization and if the facility has signed up for the national Advancing Excellence in America's Nursing Homes Campaign.

"Quality Measures" provide important information; however, they are just one piece of the puzzle in choosing nursing home care. The measures are meant to provide indicators of quality care and comparative information. Measures include 14 indicators for chronic care (long-stay) residents, and 5 indicators for acute care (short-stay) residents. The measures use data taken from quarterly assessments of individual residents done by the facility. The information gathered from the individual's assessment is then combined with the assessments of the other residents in the facility to produce a facility-wide measure for each category. **Quality Measures are designed to provide comparison information among facilities and are not intended as a nursing home rating system.**

You should use quality measure information as one indicator of care; however, the importance of actually visiting facilities and talking with residents, family members and staff cannot be overemphasized. **Discuss questions about these measures with a variety of people, including the ombudsman, facility staff, and others you talk to about the facility.**

MEASURES FOR "LONG-STAY" RESIDENTS

"Long-Stay" residents are those in an extended or permanent stay in a nursing home.

1. Percentage of residents given Influenza vaccination during the flu season.

The flu is highly contagious, and is easily passed from person to person by coughing and sneezing, or by touching some-thing with flu viruses on it and then touching one's mouth or nose. The flu can be fatal in elderly people, people with chronic diseases, and anyone with a weak immune system. In cases where the flu is not fatal, older adults in particular, may feel weak for a long time even after other symptoms go away. Residents should be given a flu shot during the flu season (October through March), and should not get another flu shot if they have already received a flu shot at another place, or if there is a medical reason why they should not receive it. Ask the facility to show you the number of residents who get the flu shot each year.

2. Percentage of residents who were assessed and given pneumococcal vaccination.

The pneumococcal vaccination may help prevent, or lower the risk of one becoming seriously ill from pneumonia caused by bacteria. It may also help one to prevent future infections. All nursing home patients should be vaccinated against pneumococcal disease. Ask if your loved one has been vaccinated for pneumonia, and if not, ask for the pneumococcal shot unless there is a medical reason why your loved one should not receive it. Ask the facility to show you the number of residents who get the pneumococcal vaccination each year, and ask if they have standing orders for vaccination of persons admitted to the facility.

A high percentage score on Quality Measures 3 through 6 may indicate there is not enough staff available to attend to residents' individualized plans of care.

3. Percentage of residents whose need for help with activities of daily living (ADLs) has increased.

A high percentage may indicate that residents are not encouraged to do things on their own, such as feeding themselves or moving from one chair to another. Ask how resident independence is promoted.

4. Percentage of residents who spend most of their time in bed or in a chair.

A high percent here may indicate that there is not enough staff to assist residents with getting dressed and out of bed or that there are not organized activities for residents. Ask questions about who is responsible for getting residents up and dressed in the morning and when.

5. Percentage of residents whose ability to move about in and around their room worsened.

Nursing home staff should encourage residents to do as much as possible on their own and to engage in activities. Again, ask questions about how staff provide assistance to promote resident independence.

6. Percentage of residents who are physically restrained.

Studies show that restraints are detrimental to resident physical and mental well-being. Restraints are often used to compensate for a lack of adequate staff to attend to resident needs and safety. A high percentage in this category is a red flag. You should ask staff what methods, other than restraints, are used to provide a safe environment for mobility. Restraints may not be used without a doctor's order.

A high percentage in Quality Measures 7 to 9 may indicate that there is a lack of adequate staff to toilet residents on an individualized schedule.

7. Percentage of low risk residents who lose control of their bowels or bladder.

Loss of bowel or bladder control is not a normal sign of aging. "Low risk" residents would be those people whose medical or physical condition does not indicate that they would have this problem. Ask questions about whether residents are toileted on an individual schedule, and how bladder and bowel movements, and food and fluid intake are monitored.

8. Percentage of residents who have/had a catheter inserted and left in their bladder.

A catheter should only be used if it is medically necessary—not to compensate for inadequate staffing levels to toilet residents.

9. Percentage of residents with a urinary tract infection (UTI).

UTIs occur when bacteria builds up around a catheter or when the area where waste leaves the body is not kept clean. Ask questions about attention to resident personal hygiene, infection control and treatment procedures if you see a high percentage of residents with UTIs.

10. Percentage of high risk residents who have pressure sores.

A high percentage on this quality measure may indicate that residents are not being repositioned as frequently as necessary. Ask questions about how often residents are repositioned, toileted, or have diapers changed and how fluid intake is monitored.

11. Percentage of low risk residents who have pressure sores.

A high percentage on this measure may indicate that staff are not encouraging able residents to get out of bed or be up and moving around. Ask questions about how residents who are mobile are encouraged to stay active and how frequently residents are toileted.

12. Percentage of residents who have become more depressed or anxious.

A high percentage in this measure may indicate that residents lack meaningful activities and/or that anxiety and depression are not being monitored. Ask questions about ways staff monitor and treat residents depression and specifics on available activities for residents. Activities should be offered based on what residents choose.

13. Percentage of residents with moderate to severe pain.

A high percentage here may indicate that residents do not receive regular pain assessments. If residents are in pain, it should be addressed quickly. Ask staff how frequently residents receive a pain assessment and how quickly medications are prescribed for pain management.

14. Percentage of residents who lose too much weight.

Too much weight loss can make a person weak, cause the skin to break down which can lead to pressure sores, or change how medicine works in the body. A high percentage on this quality measure may indicate that residents are not being fed properly, the home's nutrition program is poor, or their medical care is not being managed properly. Ask questions to ensure that resident diets are balanced and nutritious, and that staff spend enough time feeding people who can't feed themselves. Ask questions and look around to determine if residents: can feed themselves; are allowed to eat when and where they prefer to; are not rushed through meals; can choose from a menu/ foods that they used to eat at home are on the menu; have healthy snacks and alternative foods or beverages readily available to them; have their weight routinely monitored by staff.

MEASURES FOR "SHORT-STAY" RESIDENTS

"Short-Stay" residents are those needing short-term skilled nursing care or rehabilitation, but who are expecting to return home.

1. Percentage of residents given Influenza vaccination during the flu season.

The flu is highly contagious, and is easily passed from person to person by coughing and sneezing, or by touching something with flu viruses on it and then touching one's mouth or nose. The flu can be fatal in elderly people, people with chronic diseases, and anyone with a weak immune system. In cases where the flu is not fatal, older adults in particular, may feel weak for a long time even after other symptoms go away. Residents should be given a flu shot during the flu season (October through March), and should not get another flu shot if they have already received a flu shot at another place, or if there is a medical reason why they should not receive it. Ask the facility to show you the number of residents who get the flu shot each year.

2. Percent of residents who were assessed and given pneumococcal vaccination.

The pneumococcal vaccination may help prevent, or lower the risk of one becoming seriously ill from pneumonia caused by bacteria. It may also help to prevent future infections. All nursing home patients should be vaccinated against pneumococcal disease. Ask if your loved one has been vaccinated for pneumonia, and if not, ask for the pneumococcal shot unless there is a medical reason why your loved one should not receive it. Ask the facility to show you the number of residents who get the pneumococcal vaccination each year, and ask if they have standing orders for vaccination of persons admitted to the facility.

3. Percentage of residents with delirium.

Delirium is severe confusion and rapid changes in brain function, usually caused by a treatable physical or mental illness. A high percentage on this measure could mean that nursing home staff does not adequately deal with symptoms of delirium. Each nursing home should have a plan for helping residents who suffer from delirium. You should ask staff about their plan for handling and preventing delirium.

4. Percentage of residents who had moderate to severe pain.

Residents should always be checked regularly by nursing home staff to see if they are having pain. If residents have pain it should be addressed quickly. Ask staff how frequently residents receive a pain assessment and how quickly medications are prescribed for pain management.

5. Percent of residents with pressure sores.

A high percentage on this quality measure may indicate the residents are not repositioned or encouraged to reposition themselves frequently. Ask questions about how often residents who are immobile are repositioned and toileted to prevent pressure sores from developing and how residents who are mobile are encouraged to move about.

Tips:

- Compare a facility's score with others in the area and/or the State to see how it measures up.
- All of these quality measures are negative measures. This means they measure a condition that is undesirable. Consumers should look for facilities that score below the state average–and the lower the better.
- If you have questions about the quality measure information that is provided, call 1-800-MEDICARE, or contact your State Quality Improvement Organization (QIO).
- Remember, quality measures are just one factor in making a decision. Visits, talking with the ombudsman program and citizen group, reviewing the surveys, and looking at staffing issues are necessary for informed decisions.

Cautions:

- Don't assume that the information provided is 100% accurate. These measures are based on facility-reported information that is not independently audited for accuracy.
- These measures only suggest good or bad care. Also, even when these measures show percentages lower than the state average in one area (e.g., prevention of pressure sores), they don't necessarily mean there will be lower percentages in other areas (e.g., prevention of incontinence).

VISITS TO NURSING HOMES

Before making a decision about nursing home placement, visit any facilities you are considering. You can learn a great deal about a nursing home by taking time to sit and observe how staff interacts with residents. Also, speak with residents and their family members to get a full understanding of life in the home. Gather information on both quality and payment issues.

It is very important to visit homes a second and third time during the weekend or evenings – times when many nursing homes reduce their staff and services. If at all possible, take the resident to visit potential nursing homes before a decision is made. This visit can give you insight into the resident's wishes and may ease his or her fears.

Here's what to look for on your visits:

Using your senses -- sight, hearing, smell, touch:

- Do you notice a quick response to call lights?
- Are there residents calling out? If so, do staff respond quickly and kindly?
- Do the meals look appetizing? Are residents eating most of their food? Are staff patiently assisting residents who need it?
- Are there residents in physical restraints (formal or informal devices that hold residents in beds, chairs, and wheelchairs)? Why?
- Do resident rooms appear to reflect the individuality of their occupants?
- Are rooms, hallways, and meal tables clean?
- Is the environment noisy?
- Is there cheerful, respectful, pleasant, and warm interaction among staff and residents?
- Does the administrator seem to know the residents and enjoy being with them?
- Do staff and administration seem comfortable and peaceful with each other?
- Do residents look clean, well-groomed, well-fed, and free from bruises?
- Do many residents seem alert? happy? peaceful?
- Are residents seated comfortably?
- Is the home free from any unpleasant smells?
- Are residents engaged in meaningful and pleasant activities by themselves or with others?

Things you can ask of staff:

- Does each shift have enough help to be able to care for residents as they'd like?
- Do they enjoy their work? Are their ideas and information solicited and valued by supervisors?
- What activities are residents involved in?
- Are staff permanently assigned to residents?
- Are temporary staffing agencies used?
- How are the nursing assistants involved in the care planning process?
- Is the facility currently implementing any "culture change" or "Pioneer Network" practices? (for more information, see www.pioneernetwork.net or call 585.924.3419)
- How much training is given to staff?
- How often do residents who need it receive assistance with toileting?
- If residents are using disposable briefs, how often are they changed? Why are briefs used instead of toileting?
- What approaches does the facility use to prevent use of physical or chemical restraints?
- How does the staff assure family and resident participation in care planning meetings?
- What does the facility do to encourage employee retention and continuity?
- How long has the current administrator been at the facility?
- Has the facility undergone any recent changes in ownership or management?
- Does the facility provide transportation to community activities?
- What kind of therapy is available to residents?
- Can you give me an example of how individualized care is given to the residents?
- Is there a resident and/or a family council? Will the facility give you contact information for the leaders of these councils?
- What happens if someone has a complaint or problem? Are family/staff conferences available to work out a solution?
- Are residents involved in roommate selection?
- Who decides where residents sit for meals?
- Under what circumstances might a resident be transferred to another room or unit or discharged?
- Does the facility employ a professionally qualified social worker? ("Professionally-qualified" means with a bachelors or masters degree in social work.)

Things you can learn from talking with other residents and their families:

- Are residents treated with respect and kindness?
- Are residents helped with meals?
- Does the facility respect the resident's wishes about their schedule (bedtime, baths, meals)?
- Is attention given to residents at night if awake? Is there anything for them to do?
- Does the resident have the same nursing assistant most days?
- Is there a family or resident council? If so, is the council led independently by families or residents or is it directed by staff members?
- Are staff responsive to resident requests? Do they assist the resident with toileting?
- Are snacks always available to residents? Fresh fruit?
- Do residents participate in care planning conferences? Are his or her opinions valued?
- Has the resident had missing possessions?
- Who handles resident or family member concerns? Is that person responsive?
- Does the resident get outside for fresh air or activities as much as s/he wants?
- What is best/worst thing about living in the home?

The importance of fire safety in nursing homes:

A nursing home, like any institution, should have plans in place regarding fire safety precautions to ensure the safety of residents, staff, and visitors. This is especially important for nursing home residents who are frail, ill, may be unable to walk without assistance, or are immobile. Unfortunately, despite the importance of automatic sprinkler systems, new federal regulations regarding fire safety standards in nursing homes issued in January 2003 do not require that all nursing homes have sprinklers. Only those facilities recently constructed or undergoing major renovations or modernization projects are required to install sprinklers. Below are some questions to ask and things to look for regarding fire safety during your nursing home visits.

- Is the building well maintained? Are hallways and doorways clear of clutter, paper products and debris?
- Are sprinklers, smoke detectors, and emergency lighting systems installed throughout the facility? Are these systems all in working order and frequently tested?
- Is there an evacuation plan in place, are staff aware of the plan, and do they drill on the plan?
- Is there a notification system in place that alerts the fire department should a fire break out?
- What is the facility's smoking policy?
- What is the staff to resident ratio during all shifts? Fires usually occur during the night when staffing is most limited.
- What is the plan for notifying family members should there be a fire?

The importance of knowing the facility's emergency evacuation plan:

A nursing home, by law, is required to have emergency evacuation plans in place in the event of a natural or man-made disaster. When visiting a nursing home you should inquire about the facility's emergency preparedness and evacuation plans. These plans should be very detailed. Below are some questions to ask staff about emergency preparedness plans.

The plan What is the facility's emergency plan for evacuation and for "sheltering in place"? Plans will be different for hurricanes, tornados, and terrorist attacks.

- ***Staffing concerns*** Are there enough staff to carry out the evacuation plan during all shifts? What are the training procedures for staff related to emergency evacuations? Are evacuation drills practiced during all shifts?

Coordination with other resources How is the plan coordinated with other facilities in the area? Are there contracts in place with transportation and other facilities to provide housing for displaced residents? Are all the facilities contracted with the same transportation company and if so does that company have enough vehicles to accommodate all the facilities? How is the plan coordinated with other community resources, the city, county, and state emergency management agencies?

- ***Supplies*** What type and how much emergency supplies does the facility have on hand? (food, generators, flashlights, water, oxygen, etc.) If the facility needs to be evacuated, are there plans for supplies to be transported? Can residents have their own emergency supplies in their rooms?
- ***Resident information*** How are the residents informed about the plan? How will residents be identified in an evacuation? How will information about the resident and supplies such as medications be transported? Will these go with the resident or separately?
- ***Role of the family*** How and when will family members be notified about evacuation plans? How can family members be helpful in an emergency situation? Can family members meet the residents at a designated location and/or can they come to the facility to assist? Family members have the right to evacuate their loved-one on their own and move them to a special needs shelter if they choose.

Information that all nursing homes must post and make available to residents:

When you visit a nursing home, check to make sure the following information is clearly posted and visible. If this information is not easily accessible, you should ask the staff where this information is normally posted.

Daily staffing of licensed and unlicensed nursing staff for each shift. As of January 2003, all Medicaid and Medicare certified nursing homes must publicly post the number of nursing staff they have on duty to care for residents on each daily shift. Licensed and unlicensed staff include: registered nurses, licensed practical nurses, and nurse aides.

- **Name and contact information for all State client advocacy agencies** including the State Ombudsman program, the state survey agency, the protection and advocacy network, and the Medicaid Fraud Control Unit.
- **Results of the most recent state or federal survey.** All facilities must make recent survey information available and easily accessible, where individuals wishing to examine survey results do not need to ask for them. Easily accessible means in a place such as the lobby or other areas frequented by residents, family members, and the public.

FAMILY INVOLVEMENT: GETTING GOOD NURSING HOME CARE

Once your loved one is living in a facility, your continued care, support, love, and involvement in his or her life are absolutely key to getting good care there. Make sure you:

- **Visit frequently** and encourage others to visit;
- **Speak up** to raise concerns and complaints;
- **Attend** quarterly care plan conferences and advocate for individualized care;
- **Follow up** on the agreed upon care plan. Make sure the resident's doctor knows what is in the plan. Notice if the plan is not being followed and request another meeting if necessary;
- **Get to know** the staff and help them get to know the resident. Share details in writing about the resident's likes, dislikes, and daily routines;
- **Participate** in family council meetings if a family council exists, or seek out other family members to organize one;
- **Make contact** with your community's long-term care ombudsman, any local citizen advocacy groups and become familiar with the state and federal laws and regulations that apply to nursing homes and;
- **Document** (date, time, persons involved) any problems you might observe so that managers, the ombudsman, or state survey agency can investigate.

For more information and resources on choosing a nursing home, go to www.theconsumervoice.org

National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a nonprofit organization founded in 1975 by Elma E. Holder to protect the rights, safety and dignity of American's long-term care residents.

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GRIEVING THE LIVING

During COVID-19, many senior communities complied with state mandated lockdown procedures, denying entry to family and other visitors who have loved ones living within those facilities. In so many ways, this created tremendous hardship for all, but mostly for residents of facilities, or within their own homes, both sickly and healthy, who really need, love, and look forward to socialization with the world outside that facility. Hardship doesn't even attempt to describe those who had to endure sickness or death without the comfort and attention of their families, nor those families and loved ones that could not be there for the one sick or dying. This section will address grieving the living who are under a lockdown order. Here are some ways to help facilities or a loved one who is in a facility or homebound when you can't visit during the COVID-19 lockdown order:

- Discuss if estate plans and living wills are up to date
- Discuss if they have contingency POAs in place in case their POAs are unavailable to assist because they themselves are not well, they are essential workers or worse, pass away during this time.

Ways to stay connected include video chatting and providing iPads, tablets or smartphones to your loved ones, they can be dropped at the door. Many facilities are providing such devices for their residents' use with proper disinfectant protocols in place.

Here are a few things to keep in mind:

- Facilities need to spend money on extra staff, if needed, and medical/cleaning supplies at this time and it may be a hardship for them to buy iPads or tablets. Older people have had to get used to all new technology for visually visiting with family such as FaceTime, Zoom, Skype etc. and will likely want to continue using these after the quarantine is over. But let's remember there is no substitute for live in-person visits.
- Drop off goody bags of your loved ones' favorite items. No homemade food, as everything needs to be wiped off at the door.

Facilities can use:

- Card tables and TV trays (most facilities are having to implement a "stay in your room policy" and these items can help residents who are now eating in their rooms and with doing solitary activities):
- Puzzles, crossword puzzles, word searches, pens and pencils, colored pencils, adult coloring books, deck of playing cards, craft supplies...there are kits like sun-catcher paint kits they can do by themselves.
- Subscriptions to magazines or local newspapers. Most facilities are not allowed to share newspapers, playing cards, etc. at this time.
- MP3 players with music loaded, speakers, radios, or CD Players with some CDs.

Help the entire facilites:

- Chalk walks - Leave messages on the sidewalk of the facility
- Send flowers or cards - have a group of people or children make cards (fight boredom!) and send them to the facility
- Go visit at windows (but please don't touch the windows!)
- Drop off (call ahead to let them know you are coming) a gallon or two of ice cream and sundae supplies.
- Call the facility and ask how they are doing and if there is anything their loved one needs such as toiletries, seasonal clothing, etc.
- Like the communities Facebook page and encourage your family to do so, also.

AGE LIKE YOU MEAN IT!SM

TOP TWELVE TAKEAWAYS

1. If nothing else, **focus immediately on your Disability Documents** (Powers of Attorney for Finances and Health Care Decision-Making) to avoid Guardianship. Check your General Power of Attorney (finances) for:
   a. Durability
   b. Power
   c. Depth of Succession

2. When in a medical situation, **separate your Health Care Power of Attorney from the Advance Directive**, and only provide them the Power of Attorney (for those who DO NOT WANT A DNR – i.e. you would want to be resuscitated!)

3. **PAY ATTENTION DURING HOSPITALIZATIONS** (YOU OR YOUR ADVOCATE):
   a. Know your PATIENT STATUS (Observation or Admitted)
   b. Advocate for Status
   c. Know Your Rights and Know the Law (Jimmo Settlement)

4. **Check Beneficiary Designations** on IRA, Life Insurance, Annuities, Brokerage accounts for both Primary and Contingent Designations. **NEVER** name your estate as beneficiary on Probate-Avoiding assets!

5. **You don't have to spend-down your money** if faced with Nursing Home Care

6. Leverage your assets for Long Term Care options – make your money work for your Long-Term Care Needs and for a Death Benefit

7. **Protect your Family and Yourself by Protecting your Precious Assets – Primary Residence Protection**. Position for optimal transfers

8. When you design an estate plan, **FOLLOW ITS DIRECTIONS** or you may unravel the protection in the plan

9. **Don't Accept the First Answer** you get if it's not the one you want to hear – insurance companies, investment companies, health care, social security…

10. **DO NOT RISK YOUR PRECIOUS ASSETS BY TRANSFERRING OUTRIGHT TO CHILDREN/OTHERS** (applies to during lifetime and upon death)

11. **Importance of the Team,** your support network is extremely important, otherwise it is You Against the World. Your team serves as your agents

12. **DON'T** .... Don't leave it to chance! Don't do it yourself!