Fall 2017

Growing old in America, where do we go from here?

Holly Trevino
kyhojo@hotmail.com

Growing Old in America, Where do we go from here?

Holly J Trevino

Murray State University

Table of Contents

Abstract

We at times find ourselves with an elderly grandparent, parent, sibling, partner or friend and we not sure what the next step is for them concerning their healthcare of everyday living and how to obtain it. This paper will help you explore the different options of care from home care to skilled nursing facilities and everything in-between. It will also give you information to help relieve stress worry if the decision you have made is the best fit for your loved one.

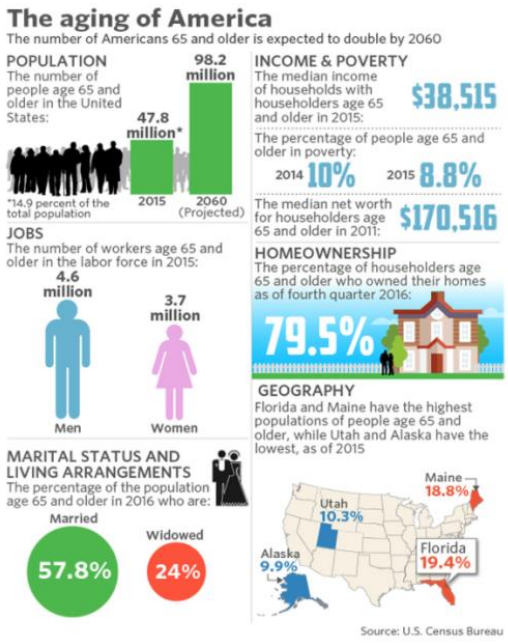
Growing Old in America, Where do we go from here?

According to the United States Census Bureau there were 47.8 million people over the age of 65 as of July 1, 2015. This amount will double while the baby boomer era starts to increase with age over the next forty years since the usual life expectancy has increased thirty years of the average American (Malito).What does this mean for the United States; it means that more elderly will need some type of health care for a positive quality of life wither this care is in their home or in some type of twenty four hour care facility. More and more are finding that their physical and mental states are deteriorating and adjusting to these challenges have become difficult and has them wondering where do I go from here and what are the best options of care?

With the rise of diseases such as Dementia, Alzheimer's, Parkinson, and a wide variety of Cancers brings many minds across the country wondering where their care will come from. Many think that staying in the comfort of their own home for the duration of their lives will be the best option but yet can produce the biggest challenges. This harsh reality can set in all too quick through sudden illnesses or accident. Who will help, this leads to stress of who will help a family member, caregiver, or friend? The largest worry is who will be responsible and will pay for the care that is needed wither it is in the home or in long term facility. Others will choose to go to a facility where care is done by professional or trained personnel. But who will make that decision and how will it be made with true authority and precision of what is best for the patient without bring extra challenges and worry to the guardian(s).

Geriatric syndrome is becoming common term you hear in the elder care world. The patients that have incontinence, cognitive impairment, delirium, falls, pressure ulcers, pain, weight loss, anorexia, functional decline, depression and multi-morbidity are becoming more common as

American grows older (Bell,Vasilevskis, Avantika, Jacobsen, KripalMison, Schnelle, Simmons). This syndrome is becoming more common in American as those over sixty five increases and is seen in ninety percent of hospitalized patients that are over sixty five in age with one or more of categories of health decline. When geriatric syndrome is involved striving to obtaining some type of normalcy for the patient in daily activities such as bathing, cooking, housecleaning, other personal care, and daily activities can become a challenge for their caregiver's without proper training becomes challenging. Whether the caregiver is a family member, partner, or friend there through stress of doing things right there is now encouragement for several different choices of help for future care now is available. Depending on the level and skill needed for care one can pick from several different options for care: Respite, Home Health, Assisted Living, Skilled Nursing short-term, long term care, and hospice care. With these types of care there are additional care such as home health aide, physical therapy, occupational therapy, social worker, and speech therapy in the home or a facility.

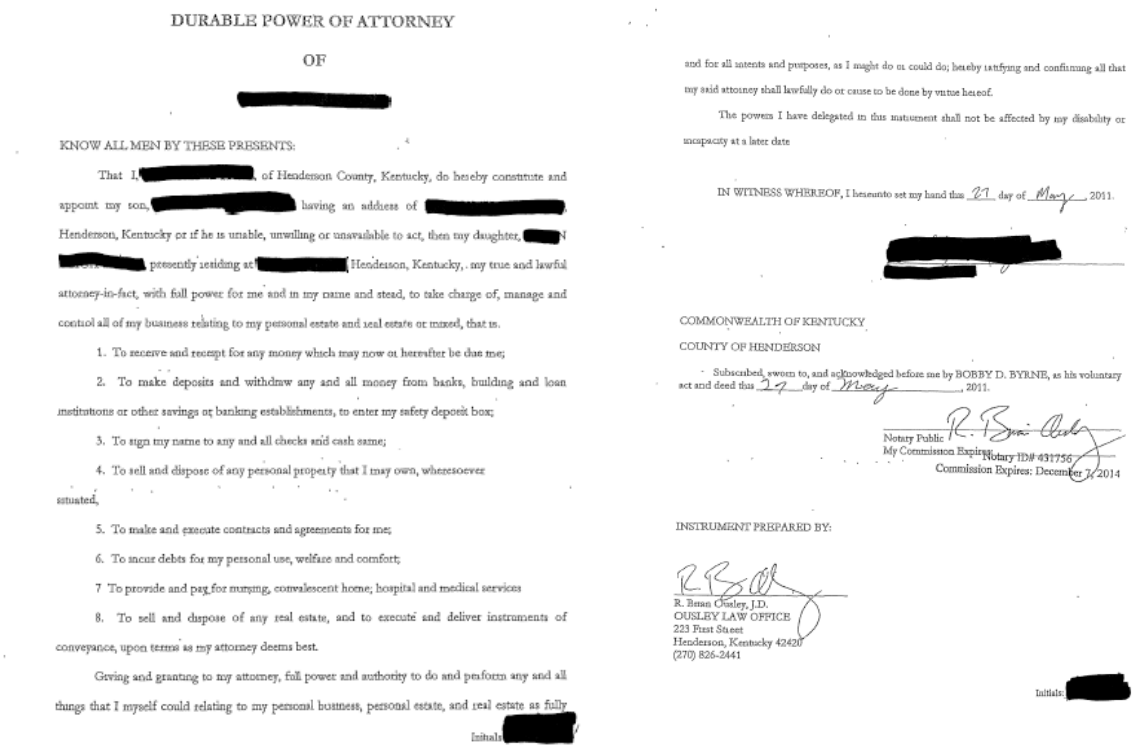


One of the biggest challenges with in-home care is with caretakers is the burden of making multiple medical or personal decisions of what is best type of care for their loved one and which they will benefit from most. The best way to save this type of task for the future caregivers is pre-planning when the opportunity before a decline in health. Many factors go into the pre-planning process of the unforeseen future for a patient. By doing the planning early while the patient's cognitive levels are still high is a way to take the weight off of the caregiver but,

sometimes a decline in health status can happen rapidly. However there are situations where there isn't a warning of decline and it will take time for recognition of the decline even for those that spend a lot of time with a patient. One of the main concern can be the challenge of who will pay for the type and level of care that will take to obtain a highest standard of care to produce a quality of life that we all desire in our elder years. Many turn to what the insurance will pay and the level of budget a patient may have before making the big decision about of the type of care they will choose and for some; at times it will determine the decision of choosing to a professional facility or personal caregivers for in-home care respite care for the effective one decline in health. Many feel that staying home is the best option for care and will enhance the patient's psychological factor in being in familiar comfortable surroundings. But in reality can be the most detrimental decision depending on the level of care that is needed. Coverage and payment is the final decisions maker of whether a person can afford to stay in the home due to paying for a private caregiver. Giving the patient the dignity of being able to choose their path is the most important of choosing the correct location for living out the rest of their life.

Advance Directives is a document that can help insure that the patient's future care and quality of life is of the upmost quality of their wishes when it patients decision making capabilities is hindered. Many, young and old, unfortunately have not considered about what will happen if a proxy or a person has not been chosen to make medical decision until the time it is needed when a person is

unable to do this for themselves. It is such an important aspect of health care that many are unaware of or just push the side. Nevertheless, it can help in the delivery of health care or complete the end of life process with ease and comfort of doing what the patient would have wanted. There is two types of Advance Directives a "Living Will" and "Durable Power of Attorney" depending on the state you live anyone can have these drafted by an attorney for find guidelines on how to write them on the internet on such websites as the national Hospice Palliative Care website. Either way, in the process of legalizing the decision, the paperwork will have to be signed and notarized by an official Notary Public. Advance Directives not only legalizes a pathway of care in the end it also lays out the decision of whom the person wants to make their medical decisions should they become incapacitated and cannot make that decision for themselves. It also gives the caregiver permission to speak about the patient's healthcare. With HIPPA (Health Insurance Portability and Accountability Act) being established in 1996 by the federal government it has increased the challenged of the ability to retrieve medical information for anyone other than the patient and/or the person(s) listed in the Advance Directives of the patient. This is the first and most important tool that anyone should complete to have in order to help make sure that the quality of life for their loved is done to their wishes and it takes the guess work out of what they would have wanted. It also gets rid for the any second doubts of the caregiver making the right medical decision for the patient in a medical emergency. The following is a sample of a short Power of Attorney that can allow the POA to act on behalf of the patient and gives them the right to speak to physicians, nurses, and agencies on behalf of their loved one. There are many websites that can give examples and forms that can be filled out should you wish to complete one without an attorney yet it will still need to be notarized.



DURABLE POWER OF ATTORNEY

OF

[redacted]

KNOW ALL MEN BY THESE PRESENTS:

That I, [redacted], of Henderson County, Kentucky, do hereby constitute and appoint my son, [redacted] having an address of [redacted] Henderson, Kentucky or if he is unable, unwilling or unavailable to act, then my daughter, [redacted] presently residing at [redacted] Henderson, Kentucky, my true and lawful attorney-in-fact, with full power for me and in my name and stead, to take charge of, manage and control all of my business relating to my personal estate and real estate or mixed, that is.

1. To receive and receipt for any money which may now or hereafter be due me;

2. To make deposits and withdraw any and all money from banks, building and loan institutions or other savings or banking establishments, to enter my safety deposit box;

3. To sign my name to any and all checks and cash same;

4. To sell and dispose of any personal property that I may own, wheresoever situated,

5. To make and execute contracts and agreements for me;

6. To incur debts for my personal use, welfare and comfort;

7 To provide and pay for nursing, convalescent home; hospital and medical services

8. To sell and dispose of any real estate, and to execute and deliver instruments of conveyance, upon terms as my attorney deems best.

Giving and granting to my attorney, full power and authority to do and perform any and all things that I myself could relating to my personal business, personal estate, and real estate as fully

Initials [redacted]

and for all intents and purposes, as I might do or could do; hereby ratifying and confirming all that my said attorney shall lawfully do or cause to be done by virtue hereof.

The powers I have delegated in this instrument shall not be affected by my disability or incapacity at a later date

IN WITNESS WHEREOF, I hereunto set my hand this 27 day of May, 2011.

[redacted]

COMMONWEALTH OF KENTUCKY

COUNTY OF HENDERSON

Subscribed, sworn to, and acknowledged before me by BOBBY D. BYRNE, as his voluntary act and deed this 27 day of May, 2011.

Notary Public
My Commission Expires: Notary ID# 431756
Commission Expires: December 7, 2014

INSTRUMENT PREPARED BY:

R. Brian Ousley, J.D.
OUSLEY LAW OFFICE
223 First Street
Henderson, Kentucky 42420
(270) 826-2441

Initials: [redacted]

When given the opportunity sitting down with an aging individual is the best to make these decisions ahead of the time to understand their choices would be in the type of care that will be desired should they become ill. Know what are their wishes can be a tough conversation for some that are healthy: where do you want to go for care, what type of care or facility they would want to live out their days in, and how will payment would be achieved for the care they desire. Many elderly by the time they reach the ripe age of sixty five many have thought about this and have a plan while others many not have initiated the consideration of future care. Insurance like at many other previous times in a person's life will play a major role in the decision of placement of care and the type they choose. Even though there are many type of insurance whether they have Medicare, Medicaid, Medicare Supplement (Medigap), private plan, or if you receive any type of veteran's benefits elderly will let the cost of care make the decision for them. This paper

will explore the different options of health care the help one gain a better understanding of what each of them have and the benefits of the quality of care each have.

Who will pay?

Medicare is an insurance program provides coverage for those over sixty-five years of age or have certain circumstances that will allow before the as of sixty-five, it will help with cost of health care, but there are times it does not cover all medical expenses or the cost of long term care (SSA.org). There is two polices you can look at, the main one that a person over sixty-five chooses is Part A is Hospital insurance and it will help with expenses while inpatient in a hospital or a skilled nursing facility, or some home health and hospice care. The majority of people are eligible for this policy if they have worked and paid Medicare taxes for a substantial amount of time throughout they careers however, one can receive Medicare if one has a disability and/or are receiving social security benefits. Initially when the time comes to be able to sign up for Medicare benefits at the age of sixty-five this does not mean that you are ready to start receiving retirement benefits and are ready to retire. It is important that you start the process of signing up three months in advance before you turn sixty five years of age, this will help get the process underway and you will be ready to receive benefits without any delays of the insurance policy once you turn sixty five with no cost to you. Part B of Medicare is the type of policy that help pay for services rendered, medical supplies, but does not cover hospitals cost like private insurance or Part A however, this policy is where the policy holder may have a premium out of pocket cost. The potential policy holder can find out what your premium by reading “Medicare Premiums: rules for Higher Income Beneficiaries” Publication No. 05-10536 located on the internet at www.ssa.gov. (SSA.gov). Along with these two types of policies there are many types of categories one would be able to have coverage the following, to determine the

how the coverage is obtain one can look at the letter at the end of their Medicare number which for many years has been the social security number which is listed on the insurance card. But in 2018 the Medicare system will roll out a new Medicare policy numbering system. The policy holder will and no longer use the use of the care holder's social security number with an letter changing it to an individualized account number to help with fraudulent use of accounts that have happened over the years.

When having Medicare there is additional coverage available to the consumer that you can add. Once you have your Medicare A or B coverage one can chose to add another type of policy known as Medigap policy which will help cover any out of pocket cost that a patient or future patient's original Medicare Part A and B will not cover. According to the ehealthinsurance.com there are normally ten plans available depending on the state you live in. Each plan is labeled with its own letter A, B, C, D, F, G, K, L, M, and N. With plan F being the most popular then Plan C (Miller). Websites like medicare.gov/find–a-plan can help you chose which plan is best for you with the additional information what that the policy may cost you according to your circumstances. The best way to choose a plan is to determine what type of additional coverage you are seeking and keeping in mind the health challenges that you may already have.

A – Primary Claimant (wage earner)
B – Spouse (spouse of retired worker)
B1 – Aged Husband, age 62 or over
B2 – Young Wife, with a child in her care
B3 – Aged Wife, age 62 or over, second claimant
B5 – Young Wife, with a child in her care, second claimant
B6 – Divorced Wife, age 62 or over
BY – Young Husband, with a child in his care
C1-C9 – Child (includes minor, student, or disabled child)
D – Aged Widow age 60 or over
D1 – Aged Widower, age 60 or over
D2 – Aged Widow (2nd claimant)
D3 – Aged Widower (2nd claimant)
D6 – Surviving Divorced Wife, age 60 or over
E – Widowed Mother
E1 – Surviving Divorced Mother
E4 – Widowed Father
E5 – Surviving Divorced Father
F1 – Parent (father)
F2 – Parent (mother)
F3 – Stepfather
F4 – Stepmother
F5 – Adopting Father
F6 – Adopting Mother
HA – Disabled Claimant (wage earner)
HB – Aged Wife of Disabled Claimant, age 62 or over
HC – Child of Disabled Claimant
M – Uninsured – Premium Health Insurance Benefits
M1 – Uninsured – Qualified For (but refused health insurance benefits – Part A)
T – Enrolled in Medicare but temporarily delayed Social Security Retirement Benefits or Uninsured – Entitled to Health Insurance Benefits under deemed or renal provisions
TA – Medicare Qualified Government Employment (MQGE)
TB MQGE – Aged Spouse
W – Disabled Widow
W1 – Disabled Widower
W6 – Disabled Surviving Divorced Wife
WA – Railroad Retirement

Whichever policy that is chosen it is best to enroll when one's sign up for Medicare before one's sixty fifth birthday, this helps with any delay in obtaining a policy and can help determine pricing since these are sold by private insurance companies. Many clients looking into the Medigap choose the high-deductible plan that is found mostly in the Plan F and which makes it more affordable. In 2016 women over the age of sixty five the average cost of a the most popular Medigap policy F was one thousand eight hundred and thirteen dollars (Kiplinger.com) per year however the deductible must be met first before any benefits go into action. If you have Medicare B the Medigap plan the additional plan that is most common is Plan N it will cover hundred percent of what Medicare B will not cover. The out of pocket cost of this plan is twenty dollar co-pay for health care services. Having a supplemental coverage such as a Medigap plan can help relieve the burden of the extra expenses that have been incurred while trying to receive the best care possible. While having this additional coverage can also give relief of knowing where the payment will come from it can decrease the stress of the one thing that people don't think about when it comes to obtaining highest form of care for someone that has a debilitating or chronic disease and an older age.

In addition to the regular Veterans eligibility health benefits given to previous active duty military there are some agencies such as American Veterans Aid that can help a former war veteran wither they have total disability or not receive tax-free benefits through programs under the Department of Veteran Affairs. Veterans that have fought in a particular time of wars will receive extra help for the cost of care when it comes to finding will help with home care, assisted living facility or skilled nursing facilities room cost, and or medical supplies that insurance or Medicare will not cover. However, there are many stipulations to receiving this type of assistance with the heightening cost of health care cost in America. This type of additional cover

help according to the American Veterans Aid website 1) a veteran will have to have been active duty for ninety days within one of the time frames of four particular wars 2) a veteran could not have been discharge with any other than a dishonorable discharge 3) a veteran that has a surviving spouse can be benefited with these benefits as well 4) a veteran must requires some type of care for your daily activities such as personal care or activities of daily living 5) a veteran have to meet the income criteria outlined by the Veteran's Affair 6) a veteran must be sixty five years or older or totally disabled to receive benefits.

Eligible Periods of War

- World War II 12/7/41 – 07/26/47
- Korean Conflict 06/27/50 – 01/31/55
- Vietnam Era 02/28/61 – 05/07/75
- Persian Gulf War 08/02/90 – proclamation of President or law

American Veterans Aid

Should one be a candidate for this type of cover one can register through americanveteraid.com website to see if a veteran qualifies for any these benefit's. These benefits are in addition to any health system benefits provided to any veterans through the Department of Veterans Affairs in the United States. The Department of Veterans affairs offers primary care and specialty physician, hospital care, and long term care facilities in over one thousand care facilities across the United States to care for our soldiers that need health care wither it be a disability or regular yearly checkups to keep a veteran healthy.

Most Americans are unaware that there is an additional insurance coverage that can be purchased and is separated than what we have already discussed. This insurance policy will that can help pay for respite, home health, and long term care and has a no other simpler name that of "Long Term Insurance". It is great options to help pay for those that qualify over the age of sixty five with a chronic or disabling condition that requires respite care in the home or through home

health or an independent living facility. This type of insurance policy is normally purchased through and independent agent and will help contribute to the payment of long term care and is encouraged to purchase this at a younger age to have a lower premium as it increases with age. According to AARP's website when purchasing at a younger age you will need to make sure that you have a "guaranteed renewable" policy which mean they cannot cancel the policy because of age or health status. The only way it will expire is if you use an amount past the premium you have paid in on the policy premiums balance (AARP, 2016). A financial advisor or a lawyer can help you make the best decision on the type of a policy that is best suited for you and your future health requirements. This type of benefit is not considered taxable income which also can be challenge for those that receive medical help based upon income. Something else that is important to have with this policy if purchasing it a younger age is to have compound inflation protection which will protect your policy once you are in need of it that it will take in the consideration of inflation of when the policy was first written. This policy is used mainly in Independent and Assisted Living facilities the most so that a patient/resident can afford a facility type respite care while staying independent in an apartment style complex where meals, housekeeping, and laundry are provided by the facility. In these type of facilities home health care is another option of care and can also be benefited from Long Term Insurance to help pay for any balances that may not be paid by Medicare, Medicaid, or a private insurance policy. You can always receive help in choosing the policy that is right for you through your state insurance department.

Respite Care

As American grow older and start to need assistance with everyday task it is hard to choose what type of care will suit the patient best. The patient's primary care physician help by assessing the

patient and will give suggestion on what type of care will offer the best care for the patient. After the assessment the physician will make a referral should it be needed for assistance other than respite care. Should the primary care physician or specialist feel that is it safe for a patient to stay in the home, respite care maybe the only form of care the patient needs. This type of care doesn't need any formal training and can be performed by a family member, significant other, or friend that is taking care of an ailing patient. Even in safe conditions this type of care needs to be well considered due to the physical, mental, and sometimes financial strain it can be on the caretaker and the patient. Home care by a family member or a loved one can eventually cause a strain and stress on the care giver without any type of break. With respite care a care giver can be hired outside of the home and the average cost runs about ten dollars an hour but can be higher per the request of the caregiver for this type of care in western Kentucky. When hiring for respite care there are several places to turn should one not have someone that they know that is willing to step in and give the regular caretaker. Many hospitals and long term care facilities keep a list of persons they have spoken with or have used for respite care for their patients or residents. Sometimes one can find a respite caretaker that is qualified in CPR and possibly have their CNA (certified nursing assistant) certificate. A respite care taker can come in the home and do light housekeeping, cooking, bathing, medication reminders, assist with dressing, and other daily activities but depending on certification nursing type skills are not provided. They play a very important role in the daily activities of the patients such as socializing, reading, playing cards, and crafts with the patient to help to have some type of normalcy in their daily lives.

Although, when one may think of respite care one would may think of in-home care only. However, more and more independent living and assisted living facilities are offering short term respite care given by their staff. This can give a much needed break for the family or caregiver

and is most often used when caregiver want to go on vacation have been hesitant because their loved one cannot travel or will not have anyone to care for them? This is a great and safe option for those families because their loved one will be cared for just as if they were at home and it can enhance their social ability with others around their age. However there is a cost for this type of care due for the services they will receive from the facility for the week or weeks of the stay in a facility. Along with respite care there are many types of agencies that do provide housekeeping, cooking, transportation, and socialization for homebound patients. Many of these organizations work on an hourly basis and are out of pocket cost to the homebound individual. This type of care gives security to families that may have to maintain a job and cannot be there during the day and help relieve stress from having to provide extra help to a loved one.

Adult Day Care

Along with in home respite care another type of respite care and can be a essential gap in care when the patient is till mobile is the every flourishing adult day and social care facilities. Many seek the care after a spouse has died and are alone in the home. According to Senior Living this type of facility fills the gap of care for over two hundred and sixty thousand Americans and their caregivers on a daily basis. The type of facilities help provide seniors with supervision and socialization in a structured type setting however there are three types of facilities you will find 1) Social – which will provide socialization for the patient and recreation with minor medical services when needed. 2) Medical – these are staffed with certified nurses and provide medication management, health monitoring, disease management, physical therapy, podiatry services3) Specialized – are facilities that will and specialize in Dementia and Alzheimer's style of day care for the elderly (seniorliving.org). The average attendee is women who lives alone or with family and fifty percent of attendees suffer from some type of cognitive deficiency

(caregiverslibrary.org). These facilities employee registered nurses, social workers, home health aides, activity directors and aides.

Elderly care is on the rise in America wither you seek out respite care which is private pay or assisted living type style of living. Adult Day Cares will intervene and help the elderly receive care a help give the patient much needed socializations especially when they become isolated in their own home due to the lack of transportation or lack of caregivers time. These facilities will can increase the patient's social skills, physical ability through exercise, and educate a patient on how to care how to control chronic illnesses such as blood sugar, blood pressure, and diet.

Social skills and activities play a large part in the daily care of a patient that seeks care at an Adult Day Care facility. They will have the opportunity to do crafts, exercise, take day trips, garden, receive music and pet therapy, and learn relaxation techniques that they can do at home to relive stress and anxiety. Having the opportunity to do this on a weekly basis can help with cognitive decline and help give the patient a sense of worth. This will increase the health of the patient versus the patient that stays enclosed in their home without any outside communication other than with caregivers.

These type of care facilities often provides the opportunity for caregiver to go to work, run errands, or give them a break from the care they provide for several hours a day to a full eight hours. It can also help prolong the need for an assisted living or skilled nursing facility. Along with socialization the patient will receive nutritional support, respite care, health screenings. The patient's family and caregivers can receive counseling for home care for their loved one at home. Many facilities do have door to door transportation which also helps when transportation is an issue for some elderly patients yet they desire the socialization and care provided.

The National Adult Day Care Services Association better known as NADSA reported in an increase of thirty five percent since 2002 adult day care centers with a total number of 5000 centers across the United States. The average cost according to a study done by MetLife it can range anywhere from one hundred and forty dollars a day to thirty nine dollars a day and many are paid for out of pocket. Medicare or Medicaid do not cover the cost of these facilities however if you have supplemental plan such as C coverage maybe available. The Veterans Affairs can also offer some financial support as we have talked about earlier in this information. Facilities can chose what the rate of care per day will cost. Many patients do not attend the Monday through Friday facilities every day.

Home-Based Primary Care

Homebound seniors with acute or chronic illnesses, even with excellent caregivers at home, may need more than respite care wither done by a family member, paid sitter or a skill professional. A patient could receive other services such as a Home-Based Primary Care given by a traveling doctor/nurse practitioner however this type of care will be charged to the recipient's insurance versus a premium paid directly to the physician for care. This type of service would be rendered should the patient need short or long term services from a medical professional. The re-invented styled home care for those that are homebound and cannot travel to and from for an in-office medical care visit can now take advantage of this in-home concierge type service. this type of the home visit is now making strong comeback and becoming widely available to senior adult in America.

This type of visit also helps with anxiety and depression that a patient may suffer when knowing they skills that may have to have to prepare themselves for a day outing and the availability of

transportation to get to and from the doctor office, especially when they have to rely on a family member or friend's schedule. Just like in history's past the days of having this type of care can be beneficial to the patient and can take the stressors of the office visit away. The in home type concierge doctors are making their way back into the health care system and is such a great advantage to receive high quality care in the home and gives the professional the opportunity to see the patient in their home surroundings which can contribute to illnesses and/or injury and this is not possible if the visit in done in-office. The in home service will provide a highly skilled physician's and/or nurse practitioner to make the house calls under the supervision of a medical doctor. These visits are conducted just as they are done in a regular physician office with regular blood pressure checks and full assessment of health.

In the majority of the cases a nurse practitioner will see on a regular basis for an in home medical visit for the physician is just as it is done in the many medical offices now under the physician's supervision. Along with medical assessments of care they can also can and will prescribing x-rays, blood work, send referrals to home health agency for nursing and therapy services should a patient require it to enhance their health status and can also been done in the home. In some cases they will make a referral to a home health, short-term inpatient therapy facility, or long-term care facility depending on the medical need of the patient. More information will follow on how home health and home therapy can be beneficial to a patient. A Home Based Primary Care Services such as MD2U out of Louisville, KY can cover large areas of services for homebound patients. MD2U's founding physician Doctor Jerry Benfield saw the need for the homebound patient and now has a practice that has a large staff of nurse practitioners that cover Kentucky, Indiana, and North Carolina. He and his staff have successful in keeping more patients at home during their illness or injury and it has helped reduce the need for an emergency room and

hospital visit. Along with lessening the need for increased twenty-four hour care such as home health and/or a skilled nursing facilities because this staff also would provide twenty four hour care. According to the MD2U website this office provides along with adult primary care: comprehensive in-home services, medication management, post hospital discharge visits, wound care, mental and behavioral healthcare, and end-of-life care (www.md2u.com). MD2U covers twenty-three counties in Indiana, sixty-five counties in Kentucky, and fourteen counties in North Carolina. Home Based Care companies work similar to a regular physician's office taking care of needs of patient's health care concerns and illness. Their billing system is very similar as to a medical office in the same manner as billing the patient's insurance as a regular physician's office does to collect for services and medical supplies rendered during an office visit. They follow along with private insurance, Medicaid, and Medicare guidelines in order to continue to consult with patients for the assistance they need with their health. This type of organization can and will team up with local home health agencies to provide the excellent specialized care for those that are unable to seek care outside of their home. They work with these agencies to enhance their care and utilize them for in-home skilled nursing care such as wound care, blood work, physical and occupational therapies, speech therapy, bath aide, and social work care should the patient need extra care on a weekly or monthly basis care plan. This can add extra care for the patient when needed and can help provide the patient and take the stress off of not only the patient but the caregiver as well.

Home Health

Once the primary care physician, specialist, or a home based physician sees a homebound patient would benefit from home health services even if they are receiving respite care in the home by a loved one, sitter, or friend they will make a referral for home health services. The doctor will do

a full assessment during the patient visit in the office and send a referral to a home health agency by his staff, many referrals are done the same day. Along with the primary care physicians other agency such as MD2U, as stated previously, will work alongside the home health agency to secure and provide the best quality of services for the patient to help them become active as much as their health will allow them to. And will help them become independent and active once again after an illness, surgery, or accident injury has occurred.

Home health has a wide variety of services that can be given to a homebound patient such as skilled nursing, physical therapy, occupation therapy, speech therapy, social worker, and bath aide. Discipline's such as skilled nursing or therapies can be the stand alone service provided or many disciplines can be in the home providing care. These disciplines work together for the good of the patient's health and communicate well so that the best possible service is provided in restoring health to the patient.

Home health does not provide any type of housekeeping such as cooking and cleaning. The goal when home health comes into the home is to educate and care for a patient to guide the patient to a healthier lifestyle, and become independent as much as possible once again after an injury, illness, or surgery or to the highest level a patient can obtain. However, at times care can be long term due to chronic illness.

Home health services the majority of the time will obtained through a referral system either from the prospective patient's primary care physicians, specialist, hospitalist, and or short term therapy facility. This is not to say one couldn't request services when in need, anyone can call an agency and they will have a representative from the company contact the prospective patient and

will work with the client or a family member and will help obtain getting the referral you need receive services from the primary physician. If a patient has not made a visit to their primary care physician, emergency room, or had a hospital stay (whether inpatient or observation). If the patient has not been in to see their primary care physician in a substantial amount of time this could a visit to the their office to get a medical assessment from him/her in which they will make the referral at that time to the home health agency of choice. Physicians will work with multiple home health agencies but will pick the best one for the type of care need for the patient. On occasion and person will cold call an agency and at that point they will work with the account executive that will help them get a referral from the primary care physician or help make an appointment to get the referral process started.

Some diseases and skilled needs that a home health agency nurse or therapist can help educate on are diabetes, wound care, medication management, in-home blood work, intravenous care, after surgery care, mobility, stability, range of motion, and monitor any serious illnesses. At times the social worker will assess a patient and find that the patient is not safe in the home and will refer the patient to a long term facility. They will also work with Adult Protective Services should they find that the patient is in an abusive situation whether physically, mentality, or finically by family, friends, caregiver, or self-inflicted due to a decrease in cognitive levels. Once the Adult Protective Services are contacted the patient becomes protected by the state and could lead to legal action against the abusers and the removal of the patient from their home putting them in a safer and more stable environment.

Home health agency normally will admit those with traditional Medicare, additional Medigap coverage, and some private insurances. This type of in home care can help a patient save out of pocket cost that would be spent on a short-term private facility or long term care by staying in

the home and receiving care. It can also help the patient being a familiar surroundings while healing or maintaining their health. However, being referred with types of private insurance to a home health agency the referral can be declined due to many reasons but mainly due to, by companies experience Company's choice, due to lack of payment from particular insurance companies. Sometimes the referral is declined due to the type of care the patient requires and the agency does not provide that type of skill. The agency does have the right and ability to refuse to take certain insurances. Home health agency will not take insurances that are slow to pay or have a waiting period of fourteen days for approval of plan of care for a patient. In this case it is not in the best interest of the patient to have to wait for insurance approval and so they will refuse the patients referral so that the prospective patient can obtain care from another agency or facility sooner.

At the point of receiving a referral there are several steps to making the start of care for the patient happen. Like it has been stated, the start of care referral is needed and faxed to the home health agency. When the referral is coming from a hospital or short term facility progress notes, medication list, and demographics of the patient will either be hand delivered to the agency or faxed. Then an office staff such as Clinical Supervisor, Administrator, or Business off Manager can assess the needs of the patient that have been requested and evaluate if the patient is suited for the type of care the

agency offers. Once that has been established they are suited for that agency the insurance will be verified for the type of disciplines that have been suggested by the primary or referring physician. During this process it will also be verified that the patient is not covered by another agency or personal injury policy. Once approved then the patient will be accepted and the process begins with entry of all demographics and disciplines needed into the company's computer system where all disciplines will be assigned for the start of care. It is regulated by Medicare to receive the typical "Start of Care" visit within 48 hours of receiving the referral and with some agency should a patient be released from a SNF (skilled nursing facility) the "Start of Care" is the same day so that the transition home is as comfortable for the patient as it can be. However there are instances when the patient request a particular day for the start of care due to illness or physician visit. A patient will receive a call from the attending skilled nurse that will be doing the start of care; this visit can take up to one to two hours depending on the patient's needs. Most agency use a start of care packet that will require the patient signature. It is always good to have the Power of Attorney or a representative there for a patient when the start of care is being done. This will help assist the patient with any questions that may not understand or should have difficulty in hearing. Again, during that time the nurse will go over in detail the type of care the agency offers and what they will be receiving. The patient will receive a "star of care packet" that they will keep in their home. The packet will provide state mandated information pertaining to their rights of receiving quality care and what the patient can expect for their care with the agency. Home health agencies provide to their patients twenty-four hours a day and seven days a week care to ensure proper treatment. When need for emergency care arises at that point the nurse will decide if a home visit is suitable or if the caregiver or patient needs to request 911 services, is needed and would suit the situation best. Each discipline that is in the

home caring for the patient will chart on each visit and communicate any changes needed made between the patient and home health agency. This will ensure that should a different displine employee come in to see the patient they will know the care that was given on the last visit. This is also mandated by insurance companies to have this type of continuous care system.

Once assigned disciplines have has been out and made the OASIS (Outcome and Assessment Information Set) which gives the tools to make a proper assessment he/she will document what skills are needed and what the frequency will be for the patient to give proper care to the patient. The Department of Health and Human Services health Care financing Administration has a particular form, Health Certification and Plan of Care CMS-485, which is filled out by the nurse and confirmed by the clinical supervisor that will provided the primary care physician the action of which the health agency care for their patient. The physician will sign and return this form to the agency for the patients file. All forms and paperwork it kept for ten years past the discharge date of a patient according to Medicare guidelines. During the course of 60 days the patient will be seen by the nurse and/or therapist and any changes to the plan of care a Physicians Order will be sent by the nurse to the physician for approval. The agency and the primary care physician have great communication through the care process to make sure the best care is being given to the patient. At the end of the sixty days the patient will be given another assessment at this time if the patient has met the goals set between the nurse and physician the patient will be discharged, however if the nurse feels that there is a justification of skills still needed for the patient the nurse will “Recertify” the patient for another sixty days. The sixty days is a time limit has been set by Medicare to ensure assessment of skills needed and to prevent fraudulent and excessive care that is not required for care or is needed. Any skilled therapies make an assesment every thirty days for continuation of care or decision of dismissal will be done from that

discipline. Therapies normally complete their care with a patient long before skilled nursing does, therefore when a patient only receives therapies they will not be under services as long as if when receiving skilled nursing discipline as well. Every form of care done for the patient is sent to the primary care physician so they will be aware and approve of the care that is being done during the course of the care under the home health agency. The communication between the home health agency and the primary care physician or specialist is mandated by the Medicare system this also helps deferring any unnecessary fraudulent care.

Once dismissed from home health a patient can be a candidate for home health care once again in the future should the primary care physician sees that they will benefit from care for their home medical needs. The physician will normally send a referral to the agency that the patient had last unless otherwise requested from the patient another agency to be used. Should a patient be in care of one agency they cannot receive care from another agency until properly discharged. Medicare will not pay for two separate home health agencies at the same time. Many times the agency will receive a referral for a patient that they have had in the past due under the same health circumstance or a different one. There are times that a home health agency will refer out to a short term rehabilitation facility or for long term care for a patient to receive care in a facility versus at home; this type of referral can be initiated by a family member or the physician.

In course of care for the patient the home health agency will provide the ordering for medical supplies that is needed during the course of care and will bill the patient’s insurance once that product has been received by the patient in their home. Most agencies have a particular company they use for their medical supplies and will keep certain supplies on hand for emergency use. Please check with the nurse or agency to what supplies will be provided and what supplies that will not be provided. Some supplies such as briefs or pull ups can only be provided under a

Medicaid Waiver program. The orders are placed for the patient and are overseen by the Clinical Supervisor and Administrator to ensure that ordering is not abused and the patient only receives supplies that are needed.

There are times that a new condition arises during the course of the care with the home health agency care and at that time the nurse will assess the condition and make a verbal call to the physician. At that time the physician may ask for the patient to make an appointment so they can assess in the office the new medical challenge the patient is having. Or they will instruct the nurse to call 911 and have the patient directly taken to the emergency room. Again, home health care is a twenty four hour service so any changes in the patient's health can be reported to the agency and a nurse will be on call to help assess and make the correct direction of what needs to be done. Once a decision is made the physician will be notified by a verbal call and/or by a written form of communication by the form of a Physician Order that will give a request for a change in care. It will be written by the nurse and then faxed to their office for signature. It is then returned by the office and put into the patients chart ether by electronic measure or a physical chart. Just a reminder all Medicare recipients charts are kept for ten years and can be requested by the durable Power of Attorney also known as POA.

At the beginning and end of the initial sixty days of care frequencies the agencies nurses, therapist, and clinical supervisor meet together for what is called Case Conference and discuss the patient's outcome of the assessment and what the future plans of care are being recommended. This communication will be submitted into the patients file and will help with future care should one discipline experience something different than the others that are giving care to the patient. Should the patient be recertified for another sixty days of care another Case Conference is preformed fourteen days before that recertification is due. This type of meeting

helps the nurses, therapist, and office staff knows the goals for the patient and how to achieve them.

The family or caregiver will be responsible for any medications that the patient will need during their course of illness. The home health agency can only give instruction on how to properly take and will monitor the medication along with informing the doctor of the medication taken during the CMS-485 form. Should a nurse see that a patient is not responding or may need a particular new or old medication they will make verbal contact with the doctor or the doctors nurse and the doctor make the decision of sending a new prescription for them, at that time the nurse will chart by adding the new medication to the Medication Profile file and the diagnosis for the need of new medication. Not only is this the guideline to Medicare but also should be policy of the company to help inform anyone that may be caring for the patient.

At times a patient may need to learn how to complete daily tasks again after an injury and the majority of home health agencies provide in-home therapist; these can be a one or all of the following disciplines: physical therapist – help with short term recovery from injury due to joint replacement, chronic pain, balance disorders, stroke and or head injuries; occupational therapy – help recover everyday skills and activities that may have been lost due to injury or a decline in health; speech therapy – helps with oral motor skills and help the patient regain the strength for proper audio speech; social work – help with social interaction and the safety of the patient while still in the home, they provide the patient an family with extra resources that can help the patient and caregivers receive quality care. These disciplines will be used alongside nursing or will be the only discipline in the home to enhance the healing process from an injury, illness or surgery. The physical, occupational and speech therapists work with the patient to help them obtain

mobility once again to the level of the patients comfort. Just as nursing the therapist will develop a plan of care to help regain and maximize independent functioning.

Although, there are many out-patient therapy organizations sometimes being home with familiar surroundings while family members and caregivers can also be involved can help enhance the progress. The therapist will help you after a serious illness, while you are recuperating from surgery or with the management of a chronic condition. Throughout the plan of care process the many or all of the following goals accomplished: learning how to walk safely around your home, assessing any risk to help in preventing falls, completing daily activities with lesser challenges, increasing strength and tolerance for better mobility, creating and individualizing a home exercise program, instructing on how to conserve energy during movements of daily activities, using assistive devices such as walkers, canes, and other apparatuses, and help recommend home leisure modifications to help the patient retain normalcy within the home. At times a therapist such as the speech therapist will assess and submit to the doctor a certain type of specialized testing that may benefit and diagnose of a new challenge the patient may have such as a swallow test. This type of test can be done in the home or at a facility. Such test can prevent future problems and decrease or eliminate hospitalization stay for the patient. Along with this type of test home testing x-rays can also be requested by the nurse or therapist and can be done in the home by a traveling x-ray company. The results are sent to the home health agency and the nurse, and will also be sent to the doctor or medical facility.

The main purpose of home health is to help the patient thrive in their own environment and help them recover from illness and/or injury within the home while decreasing hospital stays for the patient. Per the Statista website (statista.com) the number of home health agencies across the

United States have increased by 12,268 since 1967. With the ever increase amount of seniors that unfolding the number of agencies or you will see an increase in staffing with the current agencies to be able to handle the increase in the number of elderly that will be choosing to have in home care.

Independent & Assisted Living

American are living longer and many do not need twenty four hour care but do desire companionship while growing older due to a loss of spouse, lack of family involvement, or lack of family. There is a choice for the seniors to receive this type of non-medical attention and it can be received in an Independent and Assisted Living facilities. A senior patron is referred to as a resident of the facility and should be ambulatory or self-ambulatory with assistant devices such as canes, walkers, or wheelchairs to be able to live in this type of facility. Some elderly may just need the occasional attention and gives the patient the feeling of security versus the worries of living alone at home such and cues for self-medication and assistance with personal hygiene such as bathing. Not every elderly has an illness or chronic condition that requires medical overseeing, over 8 million elderly Americans receive some level of long-term care (Family Caregiver Alliance) and the number increases yearly. However at times a resident may need medical care and can receive home health from an outside agency in this type of facility due to medical care is not provided by independent or assisted living facility personnel. The only medical assistance giving in these facilities is medication cues, the staff is not allowed to handle the resident medication and are filled and normally dispersed into a medication planner by a family member or friend.

There are many types of services for the elder population that are seeking specialized care for long term and short term care. There are one hundred fifteen plus residential Assisted Living communities in the state of Kentucky according to the Ky.gov website. Many Independent and Assisted Living facilities provide short term respite stay or provide long-term apartment style living.

When looking for a facility that will best suit your loved one, making a visit prior to choosing is the best way to choose to find the best amenities that best suits the process of successful living for your loved one. Along with reviewing the many amenities that facility provides that will be beneficial to your loved one and help them achieve the ease of moving out of their home asking to see the latest state review of the facility can also help you evaluate the overall quality of the facility. Some facilities provide fully furnished apartment or the prospective resident can bring their own belongings to style the apartment and give it a homer feel which helps in the transition of not being in their home. In the state of Kentucky these types of facilities are reviewed by the Department of Aging and Independent Living of Kentucky and they perform these reviews once two years depending on there are not deficiencies in their evaluation.

Many facilities have not only an administrator but a marketer on staff that can answer the questions one may have about the facility and schedule or give an on the spot tour of the facility. Once a facility has been picked the facility will visit the resident in their home to explain the amenities and answer any questions the prospective resident may have. They also assist in the admission process. Along with personal relationships with the resident the market’s job is develops and maintains customer relationships with identified target or geographic target markets, particularly physicians, hospitals, and other markets in the assisted living industry.

Therefore they will be knowledgeable to helping find the facility that will meet the needs of a resident whether it's their facility or another facility.

Many facilities stand out as premier senior living establishment, making the transition from home to a facility much easier for someone needing to make the life changing decision. The best way to look for a facility that is suited best is know the residents budget so that the transition will be stress free when money is the main concern of an elderly resident. Many Independent and Assisted Living facilities are stand-alone facilities however many are in the same complex of a Skilled Nursing Facility. This making a transition much easier for the resident should they need the long-term care facility in the future.

Many facilities rooms are divided into two types of skilled level rooms that will help with daily living needs of those that have challenges of social, personal, and supportive needs Assisted Living and Independent Living that include little to no assistance with help in their daily activities such as dressing, mobility, and personal care. Along with these two many facilities provide different styles of rooms along with a choice of square footage to choose from: Studio Apartment (one room), One Bedroom (two rooms) apartment and a Two Bedroom (three rooms). Many of these rooms come with a continental kitchen that includes microwave and small refrigerator, walk-in closet with shelving, and personal bathroom with showers with handicap equipment for safety. In these facilities safety is of upmost importance so you will find they are equipped Emergency Alert pull cords in the event of an emergency which will alert staff of an emergency are located in the rooms and bathrooms. Most facilities although private and respectful of the resident time spent in their

apartments the staff will provide a two hour check on the resident for safety. This not only helps with safety but also give some socialization to those that chose to stay in their rooms for the majority of their time. Each resident is highly encouraged to decorated as if they never left home with a resident's own furniture. Each resident is encouraged to personalize their apartment as much like home as possible so the transition from home is well accepted with ease and cause less stress in this life changing transition. Many facilities have outside access whether is within the walls of the facility as a court yard type activity area or have small patios off of the apartments giving them more a resemblance of apartment style living. Below are some examples of floor plans for Independent and Assisted Living facilities may have.

These type of facilities help take the stress of bill paying off of the resident and include many amenities in the monthly rent such as water, electric, cable, housekeeping, laundry and three meals provided by the facility. Most facilities have the residents only responsible for private phone service whither in the apartment having a home line or cell phone service. Many facilities the resident do have the capability of doing their own laundry should they chose this helps the resident feel independent, many facilities also provide an ironing board and iron for those that chose to need it.

Along with the superior rooms these facility also provides services for their Assisted Living residents such as bathing, dressing, medication reminders, transferring, toileting, eating (only cutting up food) and grooming. The other amenities to these facilities many furnish in-house therapist or therapy rooms that encourage outside therapy agencies to come in and facilitate to utilize these therapy rooms whether it be an independent physical therapy agency or a home health therapist. As most facilities try and achieve the best amenities for their resident more and more are starting to provide such therapy equipment as exercise bikes and small whirlpools with the guidance of a therapist.

With activities being such a huge role keeping residents active many of the facilities employee an Activities Director. Activities can range from card games, crafts, shopping trips, and other outside activities. The role of the director plays an important role of keeping the resident active which increases mobility, and mental sharpness. The facility supplies each resident with an activity calendar as mandated by the state; however it is to each individual to participate with not judgment passed should they chose not to participate. Many locations now will have a multiple passenger bus/van that is equipped with a wheelchair assessable door on the side for making trips away from the facility more accessible. Every facility is surveyed for any deficiencies in pertaining to facility accommodations and care for the resident every three years by a state auditor. A report of the audit can be found in the front lobby of the facility.

Assisted and Independent living provides three hot meals a day along with fresh snacks. Many have restaurant styled serving of each meal in a localized dining room for all residents to enjoy each other's company or they can be delivered meals to room should the resident request. Facilities will employ kitchen staff along with a head cook that will oversee the nutritional needs of the resident and will plan well thought nutritional meals taking in account several dietary

restrictions. Although, not necessary many facilities now have a restaurant meal type of ordering along with the main meal that has been chosen by the head cook. Residents can take advantage of the menu should they chose to not eat what is on the daily meal plan. Many facilities encourage family and friends to eat with residents however do charge a small fee for the meals.

The biggest challenge of a resident moving to any Independent or Assisted Living facility is the cost of the facility which are mainly private pay facilities for Homestyle living. However many facilities do accept long-term care insurance and work with the Veterans Affairs Aid & Attendance benefit program as we have discussed earlier in this information. The Veterans Affairs Aid & Attendance program provides funding to help with living expenses to veterans, and their spouses, that have served in the military during an active war time however may not cover the entire cost. Other than these programs the government does not provide any other payment assistants for Assisted Living expenses through the Medicare or Medicaid programs. The cost range average for Kentucky Assisted Living Facility room is $3,500 per month which is still much cheaper than neighboring states (assistedliving.com). The best way to choose a facility is for the prospective resident and family members visit several different facilities to compare not only prices for rooms and amenities but also for what the facilities have to offer and make the decision from there. Also seeking out reviews or talking to current residents can also give a clearer picture of what a day at the facility would be like.

Skilled Nursing Facilities

At times in a elder person life respite, in-home care or assisted living style facilities are not an option for the patient due to the need for need twenty four hour skilled care for a chronic illnesses, injury or short-term in facility therapy this where the choice of a Skilled Nursing

Facility would be more beneficial for the patient and caregiver. However this is not were most Americans want to end up in their later years of life but can be the best choice for many. To be considered for a skilled nursing facility the patient can be a transfer from another facility or requires a three day hospitalization. Once moving to the facility the patient is required to have a primary care physician that is located in the county the facility is. At times this is a concern to the resident and the family to have to change physician at the end of life time.

Skilled Nursing facilities can be ran be privately owned or by a management team for a larger corporation. Either of the two have the same rules and regulations that are mandated by the Office of Inspector General. Each facility everyday operations are overseen by an Administrator that is licensed through the Kentucky Board of Licensure for Long-Term Care Administrators. The facility will also have a medical doctor on the board of directors and will also have the duties of being the supervisor of all medical operations and safety given to residents.

The biggest challenge may be to find a facility that is suitable in the area of the resident's family or home and can provide the right care the resident is needing however, sometimes this is not possible or the resident does not wish to move out of town. Many private facilities will limit the type of care they will provide to a patient due the amount of staffing available and cost of specialized care. Making the transition from a hospital stay, and not being able to return home, to a facility can be the have a positive or negative stimuli for an elderly resident and for family members. Not being able to have closure from moving from their own home to a facility can be detrimental emotionally. This can be caused by the lack of education of the different types of care that is provided by a long-term facilities, how daily operation work, or the quickness of needed this type of facility. It is important for the facility to create a great communication line and help families to help them understand the daily routine of care for residents along with

policy and procedures of the skilled nursing facility (BMC Health Services) this can be done during the initial admissions meeting. During this meeting is encouraged if possible the resident attend so that they will have a better understanding of the care they will be receiving and will allow time for any questions they or they family may have upon admittance to the facility.

Many times the main concern in choosing a facility is locality, room availability and design, cost, and safety, and outstanding care for the resident. Choosing a facility based upon privacy design has started to be a big concern as well for families wanting more privacy for their loved one while living in a long-term facility (Calkins & Cassella). It is also a challenge for some facilities trying to make census due not having a particular room styles for a prospective residents along with trying to fill double rooms with same sex resident's or similar health problems rooms. Depending on the design of a private or a semi-private room can determine privacy, dignity issues, infection control, and psychosocial challenges. The diagram provided is a traditional design that an architect may use to design in the building process. They are private, enhanced shared, and traditional shared. A study conducted on the residents having private rooms was what the resident preferred due to more privacy not only to the resident during daily activities but also with visitations with family and friends in a more private setting versus in a shared room area. Other factors that play into the private rooms being more popular are ventilation,

room temperature, room noise with television and radio usage, décor of room (Mosher-Ashley & Lemay). Having private a private room can also give more ownership of the room making the resident more proud of the area and keeping it tidier. Wither a room if private or semi-private a resident should be encourages decorating to have a more home-like atmosphere which can help with the transition and the mental status of the resident when entering the room for the first time.

One way to help the decision of choosing a particular facility can be based on the results of the annual State Survey that is mandated by the Office of Inspector General. Every skilled nursing facility across the state go through a detailed and rigorous three to four day investigation ranging from building safety, to resident safety, resident dignity, and quality of life provided by the care received. The survey time can be normally predicted around the same time each year; the survey team has a nine to fifteen month window to conduct the annual survey. According to the Office of Inspector General handbook the description of the team that may come to a facility can have several different professional disciplines on its team such as social worker, administrators dieticians, physicians to name a few but it will always have at least one professional registered nurse. Having a variety of inspectors on a team can help give an overall rounded survey with the different background knowledge. These surveyors work off a checklist in compliance with federal regulations for long term facilities that include facility safety, nutritional needs, fall risk assessment, flight risk assessment, quality of care, residents dignity and rights being upheld, and nursing and medication care.

The survey team will meet privately with the Administrator and will take a tour of the facility this will help them make initial assessment and observe of the quality of resident care and gives them the opportunity to see what needs to be assessed. With the survey being unannounced as when the team arrives for the survey this will give an average day activity assessment because it

doesn't give the facility time for quick changes. Again this walk through gives the surveyor's an initial glance in how the facility looks on an average day which is an important part of the survey and it also lets all the staff know what will be taking place over the next serval days. If a facility is operated on survey ready basis each day this walk through can give the administrator a piece of mind for a stress free audit. However should the Administrator is doesn't run a tight ship the other three hundred and sixty one days of the year they can be looking at a very stressful week for them and all the managerial staff. These audits can determine the ability for a facility to stay in full operations or shutting the doors for good and having to place all the residents at other facilities. Interviews will also be conducted with a case-mix of residents to get a resident view of the quality of care they are receiving and if they have any concerns that haven't been addressed. Along with resident interviews the team may see it necessary to interview staff to help produce evidence and understanding the type of care a resident may have received and if there where challenges the solutions that were produced to change the inadequate care. Once the survey has been completed an exit interview is conducted with the Administrator on any concerns they surveyor's may have regarding the facility or a resident(s) quality of life. At this time they will be presented with a full a report of any deficiencies that the facility may have, yet the goal is to have zero deficiencies. The Administrator will have the opportunity to respond within ten days after the completion of the survey of the action taken to correct any deficiencies. Once it is sent off a result of clearing of the deficiencies will be sent to the Administrator and possibly a visit from a survey to inspect the corrections. There are times when neglect has been reported to the OIG and a surveyor will come for an audit of that particular complaint. This will last less than a normal audit but can have the same outcome of if neglect is found in the care for the resident.

Many times the complaint is not valid and there are no actions required from the auditor or the facility.

After the survey a full report can be read at the facility and it kept in an area near the front office so that the public can view it at any time. Another way to review a survey for any facility across Kentucky can be found on http://chfs.ky.gov/os/oig/LTCinspectionfindings.htm it will inform of what that overall score. Knowing the survey results is a great way to determine a great choice in facilities for a future care of a prospective resident. However, this great tool isn't well known for the average long term care shopper.

Being on a waiting list can also be frustrating for a loved one that has chosen a particular facility for their loved one. Unfortunately facilities that stay at full capacity do not have the ability to make additions to their facilities when they want. And sometime getting that call is based upon insurance type and the type of care needed. The state regulates the amount of beds that a state can have, this does not mean each facility has the same amount. In order to build or add-on to a facility beds have to become available by the sale or closing of a skilled nursing facility. At that time the state will put of those spots for sale and a facility will purchase them and then will be given the permits to build.

Some facilities will vary on the managerial staff however some will cover two positions. The staff that you will can find in a skilled facility depending on size is Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activities Director, Human Resource, Office Manager, Maintenance Director, Dietary Manager, and a registered Dietician. Depending on the number of beds the facility holds will determine some of the management

positions will require a bachelorette degree in that particular field such as Social Services and Dietary.

The Administrator will oversee the daily operations of the facility on an everyday basis and will always be survey ready. A good Administrator is always looking for ways to improve the quality of care and improving the facility to give an upscale facility that will produce quality of life, provide dignity, and maintain the health of each resident. The Administrator manages the managerial staff, financials of the facility, facilitator of daily Stand Up meetings with all managerial staff on a daily basis, he/she is the main contact person during the annual state survey, and they also participate in the board meetings presenting the financials to the board members. Many Administrators like to have the hands on approach with the residents and their families so that they feel comfortable coming to them with any questions or concerns. The Administrator along with the Director of Nursing will hold monthly employee meetings to announce any updated changes in policies and increase the education of the staff to increase the quality of care each resident.

Director of Nursing also known as the DON has the responsible of overseeing and evaluating each nursing department staff such as: nurses, qualified medication aides, and certified nursing assistances, and are second in command behind the Administrator and stand in their position when they are not available for major decisions concerning the facility. The DON will also maintain a budget for the nursing department, choreograph nursing schedules, resolve any issues or deficiencies in the nursing department according to regulations and company policies, maintain ordering for supplies needed for the daily operations of care. They will also audit daily progress notes on the residents to make sure she/he is aware of any health challenges or repeated challenges are taking place and will devise a plan of correction. Depending on the size of the

facility a DON will have assistance in the average daily workload by an Assisted Director of Nursing (ADON), doing such task as nursing schedules, and quarterly assessments and making updates of Care Plan for each resident and making the shift nurse aware of any changes. An audit of the patient's charts will also be done by the DON or the ADON to help make sure that all current information is given. They also monitor the progress of the residents' health and stay in communication with head shift nurses about any challenges that may arise with a resident on a daily basis. The DON also can have the unfortunate responsibility of testifying in any legality that may arise from accidents resulting in death or personal injury to a patient or staff member. The Director of nursing will also attend quarterly Care Plan meetings with the resident and/or family members.

Social Service Director plays a major role in the resident's life at the facility and is present from the arrival to the facility. This staff member will manage and uphold each resident right's and makes sure that the care given to the resident is the highest standard. Also, their job duties are giving help to the resident and family members in the transition to living in a new surroundings or facility. The transition of change can be the most challenging due to new rules and regulations that are enforced versus the freedoms of living at home. The Social Service Director assesses each patient every ninety days to ensure that the level of care equals the resident's needs of care. Each resident will have a quarterly note given by the Social Service Director and kept in the residents file. In addition to the quarterly progress notes are also recorded when a resident may have a challenge with a solution to correct the challenges a resident may be having with their care or another resident. After the ninety day assessment the director conduct a Quarterly Care Plan Meeting with the Resident, the resident's Power of Attorney and/or family members to communicate the health and future needs of the resident. Notification will be sent to the Power of

Attorney or appointment caregiver before the meeting occurs. All skilled managerial departments will take part of the Care Plan Meeting with the Power of Attorney or caregiver. Encouragment of family participation of these meetings are encourage wither a concern is there or not. It is definitely a time where concerns can be discussed and problems solving happens to ensure the best quality of care. The Social Service Director will meet with families initially and give tours of the facility and answer any questions when trying to decide the best facility for the family member. Social Service position may also handle the initial admittance paperwork for a new resident.

The Social Service Director will also hold monthly Resident Council meetings which gives the residents the chance to voice their concerns with the different departments such as: nursing, dietary, and activities. They have a chance to discuss future activities, discuss special meal planning activities and challenges with meal plans, this also a place to discuss with other residents the same concerns and provide solutions. This gives them the ability to take part in their care and give them a sense of worth. In Resident Council a review of Resident Rights are also gone over during each monthly meeting all the nine subcategories will be reiterated: Right to be fully informed, Right to participate in their own care, Right to make independent choices, Right to privacy and confidentiality, Right to dignity, respect, and freedom, Right to security of possessions, Right during transfers and discharges, Right to complain, Right to visitations. There are particular guidelines and questions with responses that have to be recorded wither they are complaints and solutions or praise for the facility and/or staff these are and kept in a binder that will be presented at the time of the yearly survey. At the time of the yearly survey an impromptu Resident Rights council meeting is held in private with a state auditor, during this time the council president should be present for any questions.

The Social Service Director also works with the resident and/or family to resolve any complaints that may arise during their course of residency at the facility regarding care or safety of the resident. The resident also has the right to seek outside council with any challenges they don't feel have been oppressed by the staff of the facility. A resident or family member can turn to the State Ombudsman, this organization will help resolve complaints and recommend changes in policies and/or systems to improve the residents care (oig.hss.gov). A concerned resident or family member can find posters around the facility with the local Ombudsman contact numbers. The Ombudsman will occasionally visit the facility check on residents and the Social Service Director to see if there are any needs or questions. The Ombudsman will also provide the same type of services to the Social Service Director or other staff members should they have unresolved encounters with a resident that all solutions have not worked. Ombudsman if they see a course of action that requires the OIG to come in and investigate they will make that recommendation to them with the complaint.

Dietary Manager's responsibility is to follow the guidelines of the Dietician for each meal plan for the residents pertaining to their specific nutritional needs stated in the individual Care Plan. Residents that are in long term care are known to have chronic health issues and as a result from difficulties in their level of health can have rapid weight loss or difficulty maintaining a healthy weight. Weights are assessed once a week and reported to the Dietary Manager and recorded in the residents file. In some larger facilities they will hire Registered Dieticians in a full time capacity and they will hold the Dietary Managers position or in smaller facilities this position will be subcontract out and work only part time.. A facility can chose from many state approved companies to get its meal plans from that will give specific meal plans that are state mandated for proper nutritional value for the average skilled nursing resident. Monthly meal plans are

displayed in the facility to be viewed by staff, residents, and family according to the Office of Inspector General guidelines. The Dietary Manager is responsible for all scheduling, and overseeing all kitchen staff and giving yearly staff evaluations. They also manage and order all food supplies for meal planning. They also are in charge of monitoring any expirations of food products wither in freezer or food storage room. Many times the Dietary Manager will participate in cooking and serving meals to residents. Dietary Manager will also take part in the Quarterly Care Plan meetings with families to answer any concerns they may have regarding food preparation, weight gain or loss, and future nutritional needs that will enhance the care process for the resident that will give them the best quality of life during their stay at a facility.

Activities Directors plan and provides activities to the residents enhance socialization provide entertainment, and increase mobility, socialization, and though processing through many types of craft projects, music, and games. The director is responsible for designing and displaying monthly activity calendars in each resident's room and in any localized meeting areas. They are also in touch with community organizations and plan varies activities provided volunteer hours within the facility whether being they provide musical entertainment, crafts, or socialization. Activity Director also monitors the weekly activity levels of each resident and at time produce private activities for patient that are unable to move freely in the facility. The Activity Director takes part in the quarterly Care Plan meetings and does quarterly progress note submission and/or when needed when challenges occur. They will also do quarterly interviews with residents to see what type of activities they would like to do in the future.

The Maintenance manager plays a major role in the safety of not only the residents but also the staff and visitors. They are required to hold monthly fire drills and semi-annual tornado drills. All which are recorded with the participant's names and house in the yearly survey book that will

be provided to the auditors. During the audit the maintenance manager will meet individually with an state auditor and while he goes over the facility due the restriction of access to many rooms in the facility. The maintenance manager is also responsible for maintaining any repair to outside and inside the facility. Once a resident moves out they will restore the room back to standards of move in ready through patching holes, and painting.

Other staff members that have a more hands on care of the residents is the Head Shift Nurse, Certified Nursing Assistance, Certified Medicine Aides, Physical Therapist, Occupational Therapist, and Speech Therapist, Dietary Aides, and Housekeeping. All personnel play a major role in the resident's daily activity and care and enhancing their quality of life while at the facility. The Head Shift Nurse, Certified Nursing Aides, and Certified Medicine Aides keep progress notes on a daily shift basis on each resident, this mandated by state regulations. Health records help maintain the health of the patient and will also help indicate any health changes and concerns that may arise whether, the challenge of the patient is psychological or physical. They will record daily fluid and food intake and outtake, bathing schedule and personal care, emotional state of resident, and will make the shift nurse aware of any changes in the resident health. The DON, Social Worker, and Head Shift Nurse monitor these records and it will help each position determine what course of care can ensure the best quality of care for the resident. Daily recording of health changes also help the registered dietician determine the best nutritional plan for a resident and will also help explain fluctuations in the residents weight. Some facilities will provide therapy to home style short term care while having a fully equipped therapy room within the facility making the availability more accessible for those that cannot travel to an outside facility. When choosing a facility it is best to talk with families that have received care from the facility and understand what daily living is like for a resident. Many facilities goal is to

produce the type of care they would want for their families because when caring for residents they become like family to the caregivers of the facilities.

Palliative Care

No one wants to think of end of life care however palliative care can be the instrument that helps when searching for a long term facility. It is a very real aspect of the care process with every long term skilled nursing resident. However it is a great way to choose the best facility for your loved one. The end of life palliative care according to the Get Palliative Care website is described as care that is "focused on providing relief from symptoms and stress of serious illness. This type of care however can be administered to any age due to serious illness that does not have a curative treatment plan". The care at this time is not just for the resident but also helps the family understand the process of dying and helps counsel them during this difficult time seeing their loved in a state one never wants to imagine. With the normal ratio of one staff nurse to twenty four resident's facilities that do not take on help such as Hospice can see greater number of residents that do not receive antiquate attention in these cases. Facilities that do team up with Hospice see improvements on pain control, reduction of hospitalization, reduction tube feedings if used by the facility (JAMA, 2000). However many small facilities will not incorporate Hospice due to a smaller ratio of nurse versus residents and feel that it is unnecessary. It also can affect the financials of the facility due to have several patients at one time on palliative care. And even though this sound inadequate of a facility it is a business and that to make sure they can afford the best quality care for their residents. In smaller facilities the ratio is lessen and the attention of care given to the patient is greater. With the staff becoming more like family to the residents all the staff understand the need for attention for a palliative care patient and all pitch in to help the nurse be aware of any type of care that is needed.

Hospice Care

Although the end of life is a difficult subject for some to discuss the root of the word Hospice means hospitality and is referred to as a place of shelter and rest for the weary according to the National Hospice and Palliative Care Organization. Hospice is a type of care that focuses instead on a cure for an illness they offer support in making the patient comfortable and assist in lessening the pain, while supporting family and loved ones of the patients. Hospice staff provide skilled nursing, counseling, and Chaplin support twenty four hours a day during the course of an chronic illness. Patient will receive high quality care from skilled nurses, home health aides, certified social workers, and Chaplin's, therapist such as speech, physical and occupation when needed to help with palliative care for those with chronic illness in hopes of giving them the most comfortable surrounding during the end of life process. Hospices also have skilled volunteers that can help with light housekeeping, running errands, personal, can sitting to give caretakers a much needed rest or time to run errands. Although, Hospice has been around for almost seventy years giving care Medicare reimbursement for care was introduced in 1983 (NHPCO). However, just like a long term care facility Hospice follows the guidelines of the federal government to be able to receive Medicare payment.

Many Hospices organizations goals are to help the patient reside in a comfortable surrounding that will help increase the patient mental stability during this trying time. They will respect the decision of palliative care and DNR (do not resuscitate) wishes on behalf of the patient although proper paper work is required for the DNR request. In addition to caring for the patient, hospice also will focus on helping the family through the end of life process and afterwards through grief support counseling. They also provide tools to help the caregiver or families talk with the patient on their desires of the end of life process such as funeral arrangements and burial. These types of

tools will help equip the families as the time draws to the end of patient's life. It confirms and keeps the family focused and helps them stay in agreement with what the patient values and wishes are when they are unable to respond with this type of advance care type of planning. This helps prevent the "do whatever you can" mentality of those being left behind (Travis, Bernard, Dixon, McAuley, Loving, McClanahan). This also helps plan the type of treatment plan once the patient receives hospice care when there is a nonverbal or a deficit in the cognitive level due to illness or medication.. It also gives the patient the time to explain to the caregiver and/or family their earnest personal wishes for what they want for care and what is to follow once they expire.

Many types of hospice organizations will provide a variety of types of care for patients such as: in the home, inpatient in nursing homes, assisted living facilities, inpatient in Hospice owned hospital facilities. The following chart statists provided on the website of National Hospice and Palliative Care Organization shows the results of what the locations where death occurs in the United States. Hospice show that that majority of patient end of life process happens at home however it also shows other types of facilities that hospice can provide care.

Location of Death	2014	2013
Patient's Place of Residence	58.9%	66.6%
Private Residence	35.7%	41.7%
Nursing Home	14.5%	17.9%
Residential Facility	8.7%	7.0%
Hospice Inpatient Facility	31.8%	26.4%
Acute Care Hospital	9.3%	7.0%

In the hills of Western Kentucky Union, Webster, and Henderson counties have the availability of the Lucy Smith King Care Center located at Methodist Hospital in Henderson, Ky. This facility produces state of the art care for inpatient care for the end of life process. These types of

in-patient facilities provides twenty four hour nursing care with a hospital type amenities in addition to caring for the family during this process of care for the patient.

Hospice organizations such as St. Anthony's Hospice, much like Home Health, will receive referrals from the patient primary care physician. There are instances where a patient is receiving home health and more palliative care is requires and the physician will refer to a hospice organization diminishing the need of care for the home health agency. Once the referral is submitted hospice will see a prospective patient within the first forty-eight hours of the referral however on occasion when urgency is needed it will be a same day admission. During the course of care the hospice nurse will work with the primary care physician on a care plan to help the patient have successful comfort during their course their chronic (chronic meaning long term) illness. The main focus of the hospice team is managing the pain and symptoms of the patient. Along with emotional and psychosocial support and spiritual aspects of dying the team will also provide medications, medical supplies, and equipment.

Much of what hospice organizations are giving emotional support to those that are caring for the loved ones and caregivers. They will focus on helping the families or caregivers understand the end of life process and will help educate them on how to take care of the patient in their absences. Bereavement support is a huge part of the hospice care program. This helps those left behind cope with the end of life process and the grieving that comes after. According to the local St. Anthony's hospice that is connected with the Lucy King Smith facility has several programs

to help with grieving. They have annual children, teen and adult bereavement camps each year. They also provide a special type of grief counseling for children K-12 in an environment that is safe and comfortable to the child. They will follow up with calls and sometimes visits to the home of the loved one or caregivers to offer support during the grieving process.

Conclusion

As the population rises in the United States so does the need for health care for the elderly. Many times a patient is faced with an injury that they cannot recover from, or a chronic illness that is will not change in status. Where do you turn who do you look to for advice. With the use of the internet growing stronger each day many can make a valuable decision of where to turn to for the type of care needed of their loved one. Studying the options of respite care, home based primary care, home health, independent and assisted living facility, short term and long term skilled nursing facility, palliative care, and hospice care can help a family member make an informed decision on what needs to be done next. Although there are situations with a patient health that the order of care can be disfigured due to an emergency change in health such as cancer, strokes, injuries obtained from falls, and change in cognitive status due. And sometimes it is simply as a spouse dying.

Whatever the changes are in a senior's life it can be detrimental to not only them but also the family and caregiver. Everyone wants to be able to stay in their home through the course of their lifetime however sometimes this is not the best choice for the patient to receive the quality care they may need to sustain their health at a level they are comfortable with.

As the need for health care outside of hospitalizations increase the government also plays a major in financing the proper care for the current seniors and those that are close to bridging the

gap from their early healthier years. The information provided is in hope that one can make an inform decision and decrease the stress of decision making with knowledge of insurance, additional payer sources, and the choice of care that will benefit the patient the most. Happy hunting.

References

Bell MMS, MSc.Susan. Vasilevskis MD MPH, Eduard. Saraf MPH.Avantika, Jacobsen BA. JML. Kripalani MD Msc. Sunil. Mison MD MS MSPH, Amanda. Schnelle PhD, John. Simmons PhD, Sandra. (2016) Journal American Geriatric Society: *Geriatric syndromes in Hospitalized Older Adults Discharged to Skilled Nursing Facilities.*

Toles, Mark. Colone-Emeric, Cathleen. Naylor, Mary. Barroso, Julie. Anderson Ann. (May 2016) BMC Health Services Research: *Transitional care in skilled nursing facilities: a multiple case study.* Pulbished online 17.doi: 10.1186/s 12913-016-1427-1

Jongsma, Karin. Van deVathrost, Susanne. (October 12, 2015) Beyond competence: *advance directives in dementia research* (ch 33: pgs 167-180)

Vandepitte, Sophie. Van Den Noortgate, Nele. Putman, Koen. Varhaeghe, Sofie. Annemans, Lieven. (2016) BMC Geriatrics*: Effectiveness and cost-effectiveness of an in-home respite cre program in supporting informal caregivers of people with dementia: design of a comparative study.* (16:207)

Berglund, Dr. Anna-Lena. Johansson, Dr. Inger. (2012) *Family caregiver' daily life caring for a spouse and utilizing respite care in the community.* VARD/NORMDEN 1/2013. Publ. No. 107 Vol. 33 No. 1 PP 30-34.

www.oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/directors.pdf (April 17,2013) Department of Health and Human Services.

www.aarp.org/health/health-insurance/info-06-2012 Education & Outreach (May 2016) Understanding Long-Term Care Insurance.

www.americanvetranaid.com Benefits

www.kiplinger.com/article.../T039-C001-S001-comparing-medigap-policy-costs.html.

www.huffingtonpost.com (June 09,2013) *How to choose a Medigap supplemental policy.*

www.ssa.gov Social Security Retirement Planner: Applying for Medicare Only

Department of Health and Human Services Office of Inspector General (December 2012) *Home and Community Based Services In Assisted Living Facilities.*

Hong, Ji Hyung, Kwon, Jung Hye. Kim II, Kyu. Ko, Jin Hee. Kang, Yi-Jin. Kim, Hoon-Kyo. (2016) Cancer Res Treat: *adopting advance directives reinforces patient participation in end-of-life care discussion*. 48(2): 753-758.

Malito, Alessandra (May 13, 2017) MarketWatch: *America will soon be overrun by senior citizens. Yes, that includes you.*

www.careinginfo.org Kentucky Living Will Directive Planning for important Health Care Decisions

www.census.gov Economics and Statics Administration: (March 27, 2017) Profile America facts for features.

Calkins PhD, Margaret. Cassella, Christine. (2007) The Gerontologist: *Exploring the Cost and Value of Private Versus Shared Bedrooms in Nursing Homes.* Vol 47 No. 2 pg 169-183.

www.MD2U.com

www.nationalhospiceadpalliativecareorganizationhospice.org