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Editor’s Note

Baby Boomers, among which many of us count ourselves, are moving inexorably toward senior citizen status. Many of us are also children of elderly parents. At JNLCP, we felt that it would be a good idea to explore some of the issues we face as Life Care Planners as we address this growing population.

In this issue you will find a fine overview of the geriatric population in the United States, the differences between geriatric medicine and other medical specialties, specialists and their scopes of practice, applicable nursing diagnoses, and extensive references. This article gives you information you can use immediately in the life care plan of any client who is expected to achieve old age.

Funding is always an issue in life care planning. We also have two articles to help you help your clients - or your parents, or yourselves with advance planning needs for long-term care situations.

This issue also includes a review of an updated classics, which includes material on elder LCP and without which your bookshelf is incomplete. What are your favorites?

We want you!
As the life care planning profession continues to evolve, we must all be prepared to evolve and grow with it. Come to the annual conference in my home area of Boston MA in October. Speak your mind, meet new colleagues, get energized. You never know where it will lead you, or where you can lead us!

Increased visibility for JNLCP
Finally, I am very pleased to update you all that the JNLCP has contracted for inclusion in the excellent Cumulative Index of Nursing and Allied Health Literature, CINAHL, as mentioned in the last issue.

Cordially,

Wendie Howland
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The American Association of Nurse Life Care Planners (AANLCP) promotes the unique qualities the Registered Nurse delivers to the Life Care Planning process. We support education, research, and standards related to the practice of Nurse Life Care Planning.
Information for Authors

AANLCP invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning within the medical-legal community. Submitted material must be original. Manuscripts and queries may be addressed to the Editorial Committee. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

Text

Manuscript length: 1500 – 3000 words

- Use Word® format only (.doc)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Set 1-inch margins
- Use Times, Times New Roman, or Arial font, 12 point
- Use double-spacing, using the Word formatting feature
- Place author name, contact information, and article title on a separate title page, so author name can be blinded for editorial review
- Use APA style (Publication Manual of the American Psychological Association)

Art and Figures

All photos, figures, and artwork should be in TIFF, EPS, or JPG format. Line art should have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.

Each table, figure, photo, or art should be on a separate page, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2003)

Editing and Permissions

The author must accompany the submission with written release from:

- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.
- All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission.
- The author, not the Journal, is responsible for the views and conclusions of a published manuscript.
- Submit your article as an email attachment, with document title article name.doc, e.g., wheelchairs.doc

All manuscripts published become the property of the Journal. Manuscripts not published will be returned to the author. Queries may be addressed to the care of the Editor at: whowland@howlandhealthconsulting.com

Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and the nursing profession. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

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Contributing To this Issue

Christine Vermillion, MSN, RN, CNS (“Life Care Planning and Case Management for the Elderly: Introduction to Geriatric Medicine and Geriatric Specialists”) has worked extensively with geriatric patients in acute and long term care, and provided nursing consultation for complex geriatric patients in specialty areas including critical care, orthopedics, neurology, and diabetes. She has a special interest in the management of geriatric patients in transition from critical care to acute care, acute care to skilled/long term care, and acute care to the community. Ms. Vermillion has conducted nursing research describing operating room-acquired pressure ulcers with published findings. Ms. Vermillion is owner of RNViewpoint Legal Nurse Consultation Services and specializes in geriatric and pressure ulcer cases. She can be contacted at ccvermill@yahoo.com

Douglas Jones (“Legal Issues in Elder Care”) is one of the founders and a principal shareholder in The Elder Law Practice of Douglas R. Jones & Cynthia Orlick Jones. Mr. Jones graduated with honors from Arkansas State University in Jonesboro, earning a degree in Business Management. He then received his Masters of Business Administration (MBA) degree from the University of Colorado at Boulder, where he also graduated with honors. Mr. Jones received his Juris Doctor degree from the University of Arkansas at Little Rock. He is a member of the American Bar Association, the Arkansas Bar Association, the Lonoke County Bar Association, the National Association of Elder Law Attorneys and Wealth Counsel (a national association of Estate Planning Attorneys). He has been a frequent lecturer in business and trust law at colleges and universities. Mr. Jones has been in the private practice of law since 1985.

Darryl Hicks (“Reverse Mortgage Overview”) is Editor of the Reverse Mortgage Advisor newsletter published quarterly by the National Reverse Mortgage Lenders Association, www.reversemortgage.org
Letters to the Editor

Amputations

I would like to say the journal (Vol. IX, no. 4, Amputation) is very well done. I have printed it out for additional reference. We plan to print out a copy of the newsletters for amputation, put them in a binder, and append cards or a tear-off tab sheet for our clients to download their own copies.

I would like to submit information about an amputation surgery that we promote that is extremely beneficial for amputees. For information about the procedure, please visit www.ertlreconstruction.com

Eva J Hughes, Executive Director
The Barr Foundation
Boca Raton, FL 33432

Life Care Planning Resources

We have had two completed book reviews and we are pleased that people have noticed the major updates, added content (now almost 1,000 pages), and changes in authors. You probably know that Shelene (Shelene Giles RN BSN BA MS CRC CNLCP MSCC, Past President, AANLCP) helped add CNLCP info to the role of nurses chapter. With the Guide to Rehab being out of print, this edition (in my biased opinion) seems to be the best contemporary resource - but I will look forward to your review.

Roger O. Weed, Ph.D., CRC, LPC, CCM, CDMS, FNRCA, FIALCP

As nurses we thank Dr. Weed for his interest and outstanding contributions to the field of life care planning and particularly for his development of the problem-oriented medical record (POMR) and SOAP notes, which all nurses remember from our basic education. The review of the latest edition of the Life Care Planning and Case Management Handbook by Weed and Berens appears on page 242.

-Ed.

Errata

The following additions to the Amputation issue were received from the Barr Foundation after we went to press:

Page 70 "Books" under "Whole Again" added website link, www.oandp.com/barr

Page 174 The Barr Foundation, add www.oandp.com/barr

Page 174 Second last entry "Barr/United Amputee..." should read The Barr Foundation Amputee Assistance Fund

Page 165 Barr/United Amputee..." should read The Barr Foundation Amputee Assistance Fund and phone number to read 561-391-7601

Letters on any topic are welcome and may be sent to the Editor at whowland@howlandhealthconsulting.com. Letters may be edited for brevity.
Life Care Planning and Case Management for the Elderly: Introduction to Geriatric Medicine and Geriatric Specialists

Christine Vermillion MSN RN CNS

As America grays, Life Care Planners and Case Management nurses find themselves serving an ever-aging clientele. Caseloads include more of the over-65 elderly as well as a growing number those over 85, the “old-old.” But the elderly are not simply adults with more chronological years under their belts.

Aging is accompanied by physiologic changes, new developmental tasks and different family and social dynamics.

However, unique needs of the geriatric population often go unaddressed. Disease in the elderly frequently presents with vague symptoms overlooked by medical practitioners untrained in geriatrics. Treatment may not be tailored to accommodate physical, psychological and social needs resulting in suboptimal outcomes.

Nurse Life Care Planners and Case Managers must be versed in geriatric medicine in order to construct Life Care Plans that successfully accommodate needs of elderly clients. They must be prepared to identify cases that would benefit from specialized geriatric assessment and be able to identify the type of geriatric specialist best suited to meet that need.

Literature assisting Life Care Planners in this process is in short supply. The purpose of this article is to present basic principles of geriatric medicine and discuss use of geriatric specialists in the life care planning process.

Who are the elderly?

In 2009 over one in every eight, or 12.8%, of the American population was 65 years or older. (AOA) While most geriatric literature begins with statistics citing the number of elderly living with multiple chronic conditions and occupying a growing number of nursing home beds, geriatric specialists note that institutionalized elderly comprise only 5% of this population. Indeed, 95% of seniors aged 65 and older live independently within the community. (Bickley and Szilagyi, 2009) Fewer than 10% of these community-dwelling elders need assistance with one or more self-care activities. Of people aged 85 and older, one half of women and two thirds of men live at home without assistance. (Beers and

Christine Vermillion, MSN, RN, CNS is owner of RNViewpoint Legal Nurse Consultation Services and specializes in geriatric and pressure ulcer cases. She can be contacted at ccvermill@yahoo.com
Jones, 2006) Overall, America’s elderly population maintains a remarkable degree of independence despite existing chronic medical conditions.

What is normal aging?
Normal aging is characterized by a decline in body systems functioning with a corresponding decrease in physiological reserves. As a result, the elderly are more vulnerable to disease and medical complications, but disease itself is never considered part of normal aging. For example, a decrease in renal sufficiency is part of aging, but renal failure as a diagnosis is not. Life Care Planners and Case Managers should become familiar with these changes so that variations of aging are not mistaken for signs of disease. Comprehensive listings of physical changes of aging are available in most medical and nursing texts dealing with geriatrics. (Bickley and Szilagyi, 2009) (Hazzard, Blass, Halter and Ouslander, 2003)

Virtually every body system is affected by aging. Most systems function less efficiently. Loss of physical reserves extends recovery time and reduces the body’s ability to compensate for illness or increased physiologic demands. Illnesses may accumulate in number and severity. This physiologic decline plus disease results in excess morbidity and disability. (Weed, 2004)

What is Geriatric Medicine?
Geriatrics is a field of internal medicine that specializes in medical needs of the elderly. But geriatric medicine extends beyond disease, diagnosis and treatment of medical conditions. Geriatric practitioners assess the impact of illness on the elder’s ability to function within his/her living situation. (Hazzard, Blass, Halter, and Ouslander, 2003) An interdisciplinary approach to geriatrics is essential with core members representing medical physicians, psychiatry, nursing, social worker, physical/occupational/speech therapy, and nutrition.

Geriatric medicine encompasses the physiology of aging, illnesses common among older persons, atypical presentations of illnesses in older adults, functional assessment of older people, treatment and management of older adults in acute care, long-term care, community-based, and home-care settings.

Two features set geriatric medicine apart from other medical specialties:

1. Function is central

The hallmark of geriatric medicine is its emphasis on functional ability. (Hazzard, Blass, Halter and Ouslander, 2003) Geriatric medicine incorporates thorough assessment of basic and instrumental activities of daily living as well as evaluation of family, social, economic, and environmental factors. The aim of geriatric medicine is to achieve the greatest level of patient function with the goal of returning the elder to the highest possible degree of independence.

continued next page
Geriatric medicine strives to keep elderly clients in a non-institutionalized community setting whenever possible.

2. Geriatric syndromes
Geriatric medicine includes assessment and treatment of specific functionally based symptom clusters common in the elderly known as geriatric syndromes. (Bickley, and Szilagyi, 2009) Geriatric syndromes include incontinence, falls, fractures, instability, weakness, fatigue, dizziness, pain, cognitive impairment, depression, delirium, and medication management. (Bickley and Szilagyi, 2009) (See Table 1)

Geriatric syndrome symptoms are often overlooked by general practitioners. Many times patients do not report symptoms thinking they are part of “old age” or not relevant to medical care. This is especially true for symptoms that are embarrassing, such as urinary leaking or sexual problems. Elders may also fail to connect vague symptoms such as a “little” forgetfulness or lack of energy with an illness. Geriatric practitioners address these syndromes by asking direct questions during history taking. (Rodgers, 2008; Scanland and Stucki, 2005)

Life Care Planning for the Elderly
Nurses working with elderly clients most often prepare plans for long-term care planning, family education, and as resources for case managers. (Weed, 2004) Geriatric Life Care Planning for litigation purposes is infrequent. Perhaps the most prevalent injuries indicating Life Care Planning are fractures sustained from falls. (Beers and Jones, 2006) Other common injuries result from an exacerbation of chronic health problems and complications due to pre-existing diseases, such as a foot ulcer with diabetes. Regardless of injury, clients over 65 will most likely have multiple chronic conditions, take multiple prescription meds and have functional deficits.

The foundation of Life Care Planning is a comprehensive client assessment. Medical records are a primary data source, but may prove inadequate for geriatric clients. Medical internists and practitioners without geriatric training often neglect critical components of geriatric assessment so that the resulting plan fails to fully address the elder’s needs or include geriatric-based plans.

continued next page

Table 1. Examples of geriatric syndromes with associated nursing diagnoses

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Nursing Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence</td>
<td>Impaired urinary elimination.</td>
</tr>
<tr>
<td></td>
<td>Stress urinary incontinence.</td>
</tr>
<tr>
<td></td>
<td>Functional urinary incontinence.</td>
</tr>
<tr>
<td></td>
<td>Urinary retention.</td>
</tr>
<tr>
<td></td>
<td>Bowel incontinence.</td>
</tr>
<tr>
<td></td>
<td>Constipation.</td>
</tr>
<tr>
<td></td>
<td>Diarrhea.</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Activity intolerance.</td>
</tr>
<tr>
<td></td>
<td>Fatigue.</td>
</tr>
<tr>
<td></td>
<td>Impaired physical mobility.</td>
</tr>
<tr>
<td></td>
<td>Bathing/dressing/feeding/toileting self-care deficit.</td>
</tr>
<tr>
<td></td>
<td>Risk for disuse syndrome.</td>
</tr>
</tbody>
</table>
For this reason, geriatric specialists are most useful in the assessment phase of Life Care Planning, and nurse planners and case managers need to assure that use of geriatric practitioners has been considered.

**Geriatric Specialists**

Geriatric specialists can be found in private practice or as part of a Geriatric Assessment Team. Teams are generally located in university hospital settings with geriatric residency programs and are multidisciplinary in nature. Most assessments take place medical offices and inpatient units over multiple visits.

A comprehensive outline for geriatric assessment may be found at [ocw.tufts.edu/data/42/499797.pdf](ocw.tufts.edu/data/42/499797.pdf) (2004)

Assessment findings provide Life Care Planners with a solid basis for plan development as well as a reference for families. (Weed, 2004) This section addresses contributions of the geriatrician and geriatric psychiatrist, although other disciplines are an active part of the assessment process.

**Geriatrician**

Geriatricians are primary care physicians who are board-certified in either family medicine or internal medicine and have completed the additional training necessary to become board certified in geriatric medicine. A geriatrician’s assessment will provide a Life Care Planner with the comprehensive information needed to plan care best suited to the elderly client’s current and future needs. Unique features of the geriatrician’s assessment should include:

- Extensive history with direct attention to geriatric syndromes
- Physical examination based on geriatric physiology and atypical disease presentation recognizing that medical problems may present differently in the elderly. For example, presenting symptoms of an MI may be confusion and a general “unwell” feeling rather than acute chest pain, or chest pain may not be as severe as with younger adults.

*continued next page*

### Table 2. Activities of Daily Living Functional Categories

<table>
<thead>
<tr>
<th>Basic ADLs (BADLs)</th>
<th>Basic self-care</th>
<th>Feeding, bathing, toileting, grooming, ambulation, dressing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental ADLs (IADLs)</td>
<td>Activities to maintain independent household</td>
<td>Cleaning, shopping, laundry, meal preparation, telephone use, driving or taking transportation, medication management, financial management</td>
</tr>
<tr>
<td>Advanced ADLs (AADLs)</td>
<td>Roles that give meaning to life</td>
<td>Family, social and community roles, recreation</td>
</tr>
</tbody>
</table>
Detailed assessment of functional status (Table 2):

- **Basic ADLs (BADLs):** activities of daily living
- **ADLs:** Instrumental activities of daily living
- **AADLs:** advanced activities of daily living  
  (Hazzard, Blass, Halter and Ouslander, 2003)  
  (Jefferson, Paul, Ozonoff and Cohen 2006)

Use of standardized assessment tools that are sensitive to the geriatric patient, such as the **Mini-Mental State Examination,**  
**Geriatric Depression Scale,** and the **Ten Minute Screen for Geriatric Conditions.** The **US Preventative Services Taskforce Checklist of Assessment Areas For Maintaining Healthy Geriatric Patients** outlines a number of useful screening tools. (Miller, Zylstra, and Standridge, 2000)

- In-depth psychosocial and cognitive assessment
- Interview with family and significant others whenever possible for first-hand observations and essential details

Assessments are conducted in an office setting whenever possible to minimize distractions and allow adequate time for an elderly client to respond.

---

**Geriatric Psychiatrist**

Geriatric psychiatrists have an additional 1-3 years of training in geriatrics. They evaluate mental, emotional and behavioral symptoms in the elderly and are an integral part of management of dementia, depression, behavior problems. A geropsychiatric evaluation is generally conducted in an outpatient setting. Unique features of the geriatric psychiatry assessment include:

- Cognitive assessment including perception, attention, memory, reasoning, decision-making and problem solving
- Assessment of depression, anxiety, cognitive impairment, mood disorders and substance abuse.
- General medical practitioners frequently fail to diagnose geriatric depression which is especially alarming because rate of suicide is highest among older adults compared to any other age group, and rates for persons 85 years and older is twice the overall national rate. (AAGP 2004)

- Differentiating dementia from delirium, often medication-related or in response to change in medical condition or an acute episode
- Evaluating medication regimens to identify adverse reactions, medication interactions, often recommending changes in medication or dosage
- Evaluating and making recommendations for care for behavioral or psychotic symptoms

*continued next page*
such as hallucinations, agitation, yelling, etc. These may appear with delirium or in late stages of neurologic illnesses such as Parkinson’s disease, Alzheimer’s disease, or other dementias.

Geriatric Nurse Practitioners and Social Workers

These geriatric specialists are most useful in Life Care Plan implementation. Geriatric Nurse Practitioners provide geriatric assessment and, with prescriptive privileges, also serve as primary care providers. Geriatric Social Workers evaluate family and other support systems, provide counseling, and secure agency and community health assistive services. Social Workers also provide ongoing assessment and monitoring, changing the plan when client status changes.

Preparing the Life Care Plan

The Life Care Plan serves as a written resource and guide for caregivers, client, and family. Therefore, organization is key if the Life Care Plan is to function successfully. Multiple activity lists lead to an uncoordinated task-oriented approach and can make evaluating effectiveness difficult.

Nursing diagnosis provides a well-organized structure for Life Care Planning. Because nursing diagnosis, geriatric medicine, and geriatric syndromes are all functionally based, they can be readily combined to produce understandable planning documents that integrate nursing and medical aspects. (Herdman, 2009)

Summary

Geriatrics is a relatively new and growing field attracting the attention of many different disciplines. Geriatric specialists with expertise in the particular needs of this population will become increasingly valuable as this market segment grows. Life Care Planners and Case Managers will benefit by seeking out specialists with expertise in geriatric medicine and management to consult on elder Life Care Plans.

References


This classic life care planning reference has undergone revision since its last edition in 2001, with materials from new and familiar authors. The Nurse Life Care Planner will find useful updates in every section. Nurse Life Care Planners may appreciate entirely new, though abbreviated, material on Nurse Life Care Planning in the introductory section, “Life Care Planning: Past, Present, and Future,” and “The Role of the Nurse Case Manager in LCP,” written with contributions from Shelene Giles, AANLCP past president.

The first section, “The Role of the Life Care Team Members,” gives brief overviews of various specialties consulted in Life Care Planning. This roster includes physiatry, nurse case management, vocational rehabilitation, psychology and neuropsychology, occupational therapy, physical therapy, speech-language pathology, audiology, and economist.

Novice and seasoned Nurse Life Care Planners will appreciate the detailed insights these sections offer when including plan recommendations for collaboration. The extensive appendices in each chapter have been updated with information on new technologies, vendors, legal concepts, certifications, and support resources for Life Care Planners and clients. This reviewer hopes the next edition will list the Nurse Life Care Planner in this section, with expanded content on Nurse Life Care Planning and the nursing process, for the benefit of life care planners from other basic disciplines.

Section II, “Selected Disabilities: Topics and Issues” addresses the same ten selected conditions as the 2nd edition: amputation, brain injury, burns, HIV/AIDS, mental health, chronic pain, SCI, organ transplant, visual impairment, and elder care, each with additional material comprising recent references, statistics, costs, and resources. The table of contents at the beginning of each chapter is a helpful feature. Each also includes an abbreviated and easy-to-scan sample life care plan, especially useful to the beginning case manager or life care planner.

Section III, “Forensic Considerations,” has been expanded by the addition of two sections. “Life Care Planning and the Elder Law Attorney” includes a matrix for all parties’ participation in an elder plan. A case study rounds out the chapter’s material on financial planning, addressing financing one partner’s nursing home care,

continued page 248
One of my goals as an elder law attorney is to get to know your profession a little better. My purpose for doing so is to be able to know enough about what you do so I can spot the situations where our clients need your help. I hope this article will give you information so you can determine where your clients need our help.

The Roller Coaster
As elder law attorneys, we meet with clients on a daily basis who are on an emotional roller coaster. Life was going merrily along for them, then all of a sudden they received some bad news: a parent is in the hospital. After a few days, the news is worse. The diagnosis is Alzheimer’s, which means discharge to a skilled nursing facility. On fairly short notice (sometimes within 24 hours) the kids have to select a nursing home.

If the other parent is alive and living at home, no doubt all of this will hit like a freight train. Will he or she still be able to live at home alone without assistance, or not? If assistance is needed, what type?

If the parent is single, some of the questions are: What do we do with the home? Will discharge home ever be possible? Should we sell the home? Where are the bank accounts? Are all bills paid? How will we pay for all of this?

We realize that when adult children walk into our office, they are reeling from all the above and more. This is where we try to slow down the process, take them by the hand and help.

I personally did not realize the need for a little hand-holding until I experienced the trauma of a parent with health challenges. My Mom had an unexpected (at least, to me) stroke after valve replacement surgery. The doctor told her that without this surgery she was at high risk for heart attack or stroke. She told me that if she had a heart attack and died, that would be OK, but she did not want to have a stroke. At age 85, she was in good health, living alone, driving to the grocery store and church, and enjoying life. So at the advice of doctors, she risked the surgery. She made it through the surgery and after a 3-week hospital stay, went home. A week later, she had her stroke.

Doug Jones is an attorney in Arkansas where his firm specializes in elder issues. He can be reached at Elder Law Practice of Douglas R. Jones and Cynthia Orticek Jones, 200 N. Jackson Cabot AR 72023, 501-843-9014, doug@arkelderlaw.com.
After her stroke, it was impossible for her to live at home, so we had two years of nursing homes, hospitals, and, ultimately, hospice before her death. I knew a lot about practicing law before this time, but knew nothing about all the many day-to-day things that needed to be done to take care of my Mom. I had to learn the hard way about all sorts of things to make sure Mom got the best possible care.

**Gap Between Legal and Healthcare Issues**
Like many others before me, I had fallen into the gap between legal issues and health care issues. It seemed that no person or entity was filling the gap. It was just there. Lawyers would help families sort through the legalities, then wish them the best of luck on the health care side. Health care providers would do just the same thing from their end. Families were left to figure out how to navigate the great gap in between.

About this time, I found that a few cutting-edge elder law attorneys were recognizing this dilemma and were facing it head on in their law practices. They hired nurse life care planners, who worked directly with families to help with critical life care decisions. They would take the families by the hand and walk with them through the gap. Our firm started working with nurse life care planners a couple of years ago. Now I can’t imagine working without them. As professionals, we can help the family with all the legalities (wills, trusts, powers of attorneys, Medicaid and Medicare, etc.) then we can walk them through the gap to the health care side to make sure that their parent is getting the best possible care, in the least restrictive environment, without going broke. Now our clients have a road map.

I regret that it took a personal tragedy for me to wake up to the realization that I was doing my clients a great disservice by only providing legal services to suffering clients. When they walked in the door, they asked for legal services (will, trust, Medicaid planning, health care documents, etc.) and that’s what we gave them. Not only was this a very emotional time for them, but there were many things that our clients don’t know that they needed to know quickly. What I have since learned is that they don’t know what they don’t know. Our job as legal and health care professionals is to help them with what they don’t know (and probably don’t even want to know) with the goal of helping them get what they want.

**NOW Documents**
We mentioned our overriding 3-part goal for our clients: (1) Help them get the best possible care (2) in the least restrictive environment (3) without going broke. The first two parts are the job of the Life Care Planner. Part three is up to the elder law attorney. Before I discuss ways we can help clients preserve their estates if there is an incapacitating disability, we need to make sure that that they have the necessary legal documents in place to provide for their proper care. I call these the NOW Documents, because if they don’t have them and are of advanced age, they need them NOW!

If you think about it, a will or trust does nothing to help you. The primary benefit is for your family when you die. Both documents say who gets your assets when you die and each names a person to administer your estate. There are many other differences that we will discuss briefly below. In these continued next page
next few paragraphs, I want to discuss some very important documents that often are put on the estate planning “back burner.” Clients often consider these secondary or inferior to a will or trust in the planning process; if they discuss them at all, it is only briefly after discussion of the will or trust. However, these are the very documents that will help them now, while they are still living. I believe that the following documents are so important that we discuss them before wills and trusts.

**Property/Financial Power of Attorney (POA)**
This is a legal document in which someone appoints an *attorney-in-fact* (not to be confused with *attorney-at-law*) to make financial or property decisions for you. In effect, you grant the person named the power to take certain actions. Although a POA can be designed to be effective immediately, for estate planning purposes, it is normally not effective until you are certified incapacitated by two physicians. Gone are the days where we routinely get by with one page. Most financial institutions, brokers, and others want to see the power that you are trying to enforce specifically laid out. As a result, a properly-prepared POA may be twenty or thirty pages long. The POA should be durable, that is, be effective even if you are incapacitated.

**Health Care Power of Attorney (HCPOA)**
In this document, you appoint a health care attorney in fact to make health care decisions for you in the event you are not able to make them yourself. This document authorizes your decision-maker to make all health care decisions on your behalf, including the ultimate “pull the plug” decision, discussed in **Private Living Will**, below. For example, I was the attorney in fact under my Mom’s HCPOA after she had her stroke. For 2 years, I made all health care decisions for her, since she could not make them for herself. This is the ultimate NOW document, since it authorizes another person to make decisions that have a profound effect on your quality of life. This document needs to be separate from the property power of attorney, not just a sentence or paragraph in that document – it is much too important for that!

Also, in some states, a separate body of law governs health care powers of attorney, so they need to be designed and executed separate and apart from a property power of attorney.

**Private Living Will**
This is the state-specific document whereby the attending physician certifies that you are terminal and irreversibly or permanently unconscious. In this event the physician may withhold or withdraw treatment that only prolongs the process of dying. The private living will may be designed to require that the attending physician consult with the person appointed in your Health Care Power of Attorney before withholding or withdrawing treatment that would unnecessarily prolong your life. Having personally been the decision-maker in this situation, I can testify that it is not an easy decision. It is very helpful not only to have a very good living will that describes what treatment you do and do not want, but also to have a conversation with the person that you are appointing to make this decision for you – having had this conversation makes It much easier for the decision-maker to make the decision that you want them to make when the time comes.
HIPAA Release  Because of the privacy laws, you must authorize medical personnel to release your confidential medical information to others. Without this document, if medical providers releases any of your confidential medical information to anyone, they most likely have violated a provision of this Federal law. If you go into the hospital for an elective procedure, they will ask you to sign a HIPAA (Health Insurance Portability and Accountability Act) authorization on the spot, before your surgery. However, if you go into the hospital on a stretcher, you may not be able to sign anything. I hear stories almost every day of family members who are shocked when healthcare providers may not disclose healthcare information. Don’t put them or yourself in this situation. Sign a HIPAA Authorization designating who you want to have your protected health care information NOW – before something happens.

The above documents are necessary to complement any estate plan. They are normally referred to as ancillary documents since they complement either a will or trust based plan. However given the above descriptions, I think you understand why I think that these NOW documents are the most important documents in any estate plan.

Three Critical Estate Planning Issues
Let’s briefly look a few general estate planning issues. Again my purpose for discussing this with you is not to try to turn you into an elder law or estate-planning attorney, but to give you some basic information you need to know so that when you see client sin trouble, you can steer them in the right direction by directing them to an attorney. The major points are:

Capacity issues  The interesting thing about estate planning in general is that most folks know they need to do it and have put it off for years. Our law practice reflects the national trend: We do about 20% pre-planning (the folks who know they need to do something and are doing it in advance) and 80% crisis planning (which is planning after something happens).

In a crisis-planning case, the family usually comes to the office because a parent is in a hospital and is about to be discharged to a skilled nursing facility. Most of the time they say something like, ”Mom and Dad talked about doing planning for years, and we tried to get them to do it, but now it is too late!”

As professional life care planners, you can spot situations before it is too late and encourage clients to act. Once people lose their mental capacity to plan, it’s too late for them to sign documents. Usually Alzheimer’s, stroke or other mental or physical ailments creep up on them a little at a time, until they reach the point where they no longer have capacity. Then it’s too late to execute pre-planning documents.

continued next page
There is much legal and medical literature, statutory law, and case law discussing the concept of “capacity,” all of which is beyond the scope of this article. In a questionable case, both medical opinions and court-ordered guardianship may be required. However, a good general rule of thumb is that a person needs to know who they are, what they have, and what they want to do with it. We see many dementia clients who clearly don’t pass this test. Some are in “the fuzzy zone,” which means sometimes they could pass this test, then maybe later in the day they couldn’t. As attorneys with no medical training, if we suspect that there is a capacity issue, we don’t prepare or allow clients to sign documents. Capacity can be lost quickly. If you see clients in this stage of life and they still have capacity, strongly encourage them to see a legal professional as quickly as possible.

Key Financial Issues: Crisis Planning  
Medicaid is huge topic that deserves an article of its own, but for now, here are the essential and oversimplified facts. Medicaid is the Federal/state program that pays for a long-term care expenses. To qualify for Medicaid assistance, a client must have no more than $2,000 countable assets and no more than $1,821/month income. (These numbers change frequently, but are given here for illustration purposes.)

Non-countable (exempt) assets are the home (up to $500,000), one car, pre-paid funeral or life insurance, and personal assets at home. Everything else is countable.

If the clients are a married couple, then the countable assets are divided (subject to certain maximum amounts) between the community spouse (CS) and the institutionalized spouse (IS). The assets of the IS must be spent down to the $2,000 level.

If clients are “over-resourced” the immediate thought is to give it to the heirs to get assets to acceptable levels. The problem with this is that there is now a five-year look-back rule on all transfers, meaning that the gift must have been made more than 5 years before. If a client transfers (gives) assets to someone for less than full and fair value (uncompensated transfer) then the client may suffer a penalty as a result of the transfer. Because of the transfer, they may not be able to receive Medicaid benefits for many months. More importantly, the person who needs care may not be able to get it or may have to sell assets that they could have otherwise kept with proper pre-planning.

When people come into our office in a crisis situation our goal is to help their parent qualify for Medicaid as quickly as possible. There are often things that we can do to protect additional assets. This is critically important because the extra protected assets can be used for the benefit of the person in the nursing home to help pay for supplies, treatment, or care not paid by Medicaid.

Key Financial Issues: Pre-Planning  
A client who does proper estate planning more than five years before the onset of incapacity can protect many valued assets (such as the family farm, money, rental properties, etc.). Many times, someone going into a skilled nursing facility will want to keep a special
asset. Families often tell me that they don’t mind spending the money for long-term care, but they really don’t want to lose the farm. With proper pre-planning, done more than five years before the need for long term care arises, these treasured family assets can often be protected.

It is heartbreaking to see a family have to sell a legacy asset, such as the farm, to pay for long-term care expenses. The person needing care may feel devastated, thinking, “It’s all my fault!” that this is happening.

The life care planner can often spot cases where it is obvious that a client is heading toward the need for long-term care. You may be the first to learn that family discussions have been started, or not, or have stalled. Be prepared for some decisional conflict; often some family members will be ready to make these decisions, while others will not. If you see such a case, you can provide tremendous benefit to the family by including an elder law or estate-planning attorney in your team to help your clients make sound decisions for a safe future.

Weed and Berens, continued from page 242

seeking supplemental income for the other partner, and anticipating costs for future medical care. References at the end of the chapter will be helpful; many are given for individual states.

The chapter, “Day-in-the-Life Video Production in Life Care Planning” is a little uneven in quality, moving its point of reference back and forth between the life care planner and the videographer. Its colloquial tone is slightly jarring after the professional material before it.

However, the information will be beneficial to the life care planner who is charged with arranging such an exhibit for trial or conference, and for the videographer who is engaged for the purpose.

A final section on “General Issues” is a grab-bag of topics. “Ethical Issues and the Life Care Planner” is largely excerpted from a previous publication and touches on general professional duties, recommendations for continuing education, and malpractice. Again, this will be of most use to the newer planner/manager.

One chapter is a report of a study on plan reliability and periodic review in support of standardized life care planning practice and methodology. This was a limited study as it looked at the work product of only two planners. However, results indicated that consistent methodological approaches to planning yield consistent results.

Chapters on the ADA and LCP, technology and LCP, general resources, DME choices and the rehab equipment specialist, home assessment, vehicle modifications. Each contains a wealth of resources and links.

Finally, in “Credentialing in LCP,” an extensive explanation of certification gives one example of an accreditation agency which accredits certifying organizations. Mention of the American Board of Nursing Specialties would not have been amiss in this section.

Life Care Planning and Case Management Handbook continues as one of the best resources of its kind. What’s on YOUR bookshelf?
Collaboration

Reverse Mortgage Overview

Information from Darryl Hicks, NRMLA, Wendie Howland, and other sources

Olivia Costa, age 80, suffers from paranoid schizophrenia and Parkinson’s Disease. Yet the last thing her kids want is to have her placed in a nursing home.

“My mother’s home is her security – she loves it there,” according to Janet Broadbent, one of four children raised by Costa, who lives in a Midwest state.

Though still able to function independently at times, Ms. Costa, nonetheless, requires round-the-clock care because of dementia.

Using money from her mother’s pension and Social Security, Broadbent has hired caregivers to take care of her mother. “They help with everything – cooking, bathing, cleaning – you name it,” she said.

But that level of care requires money – lots of it. Last year, it became clear that Costa’s pension and Social Security were no longer going to be sufficient to cover the caregivers’ costs.

Broadbent initially sought financial assistance through the federal government but quickly hit a dead-end.

“I didn’t get very far with the government,” Broadbent added. “They wanted to pick the caregiver, and provide coverage only for eight hours a day. My mom, however, needs care 24-7.”

Broadbent, who acts as Power of Attorney for her mother, thought about mortgaging her own home to pay for a caregiver but, in the end, she chose to get her mother a reverse mortgage.

What is a Reverse Mortgage?

Reverse mortgages are emerging as a significant financial security tool for senior homeowners because of the broad range of needs these unique loans can satisfy.

The reverse mortgage is aptly named because the payment stream is reversed. Instead of the

Your client may benefit from a reverse mortgage - a unique loan that allows seniors to convert part of the equity in their homes into usable cash.

Darryl Hicks is Editor of the Reverse Mortgage Advisor newsletter published quarterly by the National Reverse Mortgage Lenders Association, www.reversemortgage.org
borrower making monthly payments to a lender, as with a regular mortgage, the lender makes payments to the borrower. While a reverse mortgage loan is outstanding, the borrower owns the home, holds title to it, and does not make any monthly mortgage payments.

“What sold me on the reverse mortgage was that even after my mother exhausts all the money, she still can stay in her home for as long as she needs to,” added Broadbent.

Using the proceeds from the reverse mortgage, Broadbent has hired two caregivers. “One person actually lives with my mom and takes care of all her needs,” Broadbent said. “A second person comes in once a week to relieve the other, who spends a few hours shopping for groceries and handling other errands.”

Paying her mother’s prescription drug bill isn’t as much of a chore as it once was, either. “My mother’s prescription drug bill runs about $330 a month, and that’s with free samples,” said Broadbent, “so the reverse mortgage helped out there.”

Hayes recommends the reverse mortgage to any adult child who has to care for their parent but doesn’t have the financial ability to do so.

“It has been a life saver for my mother,” she added.

Types of Reverse Mortgages

There are currently three reverse mortgage products available to consumers. The most popular is the Federally-insured reverse mortgage, called the Home Equity Conversion Mortgage (HECM). The HECM is insured through the Federal Housing Administration (FHA), which is part of the U.S. Department of Housing and Urban Development (HUD).

Seniors can also choose the Home Keeper® reverse mortgage, developed in the mid-1990s by Fannie Mae, a corporation based in Washington, DC. A companion product is the Home Keeper® for Home Purchase loan, a specially designed product that allows seniors to use a reverse mortgage to purchase a new home.

Financial Freedom Senior Funding Corporation, of Irvine, CA, has developed a proprietary “jumbo” reverse mortgage – called the Cash Account Plan – that lends up to $1 million. The HECM and Home Keeper products are available in every state, while Financial Freedom’s product is currently offered in 24 states.

Qualifying for a Reverse Mortgage

To qualify for a reverse mortgage, a borrower must be 62 years or older, own their home outright, or have a minimal mortgage balance. There are no medical requirements to qualify. There are no credit or income restrictions, and the closing costs may be financed in the mortgage. Homeowners must use the home as their primary residence and continue to pay the taxes, insurance, and routine maintenance on the property.

The property may be a single-family home, condominium, or manufactured/mobile home (built after 1976). HUD recently changed the rules governing the process for this class of borrowers, by making the approval process more rigorous, and also rais-
Condo dwellers applying for reverse mortgages will have to wait a minimum of 8 weeks for HUD to confirm that the dwelling meets their lending standards; the true wait time is likely to be closer to 18 weeks.

Properties which are legally incorporated as cooperatives but whose homes are separated from each other can apply for “site condo” designation, which is a condominium by legal description but is a single family property by all other viewpoints (may be on its own lot, very minimal common amenities, etc. Once it has the site condo designation, it cannot be changed;.

Given the FHA’s financial troubles, this development was somewhat foreseeable, and probably necessary. Condos were among the biggest price losers in the housing bust. From the standpoint of HUD, then, insuring reverse mortgages on these properties against default (i.e., the home price falls below the value of the mortgage) is very risky. And while it represents an obstacle, it’s certainly not a roadblock for those that live in condominiums and want to obtain reverse mortgages.

Reverse Mortgage Proceeds
The HECM loan limit was raised to $625,000 for the 2010 year by the Federal Housing Authority. This is a guideline for single family dwellings in the continental United States. Some areas of exception to this limit are; Hawaii, Alaska, Guam, and the Virgin Islands due to high construction cost adjustments. Multifamily units’ loan limits are higher, and such properties for consideration should be discussed with an approved HECM lender. Also, these limits may change depending on Congressional budget actions at any time.

Once a borrower qualifies for a reverse mortgage, there are several options for how the funds can be disbursed. (Table 1) The most popular option – chosen by more than 60 percent of borrowers – is the line of credit. Borrowers can change payment options at any time, subject to a small fee. One interesting feature with the line of credit (HECM only) is that it grows. The growth rate is equal to the prevailing interest rate being charged on the loan.

Table 1 Options for funds disbursement

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lump sum</strong></td>
<td>The entire loan amount is provided up front to the borrower</td>
</tr>
<tr>
<td><strong>Tenure payments</strong></td>
<td>Monthly payments are provided to the borrower for as long as they occupy the home</td>
</tr>
<tr>
<td><strong>Term payments</strong></td>
<td>Monthly payments are provided to the borrower over a specified period of time</td>
</tr>
<tr>
<td><strong>Credit line</strong></td>
<td>Borrower draws on the money as needed</td>
</tr>
<tr>
<td><strong>Combination payment</strong></td>
<td>Borrower receives a combination line of credit and monthly payments</td>
</tr>
</tbody>
</table>

As an example, say the interest rate on a HECM reverse mortgage is 4%. If a borrower obtains a $100,000 reverse mortgage and he or she chooses not to access those funds, then at the end of the year, the available balance would be $104,000.
Using A Reverse Mortgage

The proceeds from a reverse mortgage can be used for anything. Typically, they are used for the following reasons: supplement income; home repairs and improvements; medical bills and prescription drugs; debt abatement; education; travel; long-term care insurance; and prevention of foreclosure.

It is possible for a senior to get a reverse mortgage, even if they still owe money on a first or second mortgage. In fact, many seniors use the proceeds from a reverse mortgage to pay off mortgage debt, or a credit card balance.

However, if there is an outstanding mortgage, all or a portion of the proceeds from the reverse mortgage must first be used to pay off the debt because the reverse mortgage can be the only lien on the property.

If a borrower’s home mortgage debt exceeds the amount of money they could get with a reverse mortgage, then they cannot get the reverse mortgage.

Size of the Loan

The amount of money a borrower can get from a reverse mortgage depends upon their age, the type of reverse mortgage they choose, the value of their home, current interest rates, and—sometimes—where they live. In general, the older a person is, and the more valuable their home (and the less they owe on their home), the larger the reverse mortgage.

Where to Find More Information

The National Reverse Mortgage Lenders Association (NMRLA) educates consumers about reverse mortgages, trains lenders to be sensitive to the needs of older Americans, and has developed Best Practices and a Code of Conduct to make sure lenders participating in the program treat seniors respectfully.

To educate consumers about reverse mortgages, NMRLA has published three booklets:

- The NRMLA Consumer Guide to Reverse Mortgages
- Using Reverse Mortgages for Health Care
- Just the FAQs: Common Answers to Common Questions About Reverse Mortgages

These free booklets answer frequently asked questions and provide detailed information on how the reverse mortgage works, so that consumers can know their rights when working with a lender.

To receive the booklets, or to locate a NRMLA lender in your state, contact NRMLA at 866.264.4466 or by visiting its website at www.reversemortgage.org

The very comprehensive US Department of Housing and Urban Development (HUD) website, Top Ten Things to Know if You’re interested in a Reverse Mortgage can be found at http://tinyurl.com/9fkvh
or by following the links at www.hud.gov. It will give the LCP and client up-to-date useful information on limits, regulations, qualifying, and other help. This is a rapidly-changing field, so be sure to get the most current information.

**A Final Note**

A nurse life care planner is often asked to identify potential funding sources; referral for a reverse mortgage evaluation could be an appropriate in some cases.

Get to know the sources in your community. A CNLCP spoke on technology available to help facilitate aging in place, costs of home and facility care, and other related concepts at the NRMLA annual conference in 2009. Because the speaker recognized that in many cases a loan officer is an early family contact, an additional objective was to introduce them to the concept of expert life care planning.

According to the feedback, this approach was successful, with many attendees indicating that they would recommend LCP services to families as an option. This interaction also resulted in a number of referrals for LCP. Consider outreach to the financial community as part of your mission to educate the public—and as a valuable part of your professional marketing plan.
Speaker Highlights

Shelene Giles MS, BSN, RA, RN, CRC, CNLCP, MSCC
Jennifer Frye MS, CTAG/L
Dr. Edgar Ross
Patricia Brock RN, MSN, LNCC, CLCP
Jill Siebeking CTR/L, OTO
Victoria Powell RN, CCM, LNCC, CNLCP, MSCC, CEAS II
Judith Siedmyer R.PH
Reggie Gibbs MS

Mona Yudkoff RN, MPH, CRNN
Karen Cebulko RN, RN-BC, CNLCP, LNCC
Dr. David Crandell
Peggy Deleo OT
Edward Schwartz
Jon Roughan BSN, PHN, CRNN, CNLCP, CCM
Anthony Sambucini
Dr. Jeremy Goverman

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American Association of Nurse Life Care Planners

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• Medicare Set-Aside & Refresher
• The Nursing Process
• Becoming a Life Care Planner
• Nurses Mean Business

Saturday, October 9, 2010
• High Voltage Injuries
• Amputations
• Prosthetics
• Updates in Assistive Technologies
• Critiquing a Life Care Plan
• Chronic Pain Management

Sunday, October 10, 2010
• Wound Care
• Amputation Life Care Plan
• Practical Applications in Life Care Planning
• Bullet Proof Your Life Care Plans
• Bariatric Issues
• Socialized Medicine and Life Care Planning
• Vaccine Program Life Care Plans
• Life Care Planning in Non-Litigation Cases
• International Life Care Plans

Monday, October 11, 2010
• Expert Witness Skills
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