TABLE of EXPERTS Series

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Insights into ELDER CARE

The Experts

Kevin Ball

Ball Healthcare Services, Inc.

Kevin Denard Ball, BS, MBA, CQRMS, LNHA is currently employed as Corporate Administrator of Operations by Ball HealthCare Services, Incorporated. He is an experienced healthcare professional with proven leadership abilities with which he has supported company growth and development.
Kevin has worked in the healthcare industry for over 20 years.
His civic service includes his membership with the Alabama Nursing Home Association where he currently serves on the Executive Board and as a Regional Director. He has recently served as the Chair for both the Regional Advisory Board for the Alabama Institute for the Deaf & Blind, and Alabama Board of Examiners. Mr. Ball is a founding member of the Western Area Economic Development Council for the City of Birmingham and a sitting member of the University of Alabama Birmingham Healthcare Management Advisory Board. He has recently been appointed to the Board Trustees for Alabama A & M University.

Richard Brockman

Burr Forman

Richard serves as Counsel in Burr & Forman's Health Care Group with a focus in representing a variety of health care providers from large health care systems to individual providers in an array of legal issues confronting them.
Richard's experience includes drafting and responding to health legislation affecting health care and senior housing providers and representing lenders and mortgage servicers that lend to the nursing home and senior housing industry. He is the former President on the Executive Board of the Alabama Nursing Home Association and former member of the Board of Directors of the American Health Care Association. Richard has also previously served on Alabama's Statewide Health Coordinating Council and on the Advisory Board of the National Investment Center for Senior Housing.

Karen Hennecy

White Arnold & Dowd

Ms. Hennecy, past president of the Alabama State Bar's Elder Law Section, secretary of the Birmingham Bar Association's Elder Law Committee, and Top Elder Law Attorney 2014 Birmingham Magazine, concentrates her practice on the estates of decedents and protected persons, advance directives, durable powers of attorney, wills, trusts, asset preservation, Medicaid planning and all aspects of Elder Law.
She received a B.A. in Graphic Design from Samford University and her J.D. from Cumberland School of Law. Ms. Hennecy is the former director of the "Legal Counsel for the Elderly" program under Alabama's Commission on Aging Title III program. As legal counsel to the elderly, she did extensive public speaking on elder law issues, traveling to nursing homes, assisted living facilities and senior citizen centers while maintaining a practice exclusively in elder law. Ms. Hennecy continues this practice in the private sector specializing in a full probate and elder law practice.

William Shine

Synovus Bank

In 2011 Mr. Shine joined Synovus Bank, a southeast based regional Bank, with other former Capmark lenders to begin a Senior Housing Lending program encompassing term loans and construction financing for skilled nursing, assisted living and independent living facilities. Prior to Synovus, Mr. Shine was with Capmark Bank (formerly known as GMAC Commercial Mortgage) as Executive Vice President and Manager of Capmark's Seniors Housing & Healthcare Finance Group. In this capacity, Mr. Shine was responsible for both direct lending activities and placement with Institutional lenders. Prior to his joining Capmark Bank, Mr. Shine was with SouthTrust Bank where, in 1986, he formed the Specialized Healthcare Lending Group. The primary focus of the Specialized Healthcare Lending Group was as a project lender to skilled nursing and assisted living facilities. In 1993, SouthTrust completed the first securitization of healthcare loans by an originator (i.e. non-RTC assets). This securitization was rated by both Standard & Poors and Fitch with Goldman Sachs serving as Placement Agent. In total, Mr. Shine possesses more than 35 years of commercial banking and healthcare lending experience.
Mr. Shine is a founding Board Member of the National Investment Center for the Seniors Housing & Care Industry. He also served as Chairman for the NIC Conference in 1995, 1996 and 1997.

The Discussion

Q: How can individuals address the costs in their retirement/ financial plans?

Karen Hennecy: Well, it depends. First of all, there are different levels of wealth. Someone who may have $300,000 for their retirement income and long-term care needs has a very different plan than someone who has a great deal more wealth. There is still a lot of planning that can be done in either scenario, or even for someone who is down near poverty level.

William Shine: The generation facing retirement right now is really the last one with pensions. So how much do they have on fixed income, plus Social Security? If they're in their 70s, it's really too late for long-term care insurance. Realistically you need to look at that in your 50s or early 60s. Right now, for the vast majority of people, they're looking at their house as their long-term care policy and as their pension. Looking realistically at the value and the sell-ability of the house. At some point in time you need to monetize that. So deciding when to monetize that house is probably the most fundamental decision to make.

Richard Brockman: The higher-income person is obviously able to meet most of these expenses. And there are programs for people in the lower-asset echelons that can help to a certain degree. But those in the middle are the ones who have the hardest struggle. There are a variety of options, none of them perfect. Someone who has a house with significant equity can use a variety of devices to tap the equity without having to sell the home. One of these is a reverse mortgage that can create an annuity. Or just sell the house and hope that the money holds out. Long-term care insurance is certainly an option for someone in their 40s or 50s to start thinking about. But it's very much like an annuity, so it's finite. There are not a lot of long-term care indemnity policies that pay forever. So at the end of the day, it's probably the most imposing question that we have. Because for most people, there's never enough.

Kevin Ball: The way most individuals are planning to address the cost is they're just planning to work longer. Social Security and the small retirement plans that individuals have just don't cover it. It's just not enough. So the question is how can they find other income outside of some of the governmental assistance that is made available to seniors once they reach a certain age, which primarily is Medicaid? My focus is long-term care, meaning individuals who have to become institutionalized, and I'm starting to become familiar with those individuals in independent living situations. There are more programs now and communities being built that are income-based, where you can go and live in a retirement community and get rent that's based off your income. So it varies.

Hennecy: From private pay in a skilled-nursing setting, the average cost is probably about $5,000 to $6,000 a month.

Shine: If you can afford $5,000 to $6,000 a month, you basically first have a short-term stay under Medicare in a skilled-nursing facility, and then you go to an assisted living plus facility or home.

Brockman: There are a variety of initiatives out there – community-based services through Medicaid – that addresses the lower echelon. I know Kevin's company is investing heavily in affordable senior housing. There are nursing facilities that have Medicare, Medicaid, private pay and some insurance. So there are a variety of programs. One of the confusing things is trying to access and understand your options.

Q: How can individuals and families prepare for the costs of aging? What happens if the money runs out?

Shine: The hardest point is when people get in their 80s and they're no longer driving and they're frail. All of the construction boom in senior housing that has been going on for the past 15 years has primarily focused on private pay. So when the money runs out, there aren't a lot of options. Nursing homes are changing dramatically. There are still long-term residents in nursing homes, but that's decreasing every year. Affordable housing and affordable assisted living is probably the biggest hole in this market. Chicago is probably the best example of a city that has gone out of its way to use block grants and other programs to try to subsidize construction and enforce the equivalent of rent control for senior citizens, which is essentially what those programs are. You have to look at where you are. If you're in the rural South, there are not many options. If you're in an urban area, you have more options.

Brockman: One of the things that's really important is, how did the money run out? If it ran out because they gifted it to their kids, then it cuts off a lot of options. Because in order to access Medicaid, there's an amount of time from when you gave the money away before you can qualify for Medicaid; the so-called presumption that you were trying to impoverish yourself.
But when the money runs out, Medicaid is probably the sole place

to go. Alabama has a developed home-community based services program – you see a lot more out in the rural areas than in the urban areas – where Medicaid will help keep someone in their home with a range of services. But again, you have to be impoverished to access that. Home and community based services won't help if you are in an assisted-living facility. While home and community based services will pay for homemaking and some care tending services, these are limited. If you need more attention then what's available from home and community services, then you absolutely have to have a family member or friend willing to help you with dressing, bathing and things like that. There's no program right now to help you 24/7 at home. The cost of assisted living, for someone alert, in Alabama ranges from about $2,300 a month to about $4,000 or $5,000 and up for fancier communities. If you need memory care, then the cost is steeper on both ends of the spectrum. There was a time when your parents paid your tuition, so now it's time to pay for them.

Hennecy: One of the best planning tools is to just open the dialogue before age 65. If you can get the dialogue open with the children, then that's half the battle. Getting the elderly person to communicate and make plans with their children is one of the biggest obstacles.

Ball: The first plan when the money runs out is family. If you don't have family and your resources are limited, they do have resources that are income based. Obviously everything is based on those individuals who had the opportunity to earn a Social Security check. That may get you into a senior-living center or a group home to provide you with food and a place to live, but that doesn't address the medical need that the individual may have or the other social needs. There are a few programs here in Birmingham that address that, but the need is so great. We need to create more programs like this around the city. Now, once you become ill, obviously becoming institutionalized is an option where you can't come into a nursing home if you clinically have an issue that requires 24-hour supervision. This is an example of where Medicaid will come in and pay the bill in order for you to live in a skilled-nursing facility.

Q: What is one of the key issues children should keep in mind as their parents age? Should my parents have an advance directive or living will?

Brockman: You never want to be in a position where you have to make decisions for loved one who are unable to make those decisions and you don't understand their desires. An advance directive should express the wishes of the parents. So when they can't make medical decisions, you'll be able to fall back on that advance directive to help make those decisions. I always recommend that they appoint a health proxy, because there's not enough paper and ink to cover every eventuality. So you want someone who is making an informed decision. An advance directive is like a power-of-attorney. It allows you to make a decision for a person who can't make that decision. We took two concepts – the power-of-attorney and the living will, which is a self-executed document that talks about end-of-life decisions – and in the early 1990s we married those concepts by statute and created something called the health proxy. If you have an advanced directive for health care that allows you to make those kinds of decision for a person unable to make them, then the health-care provider knows who to turn to. And it's not just for end-of-life decisions. It's multi-faceted.

Ball: It's important for the child to become educated about the plans that your parents potentially have had. They may already possess a life-insurance policy, a burial plan, savings bonds, things that the kids may know nothing about. It would be helpful if that adult child had a discussion with the parents to find out what they have obtained. It's one of those things we don't talk about, as far as death and what to do if that parent is incapacitated. So becoming educated is very important.

Hennecy: If you take the time to make an advance directive but then don't share it with your children or the person you've appointed as your proxy, it's almost ineffective. Because if they're standing in the hospital and there's an emergency, and the piece of paper says this is what I want, but the child is overcome with emotion and you haven't talk to the child about what it says, then that child is still going to struggle. One of the greatest gifts you can give an adult child is to complete an advance directive and then talk to them about it. Tell them, "This is truly what I want. I've thought about this and I've written down my choices. So when you're having to make these decisions for me, you can know that this is what I want." That's very important. Advance directives are very limited except for the proxy part. There are two sections. One is terminal illness or injury, and one is permanent unconsciousness. Well, that's very narrow circumstances. There are a thousand other scenarios

that could come up. That's why it's important that you fill out the advance directive, but having that discussion with the children is the most important part.

Brockman: One of the things that's in the advance directive form is a provision that says, "My other instructions are." That was put in there so they can specify what they do and don't want. There's also a box in there that says that before a decision is made, the physician has to come out and talk to the family, not to get instructions, but to make them aware of what's going on.

Shine: The problem with the advance directive is it normally requires you to talk with an attorney. I would image that the vast majority of people don't have an attorney, and probably at least 40 percent at a minimum don't have a will. When the parent reaches age 60, the children need to ask them to plan their funeral. Because this act opens up the door to all the rest of the questions. It's a simple act, but it's a very hard act to do. The other issue would be to at least have a safe-deposit box and have your children signed onto the box. And in that box you have one place where all your financial information is collected.

Q: What are some often overlooked aspects of aging that people fail to consider?

Ball: The ability to understand that your lifestyle changes. Things happen as you age. Your circumstances will change. You have to be able to plan and prepare for whatever your scenario is. That's the biggest thing that most people fail to consider, is that your situation may change as you age.

Hennecy: If someone has a history of making eccentric choices during their lifetime when they are fully competent, then they should still be able to have that same personality when their capacity is challenged. For example, they might have regularly made purchases that don't seem reasonable, but as soon as their capacity is challenged, the children try to substitute their judgment and make the decisions they wish their parent had made. So many times, when our parents aren't able to take care of their own decisions, we substitute what we would want them to do rather than maybe what they would have done.

Shine: People are living longer than they imagined. The original concept was you'd live for a few years after you retired. Now it's more like 20 to 25 years. We all know someone who never thought they were going to live this long, and their plan stopped about 10 years ago. It's a major issue for them. So being frail in health and trapped in your home is a problem. The key question to address is when are they going to lose the ability to drive?

Brockman: Understanding when the changes come is one of the more difficult things, because it's not a light switch that comes on. Being forgetful and never remembering are two different things. You have these subtle changes, and you don't know when it's irretrievable. There are times when someone will wake up and won't know who they are or where they are, and by 10 o'clock they're fine. And that might not happen again for another month or two. Then one day they wake up and they're like that, and you think they'll be fine, but this time they don't get better. So recognizing those kinds of changes is hard. Those things fall back on the family.

Q: What are some of the questions you should ask before choosing a senior care facility?

Hennecy: Obviously you have to examine the costs and the elderly person's budget. And then see if the lifestyle that is available at that assisted-living facility is a good fit for that elderly person. I think immediately of pets, which are the most important thing for many elderly people. Some facilities don't allow pets.

Shine: You need someone to give you a true outside assessment of where your parents are in the aging process. Because when you begin looking at facilities, the place where you desire them to be may not be the appropriate place for them. That's one of the hardest issues. It's hard for a family member to be truly and calmly objective. The best option is to try to make these decisions early. Because independent living has become much more expansive. Even if it's not going to be a placement forever, it's a great transition from an individual house. With skilled nursing, there are a lot of good properties, and a lot of new properties. Kevin has a beautiful facility right by Baptist Princeton. There's a new one being built in Vestavia off Highway 31, with a lot of private rooms. But the new properties are being designed primarily for a short-term stay. So you have to know what the client really needs before looking.

Hennecy: As far as getting an objective assessment of your loved one, what I run into is people will come in and say, "Oh, she's fine. She knows exactly what she's doing." I have to explain to them that because they know her so well, it's as if they speak the same language. But if you bring an outsider in, they don't speak that language, so it appears to them that the person is much worse. The family sometimes has a hard time believing that they are as bad off as they are, so the objective opinion is very critical.

Brockman: When you are picking an environment, you have to understand what the next level is. For instance, you could start out in independent living, but then you fall and break your hip, so where are you going next? You go to the hospital for a few days, and then you have to make a decision right away as to what post-acute-care environment are you going to go with. Are you going to go back to independent living, to a nursing facility, to a rehab hospital? So you're always planning for the next level. Forty years ago, you basically had a single option, and that was a nursing home. You had those and Section 8 housing. Those were your two choices. The average age in a nursing facility back then was about 71 or 72. Today the average age is almost 90. But the average length of stay in a nursing facility is not what it used to be. Many folks now go into a nursing facility for a short-term rehab stay, and then go on to another level of care somewhere else. So they may be in the nursing facility for only 20 or 30 days, and then they're discharged. We did a study and found that 70 percent of admissions from hospitals into nursing facilities do not stay beyond (the length funded by) Medicare. They go home or to assisted living or someplace else. So it's important to understand all that when you're choosing.

Shine: It's one of those things where no one has any desire to be in a nursing home, but it's a critical part of continuing care. And if you have to do it through the hospital with a discharge planner, you're already behind the curve. A discharge planner will help you as best they can, but their job is to get you out of that hospital bed.

Ball: It depends on the locale. At the facility that is located right on Princeton's campus, I would say 80 to 90 percent of them stay there between 20 to 60 days and then are discharged home. Most of them are there for short-term rehab for conditions like strokes and knee and hip replacements. We also offer outpatient rehab services where you can go home and still continue to receive therapy while being back in your community. That's where you're seeing health care go. However, you go to rural areas and once they're admitted to a facility, they typically may stay there. So I've seen it vary according to the locale. But overall

we are seeing more turnover in nursing facilities, where maybe 20 years ago most people went in and they didn't come out. Healthcare's approach is different now. As to what questions you should ask in order to choose a facility, I turn it around and challenge people to ask themselves the question, "What do you see?" Go to these different locations, walk in, and what are your observations? Is the staff friendly? Is it clean? Did you smell anything? How were you treated? Those are the types of things you can assess about a location before you even ask any questions. You'll get a good feel of what type of environment your loved one may potentially be going into. What I'm describing is like going into Ruth's Chris or the Chicken Coop down on the corner. You get a different feeling based on the environment, and you just know it when you walk in. It's obvious. Health care is no different. After that, specific questions to ask the healthcare professionals involve staff-to-resident ratios, and how the facility performed on its last federal inspection.

Hennecy: I've often counseled clients to go to these facilities and look at the people who actually touch the elderly people. Those people who are down in the trenches and are actually cleaning your loved one. What are their attitudes? Try to observe that. To me, that's always been the most important thing in looking for the right place. Beautiful landscaping is nice, but if the people inside are not happy and cheerfully touching the loved ones, then no matter how beautiful the facility is, it might not be the right setting.

Shine: If the person you're looking for has been living in the same area for a long time, then where are their friends and their peers staying? When you're making this type of transfer, it's mitigated as much as possible if there are people at the facility who are like them or who know them. It gives them a sense of community. The biggest problem seniors in their 80s and 90s have is social isolation, especially when they lose the ability to drive. So if you can see a move also in context of a social element, that person will prosper a lot better if they're in a community in which they relate.

Q: What are the different types of senior care facilities and how do you determine which one is right for your situation?

Shine: The food groups are real simple. There's independent living, which varies state by state and it's becoming assisted-living lite. People are typically still in their 80s when they go in. It's more common to see a husband and wife go in together with independent living. Then there's assisted living. Again, it varies dramatically from state to state, but it's essentially a person who needs closer monitoring, is probably taking at least five meds, and has more need for assistance in daily living. They're a little bit frailer, have medical issues, but are somewhat stable. What we used to call intermediate care / skilled nursing in the old days is essentially assisted living in the vast majority of states. Then there's rehab hospitals, which is a short-term stay like HealthSouth. For all intents and purposes, skilled nursing homes are replacing the rehab hospital for geriatric patients. Then home health is the only other group. This is like Alacare but also home services like Meals on Wheels. Home health is probably the most interesting delivery point. It used to be home health, period, and then you needed to go into independent living. Some states are now pairing home health with independent living. There's a facility in Texas that looks just like a condo, with a common dining hall. Home health was supposed to destroy nursing homes 20 years ago, but it didn't because it's an inefficient provider of care. It requires someone going in their car from place to place to place for just X number of hours. In an independent-living setting, it's like having 200 households in one place, so you get a continuity of care. But home health is everybody's first choice if at all possible, followed by independent living, assisted living and skilled nursing. In the old days you used to sort of go down that list. Now people are building skilled-nursing facilities as feeders for their assisted living. That's the biggest change I've seen in the last five to 10 years. Basically, if the person can walk to the dining hall, that's independent living. If the person can only walk only a short distance to the dining hall, that's assisted living. And if the person has to be taken to the dining hall, that's skilled nursing.

Q: What is the difference between home health care and hospice?

Brockman: Hospice is a Medicare-driven, managed-care program for people whose death is imminent, within six months. It brings a variety of medical, social and personal services to not only the patient but also the family. It's a combination of some ministerial programs, social workers, and medical care givers. Hospice can be in-home and it can be in an institutional setting. About 8 to 10 percent of the residents in assisted-living facilities and nursing homes are on hospice. Hospice can serve folks who are already in an

assisted-living facility, but the facility can't admit someone who is hospice eligible. Hospice isn't trying to cure the patient, though they will take care of quality-of-life issues. For instance, if a hospice patient falls and breaks an arm, we'll fix the arm.

Shine: The thing people need to realize is that the hospice program, with its delivery of professionals to administer to both the patient and the family, is in essence the actual definition of what people really want on the front end when they're trying to make a decision about their retirement plan. We only have that comprehensive-care program set up at the very end of life. But that's the model that should be available throughout.

Hennecy: Generally if you're on hospice, you either have a family member caring for you or you have full-time sitters. But hospice doesn't provide the sitters. People kind of get that confused. Hospice has people coming to the house, but they're in and out. At that point, you also probably have some private-paid sitters or family members.

Shines: All of these programs will care for the bulk of your needs. But if the person needs 24-hour care, that's an additional cost and a whole other level of care.

Q: How can I access information to better understand available resources?

Brockman: Senior centers are all over the place and usually have a wealth of information. They're usually operated by the area agencies on aging. Providers, doctors, hospitals and so on usually put information at these places that people can access. Discharge planners at hospitals are pretty knowledgeable. So sometimes it depends upon the setting. There's a new program being set up called No Wrong Door. We want to have a single portal of information that's consistently available. We're trying to consolidate so everybody is singing the same hymn at the same time.

Shine: The New York Times has a health column – it's also a health blog – by Jane E. Brody, and we archive anything that comes out on skilled nursing or any type of health care. They had two columns earlier this year – "Preparing for the Unthinkable" and "Not a time for Trial and Error" – that had some of the best advice I've seen in a long time. And realistic advice in terms of setting people's expectations. Really the biggest first hurdle is expectations have to be set early.

Hennecy: One other source is there are geriatric social workers who you can hire. They're much less expensive than an attorney. For instance, the people at Alabama Aegis are extremely knowledgeable about everything we're talking about.

You could pay them their rate to help you navigate this field, and then you have an advocate there for you. I think they are under-utilized.

Brockman: You really need to have an interpreter. Someone who can sit back and look for the solution. Because what works today might not work tomorrow, so you have to understand what your options are.

Ball: Get your resource information from the actual provider. If I want to know about fishing, I'm going to the Bass Pro Shop. If I want to know how to paint a house, I'm going to the paint shop to get information. The same is true for health care. I'm a resource for long-term care. You come into one of our facilities, we're equipped with the knowledge and information to share with you. This is who we are, this is what we do, this is how we do it. If you're not quite ready for us, then this is where you need to go. Probably 95 percent of our traffic is from referrals from the hospital, where there's an immediate need for someone to come into our facility within the next week. However, we do have those adult children who are proactive and they see it coming, and they want to start familiarizing themselves with the different locations out there.

Q: How can caregivers account for the cost of caring for a loved one in their financial plan?

Ball: Most people at our facility are paying through Medicare and Medicaid. They're entering our facility on an insurance plan. For those people who have the funds to spend $6,000 or $7,000 a month, typically they're staying in and bringing sitters and those resources to the home, where they don't have to enter an institution. So therefore our private-pay numbers are not at a high level.

Hennecy: I think a lot of times when the adult children are trying to finance the long-term care of their parents, they're cohabitating. Either the parents are moving in with the children or vice versa. This is a good plan a lot of times, and for many scenarios probably the preferred plan. But as far as co-mingling the assets and the income of the parents, I think that's where you get into a tricky quagmire. That's where you might want to go talk with somebody with some expertise about the future and how that might affect the access to government benefits for the aging parent.

Shine: If you don't have children, the options become limited. But the number of seniors who are living with extended family is probably very small. Houses aren't built like that anymore. There's been a boom in what they call mother-in-law apartments being built onto existing houses.

Hennecy: Families aren't built like that anymore, either. Both the adult children are working.

Shine: So the issue goes back to the fact that, in some respects, your income is going to dictate what your options are, and you just have to be realistic about that. If it's going to be heavy care, you'll outstrip your resources no matter what you do. It's important to understand what the rules are for Medicaid. For the vast majority of people whose income is less than $30,000 a year, that's their safety net.

Brockman: We have a conundrum. We're trying to migrate people from the medicine they want to the medicine they need. But if we had a light switch and did that immediately, we'd bankrupt the country. Birmingham's economy is moved by medicine. Cleveland's economy is moved by medicine. Go into any small town in Kansas, and just about the only thing that's still open are insurance offices, banks and drug stores. And they're usually in nice buildings. That's why I said it's a conundrum. Very few people have the ability to reach into their pocket and write a check for a catastrophic illness. Open heart surgery, cancer treatment, any of those kinds of things. You can't do it. So we have an economy that depends on health care, and we have this huge influx of people who are needing care with not as many people to support them.

Q: My parents are proud and private. How can I approach them to understand what their wishes are? What are some early indicators that they need help with their daily tasks?

Hennecy: Certainly one of the earliest indicators is getting lost. If they're driving and they get lost, and that's uncommon for them, then that's a big sign. If they start purchasing the same things at the grocery store and their pantry is full of the same item. Hoarding or starting to stockpile things is sort of a psychological need to have things around. They're starting to feel a little bit insecure about being able to get to them, though they may not realize that. It's not so much that they can't think of a word or they've forgotten the name of a TV star. We all do that. It's more about some behaviors that are just absolutely unusual and not common to that person. That's a first clue. I think it's

important for elderly people to keep their hearing and vision checkups. Their capacity can be influenced if they're not able to take information in like they once could. That's often overlooked, but something you should be aware of.

Ball: Change in behavior. If they become overwhelmed by simple tasks that they typically would do with ease. Mood swings. Sometimes it's just slight changes. But if they start to need more help with things than usual, then that's the greatest indicator that something is changing. The most difficult thing is for the children to even talk about these things with their parents. To enter that conversation is very sensitive, but it needs to be a frank conversation. As difficult as it is, you have to just swallow the pill and do it. In our industry, individuals in the social services department typically have experience and are trained with family dynamics such as that. They are able to go into a situation, offer advice to the adult child and offer to even be the arbiter between the two and facilitate that process.

Hennecy: That's where a social worker would be a great tool. You have a neutral party to help bridge the gap between the adult child and the elderly person. It's a very delicate balance and can be an awkward situation.

Shine: If you're in a situation where you have in-laws, let the spouse who is not blood-related look at the situation. A non-blood-related family member helps tremendously in terms of giving that assessment. They can often be more direct and honest. There are also tremendous faith-based resources. A lot of churches have an active senior program.

Brockman: About 75 percent of these discussions are episode driven. You don't face up to it until it happens. That's when you mobilize. And it becomes a social nightmare. Because you have a child who has been looking after the parent the whole time, and in flies another child from Wisconsin who sees the parent twice a year and doesn't understand that something has happened, and comes in and thinks everything is fine. Then you get into that tug-a-war. Or maybe one of the parents married someone else, and now that person is in charge and the kids have no idea what's going on. I've seen step-mothers exclude the kids from any kind of discussion. So we need to try to education people early.

Shine: What some people have done very successfully is change the doctor. If you get in a situation where the person has been going to the same doctor for 20 or 30 years, and their health becomes an issue among different family members, find a new doctor and get a fresh assessment.

Q: How are the developing health care reform initiatives affecting care for the elderly?

Shine: We ae facing a generation coming up that is going to create a financial burden unless action is taken by the families. People need to be responsible for their own family first and foremost, asking the tough questions and providing a safety net. I think any type of governmental reform we have will never take away from the fact that there will be a bottom safety net. But that's not meant to be and should not be your long-term care plan. If you use the safety net, your ability to choose goes down dramatically. If you want to have a life like you're currently having, and a life like that for your parents, you need to start talking and thinking and planning. Because there's going to be a scarcity of resources. The resources that are being built right now are of two extremes. People who have no problem paying for it out of their pocket, and the government supported. The number of nursing homes in the country is declining every year. So when it comes to the number of places for that longer term custodial option for long-term care, you're going to have fewer and fewer choices.

Brockman: It's never too soon to start planning and understanding where the resources are. Unfortunately, many of us keep putting off this type of planning. I never wrote a term paper in college until about two days before it was due. It's the back-against-the-wall syndrome. But in this case, that is a very bad strategy. So understand where your resources are, who you can turn to, and how you can get this information. The fastest-growing part of the population by percentage is people over 90. So if you work 40 years and retire at age 65, you could literally be in retirement for 75 percent of the amount of time that you spent working. And that dynamic is going on and on and on. So just knowing the resources. Where can I turn? Because it's never too soon to start planning. Although I will say that whatever plans you make will probably be interrupted by reality.

Ball: As far as how we're being affected by the current initiatives of health care reform, we're still waiting to see. Systems are still being developed, there's still a lot of discussion, and we just don't have enough information yet to say that this is what's going to happen. It's still a big question mark. People just need to try to familiarize themselves with the different resources out there. You need to familiarize yourself with what your interests and needs are for the future, and how to make all that happen without having a financial burden being placed on individuals in your family.