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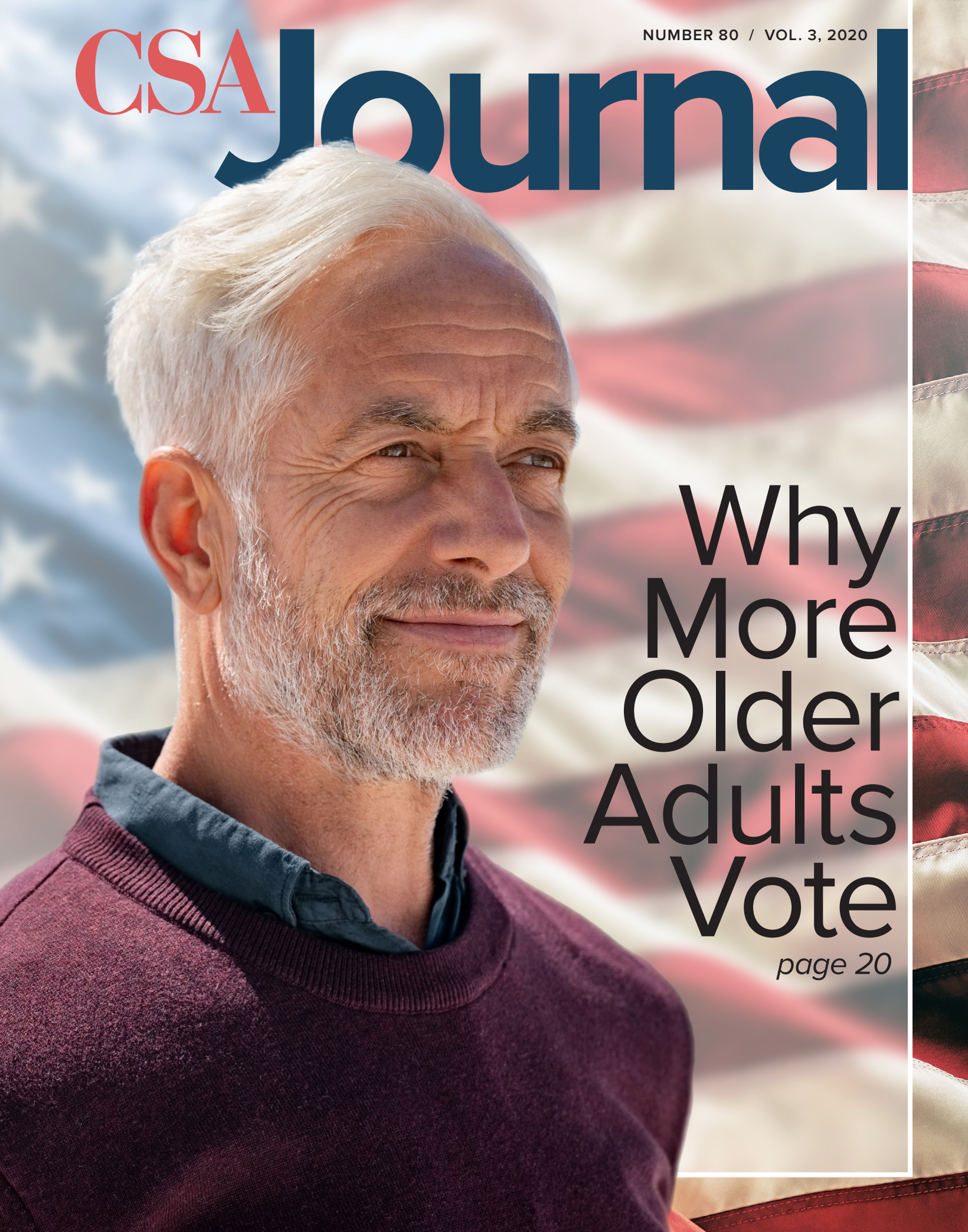

Why More Older Adults Vote

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Society of Certified Senior Advisors®

Society of Certified Senior Advisors® (SCSA) is the premier membership organization educating and certifying professionals who serve older adults. The Certified Senior Advisor (CSA)® credential is among only a handful that are dually accredited by the American National Standards Institute and the National Commission for Certifying Agencies. The SCSA education program, *Working with Older Adults,* uniquely covers aging and health, social, and financial issues important to many older adults. SCSA was founded in 1997.

PEER REVIEW The *CSA Journal* provides continuing education for SCSA members. All manuscripts are reviewed by the *CSA Journal* editor and *CSA Journal* Board. The *CSA Journal* Board approves all articles. Revisions may be required and articles must meet SCSA publishing policies and standards.

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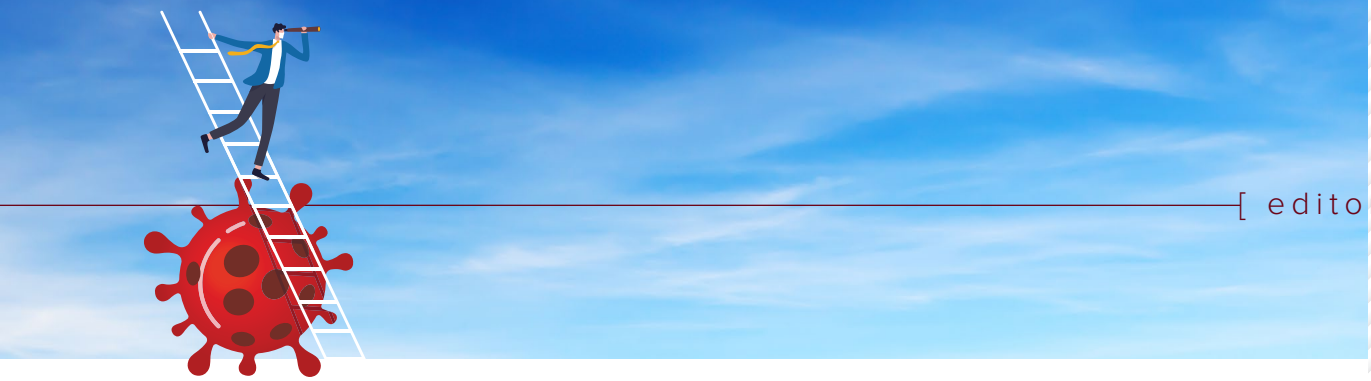
Society of Certified Senior Advisors®
720 South Colorado Boulevard, Suite 750 N.
Denver, Colorado 80246
Phone: 303-757-2323 or 800-653-1785
Fax: 303-757-7677
Email: society@csa.us
Website: www.csa.us



How will COVID-19 shape the future of the aging industry? Whether you are a practicing professional or have a business serving older adults, caregivers, or their families, you are in the midst of change and adjusting your business model right now. You have no choice. The CSA Journal Board has been analyzing how best to provide valuable information on this topic to CSAs and all aging industry professionals in the *CSA Journal*. With the consistent unpredictability of what is happening as a result of the virus, the Board has determined we will work on providing a special edition on COVID-19 at the appropriate time to address the health, social, financial, and legal aspects of older adults, caregivers, and their families, as well as businesses that serve older adults. Meanwhile, you will find COVID-19 mentioned periodically in this, and upcoming, Journal issue(s).

As we deal with the virus's unpredictability, it is still critical that all of us continue to do our best to educate ourselves on current topics and trends in the aging industry. Hopefully, you will find a quiet corner and some time to engage in this *CSA Journal* issue, reminding yourself that these articles will help you stay up to speed on ways to better serve your clients. There is still a world out there in our day-to-day work that requires us to address information beyond the coronavirus. We are confident Journal 80 will help you to fill that void.

The upcoming presidential elections are at the forefront of most people's minds. To win, candidates need to understand the immense power of the older voter. Jack Levine reminds us why by telling the story of his grandmother Minnie's advocacy efforts for women's right to vote in his article, "Lessons from Our Elders: Voting Rights" and giving his top ten reasons to vote. In addition, Jack shares why older adults turn out at the polls in greater numbers than other demographics.

While healthcare deals with the complexity of COVID-19, statistics show that older adults are the most vulnerable while receiving medical care. What's the best way to foster positive outcomes in the healthcare arena? Attorney Sandy Kraemer explains how healthcare providers can be limited by liability concerns and older adult patients and family members often don't know the right questions to ask. He explains specifically how to ask for optimal care. Reba Miller, MBA, explains how to find a hospital that provides high quality surgical care to older adults. In the Case in Point, Karen Gilbert, DNP, and CSA Journal Board Member and MBA Michelle Kunz explain how to recognize and treat delirium and how to identify the difference between dementia and delirium.

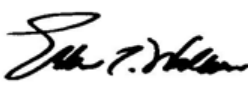
Business in aging continues to be a major focus. Learn how to become an employer of choice through improved recruitment and retention strategies by reading Jennifer Morgan, PhD, and MA Nidhi Joshi's article. MA Tim Rowan and MBA Roger McManus detail methods for strengthening your online reputation. CSA Mary Dunn explains how investment professionals develop business strategies and teams to fight senior scams.

Other topics include DNP Jill Shutes' article about how to recognize and address oft-subtle bullying in senior living environments as it manifests in verbal and physical ways. Sad but true: bullying is not just an adolescent concern! PhD Bert Hayslip Jr. continues his discussion on grandparents raising grandchildren in part two of his article. He considers policy limitations on school enrollments and grandchild medical care while explaining the benefits of the 2018 Family First Prevention Services Act.

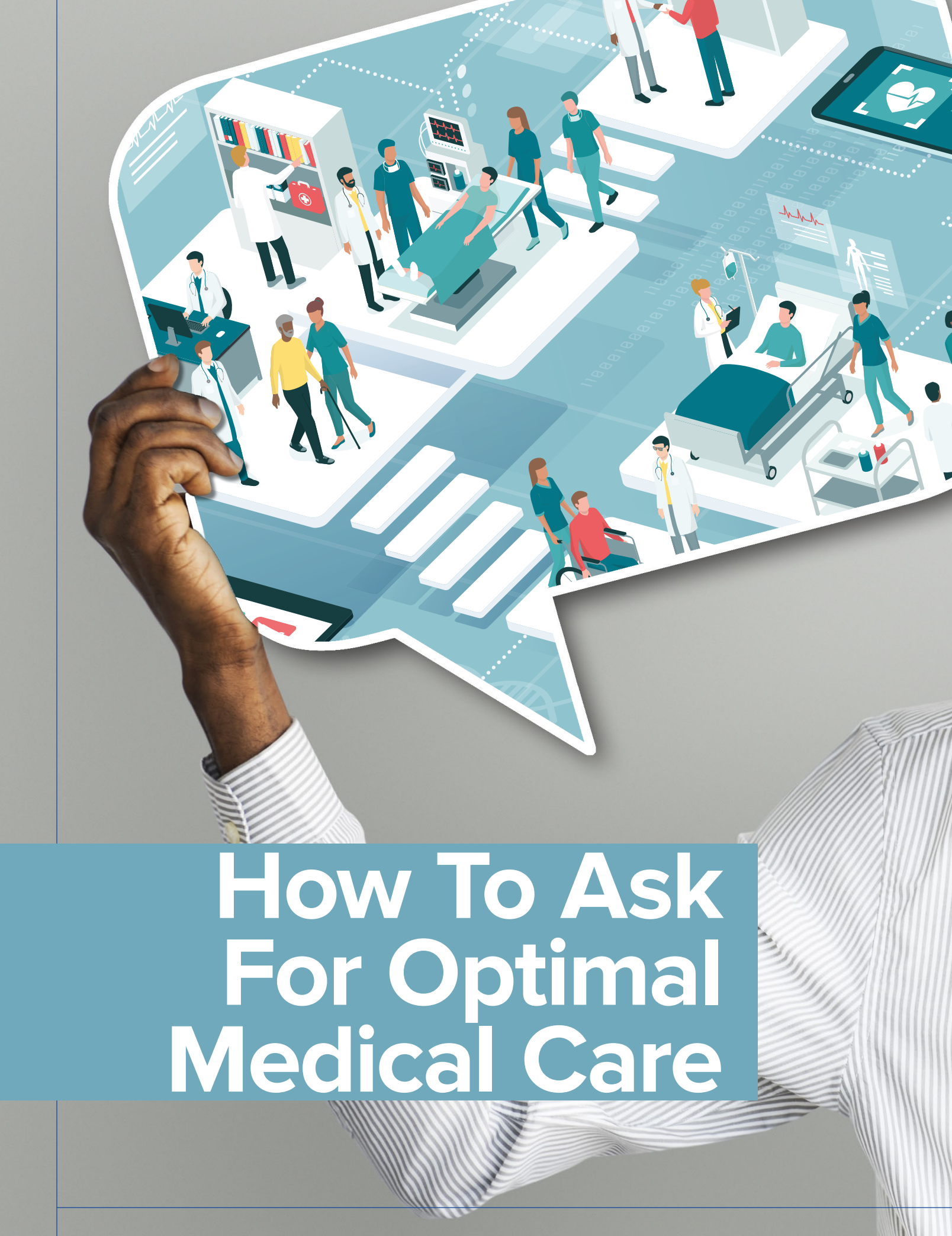
What's often ranked the number one gap in services for older adults? Transportation. CSA Erin Dwyer identifies how to start the conversation about giving up the keys, factors affecting driving as we age, signs that an individual's driving skills are diminishing, and alternative resources.

Finally, I'd like to share a positive note featuring an older adult doing her part. Famed disco singer Gloria Gaynor decided to raise awareness about how to protect against the coronavirus by creating a video of herself washing her hands while singing her 1978 hit, "I Will Survive." Watch it at https://www.youtube.com/watch?v=tvrUJ8_zqIM.

Please continue to provide feedback as we work to improve the quality and value of the *CSA Journal*. The CSA Journal Board is committed to advancing your business practices while we share recent trends and best practices.



Erika Walker
Editor and CSA Journal Board Chair



How To Ask For Optimal Medical Care

Everyone needs medical care. Knowing the right questions to ask at the right time can make all the difference in treatment outcome.

BY SANDY KRAEMER, ESQ.

Everyone, whether as a patient or a patient advocate, will need to ask health-care professionals questions about life-changing medical care at some time. What are the most effective questions to ask? Are patients, patient advocates, or providers ready to ask these questions? Will the correct questions get asked in the right time frame? Will the answers be correct and understood? Will the results be the best outcome? People are never in an optimal place to gather information, especially the *right* information, when they're worried about potential outcomes or in the midst of an emergency situation. Preparation makes all the difference regarding medical care.

Every year, more than twelve million adults seeking outpatient medical care will be misdiagnosed, according to a recent study (Docpanel, 2019). In fact, a 2016 study found that medical errors are the third-largest cause of deaths in the U.S. (Allen & Pierce, 2016). Even when a diagnosis is correct, there's still the matter of choosing the best treatment protocol, the right doctor, the optimal maintenance plan for each particular patient.

While researching my book on the subject, I asked medical patients and providers the same question: "What questions do people ask in order to get the best medical care?"

Patients answers ranged from the sardonic to the practical, evidenced in the following examples:

- "It's a provider monopoly."
- "Patients think doctors are God and should not be questioned."
- "Be an advocate and ask someone to help advocate for you."
- "Ask others about their experiences."
- "Have a plan."
- "Ask for favors."
- "Stay engaged."
- "Be willing to change."
- "Trust the system."
- "Pray a lot."

Providers answered the same question with a range of responses as well.

- "It is a horrible problem."
- "It's a huge challenge."
- "Patients don't answer questions accurately."
- "Patients understate their illness."
- "Patients blame providers for treatment failure."
- "There needs to be measurable criteria for judging providers."

Doctors, nurses, physician assistants, medical assistants, and administrators as medical care providers need to make accurate diagnoses and deliver effective and timely treatment. Health-care providers and suppliers have created legal shields to protect against liability claims. After all, the majority (55 percent) of doctors in the U.S. have been sued, almost half of them more than once (Matray, 2017). And since January 1, 2009, more than 289,200 product liability cases involving medical devices or pharmaceuticals were filed in federal district court (Botta, 2018). This doesn't count those disputes that were settled out of court. But these shields make asking for medical help effectively even more challenging.

The health care industry is at a political, professional, technological, and financial tipping point. Both patients and providers must effectively ask more questions to make the tipping points opportunities for better medical care.

Stories motivate. Information informs. With the speed and volume of new information, life-changing stories remain highly memorable. Let me begin with my own.

An E-mail Saved My Life

My congestive heart failure was progressing quickly with shortness of breath, pain down my back, frightening fluid retention, and no sleep. My new cardiologist was the third treating physician I had consulted, still looking for the best outcome. He was the first to recommend a transcatheter aortic valve replacement (TAVR) instead of open-heart surgery to replace the failing heart valve I had previously replaced thirteen years prior. Also, the first two treating physicians did not consider the urgency of my situation.

Many patients and their advocates simply fail to ask for what they want and need. On Tuesday, April 2 at 9:36 p.m., I sent an e-mail to the address listed on the professional card of my new cardiologist stating: "… time is of the essence. Is there any possibility you would be available this week to perform the surgery?" He emailed back at 10:14 p.m. stating: "I will investigate. Usually not possible to get team together on days other than Wednesday. A nurse will be calling."

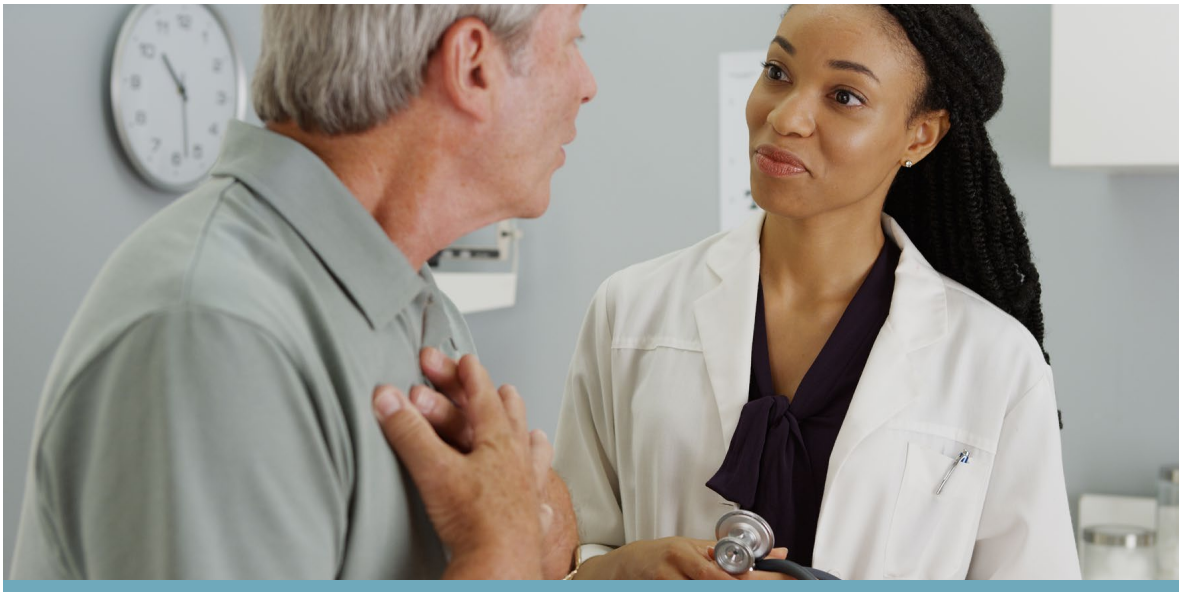
The nurse called late Thursday to advise me that the team would be available Friday morning with surgery scheduled for 8:30 a.m. When I was wheeled into surgery, I counted ten waiting team members. The procedure took ninety minutes. I was discharged on Saturday afternoon and walked one-and-a-half miles on Monday!

The cardiologist later told me that on a scale of one to four, with four being the worst heart condition, mine was a four-plus. If I believed in miracles, this experience would qualify.

Communication Failures

Patient and provider are most often strangers who have never met and may never meet again. They must build a temporary connecting bridge over which life-changing communication may flow. The communications must be open, thoughtful, clear, and correct. Two personal provider communication failures immediately come into focus.

When I was sixteen years old, I was told I had a heart murmur. This heart condition never slowed my



running, mountain climbing, or skiing. Thirteen years ago, I had open-heart surgery to replace my congenitally defective aortic valve with a bioprosthetic valve made from the sac surrounding the heart of a cow. I was also diagnosed with an ascending aortic aneurism, which was stable. I was told the bioprosthetic valve lasted an average of seventeen years, and I would have warning symptoms many months ahead of valve failure, allowing time for another valve replacement.

I always have an annual physical and see our family doctor three or four times a year for medical issues. Before leaving the office after every visit, I receive a computer-generated medical report that includes my medical history, medical problems, medications, and recommended treatment. The physician creates these reports during the office visit by looking at his computer and typing while we talk. During several visits, I asked him to stop typing while we talk. He would then pick up a small, sticky notepad and take notes for one or two minutes, and then start typing again. The report from a twenty-minute routine visit averages six pages. I quit reading the reports several years ago.

After my emergency life-saving heart valve replacement described above, I read some of my past computer-generated medical reports. Several listed, "Congestive Heart Failure Onset 8/22/2018" more than seven months before my emergency valve replacement. I confronted our family doctor and asked, "Why didn't you tell me, why didn't we talk about it?" Very softly he commented, "Oh, I'm sorry."

My first cardiologist evaluated my congestive heart failure symptoms and recommended another open-heart surgery, replacement of the aortic stem that had an aneurism, and a local surgeon. The surgeon was on vacation and the staff could not schedule the surgery.

I sought a second opinion from another cardiologist. He recommended a non-invasive TAVR procedure and not to replace the still-stable aneurism. When I told my first cardiologist that I had decided to go with the second cardiologist's recommendation, he responded, "I've been thinking about it. That's a good decision." The first cardiologist never mentioned the TAVR alternative to open-heart surgery.

One important, but simple, method to improve a patient's outcome is to ask for a second, or even a third, opinion. The medical profession is advancing at a furious rate, and one doctor may know of a new procedure or drug, while another may have experience with a number of patients with a similar predisposition. Most physicians welcome a second opinion. A 2017 study at the prestigious Mayo Clinic found that as many as 88 percent of patients who came to the center for a second opinion regarding a complex case returned home with a new or refined diagnosis that changed their care plan (Science Daily, 2017).

Both patient and provider must keep asking questions, listening, and responding until the best diagnosis and treatment becomes apparent.

Beware of the Back Pain Industry

The majority of people experience back pain sometime in life. The pain may come and go intermittently, causing mild discomfort, or become excruciatingly debilitating as it radiates down one or both arms and legs. Treating back pain is a huge and growing industry including medical doctors, osteopathic doctors, chiropractors, physical therapists, nurses, physicians'

assistants, hospital wellness clinics, prescription and non-prescription drugs, supplements, and therapeutic products. Back pain is a treatable, but often incurable, medical problem.

When my friend Rick learned I was writing a new edition of my *How to ASK* book with a medical care focus, he volunteered his own story:

> My dad was a trim high school baseball player, considered an offer to play professionally, chose the university track, dropped out after two years, eloped, and settled into a sedentary office job. He had two sons, Don and me. Dad's weight ballooned from 175 to 240 pounds. He spent summer evenings in a backyard hammock listening to Cub's baseball games. He constantly complained of lower back pain. He told us he had a congenitally deformed lumbar spine. He took pain and sleep medications, had epidural shots that temporarily reduced the pain, and eventually endured three back surgeries. He became weak, depressed, and never stopped complaining about back pain until his death.
>
> By comparing X-rays, MRIs, and CT scans, my brother Don and I realized we had the same lumbar genetic deformities as Dad. Don has gone through the same lifestyle and medical experiences as Dad: weight gain and medications, epidural shots, and three surgeries. He has a hard time walking fifty yards.

Rick didn't want to be in the same boat as his father and brother. He eats right and exercises, and combines his healthy lifestyle with advice from medical professionals. But he doesn't do everything they say might be helpful. He asks a lot of questions, and then makes up his mind. As he explained:

> The good news is I have avoided surgeries, am pain free, and walk two or three miles a day. I think the way people manage back pain makes a huge difference. I weigh less than I did in high school, exercise regularly, and learned from a physical therapist what physical work and exercises to avoid. When I have back pain, I limit my medications. The pain doctor said there were six spots in my lumbar spine where epidurals might reduce pain. I tried one, which helped temporarily, but have declined additional shots. I sleep on my back. I have learned how to manage back problems by always asking about recommended medical care choices and choosing less treatment.

QUESTIONS TO ASK YOUR MEDICAL PROVIDER

- What do I need to know about my medical problem?
- If there are test results pending, when and how will I receive the results?
- What's my treatment plan?
- What steps do I need to take and when?
- Why is the treatment you are proposing the best for me?
- What are some alternative treatments?
- Who can you recommend for a second opinion?
- If a surgery or procedure is involved, how many of these have you performed?
- What will be my recovery period?
- What will be the follow-up treatment?
- How will this change my life?

Who Will Ask for You?

Of course, there are times when an emergency situation arises and we cannot evaluate our options. In that case, we need to have someone else advocate on our behalf. Leonard tells his own life-saving story:

> Ten years ago, I was at the airport getting ready to board a plane for a business trip. But waiting to go through airport security that day, I collapsed. They called it "sudden cardiac death." I didn't know it then, but there was only a 5 percent survival rate, and half of those who live have brain damage. If victims don't receive help in the first few minutes, they don't survive.
>
> After receiving cardio-pulmonary resuscitation (CPR) from a bystander, the paramedics arrived to use defibrillator paddles to resuscitate me. I was brought by ambulance to the hospital, where I stayed for nine days, most of that time in the cardiac ICU, spending the first one to two crucial days in a coma.
>
> What decisions had to be made regarding my health and who would make them for me? Who would be my advocate and who would fight for me if needed? Thankfully, I had my wife. A critical decision that needed to be answered right away was, "'Who will perform the needed surgery to implant a defibrillator in my chest to prevent this from happening again?"

The electrophysiologist who was on call strongly recommended that she perform the surgery right away. My wife stood up as my advocate and asked the surgeon, "Who is the best electrophysiologist to perform the surgery, and what are the options for the medical device to insert?" The doctor was not offended and told her, "If it were me having the surgery, then I would have Dr. Sauer do it. He's the best and he can recommend the best model device."

Dr. Sauer performed the surgery to insert the device he recommended that later saved my life twice. He then performed another surgery that, thankfully, ended my having additional episodes of sudden cardiac death.

In my case, having an advocate who asked the right questions and made the right decisions based on the information she received paid off for me in a big way. Many of us, including myself, don't question the "experts" and often settle for what others tell us we should do. It takes someone who is strong and confident to ask for what they want and to advocate for someone they care for, rather than to just accept what they're told. It can make all the difference in the world.

A Special Favor

Debra became highly concerned as she watched Kevin, her husband of thirty-two years, become increasingly short of breath when he climbed a flight of stairs. At the top of the stairs, he would hold the banister until his heavy breathing subsided. He stopped exercising at the health club but continued to pay the monthly fee. When shopping together, he did not drive and suggested finding a parking space close to the store. Kevin and Debra's evening walk and talk were a thing of the past.

Kevin went through a battery of tests regarding his heart health. The reports came back showing no abnormal condition. The cardiologist evaluation was completed with no recommended treatment. Kevin decided to do nothing. He speculated it must be a new seasonal allergy that would soon pass.

Debra persisted. She was told their health insurance would not pay for more tests. She did not personally know any provider. She talked to a friend who had family ties to a chief hospital administrator at the local hospital. Debra asked her friend for a special favor. Would she connect her directly to the chief administrator? Her friend did.

The administrator decided more tests might benefit Kevin and scheduled tests that might identify a condition covered by their health insurance. Kevin was scheduled to meet with a physician's assistant. Consequently, those tests showed Kevin had a lung disease. With this diagnosis and insurance coverage, treatments were scheduled.

Debra says, "I had never asked for a special favor like this before, but my husband is my main priority. I persisted and my humility and sincerity kicked in."

Every time a person meets with a health-care professional, there is an opportunity to learn more by asking questions. If a patient can't, or won't, ask about alternatives, it's important to bring an advocate. Whether it's as mundane as finding out if a cheaper generic can fill in for the brand-name drug, or as critical as identifying an alternative to surgery, these questions can impact not only your pocketbook, but the trajectory of your life. •CSA

Sandy Kraemer is a retired attorney and continues as counselor and author. The stories are copyrighted and published in his book, *How to Ask* (fourth edition) available on Amazon and reprinted with permission. His books have captured the attention of national media including the *Wall Street Journal* and NBC Nightly News. His education includes Stanford University, BSCE, and Colorado University, JD.

REFERENCES

Allen, M. & Pierce, O. (2016, May 3). *Medical errors are the No. 3 cause of U.S. deaths, researchers say.* Retrieved from https://www.npr.org/sections/health-shots/2016/05/03/476636183/death-certificates-undercount-toll-of-medical-errors

Botta, M. (2018, April 4). *Pharma product and med device liability lawsuits subject of new report*. Retrieved from https://www.pharmaceuticalprocessingworld.com/pharma-product-and-med-device-liability-lawsuits-subject-of-new-report/

Docpanel. (2019, August 9). How common is misdiagnosis - infographic [Blog post]. Retrieved from https://www.docpanel.com/blog/post/how-common-misdiagnosis-infographic

Kraemer, S. (2018). *How to ASK* (4th ed.). Scotts Valley, CA; CreateSpace Independent Publishing Platform.

Matray. (2017, November 15). *Medscape malpractice report 2017 finds the majority of physicians sued.* Retrieved from https://medicalliabilitymonitor.com/news/medscape-malpractice-report-2017-finds-the-majority-of-physicians-sued/

Science Daily. (2017, April 4). *The value of second opinions demonstrated in study*. Retrieved from https://www.sciencedaily.com/releases/2017/04/170404084442.htm

When an older adult is facing surgery, a new hospital verification program makes it possible to look for a hospital that is particularly qualified to serve the geriatric population. BY REBA MILLER, MBA

Smooth Operating: Finding a Hospital that Caters to Older Adults Undergoing Surgery

Upon learning that they need an operation, the first step that many patients take is to find a good surgeon. And while having a trusted physician perform the operation is an essential part of a positive surgical experience, all the people and processes, from pre-operative instructions to planning for a safe discharge, can make a big difference, too. Many of these factors are influenced by programs and policies of the hospital itself, but even in this era of data collection and information sharing, finding results on hospital quality can still be frustratingly opaque. Enter the Geriatric Surgery Verification Quality Improvement Program, a new initiative aimed at recognizing hospitals that excel in caring for patients over the age of seventy-five.

The Geriatric Surgery Verification Quality Improvement Program (frequently abbreviated to GSV), was launched in the summer of 2019 by the American College of Surgeons and follows the model of previous surgical verification programs including bariatrics, pediatrics, trauma, and cancer. These programs set comprehensive standards that hospitals must meet in order to be considered a center of excellence in a particular area of surgery. These standards are broad, patient-centric, and take into consideration a wide range of influences on how quickly patients can get back to everyday life after an operation.

The need for age-sensitive measures in surgery is clear: people are more likely to need surgery as they get older, and there are more older patients than ever before (AgingStats, 2016). In fact, the number of surgeries being performed in retirement-aged patients is growing even faster than the retired population (CDC, 2010), meaning that a higher percentage of geriatric patients are going under the knife. As more patients present for surgery at a later age, and surgeons gain more confidence in managing the care of older patients, they are more likely to approve other older patients for operations who may not have previously been considered surgical candidates due to their age or frailty (Neuman, 2013; Shellito, 2019). And so the numbers continue to grow (Etzione, 2003).

Screening & Planning

Frailty is increasingly being recognized as an important indicator of how well a patient will do during and after surgery, and generally refers to the body's resilience, physiological reserves, and ability to deal with stress. Surgery is invasive by nature and even simple procedures put the body through a great deal of stress (Makary, 2010). But frailty is not a uniform process in aging; an active and energetic ninety-year-old who routinely plays tennis with friends is likely to be less frail than a patient who is twenty years younger but suffers from chronic, mobility-limiting illness and a decreased appetite (Neuman, 2010).

As part of the GSV, participating hospitals will be required to screen patients for frailty and other vulnerabilities that are more common as we age, such as malnutrition, loss of independence, and impaired cognition (Yang, 2011; GSV Program Standards, 2019). If a patient is deemed to be high risk, then the hospital must demonstrate that it has an appropriate management plan for patients who wish to proceed with surgery. For example, for a patient that has, or is at high risk for developing, mobility issues, there should be a pathway that encourages rehab (making physical therapy a part of surgical recovery early on) or even 'pre-hab' (building a patient's physical reserve prior to the surgery) (Mohanty, 2010).

There is also an emphasis on setting health goals that go well beyond the typical discussion of the risks and benefits of surgery (GSV Program Standards, 2019). As part of any pre-operative consult, it is standard practice for the health-care provider to explain how the operation will benefit the patient, what could potentially go wrong, and — if the patient is lucky — best case, worst case, and most likely scenarios of what will happen during and after surgery (Mohanty, 2010). For older adults, who tend to accumulate ailments over time, the surgical picture can be more complex (Shellito, 2019).

One of the standards for hospitals that wish to be verified as geriatric surgery centers of excellence is a documented conversation regarding not just the goals of treatment for the disease being targeted by surgery, but also the bigger picture of what the patient values regarding his or her health (GSV Program Standards, 2019). Since living a good life can mean different things to different patients, knowing what patients are looking forward to and what they value can help guide medical decisions (Shellito, 2019). For example, someone who lives alone and loves walking her dogs every morning may choose an option that gets her home and on her feet quickly (and gets the pups out of boarding!) even if the surgery has a lower chance of long-term success, while a person who is looking forward to a planned vacation with his favorite niece after she graduates at the end of next year may opt for a more invasive procedure with a longer recovery time.

If a patient's risk from surgery is very high, particularly the risk for cognitive impairment, an individual may decide that surgery is not the right option. Knowing what the patient's wishes are, as well as who can make decisions for the patient if he or she is unable to do so is another key piece of information for surgeons and the team of care providers to know before a patient goes under anesthesia (Shellito, 2019).

At the Hospital

The side effects of anesthesia and other medications can also disproportionately affect older patients, partly because as people age they tend to take more medications for more conditions and are therefore more likely to have drug interactions (Yang, 2011). It's also true that the liver and kidneys, responsible for metabolizing and processing medication in the body, tend to slow down over time, leading to medications lingering in the body longer than they do in younger patients. Hospitals that participate in the GSV must put protocols into place to minimize or avoid the use of these medications (GSV Program Standards, 2019). The major concern with anesthetics, analgesics (particularly opioids), and other surgery-related drugs when taken by an older adult is that they may cause post-operative delirium, which is not only unpleasant to experience but is also associated with slower recovery and, sometimes, loss of independence (Yang, 2011).

There are other things that can be done to help avoid disorientation after surgery and during the remainder of the hospital stay. Simple things, like returning glasses, hearing aids, and other assistive devices to patients as soon as they begin to wake up from anesthesia, can make a big difference (Mohanty, 2010). Imagine being groggy from anesthesia and not being able to see the nurse or hear what he's saying! Rooms are also best set up in a certain way, with an easy-to-see calendar, clock, or planned activities for the day in clear view of patients helping to keep them on track, and handrails and non-slip flooring to help with mobility after an invasive procedure. There should also be enough room for visitors, as having familiar faces and personal items nearby is not only comforting but can also help keep delirium at bay (GSV Program Standards, 2019).

There are so many people who contribute to patient care during a hospital admission, and commitment from all parties to providing outstanding care of older adults is essential (Mohanty, 2010). To become a Geriatric Surgery Center of Excellence, a hospital must have support from hospital leadership, a doctor, and coordinator who oversee the Geriatric Surgery

RISKS FOR GERIATRIC-SPECIFIC COMPLICATIONS AFTER SURGERY

There are certain surgical complications that older patients are at higher risk of developing: pressure ulcers, delirium, need for a cane or walker, and loss of independence. While age has been found to be an independent predictive factor for complications after surgery, there are other influences:

- **COPD & Smoking**
- **Functional Dependence**
- **Sepsis**
- **Diabetes**
- **Type of surgery**
- **Fall history**
- **Cognitive impairment**

(Hornor, 2019)

program, an interdisciplinary committee to monitor standards, nurses (including a nurse champion) who are trained in the care of the geriatric surgical patient, and staff who gather data to make sure that the hospital is honoring its commitment to quality. The program also emphasizes the integration of non-physician experts, such as nutritionists, physical therapists, and social workers, into the team of caregivers managing a safe and speedy recovery (GSV Program Standards, 2019).

Going Home

One of the most daunting aspects of surgery is wound and recovery management after leaving the hospital. As part of the GSV, before a patient is discharged, a second screening is done for geriatric vulnerabilities (GSV Program Standards, 2019). Checking for impaired cognition, delirium, mobility issues, and malnutrition is required. If a patient is found to be at risk, a strategy to address those issues at home must be implemented. Often this can mean short-term physical therapy or home care after discharge, but can also include meal plans and coping strategies that patients and their families can manage themselves.

Finding the Right Hospital

Hospitals that choose to be verified will go through a rigorous verification process to ensure they meet all the standards set by the American College of Surgeons. They may also go through a 'commitment' phase of up to two years while they put policies and practices into place (GSV Program Standards, 2019). Hospitals that are verified as Geriatric Surgery Centers of Excellence will be publicly recognized at: https://www.facs.org/quality-programs/geriatric-surgery

As more Americans than ever before are opting for surgery late in life, they will now be able to not only find a surgeon they trust, but also have confidence that the hospital they choose is optimally equipped to take care of their needs. •CSA

Reba Miller, MBA, is the director of Surgical Quality for the Mount Sinai Health System in New York City. She manages both surgical outcomes and process improvement initiatives for colorectal, bariatric, general, oncologic, vascular, plastic, and pediatric surgery, with a focus on minimizing disparities of care and improving access to high quality services for underserved populations. She and her husband also foster elderly and special needs dogs for their local animal shelter.

REFERENCES

Centers for Disease Control. (2010). *National hospital discharge survey: Number of all-listed procedures for discharges from short-stay hospitals, by procedure category and age.* Retrieved from https://www.cdc.gov/nchs/data/nhds/4procedures/2010pro4_numberprocedureage.pdf

Etzioni, D. A., Liu, J. H., Maggard, M. A., & Ko, C. Y. (2003). The aging population and its impact on the surgery workforce. *Annals of Surgery*, 238(2), 170–177. doi: 10.1097/01.sla.0000081085.98792.3d

Federal Interagency Forum on Aging-Related Statistics. (2016). *Older Americans key indicators of well-being*. Retrieved from https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf

Geriatric Surgery Verification Program Standards. (n.d.). Retrieved November 14, 2019, from https://www.facs.org/quality-programs/geriatric-surgery/standards.

Hornor, M. A., Ma, M., Zhou, L., Cohen, M. E., Rosenthal, R. A., Russell, M. M., & Ko, C. Y. (2019). Enhancing the American College of Surgeons NSQIP surgical risk calculator to predict geriatric outcomes. *Journal of the American College of Surgeons*. doi: 10.1016/j.jamcollsurg.2019.09.017

Hornor, M. A., Tang, V. L., Berian, J., Robinson, T. N., Coleman, J., Katlic, M. R., Rosenthal, R. A., Christensen, K., Baker, T., Finlayson, F., Lagoo-Deenadaayalan, S. A., Ko, C.Y., & Russell, M. M. (2019). Optimizing the feasibility and scalability of a geriatric surgery quality improvement initiative. *Journal of the American Geriatrics Society,* 67(5), 1074–1078. doi: 10.1111/jgs.15815

Makary, M. A., Segev, D. L., Pronovost, P. J., Syin, D., Bandeen-Roche, K., Patel, P., Takenaga, R., Devgan, L., Holzmueller, C. G., Tian, J., & Fried, L. P. (2010). Frailty as a predictor of surgical outcomes in older patients. *Journal of the American College of Surgeons*, 210(6), 901–908. doi: 10.1016/j.jamcollsurg.2010.01.028

Mohanty, S., Rosenthal, R. A., Russell, M. M., Neuman, M. D., Ko, C. Y., & Esnaola, N. F. (2016). Optimal perioperative management of the geriatric patient: A best practices guideline from the American College of Surgeons NSQIP and the American Geriatrics Society. *Journal of the American College of Surgeons*, 222(5), 930–947. doi: 10.1016/j.jamcollsurg.2015.12.026

Neuman M. D., & Bosk, C. L. (2013). The redefinition of aging in American surgery. *Milbank Q*. 2013;91(2):288–315. doi:10.1111/milq.12014

Shellito, A., Russell, M. M., & Rosenthal, R. A. (2019). Looking beyond mortality among older adults who are frail and considering surgical intervention. *JAMA Surgery*. doi: 10.1001/jamasurg.2019.4638

Turrentine, F.E., Zaydfudim, V.M., Martin, A.N., & Jones, R.S. (2020). Association of geriatric-specific variables with 30-day hospital readmission risk of elderly surgical patients: A NSQIP Analysis. *Journal of the American College of Surgeons*. doi.org/10.1016/j.jamcollsurg.2019.12.032

Yang, R., Wolfson, M., & Lewis, M. C. (2011). Unique aspects of the elderly surgical population: An anesthesiologist's perspective. *Geriatric Orthopaedic Surgery & Rehabilitation*, *2*(2), 56–64. doi:10.1177/2151458510394606

LIVING FROM INSIDE OUT: The Value of Conscious Aging and the Foray (4A+) "Beyond Self" Paradigm

"Growing" older can open possibilities never thought possible. New research supports a trio of fresh ideas for getting there.

BY THERESA SOUTHAM, PHD AND CONNIE S. CORLEY, MSW, MA, PHD

Growing in later life is not a given; in fact, many older adults are healthy and active but may still feel something is missing. We share stories and processes, facilitated by several practices illustrated here, demonstrating that living from the inside out is life enhancing for self and others. Informed by research, the 4A model previously presented is expanded to 4A+ as the journey or "foray" into the unknown of old age unfolds for an increasing number of people living long lives.

The Emergence of Conscious Aging

In many cultures, the work of elders is less about formal work and more about engaging in inner work. In the context of "positive aging," there is growing interest of "conscious aging." In this article we provide examples from participants in a research study and share practices of conscious aging in order to further enhance this complex time in the life course.

> "Maybe we've evolved as much as we're going to evolve biologically and the next real evolution of humankind is the evolution of human consciousness" (Schlitz, Vieten, & Erickson-Freeman, 2011, p. 228).

Self-actualization, a process of becoming better, healthier people, is multi-faceted and can emerge at various times. Self-actualization can be accompanied by increased instances of self-transcendence. Researcher Susanne Cook-Greuter writes that self-transcendence is not a later stage of self-actualization, but a completely separate process; one becomes open to non-rational sources of input (2000). Moody (2002) adds that through established long-term practices, we may reach higher stages of psychological functioning and "transcend" unhelpful midlife patterns.

In conscious aging, or gerotranscendence, older adults tend to become less self-focused, more selective in their social activities, and spend more time in solitude and introspection. People who engage in conscious aging practices report a reduction in the fear of death, increased broadmindedness, and a sense of tolerance, along with feelings of unity with the universe and a new view of time (Tornstam, 2005).

It is not surprising that the body, mind, *and the spirit* continue to evolve and change until the day we die. However, gerontologists often focus on the body and mind, and less on conscious aging, a process that can be viewed as nurturing spirits and souls.

Forays with and Beyond Self (4A+) Aging Paradigm

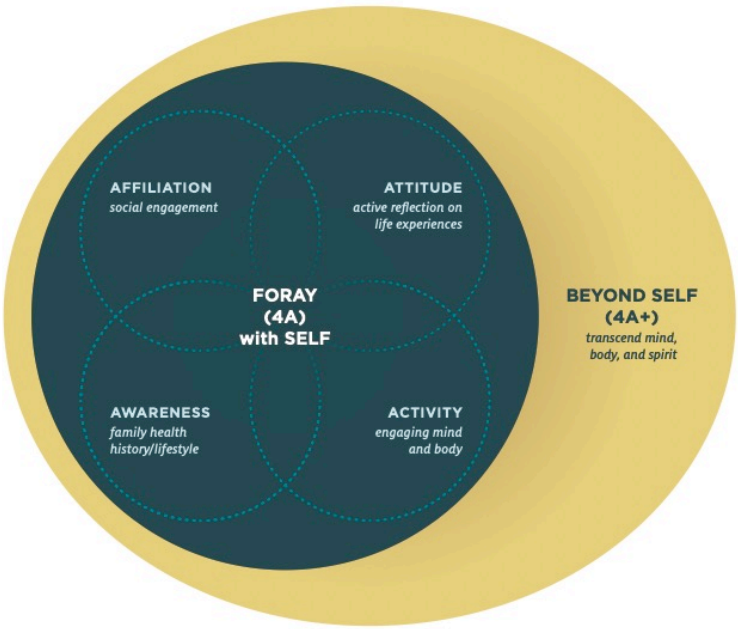
In recent research, several highly generative adults aged seventy and up were found to be not only wise, but also experiencing transcendence (Southam, 2020). Immersed in caring for others (their communities, families, and the Earth), these older adults were also informed by experiences that connected them to other worlds and ways of knowing not seen to be this world. In this article we expand on a manuscript previously published in this journal, called: *Positive Aging Perspectives and a New Paradigm: Foray (4A) into Aging* (Corley and Southam, 2018). We discuss how the specific tools, life maps, LifeForward plans, and wisdom circles can help older adults age consciously, avoid being pressured into activities created by those on the outside and, instead, lead a life from the inside out.

In the original model by Corley called "4A" (Awareness, Affiliation, Attitude, and Activity) (Corley, 2011), a range of practices were found to promote continuous development, health, and well-being in older adults. The practices led to more active reflection on life's experiences, maintaining and creating new social networks, heightened awareness of one's health, and active engagement of the mind and body. Although the participants in the recent study (Southam, 2020) engaged in these processes of actualizing the self, they were also found to transcend the mind, body, and spirit. These discoveries led to a proposal for an expanded model: Foray (4A+) Beyond Self. See Figure 1.

Transcendence has been described as "a state of consciousness that one can enter, but leaves upon returning to ordinary reality" (Cook-Greuter, 2000, p. 232). The activities described by the research participants that led them to transcendence included deepening spiritual and religious practices, letting go of possessions, embracing ongoing "relationships" with people who have died, integrating the head and heart, appreciating their shared humanity, and realizing the fluid nature of knowledge (Southam, 2020). Older adults were found to travel in and out of the ego-bound, self-actualizing self, growing through transcendence. One example is Chris, profiled below.

Chris, one of the study participants, described transcendent experiences through his lifelong pursuit of photographing nature. He has lived in his community in Canada since he was a young man, making a

FIGURE 1. FORAY (4A) MODEL (CORLEY, 2011) EXPANDED BY CO-AUTHORS TO FORAY (4A) + BEYOND SELF.



living from photography, publishing books, and giving workshops. Most of his activity has focused on conserving the region he so loves. At seventy-nine, having accomplished much over his life, he has delighted himself with what still lies in store. Now comfortably living with his partner in a house they built and working from his straw bale-construction studio, Chris describes himself as not very religious, but very spiritual. His health is good. When he was twenty-five, Chris survived a serious car accident he says should have killed him. "My father told me I was spared because I had something special to contribute. Those words were inspirational and I never forgot them," Chris said. Throughout his life, Chris has "transcended" this world by immersing himself in nature and through his photographs. One day in 2019, as he and the researcher (Southam) approached a high point in the landscape on a photographic outing, he said, "When I come up onto the plateau, I leave this other world."

Lately, Chris has been engaging in artist retreats, places where artists can stay for weeks and pursue their art. He signs up for nearby retreats and recently for one overseas in Europe. During these times alone in nature he explores other realities. He displays pure joy with techniques he employs completely within his camera:

> "Possibilities of any subject matter are endless! There are literally thousands of ways with which I can approach any subject and express myself in a way that I never have before, I never dreamt of [shaking his head in disbelief]. So now photography is opening up a world that no one else has ever seen. I've never seen it. I'm able to share worlds that [my workshop participants] don't know exist. That's pretty cool. You feel it in the audience when you show them. It is like wow!" he chuckles, and turns off the highway to the location of his next shoot.

Chris has learned his father also explored abstract themes. He was surprised to find this out when he returned to the city of his childhood. It was during a presentation he was making at a photography club where his father had been a prominent member that his father's friends approached him. He and his father shared a mentor, so he realized that he shouldn't have been surprised in their common interests.

Reminiscing and facing mortality, as Chris is doing, are all part of healthy aging. Cultural anthropologist Angeles Arrien noted that as we age, we have four frontiers to face: knowing from what we are coming and toward what we are going, becoming a mentor, coping with the natural challenges of an aging body, and embracing the inevitability of our own death (Arrien, 2007). In their recent book *Walking Each Other Home: Conversations on Loving and Dying,* Dass and Bush discuss old age as a window of opportunity, when older adults "can give up accumulating experiences and material possessions and instead appreciate the connectedness of all things" (2018, p. 11). The authors discuss a range of practices that aid conscious aging, such as being present, cultivating compassion and loving kindness, and dying into loving awareness. Dass, who experienced a stroke at age sixty-six, embodied many of these practices up to the time of his death at age eighty-eight in December, 2019.

Facing Arrien's four frontiers while engaging in practices that help to transcend the mind, body, and spirit are essential in the life of consciously aging older adults. They may travel back and forth between self-actualizing and self-transcending. Tools that are known to be helpful in self-actualization, described in the original Foray (4A) model, may also aid in self-transcendence, including autobiography, life maps, attention, intention, and deep listening (Corbett, 2013; Erikson, 1988; Gardner, 2000; Maslow, 1971; Tornstam, 2005). For the expanded model Foray (4A+) – Beyond Self, we will examine the life map, the LifeForward Plan, and wisdom circles as examples of practical tools for older adults who are interested in continuous development towards self-transcendence.

Practical Tools for Leading from Inside Out

In this section we discuss tools and activities that help older adults reflect on what has been important (see life map), focus on what is important now (see LifeForward Plan), and support their conscious aging in community (wisdom circles). These tools were self-reported to be transformative in the research. The participants were living the life they wanted to live, as opposed to just living their lives. Their experiences could be helpful for older adults who follow the Foray (4A) model to guide their lifelong learning and who are interested in a more contemplative and transcendent late life.

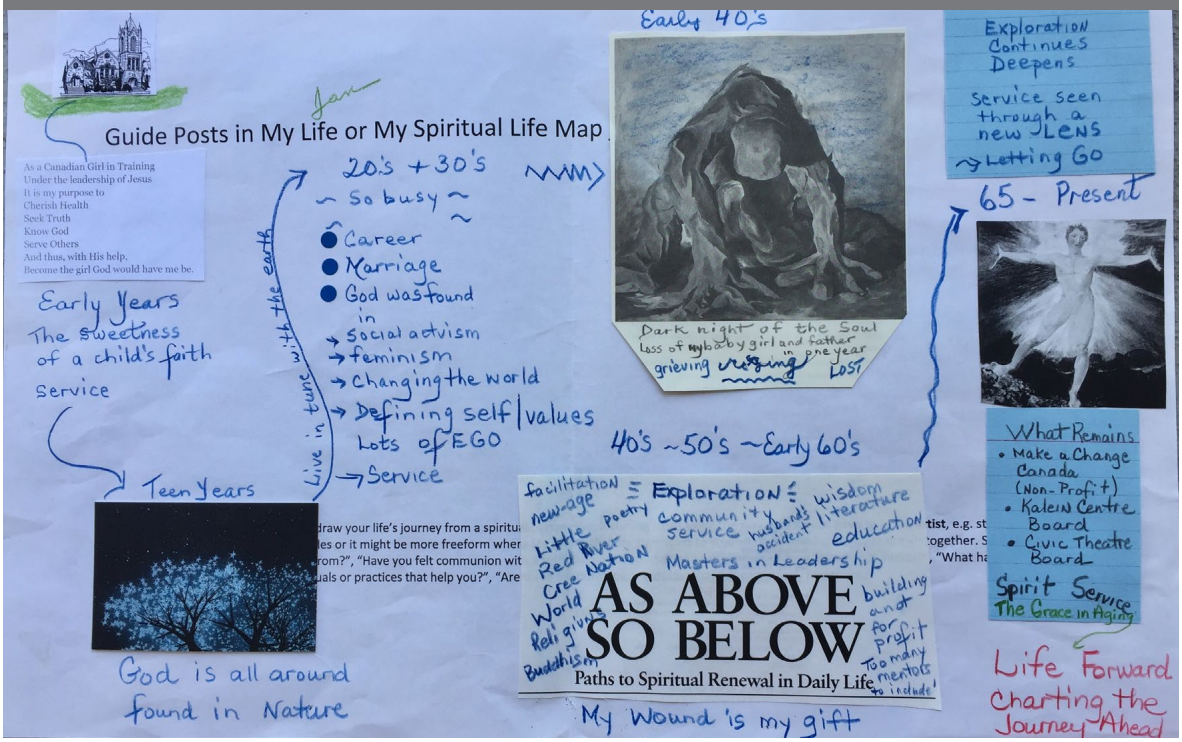
FIGURE 2. CHRIS ON HIS BELOVED CHILCOLTIN PLATEAU.

LIFE MAP

Methods such as reminiscence, life review, and autobiography have flourished in the aging field to help older adults integrate their life experiences (Cohen, 2006a & 2006b). Understanding life narratives, including major transitions and what is learned from them, can elevate wisdom, generativity, and transcendence among seniors. In the research by Southam (2019), nine participants aged seventy and up created life maps. See Jan's life map below. The life map for this study was based on the work of Hodge (2005) and Stinson (2013). An 11" x 14" piece of paper was used with the title *Guide Posts in My Life or Spiritual Life Map*. Instructions at the bottom of the page read: "On this sheet of paper draw your life's journey from a spiritual perspective, including stops along the way. You **do not have to be an artist**; e.g., stick people are fine! Your path might be linear, by decades, or it might be more freeform where life events that are significant to your spiritual development are drawn together." Some prompts on the map included:

- "What trials have you learned from?"

FIGURE 3. JAN'S LIFE MAP



- "Have you felt communion with a spirit outside of yourself or a redefinition of time, space and objects?"
- "What have you learned from life's experiences?"
- "Are there rituals or practices that help you?"
- "Are there relationships or mentors that are particularly important?"

Jan, one of the research participants, is seventy and only recently retired from a leadership position. She is already on the board of several community non-profits. For her, this project came just at the right time. Reflecting on major transitions in her life and planning what is important in the future were timely tasks (Figure 3); she was in the process of deciphering what is next for her.

Jan discusses how she transcends herself in the process of the life map:

> You [referring to the researcher] walked into my life right when I was struggling with what I'd accomplished. You were a witness. Participating in this research opened my heart. I usually ask the questions. You pushed me out of the script leading to my personal transformation. Whoever I see in my day, I speak with them differently now. It has made me very happy. At first, the life map was challenging for most of the participants. They were encouraged to "just identify four or five major transitions and what you learned from them." Once complete, the life map was transformative for all of the participants.

PLANNING FOR THE FUTURE

Tools that help older adults identify what's important in the next chapter can help them clear time and space for transcendent experiences and give them courage to age consciously. In the study by Southam (2020), participants engaged in exercises from *LifeForward: Charting the Journey Ahead.* After decades of research, study, and writing about adult development, McLean (2016) developed templates for planning out the later phases of life. The LifeForward plan (McLean, 2016) was created to help adults grow into elderhood and navigate the "rapid, dramatic, and disruptive change" (viii) that is manifest in today's world. McLean writes, "We will probably have many more chapters in our lives than our parents had. Many of us today will enjoy an added bonus round of twenty-some years of life compared to past generations. If we are going to prosper in our elder years, the work starts now!" (2016, p. ix).

Another research participant, Mary, had also just retired from a leadership position like Jan, but in her case it had been in healthcare. At seventy-nine, she speaks of the first few years after retirement as a time when she said "no" to many things. Mary knew that she needed some time to reassess and figure out what she wanted to do with the next stage of her life. She is now volunteering but is careful with her time and commitments. Divorced, she lives alone outside of town and enjoys the peace and solitude there. She describes herself as not very religious, but spiritual. She refers to her health as good. Below is an example of a portion of a LifeForward plan where Mary demonstrates her commitment

FIGURE 4. MARY'S LIFEFORWARD PLAN.

Appendix 13: LifeForward Plan

Life Forward Plan

(Adapted from Charting the Journey Ahead, Pamela Mclean)

PART ONE: Who do I want to be?

1. What are your measuring sticks for the next few years? (Choose top three and number in priority where "1" is highest priority, "2" is second and "3" last priority.

___	Accumulating – money and things
___	Respect for accomplishments
2	Love, intimacy and strong relationships
___	Good, productive, and value-centred children
___	Successful work/volunteer life
___	Pastimes, hobbies and sport
3	Spiritual Path
___	Making a lasting contribution
1	Making sense of my life and sharing it with others

2. Based on your choices above, finish the sentence "My purpose, for the next chapter of my life, is to …"

continue making sense of my life & sharing it with others, hoping my family & friends understand that strong relationships foundations give me freedom & courage to explore my own path.

3. Roles Matter (check the nature, e.g. essential, fulfilling, unfulfilling of each role now and then in the future given your purpose above)

Role	Essential		Fulfilling		Unfulfilling	
	Now	Future	Now	Future	Now	Future
Personal	✓	✓				
Couple					✓	✓
Family	✓	✓				
Friends	✓	✓				
Work			✓	✓		
Community			✓			

to spirituality and discusses the steps she will take along the way.

WISDOM CIRCLES

As older adults age consciously, they may face many barriers, such as conflicts with caregivers, family, and friends who do not see the opportunity for continuous growth in them. Wisdom circles have been defined as peer-to-peer "gatherings which help to create and maintain social connections with other like-minded persons" (Sage-ing International, 2019). They are a way for older adults to deal communally on a regular basis with life completion in a place of safety and respect. Some circles reclaim the name of "circle of elders." Jan went on to help create, and then participate in, a wisdom circle as a way to support her conscious aging. Having peer-to-peer support is vital as older adults, like others, are vulnerable to social isolation.

Conclusion

Immersed in caring for others (their communities, families, and the Earth), many older adults do not take the time to appreciate themselves or to consider whether their actions align with their own purpose. Nine highly generative older adults reported that engaging in self-reflection on major turning points in their lives, and prioritizing what's important in their upcoming years, was transformative for them (Southam, 2020). The 4A+ model was shared here along with some specific tools like life maps and LifeForward plans to help older adults avoid being pressured into activities created by those on the outside and, instead, lead from inside. •CSA

A 2020 PhD in Human and Organizational Development, **Theresa Southam** continues her research as a Fielding ISI Fellow. Her research interests include the lived experience of moving between post conventional stages of human development and emerging into transcendence, the practices that older adults use to enter and exit transcendence, the insights gathered from these travels, as well as how these insights are applied for the greater good. Theresa has contributed a blog post and book review to the Association for Anthropology, Gerontology and the Lifecourse. Theresa Southam, PhD tsoutham@email.fielding.edu

Connie Corley, MSW, MA, PhD is a professor at Fielding Graduate University and Professor Emeritus at California State University, Los Angeles. A Fellow of the Gerontological Society of America and the Academy of Gerontology in Higher Education, Dr. Corley has published widely and presented internationally. She co-hosted and produced a radio program, Experience Talks, at Pacifica station KPFK-FM in Los Angeles and spearheaded the podcast Love Goes Viral. conniecorleyphd@gmail.com · 626-532-7438 · conniecorleyphd.com

REFERENCES

Arrien, A. (2007). *The second half of life: Opening the eight gates of wisdom.* Louisville, CO: Sounds True Publishing.

Cook-Greuter, S. R. (2000). Mature ego development: A gateway to ego transcendence? *Journal of Adult Development, 7*(4), 227-240.

Corbett, L. (2013). Successful aging: Jungian contributions to development in later life. *Psychological Perspectives, 56*(2), 149-167.

Corley, C. (2011). Issues of aging. In Wildflower, L. & D. Brennan (Eds.), *The Handbook of knowledge-based coaching: From theory to practice.* Hoboken, NJ: John Wiley & Sons.

Corley, C., & Southam, T. (2018). Positive aging perspectives and a new paradigm: Foray (4A) into aging. *Certified Seniors Advisor Journal, 2*, 46-50.

Dass, R., & Bush, M. (2018). *Walking each other home: Conversations on loving and dying.* Louisville, CO: Sounds True Publishing.

Erikson, J. (1988). *Wisdom and the senses: The way of creativity.* New York, NY: W.W. Norton and Company.

Gardner, H. E. (2000). *Intelligence reframed: Multiple intelligences for the 21st century.* New York, NY: Basic Books.

Hodge, D. R. (2005). Spiritual life maps: A client-centered pictorial instrument for spiritual assessment, planning, and intervention. *Social Work, 50*(1), 77.

Maslow, A. H. (1971). *The farther reaches of human nature.* London, England: Arkana/Penguin Books.

McLean, P. D. (2016). *LifeForward: Charting the journey ahead.* Washington, DC: The Hudson Institute Press.

Moody, R. H. (2002). Conscious aging: A strategy for positive development. In Ronch, J. & J. Goldfield (Eds.), *Mental wellness in aging: Strengths-based approaches* (Vol. 17, pp. 143-144). Baltimore, MD: Health Professions Press.

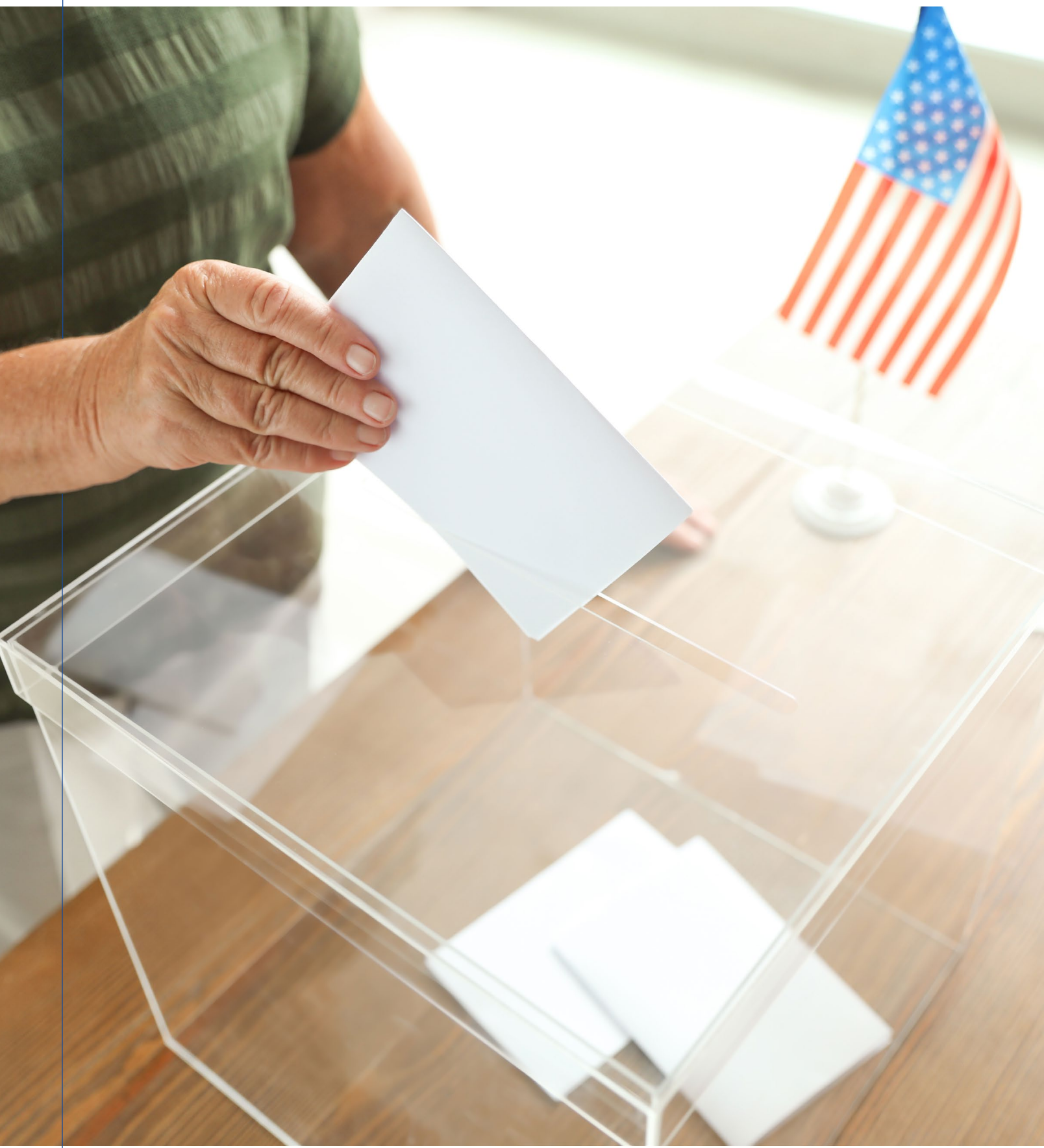
Sage-ing International. (2019). *Wisdom circles*. Retrieved from https://www.sage-ing.org/about/circles-chapters/

Schlitz, M. M., Vieten, C., & Erickson-Freeman, K. (2011). Conscious aging and worldview transformation. *Journal of Transpersonal Psychology, 43*(2), 223-238.

Southam, T. (2020). *27,000 sunrises: Everyday contributions of grateful and giving age 70+ adults* (Human and Organizational Development). Santa Barbara, CA: Fielding Graduate University, ProQuest.

Stinson, A. M. (2013). *Spiritual life review with older adults: Finding meaning in late life development.* (Doctoral dissertation). Retrieved from http://scholarcommons.usf.edu/etd/4778

Tornstam, L. (2005). *Gerotranscendence: A developmental theory of positive aging*. New York, NY: Springer.



Lessons From Our Elders:

Part 2 of Advocacy

Older adults are the demographic most likely to cast a ballot. On the centennial anniversary of women's right to vote, a look at where retirees stand as voters in America. BY JACK LEVINE, MS

As professionals advocating for older adults in a wide variety of capacities, we may sometimes forget how much the members of our older generations sacrificed for our rights, a discussion begun in *CSA Journal* 76 with the article "Advocacy Across the Generations." This includes the right to vote, fundamental to every democracy. While some may take it for granted, our elders who sacrificed through two World Wars and the Great Depression did not. Today's older adults continue to be more likely to vote than their younger counterparts. A full 90 percent of Americans over the age of sixty are registered to vote (Ansolabehare, Hersh, & Shepsle, 2012).

Voter turnout is consistently greatest among those aged sixty-five and above (Misra, 2019). In the 2016 presidential election, 71 percent of Americans age sixty-five and up turned in a ballot vs. 46 percent of those aged eighteen to twenty-nine (Misra, 2019). Although turnout was higher among younger adults for the 2018 midterms, that preponderance of older voters remained: 66.1 percent of those sixty-five and up went to the voting booth vs. 35.6 percent of those age eighteen to twenty-nine (Bunis, 2018). In fact, getting older seems to be a consistent factor with increased voting, as shown in the chart on page 22.

Why do older adults turn out at the polls in greater numbers? Brandon (2012) suggests there are four contributing factors:

- **A vested interest in social programs**. Older adults utilize a majority (53 percent) of government entitlement programs, according to

Sherman, Greenstein, & Ruffing (2012). These include Social Security, Medicare, and Medicaid, which many older adults rely on to get them through, or enhance, their retirement.

- **Reduced mobility**. Older adults are less mobile, meaning they don't have to change their voter address or re-register. If they vote at the polls and not by mail, it's likely they know where to go and don't have to put as much effort into voting as someone new to the community.
- **Free time.** Retirees don't have to worry about missing work to cast a ballot; they don't have to squeeze voting around a job or kids.
- **Social norms**. Older adults tend to think of themselves as voters, and they may talk to neighbors and friends about who they plan to vote for.

Furthermore, the cohort of older voters is growing. There will be more older adults than children by 2035 in the U.S. for the first time in history. Lower fertility rates and longer life expectancy will gray the country. Baby boomers will all be sixty-five or older by 2030, when that demographic will make up 21 percent of the population, compared to 15 percent today (Vespa, 2019).

Women and the Vote

Using the 2018 election numbers, women continued their twenty-year run of voting at higher numbers than men overall, with 55 percent filling out a ballot compared to 52 percent of men (Misra, 2018). However, that statistic doesn't hold true for older voters, where voter turnout was 68 percent for men and only 65 percent for women. Still, data show that women over fifty could decide the 2020 election (Bunis, 2019). After a hundred years, women are finally coming into their own as a voting block to be reckoned with. It wasn't always that way.

Proposals to grant women the vote began in 1848 and grew stronger after the Civil War, when abolitionists urged parity for former slaves and women both (Stansell, 2010). The 19th Amendment to the U.S. Constitution granting women the right to vote became law in August of 1920. But while the 15th Amendment, ratified in 1870, prohibited states from

Change in Voter Turnout by Characteristic: 2014 to 2018

Characteristic	2014 Voter Turnout	2018 Voter Turnout	Difference[1]
Total	**41.9**	**53.4**	**11.5**
Age			
18–29	19.9	35.6	15.7
30–44	35.6	48.8	13.2
45–64	49.6	59.5	9.9
65+	59.4	66.1	6.7
Sex			
Male	40.8	51.8	10.9
Female	43.0	55.0	12.0
Race and Hispanic Origin			
White alone, non-Hispanic	45.8	57.5	11.7
Black alone, non-Hispanic	40.6	51.4	10.8
Asian alone, non-Hispanic	26.9	40.2	13.3
Hispanic (any race)	27.0	40.4	13.4
Educational Attainment			
Less than a high school diploma	22.2	27.2	5.0
High school diploma or equivalent	33.9	42.1	8.2
Some college or associate's degree	41.7	54.5	12.8
Bachelor's degree	53.2	65.7	12.5
Advanced degree	62.0	74.0	12.0
Citizen Group			
Native-born citizen	42.7	54.2	11.5
Naturalized citizen	34.1	45.7	11.7
Metropolitan Status			
Metropolitan area	41.5	53.7	12.2
Principal city	39.1	52.4	13.3
Balance of metro area	42.9	54.4	11.5
Nonmetropolitan	44.3	52.1	7.7

[1] The difference between 2014 and 2018 voter turnout rates is significant for each group.
Source: U.S. Census Bureau; Current Population Survey Voting and Registration Supplements: 2014 and 2018.

denying a male citizen the right to vote based on "race, color, or previous condition of servitude," in practice, voting rights for African Americans were hampered by a century of racist Jim Crow laws. Black Americans were not able to legally vote throughout the nation until 1965, when the Voting Rights Act was signed into law by President Lyndon Johnson (history.com Editors, 2019).

Grandma Minnie

My own Russian-born grandmother illustrates a theme common to many Americans at the turn of the century. She arrived in the United States in 1907 at the peak of immigration, when 1.3 million foreigners entered through Ellis Island alone (Constitutional Rights Foundation, n.d.). Quickly adapting to her new home, she became a suffragist, a story she would tell many times throughout her long life. Hers was a life that encapsulated the ideals of resiliency, self-sufficiency, and hard work to achieve the American dream.

Immigration

As Cossacks sent by the Czar swept through the Russian countryside, destroying all in their path, my then-teenaged grandmother fled for her life. Accompanied by two cousins and another woman, Minnie emigrated to America at age sixteen after a two-year trek through Poland, earning enough money doing farm labor to buy her passage. Sailing under the outstretched arm of Lady Liberty would be a lifelong memory.

Almost every immigrant girl worked as a seamstress, shop clerk, or in food services. Minnie's first job was as fish girl at the Fulton Fish Market in lower Manhattan. Their workspace was behind a two-foot cutting board, sharp knife in hand.

Scores of fish girls were lined up in long rows, each hearing orders barked at them by growling restaurant stewards. From sunrise until dusk, they filleted fish by the hundreds, earning pennies per fish, with an occasional tip.

Meeting Leads to Change

Minnie Golub was eighteen, already a two-year veteran fish girl, when she was invited to a nighttime meeting. The year was 1909. What kind of meeting? She wasn't sure, but her friend said homemade chocolate marble cake would be served. Incentive enough for Minnie.

The small tenement apartment felt cramped with ten girls sitting around on rickety chairs, a few more leaning on pillows scattered on the floor. A woman in her forties with a feathered hat stood in front of them making a speech. The speaker's arms waved for emphasis, but none of the girls understood the words. The speaker spoke English, a foreign language to the Russian immigrants, whose fluency was limited to their home language, Yiddish.

"You know," Minnie smiled while telling the story, "We didn't understand what she was saying, but she was such a good speaker, we agreed. When she nodded "yes," we nodded, too. When she shook her head "no" we did the same."

After about five minutes, one of the girls who spoke some English stood up and translated. The speech was about suffrage, the fight for the right to vote. "Women work as hard as men, sometimes even harder. We raise children, wash clothes, clean house, and cook meals. Men don't have those responsibilities. Another big difference is men vote, we can't. That's got to change!"

The message was heard, and the delicious marble cake eaten down to the crumbs.

The next day on the fish line, Minnie mentioned the meeting to the girl beside her, saying the word "voting" in English. Overhearing the conversation, a burly steward leaned over. "His mustache was long,

Minnie's first portrait in her adopted country at age seventeen. The dress was borrowed, as was the paper flower she's holding.

covering up some bad teeth," remembered Minnie. "Why would anyone give you stupid girls the right to vote?" he snarled. He spat out the word "stupid" with extra emphasis.

"I had this knife," Minnie recalled. "Just like I did 200 times a day, I sliced in at the neck… of the fish. But instead of looking down, I looked right at the man as I ran the sharp blade down the backbone. At the tail, instead of pointing out, I pointed right at the man." His ugly smile turned to a frown. The silent threat was felt and responded to with equal silence. A strong young woman was a work in progress.

Women Get the Vote

From then on, Minnie Golub was a suffragist. She picketed for the right to vote as a young woman. Upon earning her naturalized citizenship in 1919, she celebrated passage of the 19th amendment to our Constitution in the summer of the following year and counted the months until she could legally vote.

Minnie cast her first vote in November, 1920… and never missed a vote in her life. In 1982, at age ninety-one, she had to be helped into the voting booth, but found the energy to cast her last vote. Her pride of achieving justice was a lifelong mission. She remembered the discrimination … being thought of as a lesser person because of her gender. Minnie was an activist with style and strength of resolve.

Her legacy of activism lives in me and all citizens who understand the special gift of freedom and voting rights. Fighting for what's right, learning how to make a difference, supporting just causes, and making sure that others feel a sense of power are hallmarks of democracy's greatness.

And now, a hundred years after women like Minnie fought (and were brutally treated) for the right to vote, they are showing strength in numbers. A 2019 AARP poll found that 95 percent of women plan to cast a ballot in November (Bunis).

Of course, there are many Grandma (and Grandpa!) Minnies, courageous women and men teaching younger generations by telling their stories of advocacy. We can honor them by writing down or recording their history and passing it along to future generations. This great country doesn't lack for heroes among older adults, and it's our responsibility to remember them and share their stories with our younger generations.

TOP TEN REASONS TO VOTE

As you doubtless noticed, this is an election year! I truly believe that voting is not just a right, it's a responsibility. There are few more influential activities than voting. It takes just a few minutes, but has impact

Minnie at age eighty-eight.

for years to come. When I think of the many who struggled, suffered, fought, and died for our right to vote, I'm motivated all the more to have my voice be heard.

The pollsters are busy making their case for which way voters are leaning. The pundits are sharpening their sound bites. The commercials, mail fliers, e-mails, texts, and phone calls are flooding in. But when all the words are said, charges leveled, and money spent, it's we the voters who hold the power to decide who will lead our nation, our states, and our communities into the future.

Here are my top ten reasons to vote:

- To honor our military personnel, our law enforcement officers, firefighters, and emergency workers who courageously fight for us abroad and respond to our needs and defend the peace at home. Those who sacrifice their personal well-being in the name of our safety and security deserve our respect.
- To honor the multitudes who struggled for civil rights, women's suffrage, and the ideals of justice, as well as for all whose diverse voices are essential for our nation's moral health and community vitality. Freedom needs affirmation.
- To be a good example to our children and grandchildren by exercising the right to vote as a symbol of our faith in democracy. By voting, we send a signal of the importance of the choices we, as adults, make to secure a better future for ourselves,

our children, and generations who will follow.

- Voting is our society's great equalizer. No matter our station in life, income, or social status, every citizen over age eighteen has the same power of one vote.
- Pollsters do not determine who wins elections; voters do. Predicting the outcome of elections, especially close ones, is at best an inexact science. Pollsters and political pundits have their roles, but, like each of us, they only have one vote.
- Elections should not be about negative ads, they should be about the options we have to promote positive policy actions. Voting for candidates in whom we believe, and for or against ballot initiatives we know will affect our future, is a perfect counterbalance to the flood of negativity polluting the airwaves and filling our mailboxes.
- Voting is now more convenient than ever. Early voting reforms and the wide availability for mail-in voting makes it all the easier for us to participate. Democracy is a team sport …. and spectators simply don't count.
- It's vital to be an informed voter. Pay attention to news reports and editorials about the campaigns. While how we vote is confidential, the fact that we have voted, or failed to vote, is public record. Elected officials know which individuals and demographic groups are voting, and those who do vote are more likely to be influential in policy debates. Non-voters are voiceless and, by not participating, can become victims of their own neglect.
- Regret is preventable. November 4th is one day too late, and "could have, should have" are sorry alternatives to acting. Have a "no excuses" attitude by committing to vote, asking others to join us in voting, and promoting a positive approach to making a difference among family, friends, and colleagues.
- Be part of making history. Because every indicator points to the prospect that the 2020 election will have impact for years/decades to come, every vote is even more important. As a Floridian, I know how close elections can be! Affecting history gives each of us a sense of pride in democracy and the power to touch the future. •CSA

Jack Levine, Founder of 4Generations Institute, promotes the exchange of wisdom and energy among generations. He previously served as president of Voices for Florida's Children for twenty-five years. He holds a BA in English Literature from Hunter College, City University of New York and a Master's in Child Development and Family Studies from Purdue University. Jack and his wife, Charlotte, are 40-year residents of Tallahassee. They have two sons, Aaron and Josh, and celebrated the birth of their granddaughter, Julianne, on Thanksgiving Day, 2017. Jack may be reached at jack@4gen.org.

REFERENCES

Ansolabehere, S., Hersh,E., & Shepsle, K. (2012, May1). Why age is correlated with registration in the U.S. Retrieved from https://scholar.harvard.edu/files/kshepsle/files/mobility_model_v6.3.pdf?m=1360041584

Brandon, E. (2012, March 19). Why older citizens are more likely to vote. Retrieved from https://money.usnews.com/money/retirement/articles/2012/03/19/why-older-citizens-are-more-likely-to-vote

Bunis, D. (2018, April 30). *The immense power of the older voter.* Retrieved from https://www.aarp.org/politics-society/government-elections/info-2018/power-role-older-voters.html

Bunis, D. (2019, December 18). Exclusivepoll: Women 50 and older could decide the 2020 election. Retrieved from https://www.aarp.org/politics-society/government-elections/info-2019/women-voting-poll.html

Constitutional Rights Foundation. (n.d.). History lesson 3: Ellis Island - The "golden door" to America. Retrieved from http://www.crfimmigrationed.org/lessons-for-teachers/142-hl3

history.com Editors. (2019, June 6). *Voting Rights Act of 1965*. Retrieved from https://www.history.com/topics/black-history/voting-rights-act

Infoplease Staff. (2017 February 11). When and where did women earn the right to vote? Retrieved from https://www.infoplease.com/history/womens-history/womens-suffrage

Misra, J. (2019, April 23). *Voter turnout rates among all voting age and major racial and ethnic groups were higher than in 2014*. Retrieved from https://www.census.gov/library/stories/2019/04/behind-2018-united-states-midterm-election-turnout.html

Sherman, A., Greenstein, R., & Ruffing, K. (2012, February 11). Contrary to "entitlement society" rhetoric, over nine-tenths of entitlement benfits go to elderly, disabled, or working households. Retrieved from https://www.cbpp.org/research/contrary-to-entitlement-society-rhetoric-over-nine-tenths-of-entitlement-benefits-go-to

Stansell, C. (2010). A forgotten fight for suffrage. *The New York Times*. Retrieved from https://www.nytimes.com/2010/08/25/opinion/25stansell.html

Vespa, J. (2019, October 8). The U.S,. Joins other countries with large aging populations. Retrieved from https://www.census.gov/library/stories/2018/03/graying-america.html

Bullying:

Not Just an Adolescent Issue

Bullying doesn't end with high school. It is common in older adult communities, where there should be a protocol for addressing and alleviating the problem.

BY JILL M. SHUTES, DNP, APRN, GNP-BC

Suzanne was excited about moving into her new apartment. This was the first time she would be living on her own and was looking forward to this next chapter in her life. She picked out new furniture and had professionals cover the interior with fresh paint. Moving day arrived, and she had a lot of help from her family. After everything was unpacked and her family had departed, it was time for dinner. She dressed for the occasion and made her way to the dining hall. As she entered, her excitement quickly turned to anxiety. Each table she approached denied her a chair. "This seat is taken," she heard over and over. Devastated, she decided to take her dinner back to her apartment and eat alone. She would not go back to the dining hall.

One may assume when reading the above scenario that Suzanne is at college. But Suzanne is a 78-year-old, recently widowed woman, and the apartment is at an assisted living community in Anytown, USA. This is what bullying looks like in the older adult community. Goodridge (2017) reported that 39 percent of tenants in a community senior living dwelling had witnessed bullying and 29 percent had experienced bullying themselves. The most prevalent forms of peer bullying were "deliberate social exclusion and hurtful comments" like Suzanne experienced (Goodridge, 2017). This is not just an adolescent concern.

"Epidemic"of Bullying

Bonifas (2012) reported that "elderly bullying" research is dragging its feet compared to related topics of youth bullying and elder abuse. Prior to 2015, there was little discussed in the literature about bullying in the senior community. Except for experts like Bonifas (2012), Wood (2007), Rex-Lear (2011), and Trumpetter (2010), little has been written about this phenomenon until recently. According to Alyse November, creator of the "Different Like Me" program, bullying among older adults is a hidden, unseen epidemic (Lade, 2014). Bonifas (2014) classified bullying into three categories: physical, verbal, and social. Bullying is defined by the National Center for Assisted Living (NCAL) with the following core elements: unwanted aggressive behavior; observed or perceived power imbalance; and repetition of behaviors or high likelihood of repetition (2017). Studies suggest that most senior-to-senior aggression in assisted living communities is verbal abuse (Positive Aging Sourcebook, 2015).

Jennifer Weiner, American writer, producer, and journalist, recently penned an editorial in *The New York Times* (2015) titled, "Mean Girls in the Retirement Home." She discusses quite poignantly the experiences her 97-year-old grandmother endured at an independent living facility. When Jennifer asked her grandmother, "How is it going?" her grandmother cried, "They won't let me sit at their table. You try to sit and they say, 'That seat is taken!' And just try to get into a bridge game," her grandmother continued. "They'll talk about bridge, and you'll say, 'Oh, I play,' and they'll tell you, 'Sorry, we're not looking for anyone.'" Weiner stated that the idea that the threat to seniors is their peers, and not the employees, shocked her. She writes that it goes against the long-time belief that "mean girls are not girls, or mean, forever."

So how do we address this issue? Acknowledge. Identify. Intervene.

Acknowledge

First, we need to acknowledge that this is a legitimate concern. NCAL created a resource as a prevention and surveillance support for assisted living providers (2017). The organization states that even though assisted living communities provide a great service for older adults to socialize with others, it's impossible to expect that everyone will be compatible with each other. This resource is designed to support assisted living providers when thinking globally and strategically about this issue, according to NCAL (2017).

In one study, the prevalence of staff witnessing bullying was as high as 28 percent, with most of this bullying being verbal or social in nature (Jeffries, 2018). Another study reported that most staff members had witnessed resident-on-resident bullying in the two weeks prior and that again, verbal and social bullying were the most prominent types witnessed (Andresen & Buchanan, 2017). One would think that with this amount of witnessed bullying there would be some specific training pertaining to this issue. However, a 2017 study found that more than 50 percent of the employees had not received formal training on the matter and only 21 percent reported that the facility had a formal policy to address bullying, even though most staff observed bullying among the residents of the facility (Andresen & Buchanan, 2017).

Identify

Once the concern is acknowledged as an actual threat, how do we identify and categorize typical traits of individuals who bully, and the victims' risk factors? Bonifas and Frankel (2012) made inroads on this issue. They found that, while men and women have some specific traits that will be discussed later, the following characteristics are identifiable in either gender.

Typically, the "bully":

- lacks empathy,
- has few friends,
- needs power and control,
- struggles with individual differences,
- uses power and control at the expense of others,
- suffers from low self-esteem, and
- is empowered by causing conflict, or making others feel threatened, fearful, or hurt.

Andresen & Buchanan (2017) interviewed staff at a long-term care facility about the incidents of bullying that staff had witnessed. The researchers found that those who bullied were more often male (42 percent vs. 18 percent). Men seemed to be more prone to

use verbal bullying (46 percent), followed by physical bullying (26 percent). Typical traits of men who bully are direct, spontaneous, verbally or physically aggressive, have a superiority complex, and are overly protective (Goodridge, 2017). In an assisted living facility where the author once worked, there was an incident with two men involving the television remote control in the community room. One of them punched the other in the face. This was not the first time they had argued over channel selection, but it had never escalated to this extent before.

Women, on the other hand, were inclined to social bullying (cliques, gossip) in 42 percent of instances and used verbal bullying nearly a third (31 percent) of the time. Goodridge (2017) reports that verbal bullying was the most commonly used type, with physical appearance as the target (being poor, homely, and/or not having clothing that is as nice as that of other people). Typical traits of women who bully are those who gossip, snipe, are members of a clique, exhibit passive-aggressive behavior, and manipulate others' emotions.

We also need to identify those at risk for being bullied. Generally, residents in assisted living communities who become victims have one or more of the following characteristics (Bonifas & Frankel, 2012):

- is a new member of the community,
- is alone (widowed or divorced),
- has a passive demeanor,
- suffers from depression,
- suffers from other mental illness,
- is heavily dependent on others, and
- has a scattered support network.

In order to help those victims, it is important to clearly be able to define and identify bullying behaviors. Bonifas and Frankel (2012) have identified certain examples of bullying behaviors that staff and visitors to assisted living facilities can look for in their residents. Physical bullying may take the form of something as simple as a dirty look across the dining hall or in the elevator, or it may constitute an overbearing presence, or even be an actual assault. Verbal bullying ranges from passive-aggressive comments or negative critical comments about one's appearance, to unsolicited sexual comments. Relational bullying is the most difficult to identify, as it is subtle in nature: ignoring a resident, gossiping, and/or participating in cliques that conspire to isolate another resident.

Those patients who are experiencing memory loss from a neurocognitive disorder such as Alzheimers may be at greater risk for bullying. This is because they may ask repetitive questions or invade personal space, and the bullying behavior surrounds getting power and control over others.

Intervene

What are the results of not intervening in the bullying behavior? Goodridge (2017) reported that some of the results of not intervening include loss of sleep, stress, anger, worry, and embarrassment. Another study found that bullying was associated with a decline in psychosocial health, reduced life satisfaction, and increased risk for depression, low self-esteem, and neglect (McDonald, Sheppard, Hitzig, Spalter, Mathur & Mukhi, 2015). If the victim internalizes the bullying, Bonifas (2015) found the victim may feel:

- helplessness,
- anger,
- fearfulness,
- depression,
- reduced self-esteem, and
- loneliness, as well as having
- increased physical complaints, and
- poor overall physical health.

Statistically speaking, it takes about sixteen years for best practice to translate from the typewritten word to actual "bedside" practice (White & Dudley, 2016). With that information, and the fact that the first authors of older adult bullying reportedly recorded their findings in 2007, we are approaching the golden hour of application at the bedside.

Andresen (2017) reported that there is ambiguity around when bullying (social and verbal) crosses the line to a reportable offense. It was noted in this study that staff intervene in bullying events based on their own moral code, rather than a specific policy or guideline. NCAL recommends that, when responding to potential incidents addressing bullying, communities have specific policies in place to address a bullying incident. Such policies ideally include staff education, reporting requirements, and a protocol to help define bullying. In the resource, the organization outlines a sample process for how to address bullying when it occurs (NCAL, 2015):

1. Staff member observes or is told about a situation involving bullying behavior.
2. Staff member assesses whether there is a potential for immediate or imminent physical danger to anyone, and if so, takes immediate steps to de-escalate the situation.

3. Staff member notifies the appropriate leadership.
4. Once notified of the situation, leadership/management also assesses the potential for physical danger, and if so, whether appropriate steps have been taken to safeguard the victim or if necessary, all within the community.
5. If the incident is less severe, staff may be able to help resolve the situation.
6. With the above information, brainstorm possible solutions, while still adhering to the residents' rights.
7. Develop a corrective plan and communicate this plan to the impacted parties and staff.

In conclusion, bullying in the older adult community is an under-identified concern. As providers of care, we need to acknowledge that this is truly a problem, help staff and residents identify which actions constitute bullying, and intervene with policies and corrective action plans to eliminate this destructive pattern of behavior. The deserving population of older adults living in facilities merits our attention to this pervasive problem. •CSA

Dr. Jill Shutes has been a gerontological nurse practitioner for over twenty years. She has worked in the areas of long-term care, assisted living, and home health care, focused on primary care of the older adult. She currently works at Jupiter Medical Center as the gerontological clinical coordinator for the NICHE (Nurses Improving Care for Health Systems Elders) program and teaches FNP-DNP students at Palm Beach Atlantic University. She has traveled extensively teaching hospital systems, ACOs, and long-term care facilities how to reduce acute care transfers utilizing the INTERACT program. She is currently a member of Sigma Theta Tau Nursing Honor Society and the Gerontological Advanced Practice Nurses Association.

RESOURCES

MyBetterNursingHome, six-part series on senior bullying in a blog by Eleanor Barbera, PhD:
http://www.mybetternursinghome.com/?s=bullying

REFERENCES

Andresen, F. & Buchanan, J. (2017). Bullying in senior living facilities: Perspectives of long-term care staff. *Journal of Gerontological Nursing*. Volume 43 (7) 34-41.

Bonifas, R., & Frankel, M. (2012, February 8). Senior bullying guest post [Blog post]. Retrieved from: http://www.mybetternursinghome.com/senior-bullying-guest-post-by-robin-bonifas-phd-msw-and-marsha-frankel-licsw/

Bonifas, R. (2015). Resident-to-resident aggression in nursing homes: Social worker involvement and collaboration with nursing colleagues. *Health and Social Work*, 40 (3)101-109.

Cardinal, K. (2015). *From social bullying in schools to bullying in senior housing: A new narrative & holistic approach to maintaining residents' dignity.* Retrieved from https://www.umb.edu/editor_up;loads/images/mgs/mgs_gerontology/Cardinal.Katherine_Capstone_Gerontology_May_2015.pdf

Goodridge, D., Heal-Salahub, J., PausJenssen, E., James, G., & Lidington, J. (2017). Peer bullying in seniors' subsidized apartment communities in Saskatoon, Canada; Participatory research. *Health and Social Care in the Community.* 25 (4). 1439-1447.

Jeffries, H., Slovak, K., & Huston, S. (2018). Measuring and addressing elderly bullying in a senior residential community. *Journal of Sociology & Social Welfare*. September 2018, Volume XLV, Number 3 (141-161).

Lade, D.C. (2014, July 3). Anti-bullying program takes aim at retirement living. *South Florida Sun Sentinel*. Retrieved from https://www.sun-sentinel.com/health/fl-senior-bullying-palm-20140703-story.html

McDonald, L., Sheppard, C., Hitzig, S.L., Spalter, T., Mathur, A., & Mukhi, J. S. (2015). Resident-to-resident abuse: A scoping review. *Canadian Journal on Aging*, 34 (2), 215-236.

National Center for Assisted Living. (2017). *Bullying among seniors: A prevention and surveillance resource for assisted living providers*. Retrieved from: https://www.ahcancal.org/ncal/operations/Documents/Bullying%20Among%20Seniors.pdf

Positive Aging Sourcebook. (2015, June 4). *Senior bullying*. Retrieved from: https://www.retirementlivingsourcebook.com/articles/senior-bullying-233

Rex-Lear, M. (2011). *Not just a playground issue: Bullying among older adults and the effects on their physical health*. (Doctoral Dissertation). Retrieved from https://rc.library.uta.edu/uta-ir/bitstream/handle/10106/6207/REXLEAR_uta_2502D_11293.pdf?sequence=1&isAllowed=y

Trompetter, H., Scholte, R., & Westerhof, G. (2010). Resident-to-resident relational aggression and subjective well-being in assisted living facilities. *Aging & Mental Health*, 15, 59-67.

Weiner, J. (2015, January 17). Mean girls in the retirement home. *The New York Times*. Retrieved from https://www.nytimes.com/2015/01/18/opinion/sunday/mean-girls-in-the-retirement-home.html

White, M., & Dudley-Brown, S. (2016). *Translation of evidence into nursing and healthcare practice*. New York: Springer Publishing.

Wood, F. (2007). *Bullying in nursing homes: Prevalence and consequences to psychological health* (unpublished doctoral dissertation). Walden University, Minneapolis, Minnesota.

Grandparents Raising Grandchildren

Part 2: Challenges, Policy, and Trends

The many and varied difficulties experienced by grandparents who are raising their grandchildren has spawned policy aimed at supporting these unique families.

BY BERT HAYSLIP JR., PHD
REGENTS PROFESSOR EMERITUS AT THE UNIVERSITY OF NORTH TEXAS

Parenting a Grandchild

As discussed in Part 1 of Grandparents Raising Grandchildren in Journal 77, it's not uncommon for professionals to run across grandparents who are raising one or more of their child's children. When retirement portfolios (or Social Security checks alone) must stretch to feed and clothe another generation, tension over scarce resources rises. Add to that the social stigma and possible feelings of inadequacy grandparents may feel, and it can create a challenge for many older adults. Aging professionals need an understanding of this growing group, their strengths and weaknesses, and the resources and legislation which can empower them.

Most custodial grandparents who are in their mid- to late-fifties would likely endorse the notion that raising a grandchild is the most important task before them. Relative to parents who are raising their children, however, custodial grandparents often have little time to prepare for this tremendous responsibility, assume it under socially stigmatizing and oftentimes negative family circumstances, and frequently have had little direct and/or ongoing responsibility for raising a child for many years.

Issues and Demands

Parenting a grandchild thus reflects one of the central challenges for grandparents who have not raised children for many years and/or who experienced difficulties in doing so. In addition, issues that are both negative (e.g. depression) and positive (e.g., fostering empowerment and resilience) are paramount in understanding the parenting quality of custodial grandparents. Contributing to the parenting difficulties some experience, grandparents may have outdated ideas about child development and discipline and are sometimes unfamiliar with contemporary issues confronting their grandchildren (e.g., sexuality, drug use, violence, technology) (see Kahana, Kahana, Goler, & Kahana, 2019; Silverstein, 2019). Grandparents of adolescent grandchildren report particularly high levels of stress, often stemming from difficulties associated with such grandchildren's increased desire for independence and an identity (see Kahana, Kahana, Goler, & Kahana, 2019). Parenting may also be more challenging when grandchildren have physical and/or psychological problems associated with parental crisis and/or maltreatment (e.g., abuse/neglect, exposure to harmful substances). In this respect, grandparents caring for grandchildren with severe behavioral problems experience poor psychological health (Fuller-Thomson, 2005; Musil et al., 2011). For some grandparents, there is also the possibility that poor parenting skills may be intergenerationally transmitted, in that some had earlier difficulties in raising their own children and consequently may face similar challenges in raising a grandchild (Gibson, 2005). Many custodial grandparents are distressed and disappointed in seeing how their adult children offspring have fared as parents and question their own parenting ability (Glass & Honeycutt, 2002; Smith & Richardson, 2008). Some do have difficulty with disciplining and setting limits with a grandchild, and some question their ability to parent effectively due to advanced age or poor health (Landry-Meyer & Newman, 2004).

In working with custodial grandparents, it is important that beliefs about having been a poor parent making one responsible for an adult child's parental failures should be challenged. Underscoring this stance is the fact that parents make their own choices in how to raise their child, and grandparents should be counseled to avoid assuming responsibility for such choices (Dolbin-MacNab, Stucki & Natwick, 2019). Indeed, adult children do make poor choices in managing their personal lives and raising their children, *despite* the grandparent's best efforts (Hayslip, Knight, Page & Phillips, In Press).

Only a small number of empirical studies have examined grandparents' actual parenting practices. Dolbin-MacNab (2006) has pointed out that while some grandparents perceive themselves as replicating the (effective) approaches to parenting that they used with their own children, others see themselves being more effective as a result of being more patient, having greater experience, and investing more time into their grandchildren. That being said, many custodial grandparents may be less efficacious parents or question their parenting skills, given the difficulties that their adult children have experienced (e.g., drug use, abuse, breaking the law) leading to their being unable to care for the child. Dolbin-MacNab (2006) has observed that while some grandparents perceive themselves as replicating the approaches to parenting that they used with their own children, others see themselves being more effective as a result of being more patient, having greater experience, and investing more time into their grandchildren.

It has been observed that custodial grandparents engage in *both* effective (e.g., giving rewards and monitoring their grandchildren's behavior) and ineffective (e.g., harsh and inconsistent discipline, difficulties with limit setting) parenting practices (Dolbin-MacNab, 2006; Smith et al., 2015). Some grandparents do have difficulty setting boundaries in defining their new roles as parents and are less sensitive to their grandchildren's needs (Smith & Richardson, 2008). Compared to parents, Kaminski and colleagues (2008) found that grandparents have less boundary clarity in the parent-versus-child roles and are less sensitive to their grandchildren's needs. This situation makes it more likely that the grandparent may be dependent upon the grandchild for emotional support. Despite these difficulties in parenting experienced by some grandparents, Kirby and Sanders (2014) found that parent skills training (i.e., Triple P program) improved (over a six-month time frame) grandchild behavior problems, grandchild relationship quality, parenting confidence, and grandparent psychosocial functioning (see Kirby, 2015).

The demands of parenting a grandchild may also be influenced by grandparents' own energy and health (Hipple & Hipple, 2008) as well as any psychological distress they may be experiencing (Smith & Dolbin-MacNab, 2013; Smith et al, 2008), where such distress is often magnified by the psychosocial and behavioral difficulties many grandchildren raised by grandparents experience (Hayslip, Shore, Henderson, & Lambert, 1998; Smith & Palmieri, 2007). However, these child difficulties might also be explained in terms of grandchildren's grief at the loss of their family of origin or as outgrowths of adjusting to a new family form (Hayslip, Shore, Henderson, & Lambert, 1998). They may also be a functioning of a grandparent's distress as mediated by dysfunctional parenting strategies (Smith et al., 2008; Smith & Hancock 2010), which may exacerbate the adjustment difficulties the child is experiencing and further undermine the grandparent's efficacy as a parent.

Parenting is a promising avenue for clinical intervention (see Dolbin-MacNab, Stucki, & Natwick, 2019), as among grandparents, parenting stress and ineffective parenting have been associated with psychological distress and compromised physical health (Dolbin-MacNab, 2006). Moreover, as noted above, ineffective parenting practices, often stemming from grandparents' own psychological distress, have also been linked to grandchildren's behavior problems (Smith & Palmieri, 2007; Smith et al., 2008). Yet, parenting skills training can improve grandchild behavior problems, grandchild relationship quality, parenting confidence, and grandparent psychosocial functioning (Smith et al., 2018).

Seeing Grandparents who Raise their Grandchildren in a Positive Light

In contrast to a view emphasizing the difficulties grandparent caregivers face in raising their grandchildren, custodial grandparenting has been recently redefined to reflect such persons' *strengths*, including such qualities as resilience and resourcefulness, benefit finding, empowerment, and positive caregiving appraisal, as well as protective factors such as social support and better health (see Hayslip & Smith, 2013). Indeed, the emphasis on a *strengths-based* or *resilience* perspective on custodial grandparenting is consistent with a more *balanced* view of custodial grandparenting: that the experience of raising a grandchild has both positive and negative consequences linked to both the demands of parenting and the inner resources of grandparents themselves. Each needs to be understood to fully appreciate what raising a grandchild is all about.

Grandparent *resilience,* or the process of demonstrating positive adaptation and positive outcomes *despite* adversity and risk can counteract the negative effects of stressors on grandparents' physical and mental health. Because the skills leading to resilience can be taught, interventions designed to promote resilience, including enhancing protective factors (e.g. social support, better health management) and reducing risk factors (e.g., social isolation), are fruitful avenues for promoting grandparent well-being (Dolbin-MacNab, Roberto, & Finney, 2013; Dolbin-MacNab, Stucki, & Natwick, 2019; Dolbin-MacNab, 2006; Musil et al., 2019).

Grandparent resilience (Masten, 2001) can thus counteract the negative effects of stressors on grandparents' physical and mental health. In this respect, Hayslip et al. (2013) found that resilience mediated the relationship between stress and psychosocial functioning among custodial grandparents. Equal attention should thus be given to enhancing protective factors (see Bigbee, Boegh, Prengaman, & Shaklee, 2011) and reducing risk factors, in promoting grandparent caregiver well-being (Yancura, Greenwood-Junkermeier, & Fruhauf, 2017). Also important is to provide grandparents with opportunities to bring forth those inner qualities reflecting resilience.

The importance of emphasizing custodial grandparents' strengths is underscored by the family trauma they have faced and the variety and intensity of the stressful experiences confronting such persons (Lee & Blitz, 2014). This is especially critical in that some custodial grandparents are facing multiple challenges (e.g., poverty and disability, raising multiple and/or problematic grandchildren, simultaneously caring for an older parent or an ill spouse) with minimal resources for doing so (Fuller-Thomson, 2005; Kopera-Frye, 2009). As social support may be protective, efforts to avoid isolation, actively interconnect grandparent caregivers, and make available support groups accessible, given their benefits (Strozier, 2012), are all important in increasing resilience and/or making its manifestations more apparent. Evidence also suggests that training to facilitate empowerment is also effective (Cox, 2008; Whitley et al., 2013).

Good physical and mental health is also protective in nature for custodial grandparents, though not all research supports this conclusion (see Cox, 2019; Yorgason & Hill, 2019). One reason for these mixed findings is that social support may be a prerequisite for better physical health and may mediate the relationship between poorer health and depressive symptoms (Hayslip, Blumenthal & Garner, 2014, 2015). Importantly, the impact of caregiving on grandparents'

physical health is relative to the presence of other factors (e.g., prior health status, intensity and recency of caregiving, social support), and whether the data are cross-sectional or longitudinal.

Policy Implications for Grandfamilies

In the context of the many challenges faced by grandparents raising their grandchildren, Cox (2019) has discussed a number of issues that reflect the importance of and need for a policy-oriented framework with which to view and support such persons. Among such issues is the reality that many grandparents are informal caregivers for their grandchildren as a function of a family crisis or associated with being an immigrant. Being an informal caregiver undermines the grandparent's legal ability to obtain education and health care for grandchildren, where only twenty-eight states give grandparents authority to enroll a child in school and forty-two states enable the grandparent to make medical decisions for the grandchild (Cox, 2019). Many states (e.g., Georgia, Maine, and Connecticut) have enacted legislation that recognizes the status and needs of informal kin caregivers to care for their grandchildren (see Cox, 2019).

In the event child welfare finds it necessary to remove a child from the home, twenty-seven states have enacted legislation to give preference to a family member in such cases versus placing the child in foster care.

In the event child welfare finds it necessary to remove a child from the home (e.g., when abuse has occurred), twenty-seven states have enacted legislation to give preference to a family member in such cases versus placing the child in foster care (Cox, 2019). This minimizes the adjustments a child would otherwise be forced to make in encountering an entirely new family environment, wherein there are no guarantees that such placements will work out. This has been formalized at the federal level via the Fostering Connections to Success and Increasing Adoptions Act of 2008. This legislation facilitates immediate placement with relatives and links caregivers to services via the establishment of Kinship Navigator programs and providing support to a child's guardian via the Guardian Assistance Program. Relatedly, the 2008 Act makes it easier for relatives to become licensed foster caregivers and provides them with more financial assistance than they would receive as informal caregivers through the Temporary Assistance for Needy Families program (TANF). To date however, grandparents raising their grandchildren have underutilized TANF benefits (Cox, 2019). Additionally, the National Family Caregiver Support Program (NFCSP) established in 2000 provides grants to states to fund grants to caregivers providing care to children under the age of eighteen in their homes; information, help in accessing services, counseling, and respite care are some of the benefits grandparent caregivers might receive through NFCSP.

Most recently, several Federal initiatives have been enacted that will have a direct impact on grandparent caregivers. The Family First Prevention Services Act was signed into law in early 2018. Its aim is to keep children out of the foster care system by providing more assistance to families of origin and extended family members in relying upon evidence-based criteria for program eligibility to receive financial assistance, mental health care, substance abuse prevention and treatment, in-house parenting skills training, and kinship navigator assistance. The Family First Act improves licensing standards that enable the placement of children-at-risk with relatives, as well as to helping families afflicted with opioid addiction to be better able to cope and continue to safely raise their children. In the event that children are placed with licensed family foster caregivers, the child's well-being, safety, and permanence of this placement with extended family are paramount (Generations United, 2019).

The other major federal legislation impacting grandfamilies is the Supporting Grandparents Raising Grandchildren Act (S 1091) passed into law in late 2018. It establishes a Federal Advisory Council to assist the Department of Health and Human Services in educating the public, as well as establishing best practices and resources to assist grandparents raising their grandchildren. A central component of this Advisory Council is making proactive efforts at outreach to states, local entities, service providers, and grandparent caregivers themselves to identify gaps in service and unmet needs to enhance grandparents' mental and physical health and psychosocial adjustment. Beyond these efforts, several bills focusing on state support for grandparent caregivers (Supporting Caregivers Act), preventing child abuse (Help Grandfamilies Prevent Child Abuse Act), and enhanced funding for the Family First Act (Family First Transition and Support Act of 2019) are being discussed

in Congress. Moreover, efforts by Generations United (an organization advocating for grandfamilies and kinship caregivers based in Washington, DC) to enhance Kinship Navigator Program appropriations by Congress are ongoing.

As pointed out by Cox (2019), policies in support of grandfamilies need to reflect their needs, especially as they relate to "what is in the best interest of the child." Supporting grandparents who are raising their grandchildren financially, emotionally, medically, and with regard to needed services that are both affordable and accessible is key to the well-being of not only the grandparent-grandchild dyad, but to the extent that such polices are preventative, they can help avoid the necessity for grandparents to step in when the adult child is either unable or unwilling to care for his/her child in a competent and loving manner. Indeed, focusing on policies supporting grandfamilies underscores the intergenerational and contextual dimensions of raising a grandchild, centralizes the critical role that grandparents play in their grandchildren's lives, and makes it more likely that challenges can be overcome and problems can be solved in a manner that enhances the quality of life for both grandparent and grandchild. •CSA

Dr. Bert Hayslip Jr. received his doctorate in experimental/developmental psychology from the University of Akron in 1975, and is currently Regents Professor Emeritus at the University of North Texas while teaching for the Osher Lifelong Learning program. He has been either Principal Investigator or Co-Principle Investigator on research grants on home health care frontline service delivery to older adults, optimizing intellectual functioning in later life, interventions with grandparents raising grandchildren, perceptions of funeral rituals across the lifespan, frontlin and psychological approaches to golf performance in older persons. He received the Distinguished Career Contribution to Gerontology Award from the Gerontological Society of America in 2016.

RESOURCES

American Association of Retired Persons Grandfamilies Guide: valuable sources of information for grandparent caregivers. https://aarp.org/realtionships/friends-family/

Generations United. An advocacy-based organization in Washington, DC whose mission it is to improve the lives of children via intergenerational programs and efforts to foster more positive intergenerational relationships. 80 F St. NW, Washington, DC 2020289-3979, https://www.gu.org

Daily Strength. An online support group for grandparents raising grandchildren

USA.gov has a website dedicated to grandparents raising their grandchildren-a valuable source of information regarding benefits and programs

Grandfamilies: The Contemporary Journal of Research, Practice, and Policy. A valuable academic resource for teachers, practitioners, policy-makers, and researchers regarding grandparents raising grandchildren.

REFERENCES

Bigbee, J., Boegh, B., Prengaman, M., & Shaklee, H. (2011). Promoting the health of frontier caregiving grandparents: A demonstration project evaluation. *Journal for Specialists in Pediatric Nursing, 16,* 156-161. https://doi.org/10.1111/j.1744-6155.2011.00284.x

Cox, C. (2008). Empowerment as an intervention with custodial grandparents. *Journal of Intergenerational Relationships, 6,* 465-477. https://doi.org/10.1080/15350770802466161

Cox, C. (2019). Grandparents and social policy. In B. Hayslip & C. Fruhauf (Eds.), *Grandparenting: Influences on the dynamics of family relationships* (pp. 301-312). New York: Springer.

Dolbin-MacNab, M. L. (2006). Just like raising your own? Grandmothers' perceptions of parenting a second time around. *Family Relations, 55,* 564-575. https://doi.org/10.1111/j.1741-3729.2006.00426.x

Dolbin-MacNab, M., Roberto, K., & Finney, J. (2013). Formal social support: Promoting resilience in grandparents parenting grandchildren. In B. Hayslip Jr. & G. C. Smith (Eds.), *Resilient grandparent caregivers: A strengths-based perspective* (pp. 134-151). New York, NY: Routledge.

Dolbin-MacNab, M., Stucki, B., & Natwick, J. (2019). Grandparenthood: Clinical issues and interventions. In B. Hayslip & C. Fruhauf (Eds.), *Grandparenting: Influences on the dynamics of family relationships* (pp. 217-232). New York: Springer.

Fuller-Thomson, E. (2005). Canadian first nations grandparents raising grandchildren: A portrait in resilience. *International Journal of Aging and Human Development, 60,* 331-342. https://doi.org/10.2190/LCR8-FJNM-F73L-58G3

Generations United (2019). *Pre-Conference: Serving grandfamilies through the Family First Prevention Services Act.* Portland, OR: June 12, 2019.

Gibson, P. A. (2005). Intergenerational parenting from the perspective of African American grandmothers. *Family Relations, 54*, 280-397.

Glass, J. C., & Huneycutt, T. (2002). Grandparents parenting grandchildren: Extent of situation, issues involved, and educational implications. *Educational Gerontology, 28*, 139-161. https://doi.org/10.1080/03601270252801391

Hayslip, B., Jr., Blumenthal, H., & Garner, A. (2014). Health and grandparent-grandchild well-being: One-year longitudinal findings for custodial grandfamilies. *Journal of Aging and Health, 26,* 558-581. doi: 10.1177/0898264314525664

Hayslip, B., Jr., Blumenthal, H., & Garner, A. (2015). Social support and grandparent caregiver health: One-year longitudinal

findings for custodial grandparents. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 70,* 804-812.https://doi.org/10.1093/geronb/gbu165

Hayslip, B., Jr., Davis, S., Goodman, C., Smith, G. C., Neumann, C., Maiden, R., & Carr, G. (2013). The role of resilience in understanding grandparents raising their grandchildren. In B. Hayslip Jr. & G. Smith (Eds.), *Resilient grandparent caregivers: A strengths-based perspective* (pp. 48-67). New York, NY: Routledge.

Hayslip, B. Jr., , Knight, R., Page, K., & Phillips, C. (In Press), Rural Versus Urban Residence as an Influence on Grandparent Caregivers' Needs for Service. *Journal of Intergenerational Relationships.*

Hayslip, B., Jr., Shore, R. J., Henderson, C. E., & Lambert, P. L. (1998). Custodial grandparenting and the impact of grandchildren with problems on role satisfaction and role meaning. *The Journals of Gerontology: Psychological Sciences and Social Sciences, 53,* S164-S173. https://doi.org/10.1093/geronb/53B.3.S164

Hayslip, B., Jr., & Smith, G. (2013). *Resilient grandparent caregivers: A strengths-based perspective*. New York, NY: Routledge.

Hipple, L. &. Hipple, J. (2008). Raising a granddaughter: Sharing our experience. In B. Hayslip & P. Kaminski (Eds.), *Parenting the custodial grandchild: Implications for clinical practice* (pp. 93-100). New York: Springer.

Kahana, E., Kahana, B., Goler, T., & Kahana, J. (2019). Grandparent-grandchild relationships: A proposed mutuality model with a focus on young children and adolescents. In B. Hayslip & C. Fruhauf (Eds.), *Grandparenting: Influences on the dynamics of family relationships* (pp. 61-80). New York: Springer.

Kirby, J. N. (2015). The potential benefits of parenting programs for grandparents: Recommendations and clinical implications. *Journal of Child and Family Studies, 24,* 3200-3212. https://doi.org/10.1007/s10826-015-0123-9

Kirby, J. N., & Sanders, M. R. (2014). A randomized controlled trial evaluating a parenting program designed specifically for grandparents. *Behavior Research and Therapy, 52*, 35-44. https://doi.org/10.1016/j.brat.2013.11.002

Kopera-Frye, K. (2009). Needs and issues of Latina and Native American nonparental relative caregivers: Strengths and challenges within a cultural context. *Family and Consumer Sciences Research Journal, 37*, 394-410. https://doi.org/10.1177/1077727X08329563

Landry-Meyer, L., & Newman, B. (2004). An exploration of the grandparent caregiver role. *Journal of Family Issues, 25,* 1005-1025. https://doi.org/10.1177/0192513X04265955

Lee, Y., & Blitz, L. V. (2014). We're GRAND: A qualitative design and development pilot project addressing the needs and strengths of grandparents raising grandchildren. *Child & Family Social Work, 21*, 381-390. https://doi.org/10.1111/cfs.12153

Masten, A. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56,* 227-238. https://doi.org/10.1037/0003-066X.56.3.227

Musil, C., Gordon, N., Warner, C., Zausziewski, J., Standing, T., & Wykle, M. (2011). Grandmothers and caregiving: Continuity, changes, and outcomes over 24 months. *The Gerontologist, 51,* 86-100. https://doi.org/10.1093/geront/gnq061

Musil, C., Zauszniewski, J., Givens, S., Henrick, J., Wallace, M., Jeanblanc, A., & Burant, C. (2019). Resilience, resourcefulness, and grandparenting. In B. Hayslip & C. Fruhauf (Eds.), *Grandparenting: Influences on the dynamics of family relationships* (pp. 233-250). New York: Springer.

Smith, G. C., & Dolbin-MacNab, M. L. (2013). The role of negative and positive caregiving appraisals in key outcomes for custodial grandmothers and grandchildren. In B. Hayslip Jr. & G. C. Smith (Eds.), *Resilient grandparent caregivers: A strengths-based perspective* (pp. 3 -24). New York, NY: Routledge.

Smith, G. C., & Hancock, G. R. (2010). Custodial grandmother-grandfather dyads: Pathways among marital distress, grandparent dysphoria, parenting practice, and grandchild adjustment. *Family Relations, 59,* 45-59. https://doi.org/10.1111/j.1741-3729.2009.00585.x

Smith, G., Hayslip, B., Jr., Montoro-Rodrigez, J., & Streider, F. (2018). *Comparing interventions to improve the well-being of custodial grandfamilies. Journal of Family Psychology.*

Smith, G. C., Merchant, W., Hayslip, B., Jr., Hancock, G., Streider, F., & Montoro-Rodrigez, J. (2015). Measuring the parenting practices of custodial grandmothers. *Journal of Child and Family Studies, 24,* 3676-3689. https://doi.org/10.1007/s10826-015-0176-9

Smith, G. C., & Palmieri, P. A. (2007). Risk of psychological difficulties among children raised by custodial grandparents. *Psychiatric Services, 58,* 1303-1310.

Smith, G. C., Palmieri, P. A., Hancock, G. R., & Richardson, R. A. (2008). Custodial grandmothers' psychological distress, dysfunctional parenting, and grandchildren's adjustment. *International Journal of Aging and Human Development, 67*, 327-357.

Smith, G. C., & Richardson, R. A. (2008). Understanding the parenting practices of custodial grandmothers: Overcompensating, underserving, or overwhelmed? In B. Hayslip Jr. & P. Kaminski (Eds.), *Parenting the custodial grandchild: Implications for clinical practice* (pp. 131-147). New York, NY: Springer.

Whitley, D. M., Kelley, S. J., & Campos, P. (2013). Promoting family empowerment among African-American grandmothers raising grandchildren. In B. Hayslip Jr. & G. Smith (Eds.). *Resilient grandparent caregivers: A strengths-based perspective* (pp. 235-250). New York, NY: Routledge.

Yancura, L., Greenwood-Junkermeier, H., & Fruhauf, C. A. (2017). "These classes have been my happy place": Feasibility study of a self-care program in Native Hawaiian custodial grandparents. *Asian/Pacific Island Nursing Journal, 2*, 103-109.

Yorgason, J., & Hill, M. Grandparents and health. (2019). In B. Hayslip & C. Fruhauf (Eds.), *Grandparenting: Influences on the dynamics of family relationships* (pp. 201-216). New York: Springer.

Factors Affecting Driving as We Age: IS IT TIME TO RETIRE THE CAR KEYS?

Relinquishing the car is a major turning point in the lives of many older adults. Family members can prepare and help ease the transition in a variety of ways. BY ERIN DWYER, CSA AND LINDA JARRETT

Whether they are sixty-five or eighty-five, for older adults a car is more than a means of getting from one place to another. It is a symbol of their independence, perhaps their last and only symbol. That's partly why it's so difficult to acknowledge when it is time to give up the keys. It's usually family members who notice that the older driver has become a danger to himself and others on the road. Should they insist that he give up his independence? Turn to others for help? How should family members approach this most delicate of topics?

Most older drivers are safe drivers. They are more likely to wear seat belts, less likely to speed, drive under the influence of alcohol or drugs, and talk on the phone or text. However, in a two-car fatal collision where one driver is seventy or older, the older driver is 3.5 times more likely to suffer serious trauma or die than younger drivers. The most recent figures from the U.S. Census Bureau indicate that as of July 2015, 47.8 million people were age sixty-five and older in the United States (Transportation Research Board, 2019). Aging impacts people differently, but the fact remains that older adults accounted for 18 percent of all driver fatalities in 2017 (Transportation Research Board, 2019).

Physical Impediments

According to Keefe's *Blueprint for Care* (2012), as people age, their visual acuity and peripheral vision declines. An older person's retina absorbs about one-third of the light received by a 20-year-old. Cataracts become common and can interfere with vision, causing glare or halos. "A driver with cataracts is 2.5 times more likely to have an accident, and that risk becomes higher at night or in inclement weather," Keefe writes (2012, p. 90). Hearing loss, which affects 33 percent

of drivers over sixty-five, presents a danger if a senior cannot hear an approaching siren.

Aging also changes reaction time; an older adult might not hit the brakes quickly enough to avoid an accident. Physical changes occur, such as joints getting stiffer and affecting the neck, upper body, and lower body. For instance, the older driver may not have a full range of motion to be able to turn his or her head far enough to the left or right to see oncoming traffic.

Then there is the subject of medications, which can affect vision and response times. Many prescription drugs, and some over-the-counter medications, display a warning not to drive when taking them because they can cause drowsiness. Additionally, medications could have a dangerous effect on driving ability if not taken as prescribed.

Approaching the Conversation

When their adult children begin noticing little signs that, maybe, the time has come to have the conversation about relinquishing the keys for a safer means of transportation, how does the family approach that subject?

Throughout their lifetime, children have looked to their parents for advice, whether it be as major as buying a new house, or as minor as how to celebrate a holiday. Now, however, they find themselves thrust into the awkward and uncomfortable position of being "the parents," the responsible ones in charge of helping their parents make a decision that affects their lives. The question becomes: How does one approach this ticklish subject with one's parent?

The first step is to gather as much information as possible about the risks that older drivers face — risks about which they probably are not aware, since they have been driving all their lives and, so far, everything has been fine. If family members have noticed signs of dementia or Alzheimer's disease, older drivers may or may not realize this. Even if they have, admitting the possibility frightens them.

Maybe family members have noticed a few dents on their parent's car, or scrapes on the mailbox or side of the garage. This might be a good time to take a drive with an aging loved one and surreptitiously assess driving skills.

Levine's *Navigating Your Later Years for Dummies* (2018) gives the following signs that may indicate that an individual's driving skills are diminishing:

- hitting the curb,
- driving too slowly,
- other drivers honking at them,
- riding the brake,
- not signaling,
- not noticing traffic signs,
- drifting into the other lane,
- getting confused at exits,
- confusing the gas and brake pedals, and
- difficulty seeing while backing up.

Starting the Conversation

After driving with an older adult and noticing some of these signs, family members may realize that the time has come. How should they have "the conversation"? First, they need to prepare because it will not be comfortable.

They need to ask how the older adult feels about his or her driving. Has she had any accidents, however slight? Is he easily distracted? Do cars or people seem to appear out of nowhere? Have friends said they are worried about the older adult's driving? Does the older person get lost, even on familiar roads? Listening skills are critical to the conversation. Allow plenty of time for him to answer and acknowledge his responses. Just as important as initiating this conversation is listening to what your aging loved one has to say.

Listening Like a Pro

In *Beyond Driving with Dignity: The Workbook for Families with Older Drivers* (2010), Gurwell and Ross give the following guidelines for effective listening techniques:

- Be a good listener and maintain eye contact.
- Let the other person vent their fears, frustrations, and other important feelings.
- Show that you're interested in what the other person has to say.
- Give your full attention to the person who is speaking, and let him or her finish before you begin to speak. (You can't really listen if you are busy thinking about what you want to say next.)
- Fight distractions.
- *Concentrate* on what is being said.
- Don't interrupt.

A subject this big and involved will, no doubt, take more than one conversation, but the initial conversation will get the older adult thinking about his or her driving skills, or lack thereof. At this point, an aging loved one may realize where a child is going with this line of talk, and family members need to be as tactful and calm as possible. They should have a line of conversation planned out, because once this talk has begun, "talking points" need to be at hand so no one will be drawn off the subject. Family members can keep

on topic by stressing driving skills, not the driver's age. Older adults are aware of their age, and probably know their skills are not what they used to be, but they have compensated by driving slower and staying in familiar territory.

Family members can avoid putting the older adult on the defensive by using "I" messages instead of "you" messages. Starting the talk by saying, "I am getting worried about your driving," instead of saying, "Your driving worries me," indicates that the person is concerned for the safety of the older adult, rather than making the family member seem like the arbitrator of the older adult's driving habits.

Empathy is critical. Family members should put themselves in their parent's shoes and imagine how they would feel if the situation were reversed. In the eyes of the older adult, he or she is being asked to give up independence. While that is not entirely true, nonetheless, that is how the older adult will see it.

Providing Alternatives

The older driver may say, "I've been driving for sixty years and have never been at fault for an accident." While that may be an admirable boast, Matt Gurwell, founder of Keeping Us Safe, says,

"Unfortunately, past behavior is not a valid predictor of future performance." He adds, "According to the American Automobile Association (AAA), we are outliving our ability to drive safely by seven to ten years, further supporting the notion that we *all* need to improve our *visionary* skills, as we will not always be able to hang our hat on a *historic* look back on our driving performance" (n.d.). Focus on the safety issue while reassuring the older adult that she can still maintain her independence. The goal is not to impede her living, but to ensure no one will suffer harm from an auto accident.

Evaluate Driving Ability

If the conversation is not going well, suggest having the person's driving skills evaluated by a third party.

Keeping Us Safe is an organization dedicated to helping older drivers. It recommends *Beyond Driving with Dignity: The Workbook for the Families of Older Drivers*, or a proprietary Enhanced Self-Assessment Program for older drivers administered by certified Beyond Driving with Dignity professionals. The organization is on the Web at https://www.keepingussafe.org, or reach out to them by phone 877-907-8841 or email info@keepingussafe.org.

AARP offers a Smart Driver course in classrooms and online at https://www.aarp.org/auto/driver-safety/driving-assessment that helps all drivers, not just seniors, assess their driving skills. By taking it together, the older driver and family member might ease the way into having a conversation about driving capability. Raising the subject could lead to more productive conversations down the road. The goal is to have a solution before an accident occurs.

Alternative Transportation

Have some transportation options ready to share. While this may be the first of many discussions, having a list of viable transportation options will go a long way to assure the older driver that the object is not to take away independence, but to increase safety.

Ride-share services such as Uber and Lyft are a lifesaver. Family members can explain how they work and install the app for their loved one. If the older person is beyond using the technology, a call from a family member is all that's needed to schedule a ride. A voice assistant (such as Amazon's Alexa) can also hail a ride, or use phone service GoGo Grandparent. Furthermore, both Uber and Lyft have partnered with third parties to increase access for older adults, eliminating the need to use an app. Jitterbug phones will summon a ride via GreatCall, and many healthcare organizations provide ride-share options for their older clients.

Friends and neighbors of the older adult can be enlisted ahead of time to provide essential rides, whether free or for a fee. It's comforting to know that neighbor "Fred" or best friend "Susie" will chauffeur a loved one to appointments and on errands. Family members can also take on some of these duties if they live nearby.

Churches and other faith-based organizations often provide volunteers to take seniors to their appointments or shopping.

Taxis may be the method of choice for some older adults, although this choice may prove more expensive. Public transportation can be a great option when it is available nearby. Family may be able to help out by researching routes to professionals and stores, and perhaps accompanying the older adult as they get used to using the bus, light rail, or subway.

Rides In Sight shows transportation options in your area that serve older adults and others with visual impairments. For help in finding the best option, call the free hotline (855) 607-4337 or visit the Web page www.ridesinsight.org.

Dementia, including Alzheimer's, Alters the Conversation

According to the Alzheimer's Association (2020), an estimated 5.8 million Americans were living with Alzheimer's dementia in 2019. This number includes an

estimated 5.6 million people age sixty-five and older. While having a conversation with an able-bodied older adult about his or her driving ability might be uncomfortable, having that same conversation with one suffering from dementia will be twice as difficult. One of the first things lost to the disease is the ability to see one's impairment.

Grandma finds herself at the bank and does not remember how she got there, or why. Grandpa leaves to go to the grocery store, and ends up lost, calling his son from the next town over.

Confronting an older driver with proof of this progressive illness will not be pleasant, and may lead to conflict since the person suffering from dementia does not believe anything is wrong. Harvard Health Publishing (2008) offers some suggestions to engage the person with Alzheimer's or another form of dementia.

- Start the discussion as soon as the person is diagnosed with dementia. Discussing driving can be combined with talking about other aspects of care.
- Document the person's driving ability by having relatives or close friends drive with him or her. Have those people make notes on specific incidents they witness.
- Having a physician present for the conversation may help avoid any conflict when emotions run high.
- Telling the older adult about the situations when poor choices were made might help in convincing Grandma or Grandpa that giving up the keys would be safer for everyone.

There's no denying that taking away the option of hopping in a car to run errands, visit friends, or access healthcare is difficult at best. However, using a variety of thoughtful techniques can ease the discomfort. "Forewarned is forearmed," and the more information we have at our fingertips, the less painful having to talk to parents or grandparents will be. The conversations spring from love and concern. The object, after all, is keeping the older adult and others safe. •CSA

RESOURCES

The Eldercare Locator, made available by the U.S. Administration on Aging, will find agencies to help older adults in every U.S. community, and will help find the nearest Area Agency on Aging. Reach the locator at www.eldercare.gov or 800-677-1116.

AAA Foundation for Traffic Safety-Supplemental Transportation Programs is a series of community-based organizations to help older adults stay mobile after they have "retired" from driving. Reach the foundation at www.seniordrivers.org or 202-638-5944.

The National Center on Senior Transportation works to "increase transportation options for older adults and enhance their ability to live more independently within their community." Reach the center at www.seniortransportation.easterseals.com or dial 866-528-6278.

Additionally, many grocery stores and pharmacies will make home deliveries.

Erin Dwyer has her MS in Speech-Language Pathology, is a Beyond Driving with Dignity professional, and is a Certified Senior Advisor. She owns and operates a residential placement and Eldercare consulting company in St. Louis, Missouri called Senior Care Authority. Erin loves helping older adults and their families find the best senior living and care options along with helping clients determine when to retire from driving. When not working with clients, Erin can be found playing music or hanging out with her six teenagers, husband, two dogs, two cats, and nineteen fish from her big, beautiful, blended family.

Linda Jarrett has made writing her career for thirty years writing for *AAA Midwest*, *Southern Traveler*, and the *St. Louis Post Dispatch* among other publications. She is interested in traveling, meeting people, and experiencing all life has to offer. When she is not writing, she does mission work for her church which involves traveling to disaster areas, and she is active in Moms Demand Action for Gun Sense in America. Linda has a passion for animals and has rescued five dogs and five cats over the past years and is now looking for a senior dog. She is also writing a novel, which is not easy since her cats like napping on her keyboard!

REFERENCES

Alzheimer's Association. (2020). *Alzheimer's disease facts and figures*. Retrieved from https://www.alz.org/alzheimers-dementia/facts-figures

Gurwell, M. J. & Ross, Y. (2010). *Beyond driving with dignity: The workbook for families of older drivers*. Published by the author.

Gurwell, M. (n.d.). Older drivers; Sometimes better historians than visionaries [Blog post]. Retrieved from https://www.keepingussafe.org/older-drivers-sometimes-better-historians-than-visionaries/

Harvard Health Publishing. (2008, August). Alzheimer's and driving ability. Retrieved from https://www.health.harvard.edu/newsletter_article/Alzheimers_and_driving_ability

Keefe, D. (2012). *Blueprint for care*. Ballwin, MO: Lifelines Publishing Company, 90.

Levine, C. (2018). *Navigating the later years for dummies*. Washington, DC: AARP, 126.

Transportation Research Board. (2019, November 12). State practices promoting older driver safety. Retrieved from https://apps.trb.org/cmsfeed/TRBNetProjectDisplay.asp?ProjectID=4795

Medicare's Hospice Benefit and Patient Harm

Palliative care is great in theory and often in practice, but Medicare's reimbursement system for hospice providers leaves much to be desired and sometimes raises grave concerns. BY MIKE KLUG, JD, CONSULTANT TO THE SMP NATIONAL RESOURCE CENTER

Medicare's hospice benefit enables terminally ill beneficiaries to live as physically and emotionally comfortable as possible at the end of life. Through a palliative approach to care that combines a wide range of medical, social, and spiritual counseling services, hospices, at their best, deliver care that enables patients to die free of pain and with dignity. For many beneficiaries and their families, Medicare's hospice benefit is key to a "good death" in familiar surroundings. But for some, the hospice experience is less than positive and can be harmful.

This article provides an overview of Medicare's hospice benefits, payment system, eligibility and election rules, and systemic issues that create the potential for significant patient harm. It concludes with guidance for professionals if they encounter concerns about a hospice provider. The article draws mainly on the analysis and findings of three reports issued in 2018 and 2019 by the U.S. Department of Health & Human Services Office of Inspector General (OIG) about the Medicare hospice program's vulnerabilities and associated risks and the need for additional

safeguards to prevent maltreatment and abuse for some of society's most vulnerable members.

Medicare's Hospice Benefit Program

Congress added a hospice benefit to Medicare's Part A Hospital Insurance program in 1983. Since then, utilization has grown to a point where roughly 1.5 million beneficiaries receive hospice services annually. In 2017, 64 percent of Medicare hospice patients were eighty years old and older. The average length of stay for patients who died in hospice care was 86.8 days; the median length of stay was 18 days. That same year, Medicare paid nearly $18 billion to more than 4,800 Medicare-certified hospice providers, of which 69 percent were for-profit entities, 27 percent were non-profit, and 4 percent were government run.

CERTIFICATION AND ELECTION

Medicare's coverage for hospice care starts after a hospice physician and the patient's attending physician (if available) certify that a patient has a terminal condition with six months or less to live if the illness runs its normal course, and the beneficiary signs a hospice election form that affirms a decision to waive curative care for the terminal condition (2008). This means the patient is choosing care to relieve and control the symptoms of a terminal condition rather than cure it. While Medicare has basic requirements for the election statement's contents, hospices design and print their own election forms. Thus, hospice election statements vary in appearance and may differ in content.

A hospice physician can initially certify a patient's terminal illness without an in-person examination. Medicare rules only require a face-to-face encounter when the time comes to recertify a patient's terminal condition on the 180th day of hospice enrollment and every 60 days thereafter. It is important to note that these recertification visits are the only physician visits that Medicare specifically requires while a person is under hospice care.

A beneficiary or designated representative can revoke an election for hospice care at any time and return to the regular "curative" benefits in a beneficiary's coverage with Original Medicare or a Medicare Advantage plan. The revocation must be in writing and must include a signed statement revoking the hospice election and the revocation's effective date. As with the election statement, there is no standard revocation form. Oral revocations are not acceptable. Hospice patients also have a right to transfer from one provider to another, and must file a signed statement with both providers to effect the transfer.

COVERED SERVICES AND BENEFITS

For those who qualify, Medicare covers an array of hospice and palliative care services including:

- Nursing care
- Physician services
- Counseling and social worker services
- Hospice aide services (similar to covered home health aide services)
- Homemaker services
- Short-term hospice inpatient care for severe symptom management and control
- Short-term respite care for caregivers
- Drugs and biologics for symptom control
- Supplies (e.g., oxygen tubing, nasal cannulas, creams, and ointments)
- Medical equipment (e.g., oxygen concentrators and tanks, hospital beds, and commodes)
- Physical, occupational, and speech therapy
- Bereavement services for the patient's family
- Other services, as needed, to palliate the terminal illness and related conditions

FOUR LEVELS OF CARE

Medicare's hospice benefit has four different levels of care: **routine home care, continuous home care**, **inpatient respite care,** and **general inpatient care**. Medicare participation rules require hospices to deliver all four levels of care as needed to their patients. The vast majority of Medicare hospice claims involve routine home care in a patient's home or residence, including assisted living facilities and nursing homes. The continuous home care level is often called "crisis care" because Medicare's payment rules specify that it may be provided only during short-term crisis periods when needed to maintain the patient at home. Care at this level consists mainly of nursing services to palliate or manage uncontrollable pain or acute symptoms.

The two inpatient care levels meet different needs. Respite care covers occasional, short-term, inpatient stays to give a needed break to family members or others who are caring for the dying person at home. Respite care may only be provided in a Medicare-participating hospital, hospice inpatient facility, or a Medicare- or Medicaid-participating nursing facility. Medicare covers respite care up to five consecutive days at a time. Medicare covers general inpatient care when patients need a short-term, inpatient stay to control pain or manage acute or chronic symptoms when they cannot feasibly be treated in other care settings, such as their own residence. Hospices provide care at this level in an inpatient unit operated

by the hospice itself or under arrangements with a hospital or skilled nursing facility (SNF).

PAYMENT SYSTEM

Medicare sets separate daily payment rates for each hospice level of care. In 2020, Medicare pays $194.50 per day for the first 60 days of routine home care. This rate decreases to $153.72 per day after the 60th day of hospice enrollment. The rates for the other care levels are $450.10 per day for inpatient respite care, $1,021.25 per day for general inpatient care, and up to $1,395.63 per day for continuous home care (paid at $58.15 per hour). Medicare reimburses providers for each day a patient is enrolled in hospice, regardless of the type or number of services provided. In turn, Medicare expects hospices to assess patients and then develop individualized care plans that detail the various services, equipment, medications, and supplies patients need at one of the four levels of care. A hospice physician, nurse, and other members of an interdisciplinary care team are to review and revise the care plan at any point to address changes in the patient's condition, but no less than every 15 days. Hospices must provide all drugs and biologicals needed for the palliation and management of pain and symptoms stemming from a patient's terminal illness and related conditions.

For most services and items, Medicare's payment to the hospice provider covers the cost of care in full. Out-of-pocket liability is generally limited to a $5.00 copayment for palliative drugs and biologicals and a 5 percent coinsurance charge for each day of Medicare-covered respite care (approximately $22.50 in 2020). Patients also may be liable for the cost of care that Medicare does not cover as determined by the hospice. Treatment for a condition completely unrelated to the terminal condition, such as an injury caused by a fall, remains available to patients through their Original Medicare (Parts A and B) or Medicare Advantage plan coverage.

Vulnerabilities and Patient Harm

The OIG's three recent hospice reports document an alarming array of vulnerabilities in Medicare's hospice benefit that put patients at risk for significant harm (2018). These systemic weaknesses stem, in part, from the hospice payment system's incentives to limit care, the certification procedure's susceptibility to manipulation, and a lack of physician oversight in the delivery of care. These problems are all the more worrisome because the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, has little authority to impose sanctions against hospices that provide poor care short of excluding them from Medicare, an option CMS rarely uses. Here are some of the key points in the OIG's reports.

PAYMENT INCENTIVES AFFECT ACCESS TO CARE

Medicare's current payment system, with its daily reimbursements regardless of the amount of care a hospice provides, creates incentives for providers to minimize their services and find beneficiaries with uncomplicated needs. In its Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity (2018) portfolio, the OIG reported that hospices typically provide less than five hours of visits from nurses, hospice aides, counselors, and volunteers per week to patients who reside in assisted living facilities. In one investigation, the OIG identified twenty-five hospices that did not report any visits made to more than two hundred beneficiaries residing in assisted living facilities. "Medicare paid these hospices," the OIG observed, "a total of $2.3 million to care for these beneficiaries." The OIG also found that many hospices seldom provide care on weekends, even though Medicare pays them to deliver services, as needed, around the clock and throughout the week.

The report raised several other concerns about access to care. The OIG found that many hospices provided only one level of care — routine home care — despite some patients' apparent need for inpatient care and crisis care in the home. More broadly, in each year between 2006 and 2016, three-fourths of hospice patients did not receive a visit from a hospice physician. The OIG concluded that physicians should be more directly involved in patient care, especially for those whose uncontrolled pain or unmanageable symptoms require inpatient care. Medicare rules, however, don't require physician visits except to recertify a patient's terminal illness at 180 days and beyond.

UNINFORMED ELECTION DECISIONS

Beneficiaries and their caregivers do not always get essential information they need at the front end to make informed decisions about hospice care. The OIG observed in its Vulnerabilities (2018) portfolio that, "Hospices often provide incomplete or inaccurate information about the benefit." It found that some election statements did not mention, as the law requires, that beneficiaries are waiving coverage for certain Medicare services when they elect hospice care. Others inaccurately stated which Medicare benefits were waived. The OIG also voiced concern that CMS doesn't do enough to inform the public about the number, type, and severity of problems that state

survey agencies found through their mandatory assessments of hospice performance.

POOR CARE WITHOUT CONSEQUENCES

In Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm (2019), the OIG described several cases it found in state survey reports that illustrate how poor care or failure to act caused significant harm to patients. In one case, a patient with Alzheimer's developed pressure ulcers to both heels within two weeks of electing hospice care. The sores worsened and turned gangrenous, leading to the amputation of the beneficiary's lower left leg. In another case, a patient who relied on oxygen 24/7 and who used an albuterol inhaler for shortness of breath also needed respiratory therapy. While the hospice care plan called for respiratory therapy sessions one to three times a month, he received no respiratory therapy for more than two months and his condition deteriorated. In a third case, a hospice knowingly failed to address the repeated theft of a patient's medications, including opioids, by a drunken neighbor. The state surveyors who reviewed the medical records cited each of the hospices for deficient care but, with limited sanction authority, could only require the hospices to prepare corrective action plans.

DEFICIENCIES AND COMPLAINTS

In Hospice Deficiencies Pose Risks to Medicare Beneficiaries (2019), the OIG found that 80 percent of the nation's hospices were cited for one or more deficiencies over a five-year period, meaning that they failed to meet a condition of participation (CoP) in the Medicare program. The CoPs detail Medicare's various requirements for initial patient assessments, care planning, staff training, infection control, and much more. State agencies (often a department of health) assess hospice performance in light of these CoPs through periodic surveys or to investigate complaints. Between 2012 and 2016, one-third of the nation's hospices — nearly 1,500 — had complaints filed against them for concerns that included failure to manage pain and symptoms, patient rights violations, and patient neglect. State surveyors were able to substantiate about one-third of the complaints. The most common deficiencies involved poor care planning, mismanagement of aide services, and inadequate patient assessments. It also found that 903 of 4,563 participating hospices, or 20 percent, had serious quality-of-care deficiencies. It further identified three hundred as "poor performers," meaning they have a history of serious violations or at least one substantiated severe complaint.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The OIG was established to protect the integrity of programs, including Medicare, administered by agencies within the federal Department of Health & Human Services. With 1,600 employees nationwide, the OIG conducts audits, investigations, and evaluations in an effort to identify and prevent fraud, waste, and abuse. The OIG also assists other federal and state agencies in developing cases for criminal, civil, and administrative enforcement.

Case Study

It can be difficult to absorb and process the pitfalls around hospice care. Following is a short case study example to put the information into practical terms.

Mary elected Medicare's hospice benefit a month after her doctor told her that she has terminal colorectal cancer. As the cancer progressed, Mary showed signs of internal bleeding. Bruises appeared on her body and she was fatigued, prompting Mary's attending physician to order a platelet transfusion to alleviate the symptoms. Bill, Mary's husband and caregiver, was taken aback when a hospice nurse informed him that they would not cover the platelets because they deemed the treatment as curative, not palliative. The nurse explained that physicians typically order costly platelet transfusions to address side effects of chemotherapy, a curative procedure. Bill disagrees with the hospice's decision.

What should Bill do? He can try at least four strategies. 1) He can complain to the hospice's administrator about their narrow interpretation of the term "palliative." 2) He can ask Mary's attending physician to speak with the hospice's medical director about the need for platelet transfusions in cancer symptom relief aside from chemotherapy. 3) He can call the Beneficiary & Family Centered Care Quality Improvement Organization (BFCC-QIO), a Medicare contractor, to request "Immediate Advocacy" in response to a quality of care concern. 4) He can file a formal complaint with his state survey agency, asking it to investigate the potential for significant harm in Mary's case.

Conclusion

Medicare's hospice benefit provides many services designed to alleviate pain and other symptoms associated with terminal illness and to provide support

for a terminally ill person's caregivers and family. But incentives in Medicare's payment system for hospices sometimes contribute to poor quality care characterized by a failure to provide medically necessary services and supplies, inadequate care planning, injury, and neglect. Aging professionals should advise older persons and their families that hospices may differ greatly in the quality and access to care. Encourage them to compare providers before making a hospice election. Medicare's star ratings on its Hospice Compare website (see resources below) are a good place to start. •CSA

RESOURCES

Aging industry professionals are well-positioned to help raise awareness about Medicare's hospice benefit, the need to compare and evaluate different hospice providers, and steps to take when their clients run into problems. Resources that may help in this effort include:

Fact sheets and flyers on hospice patient rights and protections are posted to the Office of Inspector General's website at https://www.oig.hhs.gov.

Medicare's Hospice Compare website lists hospices by zip code and provides information about certain quality-of-care measures and family experiences with specific hospices. One can compare, for example, the percentage of caregivers who responded favorably to survey questions about getting timely help and the hospice's communications with family members. The website also offers tip sheets and a checklist to compare hospices. Find it at https://www.medicare.gov/hospicecompare/.

State Health Insurance Assistance Programs (SHIPs) are a good source of information about Medicare's hospice benefits and other covered benefits. Find your state contact information at https://www.medicare.gov/contacts/.

Two Beneficiary & Family-Centered Care Quality Improvement Organizations (BFCC-QIO) work as regional Medicare contractors to address quality of care concerns with Medicare-participating providers and facilities, including hospices. The BFCC-QIOs offer an informal complaint resolution service called "Immediate Advocacy." QIO staff contact the provider on the patient's behalf when, for example, services are not provided as ordered or a facility fails to schedule a care team meeting requested by family members. Find the BFCC-QIO that serves your state at https://qioprogram.org/locate-your-qio.

To file a hospice-related complaint or grievance about poor care or a violation of patient rights, start with the hospice administrator. The federal government offers tips for filing at https://www.planprescriber.com/caregiver-resources/what-should-you-do-if-you-have-a-complaint-about-hospice-care/. Medicare's CoPs require hospices to document and address all alleged violations of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property. State Survey Agencies receive and investigate complaints. These agencies certify that hospice providers can operate within a state, conduct regular inspections to assess hospice compliance with the CoPs, investigate complaints made by the public, and cite hospices for deficiencies when they fail to meet Medicare quality-of-care requirements.

The Senior Medicare Patrol is a nationwide community education program that helps Medicare beneficiaries, their families, and caregivers to identify and report fraud, errors, and abuse in the Medicare program, including fraudulent hospice activities. Funded by the federal Administration for Community Living, SMP staff and volunteers offer presentations and informational resources, including fact sheets, a video, and infographics about hospice fraud, errors, and abuse. Contact information for your state's SMP is available at https://www.smpresource.org or by calling 1-877-808-2468.

Mike Klug, JD, works as a subject matter consultant to the Senior Medicare Patrol (SMP) National Resource Center and SHIP National Technical Assistance Center. Mike began his career as a trainer and writer for AARP's Medicare-Medicaid Assistance Program (MMAP) in 1985. He received his B.A. degree from St. Louis University in 1977 and earned a JD degree from the University of Wisconsin Law School in 1984. He lives in Iowa City, Iowa.

REFERENCES

Health & Human Services Office of Inspector General. (2018, July 30). *Vulnerabilities in the Medicare hospice program affect quality care and program integrity: An OIG portfolio*. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

Health & Human Services Office of Inspector General. (2019, July 3). *Safeguards must be strengthened to protect Medicare hospice beneficiaries from harm*. Retrieved from https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp

Health & Human Services Office of Inspector General. (2019, July). *Hospice deficiencies pose risks to Medicare beneficiaries.* Retrieved from https://oig.hhs.gov/oei/reports/oei-02-17-00020.pdf

National Hospice and Palliative Care Organization. (2019, July 3). *NHPCO facts and figures 2018.* Retrieved from https://www.nhpco.org/research/

Centers for Medicare & Medicaid Services. (2018, September 14). Coverage of hospice services under hospital insurance, Medicare benefit policy manual, Chapter 9. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

Centers for Medicare & Medicaid Services. (2008, June 5). Medicare and Medicaid programs: Hospice conditions of participation. *Federal Register.* Retrieved from https://www.federalregister.gov/documents/2008/06/05/08-1305/medicare-and-medicaid-programs-hospice-conditions-of-participation

Business owners and leaders have good reason to put a lot of thought and effort into training and compensating entry-level workers.

BY JENNIFER CRAFT MORGAN, PHD AND NIDHI JOSHI, MA

Becoming an *Employer of Choice:* Improved Recruitment and Retention at the Front Lines

The purpose of this article is to outline some promising strategies that have been used effectively by some organizations to improve their standing in the community as employers of choice by addressing recruitment and retention challenges. These strategies are generally oriented toward improving job satisfaction, thereby reducing intent to leave and, ultimately, turnover. A focus on improving recruitment and retention has multiple benefits for all three stakeholders — businesses, their workers, and their clients. An "employer of choice" is simply one favored by potential employees due to its advantageous workplace practices. Any employer, no matter the starting point, can make inroads to achieve this coveted status.

The workers at the front lines of any organization directly determine the quality of services. Yes, leadership is important. Yes, licensed and administrative staff need to be good coaches and supervisors (Sprowl & Coffey, 2020). But the frontline workers, the nursing assistants, activity workers, home health aides, care associates, dietary workers, housekeepers, maintenance staff, and assorted other roles, are the ones who deliver the vast majority of direct, hands-on care and support services to the older adults the company serves. These workers are the heart, faces, and hands of the organization.

In short, these workers are essential, a word that has taken on new meaning in light of the global COVID-19 pandemic. Having well-trained, loyal, confident, and well-resourced workers has become even more important as context complexity increases. Skills such as juggling new reporting requirements, managing informal care partners, and navigating new requirements for protective gear require high-level problem-solving skills, confidence, and knowledge about their own important roles within the business. This attachment, loyalty, skill accrual, and pride is created through strategies aimed at both recruitment and retention.

Accommodating Frontline Workers

Traditionally, aging services and supports have underinvested in the preparation and continuing education of these workers. The training requirements of direct care workers across settings are incredibly low, often left up to individual employers, and often difficult to navigate for new entrants (Kelly, Morgan, Kemp & Deichert, 2020; Kelly, Morgan & Jason, 2013; Tyler, Jung, Feng & Mor, 2010). This is problematic given the responsibility these workers hold for keeping older adults safe, healthy, and engaged in meaningful lives. The frontline workers are the closest point of contact with older adults in long-term care communities.

Research also has shown that workers need to have high levels of communication competency, problem-solving skills, empathy, and an increasing need for cultural competence, in addition to clinical skills, in order to be prepared to empower and engage older adults across settings (Berridge, Tyler & Miller, 2018; Kemp, Ball, Jason, Appel & Fitzroy, 2019; Tyler, Lepore, Shield, Looze & Miller, 2014).

The EDEN alternative model further emphasizes the need for a decentralized management structure, which empowers the staff members to make decisions regarding the care plan of the residents to support dignity, choice, and quality of life (Barba, Tesh, & Courts, 2002).

New Model Needed

Vitale-Aussem (2019) emphasizes that organizations serving older adults tend to follow the tenets of the hospitality model when looking for ways to improve the training of staff. This model equips workers with

customer service skills and offers amenities to help customers retreat, be pampered, and remove themselves from the hum-drum portion of their lives. This emphasis on providing luxurious accommodations, high-end food experiences, and catering to the whims of customers, she explains, is misplaced in supports and services for older adults. Organizations serving an older population are not hotels or resorts where people go for a couple of days to pamper themselves. These communities are homes for the older adults, or these organizations provide support in the homes or communities where older adults live. Rather than focusing on creating a vacation-like experience, business owners should be trying to make older adults feel at home wherever they receive services. This is not simply about comfort, but about these clients having a role, contributing to the running of their home, being a member of their community, feeling a sense of belonging, and being empowered to make the changes they want to see together with staff.

This reframing of the role of organizations serving an older population is crucial to understanding how to recruit and retain high quality and highly capable staff. This reframing does three things: 1) It emphasizes how any organization is embedded in the community, 2) it reorients the mission of the organization from an unwavering focus on care, safety, and health to include empowerment and engagement, and 3) it acknowledges the inclusion and interdependence of older adults, their informal care partners, the organization's staff, and other community partners involved in impacting client well-being (Kemp, Ball & Perkins, 2013). For any individual organization, this transformation requires becoming an employer of choice in the surrounding community. Because organizations that serve older adults are embedded in the community, becoming an employer of choice and being known as a great place to work with a meaningful mission can improve both recruitment and retention for the organization. This status ultimately lowers recruitment costs (e.g. more applicants, more high-quality applicants) and improves retention of current staff — particularly those on the front lines of service.

A good deal of research has focused on direct care workers' job satisfaction and turnover intentions across settings. Several types of factors are important in determining job satisfaction, intent to leave, and turnover:

- organizational factors (not for profit, Medicaid participation),
- frontline worker input into care planning,
- supervisor support,
- workload,
- career opportunity,
- perceived quality of care
- contingency factors (e.g. primary breadwinner status, single parenthood),
- health insurance, and
- compensation

(Castle, Engberg, Anderson & Men, 2007; Kim, Wehbi, DelliFraine & Brannon, 2014; Morgan, Dill & Kalleberg, 2013; Dill, Morgan & Marshall, 2013; Dill, Chuang & Morgan, 2014).

This collection of strategies for becoming an employer of choice have been gleaned through a series of studies aimed at understanding successful employer practices and the contexts in which they work (Dill, Morgan & Kalleberg, 2012; Morgan & Farrar, 2015).

Hiring and Onboarding

Recruitment should be a careful process to find both qualified and reliable hires. Beyond the requisite background and safety checks, organizations also have to make sure that the applicant is a good fit for the culture they are developing. Some promising strategies include asking direct care workers to sit on hiring committees and implementing "walking interviews" conducted on the floors, where staff are included in assessing applicant interactions with residents and other staff. Developing relationships with local community colleges or other training providers, where students can do clinical rotations at the organization, gives an employer ready access to new entrants to the labor market. This relationship affords students a job preview and allows the organization to interview students on an informal basis (Dill et al., 2012). These employers may also benefit by gaining leverage to recommend changes to the students' curriculum, such as inserting important, employer-specific training needs.

One of the most important aspects of this process is realistic job previewing, where applicants, especially new entrants to the field, have a chance to understand the realistic scope of the job expected of them. A high degree of turnover happens in the first few months of employment when workers are overwhelmed by the realities of direct care work (Morgan & Farrar, 2015). This migration can be mitigated by incorporating working interviews where applicants do some job shadowing and speak with direct care workers. When new people start a job, they are often provided training in the form of orientation. This is the opportunity for managers to help the new hires understand the mission, vision, and goals of the organization. Onboarding often gets curtailed when organizations find

themselves working short, which can encourage turnover. Strong practices of supporting ongoing hands-on training for staff, several-weeks-long processes of peer mentorship with competency checklists, getting to know individual new hires as people, and integrating them into the teams and work culture are critically important to provide new hires the tools to succeed and become empowered and engaged workers.

Standardization of training materials is key. Core values must remain the same throughout different materials. The advantage of standardization is that it helps all employees stay in sync with the organization's goals, avoiding internal conflicts. In a fast-paced work environment, a trainer can miss an important aspect of the job. A standardized outline can help trainers stay on track and make sure all the important points are covered. Every person learns differently. Some are visual learners, whereas others learn through readings. Encouraging direct care workers (DCWs) to use their senses as they learn is often a useful strategy. Skills such as active listening, observing, self-awareness, and self-management should be discussed and practiced. Employers should minimize lecture-based material (including lecture-based videos) and focus on using a variety of active methods such as role play, scenarios, discussion, and peer-learning strategies. The training material must be contextualized to particular roles to help the employees understand their valued place in the organization. An organization with a well-oiled, efficient, and thorough hiring and onboarding process will soon become known in the community as an employer of choice. Those who are quick to reimburse workers for any upfront training costs, offer full wages during training periods, and treat new hires with high levels of respect from the start earn a reputation in the community quickly as great places to work.

Compensation

Employers are constrained by budgets, reimbursement/payor systems, and local labor markets in setting wages and determining wage progression. What is often not considered is the cost of turnover. If this cost can be effectively reduced by becoming an employer of choice in the community, the savings can be reinvested into compensation strategies. A competitive starting wage and compensation package are important to recruit highly qualified talent. In addition to wages, employers have had success in developing other compensation strategies that improve recruitment and retention. Some strategies include offering affordable health insurance options — even for part-time workers (as low as .4 full-time equivalent, or 16 hours per week), improving pension plans and marketing these to older workers, and increasing the starting wage significantly above the community labor market benchmarks. Paid time off policies are also part of compensation and can be critical for front line employees who have precarious lives outside of work. Because of meager paid time off policies, workers often feel they are pressured to come to work sick, or fear supervisor retribution if they need time to take care of themselves or sick family members. Workers with generous paid time off policies, holiday differentials, and teams that work together feel valued and respected. They are much more likely to ask for time off than to quit when a crisis happens. Finally, small emergency cash grants ($100-$500) for help with unforeseen expenses can help build loyalty by allowing front-line workers to manage stressful financial situations in a way that minimizes their impact on work. The loans seem to work best when they are universally available, have quick turnaround, and require a minimum of paperwork.

Education and Career Opportunities

Career "lattices," where employees can see how to move both laterally and up in an organization or a partnership of several organizations, can increase employee satisfaction and retention. Clear vertical (moving to a higher position) and horizontal (moving to a different department) pathways are essential (Morgan & Farrar 2015). Some organizations have been successful in creating career ladders for frontline workers like direct care, entry-level, and administrative workers, whereas others focused on mid-level positions such as nursing staff (Dill et al., 2012). Encouraging employees to move ahead on the career lattice by acquiring education and training helps with retention. Further, it may also lead to better job performance due to greater commitment from employees which ultimately leads to improved care for older adults (Dill et al. 2012).

Organizations serving older adults need to think about creating both educational and career opportunities for frontline workers. Opportunities to gain credentials, degrees, and acquire competencies associated with internal and external career advancement often drive employer of choice status in communities. Eden Associate training offered by the Eden Alternative or Mental Health First Aid Certification through the National Council for Behavioral Health are some examples of certifications that improve skills for workers and could be incorporated into career advancement strategies. Some key projects include career maps with revised competency-based job tiers, and scholarship development with tuition remission (Dill et al., 2012;

Morgan & Farrar, 2015). Career maps help both new and incumbent workers understand pathways to positions with more responsibility and increased compensation. Clear demarcation of job duties and qualifications for each role can help the employees understand what is expected of them and give individuals in other roles clear pathways to advanced roles. Partnerships with other community employers can also lead to external career opportunities (Dill et al., 2012). These partnerships strengthen community labor markets and benefit both sending and receiving organizations. Sending organizations benefit because workers gain skills while they obtain credentials and are more engaged. Receiving organizations benefit from well-trained workers in established pipelines and improved recruitment.

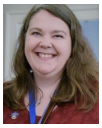
Organizations have also improved their employer of choice status by offering scholarships and/or granting tuition remission. Some organizations already partner with foundations that raise money for vulnerable older adults and sponsor community events. The development of scholarship funds to provide stipends for educational expenses provide both a recruitment and retention win for employees at the bottom of the ladder. Training or tuition funds may also be allocated to higher income workers who can afford to pay upfront costs of education. Many frontline workers pass on the opportunities to gain formal training and certification because of cost (Dill et al. 2012). Tuition remission allows educational institutions to bill tuition directly to the employer. By providing tuition remission, the managers can build a relationship of trust and interdependency between the organization and employee. This bond will motivate the employee to stay with the organization for a longer period of time and recommend it as a great place to work to others in your community.

High Performance Work Practices

High-performance work practices (HPWP) seek to both improve job satisfaction and organizational outcomes through investment in human capital (Pfeffer, 1994; Burke, 2006). HPWP are typically implemented as "bundles" of policies and practices that emphasize training, socialization, and rewards such as performance-based incentives and participative decision making (Appelbaum, Bailey, Berg & Kalleberg, 2001; Sullivan, 2004). The idea is that bundled together, these practices are more effective in achieving improved organizational outcomes (such as improved recruitment and retention and, ultimately, improved quality of life) than they would be separately. Garman, McAlearney, Harrison, Song, & McHugh (2011) describe four domains of high performance work practice: staff motivation, frontline empowerment, talent acquisition, and leadership support. Practices in *staff motivation* focus on increasing workers' awareness of, and personal stake in, the organization's vision. *Frontline empowerment* focuses on reducing status distinction and providing an environment where workers feel secure. This could be achieved with supportive practices such as flexible or self-scheduling, or decentralized decision-making, where frontline workers are responsible for making decisions in the moment. *Talent acquisition* emphasizes systematic strategies for recruitment and hiring, as well as career and skill development opportunities (see above discussion). *Leadership support* practices include awareness of how high performance work practices are aligned strategically with targeted organizational outcomes such as recruitment, retention, and improved quality. Chuang, Dill, Morgan, and Konrad (2012) found that the combination of creative input, supervisor support, team-based work, and flexible work arrangements was the most predictive of both job satisfaction and perceived quality of care.

Organizations serving older populations would do well to identify ways to improve human resources policies and practices related to these four areas simultaneously. Input into care planning and work processes has long been associated with key outcomes. Asking for and providing regular, integrated opportunities for workers to offer suggestions, be consulted, and collaborate in work groups about work processes and care is key to improving organizational outcomes. Supervisor support, where a person-centered relationship is formed between supervisors and workers and workers perceive that the supervisor advocates on their behalf, is also key. This dynamic is related to frontline worker empowerment, where workers feel safe to ask questions, make mistakes, and deliver information to supervisors. Team-based work practices, including co-worker support, are also important factors to becoming a great place to work. Finally, encouraging flexible work practices like self-scheduling and flexible hours indicate trust between employers and workers, which supports high-performance teams.

Being an employer of choice is an informed strategy, achieved by building a culture of retention in any organization. Strategies that amplify the values and mission of the organization and include frontline workers as full and valued members of the team are likely to improve recruitment, retention, and ultimately improve the lives of older adults and their families. •CSA



Dr. Jennifer Craft Morgan is an Associate Professor at The Gerontology Institute at Georgia State University. She received her BA from Franklin and Marshall College and her MA and PhD in Sociology at the University of North Carolina at Chapel Hill. Dr. Morgan is a national expert on recruitment, training and retention of frontline health care workers highlighting the impact of job quality factors on worker and older adult outcomes. She can be reached at jmorgan39@gsu.edu or https://gerontology.gsu.edu/profile/jennifer-craft-morgan/

Nidhi Joshi graduated with a Master of Gerontology degree from The Gerontology Institute, Georgia State University in May 2020. She is currently working as a graduate research assistant on Building Resources for Delivering Person-Centered Care in Georgia Nursing Homes project. She is interested in promoting a person-centered care approach in long-term care communities. Her focus is on creating a community that encourages the growth of residents as well as the employees. She can be reached at nidhijoshi181@gmail.com or on LinkedIn at www.linkedin.com/in/nidhi-joshi-gerontologist

REFERENCES

Appelbaum, E., Bailey, T., Berg, P., and Kalleberg, A. L., (2001). Do high performance work systems pay off? *Research in the Sociology of Work, 10*, 85–107. doi: https://doi.org/10.1016/S0277-2833(01)80022-4

Barba, B. E., Tesh, A. S., & Courts, N. F. (2002). Promoting Thriving in Nursing Homes: THE EDEN ALTERNATIVE. *Journal of Gerontological Nursing*, *28*(3), 7–9. doi: 10.3928/0098-9134-20020301-04Berridge, C., Tyler, D. A., & Miller, S. C. (2018). Staff empowerment practices and CNA retention: Findings from a nationally representative Nursing Home Culture Change Survey. *Journal of Applied Gerontology*, *37*(4), 419-434. doi: 10.1177/0733464816665204

Burke, R. J. (2006). The human resources revolution. In Burke, R. J. & Cooper C. L. (Eds). *The Human Resources Revolution: Why Putting People First Matters*. Oxford, UK: Elsevier Ltd. doi: 10.1093/geront/47.2.193

Castle, N. G., Engberg, J., Anderson, R., & Men, A. (2007). Job satisfaction of nurse aides in nursing homes: Intent to leave and turnover. *The Gerontologist*, *47*(2), 193-204. doi: 10.1093/geront/47.2.193

Chuang, E., Dill, J., Morgan, J. C., & Konrad, T. R. (2012). A configurational approach to the relationship between high-performance work practices and frontline health care worker outcomes. *Health Services Research*, *47*(4), 1460–1481. doi: 10.1111/j.1475-6773.2011.01366.x

Dill, J. S., Chuang, E., & Morgan, J. C. (2014). Healthcare organization–education partnerships and career ladder programs for health care workers. *Social Science & Medicine*, *122*, 63-71. doi: 10.1016/j.socscimed.2014.10.021

Dill J. S., Morgan J. C., & Kalleberg A. L. (2012). Making 'bad jobs' better: The case of frontline healthcare workers. In Warhurst C, Findlay P, Tilly C, & Carre F (Eds.) *Are Bad Jobs Inevitable? Trends, determinants and responses to job quality in the twenty-first century.* UK: Palgrave.

Dill, J. S., Morgan, J. C., & Marshall, V. W. (2013). Contingency, employment intentions, and retention of vulnerable low-wage workers: An examination of nursing assistants in nursing homes. *The Gerontologist*, *53*(2), 222-234. doi: 10.1093/geront/gns085

Garman, A. N., McAlearney, A. S., Harrison, M. I., Song, P. H., & McHugh, M. (2011). High-performance work systems in health care management, Part 1. *Health Care Management Review*, *36*(3), 201–213. doi: 10.1097/hmr.0b013e318201d1bf

Kelly, C., Morgan, J.C., Kemp, C. L., & Deichert, J. (2020). A profile of the assisted living direct care workforce in the United States. *Journal of Applied Gerontology*, *39*(1), 16-27. doi: 10.1177/0733464818757000

Kemp, C. L., Ball, M. M., Jason, K., Appel, J. A. D., & Fitzroy, A. F. (2019). Communicative Competence: Responding to Residents' Health Changes in Assisted Living. *The Gerontologist*. doi: 10.1093/geront/gnz119

Kemp, C. L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies*, *27*(1), 15-29. doi: 10.1016/j.jaging.2012.10.002

Kim, J., Wehbi, N., DelliFraine, J. L., & Brannon, D. (2014). The joint relationship between organizational design factors and HR practice factors on direct care workers' job satisfaction and turnover intent. *Health Care Management Review*, *39*(2), 174-184. doi: 10.1097/hmr.0b013e31828c8b8f

Morgan, J. C., Dill, J., & Kalleberg, A. L. (2013). The quality of healthcare jobs: can intrinsic rewards compensate for low extrinsic rewards?. *Work, Employment and Society*, *27*(5), 802-822. doi: 10.1177/0950017012474707

Morgan J. C. & Farrar B. (2015). Building meaningful career lattices: Direct care workers in long-term care. In Armenia A, Stacey C, & Duffy M (Eds.) *Caring on the Clock: The Complexities and Contradictions of Paid Care Work.* U.S. Rutgers University Press.

Pfeffer, J. (1994). *Competitive advantage through people: Unleashing the power of the workforce.* Cambridge, MA: Harvard Business School Press

Sprowl, D. G., & Coffey, W. O. (2020). Leadership coaching is the missing link to retain staff. *CSA Journal*, *71*, 57–61.

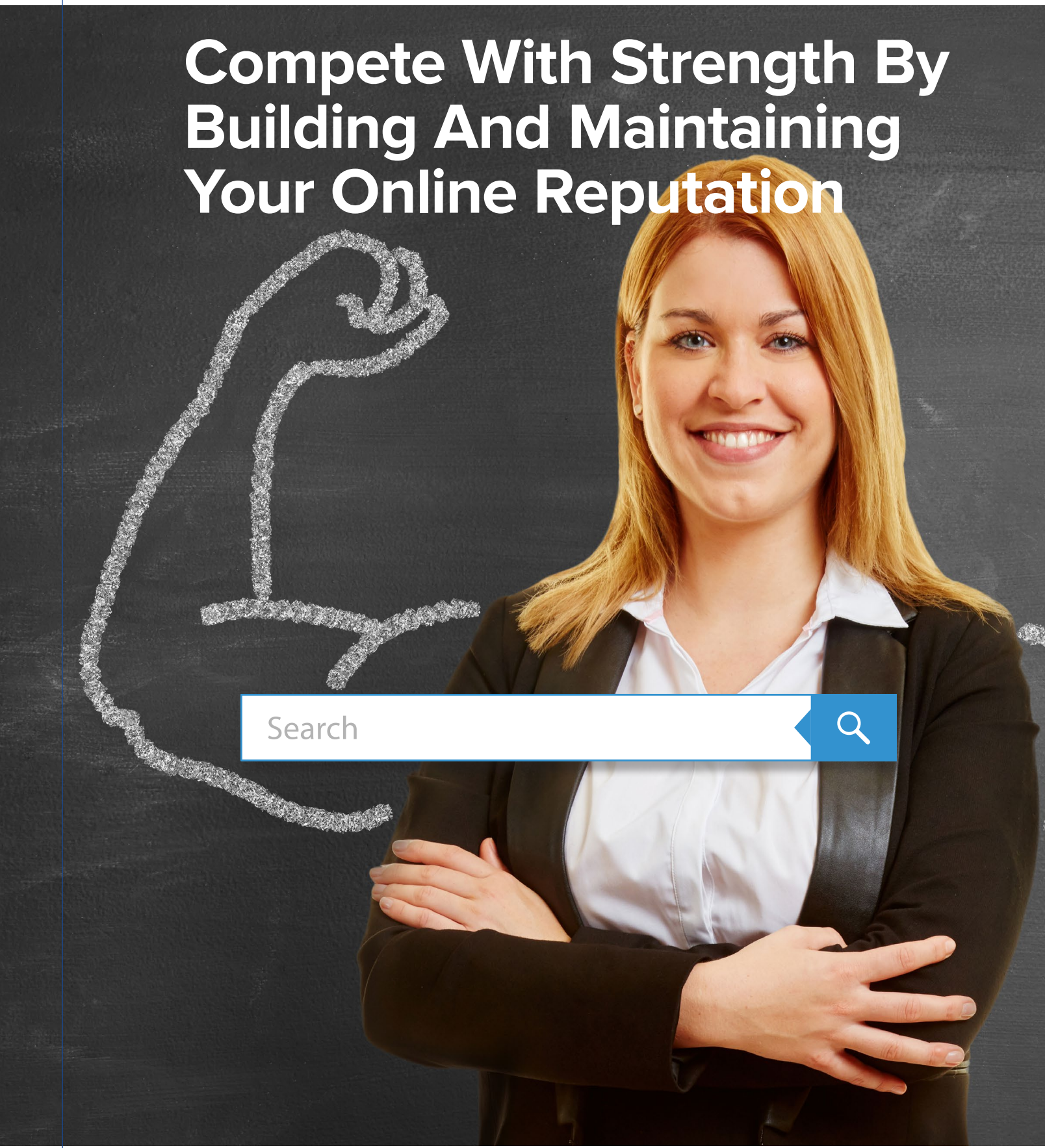
Sullivan, J. (2004). *Rethinking strategic Hr: HRs role in building a performance culture*. Chicago, IL: CCH Inc.

Tyler, D. A., Jung, H. Y., Feng, Z., & Mor, V. (2010). Prevalence of nursing assistant training and certification programs within nursing homes, 1997–2007. *The Gerontologist*, *50*(4), 550-555. doi: 10.1093/geront/gnq014

Tyler, D. A., Lepore, M., Shield, R. R., Looze, J., & Miller, S. C. (2014). Overcoming resistance to culture change: Nursing home administrators' use of education, training, and communication. *Gerontology & geriatrics education*, *35*(4), 321-336. doi: 10.1080/02701960.2013.837049

Vitale-Aussem, J. (2019). *Disrupting the Status Quo of Senior Living*. Baltimore, MD: Health Professions Press, Inc.

Compete With Strength By Building And Maintaining Your Online Reputation



Business owners serving older adults can improve returns dramatically by pumping up online search results. Here's how. BY TIMOTHY ROWAN, MA AND ROGER MCMANUS, MBA

Even those who recite the shopworn phrase "the Internet changes everything" often understate the true impact of that concept, particularly on often hard-to-define businesses such as senior-specific services. When the focus moved from TV and Yellow Page ads, which were directed to people within a defined service area, to Google's global reach and Yelp's "walking distance" users, opportunities and pitfalls permanently changed. Small, local service businesses, such as home care agencies, attorneys, financial planners and others, want to attract the older population's faraway adult child decision makers, but do not share a restaurant's need to lure someone looking for the physically nearest recommendation. These in-between businesses can leverage online marketing tools, but they must deploy dramatically different strategies.

Ben V. operates a Medicare-certified home health agency and an affiliated, non-medical home care business in Colorado. Both consistently report excellent patient outcomes. The Medicare side always scores in the high 4.x range on CMS's Home Health Compare website. Nevertheless, the independent, standalone agency struggled for years to maintain a healthy census, the premier measure of growth in a health-care business.

Among other strategies, Ben brought in an online marketing consultant who quickly determined that the company website was functional and attractive, with excellent search engine optimization (SEO) tools built into it. The next step, the consultant informed him, was to see if the website was easy to find in a typical online search.

It was not. This is not the oxymoron one might suppose. Strong SEO does not necessarily mean strong visibility in local search results. There is a good reason for that, but the explanation requires some unpacking.

Note that, in this analysis, we will consistently use the Google search engine as our example because it accounts for over 90 percent of online searches (Berry, 2020). It is safe to assume the marketing principles we lay out hold true for Yahoo, Bing, Duck Duck Go, and other search engines.

Global SEO vs. Local SEO

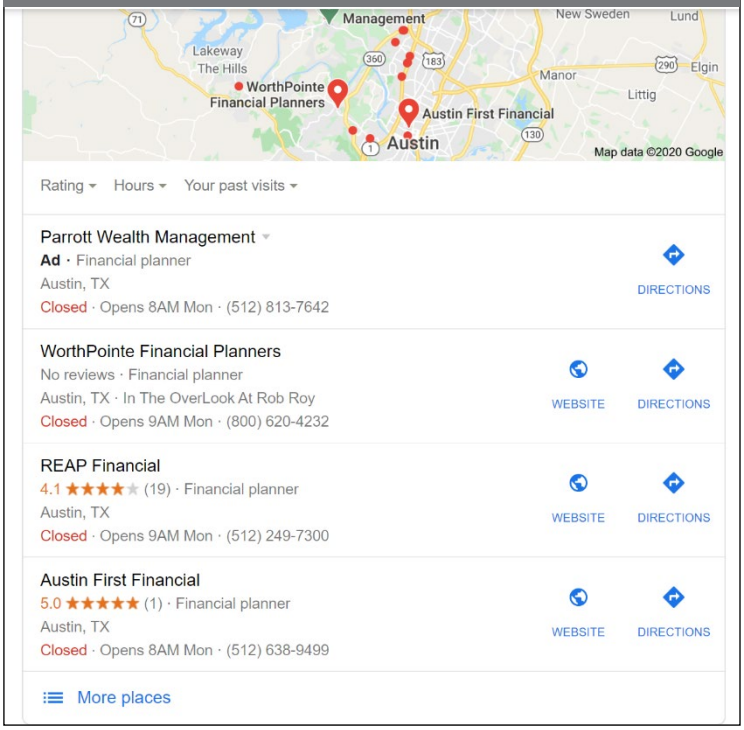
Think of the difference between searching Google for the best price on a laptop computer, versus searching for the best restaurant within walking distance of your hotel. In the former, you want Google to search the globe. In the latter instance, you want three nearby results, not three thousand restaurants from Anchorage to Miami.

Google meets these separate needs by sending any inquiry that specifies a locality to be searched through a separate algorithm it has dubbed "Google Local." Rather than the familiar, multi-page results ("about 3,040,000 results in 0.72 seconds"), Google Local displays what online marketers call a "3-pack." A 3-pack consists of three business listings and a map, with dots on the map showing the location of each business. Also displayed is a less frequently used "More Businesses" button. Click on one of the three results and its "Google My Business" page (GMB) appears. More about that later.

Every business that needs to attract local customers must know and accommodate Google's rules. Said another way, in order to strengthen online visibility in Google Local search results, a local business must pay more attention to local SEO than to global SEO. The two are distinct, but interdependent, marketing tools.

It must be added, however, that businesses catering to older adults are different in yet a third way from restaurants and computer outlets. It is the difference in *who* actually conducts a search that informs how to manage online presence.

FIGURE 1.



Who Conducts These Searches?

In Ben's home health-care case, as is true for most service businesses catering to local older adults, the "shopper," the person conducting the Google Local search, *does not necessarily live nearby*. Whether the business is home healthcare, a law practice, financial planning, or hoarding mitigation, as often as not, it is the adult child of the person needing the service who is querying Google. Yellow Pages ads and TV spots are wasted in an attempt to reach the exact person a local business needs to reach, the often-out-of-town decision maker for an elderly parent living nearby.

Here is where the most heavily weighted component in the Google Local algorithm, location, comes into play (Danaher, 2015).

GOOGLE LOCAL ALGORITHM FACTOR 1: LOCATION

It is not possible to evaluate a business's Google Local strength by searching one's own company's business category from a company office (e.g.: "attorneys [*my town*]). Google knows where the inquirer is and seems to push the closest businesses to the top. Search from your desk and you are likely to be deceived into thinking you have done all you need to do to make your company visible online. The adult child across the country will not see the same results. A pair of recommended actions should help:

1. Ask a friend or relative at least 200 miles away to conduct the search.
2. Perform the self-search anyway, but not to evaluate visibility. Finding a business with Google Local brings up the company's "Google My Business" page, the core of a business's online reputation improvement effort. In our primer below, we walk through the steps of customizing this page for optimal marketing impact.

GOOGLE LOCAL ALGORITHM FACTOR 2: KEYWORDS

A second focus within the Google Local algorithm is search engine optimization itself. The keywords the

distant adult child is likely to use in a query *must* be found as many times as possible on the company website. Traditional SEO principles are beyond the scope of this article. Suffice it to say you want to keep your webmaster focused on SEO while you turn your attention to Local SEO.

GOOGLE LOCAL ALGORITHM FACTOR 3: REVIEWS

Whether it is a choice among nearby restaurants, faraway hotels, or a plumber, the Internet has trained its users to accept the testimony of total strangers (Murphy, 2019). Word-of-mouth, that recommendation from a friend or neighbor that carries more weight than TV and Yellow Pages ads, has moved from the telephone to the smartphone.

Google recognizes this and adds a weighting for reviews to its algorithm. In addition to location and SEO, good and bad reviews of your business help Google decide how close to the top of a search, to that coveted spot in the "3-pack," your business will land. The algorithm measures three factors (see Figure 1):

1. Total number of reviews
2. Average review rating on a 5-star scale
3. Review recency (When was it posted?)

A business owner's three-part strategy to achieve Google Local dominance matches the algorithm:

1. Accumulate more reviews than the competition.
2. Encourage satisfied customers to post reviews.
3. Make it an ongoing effort so that fresh reviews appear regularly.

Psychological Awareness

A word must be added about strategy number two. Dissatisfied customers may never return and may never say why. They tend to just disappear. Angry customers, however, seem to be motivated to let the world know about their dissatisfactory experience with a business. When word-of-mouth occurred over the telephone, an angry customer might have convinced a handful of people to avoid a business. Today, one written review can reach millions of people.

Achieving and maintaining a high average star rating requires a proactive effort. While negative reviews will tend to appear organically, positive reviews can and should be encouraged. A single negative review lowers a business's average star rating. With rare exceptions, the only way to rebuild an average is to overwhelm it with a greatly superior number of positive reviews. Google *will not* remove a negative review, no matter how damaging it might be, unless it can be proven the content is:

- slanderous (proof found within the text itself),
- written by a competitor (proof is difficult), or
- mistakenly posted on your page when the customer's experience was with a different company (should be open/shut, but is not always successful).

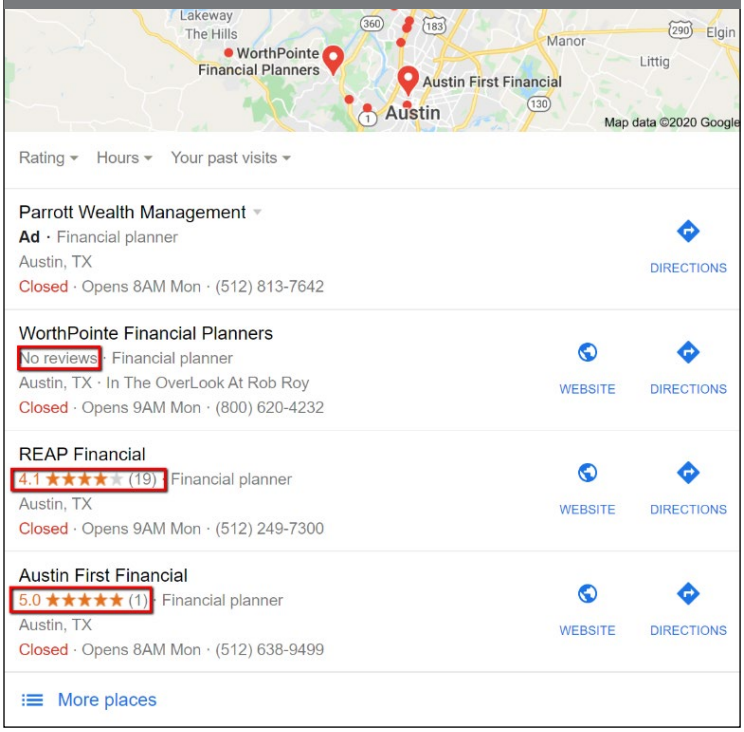
Even if one of these things is true, it is still an uphill, lengthy battle to convince Google to remove it. A professional's time is better spent focused on efforts to bury the occasional negative review by accumulating dozens of positive ones.

If Google will not remove a negative review, the next best thing is to respond to it. *Never* leave a negative review unanswered. Equally inadvisable is to argue with or criticize the review writer. Professional kindness and an offer to discuss the situation offline will ultimately pay off and can result in a positive impact on the business's reputation.

Remember: Responses to negative reviews are not addressed to the reviewer alone but to prospective customers as well. People who read reviews tend to base their decision as much on a business owner's response to unhappy customers as they do on positive comments.

Figure 2 highlights review counts and star ratings

FIGURE 2.



of the 3-pack businesses from figure 1. Note that the review count ranges from zero to nineteen and the two businesses with at least one review rate 4.1 and 5 stars.

Note: Avoid the common misconception that a perfect, 5.0-star average produces the effect of making your business appear superlatively attractive. It may have the opposite effect. In general, people savvy about online reviews tend to find five stars less believable, suspecting some manipulation has occurred. An average between 4.5 and 4.9 generates an aura of confidence that this business is honest and willing to admit it is good but not perfect.

Also, note that this sample search included a paid Google ad. Some businesses find this expense helpful, but it is usually not necessary. It is important to emphasize the superior power of "inverse marketing," where clients contribute to a company's reputation (for free) with their comments. Purchasing the top spot, above the 3-pack, is traditional marketing, where promotional language is used to build a company's reputation. In general, people tend to believe their neighbor before a company's marketing department.

GOOGLE LOCAL ALGORITHM FACTOR 4: CITATION CLAIMING

An additional key factor in Google's algorithm is a score for a business's appearance on other search and review websites. There are hundreds of these sites, bearing names such as "Kudzu," "Wikiocity," "Yellow Pages," and "HotFrog."

There are two factors here. First, more is better. Second, consistency with the company's Google listing is critical. The bots Google sends out compare non-Google listings with GMB pages. The company that is listed on more of these websites, with data that identically matches its GMB page in the smallest detail, appears more credible to Google.

Although few people use these sites to search for services for their elderly parents, it is nevertheless important to "claim" these sites, expressly to be seen there by Google. The more of them claimed, and the more the listing matches the GMB page, the bigger "footprint" (influence) Google sees. This manifests itself in increased chances of landing in the coveted "3-pack" when people search via Google Local.

DEFINING "CITATION"

A citation is nothing more than the business's "NAP" (name/address/phone number) in a directory. Most of these sites also allow a website URL to be included. Some welcome inclusion of pictures, videos, mission statements, or other promotional language. Nearly all are free, though some offer the opportunity to enhance a listing with advertising (McManus, 2019).

Equally important to the number of citations listed is consistency. If any of the above elements varies from site to site, or from the GMB page, Google's sophisticated crawler robots pick up the difference, even if it is as insignificant to the human eye as spelling out vs. abbreviating "avenue" or "boulevard." Inconsistency results in less trust in a business's online image, which translates into a less prominent appearance in Google Local search results.

Claiming as many of the more obscure search and review websites as possible can be done in-house, though it is a time-consuming task. Often, it is more cost-effective to subcontract rather than divert company human resources. An experienced online marketing consultant will charge per claimed site, or a flat fee, but will complete the task more quickly. Such a consultant should begin with one of the free tools that perform a quick analysis of citations currently claimed and unclaimed. We use this one: www.bit.ly/mysitechecker2020

"Google My Business" Pages: A Marketing Opportunity

You may have seen the Google camera car driving down your street. Whether you like it or not, a photo of your business is visible to the world on Google Maps. That photo will also turn up on the GMB page Google creates, using whatever information it can acquire. Leaving that page unclaimed damages your online reputation. Customizing it and keeping it current over time is a strategic, and cost-free, method to deliver your message to your real audience — prospective clients and their adult children.

It may be that some GMB pages go unclaimed when a business simply has not been made aware of their existence. Fortunately, once aware, catching up is easy as Google facilitates claiming and editing the page. Wise business owners consider it a "must do," an opportunity to make a good impression on Google, an impression that determines how the business ranks on searches.

GMB Customization Step-by-Step

There are many elements to optimizing a Google My Business listing. All of them are important but the key elements to focus on are:

- **NAP**. Decide exactly how this should appear and record it precisely in a permanent place. Refer to

it for consistency when claiming other sites in the future.

- **Business description**. Limited to 750 characters, this text should include as many keywords as possible. Use natural sentences to avoid the appearance of "stuffing" keywords into the allotted space. *Suggestion*: Pull language from the "About Us" page of the company website.
- **Business category.** Unfortunately, Google forces businesses into their broad, pre-determined categories, which can be challenging for niche service providers, such as professionals serving older adults. Vastly different businesses may be gathered into the "consultant" category, which is not helpful in online searches.

Note: As an example of Google's intransigence on this point, the company absolutely refuses to understand the difference between "home care" and "home health." Providers of in-home personal care services are forced into the "home health care" category, regardless of the technical reality.

- **Services.** When "category" does not serve well, make use of "services," where Google lets you describe as many services as you want, using your own words. It appears there is no limit to the number of services you may add and the number of keyword-rich descriptors you can use.
- **Service area.** Here, Google has done a great service to businesses that deliver in-home services. Google asks whether your clients come to a physical address (restaurants) or you go to their home (plumbers). In the case of home care, the answer is obvious. In the case of legal and financial advisory services, you may choose to conduct your business either way. Whatever you choose, you get to define the area in which you provide services. You may name up to twenty counties, cities, regions (e.g. San Francisco Bay Area), zip codes, or a mixture of all of these.
- **Images.** Google provides the opportunity to post twelve images on your GMB site. One of these should be a *square* version of your logo. Any of your twelve may be replaced with a short video (60 to 90 seconds is recommended, but Google does not seem to limit this.)

In Summary

Going back to the introductory scenario, Ben V.'s Colorado home healthcare agency followed these guidelines and moved from a "graveyard" position several Google pages down to a comfortable spot in the top three. Business has been good. Your business can get similar results.

While all of this may be a lot to absorb, inverse marketing remains the least expensive form of marketing available. Learning to manage one's online reputation pays off exponentially, particularly for consultants such as advisors to older adults. Attentiveness to Google reviews, coupled with coordinating your Google My Business page with your listings on other directories and search engines, enhances your visibility to your primary targets, the older adults you want to serve and their adult children. Your only investment is in the time it takes to enter the information. •CSA

Timothy J Rowan, MA, is a nationally-known home healthcare consultant and the publisher of "Home Care Technology: The Rowan Report," the industry's premier technology newsletter since 1999. He has been in home health since 1993 and has been teaching home care agencies how to manage their online reputation since 2015. Tim lives in Colorado Springs with his two dogs and plays keyboard in a garage rock and roll band. He can be reached at Tim@RowanResources.com

For well over thirty years, **Roger McManus, MBA,** has coached, funded, counseled, and published for entrepreneurs. As a magazine publisher, speaker, author, and consultant, Roger has had the rare opportunity to see inside businesses resulting in the conclusion that many call themselves entrepreneurs, but few truly achieve the levels of freedom that the title should imply. When he joined Tim Rowan five years ago to form Rowan Reputation Resources, Roger was able to perfectly blend his understanding of the issues facing small business owners with Tim's experience in senior-specific enterprises to create a business that is perfectly matched to the growth challenges faced by owners of senior-oriented consultancies today. Contact him at Roger@RowanResources.com

REFERENCES

Berry, S. (2020, January 1). *Search market share: 5 hard truths about today's market*. Retrieved from https://www.webfx.com/blog/seo/2019-search-market-share/

Danaher, J. (2015, September 14). *U.S. Patent No. 9158803*. Washington, DC: U.S. Patent and Trademark Office.

McManus, R. (2019, June 5) *What are citations and why must you manage them?* Retrieved from http://homecaretechreport.com/article/2850

Murphy, R. (2019, December 11). *Local consumer review survey*. Retrieved from https://www.brightlocal.com/research/local-consumer-review-survey/#search-frequency

How Investment Professionals Can Implement Best Practices Against Senior Scams

Fraud perpetrated against vulnerable older adults is more prevalent than ever, and financial professionals have a role in preventing it. BY MARY DUNN, CSA

When there are signs that an individual's capacity to formulate clear decisions has been compromised, the effects of aging become apparent. Older adults are high on the list as prime targets for financial exploitation, fraud, and deception. Financial industry professionals can help protect their clients before they are taken advantage of, and in case they suspect fraud may have already occurred. The author works in legal and regulatory services for a financial brokerage firm and has seen her share of shady activity.

By 2030, more than 20 percent of U.S. residents will be over age sixty-five, compared to 13 percent in 2010 and 9.8 percent in 1970 (Colby & Ortman, 2016). The baby boomer generation, which encompasses individuals born between 1946 and 1964, is driving the growth of an aging population that is expected to live longer than older adults of earlier generations, yet with far more economic challenges (DeLiema, 2016). Furthermore, a new report from the Federal Trade Commission (FTC) reveals that older

adults are 20 percent less likely to be victimized by fraud than younger populations, but when they are, their losses will be four times greater than those individuals in their twenties and thirties who are reporting the crime (Passy, 2018).

Retirees Vulnerable

Older adults sometimes feel isolated or alone and may therefore be more willing to engage in conversation with anyone who calls or writes. Taking advantage of this, scams by phone or email range anywhere from familiar tax and Social Security schemes to the more creative ploys of bogus winning lottery claims, grandkid impersonators, and fake romances.

Beyond the initial financial losses, often victims give all their information out, including their home address, resulting in more dangerous situations.

My company, a financial services business that supports investment professionals in private practice, has a number of colleagues with a large percentage of clients in their later years. This preponderance of older clients has compelled the firm to implement employee awareness and learning for the special needs of this group. Training takes place via required continuing education programs and training videos produced in its in-house studio. Registered investment professionals are encouraged to monitor the account activity of older clients, as well as noting signs of dementia. By identifying the red flags of sudden or unusual changes in behavior or account activity — particularly during a life-changing event such as retirement, illness, or death of a spouse — the advisors can elevate their concerns, make inquiries and, if necessary, take immediate action. Here are some signs of concern the advisors are taught to watch for:

- Mood changes or unusual demands.
- Signs of physical abuse, such as bruising or injuries.
- Lost or restricted communication with client.
- Out-of-the-norm client transaction requests or actions.
- New friend involved in day-to-day needs of a client.
- Third-party "coach" expressing excessive interest in client's financial affairs.

Scammers are very good at what they do, preying on the vulnerabilities of older adults by creating a sense of urgency. Only the older adult can fix the "problem" with his or her financial resources. The advent of social networking has made it even easier for scammers to sleuth out personal and family information, fashioning believable connection points for impersonating the older adult's loved ones in distress and tricking them into sending money. Scammers also hack into e-mails to obtain information for contacting their targets in an official or trustworthy capacity under the credible guise of a lawyer, police officer, or friend of the family. The following chronicles three specific cases brought forward to the legal department by its affiliated advisors demonstrating — without divulging identities — the unscrupulous tactics just described.

Case Study 1: Pay-By-Gift-Card

Scams involving Social Security benefits and credit card misuse fall under the umbrella of identity theft, with more than 14.4 million victims in 2019, according to the FTC (Cook, 2019). Every year, new scams evolve. Thieves are endlessly creative, garnering significant results as evidenced by one recent Social Security scam that generated more than 76,000 complaints to the FTC and caused losses to consumers of more than $19 million (Werner, 2019).

Pam, a 72-year-old client of an investment professional, received a call from the "Social Security Administration" claiming that her Social Security number had been stolen and was used in a fraudulent way; unless she provided cash up front, the Federal Bureau of Investigation (FBI) would be at her doorstep in twenty minutes to arrest her. Pam cooperated and provided her Social Security number, her bank account information, and where her credit card was issued. The fraudsters requested payment in the form of $1,700 worth of Best Buy gift cards.

Pam hesitated to call back the "Social Security administrator" and instead phoned her investment professional, who reported the scam to our office. The police, bank, and credit card company were notified, along with a recommendation to implement a credit freeze on all three credit bureaus and to change Pam's phone number. The Internal Revenue Service (IRS) was also contacted to obtain an identity theft protection pin number for tax filing purposes.

With the utmost sensitivity and by asking just enough questions to understand the nature of the

fraud, the advisor helped her client avoid potential financial catastrophe. The collaborative efforts of her trusted advisor and the backing of her financial team afforded Pam the best possible resources to protect her against any further fraud.

Case Study 2: Publishers Clearing House Scam

Nancy is a 69-year-old client of one of my company's investment professionals. During their meeting and discussion around estate planning, Nancy showed her advisor a letter she had received from the Publishers Clearing House customer service department stating she had won $1.6 million and to call as soon as possible to speak with agent John Robinson. The investment professional expressed his concern about the likelihood it was a fraudulent communication, pointing out grammatical errors and a missing return address on the envelope. Nancy admitted she had called the provided number, although she had not given out any personal information at that time. To impress upon Nancy how certain he believed this was a scam, the advisor put the client in touch with the home office. Staffers there forwarded Nancy a legitimate letter that had been obtained from the main office at Publishers Clearing House, explaining in detail how a winner is contacted and that the letter she received was, in fact, a fraud.

Case Study 3: Romance Scam

In the last five years, the firm has been contacted by numerous investment professionals regarding romance scams. Linda is a 41-year-old client who contacted her advisor for assistance in liquidating $60,000 from her account. After questioning her about the purpose of the needed funds, Linda shared that she was involved with a man named "Dennis" on a dating website. She had never met him, but he was in the Army, a father of two, and a recent widower. Because he was stationed in Somalia, he needed money to return home for the holidays. (This should have been a big red flag since men and women in the armed forces fly on leave at Uncle Sam's expense.) Initially, Linda had written him a personal bank check for $10,000 and was instructed to forward it to his "agent."

After the check was received and cashed, "Dennis" contacted Linda, requesting she send him an additional $60,000. Linda hesitated, but was told that to demonstrate his good faith, her initial outlay of $10,000 would be returned to her. A month later, Linda received a USPS package from "Dennis's agent" containing $10,000 in cash tucked inside a shoe box. When Linda questioned "Dennis" about sending so much cash through the mail, he claimed the money was forwarded to her that way so an X-ray of the box would not identify its contents as cash. After our office received word from the investment professional about these activities, staff contacted the Army and provided the name and photo of "Dennis," and reported the incident to the U.S. Postal Inspection Service for investigation.

The Army responded in an e-mail, stating that scams through dating websites of predators posing as officers in the Army have generated losses of over $37 billion a year for older victims of fraud. However, Linda was thoroughly hooked. Despite hearing the findings from the investigation, Linda still believed "Dennis." Unfortunately, even though the evidence was clear that this man was a fraud, Linda continued to drain her accounts and lost all of her savings.

Beyond the initial financial losses, often victims give all their information out, including their home address, resulting in more dangerous situations. One such romance scam started with the victim sending $20,000, which escalated to control of her bank accounts, vandalism of her home, and eventually, inevitable forced relocation.

Readers may have noticed that all the case studies presented here involve women. In my office, 90 percent of scammed clients are female and 10 percent are male. Whether this is because women report scams at a higher rate, are victimized more often, or the imbalance is due to another cause is ripe material for research.

Aging Professionals Can Help Prevent Exploitation

The cases shared demonstrate how financial professionals can be instrumental in exposing and preventing potential scams. Assigning someone in the organization with the knowledge, training, resources, and empathetic demeanor needed to assist victimized older adults can help them deal with such scenarios they may bring forward.

It's important for professionals to stay alert to red flags that might be indicative of financial fraud. Financial services professionals who do so are providing the best value-added services for their older clients, as well as helping to mitigate the rippling effects and risks resulting from financial exploitation. By exercising compassion, managing expectations, assessing any additional safety concerns that may arise, and surrounding victims with a network of support, further fraud may be prevented.

Implement an Exploitation Protection Program

A proactive stance will equip a company with the knowledge and actionable steps necessary to satisfy client needs, protecting them from many of the scams that exist today. The company the author works for has a plan in place for those times when a client may be the target of fraud.

Based upon the financial services industry's regulatory guidelines, it is recommended to establish an Elder Client Escalation team. When notification is received of a potential scam, it is referred to a designated trained professional, at which point the investigation begins. A meeting with the fraud team — comprised of chief legal counsel, a chief compliance officer, a professional trained to work with older adults, and a surveillance supervisor — commences, in which a strategy is discussed. Under the guidelines of the Financial Industry Regulatory Authority (FINRA) and the U.S. Securities and Exchange Commission

RESOURCES

The FTC is the nation's primary consumer protection agency. Anyone can order pamphlets and other handouts for clients on the website, free of charge. Additionally, the agency provides videos on the different types of scams being inflicted on the public and how to prevent clients and/or family members from becoming victimized.

FTC efforts to file law enforcement actions have made inroads in stopping unlawful practices and educating the public regarding consumer protection issues by way of strategic initiatives, research, and collaboration with federal, state, international, and private sector partners (Federal Trade Commission Act 15).

The Federal Trade Commission conducts research and analysis, and engages in coordinated efforts to protect older adults from financial loss and assist them with other consumer issues such as identity theft protection. The FTC, in their last fraud survey, found that 10.8 percent of adults in the United States—an estimated 25.6 million people—had been victims of one or more of the frauds included in the survey (Anderson, 2013).

Certain types of scams are likely to affect different demographic groups. For example, older adults in the survey — ranging in age from fifty-five to seventy-four — were more likely to be victims of fraudulent prize promotions than were younger consumers (FTC, 2016).

Further, the FTC is an active member of the Elder Justice Coordinating Council, a federal entity charged with identifying and proposing solutions to problems related to elder abuse, neglect and financial exploitation. The council's mission is to develop recommendations for the Secretary of the Department of Health and Human Services (DHHS) for the coordination of relevant activities. DHHS convened the Elder Justice Coordinating Council in accordance with the Elder Justice Act of 2009. The Council consists of heads of federal departments and other government entities, including the Federal Trade Commission, identified as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

In addition to the FTC, there is a wealth of information available to anyone in the business of protecting seniors against fraud. These include, but are not limited to:

- Federal Bureau of Investigation (IC3.gov)
- National Adult Protective Services (Napsa-now.org, 277-523-4431)
- AARP (www.aarp.org/homefamily/caregiving, 1-888-687-2277)
- National Council on Aging (Ncoa.org, 202-479-1200)
- The Office for Victims of Crime (https://www.ojp.gov/about/offices/office-victims-crime-ovc)

(SEC), the client is serviced in accordance with the firm's Written Supervision Procedures under Senior Suitability Rules (SSR), where all actions taken are for the sole purpose of protecting the best interests of the client.

Here are some basic guidelines to follow in establishing preventive measures to counter financial fraud when working with older clients:

1. Set up regular meetings with clients. Take notes and document behavioral changes including appearance, forgetfulness, or confusion.
2. Obtain information on a trusted contact person, such as a family member or close friend, and get a client's signed authorization to contact that person in the event of any emergency.
3. Allocate time to educate clients about financial scams and available resources to which they can turn. (See the list of resources, below, featuring organizations focused on supporting victims of financial fraud).
4. Help older clients maintain a healthy social network. Encourage them to contact senior centers in their area to maintain outside connections.
5. Understand the various state laws, rules, and regulations where the client resides, and the necessary contact information to report signs of abuse or fraud.

Scammers are experts at shifting tactics and changing their message to catch older adults off guard. This is especially true surrounding the anxieties related to the recent pandemic. The top categories of coronavirus-related fraud complaints include travel- and vacation-related reports about cancellations and refunds, reports about problems with online shopping, mobile texting scams, and government and business imposter scams. In fraud complaints that mentioned the coronavirus, consumers reported losing a total of $4.77 million with a reported median loss of $598 (Federal Trade Commission, 2020).

While Americans are washing their hands and working to keep themselves and their family safe, here are a few suggestions for clients to protect them from scammers:

- **Don't be rushed**. Whatever the call, email, text, or social media post is about, the first warning sign is when it says to respond immediately. Don't!
- **Check it out**. Before you act, do some research to see if this is a scam.
- **Pass it on.** If you are not sure, talk to someone you trust for another opinion.

Now more than ever, financial professionals must continue to have an aggressive approach to be one step ahead of the scammers and, whenever possible, get the word out on the ways to protect their clients, friends, and family from the financial hardship fraud brings. •CSA

Mary Dunn is manager of Legal and Regulatory Services and the designated Certified Senior Advisor® (CSA) at American Portfolios Financial Services, Inc., a member FINRA/SIPC firm and independent broker/dealer. Since 2015, the rise in senior scams and the consequent need for oversight has been a top priority. The firm maintains ongoing contact with the Federal Bureau of Investigation, Federal Trade Commission, FINRA and local law enforcement concerning fraud cases perpetrated against older clients.

REFERENCES

Anderson, K. (2013, April). *Consumer fraud in the United States, 2011: The third FTC survey*. Retrieved from https://www.ftc.gov/reports/consumer-fraud-united-states-2011-third-ftc-survey

Colby, S.L. and Ortman, J.M. (2015, March). *Projections of the size and composition of the U.S. populations: 2014 to 2060*. Retrieved from www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

Cook, S. (2019, June 20). *Identity theft stats & facts.* Retrieved from https://www.comparitech.com/identity-theft-protection/identity-theft-statistics/

De Liema, M. (2016, December 6). *The changing consumer demographics*. Retrieved from https://www.ftc.gov/news-events/events-calendar/2016/12/changing-consumer-demographics

Elder Justice Coordinating Council. (n.d.). What is the Elder Justice Coordinating Council? Retrieved from https://acl.gov/programs/elder-justice/elder-justice-coordinating-council-ejcc

Federal Trade Commission. (2016, March 25). *FTC to conduct consumer fraud survey* [Press release]. Retrieved from https://www.ftc.gov/reports/consumer-fraud-united-states-2011-third-ftc-survey

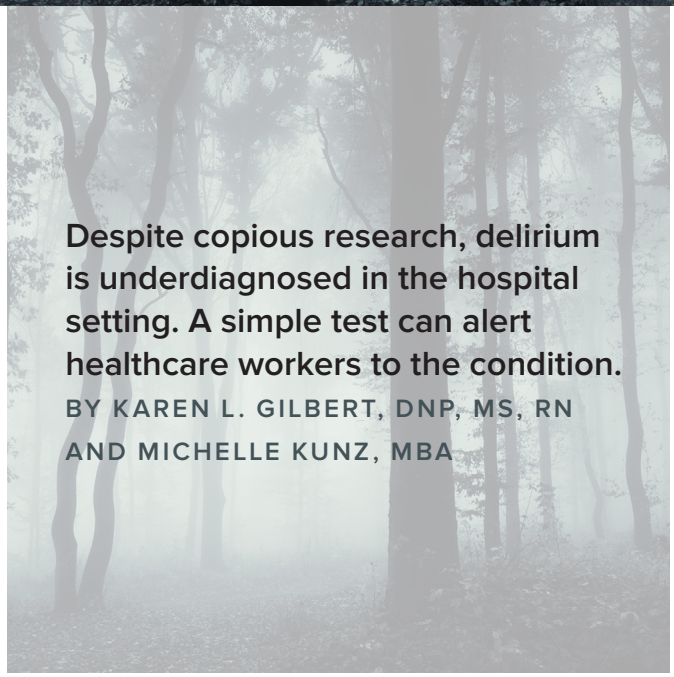
Federal Trade Commission. (2020, March 31). *FTC data shows jump in coronavirus-related complaints from consumers*. Retrieved from https://www.ftc.gov/coronavirus/ftc-in-action

Federal Trade Commission Act 15 U.S.C. 41.

Passy, J. (2018, March 10). *More millennials reported losing money to scam in 2017 than senior citizens*. Retrieved from https://www.marketwatch.com/story/more-millennials-reported-losing-money-to-scams-in-2017-than-senior-citizens-2018-03-02

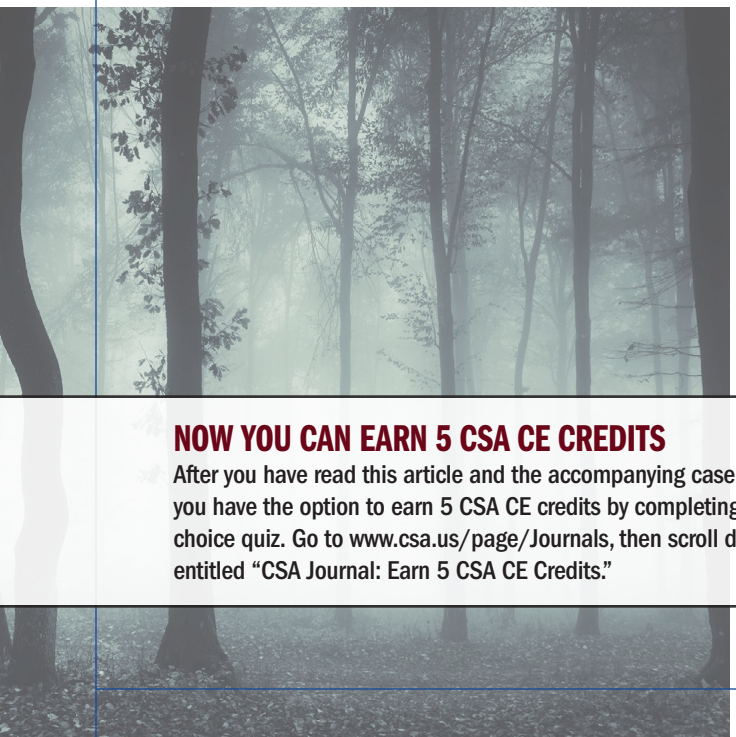
Werner, A. (2019, April 11). *Social Security number phone scam costing victims millions: FTC*. Retrieved from https://www.cbsnews.com/news/social-security-phone-scam-costing-victims-millions-ftc-warns-2019-04-11/

CASE IN POINT: Delirium



Despite copious research, delirium is underdiagnosed in the hospital setting. A simple test can alert healthcare workers to the condition.

BY KAREN L. GILBERT, DNP, MS, RN AND MICHELLE KUNZ, MBA



NOW YOU CAN EARN 5 CSA CE CREDITS

After you have read this article and the accompanying case study (page 69), you have the option to earn 5 CSA CE credits by completing an online multiple choice quiz. Go to www.csa.us/page/Journals, then scroll down to the section entitled "CSA Journal: Earn 5 CSA CE Credits."

Still Elusive After All These Years?

An acute and common disorder, delirium causes substantial disturbance in cognitive function and awareness of the environment and is generally associated with another medical event. Delirium is often undiagnosed or misdiagnosed. Unrecognized and untreated delirium may result in longer hospital inpatient stays, repeated hospital readmissions, progression of cognitive decline and general morbidity, and otherwise untimely death. According to Bush and Lawlor (2016), the prevalence of delirium can range from 18 to 50 percent of hospitalized patients, and up to 88 percent of patients receiving palliative care, and "about one-third of all delirium episodes in older adults in hospital can be prevented" (p. 129). This underscores the importance of recognizing the factors that contribute to the risk of delirium and promoting proactive approaches to minimize those risks. Those who know the patient well can inform healthcare professionals of the patient's baseline cognitive and physical conditions, and thereby play a vital role in the identification of delirium, facilitating appropriate treatment. An acute episode of delirium should not be attributed to underlying Alzheimer's disease or related neurocognitive disorder, but rather evaluated and treated as a distinct medical concern.

The onset of an episode of delirium may be rapid. Certain underlying conditions *predispose* a patient (Mittal et al., 2011). These include (and may not be limited to):

- Advanced age
- Existing cogitive impairment, such as results from Alzheimer's disease or a related neurocognitive disorder

Predictive factors include (Justic, 2000):

- Visual impairment
- Severe illness
- Dementia
- Elevated urea-creatinine ratio (determined by routine lab work)

There are *inpatient factors* that increase the risk of delirium (Justic, 2000). These include:

- Physical restraints
- Urinary catheterization
- Malnutrition
- Adding *more than three* new medications

In addition, risk of delirium is elevated by complications occurring in the course of hospitalization and treatment. Known as "iatrogenic" complications, these

include falls, adverse drug events, hospital-acquired (nosocomial) infections, and pressure wounds.

The start of delirium is usually rapid. In addition to the predisposing and predictive factors noted above, delirium is also more likely in those with chronic illnesses, electrolyte imbalance, underlying infection, surgical intervention, and withdrawal from drugs or alcohol.

Because symptoms of delirium and dementia can be similar, input from a family member or caregiver is vital for a physician to make an accurate diagnosis. The family member, familiar caregiver or certified senior advisor can provide important information as to the patient's "usual" condition prior to the acute hospitalization. Even if the patient has previously been diagnosed with Alzheimer's disease or a related neurocognitive disorder, he or she will still have a usual level of function and set of behaviors that can serve as a baseline for the hospital experience. A *sudden* change in level of orientation, mood, personality, functional ability, should be evaluated as possible delirium, and **never** simply attributed to an underlying neurocognitive disorder.

Symptoms

Signs and symptoms of delirium usually begin over a few hours or a few days from the "trigger event." Trigger events can include acute illness or injury, or a major surgery. Symptoms may fluctuate throughout the day; there may even be periods during the day with *no* symptoms. Symptoms may intensify at night and may manifest as:

- Inability to stay focused on a topic or to switch topics.
- Failing to respond to questions or conversation.
- Being easily distracted by unimportant or unrelated concepts.
- Being withdrawn, with little or no response to surroundings or interventions.
- Poor thinking skills.
- Poor memory, particularly of recent events.
- Disorientation re: surroundings and/or personal identity.
- Difficulty speaking or "word-finding."
- Rambling or nonsense verbalizations.
- Trouble understanding what others are saying.
- Difficulty reading or writing.

Behavioral changes may include:

- Visual or auditory hallucinations.
- Restlessness, agitation, or aggressive or combative behavior.
- Calling out repeatedly.
- Being uncharacteristically quiet and withdrawn.
- Slowed movement or lethargy.
- Disturbed sleep.
- Confusion regarding day and night, and/or a disturbed sleep pattern.

Emotional manifestations may include:

- Anxiety, fear, or paranoia.
- Depression.
- Irritability or anger.
- A sense of feeling euphoria.
- Apathy.
- Rapid and unpredictable mood shifts and/or change in personality.

There are three categories of delirium:

- **Hyperactive delirium.** Probably the most easily recognized type, this may include restlessness (for example pacing, trying to get out of bed repeatedly), agitation, rapid mood changes, or hallucinations.
- **Hypoactive delirium.** This may include reduced activity, abnormal drowsiness, or appearing to be dazed.
- **Mixed delirium.** This presentation has both hyperactive and hypoactive features and may fluctuate from one to the other.

Distinguishing delirium from dementia

Those with underlying symptoms of dementia are at greater risk to develop delirium. Delirium may fail to be diagnosed if simply attributed to preexisting symptoms of dementia. However, dementia and delirium may be distinguished based on **onset, change in attention span, and fluctuating symptoms.**

- **Onset.** The onset of delirium occurs *suddenly.* In contrast, symptoms of dementia begin gradually, over time.
- **Attention.** The ability to stay focused or maintain attention is significantly impaired with delirium. Early symptoms of dementia do not generally affect attention span or alertness.
- **Fluctuation.** The appearance of delirium symptoms can fluctuate significantly and frequently throughout the day. In contrast, symptoms of dementia do not generally fluctuate in the course of a day.

Unrecognized and untreated delirium may result

in longer hospital inpatient stays, repeated hospital readmissions, progression of cognitive decline and general morbidity, and otherwise untimely death (Fong, Albuquerque, & Inouye, 2016).

Frequently, in assisted living environments, skilled rehabilitation, and skilled nursing facilities, patients or residents exhibiting a sudden change in behavior, particularly with characteristics of *hyperactive* delirium, are "diagnosed" with altered mental status (AMS) and transferred via ambulance to the hospital. AMS should be viewed as tantamount to "other," i.e. a manifestation that was neither appropriately assessed nor evaluated, and which begged for critical analysis of root cause. Though the ultimate diagnosis is frequently urinary tract infection or early pneumonia, many episodes are never adequately explained. Consequently, there is no substantive plan for the patient, a disservice to both patient and family, as well as to the healthcare system.

The Confusion Assessment Method (CAM), first developed by Dr. Sharon Inouye in 1990, is recognized as a valid, easy-to-use tool (Inouye, 2014) and can be utilized to facilitate prompt recognition of delirium and subsequent diagnosis and treatment. Oh, Fong, Hshieh, and Inouye (2017, p. 1163) describe the CAM as continuing "to be the most widely used delirium instrument worldwide," and "with high sensitivity, reliability, and specificity."

The CAM can be incorporated into the electronic medical record as a regular assessment on each shift, with immediate alerts and action for positive findings; the CAM can also be provided on paper for ancillary personnel and families to utilize for providing valuable information to nursing and medical personnel. The short form of the CAM identifies the following four indicators for identifying delirium:

1. Acute onset and fluctuating course, **and**
2. Inattention, **and** *either:*
3. Disorganized thinking, **or**
4. Altered level of consciousness.

Answering "yes" to numbers one and two, and *either* three or four, constitutes a positive screen for delirium and should prompt an evaluation by the physician and/or nurse practitioner.

Justic (2000) critiqued the term "ICU psychosis," revealing that the observed changes in levels of consciousness and attentiveness, increased disorientation, confusion, anxiety, agitation, and/or lethargy, were not necessarily a function of the patient's presence within the intensive care unit, but rather *delirium,* which can manifest in *any* hospital setting. Nevertheless, our healthcare system continues to have a persistent blind spot relative to delirium and its consequent morbidity, mortality, and significant healthcare costs.

Justic (2000) provided a compelling argument for identifying delirium as a distinct manifestation, and provided etiological aspects, a description of the characteristics of hyperactive and hypoactive delirium, a description of prevalence as 10 to 50 percent of "medically ill" inpatients, and prevalence in the elderly of 14 to 56 percent. The elderly with preexisting dementia are particularly vulnerable; as cited by Mittal et al. (2011), advanced age and cognitive impairment "are thought to be the two most common predisposing factors for delirium."

Oh et al. (2017) reviewed 127 articles on the subject, published between January 2011 and March 2017. The authors cite the prevalence of *undiagnosed* delirium as ranging between 55 percent and 70 percent in the years 2000 to 2001 and still 60 percent as recently as 2015. Clearly, little to no progress has been made.

It is obvious that manifestations of hyperactive or hypoactive delirium can appear to mimic symptoms of dementia and confound its identification as an acute episode. However, as discussed here, risk factors for delirium can be identified, preventive actions taken (Akunne et al., 2012), and prompt treatment initiated should symptoms manifest (Fong et al., 2016). Once again, those who know the patient well may be the first to raise the possibility of delirium and are vital advocates for the patient.

When we can know the predisposing factors noted by Mittal (2011) and the predictive and inpatient factors noted by Justic (2000), a preventive care plan can be established (see Figure 1 on page 68).
Putting these simple interventions in place often requires strident input of those who know the patient well. The high prevalence of undiagnosed and untreated delirium underscores the frequent misapprehension of its symptoms and widespread failure to therapeutically address these events for the majority of affected patients.

Summary

Peer-reviewed studies and review articles on delirium are ubiquitous, yet delirium continues to be unrecognized or misdiagnosed 60 percent of the time. The increased acute care length of stay, morbidity, mortality, and healthcare costs warrant new approaches. The Centers for Medicare and Medicaid Services (CMS) established the use of the CAM in its required skilled rehabilitation and skilled nursing facilities. It should likewise be standard for those same patients and

FIGURE 1: INTERVENTION RATIONALE	
Toileting schedule	The patient may not "remember" to use a call bell and wait for assistance. Unassisted toileting promotes falls, one of the "inpatient factors" that increases risk of delirium.
Assistance with meals and eating	The patient may not recognize a meal tray as his/her tray and/or may not be able to manipulate the packaging; poor nutrition increases the risk of skin breakdown, which also increases the risk of delirium.
Avoid or minimize urinary catheterization	Catheterization is a recognized "inpatient factor" contributing to delirium in and of itself (Justic, 2000); catheterization can also contribute to the iatrogenic complication of urinary tract infection.
Validation as communication technique	Repeatedly trying to "reality orient" a patient with an underlying neurocognitive disorder can agitate the patient and increase his/her degree of confusion.
Minimize the addition of new medications; encourage family to bring all current medications to the hospital	Adding multiple new medications increases delirium risk; reviewing all current medications may facilitate use of those medications versus prescribing multiple new medications.
Encourage family to bring the patient's eyeglasses, hearing aids to the hospital	Visual impairment is recognized as a "predictive factor" for delirium (Justic, 2000); any sensory impairment can increase confusion/ disorientation.
Encourage family and/or close friend to be with the patient as much as possible	The presence of those familiar to the patient will mitigate the risk of escalating confusion.

residents when they are cared for in acute or other subacute settings.

This relatively simple CAM tool, taking only minutes to complete, can become a required entry on each shift via prompting from the electronic medical record in the hospital as well as the subacute settings. The tool could also be provided to Certified Nursing Assistants, physical, occupational, speech, and respiratory therapy professionals, etc. electronically and/or on paper. Via this mechanism, any clinical staff interacting with the patient would have the means to identify the presence/absence of change in mental status, inattention, disorganized thinking, and/or altered level of consciousness, with the information readily passed to the patient's assigned nurse.

Oh et al. (2017) discuss how family or other caregivers can provide information on the patient's cognitive status *prior* to the acute care episode. Establishing the baseline should facilitate a plan of care that incorporates sensitivity to the aforementioned-delirium risk factors, promotes the identification of changes from baseline, changes that should not be dismissed as underlying dementia, but assessed as a possible acute episode of delirium requiring prompt treatment. Providing family or other familiar caregivers with a CAM tool can encourage and empower those familiar with the patient's baseline to recognize signs and symptoms of delirium and alert the nursing and medical staff. The family or friend can advise the clinical staff as to the patient's *usual* mood and demeanor, level of orientation, and functional abilities, illustrating the contrast with the acute episode that may be delirium. A positive screen for delirium should prompt further evaluation by the medical staff to formerly diagnose and treat the episode of delirium. Treatment must be individualized for each patient based on the predictive, predisposing, and inpatient factors affecting the patient, as well as preexisting comorbidities, specific medication issues, etc.

A CAM tool adapted for family caregivers and others well-acquainted with the patient could resemble Figure 2.

Though a definitive diagnosis of delirium would then need to be made by the appropriate physician or nurse practitioner, educating hospital, skilled rehabilitation, and long-term care facility staff to risk factors and preventive measures, and providing a simple tool for recognizing and reporting symptoms should go a long way to improving prevention and early diagnosis and treatment when symptoms manifest.

Addressing delirium in a proactive manner also aligns with the Triple Aim of the Institute for Healthcare Improvement (The IHI Triple Aim, n.d.), i.e.:

- Improving patient/family satisfaction with care
- Improving population health
- Decreasing the per capita cost of care

The assessment of delirium and proactive approaches are neither costly nor difficult.

FIGURE 2: CAM TOOL			
Is there a change in mental status from baseline?	☐ Yes	☐ No	
Does the patient have difficulty focusing attention – is he/she easily distracted or unable to follow a discussion?	☐ No	☐ Yes, continuously	☐ Yes, difficulty comes/goes
Is the patient's thinking disorganized or incoherent?	☐ No	☐ Yes, continuously	☐ Yes, difficulty comes/goes
Does the patient display any of the following? Easily startled by sound or touch; Dozing while being asked questions; Difficult to arouse and keep aroused; Cannot be aroused	☐ No	☐ Yes, continuously	☐ Yes, difficulty comes/goes

Our aging population and prevalence of Alzheimer's disease and related neurocognitive disorders that affect adults in many decades of life should support structured education on delirium for all healthcare professionals, as well as for those in allied professions charged with advocating for and protecting the health and well-being of older adults, such as the Certified Senior Advisor®.

MARIE, AGE EIGHTY-ONE, ARRIVES WITH HER BEST FRIEND Tilly for the pre-op doctor's visit before her full hip replacement surgery that is scheduled for the following week. Marie is an artist and an avid walker. Marie gave up her car a few years ago because she was starting to have some memory issues and was afraid of getting lost. So, being able to comfortably walk every day to do her errands around town was extremely important to Marie. Other than her painful hip and her mild cognitive issues, Marie was in great health. She had suffered a serious loss when her long-time partner died suddenly two years ago, but she dealt with the ensuing depression through her art and her daily walks. Marie refused most medication, and only occasionally took Tylenol when she could no longer tolerate her aching hip.

The doctor was pleased that Marie wasn't taking medication, since that minimized any medication side effects both pre- and post-op. He was a little bit concerned about her memory issues and wanted to make sure that there would be someone with Marie, while she was recovering from her surgery, to advise her nurses about Marie's typical attitude (engaged, interested in what was going on around her) and to notice if Marie started to have a change in mood, abilities, or orientation. Tilly agreed to be Marie's "go-to" person. The doctor explained that, because of Marie's cognition problems, the medical staff might assume that Marie's dementia was worsening, when in fact, she might be having an acute episode of delirium.

The day of Marie's surgery came, the surgery was successful, and she began her recovery in the hospital. Tilly was at Marie's side for the entire process. She

stayed in the hospital with Marie, sleeping in the reclining chair. The morning after Marie's surgery, Tilly was surprised that Marie seemed incredibly quiet, withdrawn, and was moving very slowly. Marie seemed unable to focus on the menu choices Tilly was giving her for breakfast. Although Tilly expected Marie to be in some pain from the surgery, she didn't expect Marie's attitude and mood to be so different than usual. Remembering what the doctor said, Tilly informed Marie's nurse that there might be something to be concerned about.

The nurse came in to assess Marie. When the nurse asked Marie where she was, Marie said "in a hotel." The nurse noted that Marie wasn't drinking her water and was very probably dehydrated. Tilly was asked to make sure that Marie drank her water and ate her breakfast.

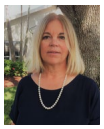
About an hour later, the nurse came back in the room, and found that Marie was becoming very insistent that she "needed to get out of this hotel…NOW!" The nurse came in to do the CAM (Confusion Assessment Method) and determined that Marie was indeed delirious. The nurse convinced Marie that it might be a better plan to try using the toilet, so she removed Marie's catheter that had been placed for the operation. Within an hour, Marie had been assisted to the toilet by her physical therapist, and not only walked with her new hip, but was able to urinate on her own. The physical therapist walked her back to bed and suggested that what Marie needed most right now was some sleep.

Tilly was also pretty tired and figured that the best medicine for Marie at the moment was to get some uninterrupted sleep, something that is hard to come by in a hospital, especially if the patient is recovering from surgery. After talking to the nurse, Tilly put a "Quiet" sign on the outside of Marie's hospital room and shut the door, closed the blinds, turned on some soothing music, and turned out the lights so Marie could get some more sleep.

When Marie awoke, the nurse asked Marie to hold her hand and squeeze every time that the nurse said the letter "A" as she spelled out "s-a-v-e a h-e-a-r-t." Marie only squeezed the nurse's hand once. The nurse told Tilly that missing two letters, or squeezing on the wrong letter, is a sign of delirium (disorganized thinking). The nurse asked Tilly to do this every hour or so, to see if Marie's delirium was waning or maintaining. Over time, Marie was able to get all three letters correct. She slowly started to come out of her withdrawn state, started talking again, and was able to get up and move. She continued to have episodes of delirium but was able to recover fully over time. •CSA

Karen Gilbert serves as a vice president for Alzheimer's Community Care. Karen is a Certified Alzheimer's disease trainer from the Florida Department of Elder Affairs and is a Certified Dementia Practitioner from the National Council of Certified Dementia Practitioners. Karen has completed her Doctor of Nursing Practice degree from Palm Beach Atlantic University. Karen received her Bachelor of Science degree from the State University of New York and holds a Master of Science degree from Nova Southeastern University.

Karen L. Gilbert DNP MS RN, Certified Dementia Practitioner, kgilbert@alzcare.org, 561-683-2700 Ext. 119



Michelle Kunz is the president of Senior Financial Care Management, LLC, in Palm Beach Gardens, Florida. Michelle worked as a finance professional for thirty-five years before starting her business, which works to assist seniors and those facing difficult medical situations. She has a B.S. in Technical Writing from Polytechnic Institute of New York University and an MBA from Baruch College, City University of New York. Michelle is a member of the editorial board for the professional journal of the Society of Certified Senior Advisors®.

REFERENCES

Akunne, A., Murthy, L., & Young, J. (2012). Cost-effectiveness of multi-component

interventions to prevent delirium in older people admitted to medical wards. *Age and Ageing*, *41*(3), 285-291. doi:10.1093/ageing/afr147

Bush, S. H., & Lawlor, P. G. (2015). Delirium. *Canadian Medical Association Journal*. https://doi.org/10.1503/cmaj.141248/-/DC1

El Hussein, M., Hirst, S., & Salyers, V. (2014). Factors that contribute to under-recognition of delirium by registered nurses in acute care settings: a scoping review of the literature to explain this phenomenon. *Journal of Clinical Nursing*, *24*(7-8), 906-915. doi:10.1111/jocn.12693

Fong, T. G., Albuquerque, A., & Inouye, S. K. (2016). The Search for Effective Delirium Treatment for Persons with Dementia in the Postacute-Care Setting. *Journal of the American Geriatrics Society*, *64*(12), 2421-2423. doi:10.1111/jgs.14585

Inouye, S. K. (2014). The CAM-S score for delirium severity Training Manual and coding guide. *Hospital Elder Life Program*.

Justic, M. (2000). Does "ICU Psychosis" really exist? *Critical Care Nurse*, *20(3),* pp.28-37.

Mittal, V., Muralee, S., Williamson, D., McEnerney, N., Thomas, J., Cash, M., & Tampi, R. R. (2011). Delirium in the elderly: A comprehensive review. *American Journal of Alzheimer's Disease & Other Dementias*, *26*(2), 97-107. doi:10.1177/1533317510397331

Oh, E. S., Fong, T. G., Hshieh, T. T., & Inouye, S. K. (2017). Delirium in Older Persons. *JAMA*, *318*(12), 1161. doi:10.1001/jama.2017.12067

The IHI Triple Aim. (n.d.). Retrieved from http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx

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