

# Is it time for a new place? Making the Case

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# Overview

1. Review common types of non-independent living
2. Decide if and when it is time to change one's living situation
3. How to decide the best type of living model for an individual
4. Helping loved ones make the decision to change
5. Overview of steps needed to make a change of place

# Types of places

- Home with Home Care
- Senior/Independent Living
- Assisted Living Facilities
- Memory Care Facilities
- Nursing Home - SAR
- Nursing Home - LTC

**PACE**

**VA**

**Hospice**

# Mostly Independent

## Home + Home Care

- Coverage of home care is limited (typically not Medicare)
- Dual eligible → look into managed care organization (MSHO f.e.)
- Primary coverage via Private Pay, hiring own home health caregivers
- Family involvement often still high

## Senior Living/Apt ILF

- Private pay, can hire help (~ home + home care)
- Some provide options for meals, transportation, medication assistance -- but at increasing costs
- May be attached to larger complex with nurses available if necessary

# Increased Care Needs

## Assisted Living Facility

- “Wild West” - CBRF, RCAC
- Wide variation in costs, services, levels of care
- A la carte services -- pay for more as you need
- Provides 24/7 cares of some sort

## Memory Care (ALF)

- Wilder West
- Memory care IS NOT a nursing home
- Behaviors can be an issue - even after admission
- You will want details if considering this

# Nursing Home

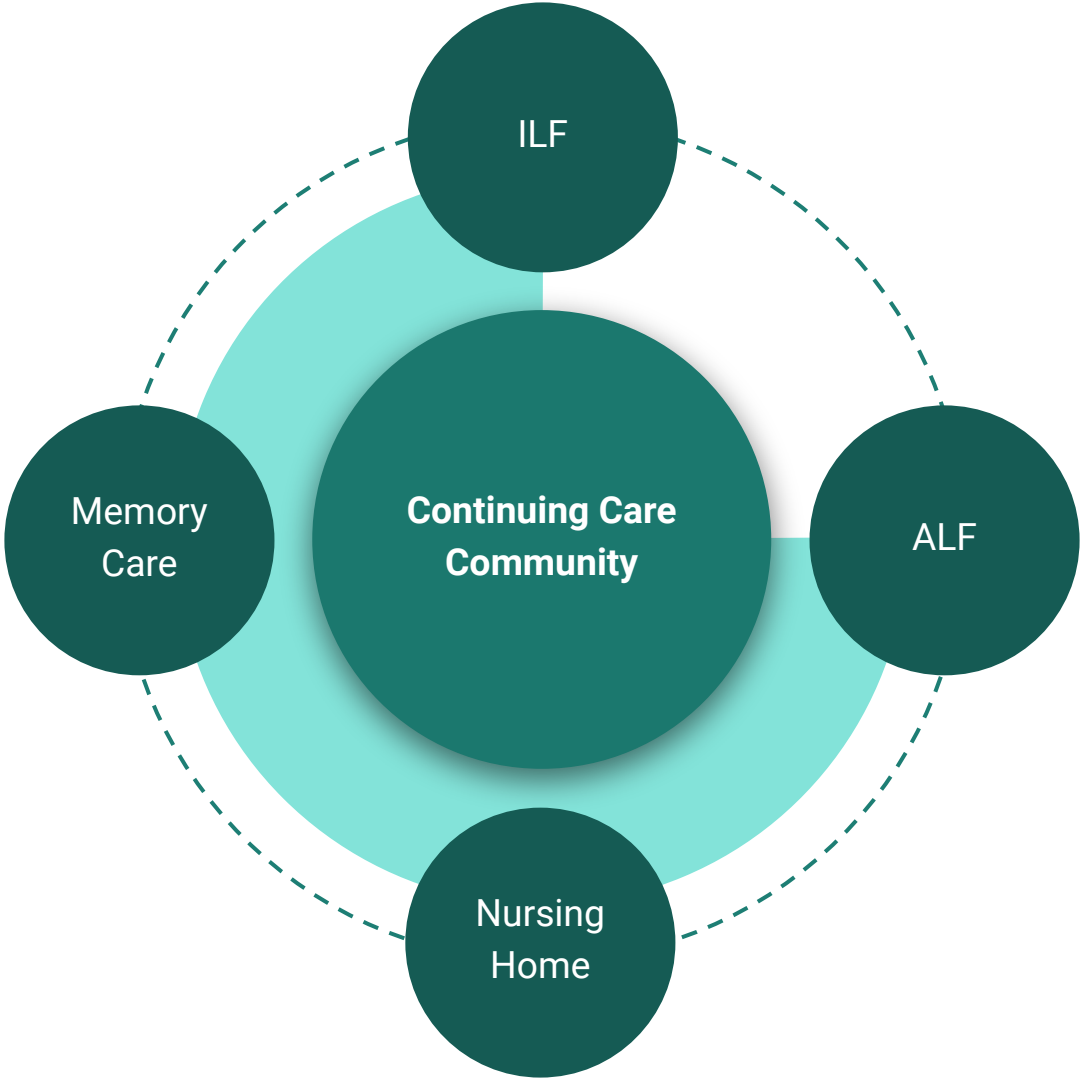
## Sub Acute Rehabilitation

- Post-hospital care, focused on rehabilitative services with medical oversight
- Doc and/or APP follows, req'd to see every 30 days (often seeing at least weekly though)
- Medicare coverage first 20 days, co-pay after
- Transition to one of the other levels (home, ALF, LTC)

## Long Term Care

- Highly regulated via Depts of Health: staff ratios, protocols, meals, etc.
- 24/7 care, all cares with escalation available (including SAR level when needed)
- Private pay until/unless Medicaid eligible (“spend down”)
- Doc/APP required to see ~60-90 days, often more frequently

CCRC



# Considerations

- Cost
- Coverage
- Care needs
- Companionship
- Compatibility
- Continuity (CCRC)



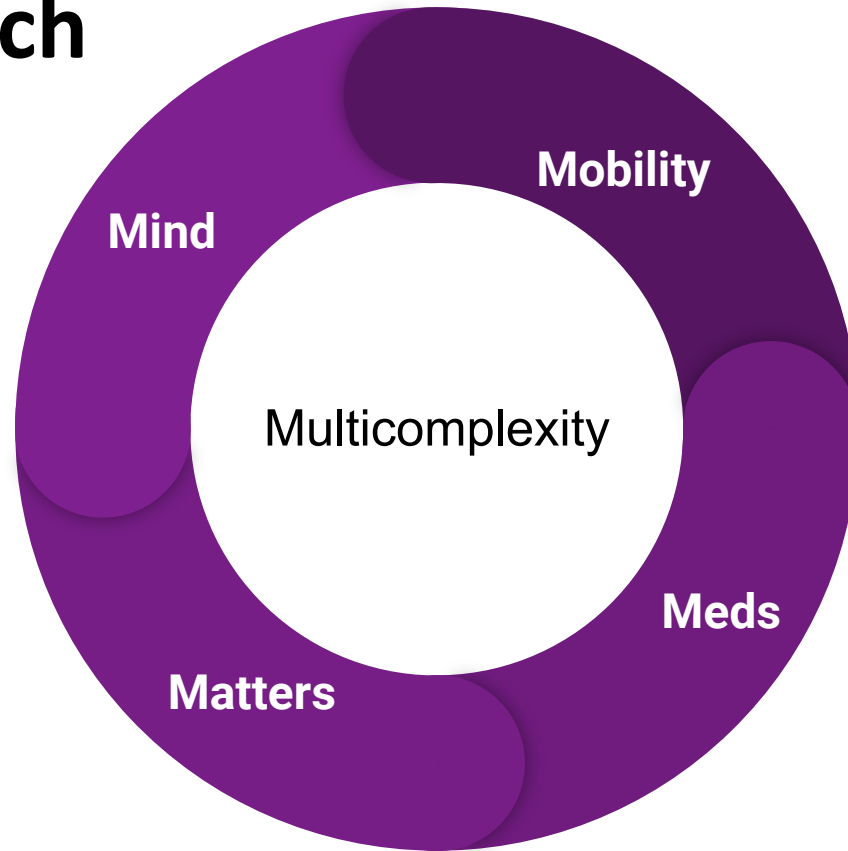
*When?*

Home is never  
no longer Home

But, home may no  
longer be best

When can a House no  
longer be Home

# 4Ms Approach



# Mobility

## Where to

- Driving
- Shopping
- Stairs
- Hallways
- Kitchen
- Toilet
- Bath
- Bed

## Modifications (#, type)

- Railings
- Grab bars
- Bed bars
- Canes
- Walkers
- Wheelchair
- Lift chair
- Stair lift
- Other people

## How often

- Transport only
- 1 hour every day (“Bath aide”)
- 3 hours 3x/week
- 8 hours every day
- 24/7

# Medications

## Regimen

- How many Medications
- Regimen complexity
  - (> 2x/day = complex)
- Types of meds - oral, injection, infusion
- Dexterity, Vision
- Swallowing
- Memory

## Side Effects

- Hypoglycemia (low blood sugar)
- Hypotension (low BP)
- Confusion
- Drowsiness
- Falls
- Bleeding

## Oversight

- Family assistance
- Nursing assistance
- Regular lab monitoring
- Frequent side-effect evaluation

**Table 3.** Treatment Regimen Based on Clinical Practice Guidelines for a Hypothetical 79-Year-Old Woman With Hypertension, Diabetes Mellitus, Osteoporosis, Osteoarthritis, and COPD\*

Time	Medications†	Other
7:00 AM	Ipratropium metered dose inhaler 70 mg/wk of alendronate	Check feet Sit upright for 30 min on day when alendronate is taken Check blood sugar
8:00 AM	500 mg of calcium and 200 IU of vitamin D 12.5 mg of hydrochlorothiazide 40 mg of lisinopril 10 mg of glyburide 81 mg of aspirin 850 mg of metformin 250 mg of naproxen 20 mg of omeprazole	Eat breakfast 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
12:00 PM		Eat lunch 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
1:00 PM	Ipratropium metered dose inhaler 500 mg of calcium and 200 IU of vitamin D	
7:00 PM	Ipratropium metered dose inhaler 850 mg of metformin 500 mg of calcium and 200 IU of vitamin D 40 mg of lovastatin 250 mg of naproxen	Eat dinner 2.4 g/d of sodium 90 mmol/d of potassium Low intake of dietary saturated fat and cholesterol Adequate intake of magnesium and calcium Medical nutrition therapy for diabetes‡ DASH‡
11:00 PM	Ipratropium metered dose inhaler	
As needed	Albuterol metered dose inhaler	

- 12 medications
- 19 doses/day at 5 different times
- Multiple other recommended activities
- High risk of drug-drug interactions

Boyd CM, Darer J, Boulton C, Fried LP, Boulton L, Wu AW. Clinical Practice Guidelines and Quality of Care for Older Patients With Multiple Comorbid Diseases: Implications for Pay for Performance. *JAMA*. 2005;294(6):716–724. doi:10.1001/jama.294.6.716

# Mind

## Cognition

- Mild Cognitive Impairments
- Dementia
- Psychiatric illnesses
- “Cognitive Load”
- Impact on other tasks

## Behaviors

- Kitchen!
- Hygiene
- House cleanliness
- Driving ability
- Wandering
- Sleeping (lack of)
- Partner risk
- Falls (Bathroom!!!!)

## Interventions

- Daily assistance
- In home caregiver
- Family or caregiver stays overnight
- Locking doors
- Medications...



# Multicomplexity

Mish-Mash

- Multiple meds
- Multiple doc appointments
- Multiple therapy appointments
- Grocery store
- Supplies
- Pharmacy

Of

- Risks at home
- Desire for independence
- Work
- School
- Overnights

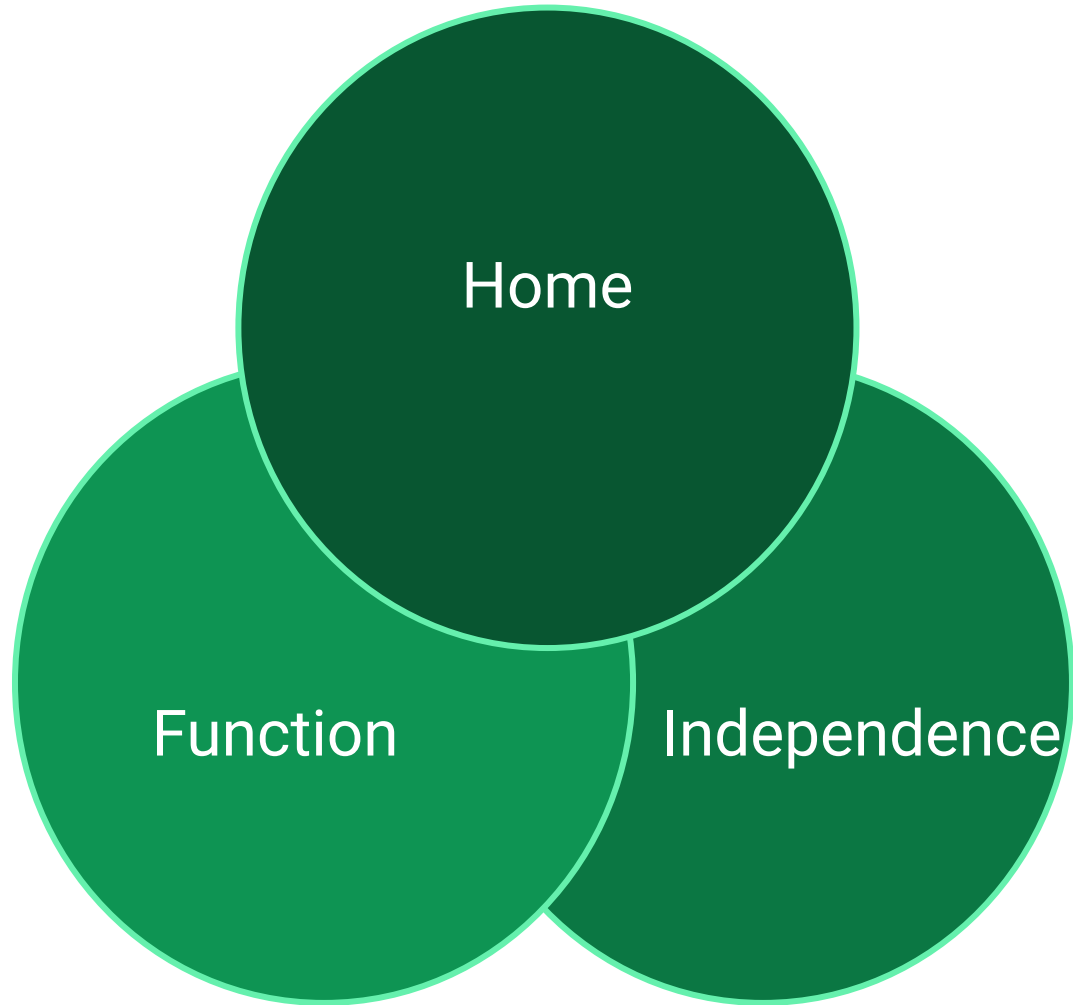
Everything

- Cognitive Impairments
- Behaviors
- Is someone at home to help and when

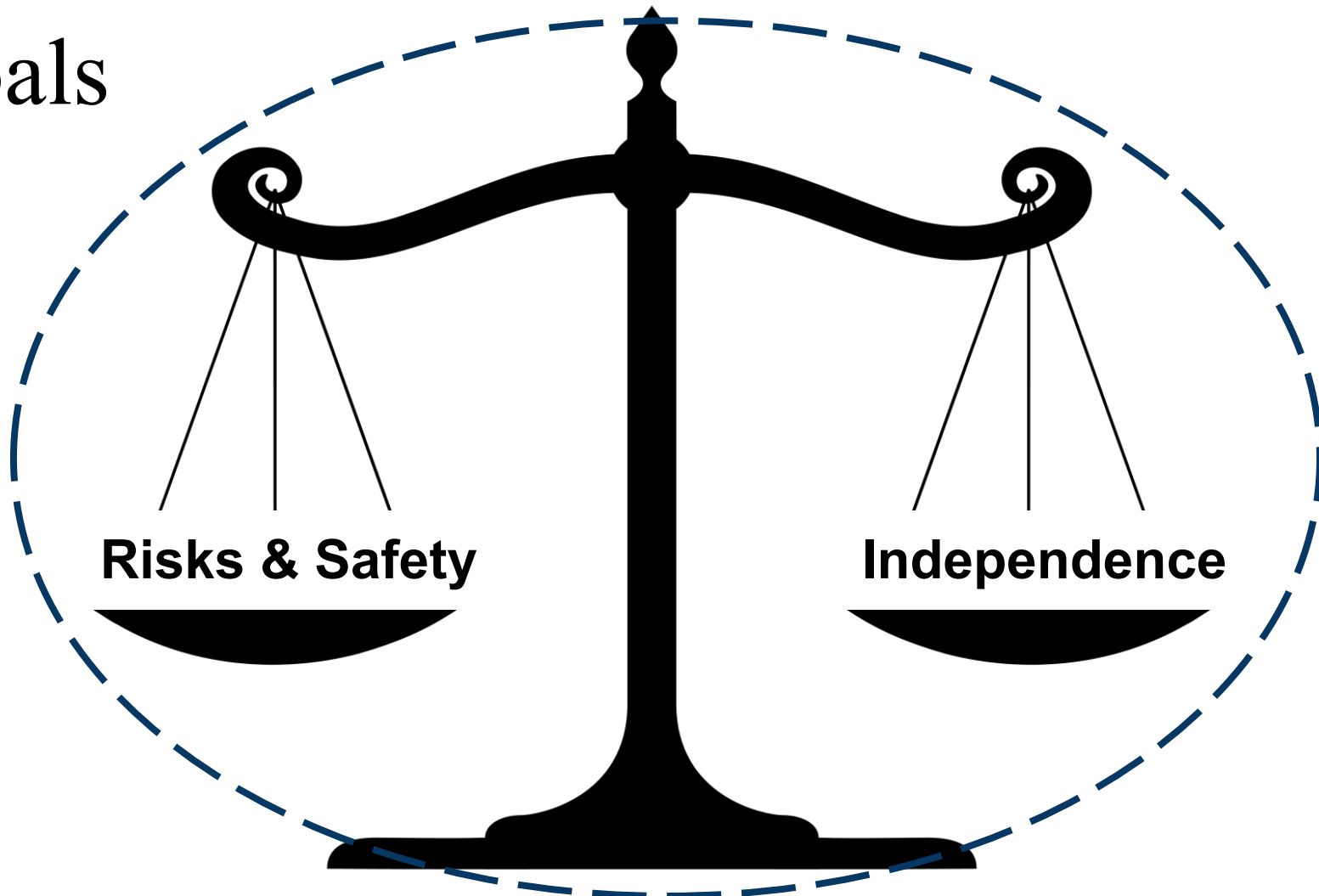
*Who's taking care of Whom Dilemma*

## (What) Matters

- “Rather die than live in a nursing home”
- “I was born here. I raised a family here. I will die here.”
- “Home is where my family is.”
- “I don’t want to be alone anymore.”



# Goals



# How to Talk About it

Much like other  
“Goals of Care” Talks

# ★ Having the Talk

*W's*

1. Wish
2. Worry
3. Wonder

# I Wish

- You could continue living in your house
- You could return to your ALF
- Things were different

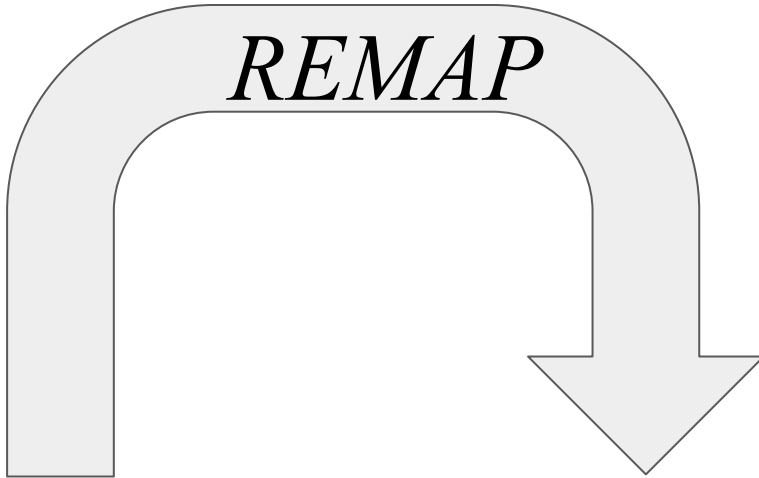
# I worry

- About how much more help you have needed at home
- I will not be able to provide as much time as you may now need
- About you being alone in your place

# I Wonder

- If we should consider having more help for you at home
- If it is time for us to make a change of place
- What you might think of a different place

# ★ Having the Talk



1. **R**eframe
2. **E**xpect emotions
3. **M**ap the future
4. **A**lign Values
5. **P**lan steps that match values

## Reframe Sit'n

- Given our concerns, I think we should talk about next steps
- I don't think going home is an option so we should talk about other possibilities

## Expect Emotions

- Tell me more about that
- This can be a lot to deal with
- I can tell this concerns you, can we talk about that

## Map Future

- Given what we have talked about, what is most important to you
- What concerns you as you think about your future

## Align Values

- It sounds like the most important things to you are...
- These are important and I wish to help support you to achieve these

## Plan Steps

- Here are options to help support X, Y, Z
- We should talk more with your family...
- We should review this again...





**Getting**

The diagram consists of two adjacent rectangular boxes. The left box is dark red with a lighter red border and contains the word 'Getting'. The right box is dark red with a dark red border and contains the word 'There'. A light red arrow points upwards from the top center of the left box, and a dark red arrow points downwards from the bottom center of the right box.

**There**

# Admissions

## Senior Apartment

- Typically much like other apartments
- Generally, have certain requirements
  - Age
  - Limited (if any) care needs
- Downsizing

## Assisted Living Facility

- Facility forms
- Financial reviews
- Medical exam (usually within 1 month)
  - May require a PCP change
  - Medication orders
  - Care Plan
- Infectious disease clearance (TB)
- Functional assessment

# Nursing Home Admission

## Direct Admission from Home or ALF

- Referral from PCP to Area Agency on Aging
  - or in MN SeniorLinkageLine
  - Determine eligibility
- Preadmission screening
- SW management for transfer
- Financial/Insurance coverage
- Infectious Disease clearance
- Medical evaluation and orders for facility
  - Almost always transition to new physician

## Hospitalization → SAR → LTC

- Short cuts steps for direct admission
- PT/OT evaluation during admission
- Medical evaluation and management both in hospital and SAR
- SW management during admission and SAR for transitions
  - Also assist with move to assisted living or home with home care

# Other important steps

- Health Care Advocate
- Health Care Directive Discussion
- POLST
- POAF a.k.a “Power of Attorney”

# Resources

- AARP - aarp.org
- SeniorLinkage Line - <https://mn.gov/senior-linkage-line/>
- MN Department of Human Services - <https://mn.gov/dhs/people-we-serve/seniors/>
- CMS Nursing Home Compare - medicare.gov
- UMN GWEP website - <https://mngwep.umn.edu/> (tailored to health professionals)
- Geriatricians (few and far between)

Questions