MEDICARE MADE SIMPLE

CONVERSATIONS WITH EXPERTS TO HELP YOU RETIRE WITH PEACE OF MIND

JOHN FOX

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Finally, I would like to thank all of you who take the time to read this book. I hope you find the information useful and worth sharing with others.

INTRODUCTION

For many people, turning 65 is the most significant birthday in their life. It's the beginning of a new stage of life. If you aren't retiring then, it's in the cards. Or maybe you've already begun your retirement. But no matter where you are in the retirement process, for the vast majority of Americans, age 65 means Medicare. You are now eligible for this healthcare coverage you've contributed toward throughout your career.

Which means you have to enroll. But that's easier said than done. I can't tell you how many times highly educated, successful professionals have told me they couldn't understand how to enroll in Medicare. They're even more confused about the coverage. Which option is the right one? What coverage do they need, and what should it cost?

The government will give you a handbook to help you through the Medicare Maze. It's called *Medicare & You.* But while it's informative and helpful, it's not intended to answer everyone's questions.

A number of people get advice from friends and relatives when they become eligible for Medicare. "This plan worked for me. I think this is the best option for you." Never make your decision based on that advice. Everyone's situation is different, and you could be making a costly mistake if you don't take the time to become educated before making this decision.

As I've worked with my clients, helping them make informed decisions about Medicare, I realized there was an information gap out there. I thought, "Wouldn't it be great if people could get all the information they needed in one place? Wouldn't it be helpful if one book answered their questions, gave them the key facts, and also provided advice from experts on a variety of subjects, not just Medicare?" Because Medicare is just one piece of your retirement puzzle. There are also legal pieces, tax & financial pieces, lifestyle pieces and many more.

So this book is much more than a Medicare primer. It's a retirement lifestyle guide. It contains interviews with people who specialize in these areas. They're sharing their knowledge and insights in a way that's beneficial and easy to follow. No government-speak here. These experts are professionals I trust enough to recommend to my clients.

Every community has professionals like these, who are there to help you when you need it. I hope the information contained in this book will be the encouragement you need to finalize the planning that could make a big difference for you and your family.

This book is all about proper planning, and making informed decisions. Because with the right information, you can make the right decisions at the right time.

None of us gets through this life unscathed. We all deal with challenging situations, but if you take the time to plan, those situations become less challenging. Retirement is a big challenge. It can cover up to a third of your life. Use the

information in this book to make the decisions you need, to live the retirement lifestyle you want.

John Fox
March 2019

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CHAPTER 1

MEET JOHN FOX

People who know me weren't surprised to learn I was publishing this book. They know how passionate I am about educating people about Medicare, helping them navigate through what can be a complicated and challenging process, avoid costly mistakes, and retire with peace of mind.

But there are things even my closest friends don't know about how I got here. Here being this point in my career, and here in Spokane. So for those of you who know me, and those of you who are just learning about me in this book, here's an abbreviated version of my story. Just who is John Fox, and why am I doing this book, this way, at this time?

I'm not originally from Washington State, but I've spent most of my adult life here and I might as well be a native. I grew up in Phoenix, Arizona. As a kid, I developed the work ethic that has served me well all my life. I worked all through high school. And I knew the military was going to be the first step in my adulthood.

I actually enlisted before I graduated. In those days, you could join the military in your junior or senior year in high school and choose your first assignment. My girlfriend, who's now my wife, and I went to the Army recruiting station. Of course

in those days they didn’t have computers to show you all your options, they just had a photo album of all the military bases.

Remember, we grew up in Phoenix. So when we saw the pictures of Mount St. Helens and Mount Rainier and all the green trees in Washington, it was an easy decision. We chose Fort Lewis, near Tacoma, which as you may know was merged with McChord Air Force Base in 2010.

That’s where I had my first assignment. And that’s where our daughters, Jennifer and Aimee were born. Then, when I got out of the military, we went back to Phoenix. Because that’s what most people do when they get out, they go back to where they’re from. But after we did that, we realized how much we loved living in Washington, so we moved back and have lived here ever since.

I didn’t take a direct path to my career in insurance and Medicare. When I was in the military, I was a cook. So when I got out, I stayed in food service for a number of years. I really enjoyed it. I didn’t continue as a cook, I worked for Denny's as a restaurant manager. I took a lot of pride in the fact that people would come into our restaurant and have an experience that was unlike a traditional Denny's. If you hire people who love what they do, and train them well, it shows. I just loved hearing people who ate at our restaurant for the first time say, “I can’t believe this is Denny’s.”

A logical question is if I loved it so much, why didn’t I open my own restaurant? Bear in mind, this was back in the early 90’s. There was so much talk about mandatory healthcare. When I

looked at how thin the margins already were in the restaurant industry, and all the overhead costs, I said, “This just doesn’t make sense to me.” If the margins got smaller, and you’re working harder for less money, that’s not the kind of business for me.

After looking at real estate, and franchises, and other options, I looked into the insurance industry. I realized I could help people, and make a decent living, so that was my choice.

This was 1994. Now, I've always been the type of person who sticks to things. I’ve been married for 38 years. I have great long-term relationships with people. And when I entered the insurance industry, I went to work for Country Financial and stayed there for 22 years.

Unfortunately, many insurance agents work somewhere two or three years, then go somewhere else for a few years, then another, and end up working a number of places in their career. I was fortunate. I found a great company. I was at Country Financial for 22 years. This was on the other side of the state in western Washington. It was at Country Financial that I learned the importance of educating your clients and not worrying about selling a specific product. Insurance is meant to transfer risk from your client to the insurance company for situations that may otherwise create a financial hardship. Every person has their own risk tolerance and needs. I found that people will make very good decisions if you take the time to learn their situation and give them the information they need.

I started out as a rep, building my own business, and was successful at it. After a few years of high production, they asked me, “Would you be interested in going into management? We’d like you to hire agents like yourself and train them to do what you've been doing." I loved the culture of the company and had first hand experience learning from the great people who worked there so I took the position. I’m very proud of the work we did helping people with their insurance and financial needs. My career at Country Financial was rewarding in many ways, so it worked out pretty well for me. My sincere thanks to Joe Powers for giving me that life changing opportunity.

I was fortunate to be in the position to retire at age 55 with comfortable retirement benefits that would allow me to pursue other interests. So that gave me the opportunity to go out on my own.

I retired from them and we moved here to Spokane. Our daughter Jennifer lives here with her husband Eddie and their son Cooper. They will be adding a daughter to the family soon. Our other daughter Aimee is in Vancouver with her husband Aaron, and they are having a daughter in a few months. So, my wife and I will be lucky enough to have two grandchildren local, and another here in the state, so we can see all of them regularly.

When I started my own business, I decided instead of being a broad-based advisor, I could specialize in one area. And I couldn’t have chosen a more important one. Do you realize this is the biggest transfer of age groups in history? 10,000

people a day are turning 65 in this country. And that will continue for more than 10 years. So with the knowledge I've acquired over the years, and my experience, working with seniors and helping them with their Medicare needs was the perfect fit.

I get to make a difference in people's lives at a time that really matters. It's not about saving people money, although that's nice. It's relieving them of the insecurity, and getting them through the confusion, so they can have a better healthcare experience.

When people have the wrong healthcare plan, they don't want to use it because it's costing them too much money. If you can educate them on their options, and teach them how to be better advocates for themselves, their whole healthcare experience is better.

Let me tell you about a couple I worked with. The wife has a chronic disease. They were concerned they'd have to skip appointments because it would cost them too much money. But I showed them how to utilize their plan properly. Now they get the care they need, and the stress is gone from their lives. In fact, I just met with them not long ago, and the way they thanked me when I left made it all worthwhile.

I also recently met with a retired school teacher and her husband. Teachers have options. While they're still working, they typically have an HMO or PPO plan through the school district. It's a great plan, and it usually doesn't cost them much compared to what many people pay.

When they retire, they can stay on that plan or they can move to Medicare and get traditional Medicare supplements. Because many people are resistant to change and comfortable with their network, they'll stay with their plan. But it can be very expensive when they retire. It can cost them $400 to $500 a month.

This particular couple is among those who stayed on their plan because they were comfortable with it. But then I showed them their Medicare benefits. I showed them how they could get a comprehensive plan through Medicare for 20 to 25 percent of what they're currently paying. Their eyes lit up.

When I sit down with people and show them the plan they already have access to, and how much they can save, and eliminate their confusion and get them signed up, it's making a significant difference in their lives. Especially when it's a husband and wife. Instead of saving one person $400 a month, you're saving two people $800. For people on a fixed income, that's a huge impact.

That's what I love about what I do. I help people. The fact is, every one of us is going to have some sort of health setback in our lives. But the people who have the right plan in place, and know how to use it properly, are the ones who weather that storm.

On the flip side, what would I change about it if I could? It's something I educate people on every time I have an

appointment. I always encourage them, "You need to contact your Representative in Congress."

That’s because years ago, Congress passed this silly law which prevents Medicare from negotiating drug prices with pharmaceutical companies. How absurd is that? I don't know any reason anyone would vote for it. It’s certainly not in the public's best interest.

I know people who have a prescription drug plan through Medicare, but go to Canada to get some of their drugs. Prescriptions that would cost up to $1,500 a month here are costing less than $100 a month in Canada.

I think it’s a crime that the pharmaceutical companies who are supplying the drugs to Canada for so much less are charging Americans so much more money for the same drugs. Congress is allowing it because they handcuffed Medicare. If I could, I would change that in a heartbeat.

I don’t consider myself someone who does sales. I believe I’m an educator. I never ask somebody to make a buying decision when I meet with them. The only thing I want to do on that very first appointment is provide education. I explain to them, "I'm not going to call you back. I'm not going to be calling you back and asking if you’ve made a decision.” I just tell them to think about what I’ve said, and think about their best option, and if they’d like to hire me to implement this, give me a call. Then on that next meeting, we come up with an appropriate plan.

I should point out, when I say hire me, it doesn't mean clients have to pay me. The insurance companies compensate agents for writing those plans. The clients are just going to ask me to help them put a plan in place.

Because I do it this way, I always have at least two appointments with new clients. The first appointment is nothing but education. In the second appointment, we review all the information, make sure the decision they made is appropriate for their situation and there are no surprises, and then we implement the plan.

I'm very proud of the fact that most of my business is referrals. Many are from other professionals and previous clients, but I also get referrals from people who didn't become my clients. About 20 percent of the time, when I meet with prospective clients, I realize I'm not going to be compensated financially for my time, but I can still help them. Maybe part of their plan is fine and part of it just needs to be adjusted. Or maybe the best plan for them is with a company I don't work with.

There are 26 companies that sell some form of Medicare plan in my area and many more in bordering states I work in. I'm appointed with nine of them. I don't believe it's possible to be appointed with 26 companies and do a great job with all of them. I made a decision when I went in the business that I wouldn't just steer people to just a company I represent. The best advice I've ever received, in life and in business, was to be honest at all times.

If I meet with somebody and discover that the plan most appropriate for them is one I don’t represent, I’ll help them self-enroll in that plan or refer them to a Medicare agent that I trust and represents the appropriate plan. Now they have a Medicare plan that’s the right one for them. I'm not the actual agent. I'm not going to get compensated for it. But I've done my job. That's why people come to me, to help them make the right decision.

And down the road, many of those people refer their friends to me, and those friends become my clients.

It’s very rewarding when the phone rings and someone says, “Hey John, I was just talking to my accountant and he said now that I’m turning 65 I need to talk to you about Medicare.” I don't think there's a bigger compliment in the world than when somebody trusts you enough to send you someone who’s an important client to them, or a friend, or a relative. Every time I get one of those referrals, it feels like a pat on the back. It feels like somebody's saying, "John, I trust you. There's somebody important in my life, and I'd like you to take care of them."

Whether it’s someone who’s a referral, or anyone who’s coming to see me for the first time, let me tell the best time to have that conversation. 90 days before you turn 65. Or, if you’re already on Medicare and you’ve moved here from somewhere else, you’ll have a special enrollment period with a certain amount of time in which to change plans.

But whatever you do, don’t procrastinate. I’ve had people call me two or three days before their deadline in a panic. There are times I meet with people at 9 o’clock at night to make sure they meet their deadline.

Procrastinating is a big mistake I see people make. But the biggest one I see is people who go on Medicare and don’t purchase the prescription drug plan. If they need it down the road, which many people do because your health changes and your prescriptions change, they get hit with a costly penalty. Later this week I am meeting with a couple dealing with that. They have been on Medicare a number of years now. They’ve never had the prescription plan, but now they need some very expensive prescriptions. If you don’t purchase a prescription drug plan with Medicare when you’re eligible, you’re penalized one percent per month for every month you go without. In this man’s case, he’s facing a 72% penalty, which he’s going to pay every single month for the rest of his life.

Unfortunately, that’s a common mistake. When people turn 65 and go on Medicare, they’re pretty healthy and decide a prescription drug plan is a waste of money. But they don’t realize, because no one explained it to them, that you can get a prescription drug plan for $15 or $16 a month. Paying that all these years would have been much less expensive than the penalty this man will pay for the rest of his life. Sadly, he doesn't have a choice, because he needs the drug plan now. He wasn’t properly informed when he was 65, and that’s going to cost him.

I also try to educate and help people through volunteering. I'm on the board of WASHAA, the Washington State Health Advocacy Association. Its mission is to educate consumers on how to be their own best health advocate. Because when someone is diagnosed with a serious disease or chronic illness, it's a time of shock and worry and concern. You don't think to ask what resources are available to help you deal with this. I want more people to know about the many resources WASHAA provides, and I want to help them provide more.

I'm also active in SANEWA, the Senior Action Network of Eastern Washington. This organization is all about helping seniors live better lives. From raking leaves at their homes, to raising money for Meals on Wheels, and many other things all aimed at having a positive impact on the lives of our senior citizens.

These are both wonderful organizations that help many people. Since my goal for this book is to help people, and I'm not doing it to make money for myself, I'm donating all my royalties from book sales to WASHAA and SANEWA.

Which brings me back to where we started. Why this book, and why now? As you've probably figured out by now, I'm very passionate about making sure people get the right Medicare coverage at the right price. It's so frustrating to me to see all the misconceptions people have about Medicare, and the costly mistakes they make.

The government does publish a book every year called *Medicare & You*. It is 130 pages this year and has lots of information. Naturally they have to cover all the minutia that may pertain to small groups of people but does not apply to all Medicare recipients. It is the minutia, which seems to cause confusion to the people it does not apply to.

So I thought, "Why not write a book that covers the basics, all the main points, for the majority of the people?" But as I began writing it, I realized there were things I needed to talk to experts about, to provide more information and clear up more misconceptions. For example, hospice. People think that's where you go to die, but in reality, hospice is about giving people the best possible life with the time they have left. Another example is estate planning. It's not planning for death, it's planning for life, and it's not just for wealthy people.

I realized if I could share my knowledge of Medicare, and interview experts in all these other areas, I could create a book that would encourage people to be proactive, and take care of things before they're a crisis. In other words, help people.

I learned a lot doing these interviews, and you'll learn a lot reading them. So here's my hope for this book. If you come up to me in six months and say, "John, I read your book," I hope you'll finish that sentence this way: "I want to thank you for prompting me to finally take action and do the things I knew I should have been doing anyway."

BECAUSE TOMORROW IS NOT PROMISED

We begin with the financial side of retirement. Making sure you have the income you need, making sure your assets are protected, and making sure your family is secure after you're gone.

Many people choose to continue working past the traditional retirement age of 65. Even if a person has a comfortable and secure income, it may be a great option to stay engaged in the workforce and spend time with people. Many others have no choice but to keep working, because they don't have the financial resources to live comfortably. Fortunately, there are many more options for them. We'll hear from someone familiar with that hiring process.

We'll also look at some of the common mistakes people make when planning for their retirement income, and how to avoid those mistakes. There will be some eye-openers in that chapter.

But first, we look at protecting your assets and providing for your family after you're gone. There are many reasons to have an estate plan, and at the very least have a will. I realize, this topic can be overwhelming. Many people know they need to plan, but haven't taken the steps.

If you die without a will, the probate court will use the laws of your state to decide who inherits your assets. That may not match your wishes. Your assets may not go to the people you would have chosen, or they may even go to the state. Pre-planning can also help a surviving spouse avoid living in poverty. If one spouse faces a serious health issue, medical expenses or nursing home care can wipe out a couple's assets unless they have a proper plan in place.

Elder care attorneys don't just prepare wills and trusts. They also help you plan the best way to use your assets, and to receive the care you may need as you age without impoverishing the surviving spouse. I think of pre-planning as another way of showing your spouse and family how much you love them.

I was fortunate to interview two eldercare attorneys for this book. They have different backgrounds and paths to their careers, but both have a passion for helping people. I hope you will reach out to them or another eldercare attorney in your community.

CHAPTER 2

HOLLAND MCBURNS

Holland McBurns is the Managing Partner of Evergreen Elder Law in Spokane, WA. The firm provides pre-planning and crisis planning for Medicaid and long-term care, special needs planning, estate planning, estate administration, and guardianships. Holland has authored a book on elder law and estate planning in Washington State, which she plans to provide free to the elderly community to help them consider their long-term care and estate planning goals.

Holland's many awards include the 2017 and 2018 Top Lawyers featured in *Spokane Coeur d' Alene Living*, the 2016-2017 10 Best Attorneys by *American Institute of Legal Counsel*, the 2016 Client Satisfaction Award from *The American Institute of Legal Counsel*, and the 2004 VLP award for legal representation of indigent clients.

Holland McBurns founded *Evergreen Elder Law* in 2000 with the desire to help people with their estate planning needs. She has created a great team, with a reputation as a trusted resource. Holland and her staff work hard to help people

preserve their estate while keeping their options open through pre-planning.

I enjoy meetings in Holland's office. It is comfortable and has one of the best views of the Spokane River and falls in town. Her staff has a way of welcoming everyone as if they are a part of a large extended family. Their passion for helping people is evident.

John: Holland, let's start with what your firm does, and the impetus for you to specialize in elder care.

Holland: We emphasize elder law and estate planning. Of course, estate planning is not just for seniors. It's for all age groups, particularly if you have minor children, but definitely for people reaching the age of retirement. The elder law piece is comprised of guardianships and long-term care planning, as well as probate and estate administration. A guardianship is the process where, if you fail to have a Power of Attorney in place, a judge in Superior Court will determine who will have the authority to make your medical and financial decisions. It can be a lengthy and expensive process, so I always encourage everyone, of any age, to have a well-drafted Power of Attorney in place to avoid a guardianship.

John: I've dealt with many people who faced challenges as a result of waiting too long to do the planning that should have been done. The family ends up in

crisis mode, having to make decisions dealing with issues that could have been addressed. It sounds like the guardianship is kind of like a crisis mode decision because they didn't do the planning in advance.

Holland: You're absolutely right. People don’t want to address those issues, or even think about the process of getting older and losing capacity. Those are often difficult subjects and difficult conversations. But it doesn't have to be a crisis. That's where I like to educate people and tell them there are other options. You can avoid having a crisis by simply having the correct documentation in place, or by having those discussions ahead of time.

Also, people often think, “I have a spouse, they automatically have that power,” and that is not accurate. In particular, there could be a disagreement over whom will be making decisions. They could have avoided that huge mess by just having well drafted Powers of Attorney in place, just in case.

John: What brought you to elder law?

Holland: I always had a passion of working with seniors. I find it very meaningful and rewarding. I also really enjoy listening to their stories, which are often so interesting. I've found they’re always very

appreciative when I just sit down and listen to them, and I typically always learn something as well. I was always very close with my grandparents growing up and had wonderful relationships with them. I think that's probably where it started.

John: In addition to people who haven’t planned, you probably also deal with people who put their plan together 20 or 30 years in advance. Things change in our lives. When's an appropriate time for people to take another look at their situation and just make sure everything's up to date?

Holland: I usually recommend that people have their estate planning documents reviewed at least every 10 years. Laws can change, your goals can change, and family dynamics can change, so have a review at least every 10 years. That doesn't mean any of the documents need to be changed, but it's a good idea to have them reviewed.

John: When you sit down with people who are nearing retirement, or have already retired, are there specific documents or specific plans you recommend to them?

Holland: It depends on their particular situation. What property they own, what their goals are. Not everyone has the same goal. We have to take everything into consideration in recommending a plan.

But the essentials are a Power of Attorney for medical care, Power of Attorney for finances, and a Healthcare Directive, also called a Living Will. Those are extremely important to have in place. Then, if they're married, sometimes we do a community property agreement and authorizations. We want to have HIPAA authorization, and an authorization for my office to work with whomever they've designated as Power of Attorney. Those are the essential bare minimum documents. We also talk about whether a Will or a Trust would be appropriate for them, taking into consideration things like their assets, their goals, and the family dynamics as well.

I try to draft my estate planning documents in such a way that there is little likelihood for contesting. No one wants to see their estates dwindle because a bunch of family members fight over it. If there's a high likelihood that there's going to be some contesting, we may recommend a Trust where there's less likelihood of the ability to contest in those kinds of situations.

John: Earlier you mentioned that many of a couple’s assets often go toward caring for a spouse who became ill or injured. You want to give them the best care possible, but draining those assets can leave the surviving spouse in a much lower standard of living. How do you address that issue?

Is that a topic you bring up when you're doing planning with folks?

Holland: Absolutely. I always try to take that opportunity to educate people that there are ways to preserve your estate and not go broke paying for someone's care. There are two government programs available to help pay for care. One is Medicaid and the other is a veterans' benefit called Aid and Attendance.

Medicaid is a welfare program, which means it is a tested benefit. Your resources and income must be beneath a certain threshold. However, there are strategies you can implement to preserve your estate and be above that threshold, and still qualify for Medicaid. There are similar types of strategies for the VA benefit as well.

The VA benefit provides up to approximately $2,200 a month, tax free, directly into the veteran or surviving spouse's bank account. If there's an ill spouse in a facility, the veteran's benefit can help offset the cost of care and preserve part of the estate for that well spouse who may still be living at home. It helps us make sure the well spouse doesn't go broke paying for care.

We also look at a single person having to go into a facility. I don't want to see that person have to spend their entire estate down, then go on

Medicaid and be destitute. I'd like us to preserve some of their assets, and have some resources available to them. Medicaid only allows seniors to have about $60 a month from their income. Frankly, that barely pays for a haircut anymore. Our goal is to just preserve some cash so that senior in the facility may be able to pay for going out to dinner with a family member for their birthday, an extra set of dentures because they've lost theirs, or any other expenses. It's important to have something available for them.

John: Are people able to qualify for Medicaid and still have in-home care, so they aren't forced to live in a nursing home?

Holland: Yes, absolutely, and the veterans benefit is available to them as well. In fact, I always make sure to ask what each individual's goal is, because it is never safe to assume. For example, I currently have an 85-year-old senior client. I asked her if she wants to stay at home. Absolutely not. She's feeling very isolated. She wants to go into a facility. She wants to eat meals with other people. Other people want to stay home as long as possible. It is particular to each individual, and we help people accomplish those goals.

John: It's unique that she recognizes the isolation. I've found over the years that some of the people who are most resistant to leaving home, and only did so

because it was safer for them to live somewhere else, actually loved their new environment once they embraced it. They love the camaraderie and the people that they get to know. It's almost like another family for them.

Holland: I agree. I've had numerous clients who were hesitant about going into a facility, but it ended up being a very good thing for them.

I think part of the tipping point there is when the senior is no longer able to drive. They've lost their independence. They're not able to go to church anymore, go to the grocery store, or really interact with people, and that's when things start to change.

John: Yes. How do the veterans benefits work? Are they only for retired veterans? Do they have to serve a certain number of years?

Holland: That's a good question. It requires 90 days of consecutive active duty, and one day has to have been during a period of war. They didn't have to serve in combat, just during a period of war. And they must have an honorable discharge. Also, similar to Medicaid, there's an income and asset requirement, as well as a medical need, of course. Even above the thresholds we can still get some of them qualified for the benefit. It's a great benefit. It's very complex to apply for, and to actually get

approved by the VA because they make it a little bit challenging, of course.

John: What about age? Do people have to be over 65?

Holland: No. If we could prove they have a medical need, we can get them approved under 65.

John: Are we looking at veterans with medical needs and lower income? Does the income matter?

Holland: It does, but that's typically the easy part for me, to get them qualified income-wise. They don't have to be low income. Absolutely not.

John: I know people who have terrible medical expenses, but are still working. Then you have others who have disabling medical conditions where they're not able to work.

Holland: Typically the target people we help are those who are under 65, disabled and have extremely high medical expenses, or over the age of 65, not working, and need or are receiving in-home care or need to go into a facility.

John: And of course, as we discussed earlier, anyone that wants more control later in their life should do some pre-planning ahead and not wait until it's an urgent situation. Because then you may no longer

have control over the decisions being made, and rely on someone else to make those decisions.

Holland: Plus, if you fail to have your Powers of Attorney in place and a guardianship has to be filed, the judge will make the decision on who's going to make your medical and financial decisions. That's not always the person you would have chosen, or it could be someone you don't even know.

Many times, I've seen a blended family with a new spouse and children from a prior marriage, and it ends up being a huge fight between everyone. We end up going to trial, and while we're waiting there's no one designated to make those decisions. There could be an unreasonable delay in healthcare decisions and all kinds of problems. Also, litigation like that is very expensive, and very time consuming. It could all be avoided by having well-drafted Powers of Attorney in place.

The same with a Will or a Trust. I want to make sure I'm the person deciding how my estate is distributed. I don't want my estate distributed by a judge based on a state statute. Also, I have minor children. I want to be the person deciding who will be their guardians if something were to happen to my husband and me. I don't want the state making that decision. If I don't have a guardian listed for my children, CPS will likely take them and find placement for them, whether it be with family

members or non-family members. Even if it is family members, what if they're fighting over it? That's all unnecessary and I don't want that to happen.

John: It's terrible for the children and can create lifelong conflict for the family. I know we can't cover every single scenario, but what is the process when there's no Will? Let's say for a typical nuclear family, a married couple with children?

Holland: It depends on how the assets are held. If they're community-owned assets, with right of survivorship, some of those assets will automatically go to the surviving spouse. There are different ways to hold assets as a married person. You can hold them as your separate property, meaning they aren't part of the marital community, or you can hold assets as a joint tenancy with right of survivorship, or what we also call community property. It really depends on how those are owned.

It also has to go through what's called the probate process. If you have no estate planning documents and you're married, the probate process is the process whereby a judge determines how your estate is distributed. There's court oversight, and typically an attorney is involved, and it's a minimum of a four-month process.

John: Which is another big reason for people to do pre-planning, so their family doesn’t have to go through that process. A lot of people are intimidated by the costs. Do they have to do the whole plan at once or can they do it in stages?

Holland: Absolutely. We have the essential estate planning documents that I’d like to see done for everyone. Then, depending on individual or family circumstances, we may recommend other documents that don’t have to be done right away. For example, long-term care planning could be in addition. We'll start with the estate planning documents, get those pieces in place and then at least start the conversation of what the long-term care planning looks like and what we can do to help.

John: We've covered a broad range of topics in a relatively short period of time. You have a lot of experience in this area. Is there something I should have asked you about that I haven't?

Holland: Often I get people into my office who say, "There's nothing I can do. I have to spend down my estate to qualify for Medicaid, so I'm going to go broke. I understand you can't help me because of everything I've read." That is absolutely incorrect. There are many ways we can strategize to get people qualified for Medicaid, or that veteran's

benefit, without having to spend down all of their assets.

The worst scenario is when a senior comes into my office and says, “My husband’s in a nursing home. I’ve spent everything I have on his care. I've sold my home. What can you do to help?” That’s the worst-case scenario because they're coming to me too late. I want people to know ahead of time. There are things we can do to prevent that from happening. We have to keep the well spouse from going broke. It doesn't need to happen. It shouldn't happen.

John: This is not just in elder care. It is in almost every aspect of our life as we get older. Planning in advance saves so much anxiety and heartache. It actually gives you a peace of mind.

Holland: It saves time, stress, burden, and also money, honestly, by paying the money ahead of time to have a plan in place for long-term care and your estate. You save much more money on the back-end by not having to go through probate, or by having a plan in place on how to pay for long-term care. Having a plan ahead of time actually saves money.

John: Wonderful. Holland, thank you very much for spending this time with me. You’ve provided some extremely beneficial information.

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It's tragic when I meet or hear of someone who did not have an estate plan in place and as a result, they or their family suffered financially. Or they missed out on benefits to which they were entitled, and which would have made a huge difference in their life and lifestyle.

Holland and her staff have a wealth of knowledge in this area, and are in a position to help you avoid that mistake.

CHAPTER 3

JENNIFER BALLANTYNE

Jen Ballantyne is an elder law and estate planning attorney whose firm in Liberty Lake, WA is called *Estates and Elders Law PLLC*. Jen chose this field while serving as caregiver during her mother's six-year journey with Alzheimer's. She developed a passion for helping other families navigate the challenges of aging and disability.

Jen helps elders and their families plan for long-term care, preserve assets and apply for government needs-based benefits to pay for care. She also helps clients plan their estates with Wills, Trusts, Durable Powers of Attorney, and ensures they have appropriate decision makers in place for finances and health care, including end-of-life care.

I knew of Jennifer Ballantyne before I met her. I had read a fascinating article about her in a local publication. The article mentioned she had founded *Estates and Elders Law* after graduating law school at Gonzaga University. I was impressed that she had gone back to school after retiring from a successful corporate career.

I happened to be at Starbucks one day when Jen walked in and I recognized her from the article. I introduced myself and since the place was so busy, invited her to join me at my table. We talked for at least thirty minutes as we shared information and learned about each other. We have seen each other many times since as we are both members of *Senior Action Network of Eastern Washington.* Not only does she run a successful law practice, but Jen is also an active volunteer who contributes her time to help others.

John: Jen, let’s begin with your path to becoming an attorney and specializing in estate and elder care.

Jen: When I was in my late 40s, my mom was diagnosed with Alzheimer's disease, and we had no family history. I come from a small family and didn't really have any experience with illness and death until I was an adult. I was inspired by my mother’s illness and how we helped her through that period of time. I realized afterward that it was my great privilege to take care of her, and that I would never want my children to go through what I did. I decided to do something to help other families who were on a similar journey.

I had another career for over 33 years in high technology, most of it in sales. That afforded me the opportunity to be able to pay for law school. So when I was 58 years old, I went to Gonzaga. My husband and I moved away from our long-time home in Dallas, Texas, to Spokane. I went in knowing that I always

wanted to work with elders and their families. I entered law school in 2011 and graduated in 2014.

I knew this is what I wanted to do as soon as I got a taste of it. Gonzaga has a fantastic elder law clinic for low-income elders, and I was able to work there while I was in law school, as well as for a local firm. Now I'm privileged to be out on my own in solo practice so that I can help exactly who I want to help.

Gonzaga has a clinical program called the University Legal Assistance which is staffed by law students and supervised by attorneys. I was always volunteering to take every case I could; I worked between semesters. I just knew that if I was going to know anything about practicing law when I graduated, I needed to practice law in law school.

I'm really happy for the education, and being able to apply that education in helping seniors and their families now.

John: I think it's fascinating that at 58, you chose, not just to go back to school, but to go into such a demanding curriculum.

Jen: The hardest thing was dealing with my ego. I had come from another career where I was at the pinnacle of my performance and then I was a lowly law student like all the other kids.

It's such a fascinating education, and right away I was able to see the practical applications to the social problems that elders have as well as the legal problems. For me that's a really interesting thing about my area of practice. I do estate planning and I've got my eye on possible long-term care needs. Because most of us are going to face our own aging and declining health, and that of our family members. And since I had that life experience, it's made a huge difference.

John: Why do you think so many people put off planning? What is it, that procrastination in people, which causes them to put it off?

Jen: Well, that denial is a useful emotion. We don't think it'll happen to us. These are tough topics: aging, the decline in functionality, the loss of independence, illness, death-- not just our own. I think we face it first with our grandparents and then our parents. That's when I often will see people whose grandparents and parents haven't done any planning, and the first time a younger person has to deal with it is mid-crisis.

John: Say we have Jane and John Doe, who have been married a long time, have kids, and have done pretty well financially. They didn't do any planning, then one or both of them starts suffering some chronic illnesses If you project out a few years, what's the difference between this situation and that of someone who has done some planning? A lot of times people come in

when it's an emergency. If we could prevent the emergency, what does that scenario look like?

Jen: Oftentimes people will experience someone else's emergency, when it happens to someone else they know. I think you're going to make better decisions and you're going to have more options if you do all of this ahead of the need, or ahead of the crisis.

John: And we're not talking about waiting until you're 60 or 70 even, right?

Jen: No, in fact, even young adults, particularly those who have young children under the age of 18, they will need a guardian for those children. Children can't inherit outright, so you may need a trustee for a trust where you may leave them your assets. So, it is something younger people should do as well. I'm amazed at the number of older people who have never done anything, or if they have, it's time to get things updated.

When you think about the issues of aging and decline in health, you're thinking in terms of long-term care and what will be needed and how will you pay for it. So, there are basically three ways to pay for long-term care. One is through long-term care insurance to purchase affordable long-term care insurance, you've got to do that in your 40s or 50s. It's sometimes available when you're in your 60s and older, but it's going to be much more expensive, and you have to qualify for it from a health standpoint.

The second way would be through your investments. And then the third way would be to qualify for government needs-based benefits. However, as a single individual, you pretty much have to be impoverished. You have to spend down your countable assets under $2,000, in order to qualify for those benefits.

As an attorney, I try to give people a lot of options in their particular situation. Sometimes we can predict what will happen by a person's family health history, particularly diseases. You have to look at people's current health and how well they're taking care of themselves. You have to look at the health of their bank accounts. When we think of retirement, we think of replacing income. When we reach retirement, we face a lot of challenges in terms of paying for the cost of medical care: insurance, prescriptions, dealing with the Medicare doughnut hole.

Currently in Spokane, long-term care can run between $5,000 and $13,000 a month, depending on the setting. Most people want to stay home, but if you want 24-hour care, 7 days a week, it'll run about $4,000 a week, and most people just don't have that kind of money.

John: And the thing is, most people don't want 24-hour care, but they can’t predict what their health does in the future.

Jen: That's a really good point. You just don't know. I read a piece of advice by a columnist named Carolyn Hax and I thought she just said this so beautifully. As we age, we're all just one illness or accident away from a future we never imagined.

I want people to think about what that might be like and what their expectations are for themselves or their spouse, how they've prepared for it or not prepared for it, as well as what their goals are. Because nobody saves all their lives to spend every penny on their long-term care. Everybody wants to leave a legacy of some kind. They may want to leave it to their children or a charity. They want somebody to benefit from their life's work.

John: Often times, a married couple who has been together for many years, one of them suffers some sort of debilitating illness or injury, and the resources are spent to make that person as comfortable as possible. It is not uncommon that the surviving spouse is left with fewer assets than what they started with together, and now the surviving spouse has a much lower standard of living. And if they have a long life, they suffer financially because of that. Can you address those issues in your planning, to protect the surviving spouse from the debilitating illness that someone else has had?

Jen: I once worked for an attorney whose mother wouldn't take her advice. She ran through all of their money taking care of the husband, to keep him at home.

Unfortunately, three weeks after he passed away, she had a major stroke and ended up in an adult family home for many years on Medicaid, government needs-based benefits.

I would say that most married people are concerned about how their spouse will be affected. Fortunately, when people need government needs-based benefits, the law is very generous for transferring assets between spouses. So, one of the things we do in Medicaid planning is make sure that we understand what the contingency plan is if there is a crisis. If one of the spouses does need long-term care, then we're prepared to make the transfer of assets to the name of the surviving spouse.

I encourage my clients to include in their wills the contingency for something called a Supplemental Needs Trust, used to preserve half of the assets of the spouse who is first to die, and also preserve eligibility for government needs-based benefits for the surviving spouse.

John: How does that work? You have two halves, the ill spouse passes away, and those assets are still preserved?

Jen: If the contingency for the supplemental needs trust is in the will, then at the discretion of the executor, that trust can be created. The surviving spouse benefits just as they would benefit if they'd received an outright gift of half of the estate of their spouse who died. So,

they still benefit from it, but the funds are held in trust, which is a legal arrangement for holding assets. And they're managed by a trustee for the benefit of the surviving spouse.

Now the surviving spouse is a single person, and under normal regulations, would have to spend down in order to qualify for government needs-based benefits. We leave that option open. It’s always a good idea as people get older. We have the surviving spouse spend their half first, preserving what's in the trust. It can still be spent for the benefit of the surviving spouse, but if it isn't all spent, then it can go to the children, or charity, or whomever. So that way, we know that we can preserve at least half of the assets.

There are other tricks of the trade for preserving assets. When you need these government needs-based benefits, there's a five-year ban on gifting prior to the time that you need to qualify.

John: Now the look back period is five years, versus what it used to be.

Jen: Yes. I have clients come in all the time and they say, "I want to give my house to my daughter, so the state won't take it." And I tell them, "The state does not want your house. They want to be reimbursed for anything that they've spent for your care." And in a practical sense, the way they're ensured that they'll be reimbursed is by putting a lien on any real property.

John: It seems like such a minor thing, but it's important. People are putting their adult children on their checking and savings accounts. I've seen real horror stories because of some family dynamics that go on with adult children, such as divorce or bankruptcy. Can you address that?

Jen: It's a huge issue as we age and decline in health. If you're over 60, it's possible you need someone to help you make financial and medical decisions. In order to allow that person to help, you have to give them authority over your affairs. If vulnerable adults are exploited, it very often is a family member who has done so.

People who start planning at a young enough age have a wide variety of people available to them to take the authority and be responsible with it. In a power of attorney, the role of the named agent has a fiduciary responsibility, and has to do what Mom would want, even if you don't agree with it. And you have to follow the standards of the law, which are really high for people in fiduciary positions. It's a very important job you must do it as honestly and straightforwardly as possible.

John: Is it a good idea for a parent or a grandparent to put someone else as a co-writer on their financial instruments, their checking account, or savings account? Shouldn't it always be done through the legal portion? Because isn't that where real problems happen?

Jen: It's such a complicated area of law. It really depends on the family situation. This is something that's very interesting in elder law. We can't do anything in a vacuum; we really have to understand what the family dynamics are: whether the children get along, whether the child chosen to help is the appropriate choice for them. We also have to consider bank policies. There can be issues of mismanagement if there is ill will, and banks will have policies in the small print that make them not liable for this.

If you have one child and you want everything to go to that child, it's a very straightforward situation, assuming you trust that child. But if you have multiple children and you put just one daughter on your bank account, and the bank assumes that daughter is a co-owner, the bank has set the account up as joint tenants with right of survivorship, when you die, that money belongs to that daughter, not to all five children. Even though your will might say, "My five children are to share my estate equally."

It's just something to careful about. I try not to scare people. I tell them what might happen and ask them how they feel about it. And a lot of times, people will name a couple of kids to work together in these various fiduciary roles, or they'll name a trusted son-in-law or other person. I always ask people to give me at least three names, so that we've got somebody likely to be willing and able. Even at the time they execute that person might not be able to come to

serve at the time of need, so I like to have another couple of names. If not Bob, then Jane, and if not Jane, then Laura so that in the documents, we're set to go.

John: What are the documents that you would typically recommend? You mentioned power of attorney. I'm guessing health care directives?

Jen: The most important documents, in my opinion, are the durable powers of attorney. Every adult should have those documents, but they do become more important as we get older. One of them has to do with naming an agent to help you with financial decisions and financial management. The second document would be a durable power of attorney for health care purposes, naming an agent to make medical decisions for you, things like admitting you to the hospital or discharging you from the hospital, or agreeing to treatment, or admitting you to a nursing home, or having access to your medical information, which is protected by HIPAA privacy laws.

Those are critical documents. You should have a health care directive, because at the point we need that health care directive, you are in either a terminal state or a permanent unconscious condition, and anything the doctor did at this point would just prolong your death and not your life with the hope of recovering any quality of life. And so, in my experience, the vast majority of people in that situation just want to die naturally. They don't want to spend weeks or months

hooked up to machines to be able to breathe and eat and drink and that kind of thing.

If you don't have that written down somewhere, we only know what your family says, and this can be a major area of disagreement amongst children. Because people have different conversations with different kids at different times, and they have their own particular opinions or convictions. So, the best thing is to have it all in writing.

John: The things I want today are way different than they were 20 years ago. So, an adult child might still be remembering a different version of their parent, but they may not think about the life experience they've had. It's hard for them to let go. So it is very important to have things spelled out clearly for people.

Jen: If you are hospitalized without your written permission, the hospital cannot share information about your medical status by the HIPAA law. So, I prepare a document that lists names of people that they would like to have information about medical status, if they were in that situation. We talk about these other documents when they come in for a will. We all hear the statistics that half of people don't have a will. Sometimes, you don't necessarily need a will, but by the time we're using that document, you're certainly not going to be available for us to ask you what you meant. So, it's important to get your wishes for your estate and for a number of other things.

If you have a disabled child that you've been able to provide care for, but the child is likely to outlive you, you're going to need a succession plan. Not just the care for the child but also for how that care will be paid. That's an important thing we memorialize in wills. We have something called Intestacy Law, which favors blood relatives. So, if you die without a will, we look to see who your next of kin would be. A lot of times, people have someone unrelated to them who they want to leave things to. I have a lot of clients who leave a great deal of money to charity. That's along the lines of thinking about that legacy. The law will not give your money to charity; you have to do that through your will. And of course, the will is a vehicle for the supplemental needs trust. It has the instructions for your personal representative, which is your executor, to create that supplemental needs trust for the benefit, typically of your spouse. But it also could be for a disabled child.

I have a fair number of clients who have children who either have issues with drugs or alcohol or who have never been good with money. They feel that if they were left a lump sum that it would be gone. So, we use those trusts for that purpose as well. If they have a child who predeceases and leaves children, they want that child's share to go to those children. If those kids are under the age of 18, we've got to have a grandchildren's trust in a will.

Most people would not want to hand a pile of cash to an 18-year-old anyway. Typically, funds for a child are kept until they're 25 or so, past school and just beginning to get a bit of flavor of adult life. That money can certainly be used for their benefit beforehand, but they just don't have the reins until they're more mature.

We use wills for all of those purposes and many others. And people like the idea of having a will, I think. It's good to see in black and white. Even someone who has the smallest estate, they want to have it go to somebody. And I've had people do so many creative, fun things. I had a woman whose husband and only child died, she had a long list of beneficiaries that were like a son, like a daughter.

I just had a lady give $1000 love gifts to about 20 different names, people that she just wanted to surprise. She wanted to make sure nobody knew about this before she died. She wanted a surprise love gift to go to people who'd really meant something to her.

Wills are important, and it's always really a great conversation with people, because it sends a message to people after you're gone. Sometimes not a positive message, if you've left someone out. But often, it's your last chance to say I love you.

John: So, if someone who is married and does not have a will and passes away, does the whole estate automatically go to the spouse?

Jen: No, not necessarily. Another document that we use for long-married couples in particular is called a community property agreement. I consider that a will alternative. It's a contract between husband and wife that characterizes their property. If I have a client who's been married 40, 50 years and they tell me they were poor as church mice going into the marriage. I ask them if they'd be interested in signing this contract. Basically, it says, all the property we have is our community property. So, when you get married, there's husband/wife, but then there's also the marital community under the law.

Anything they've acquired during that married life is presumed to be owned by the marital community. Each has an undivided one-half share. So, it is possible for married people to have separate property. They can bring property into the marriage, so something they had before, but they always have to keep it separate. They can never take joint funds and use it.

There is no co-mingling of funds with that separate property. They can also be given gifts or inherit money during their marriage, that as long as they keep separate, then that's their separate property to give as they like. My community property agreement says everything we have is community property and everything we're going to acquire is community

property, however, each reserves the right to give away their half by will.

Occasionally, I'll have a client who, even though they're long-married, one of the spouses is set from an inheritance. So, the other spouse then feels free to leave the money not to the spouse, but to charity or the children or something else. So, it's just important to know what a couple's individual goals are. I have very few people who completely separate their funds. Most married people consider their property to be community property.

We look to see what community property there is. And community property, by law, goes to the surviving spouse. But separate property is shared between the surviving spouse and any children from a prior relationship. I do a lot of planning with blended families. A lot of older people will be divorced or widowed, and they'll remarry. But they each come with a set of kids and certain assets, so then we have to plan ahead that way, too. It's not always an even division. Some blended families feel like one big, happy family, and some are very clear that “my kids get this, your kids get that,” kind of thing.

If we have that community property agreement and it is all community property, we have no probate. It's very easy to settle an estate like that. We just record the community property agreement and the death certificate.

Probate is not an onerous process in Washington; it's not an expensive process, unlike states like California. But my philosophy is, if we can avoid it when we're doing the planning, if we can think ahead to what this particular estate will be like to administer, then let's do it. We use things like the community property agreement. If you are a single person and you have a house and you want that to go to your daughter, we have another tool called a Transfer on Death Deed which allows you to make a gift, just like you would in a will, but you make it at the moment of your death, a gift of real property. It's revocable during your lifetime, so if you want to sell that property or give it to somebody else, you can change your mind.

We record it with the auditor during your lifetime, and if that's the last deed in the file, then that real property goes to your beneficiary at fair market value on the date of death, so there's no capital gains tax to pay and there's no probate. So probably the vast majority of probates are to clear title to real property. Washington legislators gave us these Transfers on Death Deeds as a way to avoid that. I still do a fair number of probates that are solely for the purpose of clearing title to one piece of property.

John: So again, another great reason to do some advance planning.

Jen: We don't always know if you're going to die owning that house, but it's a way to educate clients that your financial life will surely change. You should get the

documents in place so we have a benchmark, and then come back every time you have a major life change, just so we can look at what assets do you have, what have you cared for.

John: It's amazing how much our life changes in five years. I see Special Needs Trust advertisements all the time for estate planning attorneys that are doing seminars on trusts vs. wills and avoid probate. What is your stance on this? Is that a controversial topic?

Jen: I think it depends on the attorney, I see them too, you are referring to a vehicle called a Revocable Living Trust.

If you live in California, everybody's got a Revocable Living Trust, because by law, attorneys can charge a percentage of the value to probate your estate which are large in California, because the cost of real estate is so high. So, you can have what would be considered an exorbitant fee to probate an estate in California. The way you get around that is by setting up that trust arrangement, which is just a legal arrangement for holding assets. You set that up during your lifetime, then instead of having a will that's probated, you have a trust that's administered after you pass away. They do have their uses in Washington, but a less expensive, less complicated solution is really the will with the Supplemental Needs Trust or the contingency for it, so it can be created.

John: So, most of us can get by with a will and a Supplemental Needs Trust.

Jen: The Revocable Living Trust does provide protection from the probate process. You've still got a state administration. And where I find people fall down in two ways with those is that they pay an attorney a lot of money to create one of these Revocable Living Trusts, and they'll usually deed their house in there right away, and then they may or may not put all the other assets in it. So, when I describe this to people, I have a visual and I say I've got a big box and that's your trust. When you die, if everything is in that box that you own, we're good. We can just administer your trust. But usually what happens is people put a few things in the box, and then they get lazy about it or they forget, and we've got a bunch of things outside the box. So, we don't necessarily avoid probate.

Another good reason for it is creditor protection. If you are the kind of person who dies owing a great deal of money, you might have some protection there. I had an estate one time where really the only thing left of value was the house, and we didn't know it at the time when the decedent passed, but we discovered later that that house was in the name of a trust that he had created. He never mentioned that to anybody in his family. He wanted it preserved for his son, and thankfully we could do that because otherwise there were no assets in this estate.

Another thing is failing to provide Medicaid protection. Medi*care* pays for doctors and hospitals, and that's your insurance entitlement from the federal government, for which you pay premiums and you have to buy a supplement to pay for the things it doesn't pay for. That program does not pay for any long-term custodial care. So, when I talk about government needs-based benefits, it's around somebody needing to pay for long-term care that they don't have another way to pay for through their own private funds or long-term care insurance.

With those Revocable Living Trusts, when people put their house in there, that makes it a countable asset. For Medic*aid* qualification, a house is not a countable asset. So, when somebody needs to apply for Medicaid, after they've spent all this money creating this trust, we have to liquidate the trust. We have to take everything out of the box. Have to take the house out and deed it back to the individual so that it doesn't count against them in qualifying for Medicaid.

So that's why we don't favor them. There are attorneys who feel that this is a better thing to have than nothing at all, and they promote these through seminars. I know one attorney in particular does about 70 of these a month. But people bring them in all the time and say, "I've got my big red binder and I don't understand a word of it. And I don't know if anything's in there or not." And they may come in with the

binder, but they never put a single asset in the box. So, they don't really have a trust, they just have a binder.

You have to make this easy for people to understand. I struggle with this a lot, because I want to be understood as an attorney and I want to educate, and I want people to trust what I say. I think the simpler you can make it for people, the more they'll trust the process. My job is to explain the law and help them leverage it.

John: Then they will follow through and make decisions.

We've talked about a lot today. Is there anything else you wanted to share?

Jen: We touched on it a little bit, but I wanted to talk about why people delay these things. I see people delay, perhaps because they have misconceptions about attorneys. I recommend attorney-prepared documents, versus things that you can find on the internet or through places that come without a warranty.

I think people fear attorneys, that we're going to somehow take advantage of them or we're going to charge too much. You can get very reasonably priced documents. Sometimes I have people who still insist on preparing those documents, but they'll come in and pay me to let them know if those meet their needs or not. And inevitably, I end up doing documents for them. I try to come up with a price that they can

afford and feel good about, that feel they've got attorney-prepared documents that really accurately reflect their wishes. The cost for doing it wrong can be really high.

John: You know what's interesting to me is the celebrity planners out there that speak to the masses, like Suze Orman or Dave Ramsey, a lot of what they say is valid and true. The challenge is, they're speaking to the masses. Each individual that we deal with, their situation is unique and different, so when we go that do-it-yourself route, we don't know what we don't know. I don't want a cookie cutter. I don't want the same thing as everybody, because I'm not the same as everybody. But when you're on a national platform, they're not really talking to the individual. So, they have general advice. I agree with you. I really believe we all should deal with professionals when it comes to many things in our life, not just an attorney.

Jen: I agree. What we sell as attorneys or financial managers, even a variety of different doctors, we all sell our services, and we have a lot of education and experience. I've helped almost 250 families. It's amazing to me, but that's a lot of conversations. Every day the law changes, and the analysis of the law by courts change. We get smarter through experience. So, when you go to an attorney for these documents, you get a pinpointed analysis of your particular situation. And then the opportunities to get all of that down on paper in case you’re not here to ask.

John: I would encourage everybody that's reading this, if you haven't done your planning, make the call and you'll feel better about doing it. Anyway, Jen, thank you very, very much for spending this time with me, I appreciate it.

Jen: You're welcome. Thank you for the opportunity.

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You have now received information from two trusted attorneys who specialize in elder care and estate planning. Thanks to these interviews, you understand the benefits to yourself and your family for taking the time to do this now.

I wish people did not associate estate planning with just wealthy people, as the truth is nearly everyone should do estate planning. It may be more complicated for the wealthy but it's not any less important for the average person.

Okay, you get the point. Go call an eldercare attorney.

CHAPTER 4

INCOME PLANNING

No interviews in this chapter, just a desire to encourage as many people as possible to take the steps needed to minimize income planning mistakes in retirement. I meet a surprising number of people in my practice who have financial insecurity. They may or may not have saved much during their working years, but they are so influenced by their fears or preconceived notions, that they have not met with a financial advisor to help them understand the best way to utilize the resources they do have. Consider this a poke and a prod to encourage you to take the next step to financial security. You will not regret it.

Retirement and financial planning are interesting subjects to me. It is amazing what the power of compounding over the course of 30 or 40 years will do to even a modest savings rate. Unfortunately, many people have the misconception that they must save a large amount of money from each paycheck to make an impact on their retirement years. That may be true if they have waited until they are middle age or older before they started saving but it is never too late to improve your future.

Ideally everyone would save at least 10% of their income throughout their working years. It is the consistency over a long period of time that produces the best results. That is not

to say that folks who waited until later in life are doomed. Start where you are now and seek the advice of a professional.

There are consequences for the decisions we make, and some of them are life changing. Doing nothing is going to produce the most negative results. Meeting with a professional will help you understand the different tax implications of your accounts as well as which assets should be utilized earlier. They will also suggest which would be better left invested until later. We all hope to enjoy decades of retirement, so we do need to keep a portion of our funds invested to help offset long term inflation.

A financial advisor who has your best interests in mind will take the time to get to know your current situation and goals before offering specific advice.

Every person's situation is different. Although friends, family and coworkers have your best interests in mind when they give financial advice, they do not know what they do not know. It is that well intended lack of knowledge that can cost you dearly at the time in your life when it is harder to recover from financial mistakes.

If you do not have a personal financial advisor, I encourage you to interview a few professionals to see who you trust and connect with. They have the expertise to help you understand your expected retirement income by analyzing your future benefits like social security, 401k, IRA's or other tax deferred investments. They will also spend time educating you, so you do not over react to market fluctuations. Having a well

thought out plan will increase your confidence as you enter the best years of your life. Enjoy it, you have earned it!

CHAPTER 5

ASHLEIGH MATHEWS

Ashleigh Mathews, PHR, SHRM-CP is the Human Resources Manager at DAA Northwest, a vehicle remarketing and repair service. Many of the positions at DAA are great opportunities for seniors.

Ashleigh received a B.A. in Business Management, with emphasis in Human Resources, Management and Marketing, from Eastern Washington University. She earned her PHR in 2009 and SHRM-CP in 2015.

Ashleigh has served various chair positions for the Eastern Washington *Susan G. Komen Race for the Cure* chapter. She enjoys traveling, running half marathons, testing new recipes and most importantly, spending time with her family.

I have first-hand knowledge of DAA Northwest, and of their part-time opportunities for older folks, since I've actually worked for them. During the winter months, I have a fair amount of free time. I like cars and I like to drive, so I've driven for DAA. I enjoyed it and I met a lot of nice people. I plan to do it again.

As HR Manager, Ashleigh Matthews has plenty of experience hiring retirees and senior citizens. If you're considering part-time work, whether out of need or to give yourself something to do, I think you'll find this interview very beneficial.

John: Before we get to the employment opportunities DAA Northwest offers for retirees and other older folks, let's start with the company itself. What does DAA Northwest do, how big is the company, and where do you do business?

Ashleigh: That's a big question. DAA is a vehicle re-marketing company. We offer vehicle re-marketing services, and that includes an umbrella of things, but most people see just the auction component of it. So, we are a wholesale auto auction, and we offer a weekly sale to our customers, traditional in the lanes where you're live-bidding, but also you can participate online. Our customer base is made up of institutional buyers, which are banks, credit unions, vehicle manufacturers or vehicle rental companies that need to liquidate their off-fleet or off-lease consignment.

Then we have car dealerships that bring their vehicles that have been traded in. As part of vehicle re-marketing, we also do full auto body repair. We have two full collision repair centers

in Spokane, one at the auction on our campus and then a second one on the South Hill.

Our main purpose is to offer those vehicle re-marketing services and establish long-term relationships with our customers and be their auction of choice so that we can be successful and provide a good working environment for our employees, and that includes all the benefits that we offer, as well as giving back to the community. That's something that is really important to our ownership and really to the auction as a whole.

John: That was surprising to me. Even part-time employees qualify for some benefits.

Ashleigh: Yes. It depends at what level you're part-time. You can still get full medical and dental benefits if you're part-time and working 30 hours a week. Less than 30 hours a week, you don't qualify for medical and dental, but you still qualify for 401(k) after you've been employed with us for a year. Paid sick leave is available to you, and we also have discounted gym memberships. Opportunity for full-time employment is a big perk. We always post our open positions internally as well as externally. Preference and priority are given to our internal applicants before external.

John: Do you have some of your part-time drivers become full-time drivers?

Ashleigh: Yes, absolutely.

John: What is so intriguing to me about DAA is there are a lot of people that want to work either because they want to earn extra money, or they want the social element, but they don't want a full-time, difficult job. They want something fun to do. And this is something fun.

If you have someone who has a lot of mechanical background or body shop background or something like that and they don't want to work full-time, do you have part-time positions for skilled positions like that as well?

Ashleigh: Yes, we do. It’s a nice fit for part-time roles where you want a little bit more than just the four hours that you're driving in the sale. We have a full inspections department that does vehicle inspections, both pre and post-inspections, and that's a kind of complicated area, but if you have mechanical background, it's really great to staff that position with part-time folks. We move them to a contract status, so they become a 1099 employee.

It's still considered a "sale day" position, you're usually here either Wednesday and Thursday or Thursday and Friday to go through all of the

vehicles that need to be inspected each week. It's 250 to 375 depending on the size of the sale. What you're doing is inspecting the unit for frame damage and then taking it for a ride on the test track to identify any mechanical issues that might be wrong with that unit.

John: So, is that pre- and post-sale?

Ashleigh: Yes. There are opportunities for both, so that's where one of our sale day drivers went. We look internally for those positions if it's still part-time but it's more hours and there is a significant increase in the pay. Right now, 35 dollars an hour at a contract rate. Lot crew opportunities also exist, and our lot crew is responsible for staging our lot for the sale each week.

John: Tell us what that driving position entails. What does that day look like?

Ashleigh: First, I'll give you a little history on the auction so that hopefully it makes more sense. We hold a weekly sale, and, on average, we will run between 1,300 and 1,800 units through that sale. And when I say run through the sale, we physically drive every single one of those vehicles through our auction barn. And we have the capacity to run 11 lanes in the barn at a given time, but each lane requires 14, 15 drivers for us to execute the sale. So that's a lot of drivers. We

need about 150 every single week to pull off our sale.

I check in about a half an hour before the sale starts and you get your lane assignment. You're assigned to drive through a specific lane that day, and you'll stay in that lane until all of the units have run through the sale.

You'll drive your car through the lane and then you'll bring it right back to where you picked it up from, park it, and get into the next available car. It's driving in a big circle.

John: And what types of vehicles?

Ashleigh: All kinds of cars. From brand new trucks to old beaters. We sell it all. There's a market for every single vehicle.

John: Motorcycles? How often do you sell motorcycles?

Ashleigh: We have a motor sports sale at least once a month.

To drive our motorcycles, you have to have a motorcycle endorsement.

Harley is a customer of ours and so we have a lot of fun Harleys back there that you get to ride.

John: So, seniors especially, we have snowbirds, we have people who have reached a time in their lives when they get to do a lot of things that are fun and important to them, so although they might like a part-time job, they want flexibility. So, talk about the flexibility.

Ashleigh: We are very flexible, and we know that this job is very unique. It's one day a week, it's three and a half hours to maybe six and a half hours depending on the size of the sale or what lane you get assigned. Some lanes run longer or shorter than others. But basically, you sign up to drive week to week. So, if you're here this Thursday, you will sign up yes or no if you'll be here next Thursday.

If you say no that you won't be here, we ask for an expected return date and that could be the very next week or it could be three months from now when you get back from Arizona for the winter time. For us, it doesn't matter, we just would like to know when you're going to return so that we can plan.

John: You also have food service, right?

Ashleigh: Yes, we call it the DAA grill. And it is operated by Longhorn Barbecue, so we built the storefront, the restaurant, if you will, and then they staff it and manage that crew. But we offer full-service breakfast and lunch. They start at about 6:00-

6:30am on sale day morning, and they remain open for an hour after the sale ends, whatever time that may be.

John: So, the sale days are every Thursday?

Ashleigh: Every single Thursday except for the week between Christmas and New Year's. Thursday sales always start at 9:00am, so our drivers check in at 8:30am. And then once a month, we have a promo sale, which just means we have a larger sale, we are running more units on a promo week than a regular week and there's a theme and typically a party associated with the promo sale. So, on promo weeks, we also run a fleet lease sale on Wednesday afternoon, so it's all typically fleet or lease vehicles. That sale starts at 2:00pm and usually runs until about 5:00 or 5:30pm.

John: I felt like this was important information to share. You can't communicate with everybody, but the more you can get that message out and say, "Hey, here's a great opportunity for the people who really are looking for something fun to do and earn some extra money."

Ashleigh: Absolutely. And I get a lot of calls from women that will say, "Well, I heard that only men can drive out here," which always just makes me laugh in this day and age, but no, men, women, you must be over 18 for insurance purposes. Or folks that say, "Well, I'm retired, am I somebody

> that you would consider?" A majority of our sale day drivers are seniors, most of them are retired, and this is a fun opportunity. We also employ college students, kids right out of high school that aren't quite sure what they're doing. We have a lot of service-industry people that work for us as well, so they tend bar or work in a restaurant and Thursday is their day off, so they can pick up a couple extra bucks and drive some fun cars, it works for them. I think it's a great opportunity. Get out there and meet some people. I just love our driver staff.

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There are many opportunities for people who want to work past retirement, whether they’re doing so out of need or would like to stay active and earn extra income as a bonus. Some positions are available to people with specific and specialized skills. There are also many employers that value the senior workforce because of their work ethic and reliability.

Occupations that welcome part-time employees include:
Courier: Many auto parts companies hire people to deliver supplies to repair shops.

Food service: Starbucks to fine dining restaurants offer wonderful part-time employment.
Retail: We are surrounded by national chains and small local specialty stores that value part-time employees.
Bus driver: Many school districts are eagerly hiring and training drivers.
Bank teller: Credit unions and banks are wonderful places for part-time work.
Assisted living facilities: Everything from activity coordinators to food service opportunities are available in assisted living facilities and nursing homes.
Event attendant: Concerts, athletic events and theaters all need people to help with everything from ticketing to ushering.

I've had many clients working part-time in these occupations and numerous others. I've found it interesting that many people like their part-time work more than their longtime careers. I think it is because they are now working in low-stress occupations, and working a schedule that fits their current lifestyle. As an added bonus, many make new friends in their new positions.

HEALTH MATTERS

The luckiest retirees are the ones who have the financial resources to live the lifestyle they want, and are healthy enough to enjoy every aspect of their retirement.

But for many people, health issues sidetrack even the best-laid plans. In this next section, you'll get valuable information and advice regarding a myriad of health-related topics.

You'll learn about a valuable resource to help you deal with the high cost of prescription drugs, which is having a devastating effect on all too many retirees.

I'll share a Medicare primer to answer your key questions, whether you're already on Medicare or getting ready to sign up.

You'll hear from an expert on healthy living, who can help you take steps now to live a healthier life later.

But we begin this section with a critical resource for seniors and all adults who find themselves struggling with health issues, long-term or short-term, and need help navigating the maze of the medical profession and the insurance industry. Health advocacy is a new career, but it's one that is growing rapidly as more people learn how it can help them get the treatment and coverage they need.

CHAPTER 6

ROBIN SHAPIRO

Robin Shapiro is co-founder and Board Chair of the non-profit *Washington State Health Advocacy Association* (WASHAA). She has a distinguished history advocating for a patient-centric focus on the delivery of health care and mobilizing support for that mission.

Robin has several decades of experience in health communications. She previously worked with the Centers for Disease Control and Prevention, and founded several companies that engage patients in sharing their personal medical story to help others. Robin has been recognized by *Seattle Business Magazine* as a "Woman to Watch," was a finalist for WBO's *Nellie Cashman Women Business Owner of the Year*, and was selected as a *40 Under 40* Honoree by the *Puget Sound Business Journal.* She also serves on the board of the *Seattle University Innovation and Entrepreneurship Center*.

I met Robin Shapiro a few years ago when she conducted a workshop explaining the mission of WASHAA. I was so impressed, I became more involved and eventually joined the

board. It has been a great experience learning from all the committed board members who are trying to help patients enjoy a better healthcare experience.

I interviewed Robin in order to share this valuable information with you in the hope that you will feel more empowered in navigating the healthcare system.

John: Robin, let's start with what led to WASHAA, and what exactly the purpose is.

Robin: The intent of WASHAA is to help people engage in their healthcare, and understand how important it is for each of us to know our choices, and feel confident and in control of the choices and management of our own health. Nobody teaches us how to be a patient or a participant in our own care. That's our goal, and we do it three ways: health advocacy awareness, skill building, and connection to resources.

The first is to increase awareness about what health advocacy is. We try to make sure ordinary people understand this concept, and also have access to the basic knowledge of what it means to be in charge of your own care, to make the best decisions possible to get the best care possible.

The second is teach health advocacy skills. That's through our various public talks, workshops, or meetings. We also have a number of tools we use to help people work through different health advocacy

concepts. One example is managing your medications. Many of us use multiple medications. It's not unusual for people to have a variety of health conditions. But no one teaches us how to look at our overall use of medications to make sure all of them are necessary, we're using them correctly, and that we look at them periodically. So that would be one kind of tool.

The third is connect people in our state to local health advocacy resources through our inquiry program. For example, a woman who recently contacted us had been refused medical treatment at a cancer center, even though the doctors had space in their practices to treat her and she had insurance. She did not know her rights as a patient. You wouldn’t know this unless you’re faced with it, but doctors and institutions do have the right to refuse treatment unless it's in an emergency. So people need to understand there are certain things you need to be aware of in order to get treatment and be a good patient and participant. A lot of it is good communication skills, and being compassionate toward our doctors and other healthcare providers.

You asked how I got into this. I think my whole life has been focused on thinking about what motivates people to change, and I've always been interested in people's health and healthcare. My early career was in public affairs work in Washington DC, working on the AIDS issue in the 80s and early '90s.

After that I worked for a biotechnology company, and I was really taken with the patients I met and their interest in sharing their positive experiences about getting their disease under control. I was really fascinated by what motivates somebody to take charge. How do you survive challenging diseases? How do you manage through difficult times?

Later I created a company that actually helps people share their stories, and their tips and inspiration for managing their disease, on behalf of biotech and pharmaceutical companies. Then I became curious about this concept of independent health advocacy. How can we inspire ordinary people, who aren’t faced with this dramatic disease where they're thinking about a specific medicine or treatment, to become more engaged in managing their own health? What would that take?

I met Beth Dropper, who was a nurse, with this concept for an independent health advocate company that we ended up co-founding, called Allied Health Advocates. It was a not-for-profit company, which was pretty ahead of its time, along with the whole idea of independent health advocacy. We found there was basic information people wanted and needed, but no vehicle to find that. So after gathering together a group of like-minded people, we founded WASHAA with the

intent that every person deserves to be in charge of their own health care as much as they are able.

Our mission is helping people transform from patient to active participant in their care. We've done a lot of education, and we connect people with experts and health insiders to really demystify this whole health care system. Virtually every day we have contact with people who have some type of interaction with the healthcare system, and most of what we hear is that it's very daunting and very complicated. So health advocacy is all about understanding the person and what they need, supporting them and their wishes and their point of view, and helping to assert their rights and their ability to have control in their own medical decision making. I use the acronym "USA", which stands for understanding, supporting and asserting the particular person's point of view.

John: Talk about WASHAA's educational presentations. What do they cover and where are they held?

Robin: We give a number of different talks, from basics to the emerging field of health advocacy. That could be for professionals who work in allied industries like financial planners, insurance brokers, or health HR people, who want to understand how this can help their clients be more in control. Those professions are all about making sure people have some type of plan in their life. We believe in having a plan of advocacy.

Second, we have an introductory session for communities called “Patient Know More.” That means once you know a bit about health advocacy, you're not going to just be a patient. You won’t be reactive, you’ll be more confident and in charge. This presentation is generally done in senior communities and other places where people want to understand the basics of becoming more confident and engaged in their own care.

That’s followed by a very robust three hour workshop, which is our volunteer health advocacy training for volunteers, consumers, and family members. John, you've taken that training. It covers basic concepts, but participants also workshop a lot of the ideas around health advocacy. How do you utilize a friend or family member or health advocate to be effective in a doctor visit? How do you know who to pick as your advocate? How do you gather medical records? Some of us have family or friends who can help, others don’t. So what are your options in terms of having somebody by your side to help make sure you have choice and control in your medical decision making?

We also recently added a great easy workshop called “The ABCs of an Effective Doctor Visit.” It's all about having limited time with your doctor. How are you going to make the most of that? We generally give those presentations anywhere in the community.

John: That is my favorite presentation, because it's such an important topic and it's so interactive with the audience. I think just about anybody can relate to the frustration of going to the doctor and sometimes leaving without feeling that you understood everything that went on. I think this helps prepare people to have an effective visit and a better experience when they go to the physician.

Robin: These presentations also educate the public about how to be compassionate towards our providers, because part of being effective is making sure you are aware that this is not just a one-way transaction when you go to the doctor. It's really about a relationship, which means it's on both sides to understand and work towards effectiveness.

Another presentation I hope we'll be able to do next year is "Taming the Medicine Cabinet," because there are a lot of issues around medication management, and just the basics of working with your pharmacist and doctor. Many of us don't have one doctor who looks at all our medicines as we go through healthcare issues. This is important because when we look at medical events and preventable medical deaths, a lot of them have to do with medication management.

John: Also the cost of medications. I think this would be a great topic. As I deal with my clients, I see over and over again that they have a great health plan and can afford their medical care, but the prescriptions

can break people. It's shocking and frustrating how much people spend on medications.

Robin: We're happy to be responsive to what people feel they need to learn about. If there are other topics the community would like help with, we're always happy to put together presentations or partnerships to help get at the most daunting questions for patients.

John: I want to reiterate to our readers, I’m on the board of WASHAA. My involvement started when I went to a meeting searching for resources for my clients. Because in dealing with the senior population, you get many questions regarding not just healthcare and medications, but physicians as well. They express a lot of frustrations with their healthcare experiences. I was so impressed with your mission and passion, I became involved with the organization, and was fortunate enough to be asked to join the board. So I should make it clear I'm not just doing this interview to share information, but also because of my involvement. I see great value in what we're doing and I want people to be more aware. What’s the best way for them to learn more about what WASHAA does?

Robin: We're pretty easy to find. Our website is www.washaa.org. We also have a presence on Facebook and Instagram and Twitter. The best way to know about resources and our activities is to sign up for the monthly e-newsletter. You will know

about all our events across Washington State, along with periodic updates on tools and news in the health advocacy field, and how to connect both in Seattle and Spokane. Maybe we'll have activities in other parts of the state in the future.

If you want to join as a supporter member, which we would really appreciate, that's a $50 donation annually. It helps us do these activities in the community. We are a not-for-profit, and we only have a part-time staff person, so the cost of running the organization is kept fairly low. But we do need that infrastructure to respond to citizens of our state, to make sure we're staying on top of the issues and connecting people to resources.

The other thing is if people are interested in this topic and want to volunteer, there is an opportunity to express what you might be interested in doing. We can always use your help.

John: Is there a place on the website for someone who would like a speaker to come and do a presentation at one of their meetings? Certainly employers, church groups, civic organizations and others would be interested in that.

Robin: Yes, they can. Under the events and programs tab you can request a presentation right on the website. All the presentations that we spoke about are listed as well as other opportunities.

John: We haven't touched upon the difference between a volunteer health advocate, someone such as a family member or a friend who goes to the doctor visits with you, versus a professional advocate who might be paid by a patient on their behalf. Can you talk about the differences and the emerging field of professional health advocacy?

Robin: What most people do is ask a family member or a friend to come with them as their health advocate, as an extra set of eyes and ears at the doctor visit. It’s great if you have somebody you trust who can effectively support you in your doctor visit or trying to gather medical records. That person doesn’t have to be a trained medical professional to be effective in supporting and advocating for someone.

Also, different communities are activating volunteers to serve as volunteer health advocates. This would be someone you don't have a previous relationship with. Their role is just to support you in a doctor visit, or gathering medical records, or listening to you prioritize your health issues. This is usually orchestrated through communities. For example, we have a longstanding relationship with the Phinney Neighborhood Village here in Seattle, which has a program to do this.

The third area is professional health advocates. They’re called a lot of different things, because it's an emerging field. Some people hire a geriatric care manager or a life care manager. That's a trained

professional that has taken specific classes and has certain degrees. They can do a variety of different tasks. There are also independent health advocates that specialize in specific areas. For instance, within our WASHAA community, we have independent advocates that focus on insurance issues, misdiagnosis or difficult diagnosis, cancer navigation, and senior care. One woman recently joined us as a death doula. That's someone who can be your coach and supporter through the process of death.

Whatever their area, health advocates are going to understand the patient or participant, support that person from their perspective, and help them assert their rights and choices. They can range in cost, and it's generally not a reimbursed medical expense. People can expect to pay between $50 and $250 an hour, depending on what the person does.

John: Again, this is a field the public is not necessarily aware of.

Robin: Correct. But I just spoke with somebody in the field nationally this morning, and he said there will be a new nationwide survey of consumers, and their understanding and awareness of patient advocates. So we'll be learning a little more about how aware people are of this concept. That's great because it's difficult to change what you don't measure.

John: Is there anything you wish I would've asked you about, or a piece of information you'd really like to share?

Robin: We all know healthcare is complicated, but on the flip side of that, people should know that getting better care is within their reach, and is something that is very achievable. But like anything else, it's what you put your attention on. You have to be willing to spend a little time and be a little curious to develop your own health advocacy skills and muscles, if you will. That means finding organizations like WASHAA, and reading, so you as an individual can take more control and charge of your health.

The third leading cause of death in our country is unnecessary medical errors in hospitals, and nobody talks about that. It's fascinating to me why our society does not put a greater emphasis on what we as individuals can be doing to help make sure we stay safer and have a simpler way to approach how to manage our own care. I think WASHAA does a good job at educating consumers, but we need to be doing more. I would love to hear from different organizations and people that want to spread the word. We're ready to help.

John: It's interesting to see the response from people when we do the presentations. I think when they sit through one, especially "The ABCs of an Effective Doctor's Visit," they recognize some things they have allowed to happen in the past that they wish they

would have done differently, during doctor's visits and in their treatment plans, because they didn't have either the confidence or the tools to address their concerns. Once they have that skillset, they are more empowered to be effective advocates for themselves.

Robin: We hear that after people take the presentation. It seems like pretty simple information, but somebody needs to tell you, "Yes, you can do that." People don’t have the confidence to do things like ask for a longer doctor appointment. “Can I really do that?” Yes. Actually you can.

John: It’s not just from the patient view. You're also talking about how to communicate more effectively with the physician and to be kind. People learn about the stresses and issues physicians deal with on a daily basis that could have an impact on their ability to communicate with you effectively.

Robin: Correct. And as I mentioned earlier, doctors do not have a requirement to treat you. And as there are fewer and fewer doctors treating more and more people, you as the patient need to be really cognizant and compassionate or you might not have a doctor who will be willing to treat you. People need to understand that our doctors and medical professionals are human. We have to have compassion toward them, and really partner for effective choice and control. Be who you are, but be

compassionate. We know that that really makes a difference.

John: Robin, this was wonderful. I am so grateful for you taking the time to share this information with us.

Robin: Thank you, John. We're fortunate to have you participate on our board and be trying to build this area of interest.

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There are many reasons to hire a patient advocate. Whether you’re the patient, or a relative living many miles away from an ill family member who needs assistance with healthcare. Time is more important than money for some people. A professional patient advocate is ideal for anyone that has the financial resources to hire this type of help. WASHAA and other organizations around the country attempt to educate the public about available advocate resources.

WASHAA also uses many resources to train the public how to be empowered self-advocates or volunteer advocates helping others. Educational presentations are available to large and small groups who would like to learn helpful tips to improve their healthcare journey. I hope you find these resources valuable if you or a loved one faces an unexpected diagnosis.

CHAPTER 7

APRIL BOX

April Box is a private healthcare advocate with *Hip Help* in Spokane, WA. She helps her clients with the mental, emotional, physical, social, environmental, and spiritual aspects of their diagnosis or surgery.

April was born with dislocated hips, but her family didn't know until she tried to walk and kept falling down. As a toddler she was successfully treated for Developmental Dysplasia of the Hip (DDH) and had a normal childhood, but developed significant hip pain as an adult after childbirth. She has since had five hip surgeries, and her life is back to normal.

In her role with *Hip Help* April advises her clients and advocates for them in dealing with their medical provider, hospital or insurance company.

I met April Box in 2016. I had been invited to a meeting of SANEWA, the *Senior Action Network of Eastern Washington*, which is a wonderful group of professionals who work with

our aging population. They educate each other about resources available to senior citizens, as well as participate in volunteer activities and community outreach.

I joined the group after my first meeting. I was impressed with its mission, as well as the passion the members had for improving the lives of seniors in the community. For example, SANEWA raised $25,000 for Meals on Wheels just a few weeks before I began working on this chapter. They also do several community projects each year to enhance the lives of our more vulnerable community members.

April is a caring and compassionate person with a heart for helping people during their health care journey.

John: I'm looking forward to learning how advocates can help people in their medical journey. April, what led you to starting your company, *Hip Help*?

April: That's a long story. I've had five hip surgeries. I was born with dislocated hips, and I started my surgical journey when I was about 30, including three surgeries in three years after having my first baby. I had to become my own advocate because of how it went. My third surgery was a challenge. It was a total hip surgery. Fantastic surgeon and technician, but horrible bedside manner. Remember, this was the third surgery in three years. My left calf was pretty much emaciated because I hadn't walked on that leg for three years. He just ordered the regular six weeks

of physical therapy. I could barely even walk, let alone do physical therapy.

It turned out he had dislocated my pubic bone. When this happens, you can't walk. You don't have any stability. Nobody could figure it out because he just did a hip panel. Finally, I had the doctor do a whole pelvic panel and they saw the dislocated pubic bone.

Also, after that surgery, my first night in the hospital was a bit alarming. I had to go to the bathroom. The nurse brought me a wheelchair, but because of the equipment around my bed, she had to stop a few feet away. She wanted me to hop a couple steps to the wheelchair. I said, "I don't think my doctor wants me to hop." I picked up the phone and said, "Do you want me to call my doctor?" She left, a different nurse tended to me, and I never saw her again. Also, nobody asked me to hop after that.

That was my first time having to advocate for myself. I had to do it again when I needed more help because I couldn't get around. I was limping and it hurt horribly. I was pain-free lying motionless or walking on crutches if I didn't put any weight on that leg, but other than that it was excruciating. I reported this pain to my general physician, and he ordered an extensive physical therapy regimen. Six weeks of hip therapy, six weeks of ankle therapy, six weeks of back therapy. He also got me fitted with orthopedic shoes.

He did all he could. I even started acupuncture therapy to ease myself off pain medication.

John: I don't think anyone who knows you now and doesn’t know your history would have any idea you’ve had all these hip surgeries.

April: And I’ve only told you about the first three. My final two went well, thanks in part to medical advances. I also had a doctor who was very caring. My only complaint was once again I was only prescribed the regular six weeks of physical therapy. Therapy is essential but it’s far from complete care. They also need to inform you of things like what durables you need and what your diet should be. Those are things I’ve learned through the years doing it myself. What I needed to do, to be at the best health I could be.

John: So after going through this yourself, you decided people need assistance so they don't have that same experience.

April: That’s right. I'd been active on social media quite a long time. Even before Facebook, there were niche websites. One is called *Totally Hip,* a place for people to share their stories so others can learn from their experiences. I'd been active on that site forever. When Facebook became popular, communities like *Totally Hip* exploded in popularity. After seeing how many people had similar struggles with their medical

and surgical journeys, I knew there was a market for health advocacy.

Hip surgery is the number one orthopedic surgery in the world. The actual surgery is pretty simple, but you have to be prepared for it, and then you have to know what to do afterwards.

John: In your practice, do you specialize in helping people with hip problems, or do you work with anyone?

April: I help anyone going through a complicated medical situation. I have had a lot of experience being a navigator for friends and family.

John: Let's talk about a navigator. A lot of people don't know what that is.

April: I call it either bedside or medical navigator. It's someone who holds the person's hand as they prepare for doctor's appointments, goes with them, takes notes, visits them in the hospital, and makes sure their home is ready for them to come back.

Different surgeries have different precautions afterward. You have to be prepared. For instance, you can't get your hairdryer out of the bottom cabinet, because you would bend past your precautions.

John: You're going to help them visualize what they're going to be doing during this recovery process.

April: Right, the activities of daily living. How are you going to fulfill those? And not just after surgery. There are issues with various medical conditions. Take cardiac patients. They need to have a precise scale at home because they need to weigh themselves daily. In the hospital, they constantly weigh you and take your blood pressure and pulse. You need to keep doing that at home.

John: So your clients would not just be surgeries or injuries. It could also be people dealing with chronic illnesses.

April: Yes, even rare diseases. If any patient is having difficulty communicating with their medical team, I can be instrumental in helping with that. I can show you the best way to engage with them, and make it as easy as possible to get the care you want. For example, if your doctor is extremely busy, let the scheduler know you'll take cancellations. That helps them because it shows them you're flexible, and it helps them fill holes on their schedule. Cancellations become downtime for them. You're helping them be more efficient and more profitable.

Many people don't realize there is an abundance of patients and not enough caregivers. Doctors can get overwhelmed. The easier we can make it for them to meet our needs, the more we're going to get that little bit of extra help.

John: Often one spouse outlives the other for many years. Many seniors have children living across the state or country. Many people are dealing with an illness or injury on their own. And I would imagine even someone who is normally very sharp and organized can be stressed by a diagnosis and need a little assistance in guiding them through their medical journeys. Not to make decisions for them, but explain all their options.

April: Exactly. Exploring all the options is a complicated equation. I understand it completely. I've been the patient in the room so many times. You hear that diagnosis and it can be devastating. I call it "micro-grief". You may not hear or comprehend what's said after that. You really need someone there to absorb all that information. I can do that. I prepare my clients beforehand, make sure we have the most important questions ready, get them answered, and explain it to them in detail afterward. I'm actually helping the doctors as well, because they don't have to spend as much time explaining details to the patient.

And afterward, if there is a question I can't answer, I can call the doctor's assistant and get the answers. I can also write down the medications that are being requested and look those up and see if there are any interactions with what the patient is already taking. So I'm not just helping the patient, I'm helping the whole system run better.

Another thing I can do is assist with compliance. Most patients are not very compliant. We don't take our medications the way we should. We don't do the therapies the way we should. I can help encourage people to do that and stay on track with these daily tasks.

John: I'm sure there are regulations in the field of patient advocacy. Is there a code of ethics?

April: Yes, it's called "The Code of Conduct & Professional Standards." It's quite lengthy. Some of the key points are transparency and patients' rights. Transparency is one of my favorite things. I want to be as transparent as possible with my clients, because my ultimate goal is that they don't need me anymore, that they learn how to advocate for themselves.

For example, my first client. I talked to her on the phone for 20 minutes. I explained how you get ahold of the doctor, how you let him know what your problem is, and how you get it resolved. She was thrilled. It only took 20 minutes and now she knows how to do that. She doesn't need me to do it for her.

This is a very important component. It clearly states, we can guide and assist client patients in medical decision-making but at no time make decisions about health or medical care or payments for medical services on their behalf.

John: How would you handle a client who is outside your area of knowledge?

April: I know I can’t do everything. I have a referral network. I have some advocates in my network with specific knowledge of some rare diseases. I can refer my clients to these advocates as necessary. This takes some discipline and me saying “no” to potential clients at times.

John: So you have to set boundaries also.

April: Yes. There are things I can’t legally or ethically do. In addition to boundaries, I also stay up to date on the most recent information. I have a long list of very well-respected websites to find out about disease processes. I also know nurses and doctors, and can talk to them. I'm not doing this by myself. It is a single business but I can't do everything in all of it.

I really appreciate you asking about that because advocacy is an old but new thing. Families and spouses have always advocated for each other in medical situations. We’ve just professionalized it because, as you pointed out, families are so much more fractured, and the medical system has become way more complicated.

John: But even in the case of family members, if you go to the physician with your spouse and you're discussing a serious issue or a significant diagnosis, it’s likely

you'll both be in shock. A professional advocate is less emotionally invested than a patient.

April: Right. Patients and their families are both hit by that micro-grief. I adjust all parts of your life. I cover the medical, the emotional, the social, the environmental, the spiritual, community and more.

Community is an important aspect. When someone has a long-term illness, at first everybody is there to help. But as you manage that illness for however long you're dealing with it, you need to maintain contact with that community over a long period of time. For example, a patient may go back to their church and ask is someone could come and mow their lawn. There are great tools online you can set up to get that kind of care. I can get you plugged in and get people around you to make that burden easier.

John: As I was researching advocacy, I saw a physician's blog post on the Johns Hopkins site, saying he encourages patients to bring a patient advocate to appointments. Overall, how do physicians and the medical profession respond when someone has an advocate with them?

April: Initially, they're taken aback a little. I think they see me as a little bit of a threat because I might challenge their decisions. I might offer up different ideas, but I really try to put them at ease saying, "We're all working together here. I am not trying to undermine

anything you do." In fact, I'm hoping to help encourage the patient to understand more, because I rarely see a person who doesn't want to be educated about what's going on.

I'm going to encourage patients to follow what their doctors are offering unless I see some egregious error, and then I'm going to say something because that's part of our ethics code. And yes, sometimes doctors don't like that, but I'm all about that transparency and honesty because when it comes to medical issues, we're all aiming at the same end result, which is the best outcome possible.

John: Great points. None of us escape this life unscathed. We all end at some point. Do you find that you end up having end of life discussions with folks?

April: Not as often as I would like. I wish end of life discussions could be done upfront with my clients, but it would be really off-putting. It's such a touchy subject. You don't want to assume anything. I try to get to know my clients as well as possible, but you never know how people will react to that discussion. I'm very comfortable with the end of life. It's been in my family forever. My mom worked at a mortuary. My grandmother was a home health aide. I grew up hanging out with old people. I have no problem talking about death, but it's a very touchy subject in this society, so I tread lightly. But it's so important.

If they’re tech savvy, I send people to a fantastic website, https://www.gyst.com/. It stands for “get your you-know-what together.” The woman who started it lost her husband in a bicycle accident. They were young and hadn’t prepared anything. It was tragic. I met her at an advocacy conference.

She set up the website so it covers all the legal ramifications of your end of life choices. It follows all the laws for each state. Some states allow you to do your own paperwork, while others require a lawyer. You just select your state and the site will guide you through the entire process.

And it's not a downer. It's a really uplifting place. Although planning your own end of life may sound dreadful, this site makes it empowering, and encourages families to talk about end of life planning.

John: Some people leave scratching and clawing and fighting for every last breath, no matter how much they’re suffering. Others seem to be at complete peace. And you often see different family members wanting different things. One might want that person to fight for every breath, while another says, “I don’t want to see them suffer anymore.” This is a difficult conversation to have with families.

April: But it’s so important. It’s a tragedy when someone passes and their family doesn’t know what they want to do for their end of life care. Which is why I try to

have that conversation as soon as possible, as soon as I think we're comfortable enough with each other to do that.

I'm young, but something could happen to me any time. Luckily my children know what I want. I'm going to have my body sent to the University of Washington so they can do whatever research they want. Science is going to learn from my body, and that just thrills me. I had one of the first non-cemented hips. They can learn more about it.

John: The field of health advocacy is really not very well known. Many people are not aware of it at all. So how do you promote yourself in the community? How do people find out about you other than word-of-mouth?

April: If they search online for health advocacy, I show up, because I'm the only one in the area. I also get a lot from the WASHAA (Washington State Health Advocacy Association) website. And I'm on social media.

Looking ahead, I think the best way for me to do it is to educate the medical community more, so when they find someone who's struggling and seems like they want some help, they might think of me and say, "I know someone who can help you with this."

Three things need to happen for someone to think they need an advocate. First, they have to know that advocates are available and what they do. Second, they have to have the wherewithal to find them. And third, they have to have the actual need. I just try to blanket everybody so when they get to that point of needing it, they know where I am and when they can find me.

John: Are there any questions that you wish I would have asked you?

April: I'm really excited about certification. That may help with marketing too, having some letters behind my name. The Washington Advocates began thinking about certification quite a few years ago, but it takes a lot of time to get everything worked out. They recently created certification programs that are quite robust. They just gave the first test in March, 2018. I tested in September, 2018. Obviously the medical field has a wide range of certifications. I think this will give the profession of advocacy some legitimacy, especially to other professionals.

John: I have one last topic I'd like to discuss. Many hospitals and insurance companies have what they call patient advocates. But aren't they really the institution's advocate?

April: Yes, you have to look at who's paying that person. An "advocate" who's working for the hospital or

insurance company will have their interests in mind. I work for my clients. Their interests are always my top priority,

John: So if the hospital or nursing home has a patient advocate or social worker, it's not that you shouldn't listen to them, it's just that you have to realize they're being paid by the institution that is supplying their services.

April: Exactly. Patients have to be careful to understand an advocate's goals. Hopefully everybody in the medical field is going to be as transparent as possible, but sometimes it's not spelled out. Patients have to be aware.

John: Thank you for your participation April. You provided a lot of very useful information to anyone who is going through this type of situation.

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It is not uncommon for people to attend doctors' appointments and treatments alone, with so many families living great distances apart. Having a patient advocate for yourself or a loved one can improve your healthcare results by having a person who is tuned in to your needs. They can

ask clarifying questions and take notes for you so you can adhere to medical advice.

How many times has a family member asked you about your appointment and you could not remember the details? I know this has happened to me as I tried to understand an unexpected diagnosis.

Patient advocacy is a relatively new field but with people like April in the career, I expect many more people to benefit from these professionals.

CHAPTER 8

SABRINA GONDER

Sabrina Gonder is the owner of *Get Healthy with Sabrina* in Spokane, WA. She is a Certified Holistic Health Coach, board-certified Nutrition and Holistic Health Counselor, and a Certified Corporate Wellness Specialist**.**

Sabrina is also a graduate of the *Institute for Integrative Nutrition*, where she trained in more than 100 dietary theories and studied a variety of practical lifestyle coaching methods. She inspires others to live life to the fullest by integrating a positive mindset through nutrition, physical activity, relationships, spirituality and career.

It is never too late to take steps to enjoy a healthier life. So many decisions we make today will impact our future lifestyle. It is great to have a resource like Sabrina Gonder to help people learn about fitness and nutrition.

Living independently as we age has a lot to do with maintaining a healthy weight and minimizing age-related muscle loss. Sabrina is passionate about helping people reach

their healthy living goals. I am excited to share this very interesting interview with you.

John: Sabrina, what is the primary focus for *Get Healthy with Sabrina?*

Sabrina: I'm a board-certified health coach and a corporate wellness specialist. My primary goal is to educate and support my clients so that they can live their best life, whatever that looks like for them.

John: Do you have clients who come to you from private life or is it through referrals from physicians? How does that work?

Sabrina: My clients come from both sources and people find me through personal referrals. I'm on social media, Facebook, LinkedIn, Twitter and Instagram. My office is within Pearson & Weary Chiropractic. I have four physicians at Pearson & Weary Chiropractic, as well as three massage therapists and two movement specialists who refer to me. Then I have physicians from the community who refer to me. The average visit with a physician now is seven to eight minutes, and they just don't have time to talk about the types of things that I can help people with.

John: Do you work with all ages? Is your primary focus with seniors?

Sabrina: I have a broad age range, but most of my clients are 40 years and older.

John: Some of what you're discussing reminds me so much of the emotional cycle of change. What's the most challenging thing for clients to adjust to as they make these changes in their lives?

Sabrina: Change, number one. The brain doesn't like it. We like the familiar. So change can be really threatening. Eating differently can be really hard for people, because we have what I call an historical way of eating. Whether that's because mom and dad made you clean every bit of food off your plate, and you have a hard time as a 60-year-old leaving that little bit of food even though you're stuffed. It might be the foods you ate as a child that you're still eating into adulthood, even though you know those aren't the best foods.

John: The emotional aspect of change can be difficult for many people.

What's the process that you take new clients through?

Sabrina: I have a primary intake that I take all my clients through. I ask questions to find out what they want. It’s a data gathering process, especially in the beginning, and all along the way. It's really about discovering what they really want for themselves.

John: Is it a challenge when the individual can't clarify what he or she wants?

Sabrina: It can be. I'm in this fantastic training called Intrinsic Coaching. It’s a completely new way of getting people to share what they want. A lot of people haven’t been asked that, or they haven't been asked for a very long time, and they haven't thought about it.

John: It seems like a lot of people are afraid to get clarity with purpose. It may be because once you have that clarity, you have to take accountability.

In addition to your work with individuals, do you work with groups?

Sabrina: I teach a lot of different classes. I've taught workshops on sugar addiction, stress management, Kombucha, and depression. Those are always taught in groups. In the corporate setting I teach group classes. I enjoy that because there's a lot of learning that goes on outside of what I've brought to the workshop. Somebody might share that they've made this, or they've eaten that, or this is their experience, and the great results they are having.

That's really powerful. Healthcare is headed toward the use of more group settings. If you're a diabetes doctor, and you have a class for all your diabetic patients to attend, you might have 20

people who show up. You share the information that you would have had to share 20 separate times. It’s efficient for the provider and the coach, and it's also very powerful because you have that group dynamic.

John: I've noticed a lot of discussion in the news and journals about the effect of inflammation on health. How does diet affect inflammation?

Sabrina: It's the main driver. In the chiropractic setting everybody who comes in the door is inflamed. They have pain. If they are inflamed because their knee was injured and they get it worked on that can help. But if they're drinking pop and eating sugary carbohydrate laden foods all day, they're still creating inflammation in the body that's going to affect that knee.

John: What causes inflammation? I've always thought inflammation was caused by trauma, primarily a sports injury or overuse or whatever. I'm trying to understand how diet affects inflammation.

Sabrina: Diet is a huge part of it, and it is one that people have a hard time wrapping their brain around because, like you, they think it's from an injury. When you cut your skin and that becomes inflamed, it gets red. Our bodies are amazing. They will heal that spot. Maybe you'll have a scar, but that inflammation will go down, the wound will heal, and you go about your way. Many of us

fuel their bodies with sugars and toxins, the average woman puts over 200 toxins on her person before she walks out the door every single day.

All those toxins create inflammation in the body. There's that internal inflammation that you can't really see. I work with a device called the BioPhotonic Scanner. It measures a person's antioxidant level. The reason that's important is that can be a marker of what's happening inside. If your inflammation level is high, then your antioxidants typically are lower. You want the antioxidant level to be high. That lack of high antioxidant protection and the resulting high inflammation can lead to diseases. It’s a fun tool that's non-invasive. It takes 30 seconds to measure the score. Then we can have that anti-inflammation conversation. That comes into most of my coaching sessions, how to get people out of that inflammatory space.

John: Is it primarily sugars? Would that also include white breads, white pasta, and things like that?

Sabrina: Yes. Sugar is one of the biggest drivers of inflammation in the body.

John: When someone works with you, Sabrina, is there a typical time frame for that relationship?

Sabrina: There is, and it depends on what's going on in the body. If they want a few tips on how to clean up their diet, and they're eating pretty clean now, and their life is pretty good, it might take three sessions. I don't hang onto people longer than I need to, because I'm not doing my job if I don't get them where they want to be and get them on their way. A typical program for somebody who’s really trying to eliminate inflammation, or drop a significant amount of weight, or really deal with a stressful situation in their life, would be a three to six-month time period. And that might sound long, but I don't see them every week. I see them every other week. So that would be six to 12 sessions.

John: If they're making progress, that's great. If they're not making progress, that's probably why they need to see you even more.

Sabrina: That, and they might be stuck. It depends on the person, and it depends on how motivated and how supported they are.

Everybody's different. I just hold that space and love them through it, because they are competent, capable, and complete as they are.

John: From listening to your enthusiasm my guess is you're a combination life coach and wellness coach. You veer into the life coach area too, right?

Sabrina: Absolutely. In fact, more people remember me as a life coach. That's exactly what I do all day. I help people with whatever they need to address. What I do is almost a hybrid. It's like a life coach with this huge dietary training track.

John: I know over the years when I was hiring and training employees, the more successful I was at affecting how they responded to their perceived pressures, insecurities, and doubts, the more successful and happier they were. The emotional connection is so important for people to have success in their life.

Sabrina: I love that you get that, because over 70% of people are not happy in their job, and we spend so much time there. That's one of the things I can help people with as well. Either finding something, one little thing they like about their job, and building on that, or helping them to explore other options. I've been in jobs where I wasn't happy, and it's miserable.

John: People sometimes have unrealistic expectations, especially with the explosion of Facebook and social media. They get this idea that everything needs to be perfect all the time, but that's abnormal. The normal thing is to have a few challenges here and there, and to work toward overcoming them, and not be so disappointed that things aren't perfect all the time.

Sabrina: It is important to feel safe to share your concerns with somebody. I think people are lonelier now with all the social media than they've ever been in history. With all this "connectedness," I think people feel more disconnected, because there's very little face-to-face interaction. I do coach over the phone, but my preferred way is face-to-face, because I can see their body language. Of course, I can hear the tone both ways, but it's just a different interaction when you're with a human being.

John: So much of social media is superficial anyway.

Sabrina: We're not going to put our worst look, our worst meal, or whatever online for everybody to see. It's our vacations, our grand babies, or babies that we showcase. We post all the things that we want to look good at, around, and with. It is a kind of falsehood.

John: Let’s discuss working with people with chronic health conditions.

Sabrina: I help people with chronic health conditions, and that's more of my aging population. It goes back to a lot of different things. It could be looking at trauma or looking at their history of eating. Our food isn't the same, and that conversation happens with most of my clients. You might be eating three or four servings of fruits and vegetables a day, but it just isn't enough anymore.

It’s looking at ways to get more of the good, and less of the bad, and helping them to reach their goal.

What's critical is that there's an early win because we're impatient. That gives them some hope. If there's no hope, there's no chance that they're going to do much of what is discussed or agreed upon. I partner with my clients. I say it's not a dictatorship. I don’t tell you what to do. You come in, and I really want to know what you want, and then I will help you. I partner and walk that journey with you to get you where you want to go.

I offer support via texting, phone, and email in between sessions, as well. Typically, sessions are every other week, so that people have time to incorporate those changes they've decided they want to make. If you meet more frequently than that, it's often not enough time for them to get those changes into their life.

John: Both of us work with a lot of seniors. One of the things I've noticed is how much their lifestyle changes when they lose their husband or wife. There's less cooking, because you're cooking for one instead of two. There may be less structure to their day and that seems to lead to more processed foods versus the types of foods they used to eat. Do you see that as well?

Sabrina: Absolutely. When you look at our grocery stores, look at how many more refrigerated cases and freezer cases have been added than we had not that many years ago. It is more challenging to cook for one unless you've got a significant amount of freezer space. I'm always encouraging people to cook once and eat multiple times. It doesn't mean you have to eat the same thing all week long. You can freeze it and have it another day, another week. That is a big challenge for our seniors. They want to buy foods in portions for one and in appropriate portion sizes.

John: The other thing I see is that once people start developing those chronic health issues their willingness to exercise decreases. People think of exercise as a structured thing, but it can be something as simple as walking. Some people have a real challenge motivating themselves to walk.

Sabrina: That's where community comes in. I think that the social isolation that's happening, not only with our seniors but especially with our seniors, is damaging and leads to people passing earlier.

John: When you work with a couple, let's say you work with an individual who's married, do you find that there's a spillover effect?

Sabrina: That's always the hope, and generally yes. Those at home can also be saboteurs as I call them. A good example is if somebody wants to get off potatoes,

and they want to eat cauliflower mashed potatoes, but the husband or kids won't eat them. Primarily, I work with women. I think women seek out help a little bit earlier and more often than men do. So, they'll try something new, and they'll get pushback. So that can be a challenge.

The beauty is when it does spill over in a positive way. I had a fantastic experience with a client who had diabetes. Her husband also had diabetes She has two children. She was just in tears over this diagnosis. It was very traumatic to her, and she took it very seriously. She went through my program, reversed her diabetes, and she got her boys eating better. They had never eaten vegetables in her house. Zero. No vegetables, nothing green. So, she introduced all different types of vegetables, and the whole household was eating vegetables. They all lost weight and they were feeling better. That is what excites me. Those changes are what get me up in the morning. Who knows what she's done for that family by making those shifts?

John: I appreciate your bringing up chronic health conditions. Unfortunately, that's a part of aging for many people. Having some professional advice on how to cope and deal with that, and hopefully implement changes that can improve quality of life, is so important. You can make a big impact on

the quality of a person's life, even with chronic health conditions.

Sabrina: Absolutely. You know that saying, "If I would've known I was going to live this long, I would've taken better care of myself." I think that we have to think with the mindset that we're going to live to 100. There's no reason why we shouldn't all live to 100.

Folks who live in the Blue Zones, as Dan Buettner has called them, live multi-generationally. They're in community every single day. They're physically active. It doesn't mean going to the gym. That's why I use the term movement instead of exercise, because the word exercise has gotten a bad reputation. Their exercise might be gardening or walking child to school, or something like that. They all eat regionally. The only such place in the United States, sadly, is in Loma Linda, California.

Something interesting about that is that they have two growing seasons. We don't have two growing seasons here, so it makes it more challenging to get fresh produce. All of those things contribute to those people living to 100+ on a regular basis. It's not the exception, it's more of the rule. It's all of those components. It's the connection. It's having a purpose for getting out of bed. They are either cooking, cleaning or helping with the kids. If we look at that more closely, I think it would really

help with the chronic health conditions in our city, our state, and our country.

John: When I was younger, I always thought that the normal progression was to work hard, save your money, and retire. What I noticed is that there are a lot of people in their 70's and 80's who are still very much engaged. They're not working because they have to. They're working because they have purpose. They do something that's meaningful that they're passionate about, and they're staying engaged. As I've gotten older, it's completely changed my opinion about whether you should look forward to, at least for me, I can't speak for everybody of course, to completely retiring.

Sabrina: That's what I love about my work. As long as I can speak and have my mental faculties, I can work until the end of my days. That's a really important topic. When people aren't happy in their careers, they're counting the years, the months, or the days until they can say, "I'm out of here, I'm retired." And the people that are the healthiest are the ones that still have some kind of meaning in their life, whether it's volunteering, or working for some amount of money, or helping within the family. I see that all the time.

John: How do people get hold of you?

Sabrina: They can reach me through my email at gethealthywithsabrina@gmail.com, or they can

call me at 509-270-2665. I also have a website. It's gethealthywithsabrina.com.

John: When people call you, do you conduct a screening on the phone and then schedule an appointment? Do you have a consultation face-to-face? What's that first approach?

Sabrina: It depends on how they came to me. If they've been referred to me from a physician, then usually it's, "So-and-so referred me, and they want me to see you for this." It's a little quicker with somebody who has been referred. If it's somebody who has heard about me from a friend they might say, "My friend said I should talk to you, but I don't really know what to talk to you about," then I'll go into a lengthier question and answer series, to see if we're a good fit.

John: I am so grateful that you took the time to talk with me today.

Sabrina: Thanks so much.

To Contact Sabrina Gonder:
Phone: 509-270-2665
Email: info@gethealthywithsabrina.com
Website: http://www.gethealthywithsabrina.com/

Many people are intimidated about starting a weight loss program or going to a fitness center. It may have been years

since you have been active in any type of physical activity, so it is a good idea to have someone like Sabrina to provide education in both nutrition and safe, fun activities to improve balance, strength and overall fitness.

I think you will find it very enjoyable as Sabrina has a passion for helping people. Don’t wait for a new year’s resolution to start down the path to a new you. You deserve it.

CHAPTER 9

MEDICARE FROM A to D

I want to take the next few pages to lay out some of the basic information about Medicare. Let me emphasize "few pages". If I were to cover all the possible scenarios and situations and solutions, this chapter would make *War and Peace* look like a pamphlet. But this should give you a general idea of what you can get and how to get it. However, I encourage you to speak to a local professional in your area to get personalized advice.

Enrolling in Medicare

There are certain situations where a person will automatically receive Medicare benefits. The most common reason a person receives Medicare benefits prior to age 65 is because they are disabled and have been receiving Social Security benefits for at least two years. They will be enrolled in Part A and Part B which will be explained later.

Most people pay Medicare taxes during their working years. If you or your spouse are applying for coverage due to turning 65, one of you needs to have at least 40 quarters of employment in which you paid Medicare tax. Under these conditions, there is no premium to enroll in Part A. Note: You should enroll in Part A even if you continue to work past age 65 and have health insurance through your employer. The size of the company you work for will determine if Medicare Part

A is your primary or secondary coverage. Part A is primary for employers with 20 or fewer employees and secondary for those with great than 20 employees.

If you are receiving Social Security income prior to age 65, you will automatically be enrolled in both Parts A and B, which will take effect on the first of the month that you turn 65. If you are not receiving Social Security income prior to age 65, you need to contact the Social Security Administration to enroll. Although there is no premium due for Part A for most people, Part B does have a premium. In 2019 the premium for Part B is $135.50 per month. The government typically releases the next year's premium amount in November. It is projected that premiums will increase approximately five percent per year through 2026.

You should be aware, Medicare premiums are higher for high-income earners. That is a small percentage of overall retirees, so I am not covering the specifics here. The main thing to know is if your household income is below $170,000 per year, you will pay the standard premium. Contact Social Security or your local advisor if you are in the high-income group.

Low-income households may have lower premiums. A person receiving Medicaid may be eligible for subsidized Medicare coverage, or even qualify for coverage at no personal expense. There are specific plans for lower-income people, who are classified as fully dual eligible. Anyone who is on Medicaid for at least two years regardless of age should review their options with an agent who specializes in Medicare to learn about the plans available to them. Many of

these plans include benefits like dental, vision and over-the-counter products.

These days, it is more common for people to work past age 65. If you do, you have the option to enroll in Medicare or continue your health coverage through your employer if available. It is a good idea to compare the cost and benefits of both. Your HR department and a professional insurance agent can help you with the information you need.

Don't procrastinate! There are specific times when you can enroll in Medicare. If you do not enroll during your initial enrollment eligibility period, you will face lifetime penalties when you finally enroll. You can sign up for coverage three months before your 65th birthday, the month of your birthday and three months after your 65th birthday. I will include a chart later that will show you all the enrollment periods.

There are several options for enrollment. You can apply for Medicare online at www.ssa.gov/benefits/medicare/. You may also enroll by phone by calling **1-800-772-1213**, or schedule an in-person appointment at your local Social Security office.

Once you have enrolled in original Medicare, you still have some choices to make. You must understand what is covered with Parts A and B before you make those choices.

Original Medicare is provided by the federal government and consists of Part A and Part B. The government pays your healthcare provider directly for covered services. You can go

to any doctor in the country that accepts Original Medicare. You do not need permission from your primary care physician to see a specialist. You typically pay a co-pay for each service you receive, and there are limits on the amounts that doctors and hospitals can charge you. Your out-of-pockets costs can still be quite high with Original Medicare when dealing with serious health issues, but there are ways to minimize your out-of-pocket costs. We'll address them a little later.

Part A

Just what is Medicare Part A? It starts with hospital care. Whether you are in the hospital for a serious injury or disease, part of the hospital stay is covered under Part A. You may be released from the hospital to go home but you may also be referred to a skilled nursing facility, nursing home care, hospice or home health services. All of these have some coverage under Part A.

Part A benefits begin on the first day you receive service as an inpatient in a hospital, and end after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

Medicare Part A will pay for your semi-private room and board, general nursing, and miscellaneous services and supplies except for your co-pay. Your co-pay out-of-pocket cost in 2019 under part A is $1,364 for up to 60 days of hospitalization. If you are hospitalized more than 60 days, you will pay $341 per day for the 61st through 90th days. If needed,

there are an additional 60 lifetime days, which will cost you $682 per day.

Part A also covers approved skilled nursing care once you are released from the hospital. You must have been an inpatient in the hospital for three days and enter a Medicare-approved rehabilitation facility within 30 days after leaving the hospital. Medicare will pay all approved amounts for the first 20 days. If you need longer care, Part A will pay all costs except $170.50 per day for days 21 through 100. You will have no coverage past 100 days.

Most expenses associated with hospice are paid by Part A, assuming you meet Medicare's requirements. The primary requirement is a physician's certification of terminal illness. Out-of-pocket costs associated with hospice care consist of very limited co-payment and coinsurance for outpatient drugs and inpatient respite care.

Part B

(Remember that you pay a premium for Part B of $135.50 per month for 2019)

Part B of Original Medicare helps pay for your physician visits and outpatient care. You will have a deductible of $185 as of 2019, plus your co-pay of 20% of covered services. This coverage includes medically necessary services and supplies needed to diagnose and treat your medical condition.

You do not have out-of-pocket costs for most preventive services, which include some screenings and vaccinations.

Part B covers additional things like clinical research, ambulance services, durable medical equipment, inpatient and outpatient mental health and getting a second opinion before surgery.

There is no cap on your out-of-pocket costs with Original Medicare. You need to consider how high the 20% co-pay on Part B expenses can be. That is why many people consider adding a supplement plan, also called Medigap Insurance, to Original Medicare or decide to purchase a Medicare Advantage Plan instead of Original Medicare. We will compare these options soon but first, I would like to go out of alphabetical order and explain Part D before getting to Part C.

Part D
Prescription Drug Coverage

Although Original Medicare Parts A and B are provided by the federal government, Part D is provided by private insurance companies who have contracts with the federal government. This is not required coverage, but it is highly recommended. Most of us will end up with multiple prescriptions as we age and many of them are very expensive. If you do not purchase a prescription drug plan (PDP) when you are eligible, if you ever do decide to purchase a plan you will pay a permanent penalty of one percent per month for each month you did not have coverage. This may not seem like much of a penalty, but here’s the math: three years without coverage means a permanent 36 percent penalty if you then buy a PDP. I have met many people who are in their late 60s and early 70s who now need drug coverage, and are stuck paying much higher

premiums because they did not put a plan in place when they were first eligible.

You can get a PDP by purchasing it from a private insurance company to go with your Original Medicare or you can purchase a Medicare Advantage Plan that includes prescription drug coverage. I will discuss Advantage Plans (Part C) in the next section.

As you read earlier, I live in Washington State. Here, the cost of a PDP ranges from$13.60 per month to over $100 per month. You should not make the mistake I see so many people make by purchasing a plan based on the premium. Each plan has its own deductible, co-pay and formulary. A formulary is the list of drugs covered by that plan. Therefore, it is important to compare the total costs of the plans based on your specific prescriptions. I ask my clients to keep me updated on their prescription changes, so we can make sure their current plan is still appropriate for them. Changing your PDP as your prescriptions change can save you plenty of money. It is normal to resist change and keep the same PDP for years, but you may be wasting hundreds or thousands of dollars every year. Let’s look at the payment stages of a PDP.

Annual Deductible

Each PDP plan has an annual deductible. Some deductibles are zero. In 2019, PDP deductibles will range from zero to $415. Your plan will not pay for prescription expenses until you have paid your deductible. You will pay for your drugs out-of-pocket until you reach your deductible amount.

Initial Coverage

Once you have met your deductible, you enter the initial coverage stage. In this stage, you pay a co-pay or coinsurance. The amount you pay will depend on the specific drug and what tier the drug is in the formulary. Your plan will likely have five tiers of drugs:

- Tier 1- Preferred generic
- Tier 2- Generic drugs
- Tier 3- Preferred brand name drugs
- Tier 4- Non-preferred drugs
- Tier 5- Specialty drugs

In 2019 you will stay in the initial coverage stage until you and your plan pay a total of $3,820 which is based on the retail costs of the drugs. Many people stay in this stage the rest of the year and never enter the coverage gap, also known as the donut hole. While in the initial coverage stage you will pay a co-pay, which is a flat amount per prescription, or a co-insurance which is a percentage of each prescription cost.

Now let's look at the coverage gap, which is based on the Total out-of-pocket costs, also known as "TrOOP". TrOOP includes all payments for medications in your drug plan formulary and purchased at a network or participating pharmacy. This stage includes your deductible (if any), and your co-payments or co-insurance during the initial coverage stage. After spending $5,100 out of pocket in 2019, you move to the catastrophic stage of Part D coverage.

Once you enter the catastrophic stage, you pay the greater of a percentage or co-pay for the rest of the year. The

percentage you pay during the catastrophic stage is five percent of the drug cost. The co-pay is $8.50 for brand name drugs or $3.40 for generics. Your cost is determined by which figure is higher.

Medicare Part D: Prescription Coverage
Who pays what?

Step 1:	**Annual Deductible: up to $415**	**Total Cost of Drugs: Many plans have $0 deductible**	- **Member Pays all** **Plan pays nothing**
Step 2:	**Initial Coverage: Less than $3,820 based on retail costs**	**Copays or Insurance**	- **Member pays part** - **Plan pays part**
Step 3:	**Coverage Gap: Less than $5,100 based on Tro-oP**	**25% of Brand-Name Drugs 37% of Generic Drugs**	- **Member pays MOST** - **Plan pays little**
Step 4:	**Catastrophic Coverage: Greater than $5,100 based on Tro-oP**	**The greater of 5% or $8.5- (Brand Name) $3.40 (Generic)**	- **Member pays a little** - **Plan pays most**

If you want prescription drug coverage while on Medicare, you will purchase either a stand-alone PDP to go with original Medicare or a Medicare Advantage Plan that includes prescription drug coverage. In either case, you must live in the service area of the plan you want to join. I also want to stress the importance of comparing plans periodically, especially if you are prescribed new drugs since you purchased your current plan. Plans may also change their formulary from year

to year. They will send you an annual notice of change to notify you of their changes, so it is important to pay attention to the material you receive from your insurance company.

You can go to www.Medicare.gov to compare plans yourself. You can also contact volunteer organizations that provide free help with Medicare and health care choices. The one here in Washington State is SHIBA (Statewide Health Insurance Benefits Advisors). Call them at **1-800-562-6900** to find local SHIBA resources. All states have similar organizations that go by different names. Of course, you can also call a local licensed insurance agent. Your insurance premium will be the same no matter how you purchase a Medicare plan. Insurance agents are compensated by the insurance company and are generally able to meet with you when and where it is convenient for you.

Part C
Advantage Plans

Back to alphabetical order now. You may notice that much of the advertising for insurance companies that sell Medicare insurance is for Advantage plans. Advantage plans are required by the federal government to provide at least as much coverage as Original Medicare Parts A and B benefits. When you enroll in an Advantage plan, you will stop getting your Medicare benefits directly from the federal government. They will be administered by a private insurance company contracted with Medicare. Many Advantage plans contract with doctors, hospitals and other medical providers to service their members. This is commonly referred to as the Medicare

Advantage plans provider network. Some networks are larger than others and some physicians and health-care facilities are contracted with multiple Advantage plans. The providers in these networks agree to coordinate care and provide services that may be lower than their normal fees.

Medicare Advantage plans usually offer more benefits than Original Medicare Parts A and B. Many Advantage plans offer additional benefits that may include one or more of the following:

- Medicare Part D prescription drug coverage
- Routine vision care
- Routine hearing care
- Routine dental care
- Gym membership
- Over-the-counter benefits

Over-the-counter benefits will allow the member to order items that you would normally purchase such as medical supplies, vitamins, OTC medicines, bandages, etc. You would normally spend your own money on these common items, but the plan will allow you to order them at no cost to you. Generally, they will also ship these items at no cost. Members place their orders online or call a toll-free number to place an order. Some plans are also providing a debit card that can be used at specific locations, so you can acquire authorized products as you do your normal shopping. I think this will soon become the most common way of accessing this benefit.

The only difference in supplement plans with various companies is the price. That is not the same for Advantage

plans. Advantage plans can have a wide variety of premiums as well as many different coverage options. The same company may also have several different Advantage plans to choose from in the same county. These plans will have different premiums and widely varying optional benefits. You also cannot assume that just because your physician is covered with one plan, he or she will be covered with a different plan with the same insurance company. The same can also be said for drug formularies. This is where an insurance agent that represents multiple companies in your area can help determine which plan may be an appropriate fit for your specific circumstances.

A zero premium plan can be very enticing and may be appropriate for your needs, but it is not the most important factor in making your decision. It is not unusual for your overall annual out-of-pocket expenses to be less with a Medicare Advantage plan with a modest monthly premium than one with zero premium. Advantage plans with an out-of-pocket premium generally have lower co-pays and co-insurance, as well as lower maximum out-of-pocket expenses.

Each insurance company that provides a Medicare Advantage plan also has its own drug formulary, prescription drug deductible and co-pays or co-insurance. They also have their own co-pays or co-insurance for doctors' appointments, lab tests, outpatient surgery, etc. This is another reason it is so important to understand how to compare multiple plans and not just focus on the premium price.

In some cases, joining a Medicare Advantage plan might cause you to lose your employer or union coverage. This means you may lose coverage for your spouse as well. Check with your benefits department before making a decision if you are still receiving group medical coverage when you are eligible for Medicare.

Here is a quick visual review of your Medicare options:

How does my other insurance work with Medicare?
When you have other insurance and Medicare, there are rules for whether Medicare or your other insurance pays first.

If you have **retiree** insurance (insurance from your or your spouse's former employment)…	Medicare pays first.
IF you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **20 or more employees**…	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's **current** employment, and the employer has **fewer than 20 employees**…	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your family member's **current** employment, and the employer has **100 or more employees**…	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family m ember's **current** employment, and the employer has **fewer than 100 employees**…	Medicare pays first
If you have Medicare because of End-Stage Renal Disease (ESRD)…	Your group health plan will pay first for the first 30 months after you become eligible to enroll

	in Medicare. Medicare will pay first after this 30-month period.

Note: In some cases, your employer may join with other employers or unions to form or sponsor a multiple-employer plan. If this happens, the size of the largest employer/union determines whether Medicare pays first or second.

Supplement Plans
(Medigap)

Advantage plans can have many variations in optional coverages, drug formularies and physician networks, which makes it very important to know how to compare plans to your unique needs. Not all counties in all states have access to Medicare Advantage plans, and even if they do, the benefits can vary from one county to another. Supplement policies are very different. These policies must follow federal and state laws intended to protect you, and must be clearly identified as “Medicare Supplement Insurance” These policies are all standardized regardless of which company you purchase from. The policies are identified in most states by letters A through D, F, G and K through N.

All policies offer the same basic benefits, but some offer additional benefits, so you can choose the level of comprehensive coverage you want.

Starting January 1, 2020, Medigap plans sold to new enrollees will not be able to cover the Part B deductible. Because of this, Plans C and F will no longer be available to people new to Medicare. Anyone who already has one of those plans will be able to keep it as long as they are on Medicare.

One of the key features of a Medigap policy is that you can go to any doctor in the country that accepts Medicare. You are not restricted to a network. You also do not need a referral from your primary care physician to go to a specialist. These policies are especially popular with people who like to travel frequently or split their time between multiple residences. Some Advantage plans are expanding their available networks to accommodate this group of people as well but their networks will still be much smaller than original Medicare with a supplement plan.

Please remember, Supplement plans and Medicare Advantage plans are different, but both provide comprehensive health coverage and neither one is better than the other for all people. You can change plans every year during the Annual Enrollment Period if needed. You do not need to do anything if you are happy with your plan as they all renew automatically on January first.

There are plenty of professional insurance agents in your community willing to help you make a good Medicare decision. The right agent will take the time to educate you and let you make a decision on your timeline.

CHAPTER 10

KELLY ARMSTRONG

Kelly Armstrong, MSW is the Executive Director of the *Prescription Drug Assistance Foundation* (PDAF). She has been part of the growth of the organization since 2009 when the first pilot program began in Spokane.

Kelly has more than 30 years of experience working in the healthcare industry as a social worker, case manager and in various management and executive roles. In her free time, she enjoys walking, hiking, snow shoeing, cooking and studying natural health and nutrition.

If you haven't experienced the high cost of many prescription drugs yourself, chances are someone close to you has. This is causing a financial hardship for many families. Fortunately there are organizations like *Prescription Drug Assistance Foundation* that help individuals look for ways to lower their costs for the more expensive drugs they may need.

I have heard from so many people that are negatively impacted by high drug prices. So I was very relieved when I met Kelly Armstrong. I now have a resource to share, to help

people with this challenge. In this interview, Kelly explains how her organization works to help with this important need.

John: Kelly, can you give us an overview of the *Prescription Drug Assistance Foundation*? What do you do, and how was it founded?

Kelly: We were founded in 2005. Dr. Samuel Selinger, who is a retired cardiothoracic surgeon in Spokane, was taking part in a community wide health care taskforce which identified prescription costs as a problem. Some of Dr. Selinger's patients were having these concerns. He decided to devote his philanthropic efforts to this.

The board looked at how we might implement something from scratch in Washington State. One model they found in Kentucky warehoused medications and gave them to people. They decided that didn't really make a lot of sense for us. It seemed like a high cost way to go. We really wanted to be a lean non-profit that fits into the health care system that already exists.

Based on their research they decided on the model that is still close to what we use now. We have organizations in various communities, clinics and hospitals primarily, that give us free space in which to work. In kind space. Our only costs are staffing and supplies. We get our funding through grants and fundraising.

We started some pilot projects in Spokane and Seattle. We help people who are low to moderate income access the prescription assistance programs that are available through the pharmaceutical companies, co-pay assistance foundations, and some generic discount resources. We also educate people on how to find the best prices for their prescriptions.

The roles grew from initially just helping people get on to prescription assistance programs, to what do you need to access your prescriptions. Where are you having difficulty and how can we help you?

John: You're probably overcoming some misunderstandings from a lot of people. They probably assume that you can give them drugs.

Kelly: It gets complicated quickly, and that's one of the problems that we've seen over the ten years that we've been in business. We actually started in 2009. So, the board started in 2005, the first pilot project started in 2009, and that's what we're working from today.

There's an application process to most of these programs, and each of the pharmaceutical companies and co-pay foundations have their own criteria and their own way of accessing their resource. You might have a patient who has three or four medications that are high cost or basics such as inhalers, insulin, and cardiac medications, which is not uncommon. Then we're looking at three or four different

programs, with three or four different sets of criteria, three or four different sets of supporting documents that need to be provided to get through the process of that particular organization. So, that is what we do. We don't hand out medication. We help people use the resources that are already available, nationally, to get those medications.

John: Are all of your clients low income?

Kelly: No. In fact, there's a correlation between the cost of the medication and the amount of income that a household can have. So, I would say the majority of our clients are somewhere between two hundred percent and seven hundred percent of the federal poverty level. The income for a household can get quite high for some of the higher cost medications.

John: That's not taking into account household expenses. It's just based on income.

Kelly: It's based on gross income for the most part. There are a couple of companies that will consider other medical expenses and such, but the majority of them look at gross household income.

John: It's a frustrating thing working for people on Medicare. It seems backwards that medical care itself is not an issue. Medicare is really wonderful insurance for that. The thing that hurts the people is the cost of prescription drugs. It's the thing that just seems to break them.

Kelly: Right. We’re seeing that national attention is on medication costs. It is a problem. We've seen some shifts over the past ten years. Just to go back, in 2009, the majority of our population at that point were uninsured low-income folks. When the Affordable Care Act came into being a lot of those people all of a sudden were now eligible for Medicaid, and they then had access to necessary drugs. When that happened suddenly our Medicare population was growing because their benefits were changing in relation to their prescription drug cost. And their tier levels were changing, and the formularies were changing. I don't have anything scientific to back this up, but it appears that as our lower income populations got access, our senior populations started losing access.

John: I have people who tell me that they go to Canada, probably once a quarter for prescription drugs. As they become elderly, they worry about how they will be able to afford their medications when they can’t travel to Canada. Some of those folks I've referred to you, but not everybody qualifies, right?

Kelly: No, not everybody does. Some companies, for our Medicare Part D prescription drug population, require additional criteria that must be met. For instance, let's say a person needs some of our most common drugs such as inhalers and insulin and cardiac related. Most of the companies that provide inhalers and insulin require additional criteria if you have a Part D prescription drug plan.

The patient may need to spend five percent of their household income out of pocket on their medications before they are eligible which is a real problem for most of our clientele. Other companies will have a set dollar figure that has to be spent by the patient on their medications before they can apply.

People may end up charging some of the cost to a credit card or borrowing money. We'll work with them and say, “You have to meet this threshold and once you do, then we're going to help you apply to get it free for the rest of the year. That’s a hindrance in people getting their drugs. The other piece that is common for patients on Medicare with a Part D drug plan is once we get them eligible for a program, the program ends December 31st and we have to start all over again starting January first with the new benefit year.

A lot of patients may have only met that out of pocket requirement in September or October after paying for seven or eight months, and so they are only able to apply and get covered for maybe a three-month period at the end of the year.

John: So, this is a busy time of year for you.

Kelly: Yes. And then January is going to be very busy again, because we're starting over.

John: It’s almost as if the bigger you get, the more unmanageable it becomes, because you have more and more people that you have to reapply for, right?

Kelly: Yes. We have patients that we've seen since 2009 who continue to come back every year. And we allow them to come back and renew with us as often as they need to and want to. We have other patients who get the hang of the application process who are able to manage it on their own. But the majority of them don't do that. The majority of them prefer to come in, even though they may be capable, because it gets so complicated.

John: Some people may not think that they would qualify, or they don't want to go through the application process. What are some of the cost saving tips that you give people?

Kelly: We teach people that sometimes the cash price of a medication is a lot less expensive than the co-pay.

When you go to the pharmacy you need to be assertive and ask for the cash price of a medication, and then look at what the price would be if you were to run it through your insurance. If the cash price is cheaper, then insist that they don't run it through your insurance.

Another thing is, pharmacies all charge differently. It depends on what they're paying for the medications when they purchase them. There's a markup on all

medications. Pharmacy A may get an Advair inhaler for, I'll make up a number, for five hundred dollars and then pharmacy B has to pay seven hundred and fifty. Maybe pharmacy A is able to buy more in bulk than pharmacy B, or they've got a better negotiating position somehow. The pharmacies take that base price and build their profit margin on top of that, and so your prices will be different from pharmacy A to pharmacy B.

Just recently there's been some research on that in Washington and Oregon, showing the disparity in price can be as much as three, four, five hundred percent between pharmacies. We try to teach people to call around, take a look, especially when you've got new or higher cost medication. The drugs in tiers three and four should be looked at carefully. Shop around before you decide which pharmacy you'll use.

John: It's the same thing with prescription drug plans. Somebody may be on four or five prescriptions and you run the comparisons. One company may be charging 16 dollars a month to cover all those drugs, another company you can get them all covered for 80 dollars a month. So, it's not like those are the same either.

Kelly: There's no consistency.

John: Let's say you've always gone to Walgreens or whatever the company is, but you find that a different pharmacy has a lower cash price for one of

your drugs, you can still get drugs at your preferred pharmacy for your insurance co-pay, but the cash price you can get somewhere else.

Kelly: That's exactly right. We also can help somebody get a drug through a pharmaceutical company. I like to tell people to have a calendar, have an organizational tracking system, because that's the complexity that you're bringing to procuring your medications. You're going to save money, but you will work with multiple resources rather than just one single pharmacy, in all likelihood, in order to get your best prices.

John: What’s the time frame once somebody reaches you?

Kelly: There's a process in place. Generally, our first contact with a patient is on the phone. We'll do a phone screening with them. We ask basic questions. What's your household income? What medications are you struggling to purchase? Do you have insurance? We can quickly determine whether we're going to be able to help them.

Then we'll bring them in for an appointment at one of our locations. If they're not able to come in, we'll do the full process over the phone. We do a phone interview and handle everything by phone and mail.

In Spokane and in Seattle where we have our key sites, people come in for a face-to-face meeting. We go through their medication list to see how we can provide the best service for them. We look for

applications we can do for free medication, which usually is for higher cost brand name medication.

During the appointment we complete those applications. We discuss what supporting documents need to be provided. Sometimes we need to get an itemized printout from the pharmacy so we can establish how much has been spent out of pocket since January first. Sometimes we need to do a low-income subsidy or extra help application. We do those regularly because some of the pharmaceutical companies require that we get a denial before we can apply to them for assistance.

John: How many people do you have on staff?

Kelly: In Spokane we have one-and-a-half. I count as one and then another half. We’re very lean.

Kelly: We are growing. They've picked up on us out there, so we are getting quite a few referrals from Tri-Cities, Moses Lake, a lot of rural areas and Stevens and Pend Oreille Counties, so we're serving a wider area. A lot of organizations have hooked on to us.

John: Let's talk about funding. How do you get funded? Because I would imagine, just based on the growth we've talked about, you're going to need more help.

Kelly: Yes. We're surprised that we haven't grown bigger since we're in our tenth year. Funding is the difficult part. We're grant funded as a non-profit so on top of

seeing patients and running the organization, I also write grants.

We have some long-term funders in the different regions. In Seattle and in Spokane, we have some funders that have been with us almost since the beginning. They continue to fund us year after year. We have to ask for that money or write grants for that money year after year. They continue to do so because our return on investment is so high. We've run anywhere from 18 to 28 dollars per one dollar spent on the program as return on investment, which is extremely high. It’s because we're so lean, so streamlined, and we have so much in-kind support from organizations like this. We hold a fundraiser once a year. We pursue grants, hospital funding, just a variety of things enable us to provide services.

John: Do you get donations from individuals?

Kelly: Periodically. We have a donor page on our website, www.prescriptiondrugassistance.org. We happily accept donations from anybody who would like to provide them.

John: Do you have a newsletter that goes out to folks?

Kelly: We don't. We are a small organization. There's only so much that can be done. Patients are the focus, and we keep up with what we have. We'd love to grow, that's one of our goals that we're working towards.

John: It's such a critical need in the community. There’s rarely a week that goes by that I don't have somebody either in tears or near tears talking about their prescriptions.

Kelly: Usually by the time people find us, they're in that state. They have already exhausted all their resources. They've exhausted all of their financial assets and they're desperate. It would be so great to be big enough to be able to help people before they get to that desperate state.

John: This is a wonderful organization. When I talk to people who utilize your services, they feel that you lifted a weight off their shoulders. You add hope to their lives because they really are in dire straits concerning their prescriptions.

Kelly: That’s the experience we have at all our sites. The service we provide is desperately needed throughout the state and we get feedback from patients in all our communities. It provides support and encouragement, kind of like a hug.

The population we serve is more middle income, maybe lower middle, even middle higher income, and that's not a population that gets focused on. It's a lost population. When we're writing grants, or going after funding, we're trying to do it for a neglected population that doesn't get attention. There's nobody beating the drums out there, saying these needs exist and there's a crisis happening.

John: How do people get involved?

Kelly: There are a couple of things that we've done since the beginning. We do track the value of prescriptions we're bringing into our communities. We have data showing the number of patients we're seeing, what zip codes they live in, what income levels we're working with.

We have raw data that we've been collecting since 2009. That data helps support what we're doing. The second piece, here in Spokane, is we have a research project associated with the program through the Providence Research Center. It is a separate thing. We ask new intakes and new people if they're interested in participating. It’s basically a paper project. We ask people how their health has been both physically and emotionally in the past four weeks. We ask them four times. At intake when they sign up and at six, 12, 24, and 36 months.

That is what the volunteer's doing. We do follow up surveys with the patients asking them again, how has your physical and emotional health been in the past four weeks. It’s called the SF8 survey. It has about eight questions on it so it's pretty quick and then they just rate how they are.

In 2015 and 2016 we were able to work with a statistician at WSU who volunteered his time. We analyzed our first three years’ worth of data. We were able to get published in a peer reviewed

pharmaceutical journal. The data showed that by having prescription assistance programs available in our communities, having a coordinator such as myself, we reduced hospital emergency room admissions by 51 percent. That is a huge statistical number. Also impacted and slightly improved were people's overall feelings of wellbeing.

John: You talked about inhalers, diabetic and cardiac drugs. Those three, if you could make sure people had the proper medication, that would keep them out of the hospital. That would lower complications.

Kelly: That's what we're doing. Our research shows those were our top three medication categories, respiratory, diabetes, and cardiac. It highlights the correlation to the hospital ER admission drop rate in the patient population we're working with. We continue to collect data because we're so small, it's hard to get the word out.

We have a principal investigator who's a pulmonologist in Spokane with whom we're working. We're looking at what we want to do with the data we have now. Hopefully, we can find an investigator who would be interested, or who would work with us and/or our principal investigator to figure out what we want to do next. The primary assessment proved that we are impacting hospital admissions and improving quality of life for people, so where do we go from there?

John: It's a real emotional issue. This is a big, big problem. It will take very smart, creative, diligent people to fix it, but I'm hoping that it's in the process.

Any last word? Anything that you wish I would've asked you about, or that you should've mentioned?

Kelly: I think we've pretty well covered everything. We want to increase awareness that there's more help available than people are accessing. For middle income people this may be the first time they've come across a situation where they can't manage on their own with their own resources. I want to take away any barriers that are there.

John: I'm going to encourage people to call you and to go see you. This was a very informative discussion. I hope it helps a lot of people. Kelly, thank you so much.

Kelly: Thank you. I'm excited that you're putting out a book. It will help many more people.

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Have you noticed a trend in these interviews? The people I've met who work with our senior population have a sincere passion for making a difference in the lives of their clients. I

don't know how Kelly is able to keep up with the demand for her services, but she does it with energy and enthusiasm. I know my clients who have worked with her are very appreciative of her efforts to help them.

Now you too are aware of a great community resource for people who are dealing with the high cost of some prescriptions. My hope is you or others you know will benefit from the information Kelly has shared if you ever need it.

LIFESTYLE OPTIONS

As we age, our goal is to live independently in our own home as long as possible. That can be your longtime home, or a move to a senior community, where you can make new friends and enjoy a new active lifestyle.

But not everyone can do that. There are many lifestyle options depending on your needs. Many senior communities actually offer most or even all of those options, from independent living all the way to skilled nursing or memory care. I interviewed someone from one such community, and I came away impressed with what they provide and the setting in which it's provided.

Before that interview, I want to address the important issue of home care, which can make all the difference for people who want to remain in their home.

As illness or injuries or surgeries start limiting a person's ability to do all the household or personal care functions we take for granted, it is quite common for people to need home or health care for a limited time until they recover back to independence. Others need that type of assistance long-term.

A regular visit from a compassionate caregiver can be the difference between daily struggle and decline or maintaining independent living for years.

These next two interviews with representatives from home and health care agencies will detail the different types of care available.

CHAPTER 11

JEN TAYLOR & COURT ABELL

Jennifer Taylor, BSW MGH brings 20 years of experience to her role with Home Care Assistance. She received a Bachelor's of Social Work with an emphasis on aging and a Master's Degree in Geriatric Healthcare Administration, along with a Graduate Certificate in Management and Strategic Planning.

Jen managed a home care agency for 16 years and spent two years doing case management with a nonprofit. She believes having the opportunity to give to others makes for the most remarkable day at work anyone could ask for.

Court Abell has worked in the health care field for almost a decade, with a diverse background in sales, marketing and community outreach. He enjoys solving problems and helping families find solutions.

Court found his passion for this field after watching his grandparents struggle to find happiness and joy in their later years. His goal is to become an expert in senior care and is

constantly learning about the newest advancements in home care.

Jen Taylor and Court Abell are two of the team members at Home Care Assistance in Liberty Lake, WA. They helped me understand the difference between home care and home healthcare. If you listen to the podcast we did together you will hear the enthusiasm they have for serving their clients.

It is obvious after spending time with them that they love helping people and put in the extra effort needed to help people find the resources available to them.

John: Jen and Court, before we get to what Home Care Assistance does, I'd like to learn about your background, and what led you to this field.

Jen: I had no intention of ever doing home care. In fact, early on I thought I wanted to be an RN. But I was a single mom with three kids, and I needed to support them, so I actually worked three jobs, and one of them was home care. I was basically a bath aid for about three months before they asked me to work in the office. I spent a short time as a care coordinator, then worked my way up to manager within my first year. I stayed there for 17 years. During that time I went back to school and got my bachelor's, then got my master's online.

And I learned nursing wasn't the right path for me, because once I began spending my days with the clients and their families, there was nothing else I wanted to do. Even though I was on call 24/7, and missed holidays, birthdays, soccer games and track meets. I've heard some of the best love stories from my clients, I've heard about experiences during the war, and just stories about how they've lived. They're such a wealth of knowledge.

John: I agree with you 100 percent. I love hearing my clients' back stories, and their experiences. Their stories are fascinating.

Jen: I cared for an elderly couple who came here from Poland. The husband survived through Hitler's time because he spoke five languages, and when he was approached by the Germans he was able to speak to them in German. He worked at Fairchild as a skills survivalist, teaching them how to survive being interrogated.

I took care of both of them until they passed away. They had no children. Because my grandmother was Polish, we had a special connection. He looked at my family tree and was able to tell me where we're from. He had his Polish Free Army uniform on a mannequin. He was amazing, and they both taught me so much.

For me, it's always been about the clients. Even when you're helping your caregivers deal with issues in

their lives, the support you give them lets them provide even better care for the clients. That's a different perspective, but it's a very people-oriented business.

John: So you educate the caregivers not just in the technical end, but also in the listening and the emotional aspects of the job. Court, how did you get here?

Court: I graduated from Oregon State with a business degree and a corporate communications minor, and had no idea what I wanted to do. One of my business professors told me Enterprise had a great manager training program, so I started out in the rental car business down in Sacramento. One day I rented a car to a man, and when he saw how I interacted with people and remained calm, he told me he was a home health administrator and they had a position I should apply for. I said, “I don’t know anything about home health,” and he said they would teach me what I needed to know.

I got the job and did a lot of on-the-job training. After about a year and a half I moved back to Oregon and worked as a physical therapy rep. I met my wife, who was living in Seattle, so I moved there and worked for Careage Home Health, where I learned more about home health and every branch of the health care system. We had a child and were going to move back to Oregon, but this company asked me to help open

up this branch here in Spokane. To me, health care is all about the people we help.

John: You're really making a difference.

Court: My grandfather was in the Korean War and his stories are awesome. I would tape him and listen to his stories over and over. I know how special grandparents are. We can help prolong that relationship, and help families actually spend time with them as a person. I love that part of this job, and I love working hard for the patients.

One thing we all do is go above and beyond. Jen didn’t tell you this, but she’ll buy patients and residents groceries if they need them. It’s just one of those things you do. We work harder than anyone else. They don't even look at the business side of it. That will come if you're doing the right things and have the right team. Home Care Assistance is letting us build our culture, and that's customer service.

John: How long has Home Care Assistance been here in Spokane?

Court: Almost exactly a year. There are days home care can be very stressful. In this field, that work-life balance can be difficult. We take pride in answering our phone at 9:00 pm, and not having it go to a phone tree. When they call, they need someone. If a facility's calling me at one in the morning, I know they

don’t want to be making that call. People appreciate that. It's been a good year. It feels like a lot longer.

John: I noticed on the website that your care providers will go on vacation with clients. So if someone has a chronic illness and wants to visit family out of town, or go on a trip, your people can go with them and keep them comfortable?

Court: Absolutely. The family just needs to agree to pay for 24-hour care, and the travel expenses for the caregiver. The caregiver’s job doesn’t change. You’re still there to help the patient. You’re not on vacation. We even had one go to Hawaii for a family. That’s not a bad place to work for a week.

John: What a wonderful thing for people who have health issues but still want to go places and participate in things. Speaking of caregivers, can you explain respite care? That’s something not everybody is aware of.

Jen: Respite is basically a period of time where we'll provide a caregiver so whichever family member has been providing the care has an option to be away for a while, and do their own self-care. The number of people providing care for relatives is continuing to grow. For some it’s practically fulltime. Respite care gives them a break. Maybe even the opportunity to take a real vacation.

John: So respite care could be once a week, or once a year, or any time?

Jen: It all depends on what the caregiver needs time for. I can relate to this. I’m part of the sandwich generation. I still have kids at home, but I'm already caring for my mom. I’ve had some help from family members, but people here have asked me if I want to be part of the family care respite program. It’s for anybody of any age.

John: I’ve noticed over the years that when someone starts out as a family caregiver they’re thinking, “I’ve got this. I love this person. I can care for them.” But things change over time. The person’s health gets worse, or the stress level increases. So just because they were super human at one point doesn't mean they have to be that way the rest of their life.

Jen: They usually don't recognize how much it's changed until something happens. Their own health often deteriorates. Sometimes you end up with two people now needing care.

Court: They stop taking care of themselves because they're so busy taking care of someone else. They lose track of that. We do quite a bit of respite care. It’s really important. We let the family know, "Take this time and really use it for you. You're caring for this person all day. In order to give the best care, you need to be taking care of yourself."

John: When people pay for your services, is it primarily private pay, or do many people have long term care insurance?

Jen: I have 27 claims that are technically under me right now. Only two of them have long-term care insurance.

Court: Most are private pay, until Medicare does that companion care coverage. It’s in the works, which is good because that’s going to keep a lot of people out of the hospital.

Jen: Maybe this support can help them prolong that huge step onto COPES or full Medicaid in a facility for a year or two. If you think about it, paying for that piece at home is still going to be cheaper than paying for that person to go into a facility. I always tell people, if you can be at home safe, with all your needs met, for 30 hours or less with the current average rate of home care, it is cheaper than to go to assisted living. Where would you rather be? Now once you get over 30 hours, it's a preference, and you need to review your assets and the financial safeguards you have in place. But it's still a viable choice. Keeping them in their home is actually saving everybody money, and providing them a better quality of life. I never want to see my mom in skilled nursing, but she also knows I will never be her fulltime caregiver. I can't do that.

John: I’m a firm believer in long term care insurance. My wife and I both have it. I think of it as anti-nursing home insurance, because if you have that protection that's going to pay some, or most, or even all of your home care expenses, you can stay home, and your spouse or children don’t have to be your fulltime caregiver.

Jen: The other bonus is, when you are a couple, staying home actually saves you money. What often happens is one spouse will have a chronic medical issue and need more care. Maybe they’ve sold their home and live in a retirement community. Say the wife is the one who needs more care. She can’t get it there, so now they’re still paying for the $3,000 apartment but now they’re also paying eight, nine thousand dollars or more for her to be in skilled nursing. They could have stayed together and she could have gotten whatever care she needed, even 24-hour care, and it would have been considerably less money.

John: It is heartbreaking when you see people separated after spending 50 years or more together. That’s part of the reason planning is so important.

Jen: Many people just don't want to sit down and plan for it, because it just seems so far away.

John: Can you explain home health versus home care?

Jen: I explain it to clients like this: “There's a reason health is in the middle. Health means medical, which means there's a medically licensed professional. An RN, PT, OT, speech therapy. That's medical, so that's home health. Home care is non-medical. We don't do anything medical.

Court: We do things that home health can't do, and vice versa. They're in there an hour tops doing the physical therapy, but they're not there to help with laundry, or housework.

Jen: I tell them, “You're going to have both. They're going to come and do a brief succinct visit, and they're leaving. They're not going to be here to help you get dressed, and get out of bed, get your meals done, or remind you to take your medications.

Court: Things we take for granted. It’s interesting, a lot of the time discharge planners or social workers at some hospitals or facilities don't really know the difference between home health and home care. Sometimes they think it's the same thing, or under the same umbrella, when in reality they're completely different.

John: Until just now, I didn't know the difference, and I've been exposed to this for years.

Jen: It's really unfortunate, most of the time they wait until crisis mode. We get the crisis client. But if we

had the opportunity to meet them at the beginning of their journey, we could have provided them more support, more assistance, more guidance to navigate systems, especially when they're eligible for VA benefits. That's a lengthier process, and if we're getting them at crisis mode, we can't even offer that to help them offset the cost.

I ask if they have their legal matters in order. “Do you have a power of attorney? Do you have a will in place?” If they don't understand the difference between the proxy and the healthcare directive, I explain it. If they need those services, right then and there I’ll say, “Here are two names. Here are their numbers. I trust them both intimately. Call one or both of them.” The same thing with financial details. "You have an inheritance from your parents? Is that protected?" If the answer is no, I tell them to meet with someone to protect their assets as soon as possible.

I look at the most cost-effective way to meet their needs. Is there a family caregiver involved? Can I refer them to a family caregiver support program and start to get some of those benefits from them? Are they connected to the VA hospital, would they be eligible for a home health aide to offset that? Are they asking me for a bath aid, but they have home health, which I know will provide a bath aide for free? I look at everything. I have a little joke I always tell them about their money. “You always said you were

saving for a rainy day. It’s not pouring yet, but it’s sprinkling, so we need to dip into it."

Court: It's like being an expert in aging. We're not just doing home care. We're really taking it upon ourselves to make sure they're getting the right things at the right time.

Jen: I don't care if they're our client or not, I'm going to point them in the right direction.

John: So the crisis mode comes about because whether it's a couple or an individual, as they're aging, things can change. Then friends or family members start noticing things.

Jen: Sometimes there’s a major medical event on either side. Mom has a fall, or now the daughter has a medical condition and can’t care for Mom.

John: It seems like it's just logical for people to plan ahead and visit with you, even for the “what ifs,” because many times with chronic conditions, it may be manageable now, but you know it's going to escalate. Why wait until then to put a plan in place? Why not be proactive and meet with people and get educated?

Jen: I’ll ask, "Do you have your POLST?" The answer is usually, "What's that?" It’s the “Physician Orders for Life Sustaining Treatment.” Basically, they need to get

their care team in order. Who are they going to use for financial, who are they going to use for legal, what's their preferred home health, what's their preferred hospital, what’s their preferred home care, do they have a preferred hospice?

Sometimes we're the ignition for that important family conversation. We might say, "We can't contact all three of you every day with updates on Mom. Who's our go-to person?" You might witness one heck of a family dispute at that point. I’ve even been in a client’s house with their family fighting over a chair. I had to ask them to leave until my caregiver and I finished what we were doing.

John: What I’ve seen quite a bit is when you have extended family, one might have had the conversation with Mom or Dad about end of life issues, but the others are not as in the know. Then they want everything done that’s possible, even though the parent said, "I've had a good life. I'm at peace."

Jen: If you didn't write it down, it didn't happen. That really does apply.

John: Then if parents don’t have it in writing or communicate with the family, it can create serious animosity between siblings.

Jen: The hardest part of our job is never usually the client.

Court: It's the family.

Jen: You have so many different parties involved with different interests. Bear in mind, we spend the majority of our time working with the families.

Court: And dealing with expectations. We want to make sure they know up front, “This is what's going to happen." Some want the moon, but that's just not how that works. Really setting a realistic expectation for them helps in the long run.

Jen: Sometimes they have a misconception of who we’re going to send. They’re expecting Mrs. Doubtfire. But the average caregiver is 30 years old, and may have piercings and tattoos. We can’t have a policy about that.

Court: You wouldn't have any caregivers.

Jen: But sometimes a 90 year old sees the arm covered with tattoos and says, “I don’t want them in my house.”

Court: We do stress to our caregivers, try to cover up for the first few shifts, because we want them judged on the kind of care they’re giving, not what they look like. We have one who’s a great caregiver, but a family that’s very conservative took one look at her and didn’t want her there. It’s sad because she would have been great for them, and we had to have the

conversation with her that they didn’t feel comfortable with her looks.

Jen: In a facility, you just get who you get that day.

Court: But you're paying good money, and you expect certain things. If it's not that, they'll let us know. One thing they have to be comfortable with is different caregivers coming in.

John: It's not always the same person.

Court: No, things happen and they need to be flexible in that part. Part of our job is setting that expectation that there will be two or three caregivers introduced to them because things happen. If one needs to leave, we introduce a new caregiver. On any first shift, myself, Jen, or Cash will be there to introduce the caregiver to the family. We don't just send the caregiver blindly. If they haven’t met the new caregiver yet, we introduce them. All this helps with answering the questions. We go over the care plan with the caregiver and with the family, and get them to sign off on the care. Not all home care companies provide that personal introduction.

And we always call the family and the caregiver after the first three shifts, and find out how they went. If there was a little thing, we let the caregiver know. Or if there was something major, we can change it

immediately before it gets out of hand. We're more about being proactive rather than reactive.

Jen: We're very high touch. I have some clients who often text or call me, and I talk to them two to three times a week.

Court: They love that personal care. You can tell, some want to be more engaged and some don't. We do a good job of knowing which ones, and how they want to be communicated with. In the interview for our first assessment, we'll ask, "How would you like to be notified? Would you like a call? We have an online portal, you can log in and see what the caregiver is writing after each shift. Or if you'd like us to write it out by hand and leave it in the room, we can do that too." We have a lot of different ways to keep in contact and keep them informed on the care.

John: If they need to contact you, is there someone receiving calls 24 hours a day?

Jen: When we're not here, our main office phone number goes to an answering service. They know which one of us is assigned each week as far as a client or caregiver. But what ends up happening more often than not, is when I sign up a client, they're given my business card and the first number there is my cell phone. Nothing gives them a warm fuzzy like knowing, "I don't even have to call that office. All I have to do is call Jen, the one who makes it happen."

I know that's what my clients want. I give all of them the same good customer service, because whether they're spending $10,000 or $100, they should be treated right. I want to be treated that way as well and it's hard to find. You don't get it much anymore.

Court: It's the same with me. I give out my cell phone number and I get calls and texts all the time. It's just part of the job. They want the answer now and I'm absolutely there to give it to them. I don't like when they get passed around the phone tree. I like straight to me because I know what the problem is, I know how to fix it immediately, and I don't like hearing it from someone else. That's why we do what we do.

John: Is there anything we didn't cover that you'd like to bring up?

Jen: My biggest advice to someone is they need to become educated. You should know and be prepared for the other end of that time span as well. Know there's hospice and what that means. Know there's home health and what that means. Know what home care means. Do some homework. Call and say, "I just want to know about your services. What do you do, how does it work?" There's absolutely nothing wrong with knowing that. Then you can tell your kids, "I've already talked to these places. These are the ones I like. If I need anything, I want you to call these places."

John: I love that. That's exactly why I'm doing this, as an educational piece for people. To prepare them in advance. Don't wait until it's crisis time because it's hard to make good decisions in a crisis.

Court: If you plan early enough, it's so much easier emotionally and financially. You know what you're getting into, instead of the crisis mode, 24-hour care, and then you get the bill and you're blindsided.

John: Thank you both very much. You shared a lot of information that can help a lot of people.

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Jen and Court often deal with people twice their age or older. And you can tell they know how to relate to seniors and their families in a way that's reassuring and comforting. The information they provide, and the services provided by Home Care Assistance, make a significant difference in the lives of their clients.

CHAPTER 12

JACKSON WILLIAMS

Jackson Williams has been Relationship Manager at *Family Resource Home Care* in Spokane since 2016. He previously worked in the nonprofit sector, primarily doing fundraising and community outreach, and continues to help local organizations on a volunteer basis.

He serves on the board of the *Senior Action Network of Eastern Washington* and *Southside Community Center*. He also serves on event/fundraising committees benefiting *Greater Spokane County Meals on Wheels, Hospice of Spokane, One More Time Northwest* and *The Village at Orchard Ridge.*

In his spare time, Jackson enjoys exploring the beautiful outdoors of the Inland Northwest, gourmet cooking and entertaining, fine dining, concerts, traveling (especially to warmer destinations), and woodworking.

You never leave a meeting with Jackson Williams without feeling better. His passion and energy are contagious and his

pride in *Family Resource Home Care* is so great you would assume he is the owner of the company. They have a wonderful team in place and are eager to help.

John: Jackson, your title is Relationship Manager. Tell me, what does that mean?

Jackson: I believe it's about establishing a relationship either with the prospective client, with the referral source or with the community member. It's about utilizing that relationship that I can tailor their needs, in terms of education, as to how we can best collaborate to promote the best outcome.

I work with a variety of referral sources such as discharge planners and social workers. I work with them to detail and describe the services that we provide to make sure that they're aware of what we do in the community, what our caregivers do, and then identify appropriate referrals in patients that would benefit from our services to improve their outcome.

I work specifically with prospects in the general community to do presentations and education about home care, the specific services we can provide and how we can improve their quality of life. For me, as I look at the senior population, what I'm most passionate about, is making sure that folks have access to services, even beyond home care. That's one thing that I actually love about family home care in particular because of

our depth and breadth and size. Each of our clients are assigned either what we call a case manager or a care coordinator upon the initial free assessment. We're not only talking about the different home care services that we can provide, but then also doing things such as a safety assessment check.

One gal, for instance, just started on our bathing grant and after our bath aide went in the first day, we noticed, she phoned three times in the last month. She was in need of some fall prevention. So, we're in the process of making a referral to home health right now. We take a holistic kind of approach.

One time, when we were doing the assessment, we noticed that there was no food in the fridge except for a two-liter bottle of Mountain Dew. We made a referral to Greater Spokane County Meals on Wheels and they're now getting that service.

For me, my passion is seeing that seniors get access to the services and resources in our community to promote safety, security, independence and autonomy.

John: That's exactly what we want to do, is to provide these resources for seniors. It really comes down to education, do you agree?

Jackson: It's so much about education. Spokane is blessed to have an incredibly rich and generous network of those folks that can provide solutions. As you know, you're a member of SANEWA. That's over 110 members that represent differing industries, whether they help with insurance assistance, navigating that journey, home care, home health, hospice, assisted living or independent living.

They all come together to weave that tapestry of support that really does help cradle, nurture and allow the senior community in this region to thrive.

John: I actually just found out about Donor Closet.

Jackson: Donor Closet is a great organization. We have this program called Charitable Blessings through Family Home Care. We had a client whom we determined needed a new electric chair because his was not in proper condition. So, we started pricing them at places like DW Healthcare and it was going to be almost $1,000.

Someone said, "Call the Donor Closet and see if they have anything." So, we called. They had the perfect chair. I think they had a sticker price of about $500 on it. Once we told them what we were doing and it was going to be kind of a Christmas present, more-or-less, they took the price down to $300. It was just a great resource for everyone.

John: I am a board member of WASHAA, Washington State Health Advocacy Association, and here locally, I was meeting with some of our members. I was talking to them about, "I've had some clients lately who couldn't afford their medical equipment. Wouldn't it be great if we had sort of a library system where we could just loan that to people?"

As I started researching it, I found out about the Donor Closet. Now, I haven't spoken with anybody there yet, but I just saw one of their trucks. I'm wondering if they only sell, or do they loan equipment out?

Jackson: I don't know if they loan. I'm leaning towards thinking they don't. I think they just sell. It would be a great service to provide, however.

John: But even then, that's at a huge discount. That's a blessing for many, many people.

Jackson: When they sold to us, we're talking a 70% discount and they worked with us to deliver it. It is especially a blessing when they're home bound and don't have any access, don't have a lot of financial means available.

John: I want to get back to you. Tell me about your career path, what led you here?

Jackson: I was a sociology major at Whitworth University, with an emphasis in community action and social service. By chance, my senior year, I happened to take a special interest class called Aging in Society. It was at that point where I was exposed to the fact that there was the silver tsunami coming through, and there was such a huge need for that population.

I worked there approximately eight-and-a-half years in their Development and Outreach Office. I loved that position because I was able to make a huge difference in the community. I started out, frankly, as an entry level position where I was just doing gift processing and donor acknowledgement. From there, my responsibilities increased to the lead point person on all of our major fundraisers, our community education seminars and events, and doing grant writing. I learned not only what resources were available beyond hospice, but how that holistic approach is necessary for a senior to thrive.

Through the fundraising efforts of Hospice of Spokane, I got to meet some of the folks from Family Home Care who were instrumental in supporting Hospice of Spokane, not only serving on fundraising committees but actually making a $25,000 commitment to name the Hospice House North kitchen.

I got to know the culture of Family Home Care, which to me, really separates them from the average home care agency. They're a locally owned, family operated, organization that really is committed to serving seniors and that's lived out through what we call the FHC way, which is compassion, respect, integrity and family. It's those values that are the core of this company. Not in only how we do recruitment and retention of our caregivers, but how we approach our clients. We don't just call them clients. They're part of our family. We treat them as such and we honor them.

In that tradition and in that spirit, we work to find them their resources as if it was our own grandmother, or cousin, or whatever the case may be. That's what shaped my career in terms of how I ended up as Relationship Manager and working at Family Home Care and the senior services industry.

John: You get a sense of the culture just by interacting with the people in the organization. Family Home Care is a pretty impressive organization. It has the family feel, but at the same time, Jeff is very involved nationally.

Jackson: He actually serves on the board of the National Association of Home Care and Hospice. He is one of, I believe, six board members. He represents our region. We're very engaged in our community because of our history of being in the inland northwest over 50 years.

We've been able to establish relationships with not only other community stakeholders, but especially with our elected officials. We've been able to use that as a platform to advocate for our region and for our community and frankly, for the nation. We want to ensure that folks are getting the best access and we're recognizing where there are disparities and trying to correct them as such.

John: How do your clients find you?

Jackson: I would say most often it's based on a referral from either a physician or a discharge planner, or a social worker or a community health worker who says, "You know what? You need some additional assistance. You're not to a point where you need to go to a retirement community, whether that be an independent, assisted, or skilled, but it would behoove you and benefit you to have the ability to stay in your home longer if you had the assistance of someone in your home for providing support with activities of daily living."

John: Are most of your clients temporary or long term?

Jackson: The majority of them are long term. There are some that we have just as respite cases, or what they call PRN, or as needed. Let's say family goes out of town and they just need someone to essentially come over and make sure that mom is getting up, that she's being dressed, that she's

having her food, that she didn't have a fall in the middle of the night, just that extra reassurance.

That actually brings me to one myth that I wanted to address. A lot of folks think if I do home care it's going to be so expensive and I can't afford it and it's going to be around the clock, 24/7. Of our 300 clients, only one person needs 24/7 care. The vast majority are consuming only a few hours a week, and it's just those couple hours of services that they may need per day or per week that provide them with support to remain in their own home.

It's just little things that we do. It may be housecleaning. I actually got home care for my mom because I came to visit her once and I noticed that she was really favoring her leg, and I was like, "What's going on here mom?" "Oh, well maybe I happened to go down to make the bed and I pulled something," and now she has compromised mobility. So, I was like, "Okay, so we're going to start with housekeeping." So, we just have someone come in twice a month, to change the sheets, so that she doesn't have to do that.

I'm hopeful that as she progresses and her needs increase, she'll be more open to that. That's kind of why I planted that seed. I've encountered a lot of folks that are fiercely independent and don't need assistance and don't want it. My mom, case in point, has been like, "You know, it's really nice just

to have them here. It's nice to have their company." It improves quality of life, and like I said, also allows them to stay in their homes.

John: So, family home care is not just providing help with activities of daily living?

Jackson: Yes and no. Our bread and butter and our focus is activities of daily living, but that can include a variety of things beyond working directly with the patient. Obviously, we're working with them to help them maybe use the restroom or dressing, but we're also doing things like housekeeping, and assisting with pets in the home that maybe need to be fed or walked. Doing meal prep, providing transportation, doing shopping, doing cooking, whatever we can do to improve their quality of life.

John: And I read on your website that the average cost per month for your clients is actually relatively low. I'm beginning to think that staying at home for as long as possible, which most of us want to do, is actually economical.

Jackson: In a recent survey, 90% of folks indicated that if they had the choice they'd want to remain in their residence. It is much more cost effective. Like I said, the biggest myth that I encounter is when a client thinks they will need to hire 24/7 care and can't afford it. The bulk of people do not require that type of involvement and intensity of service.

So, we're talking as low as 10 hours a week. At 10 hours a week, for a month you're looking at about $1,200. That's considerably lower than any other residential setting with the exception of subsidized housing obviously, which some folks do qualify for.

John: So, someone from your organization meets with each individual or their family and you do an assessment?

Jackson: We do an assessment, and during that time we review all the different services we can provide. From that point, we develop personally tailored care that our home care professionals (HCPs), do in terms of providing the support and assistance. That kind of care is very fluid. It's flexible, so as needs change or increase, we can customize and specialize it to meet their needs.

Typically, we're only there to help with bathing and dressing and doing medication reminders, but then it comes up they have a doctor's appointment they need to go to, we can add a transportation component. It's a very flexible, live document, if you will.

John: And no long-term contracts?

Jackson: Correct. No long term contracts. Just so we're all on the same page, we do require that a service agreement is signed, but by no means is that binding, so folks are able to cancel services at any

time, or decrease services or increase services as needed.

John: So, do you get most of the inquiries from the public, patients themselves, or from family members?

Jackson: In my experience, it is equally all three. I'm going to say one third is someone who recognizes that they have increasing needs, one third is a family member who recognizes that there's a change of situation and that someone potentially would benefit from home care services, and then one third are from trusted referral partners like social workers, discharge providers, and physicians who are seeing these clients and patients and saying, "Hey, I know you think that you're doing great and that you're doing well, but you could be doing that much better if you looped in this level of care."

John: Nowadays, when you go in for surgery or some sort of procedure they don't just send you home anymore. They're asking questions. They're wanting to understand if there is support intact.

Jackson: I believe that our healthcare community is committed to seeing that person achieve the highest level of success and has the best outcome, although frankly with the addition of some of the structures with ACA, if someone bounces back to the hospital and is readmitted within 30 days, that hospital may receive either a ding on their record

or a lower level of compensation, so they really now are being forced to ask some of those probing questions.

Say, for example, you're going to discharge home. Who's there to take care of you? Who's going to support you? How are you going to get your prescriptions from the pharmacy? Who's going to provide that support? You've been hospitalized for a hip fracture. You're going to initially have your rehab at a skilled nursing facility. As you discharge from that skilled nursing facility, what type of supports are you going to have? What kind of services?

Even if you have home health, let's say you have physical therapy, which would be a Medicare benefit. That therapist may only visit you two or three times a week. Who else is going to be there with you to not only hold you accountable to do those exercises on a daily basis, which is going to enhance and accelerate your recovery time, but also be there to assist you with getting up in the morning, getting dressed, using the restroom, assisting with meal prep or doing the cooking so there's well-balanced nutrition, because that's obviously a key ingredient in recovery as well?

Who's going to be an advocate for you and contact your physician when you are discharged with a med list, but that med list differs from what is listed on the bottles that you've been taking for

years? How are you going to get that clarification without being overwhelmed?

John: I think there's a broad range of services that maybe people haven't even thought of. Because most of us have this preconceived notion of what home care is.

Jackson: And frankly, a lot of people confuse home care and home health. Home health is a skilled component, so there you're talking about physical therapy, speech therapy, occupational therapy, nursing services such as diabetes education or wound care. Because of that skilled component, it requires a doctor's order. But there is a Medicare benefit as long as they do have that doctor's order and recent patient visit.

With home care, it is deemed private duty custodial, nonmedical services, so unfortunately Medicare at this point does not reimburse for those services. However, we have heard from CMS that they are looking at revising their reimbursement structure and in the near future there may be some coverage available for home care, so we're really excited about that.

John: So, the medical care is more of a short visit?

Jackson: Well, it's a shorter visit, and then typically I believe your average home health certification is about six

weeks. It's very intentional. It's to improve on a specific focal point related to something like PT.

We frequently collaborate with those folks, like I said, because they're only in there two or three times a week. We can be there every day. Additionally, we can be an extra set of eyes and help advocate for our clients, so if we notice there is someone who is in PT, at that point the home health exits but we're still working with this client and we see that there's a decline, we then can proactively Work with this client, we see that there is a decline. We then can proactively loop in Home Health again. And say, “Hey, we think it would benefit from you coming out.” Or, “Hey, that wound that you were caring for Mrs. Jones, that wound's trying to get weepy again.” We're going to reach out to you proactively, versus resulting in that emergency room visit, or hospitalization, which is not only traumatic in nature, but also, not cost effective.

John: So, when it comes to paying for home care, it's a possibility that may be a component of Medicare in the future, but long term care, does that pay for some of these services? If someone has long term care insurance?

Jackson: Yes, certain long term care policies, definitely. Through the Veteran's Administration, there may be some benefits available including even beyond just an allotment of home care hours or benefits,

the aid and attendance program, which is also available to surviving spouses, and depending on certain criteria that are met, would provide them with a cash benefit that they could use to support home care, or any other service. Even assisted living. As far as independent living, I think if there needs to be services rendered more than just what would be in that of an independent setting. Medicaid requires an income eligibility component, and to be qualified by the state. About half of our clients are would be private pay.

John: So, part of that intake assessment that you do is also discovering how this can be paid other than out of pocket.

Jackson: We're always looking to tap into those resources. I highlighted the event attendance component. That's a program that a lot of people aren't familiar with. It can be a very challenging program to get qualified for because of the amount of paperwork involved.

Jackson: I work with an attorney who makes sure folks get connected with the services and benefits that they're entitled to. We'll pre-qualify someone and say, “Did you serve during these certain dates? What is your income? Do you require assistance with at least this many ADL's?” And then from there, we'll actually collaborate with the veteran services officer to say, “Hey, we've already pre-qualified them. Here's this documentation we

were able to locate for them," because there are certain forms you need to submit, and we'll help guide them along that process to ensure that they can get those benefits.

If upon assessment, we believe because of income that they could qualify for Medicaid, we'll direct them to home and community services and say, "So here's where you start, here's the paperwork you're going to have to fill out."

For the past 15 years through the Area Agencies on Aging, specifically in our region, long term care of Eastern Washington, we've been rewarded a Bathing grant, for folks who have limited income. I believe this year the requirements are: a single person household, under $1523 in income, under $10,000 in savings, they live in Spokane county, and are over 60 years old. They can qualify to have up to two baths per week free of charge. It's been a sliding scale beyond that point, I say that because I'm paying for my mother's home care. I tried initially to get her the bathing assistance after she had her fall.

She makes slightly over that threshold. She makes around $2200 a month, and her copay was going to be $3.86, so much more affordable than your traditional home care, and again provides a great resource, not only in providing the bathing services, which are essential, but also being that extra set of eyes, as we're bathing them, because

you obviously get to know these folks in the most intimate way. If you notice, “Oh, you've got a wound on your back, that maybe you're not aware of." We then can make that referral to Home Health and be that proactive agent.

John: And plus, I would imagine when you're spending time with people, they're also sharing with you how they're feeling, and any new symptoms, things like that.

Jackson: Exactly. And they do become a trusted confidant. We have a lot of our clients that liken their caregivers to family, and to that primary support. You know, I've come in from weekends where we get voice mails from clients. “Had this care giver not recognized this sign or symptom, I probably would be dead right now. Thank you for being so proactive. For getting me to the hospital, for noticing that I had that UTI, because I didn't know what was going on. I just knew that I didn't feel well. I felt like I was going crazy.”

And our caregivers are highly skilled, licensed, bonded, insured folks who have received a significant amount of training, so they can really work to promote a healthy outcome for our clients.

John: Jackson, you’ve shared some great information. Is there anything else you'd like to share?

Jackson: I would just encourage folks to do as much research as possible, not every provider is the same.

John: What should they be looking for when they research? Because they may not know what they should I be asking.

Jackson: I agree. Especially in Washington, home care is highly regulated through the department of health. That is not so much the case in the state of Idaho. In the state of Idaho, you actually can work for a home care agency without having any education, licensure, or any type of background in the industry. And so there are questions that I encourage people to ask. Are they an accredited home care agency? Are they licensed, bonded, and insured? Do they require that their caregivers maintain a certain level of licensure, and if so, what is that?

In that same vein, what is the agency doing to promote, or encourage continuing education? As we see people age, we see that care becomes more specialized, and has increasing needs. Recognizing that and seeing how that population is growing is important. We have a very robust continuing education program and we encourage our care givers to pursue specialty certificates for certain areas such as dementia, diabetes management, and end of life. They would have additional training knowledge in order to be able

to better meet the needs of those specific clients that are more high-acuity than just your average, “Oh, we're just going to help you with getting dressed.” Versus, “We're going to help manage the progression of your disease.”

I would encourage people to be open to the idea of home care. To at least allow that free in-home assessment to take place. A lot of times there are, especially from referral sources, perceived financial hurdles. Where they're saying, “Oh well, I'm going to make the assessment that this patient doesn't have the capacity to afford your services." And that may be the case, but as we've come to discover, this is a unique generation we're serving. A lot of these folks survived through the depression. As a result of that, they have a mindset where they may not appear to be affluent, or have the means. One case in particular comes into mind, there was a gal who was living in a trailer, but she literally hoarded hundreds of thousands of dollars, because she didn't didn’t’ trust the banks. So, she appeared to have no assets.

Often times too, we reach out to the adult child who lives on the East Coast, who says, “Yes, I'll pay $1200, $2000 a month so I can have extra piece of mind and know that my mom's safe, or my dad's safe, and they're not going to fall.” And it's not going to be that phone call at 2AM from a hospital saying, “We've just admitted your parent, because

they've had a fall, and they have a hip break." Now they're going down this whole course that could have easily been avoided with looping in our support first.

John: And you're right, not everybody is disclosing their assets to their doctor.

Jackson: There are a lot of people who don't. And then also, being what we are, a Medicaid provider. For those folks that do have a genuine need as determined by the state and meet the income eligibility requirements, though it is a daunting process to get qualified, we can support them too.

There are lots of resources. There's the ocu-bathing grant, which is unique to family home care. So I just encourage folks to do that research, to look at what different options may be available. Not even within home care, but also within Home Health, within Hospice. Both Home Health and Hospice are Medicare benefits if you're deemed eligible by your physician. And coming from someone who worked at a Hospice organization for eight and a half years, I can tell you it is a huge blessing that has been granted to not only the patients, but especially the family. It allows a trained expert who specializes in the disease or prognosis, or end of life to educate the family, to support the patient. And then even after that patient passes, there's bereavement support for 13 months.

The patient is so well supported when they start receiving care from the Hospice team, but I feel like, in all honesty, the family reaps most of the benefit, because so often, they're able to return back to their role as son or daughter, and not care giver. It allows them to not feel so overwhelmed because they have the ability to receive respite support from volunteer services. Or they're able to be educated, because so often, they're struggling because they don't know where to start, and you have a skilled expert that comes in and says, "Okay, so here's the prognosis, here's the typical journey, here are the resources, here's a phone number that you can call 24/7. No question is too dumb."

It's a huge relief to have that type of support available to you. And it's free of charge, if they have eligible Medicare. And one thing I think a lot of people don't know about Hospice, is that not only is it the support from the nurse and the social worker, and the chaplain, but anything related to the terminal diagnosis is also covered, which may include prescriptions, complimentary therapies, or DME. So, it's huge.

John: And it's all geared towards comfort.

Jackson: Exactly. It is all towards comfort care, palliative care and emphasizing comfort, dignity and peace of mind. So, often when I was chatting with people about Hospice, they felt like, oh Hospice is a death

sentence. It means that you're throwing in the towel, it means you're giving up hope. And to me, I feel like it loops in an additional layer of support that allows the hope to thrive.

John: Jackson, you have shared some great information. I thank you for your time. This was wonderful, and I'm looking forward to sharing it.

Jackson: Oh John, thank you, I think this is going to be a great resource. Please do.

To Contact Jackson Williams:
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You now know the difference between home care and health care, and how each option might apply to your family's needs, either now or down the road. By conducting these two interviews, I learned the distinction as well.

Together, we also learned about all the different types of services available, and how agencies like the two represented here are able to help their clients maintain the independent lifestyle they want, and give their families the peace of mind they need.

CHAPTER 13

CLAUDIA OUWERKERK

Claudia Ouwerkerk is the Marketing and Senior Housing Director at *Good Samaritan Society*, which allows her to fulfill her passion for working with senior citizens. She educates people on the various types of housing provided, including independent cottages, housing with services, assisted living, skilled care, and memory care.

Claudia is also a board member of *Senior Action Network of Eastern Washington*. She spends much of her time giving back to the community through outreach, volunteerism and fundraising for organizations including *Meals on Wheels, Honor Flight, SNAP, Alzheimer's Association, Catholic Charities, The Falls Coalition* and *Northwest Dinner Among Friends*.

Every time I'm on the grounds of Good Samaritan Society's Spokane Valley location, I notice something different. The feeling I get is it's like a camp. You see all that beautiful grass and the trees. It's a country setting. It's totally unlike the institutional-type setting people often perceive when they think of senior living.

When you're with Claudia Ouwerwerk, you can feel her passion for helping senior citizens live life to the fullest.

John: Claudia, let's start with the path that brought you here to Good Samaritan Society.

Claudia: I've been surrounded by seniors most of my life. My aunt actually started the very first senior center in the United States. She was recognized by President Nixon for doing that. That's kind of where I grew up. My love for this age group started when I was just a child still crawling around on floors.

My heart has always been working with seniors. I started in retirement communities at a young age, working in assisted livings. I was a med tech for many years, so I provided the medications for seniors. I also did some work in home health. But my real love was working at a retirement community, getting to know the people living there and what motivated them to make the decision to come to an environment like this.

I discovered that I got much more satisfaction in my life being around them than I did being with people my own age. I found that serving them was something that fulfilled my soul. It gave me a reason to lay my head down on the pillow and say, "I did a good job today because I was able to help someone." And in the process, it has helped me grow into the woman I am today.

I'm very grateful for that path because it educated me in a lot of different ways to be able to be a resource for the community. I have a lot of resources for people. I can help people through situations they've never faced before. Not necessarily coming to Good Samaritan, but just making the next part of their journey a little bit easier.

John: I think you know, you can't be around seniors very long without absorbing some of that wisdom. The more you're around people, the more they share their stories and their life lessons. You just absorb it.

Claudia: That's right. We're lucky to still have the greatest generation. But it is quickly passing away, and with it, those stories and that wisdom. These are truly people who pioneered trails before us. It saddens me when people don't take an interest in that because these are life lessons. This is the generation of people that embodied kindness, compassion, the things you don't learn in school. It's just who you are.

These are people that had a lot of love for the work that they did. They had a lot of pride for their country. I myself have been enlightened many times about who they are, what they can do, and their tenacity. Their tenacity to overcome trials and tribulations in their life with class, grace, and the strength to endure. Especially if you've seen

them lose a spouse, you see how strong they are. I can't get enough of it. I brought my children into this industry too, and hopefully they see what I have seen and they're able to absorb some of that from this generation of people because it really does have the seeds of how to be great in what you do and how you carry yourself in life. Plus, they're a lot of fun to be around.

John: Tell me the history of the Good Samaritan Society. When I first saw the name, I actually thought of the Good Sam Club.

Claudia: Many people think that. So here’s our history. First of all, we’re a Lutheran organization. There are seeds to that. If you’re familiar with Bible stories, you’ve probably heard the story of the Good Samaritan. We were founded by a pastor in North Dakota named "Dad" Hoeger. In 1922, he had a vision to be able to help children with polio. But it evolved as he learned there were many seniors out there needing care that couldn't be provided in the home. He started some of the first nursing homes in the United States.

The Good Samaritan really grew out of the parable that we stop and help those along the way that no one else wanted to help. That mission is still very much alive in the Good Samaritan Society. We are the largest non-profit organization for senior care in the United States, with about 240 properties. We take in a lot of those that no one else wants.

We have quite a few indigent people on campus, so we work a lot with Medicaid.

We still have nursing homes, but we've expanded on that, knowing there is a continuum of care needed in people's lives as they start to age and start to need more care. So we've grown into the areas of independent living, assisted living, and memory care in order to meet those different chapters in people's lives.

John: Do you have all those different levels of care in this location?

Claudia: We do. We are a continuum of care. We have 56 cottages here on campus. We have 79 independent apartments with services. As people age in place, they may need some additional services, so we provide some of that. Of course, we have our skilled nursing center which has been here since 1953. Then we have assisted living, for people that might need some general oversight, help with medications, or things like that. Then memory care for those that are struggling with different types of dementia or Alzheimer's. We're able to meet a lot of different scenarios.

We may have a client living independently in a cottage, but their loved one needs a little bit of care in the nursing home. Maybe they've had surgery, like a hip replacement. They can have

their physical therapy there, heal, and get back home.

The whole idea of this continuum of care is to allow people to get the care they need or be with their loved one, all in one setting. And we're able to help with the activities of daily living. If people aren't able to drive any more, we provide transportation to and from doctor's appointments. We also have an outpatient clinic here on campus, so if people need physical therapy, occupational therapy, or speech therapy, they're able to receive that care here. We also contract out with other agencies to support someone in their home. There are lots of home care and home health agencies that come in.

John: Good Samaritan was founded by members of the Lutheran church. Does that play into any qualifications for someone to live here?

Claudia: It is open to everyone. But because we're faith-based, you have access to a chaplain if you need one. It is a 55-plus community. Of course, that doesn't apply to the nursing home. By the way, we call them care centers now because there's such a negative connotation on nursing home. You'll see that has changed across the country. That's important to be able to break down that façade of, "I'm going to an old folks' home." It makes people more comfortable about reaching out for care, or possibly try to access it a little bit earlier.

To be 55 and older deals with the independent situation. We offer services that are more along the lines for somebody in that age group, including opportunities for their families and grandchildren, like barbecues and things like that. We often have a lot of kids running around here.

Of course there's an application and background process. Once they pass that, we look at their likes or needs to determine what type of residence is appropriate.

John: Do they purchase or rent?

Claudia: For the apartments, it's a monthly rental. It's not subsidized housing, but it's not the most expensive place, because the idea of Good Samaritan was to provide affordable housing for people in a safe environment. We do try to keep our costs lower than what you'll see in town. Our houses have an option to rent or you can do what we call an entrance fee. They pay a fee to move into the home, which they purchase. Then there's a monthly maintenance fee, which is dictated by what they can afford.

We also have what we call a 60/40 option, which allows them to live in a cottage for $839 a month, including all utilities except for phone and internet. We take care of the grounds, along with the structure, which means we would pay for things like a new roof. Good Samaritan also pays the

property taxes. So there are advantages to living in one of our homes as opposed to staying in their home, where things can become difficult or costly.

Of course, all the homes are one level. There are wider doorways for people that use walkers or are in wheelchairs. It makes it much easier for them to come into a home and live there for longer periods of time.

John: Do you have a waiting list?

Claudia: Yes we do. It’s a very good deal. There are also wonderful communities in town, but because of all the amenities and what we offer, living here has its advantages. I should point out, if a couple is on a waiting list and one spouse develops the need for skilled care, the other spouse could supersede that waiting list and get into an apartment or home much quicker, because they're a priority to us at that point.

While people are waitlisted, we provide lots of opportunities to attend different events, to come in and have meals, or go on our outings. If they can interact with residents that are already living here, it allows them to see that they can do this, and that they aren’t coming to an old folks’ home. They can live, thrive, and do well here. Just before you arrived, we had a group of about 20 residents out front exercising. We offer all sorts of programs to

maintain your wellness. That's something that's very important to people, to stay well.

John: When I meet with clients to discuss their Medicare needs, many still have this preconceived idea about senior facilities. I tell them, "You know what? People who live there are some of the most active people I know."

Claudia: Actually, there are statistics that show we can add longevity onto someone's life. As people age and it becomes harder to go out, they become isolated and sedentary. They start to eat foods that are easier, but not as healthy. It starts a domino effect in their health.

Being isolated and not having regular conversations with others causes people to start to lose speech. Brain synapses are not firing and giving information from one side of the other the other side of our brain.

When we see people engaged, when we see people partaking in conversation, they tend to eat better. That's why meals together in a common area can actually create people to come out of themselves a little more, expand their abilities in speech, even stave off dementia because they're active and they're engaged.

You've seen this type of industry evolve over the years to address these issues. We actually have

baby boomers on our waiting list. They see the value in not having to care for a home, being able to hop on a cruise and go around the world if they want, and know somebody's taking care of their place. That's value to people.

I think when people consider a move like this, their biggest fear is, “I’m leaving everything I know.” But here’s the beauty. A house is just walls. You're the home. Your memories stay with you and they come with you wherever you go. You create new memories. It really is a valuable option to you if you want to stave off aging quicker. Engagement is important, movement is important, activities are important.

The saddest thing I have witnessed is people waiting too long to enjoy it, because they have that preconceived notion. I don't know how many times I've seen somebody come here in a panic, in a crisis. But I love seeing the ones who come here and start engaging with people, and see how happy and active the people here are. They're taking trips. They're going to the Y. They're hopping on buses. I think people are always pleasantly surprised.

I think it’s important for people to actually get out and tour places. Not just here. Every place has something to offer. And talk to the residents. They’re the ones living there. Ask them what you need to know. That way, you can see that these

aren't old people, these are valuable, wonderful people.

John: When is the time for somebody to start considering a different type of living arrangement?

Claudia: I get that question a lot. Often it's from the children of seniors, who say, "I'm starting to see Mom do this. I'm seeing Dad do this." I've learned something important from this age population. I want to be able to make the decision when I can. I don't want my children to have to make that decision for me. Many seniors are grappling with the desire to stay as independent as possible. Part of being independent is making decisions to make the best step forward to what you have in front of you, and make it an even better plan for your life.

John: Don't we make better decisions when we make them before we have to?

Claudia: We do. People can tour 15 different places before making a decision. But they've made the decision that's right for them. You don't know what opportunities are out there unless you get out there and check them out. If your children have to make a decision for you, it's usually too late. It's a crisis. Or the relationships have reversed where children become the parents and parents become the children, and both groups are resentful of that.

If we make a decision and feel good about that decision, it takes a lot of stress off everyone.

Claudia: So when is the right time? When we do start to see failure. If we see our health taking a change, if we're experiencing more depression, if we are starting to hire for services to come in, when we can't care for our yards anymore. If we're falling. We really need to be proactive on that because a fall can change the trajectory of someone's life. What are we doing to maintain our independence even in our own home? If we're not ready to make a move, are we looking at some other entity to help us to maintain our independence in the home?

I think truly you make the decision to do it when you already see that your children are coming in and doing those things you never thought you would have to ask your kids to do. If your kids are doing more for you than you can do for yourself, it's time to look at those opportunities because you want to make it when you can still do that, otherwise you might bypass the independent side and go directly into assisted living.

John: Sure. That's what we're talking about. There are people who choose the independent living side so that there is a continuum of care over time.

John: What about long term care insurance? Do you have many people who utilize it?

Claudia: Yes. In fact, we bring educators in to talk about that. What does it mean for people? Do they need somebody to take a look at their policy and explain what's there? What exactly does it cover? No offense to insurance companies, but they're proficient at not allowing you to have your money. And a senior isn't one to be aggressive, or an advocate for themselves if they don't really understand everything. They're really counting on that person on the other end of the line to give them the best information for them to move forward. That isn't always necessarily what happens.

When I first started my job here, a retired lawyer moved onto campus. He got a long term care insurance policy. He read through that policy carefully. He paid a higher premium in the beginning so it wouldn't be raised as it matured. Unfortunately, that company went out of business and sold it to another company that didn't do that. It caused his policy to mature to a point where he couldn't afford it. He was in my office in tears because he couldn't afford the premium any longer.

But several people that live in our nursing home have long term care insurance and it has helped them immensely. I've experienced that myself. I took care of my grandmother, who had Alzheimer's. I had to put her in a facility for a while

after she broke a hip. That long term care insurance paid $275 a day for her stay at a very nice facility that provided wonderful care. Without that policy, I don't know what type of facility she would have ended up in.

John: It's so important to educate people to at least look at that option. It's not right for everybody, but for the right people, it's a blessing. Talk to me a little about the look of Good Samaritan. I mentioned earlier that it almost has a park-like setting. Much different than the institutional look many people perceive for nursing homes or senior facilities.

Claudia: Well, we're on 200 acres. But if you go to different Good Samaritans, it's the same feel, that you're one with nature and you can walk out and take in the beauty of what's available to you. Places don't have to be horrible just because you get older. It can be a place where you thrive. It can be a place where you can build upon your spirituality. It can be a place of growth, to help you through whatever transition you're going through.

I love how the whole idea of senior care has so evolved over the years. I used to work for Leisure Care, which was on the cutting edge for senior care. They're building properties on university land, so people from the university can interact with the residents, and they can interact with the kids at the university. Or maybe continue their

own education and get that degree they couldn't do because they were raising families.

They're putting in golf simulators and bars and other things. Senior care is ever evolving. As baby boomers, we're probably going to want more than this generation wants. We may also be open to this idea because owning a home is expensive as you get older.

John: Think about it. If you stay in your home, you're doing much more maintenance, which is costing you money and robbing you of the time to do the things you're passionate about. What a great time in your life to not have the chores to do and be able to pursue your passions.

Claudia: Here's something else to consider. We have lots of people that live here that are snow birds, so they have other homes. We have people that leave six months out of the year. We have an RV lot, so we have residents who will take off for a few months at a time. They're active and living their lives.

They can leave, knowing their home is going to be cared for, and they aren't spending huge amounts of money, so they can afford to go and do things. We do keep costs down, which allows people to have the money to be able to enjoy their lives. Because it's really about the quality of life at this point.

John: Food is important to people. So tell me about the food service here.

Claudia: If you ask one person about the food here, they love it. If you ask someone else, they hate it. One hard thing about aging is your palate ages too. Things like medications can change the ability to taste foods. Dentures too. Taste buds are covered up a bit, and you need your whole mouth to be able to take in that food and enjoy it. Lots of things can change.

I think the food is good here. But I don't eat here every day. I'm a vegetarian and they tend to lean heavy on the meat side, unless it's Friday, which of course means fish. But there’s a wonderful salad bar, with a great variety, and they can eat as much as they want. In fact, we provide them with to-go containers because we give them too much food. Sometimes they complain about that, but it’s part of the design. If they’re not feeling up to eating as much, we know they're taking food home and they’ll have it for dinner if they don’t have the opportunity to cook for themselves.

They have a full kitchen in the apartments, but many have chosen not to cook anymore. They can come down for all three meals each day, two meals, or just one. They can do whatever they want. It’s their home.

I do think we have a good meal program here. They do a lot to make it flavorful. There are also alternatives if people don't like what's being served. We just had all our menus revamped by our national campus. Of course, they have a nutritionist that looks over everything to make sure we're meeting all those needs for an aging person.

John: How do people find out about you?

Claudia: That's something I love to do as the marketer. I'm involved in different groups that gives people a face to go along with Good Samaritan. I'm active in philanthropic type events. And we advertise. I have regular commercials that run. We advertise in the Spokane Coeur D'Alene Magazine and a lot of ancillary magazines. We have some outlying areas. That's the beauty of Spokane. We have these small towns like Cheney and Fairfield that have local newspapers where I advertise. And occasionally I do radio. When you're full and have wait lists, you pull back a little bit because you don't need to do as much advertising. But I do keep consistent commercials going along with some print.

We're also online. You can go to our national website, www.GoodSam.com, and learn about us there. There are some wonderful articles and videos. If you aren't ready to come and talk to us yet, but still want to check it out, they have some wonderful educational opportunities at our

national campus. I think we do a pretty good job of that.

And once a year, the Good Samaritan national campus will do commercials in different areas as test sites. We've had several of those happen in Spokane because it’s has been such a popular place for people to move to.

But mainly it's face to face, because that's what makes it real. I can send out as many brochures as possible, but that doesn’t let me talk about the opportunities here. If I get a chance to speak in front of people, like this conversation you and I are having, I think it does a lot to educate the community on what's out there.

One of the other things I’ve found valuable is calling the different agencies that are going to support people on campus. They do a lot as far as referring to us. We do have a VA contract, so we have a lot of veterans living here on campus. We have a wonderful relationship with the hospitals. That's where we get a lot of our referrals from.

But I think the greatest thing is referrals from residents to their friends. We have a lot of those, and that is something I'm most proud of, because it's them talking about their lives here that gets people to come here. Our residents are out greatest asset. Several people on the wait list are friends of our residents.

John: Is there something that you wish I would've asked you about?

Claudia: We covered a lot. I do think the most important thing is, when we are venturing into this area, that we really do take an honest hard look at ourselves and what we want for our future. Do we want to be a participant in that? Do we want to make that decision ourselves or do we want someone else to make that decision? To be realistic about changes. That’s a hard thing for anyone to do, no matter what age you are. But if you are starting to see that things are declining, you want to be able to make those decisions for yourself. Because you will continue to decline if you don't make the effort to change that.

People get frightened, or make allowances. If we’re starting to fall, we don’t tell people that’s happening. But we hold on to things as we're walking in our home. Or we’re just living in our space. Look around your space. Do you see things starting to pile up? Is there food next to your chair because it's easy to pull cereal out of a box and munch on that all day as opposed to standing at the stove? That’s the denial of self.

We are going to age. But we can do it gracefully and with the empowerment of, "I'm going to make my decisions. I'm going to do everything I can to be well. I'm going to take my medications correctly. I'm going to exercise. I'm going to enrich my mind.

I'm going to see my doctor on a regular basis." Those allow you to be the captain of your own ship. I can't emphasize that enough. I think people don't recognize that they're failing a little bit, and they need to do something to change that. That would probably be the biggest thing.

John: Claudia, thank you so much. You pointed out a lot of very important things.

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It wasn't too long ago that multiple generations of families lived within a short distance of each other. This proximity created a built-in support system for elders as they aged.

Today, countless families are separated by hundreds, even thousands of miles. We can easily stay connected through Skype, FaceTime, and other tools, but providing support and care long-distance is a challenge.

The interviews in this section shared valuable information about care and lifestyle options.

PRE-NEED & FINAL PLANNING

End of life. There, I said the words no one wants to hear and no one wants to think about. But it's something we do need to think about, and plan for. Whether we're doing that for our own sake, or to make it easier for our families at such a difficult time.

I hope you look at the next two interviews as uplifting, not downbeat. Because even though they deal with this somber subject, the message is one of comfort and peace of mind.

When people hear the word hospice, they think of death. But as you'll learn, Hospice of Spokane believes it's really about life. About quality of life and getting the most out of the time we have left.

But first, we look at pre-need planning. All too often, families have to plan a funeral during a time of deep grief and great stress. Many people do not realize they can preplan their arrangements, years or even decades before they're needed. They don't realize what a thoughtful gift that is for their loved ones.

I reached out to the staff at Fairmount Memorial to learn more about this important topic.

CHAPTER 14

BILLIE HOERNER & CANDACE ARAMBURU

Billie Hoerner is the Sales Manager for Fairmount Memorial Association. She has worked in the cemetery and funeral business for more than five years, and is passionate about educating people on the importance of advanced planning.

Billie is also a licensed life insurance agent in Washington State. She graduated from Eastern Washington University with a Bachelor's degree in social work.

Her hobbies are cooking, camping, and watching sports with her friends and family. Billie lives in Spokane with her husband and children.

Candace Aramburu is the Marketing Director for Fairmount Memorial Association. She has worked in the funeral industry for several years after previously working in wealth management.

Candace graduated from the University of Idaho with a Bachelor's degree in public relations. She is always looking for

innovative and new ways to educate people on cremation and memorialization.

Her hobbies include spending time at the lake, baking, and spending time with her family. Candace lives in Cheney with her husband and son.

Billie Hoerner and Candace Aramburu help families at one of the most difficult times of their life. But they also help families years before the loss of a loved one, and help spare them the challenges of planning final arrangements while in mourning or even shock.

I did this interview to bring more awareness to pre-need planning, and how reassuring it can be for you and your family.

John: Fairmount Memorial Association is more than just cemeteries. Talk a little about what you offer.

Candace: Fairmount Memorial Association has seven cemeteries in the Spokane community on our nonprofit side of the company. On the for-profit side, we have Heritage Funeral Home, and three cremation storefronts called Pacific Northwest Cremation. We opened those because of the movement toward cremation in the Pacific Northwest. Our cemeteries have been here since 1888. It's a really cool company to work for

because we're run by a board of directors and all the decisions are made locally by our board.

John: Let's find out about each of you individually.

Billie: I’m the sales manager. I've been with the company a little over five years. After about seven or eight months I realized it really was my calling. I enjoy meeting with families, helping them with the pre-need side so they’re protected, and also working with families who had just lost a loved one. It's very rewarding to help people during that difficult time, and it’s equally rewarding to help people pre-plan their arrangements, because you know they're giving their family a really good gift. They're hard decisions for people to make, but the benefits are truly important.

Candace: I’m the director or marketing and community outreach. I came to the industry about a year and a half ago. It's not something people dream of doing, but the longer I've been here, seeing what our funeral directors, our family services and our grounds crew do every day for the community, has had a huge impact on my life. I always get very emotional when I talk about it because it's so great.

I see it as getting the opportunity to educate people on something that they don't always want to talk about. The more people know, and the more they're aware and able to have these

conversations with their family and know that it's a normal thing, the better. Making them feel comfortable enough, and educating them on all of the things they can do, has really been rewarding for me.

John: I feel this is one of those things people need to get more comfortable with, and more knowledgeable about, so they can make good decisions and not put it off until someone else has to make the decisions in one of the worst times of their life.

Very few people plan ahead on this. Why is it that? Why do they put it off so long, or until someone else is forced to make a decision? How can we get people to understand the importance of pre-planning?

Candace: They don't want to think about it, because to most people, death is scary. If they've experienced a death in their family, it wasn't a good memory. For us, it's explaining to people and educating them that pre-planning is the best gift you can give your family. This gives them the ability to not only make the decisions you wanted, but also to carry out your memory. We plan for graduations, we plan for weddings, but people tend to push off funerals and memorializing because it's scary, and we don't want to talk about that until we have to.

You can pre-pay, or you can pre-plan without paying for anything, but just have the

conversation. Make sure it’s what you want. Let your family know now so that it can be carried out exactly how you've envisioned it.

John: Let's imagine two different scenarios. A family shows up when a loved one has passed away, with no pre-planning. What’s their experience versus when someone has already pre-planned?

Billie: When we meet with a family that hasn't planned anything, or their loved one didn't plan anything, the family is left to make a lot of decisions. “Do we cremate? Do we do burial? What would my loved one want?” They're grieving the loss of their loved one, and now they have to make some major lasting decisions. There is also the financial burden of it. A lot of times, you see families struggling to gather all the money they're going to need to do whatever they decide. There's so much to plan, and it's usually done in a very short amount of time, when they are already in shock and in grief.

The families we meet with that have already pre-planned tell me over and over, “This is such a relief. I'm so glad Mom already had this all taken care of.” All they really have to do is come in and talk about the little details and sign the paperwork. They don't have to worry about how they are going to come up with the money, or if they are doing what their loved one really wanted to do. It leaves the family the opportunity to spend more time with their friends and family, and share in the

memories and celebrating the life of their loved one, instead of having so much stress over what decisions they have to make.

John: Having to spend all that time making these decisions, maybe consulting with other family members, is likely eating up a lot of time that might be better used consoling the family members in the grieving process.

Candace: And just enjoying their memory of their loved one.

Billie: If there weren't plans already in place, a family could spend hours with the funeral director making all those decisions. If it was already put down on paper, everything is already determined. "This is what I would like. This is what I'm going to wear. I would like this kind of service." Not having to figure out all those details would make a big difference.

John: As a child, I don't remember a family member ever being cremated. Now, it just seems so common. What has created that change? Is it a cost issue?

Candace: I think Washington State now has about a 70 to 75 percent cremation rate. I think the Pacific Northwest is a unique part of the United States because the cremation rate is so high. I think a lot of that has to do with us just being a very educated part of the United States, but the people are very transient, and we're movers, not set to a specific

location. Things change, and we're quick to the new way of thinking. I also think cost probably plays a little bit into it. Cremation can be less expensive when compared to traditional burial.

Billie: Times are just changing. I don't think people really want the traditional funeral. It's really more about celebrating a life. It's not as important to do a viewing, or it's just a different way that people are doing services. They think, “Let’s do a cremation and then we'll have a big celebration.”

John: Do most people take the ashes home?

Billie: There's a large group of people that do, but we educate people that they could take the cremated remains to the cemeteries. A lot of people don’t know that. We have a lot of really beautiful options for that. I think over the next 20 or 30 years, it is going to change. Because, they take Mom home, put her on the mantle, and then the next person passes away. So at some point there's going to be a collection of remains that the family doesn't know what to do with. There are a lot of options in the cemetery.

Candace: We have things that fit all different families, whether it's a cremation garden or a glass-front niche where they can keep some memorabilia or pictures of their loved one alongside the urn. Ground burial is even an option. People that

purchased family plots years ago can use them for the cremated remains.

People don’t realize there are so many options. When my friends tell me they’re just going to be scattered, I ask them if they realize how many people have been affected by them, or they’ve left a lasting impression on. How will those people have a place to come remember you? That’s why a cemetery is such an important part of our lives. It gives people a place to go.

Scattering is popular, but I always tell people, "What if that land changes? What if a Walmart comes in?” 20 years from now, a lot can change, but our cemeteries will always be here.

John: There is something very special about the process of visiting a cemetery where one of your loved ones is. It's a very reflective, peaceful time, and that is important. You mentioned the cemetery will always be here. I’ve noticed in some small communities, cemeteries are not very well maintained. Why are some cemeteries so gorgeous and beautiful and well maintained, and some look like they've been abandoned?

Billie: The smaller cemeteries that you're speaking of are probably not endowed. Some of the bigger ones, like ours, are endowed cemeteries. Each time we sell a piece of property in the cemetery, 10 percent of the cost goes into an endowment fund. That

money sits there and we don't touch it. The fund will always care for the cemetery.

John: Are they just using the earnings from the endowment and not the principal?

Billie: Part of the earnings is used for maintenance and care of the cemetery. The main principal remains in that endowment.

John: Let's go back to pre-planning. People can pre-plan and pre-purchase. What's the difference?

Billie: If you pre-plan and pre-purchase on the funeral side or cremation, we use an insurance company that holds the funds for those pre-arrangements. We meet with the family, find out what they want, write it up, and then they can either pay in full or make monthly payments. It goes to the insurance company. When they pass away, those funds are available right upon death to pay for their arrangements.

If a family just wanted to put something in writing, so everyone knows, "I want to do cremation, a memorial service, and here are the details," we'll also keep that file at our funeral home. They would just let their loved ones know that we have the file. We would have all the information of the person's wishes. But it hasn't been pre-funded, so the family would still have to pay.

John: What happens with escalating costs over time? What if someone pre-pays and lives another 30 years?

Billie: We guarantee the goods and services at the time you sign up. The insurance policy does gain some value over time, so there's a little bit of a buffer in the escalating cost. But your family will never have to pay extra money.

John: If they're pre-paying and they decide to make payments instead of paying in full, is there a typical length of time for those payments?

Billie: For our company, on the cemetery side, it's 60 months. On the funeral side, it's an insurance policy that goes up to 10 years, depending on your age and your health. You don't have to go to a doctor; it's not that kind of insurance policy. We just have some general health questions.

John: What happens if they pass away two years into this 10-year plan?

Billie: Then the insurance would kick in, and pay the full funeral amount they had picked out. In addition, for people who don't qualify for the insurance product or don't want to use it, we also have a trust that guarantees your services. It's normally $100 down, then monthly payments. But if people are on a limited income, we can make the payments as low as $10 a month. Obviously the

payments would last longer. Also, it's not like an insurance policy, which lapses if you miss a couple payments. This option is a little more flexible, which works for certain people.

John: When a family member dies, is there a typical length of time from that date to the services?

Billie: There are some variables. Are they being buried, or is it cremation? If it's a burial, certainly there's more of a time limit. One of the nice benefits for cremation is families can wait a while for services if they want. Sometime they need that. Family members can't get here from out of town, or it's the middle of winter and they would rather do it in the summer. We do see that more often. The time frame usually depends on the family's wishes.

Candace: A lot of people think when there's a death they have to make these decisions right away. But one of the things our funeral directors always tell people is, "Take a few days. Think about it. Your loved one will be fine in our care. Just make the right decisions. It doesn't need to be done right now. You have a few days, so really think about what you want, and just make the right decisions."

John: If someone does decide not to put this off, and actually look into it so they can take charge of their arrangements, what steps do they take? What happens when they call you?

Billie: We would meet with them. We have trained counselors that will help lead them through that process. There are a lot of questions. Basics like whether they want cremation or burial, and what they envision for a service, and then we build from there. The counselor would give them the available options, and the family would decide what works best for them. if they decide to pre-fund, certainly there’s paperwork to do, so we get that all done.

John: Here’s a hypothetical question. One spouse is cremated, the other is not. Can they be buried together?

Billie: Yes, absolutely. That's actually pretty common. When you buy a plot, you would need to purchase an additional use for that plot. We can do a cremation and a full burial, or we can even do two full burials in one plot. It’s called the double depth. The vault is deep enough to hold two caskets. If it’s a combination, we can do one burial and up to three cremations, or we can do up to four cremated remains in one plot.

Candace: A lot of our niches can also hold two people.

Billie: Some that are even bigger. We have family niches as well.

John: What is a niche?

Billie: A niche is in either a mausoleum or a burial wall you'll sometimes see outside. It's essentially a little niche in the wall that can hold cremated remains. In the mausoleums there are also crypts which would hold a casket. Some people don't want to be buried in the ground, so this is an aboveground option.

Candace: It's also not outside, which can be appealing to people given how long our winters are here. The family can gather inside around their loved one's niche.

John: This has been a very comprehensive interview, but is there something you would like to share that I haven't asked about, or something that's worth reinforcing?

Candace: When people are choosing cremation, a lot of them don't understand their options, both on the funeral side and the cemetery side. There are many different options. It's possible to have a viewing and an open casket service, then be cremated after the service. I think a lot of people believe if they're cremated they don't have the option of a viewing or a traditional funeral service. Those are all possibilities when you're choosing cremation.

I should add, when you are pre-planning, remember to do your research. Have a list of all the questions you need to ask a funeral provider,

from who will pick up your loved one after they pass, to where they will be taken, and everything that happens along the way. It's important to know all the details. And take a tour. Visit the funeral home, the cemetery, the crematory. Meet the people. Really understand the team that will be caring for your loved one.

John: It really is a gift to the family to do as much of this planning in advance that you can. Thank you both very much. This is going to be very helpful to people. If nothing else, I hope it leads people to have these conversations with their families, and then call someone and say, "Help me. Help us make some good decisions."

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No one wants to think about death. But planning your final arrangements, hopefully many years before they're needed, is one of the most loving things you can do for your loved ones. Doing this allows them to grieve without the added stress of making complicated and challenging decisions.

As more people become aware of pre-need planning, more families will have an easier time of it when going through the difficult time of losing a loved one.

CHAPTER 15

GINA DRUMMOND

Gina Drummond has been the CEO of Hospice of Spokane for more than 15 years.

She is a registered nurse and has a Master's Degree in Nursing from Montana State University. Gina served 10 years at Peace Hospice of Montana in Great Falls before coming to Spokane.

Hospice of Spokane was one of the first hospices in the nation. It marked its 40th anniversary in 2017.

Dignity. Compassion. Comfort. Those words come up again and again when talking with someone from Hospice of Spokane.

It's important to note that while Hospice assists people at end of life, their focus is not on death. It's on life, and making sure that both the patients and their families have the comfort and peace of mind they need. I know you'll find Gina Drummond's interview as reassuring as I did.

John: Gina, you have a 23-year career with hospice. Take us back to the beginning and tell us what led you to hospice.

Gina: My background is nursing, and I came to know hospice care as an oncology nurse. I remember being so drawn to the way the hospice team came in, met with the patient and family, and provided the support, education, and guidance that was needed without taking their hope away. That allowed them to take it all in, at their own pace, and I remember feeling I wanted to be part of that.

I think it's so important for us at the end of life, as throughout our lives, to be truthful with one another. It can be such a relief for hospice patients and their families to have nurses, social workers, and chaplains who attend to their needs and allow them to talk honestly and freely about how they’re feeling and what they’re experiencing.

I like to say that we see tremendous healing at end of life, in patients and in families. We're reminded of what sacred work we do, and how honored we are to do it. When I found hospice, I knew I had found what I was truly passionate about and could spend the rest of my life doing.

John: I've dealt with many clients that go through illnesses and end of life care. I've seen people who embrace the journey and have a real grace and peace about what they're experiencing. I’ve also seen people who

were bitter. I'm sure you experience a wide range of emotions as people are on this journey.

Gina: We are all going to face it differently. My guess is the way we face our end of life journey is probably going to look a lot like how we've faced other challenges in our life. The people who inspire us have probably met most of their life challenges with grace and dignity. We can all be inspired by that, and learn from them, and hope it influences how we approach the challenges in our lives. Life doesn't always go the way we expect. There are people who feel betrayed. We do hear things like, “I thought I was going to get to retire. I thought I was going to have time with my loved ones and live the golden years." I think how people handle this has to do with how we've met challenges in our life and what we have relied on.

John: What happens when people discover they should consider hospice care? I’ve seen people in that situation automatically think, “I’m dying.”

Gina: People are reluctant to talk about hospice. They're reluctant to embrace our care. Often, they think this means they’re giving up, and they can no longer have hope. But I like to remind people that hospice is truly about life, living, and maximizing the quality of the time that’s left. We focus on making sure every person we serve has the best quality day they can possibly have, and their families have the support they need. Once we get those symptoms managed, we can help folks explore what's meaningful to them.

How do they want to spend this very important time and with whom? We strive to overcome the notion that hospice means giving up.

Research has actually shown that with hospice's involvement, people not only get better quality time, but they may get more time, because we're not just providing symptom management, but also great medical care. We've changed dosages or discontinued medications with people because they weren't needed anymore. We help people get better quality of life, and address issues that will allow them to live better, longer lives.

John: I would think emotional care as well. Just being around people who truly care about their well-being, at this moment, has to affect their mental state.

Gina: I talk about hospice care being mind, body, and spirit. The needs we address are physical, emotional, social and spiritual. We provide a very comprehensive and holistic care to not only patients, but the entire family.

John: I have never heard anything but praise from anyone who has experience with hospice. That's patients and their families. So this resistance to hospice tells me there's that misunderstanding about what hospice is. It's great to be able to have this conversation and share with people what hospice is really about. Maximizing the time left. Be as comfortable as possible. Be as engaged and loving as we can. So

people understand hospice is not something to be fearful of, but possibly to embrace.

Gina: For someone who is really reluctant and has a lot of fear about hospice care, I also like to remind them that hospice doesn't dictate the outcome. If anything, you're going to get better quality of life, and possibly more time with hospice's involvement. Because we have people going in to address the safety in your home, get the equipment that's needed, adjust medications that are required to manage symptoms, and manage other issues or medical conditions they may have.

In fact, when we address those things, occasionally people stabilize and get discharged from hospice. Nobody's happier about that than us. We call it graduation.

John: Where does hospice care take place?

Gina: Hospice is a philosophy of care and can be provided in whatever setting the person calls home. It can be their own home or the home of a family member or friend. It can be a skilled nursing environment, an adult family home, an assisted living environment or the hospital. It can also be Hospice House. We have two locations within our community, one on the south side and one on the north side.

John: When they're at Hospice House, is there a time frame that you decide it's time to move someone into the hospice house? How does that work?

Gina: Usually someone goes to Hospice House because their care needs have become difficult to manage, or maybe they don't have a lot of support in terms of family, or maybe they're frail and an elderly spouse is not able to manage it anymore. For the most part, people want to die at home. It's where our loved ones are, and our pets, and our things, and it’s our familiar space. But if that’s not possible, it's not possible because we don't have the support that we need there, or because our symptoms need real aggressive management, Hospice House is a wonderful second best.

John: How do people pay for hospice? Does insurance take care of this and, if so, what type of insurance?

Gina: 85% of the people we serve are 65 or over, so most are Medicare beneficiaries. Medicare pays for hospice care. The Medicare hospice benefit was designed to meet the unique needs of those who are facing terminal illness. A small percentage are under 65 and on Medicaid. The rest have private insurance or no insurance. As a community non-profit, our goal is to make sure everybody gets the care they need, regardless of their payer source, or whether they have one.

Private insurance typically models its hospice benefit around the Medicare hospice benefit. And, certainly, Medicaid mirrors Medicare.

John: Because you’re a non-profit, you probably have grants and fundraisers and donations from people.

Gina: We’re so appreciative of the community support. We couldn’t do it without that support. It’s been essential to us.

John: What's the process? When someone is told by their doctor or someone else they should consider this option, who calls you? Do you go meet with the person and their family at their location?

Gina: Sometimes the physician’s office calls us, or someone at the hospital, or the skilled nursing environment, or whatever long term care setting they're in. There are times the family calls us. Hospice requires a physician's certification of terminal illness, that they have a prognosis of less than six months, and they're no longer seeking aggressive, life prolonging treatments.

We meet with them wherever they are. Certainly we want essential family members to be present, or whoever they determine should be at the meeting. I always encourage our admissions team members to start with asking the patient what's been going on. I think it's important for people to start with their story, rather than for us to start with our list of ways

we can help. It’s important for us to know how things have been going and what their challenges are. We listen, then share, and then we listen again. By the end of the meeting, my hope is they don’t see us as people who are going to come in and tell them how they should be doing things differently, but see us as people who are going to listen intently and address issues they're willing to help us address. Because they're in the driver's seat. They're in charge. Our job is to just help them navigate and achieve as much comfort and peace as is possible for them.

John: You said they have decided not to seek life-prolonging treatment?

Gina: They're no longer doing aggressive treatment. We don’t offer that.

John: So this is the point where someone truly has to face mortality.

Gina: My goal always is for people to know it's not that you can't have hope, because we're creatures of hope. As we go through our lives our hopes shift. Certainly at end of life. So it’s not that you can't have hope, it's just that maybe your hope is going to shift a bit. What’s meaningful to you now? How can we facilitate what and who are important to you, and make sure you spend your days doing the things that mean the most to you.

John: So receiving hospice care does not necessarily mean bedridden? Let's address that.

Gina: The most common feedback we receive on a satisfaction survey is, "We wish we'd known about you sooner." Our goal is to make sure you feel so good, you can focus on what's meaningful in your life and how you want to spend this precious time.

My own father is on hospice care right now. Three weeks after his admission, he went and bought a different car because he was having trouble getting in and out of the one that he had. He's still living his life, and he's focused on the things that mean the most to him. Spending time with family, sharing his stories, and parting gifts to loved ones, doing the things that are meaningful to him. And he's focused on life.

John: That's a wonderful thing for people to realize, that you don't have to wait until you're bedridden to start receiving this compassionate care. I'm really sorry to hear about your father, but I thank you for sharing that. I know that's not an easy thing to talk about, but it's a great example of what people need to hear, to be open to how much more comfortable they can be at this phase of their life.

Gina: I think when we go through our lives being aware of the fact that we will die, we live a little differently. It's a great awareness for us to have, because we are probably more mindful of making sure we're on good terms with all persons as much as possible, and we

don't let the small stuff get in the way of what's really important. But for people at end of life who maybe haven't spent their days with that knowledge, it's a little more challenging.

John: You're right about how much we learn from the time we spend with people who are going through an illness or dying. Because for whatever reason, they're willing to share more of their life. I've known people for years, and when they're ill the stories they tell you are much different than what they've told you before.

Gina: There are no masks. You're more focused on what really matters. And hopefully, for those of us who hear those stories in the work we do, such as you and me, it changes the way we live.

John: Absolutely. It's made me very aware of how precious even the small moments of time are. I'll give you an example. I went out yesterday morning to get the newspaper. It was early, but the sun was shining and it felt wonderful. I went back in the house, washed a plum, went back outside, and just stood in the sun and ate the plum. I thought, "I never would have done this when I was 30, and had young children, and life was different."

Gina: You might not have noticed. There's a book called *The Miracle of Mindfulness.* It's a great book about what you're talking about, just being present to the moment. When you're washing dishes, enjoy the task

instead of resenting the time you're spending doing it. Just be present to that moment.

I think in the work that we do, we talk so much about the power of presence and what it means to be with someone who's totally present. We want that to be the experience for the patients and families we're with, because they might not have tomorrow. You want every second you are with them to feel special.

John: It reminds me how in tune you get to people, partly because of the stories they start telling. I had a friend who was in her 80s. She wasn't dying, but she was ill, and she's since passed away. When I would sit with her, she would tell stories of her childhood. One was how her family couldn't afford a car when they first came out. So they would make a trek into town with their donkey once a month to get supplies. They couldn't even afford a wagon, so they loaded the donkey and everyone carried things. It was a two-day roundtrip, so they would camp on the side of the road overnight, year round, the whole family. They didn't like to leave anybody home. She remembered making this trek countless times as a child.

Gina: And that it was special time.

John: It was. That's the kind of story she loved telling, and I loved hearing. But she didn't tell stories like that prior to her becoming ill. Because life was quicker. Everybody has so many other things going on. But there's this stage where everything slows down and

conversations change, and they're far more meaningful.

In the time you've been with hospice, what changes have you seen?

Gina: We've seen a lot of growth in the hospice industry. More and more people are being served by hospice at end of life, and I think that's a good thing. Also, I would say many years ago the majority of the people we served were cancer patients. Now, less than half have a cancer diagnosis. I think we've done a better job over the years of making sure everyone has access to hospice care, and educating the community about the difference that hospice care can make for anyone with any terminal diagnosis.

There's also more regulatory scrutiny than ever before, and more regulations added to ensure that all hospice care providers serve patients who are truly terminally ill. We need to be good stewards of the Medicare dollars that support hospice care. Our job is to make sure if people do stabilize, they get discharged from hospice. We also need to make sure every person we admit truly meets the guidelines in terms of having a prognosis of less than six months and being terminally ill. There are hospices out there that have not been as vigilant about that.

John: Who are the caregivers for hospice?

Gina: The team is comprised of physicians, nurses, certified nursing assistants, social workers, chaplains, counselors and therapists, and specially trained volunteers. The team's job is to make sure every person we serve has the best day they can possibly have, and as many of them as possible. And, to support their families in the meantime.

John: I've met a few volunteers over the years. Every one of them tells me it's the most meaningful work they've ever done in their life. Someone reading this might be interested in helping. What do you look for in a volunteer? What are their roles?

Gina: There are many varied roles in the organization for a volunteer. We have volunteers who sit at a patient's bedside. We have volunteers that help with outreach, development, and our community fundraisers. We have volunteers that help with bereavement. We have volunteers who help with mailings. It's a wonderful opportunity to help people at end of life.

We look for people that are great listeners, who don't come in with an agenda, who are willing to be present to people's pain, and not feel they have to fix it. I think it's so important for anyone involved with hospice care, to know that people need most from us is unconditional, positive regard. We listen as they share their stories, and we listen as they share the ways they don't feel good about how their life went. We are there for them.

One way our volunteers support people at end of life is writing letters. Sometimes patients want to write letters, but don't have the ability to physically do that. So they can dictate a letter to the volunteer. It can be a letter to a son or daughter they've had a very complicated relationship with, and they have hopes for some reconciliation. Occasionally those letters make a big difference, and we see tremendous healing. Sometimes, they decide not to send it, but there’s value in having written the letter.

John: We’ve been taking about hospice care. We hear the phrase palliative care as well. Can you tell us the difference?

Gina: Palliative care is all about support, and symptom management, and helping people feel as good as they can for as long as they can. That support can be physical, emotional, social, or spiritual. Our palliative care program was designed to meet the needs of individuals and families who are facing a life-limiting, or life-threatening condition.

Hospice is always palliative care, but palliative care is not always hospice. Palliative care is broader. Hospice requires that a patient have a less than six month prognosis, and that they're no longer seeking aggressive therapies. With palliative care, there's no such requirement.

John: When I do these interviews, I don't always know what I should be asking. I just know what I'm interested in.

Is there something you would like to share, that you're thinking in the back of your mind, "Gosh, I wish he would have asked me about this"?

Gina: I didn't say much about bereavement support. That is such an essential part of the care that we provide. As we journey with that patient and family, and the loved one dies, we provide the support that family needs beyond the death. It can be tremendously essential to a frail, elderly spouse who now is alone, or families that are really struggling with a loss. Not just the loss of a parent, it can also be the loss of a child. Bereavement support is tremendously important and essential in terms of the work we do.

I would also reiterate how important it is to think about hospice care sooner rather than later. Our median length of stay currently is about 12 days. That means half the people that we admit are gone in less than two weeks. They likely could have benefited from hospice care long before that. It's hard to make the kind of difference we know we can make, when we have a limited time. Sometimes it's just hours. All we can really hope to do with that time is help get those symptoms managed, and educate that family about what's going on.

Education is such a huge part of what we do. When people have the education and preparation they need, they can feel more empowered. When they feel more empowered, the fear and anxiety can be minimized and fall away.

We serve patients of any age, with any terminal condition, any end stage disease process. So much of what we do is about caring not only for the patient, but also the family. Because this is their journey, and our job is to help them navigate this time with as much comfort, dignity, and peace as they can possibly have.

We know in healthcare we can't always cure. But there's usually some room for healing in our lives, and that's certainly what hospice care is all about.

John: Wonderful. Gina, thank you so much. This has been very informative.

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I got a great deal of comfort out of this interview, and I hope you did too. Families deal with Hospice at such a difficult time. Knowing the end is near for a loved one, and wanting them to be as comfortable and peaceful as possible.

Hearing Gina describe their work as sacred, and how honored they are to do this, makes you realize how special this organization and its people truly are.

I didn't come away feeling sad, I came away feeling uplifted, knowing that myself or a loved one would receive this type of care at this critical time.

A SPECIAL GIFT

I found this final interview especially inspirational. There are several reasons I wanted to interview Tiffinay Walker, of *One More Time*. The first is because I am so impressed with their mission. I want to make sure as many people in my community as possible are aware of this organization.

I also want people from around the country to know about *One More Time* in case they would like to introduce this concept where they live.

Finally, this is a non-profit that is supported by donations and fundraisers and they would appreciate any type of support the public is willing to provide.

I think you will be as moved by her interview as I was.

CHAPTER 16

TIFFINAY WALKER

Tiffinay Walker is the founder and CEO of *One More Time*, a new non-profit which was established at the end of 2017. Its mission is to help adults with life-limiting conditions enjoy a memorable experience they would not otherwise experience.

Tiffinay envisioned this unique and wonderful idea after the sudden death of her father, when he was only 58 years old. Although she can no longer have memorable moments with her father, it fills her heart to offer and re-create these experiences for others.

One More Time currently can provide experiences in the five Northern Counties of Idaho and Spokane.

I saved this interview for last for a couple reasons. One, because I couldn't group it with any of the others. While *One More Time* can do wonderful things for retirees or senior citizens, their mission is not exclusive to that age group. They can help people of any age. And the mission itself is truly unique.

The other reason is because I found this conversation to be so emotional. When you hear how Tiffinay started this organization, and what she gets out of it, I think you'll be as moved as I was.

John: Tiffinay, please explain what *One More Time* does, because it's fascinating to me.

Tiffinay: *One More Time* is a non-profit company that helps adults with life-limiting issues have a memorable experience one more time. That's where the name comes from. The idea came from the sudden loss of my father in February 2017, at 58 years old. He got pneumonia and was stubborn and went to work anyways. He became septic and passed away. With the grief and loss I felt, I wanted to do something to memorialize him but couldn't decide what.

Then seven months later I helped a woman nearing the end of her life with Huntington's disease. That's a truly horrible neurological disease that takes away your physical and mental abilities. Patients get extremely thin because they're constantly moving, and can't take in enough calories because they can't control their swallowing.

This woman needed to see a doctor to get hospice care. I agreed to drive her, accompanied by a friend of mine who's a nurse. When we got back home, this woman who had been non-verbal for months, spoke. She said, "Don't stop driving." She was enjoying being out. So we did. We drove around

some more. And she died 36 hours later. This was her last time in a car, enjoying the sunshine.

Her death was the catalyst for me. Could I do this with other people? Is there anything like it? I began researching, and there isn't. There are different legacies and things, but there is not that "Let's help with a bucket list item" or "Let's do something." So I started doing the paperwork for 501(c)(3) and got it back from the IRS at the end of 2018.

John: I was so intrigued by your organization. I was discussing this interview with my wife and told her the best description I could come up with for *One More Time* is *Make a Wish* for people who are adults.

Tiffinay: That is exactly right. That's the typical description that I use. Everyone is so familiar with the Wishing Star Foundation and what they do. But they stop when you become 18, so if you're diagnosed with terminal brain cancer at 22, *Make a Wish* isn't going to take you on a hot air balloon ride but *One More Time* will.

The outpouring of support has been amazing. People hear about it and want to help. They're always asking, "Have you done this? Have you done that?" Someone offers their boat, or their son's boat, to take people fishing or just for a ride

John: Let's talk about your background, because your career does play a role in this.

Tiffinay: I do community outreach for home health. I've actually spent my whole life in health care. My mom worked at a Good Samaritan, which is a long-term nursing home, when I was one. I was volunteer of the year there when I was 17.

If I had any regret about *One More Time*, it would be that I didn’t think of it earlier. I spent all this time with the elderly, and we did all these things with their recreational activity groups, but I never thought about taking it further.

Also, I’ve been a Certified Nursing Assistant for 20 years, so I’ve been trained to do this, and that helps in coming up with ideas. Because I’m a CNA, I was able to transfer the woman I mentioned with Hutchinson’s Disease. I was also able to personally take a woman to a Willie Nelson concert a few weeks ago. Otherwise, I’d have to ask people for a lot more help.

John: How are you funded?

Tiffinay: We get donations. I also took a class to write grants. I haven't written one yet but I plan to. That's my new goal. Also, because of my home health background and the fact that I’ve lived here my whole life, I have many close, long friendships and working acquaintances.

A friend who works at Auburn Crest Hospice decided she wanted to do an event for us. So she's putting on what's being called the Ruby Red Premiere, on a Wizard of Oz theme. We're going to do one every year on a different theme. In addition to chairing this event, she and her husband own a tackle shop. They did a family day and donated $400 of the proceeds to us.

Then, Garden Plaza heard about us and loved the idea of what we do, so they're throwing a Festival of Trees called Deck the Halls, and all of the money from that is also going to *One More Time*.

John: That is wonderful.

Tiffinay: And it just keeps snowballing. People are always coming up with ideas. We did a paint night at Ridge View. A local artist offered to teach a class. We had a man who wanted to publish a book, and Bitter Root Mountain Publishing in Coeur d'Alene took it on and did the editing and design for free.
So to answer your question, people have just been helpful. That's where the money comes from.

John: How do people find you? Are they referred by other professionals? Because there's such a caring network of people here in the Spokane and Northern Idaho area.

Tiffinay: It has been all referrals that way. They've all come from hospice with the exception of my treasurer's

husband. He has terminal cancer, and when we first got started I told her I wanted to do something for him. He had gotten sick so suddenly he didn't have a retirement party. One day he was at work, the next day he was gone. He had worked with many people during his career and was very well liked. So he asked for a retirement party. We threw a party for about 600 people. That was our inaugural event.

John: It appears to me that this gift you're giving is not just to the individual, it's also a gift to the family, because it's creating memories and allowing them to share.

Tiffinay: It really is. When we took that woman to the Willie Nelson concert, I called her husband to talk to him about presenting her with the tickets, and he said, "I feel like we won the lottery and never had to buy a ticket." It was such a sweet thing when he said that. It makes me so happy. So yes, it's for their families as well.

John: You're helping to create memories and they're sharing a very positive experience in a possibly very sad and challenging time. Because everybody deals with this stage of their life differently.

Tiffinay: One of the programs we've been consistently doing is birthday parties for people in hospice. We get their favorite dessert, and they get a celebration. If the families allow us, we post the pictures on our Facebook page. We did one party around a holiday

so I was late to post the pictures, but when I did, his son thanked me because that was the last picture taken of his dad. He said, “You made his day and we had a special memory, and then this picture pops up on my feed, which was wonderful.”

John: Where can people find your Facebook page?

It’s called *One More Time NW* because right now we're only doing Coeur d'Alene and Eastern Washington. The page is just getting started. We also need to get the website up. I want to start airing podcasts, to help share these stories. It’s another way to keep memories alive. I’m calling them “Tell Me Your Story One More Time”.

John: Other than the website, what else is on your wish list right now?

Tiffinay: I'm trying really hard to get a hot air balloon because it's something I did with my father. It was very random. In fact, my mother and sister didn't even know that it happened. It was the Idaho centennial, back in the 90s, and one of the banks got a hot air balloon. My dad said, "Hey, let's go do that." I want to have a hot air balloon day. I've had a lot of trouble finding a company that’s open to doing that, because it's going to be seniors, or people in hospice, or those with other issues. But I have my fingers crossed that I've found one.

I actually have a woman now who’s only 55, who has colon cancer that has spread. She said a hot air balloon is on her bucket list. So I really want to get it for her.

John: I hope that happens. I would imagine, as time goes by, you may even have a menu of experiences for people to choose from, because of all the people and businesses committed to supporting you. So people who may not have an idea what they want would look at a list and say, "I would love to do that."

Tiffinay: A client I take care of for my real job is Catholic. She was telling me one of her favorite moments in her entire life was being with her great grandson, who is a priest, when he did his first mass. It was so important for her. I remember thinking, “I would never have thought of that. I have to remember things like this.” I imagine we’ll get more ideas as we progress and grow.

Here’s something that surprised me. I got the kids gold passes at Silverwood, so I have this availability, and I’ve offered to take people on the roller coaster, but so far nobody wants to do that. I really thought that would be one of those “I want to do that one more time” things.

John: There are a lot of other great things to do at Silverwood besides the roller coaster.

Tiffinay: Exactly. I will keep getting the the gold passes because my kids will use them and then if somebody ever says they want to do it, we have the option.

John: Is it common for someone to request seeing a family member that is far away? Maybe not going there, but having them come here.

Tiffinay: I haven't had that yet. I think it's because we are so new. One of my advisors when I started, who had worked at *Make a Wish*, was concerned that I'd be inundated and not be able to keep up with it. That hasn’t happened. Our growth has been slow, through word of mouth, but we’ll probably hear more of those as we grow.

John: What's the selection process for someone to qualify for an experience with you?

Tiffinay: Life limiting. We did it that way so it doesn’t have to be terminal. It means we can help somebody with a life-altering disease do something they wouldn't normally be able to do.

Somebody who is 30 years old with muscular dystrophy could still live another 50 years, but he's not going to be able to do something physically without assistance. Life limiting is broad, and that’s deliberate, so we can help anybody that needs or wants help. My board has to approve everything, and so far they’ve done that.

We do have an actual application they must fill out. They have to tell us what they're requesting, whether it's for themselves or someone else, what the person's limitations are, and why they're requesting our help. There's a proposed cost with it, but so far it's all been reasonably priced.

John: Is there someone to help people fill out that paperwork?

Tiffinay: We would help them. Also, social workers have given me several of my event referrals, and they've filled the application out for them.

John: Is there a question or questions that you wish I would have asked? Is there something you'd like to share that maybe I have not asked about?

Tiffinay: People always say how giving I am. I'm receiving so much more. It's very cathartic for me to do these things. I can't do things with my dad anymore, but I can do things with other dads.

John: Every one of these experiences is also a memory for you. I experience that with my woodworking, when someone who has never done it before comes in, spends a few hours in the shop, and leaves with something they made with their own hands. I cannot wait to work with you and some of your clients.

Tiffinay: This is so much fun for me, and it’s so emotional. I cry after every one. I was bawling after one of our birthday parties. I couldn't help it. My children are young, and they didn’t understand. They kept asking me if I was sad, and why I do this if it makes me cry. It’s hard for them to grasp that I was crying because I was happy.

John: I certainly get it, and I’m sure the people you help do as well. Tiffinay, thank you so much for helping us spread the word about what you do at *One More Time*.

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It can be the simplest thing that brings joy to the life of someone who has been faced with life changing health issues. I hope you or your family has access to an organization like One More Time if it is ever needed. Organizations like this can only provide these valuable services because of the support they receive from people just like you. Whether it is volunteering, participating in one of the fundraisers or donating money or services, your support directly enhances the lives of adults who may be facing the most challenging obstacle of their life. Your support is meaningful and appreciated.

CLOSING THOUGHTS

I hope you got as much out of reading these interviews as I did conducting them. These professionals shared a wealth of knowledge, not in legalese or government speak, but in plain English that's clear and easy to follow.

Retirement can be scary. Medicare can be confusing. It's all too easy to make costly mistakes. But one of the biggest mistakes is easy to avoid. Don't go it alone. Don't try to wade through these challenging and uncharted waters without guidance.

Medicare is not one size fits all. There is not a "best" policy for everyone. But there will always be an appropriate policy for anyone's individual situation. That is why I encourage you to speak with a local insurance agent that specializes in Medicare insurance to get personalized advice. I also suggest you meet with an independent agent that represents multiple companies. Agents who only represent one company are much more likely to try to sell you their product than educate you so you can make an appropriate decision.

Decisions do have consequences. I want this book to be a valuable resource, so you can understand the consequences of your Medicare decision, and all decisions related to retirement. Because Medicare is not the only thing we need to think about as we approach our 65th birthday, or even if we're still years away. There are many other important

decisions that should be made. Decisions that many people know they should make but keep putting off.

The people I interviewed in this book can help you make those decisions. I'm also happy to have that conversation with you. And I can assure you, it will be strictly educational. Not a sales pitch. Because if this book hasn't already made it clear, I believe my mission is to make sure people are informed, make the right decisions, and avoid the mistakes that can cost them financially and coverage-wise.

My contact information is at the bottom of this page.

But whatever you do, please use the information in this book. The Medicare coverage you need is there for you. The retirement lifestyle you want is there for you. It takes planning and education, but you can overcome the challenges and get through the confusion, and come out with confidence and peace of mind.

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