



## VDA WEEKLY E-MAILING

March 26, 2013

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### NASUAD and ACL Weekly Updates

*Tim Catherman, Director, Aging Operations*

Here is a link to the weekly National Association of States United for Aging and Disabilities (NASUAD) update: [http://www.nasuad.org/newsroom/friday\\_updates/friday\\_updates.html](http://www.nasuad.org/newsroom/friday_updates/friday_updates.html)

Here is a link to the weekly Administration for Community Living (ACL) update: <http://www.acl.gov/NewsRoom/eNewsletter/CurrentNewsLetter.pdf>

### Home Use Devices Emergency Guide

*Elaine Smith, RD, Program Coordinator*

“Home Use Devices: How to Prepare for and Handle Power Outages for Medical Devices that Require Electricity” US FDA.

Note: The web links in this document may change over time. DARS-VDA does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.

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<http://www.fda.gov/MedicalDevices/default.htm>

## N4A Nominations for Aging Innovations and Achievement

*Tim Catherman, Director, Aging Operations*

### N4A Nominations for Aging Innovations and Achievement

National Association of Area Agencies on Aging (N4A) call for nominations for the “Aging Innovations and Achievement Awards”. The deadline is Friday, April 12, 2013. More information can be found by clicking on the link: [http://www.n4a.org/pdf/2-Awards\\_NomProcess\\_2013.pdf](http://www.n4a.org/pdf/2-Awards_NomProcess_2013.pdf)

## Housing Virginia’s Upcoming Succession Training

*James A. Rothrock, Commissioner*

Please see the note and link below on an upcoming training session

Greetings from VHDA!

FYI - Housing Virginia is sponsoring a one-day Succession Planning class at three locations around Virginia. This is a very important topic for many organizations with aging leaders and staff. Use the link below to obtain additional details

<http://archive.constantcontact.com/fs121/1102712869256/archive/1112755089391.html>

## Webinar: Implementing Policy Change to Advance Falls Prevention: Training, Examples, and Resources

*Elaine Smith, RD, Program Coordinator*

Thursday, April 11<sup>th</sup> at 3pm Eastern. Find out how you can have a real impact on older adult falls prevention through policy change. Please join NCOA for a webinar to 1) receive training on goals and identified policy changes to advance falls prevention, as featured in NCOA’s

<http://www.ncoa.org/calendar-of-events/webinars/implementing-policy-change-to.html>

2) discuss strategies and indicators for implementing the policy changes; 3) discuss real world examples of falls prevention policy changes being implemented; and 4) learn about resources for advancing falls prevention policy changes in your state or community. Register here

<https://cc.readytalk.com/cc/s/registrations/new?cid=dxfovta9x79a>



## Targeted Technical Assistance to Build the Business Capacity of Aging and Disability Community-Based Organizations for Integrated Care Partnerships

*Kathleen A. Vaughan, NWD Coordinator*

The Administration for Community Living (ACL) is announcing an opportunity for up to ten (10) coalitions or networks of community-based aging and disability organizations to participate in a learning collaborative and receive targeted technical assistance related to business acumen.

Applicants must be seeking to build their business capacity and align their service capabilities in order to contract with health care entities to provide community-based long-term services and supports. No direct funding will be provided through this initiative; rather, this collaborative will deliver targeted technical assistance through a variety of different means, as noted within the announcement.

Applications must be submitted electronically via email to [Lauren.Solkowski@acl.hhs.gov](mailto:Lauren.Solkowski@acl.hhs.gov) by 11:59 p.m., Eastern Time, **on Friday, March 29, 2013**.

Link to the full announcement: <http://www.acl.gov/Programs/docs/Targeted-technical-assistance.pdf>

## NCOA Webinar

*Tim Catherman, Director, Aging Operations*

- Thursday, April 4, 2-3:30 p.m.
- [Register now http://www.ncoa.org/calendar-of-events/immigration-reform-key.html](http://www.ncoa.org/calendar-of-events/immigration-reform-key.html)

As Congress considers comprehensive immigration reform, it's important for the aging and disability communities to be engaged. Immigration reform:

- Provides opportunities to strengthen the direct care workforce and address the projected shortage of workers as the baby boom generation ages and more individuals need long-term services and supports.
- Must remain fully inclusive of aging immigrants and immigrants with disabilities and provide access to health and economic security benefits.
- Can increase the number of younger workers, strengthen the Social Security trust fund, and produce economic benefits for the country as a whole.

Get an overview of key issues in immigration reform and a vision for creating a more just and caring society across generations.



**Speakers:**

- Ai-jen Poo and Sarita Gupta, Caring Across Generations
- Rahnee Patrick, Hand in Hand: The Domestic Employers Association & Access Living
- Ivy Ngo, Southeast Asia Resource Action Center
- Jenny Rejeske, National Immigration Law Center
- Eva Dominguez, Alliance for Retired Americans & Latinos for a Secure Retirement

The webinar will be recorded and posted online.

## HIV and Aging Webinars

*James A. Rothrock, Commissioner*

Please see information below sent to us by Carmen Sanchez with the Administration for Community Living.

ACRIA Center of Expertise on Aging & HIV, STIs, and Viral Hepatitis – Course Offerings for April –September 2012

1. Promoting the Health of Older Adults living with HIV- June 2 & August 21
2. Working with Older Adults living with HIV recently released from Correctional Settings- June 9 & August 21
3. Resiliency of Older Adults living with HIV- May 22 & July 24
4. Sexual Health for Older Adults living with HIV- August 28

To register, go to: [hivtrainingny.org](http://hivtrainingny.org) to create an account and register.

This is funded by the NYS Department of Health.

## Emergency Prep Webinar on High Rise Evacuation

*James A. Rothrock, Commissioner*

From: FEMA-Disability-Integration-Coordination [<mailto:FEMA-Disability-Integration-Coordination@fema.dhs.gov>]

Sent: Friday, March 22, 2013 10:41 AM

Subject: Announcement of emergency prep webinar on High Rise Evacuation

Dear Colleagues;

Marcie Roth, Director of FEMA's Office of Disability Integration and Coordination, would like to share with you the message below from the Pacific ADA Center regarding their upcoming webinar. The next in the "Emergency Management and Preparedness - Inclusion of Persons with Disabilities Webinar Series" will discuss "High Rise Evacuation for People with Disabilities" will take place April 10, 2013. You can register to take part in this free webinar by following the links



listed below. If you or someone you know would like to be a part of this event please feel free to send this forward.

[Pacific ADA Center]

Announcing "High Rise Evacuation for People with Disabilities" - the next session in the "Emergency Management and Preparedness - Inclusion of Persons with Disabilities Webinar Series" to be held on April 10th Produced by the Pacific ADA Center and supported by the Great Lakes ADA Center.

When emergencies strike and people in high rise structures are involved, organized evacuation of the building is necessary. People with disabilities are often thought to be hindrances to this organized evacuation or, worse, are afterthoughts in the evacuation process - putting them at greater risk. This session, will include representatives from building code, evacuation chair development, and fire agencies to discuss how planning, building codes, and evacuation chair and other technologies are being used to improve the evacuation of people with disabilities from high rise buildings. We encourage you to join us on April 10th!!

Title: High Rise Evacuation for People with Disabilities

Time: 2pm ET/1pm CT/12pm MT/11am PT/8am Hawaii

Presenters: Marsha K. Mazz, Director of the Office of Technical and Information Services at the U.S. Architectural & Transportation Barriers Compliance Board (Access Board);

Kimberly Paarlberg- Senior Staff Architect in Technical Services with the International Code Council (ICC)

Glenn Hedman, Clinical Associate Professor, Department of Disability & Human Development and the Director, Assistive Technology Unit at the University of Illinois at Chicago and

Allan Fraser, Senior Building Code Specialist on the National Fire Protection Association staff

Registration: Free on-line at <http://www.adaconferences.org/Emergency/>

These 90 minute webinars are delivered using the ElluminateLive! webinar platform and all sessions will be closed captioned.

The previous sessions in this free series addressed the Federal Response to Emergencies and the State, Local and Community Response to Emergencies. These sessions were recorded and can be reviewed at [www.adaconferences.org/Emergency/Archives](http://www.adaconferences.org/Emergency/Archives)<<http://pacificada.us5.list-manage1.com/track/click?u=6df066ba31e8d8962f4ac9470&id=89b3df9870&e=876ec07b4c>>



The Pacific and Great Lakes ADA Centers are both members of the ADA National Network <<http://pacificada.us5.list-manage.com/track/click?u=6df066ba31e8d8962f4ac9470&id=93bc009f2e&e=876ec07b4c>>

[ADA National Network Information, Guidance, and Training on the Americans with Disabilities Act]

## Alzheimer's Association National Chapter Statistics

*Tim Catherman, Director, Aging Operations*

The National Chapter of the Alzheimer's Association has released the 2013 Alzheimer's Disease Facts and Figures information. You can view the press release and follow the two links below for additional details.

[Virginia Alzheimer's Facts and Figures](#)

[2013 Alzheimer's Disease Facts and Figures - National](#)

## 7<sup>th</sup> Annual Statewide Triad Training Conference

*Tim Catherman, Director, Aging Operations*

The Office of the Attorney General in conjunction with the Virginia State Triad Office and the Virginia S.A.L.T. Council will hold its [7<sup>th</sup> Annual Virginia Statewide Triad Training Conference on April 9 - 11, 2013 at The Williamsburg Hospitality House in Colonial Williamsburg](#). This year's theme is "Triad: A Revolution in Crime Prevention for Seniors", where law enforcement, senior citizens, senior service providers, non-profits and state and local government representatives will come together to learn more and share ideas on reducing criminal victimization amongst the elderly. Attorney General Ken Cuccinelli; NATI (National Association of Triads) President Ed Hutchison; and UNOS (United Network for Organ Sharing) PR and Marketing Director Lisa Schaffner will be addressing this year's Conference.

This is an excellent opportunity to come and network with law enforcement and senior leaders to learn what a positive impact Triad can have for your seniors as well as to learn more about what Triad can do for you in your community. The following sessions will provide a wealth of information: Triad 101 (how to start a Triad); Jumpstarting a Stalled Triad; Protecting Virginia's Most Vulnerable Citizens (focus on Medicare Fraud, Medicaid Fraud & Elder Abuse); Domestic Violence in Later Years and Available Resources in Virginia; Crime Stoppers - Getting Involved Again; Project Lifesaver; Be Scam Smart: Fraud and Scam Prevention for Virginia's Senior Population; Facebook: Friend or Foe?; Understanding Reverse Mortgages; Alcohol and Aging Awareness; and Financial Exploitation of Seniors. The Conference will conclude with a Triad



Roundtable, where you can get answers to questions not previously asked or share your best practices with others.

Attached is the Triad Conference registration form. Please feel free to forward this information to your contacts within your community. **The early registration fee is \$50 if received by March 18. After that date, the fee will increase to \$75. Hotel rooms have been blocked off specifically for Triad. To receive the special hotel rate of \$96, please call The Williamsburg Hospitality House by March 18.** Additional information is posted on our [website](#).

If you have any questions about the conference, please do not hesitate to email or call *Juanita Balenger* at (703) 277-3540. I look forward to seeing you in April!

## End of Life Decision-Making

*Amy Marschean, JD, Senior Policy Analyst*

TIME Magazine columnist and best-selling author, Joe Klein, appeared at a community event in Richmond on March 21, 2013, sponsored by MEDARVA Healthcare and CBS6 exploring what he learned while making medical decisions for his parents in the last days of their lives. Attached is his story, "The Long Goodbye," and the guide that was distributed to help initiate this important conversation with loved ones and the information needed to be prepared when the time comes.



DIVISION FOR THE AGING  
VIRGINIA DEPARTMENT FOR AGING  
AND REHABILITATIVE SERVICES

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the compassion to care, the leadership to conquer

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**CONTACT:** Sherry Peterson, CEO Alzheimer's Association Greater Richmond  
804-967-2585, [speterson@alz.org](mailto:speterson@alz.org)

**NEW ALZHEIMER'S ASSOCIATION REPORT REVEALS  
1 IN 3 SENIORS DIES WITH ALZHEIMER'S OR ANOTHER DEMENTIA**

*2.3 Million Americans are "Long-Distance Caregivers" for people with Alzheimer's;  
Costs for Long-Distance Caregivers are Almost Twice as High*

Richmond, VA , March 19, 2013 – According to the Alzheimer's Association *2013 Alzheimer's Disease Facts & Figures* report released today, one in three seniors dies with Alzheimer's or another dementia in the United States. The new report shows that while deaths from other major diseases, such as heart disease, HIV/AIDS and stroke, continue to experience significant declines, Alzheimer's deaths continue to rise – increasing 68 percent from 2000-2010.

Virginia is home to more than 130,000 people living with Alzheimer's disease. With deaths from this disease continuing to rise, it is clear that urgent, meaningful action is necessary," said Sherry Peterson, CEO of the Alzheimer's Association Greater Richmond. "Our community needs to come together to fight against this disease, particularly as more and more people age into greater risk for developing a disease that today has no cure."

Alzheimer's disease is the sixth leading cause of death in the United States and is the only leading cause of death without a way to prevent, cure or even slow its progression. Based on 2010 data, Alzheimer's was reported as the underlying cause of death for 83,494 individuals – individuals who died *from* Alzheimer's. Alzheimer's Association *2013 Facts and Figures* reveals that in 2013 an estimated 450,000 people in the United States will die *with* Alzheimer's.

According to Alzheimer's Association *2013 Facts and Figures*, a recent study evaluated the contribution of individual common diseases to death using a nationally representative sample of older adults and found that dementia was the second largest contributor to death behind heart failure. Among 70-years-olds with Alzheimer's disease, 61% are expected to die within a decade. Among 70-year-olds without Alzheimer's, only 30% will die within a decade.

**Human and Financial Toll of Alzheimer's**

More than 5 million Americans are living with Alzheimer's disease including 130,000 here in Virginia. Alzheimer's and dementia place an enormous burden on individuals and families. In 2012, there were more than 15 million caregivers who provided more than 17 billion hours of unpaid care valued at \$216 billion. In Virginia, that translates to 443,000 caregivers providing 504 million hours of unpaid care that is valued at \$6,216,000. Individuals with dementia often require increasing levels of supervision and personal care as the disease progresses. As symptoms exacerbate as the disease progresses, the care required of family members and friends can often result in increased emotional stress and health challenges for caregivers. Due to the physical and emotional toll of caregiving, Alzheimer's and dementia caregivers had \$9.1 billion in additional health care costs of their own in 2012.

The burden on the nation's health care system and government programs is also enormous. According to Alzheimer's Association *2013 Facts and Figures*, the total payments for health and long-term care services for people with Alzheimer's and other dementias will total \$203 billion in 2013, the lion's share of which will be borne by Medicare and Medicaid with combined costs of \$142 billion. Despite these staggering figures today, by 2050 total costs will increase 500 % to \$1.2 trillion.

### **Special Focus on the Long-Distance Caregiving Experience**

Alzheimer's Association *2013 Facts & Figures* also explores the challenges faced by long-distance caregivers for people living with Alzheimer's. The report finds that nearly 15% of caregivers for people with Alzheimer's or another dementia are "long-distance caregivers" – caring for people with Alzheimer's disease who live at least 1 hour away. These long-distance caregivers had annual out-of-pocket expenses nearly twice as high as local caregivers – \$9,654 compared to \$5,055.

The Alzheimer's Association offers a variety of educational and support resources for people living with Alzheimer's and their caregivers – a list of upcoming programs can be found on [www.alz.org/grva](http://www.alz.org/grva). Additionally, the Alzheimer's Association has a variety of resources available 24 hours a day, seven days a week including the toll-free Helpline (1-800-272-3900).

# # #

*Please copy and distribute*



*Virginia Attorney General Ken Cuccinelli  
&*

*The Virginia State Triad/S.A.L.T. Council  
cordially invite you to attend the*

**7th Annual Statewide Triad  
Training Conference**

*“Triad: A Revolution in Crime Prevention for Seniors ”*

*April 9 – 11, 2013*

*Registration begins at 3:00 p.m. on April 9, 2013*

*The Williamsburg Hospitality House*

*415 Richmond Road*

*Williamsburg, Virginia*

*Planned workshops include:*

*\* Financial Exploitation of Seniors\* Medicaid Fraud and Elder Abuse & Neglect \*  
Frauds & Scams Targeting Seniors\* Programs for Your Triad \* How to Start a Triad\*  
Internet and Social Media Safety\* Project Lifesaver\*and more*

*To register, complete the attached form and mail it with a \$50 fee per person. After  
March 18, the registration fee will be \$75 per person.*

*Make checks payable to: “Virginia State S.A.L.T. Council”  
Federal Tax ID Number: 30-0054193*

***The Williamsburg Hospitality House  
415 Richmond Road  
Williamsburg, VA 23185***



Once the capital of the Virginia Colony, you will experience the 18<sup>th</sup> century charm of Williamsburg at the Williamsburg Hospitality House. You are steps from the vibrancy of Colonial Williamsburg with its historic landmarks such as the College of William and Mary, the Capitol, the Governor's Mansion and historic taverns. Within a short walk or drive, you will find Merchant's Square, more shops, restaurants, local attractions, golfing, and historic Jamestown and Yorktown.

**Room reservations:** call 1-800-932-9192; fax to 757-229-073; or visit: [www.williamsburghoshouse.com](http://www.williamsburghoshouse.com). Use group code: 040913ATTORNEY. **Hotel reservations must be made by March 18, 2013.** After that date, rooms go to a space-available basis only at the hotel's prevailing rate. **Be sure to mention the "Triad Crime Prevention Conference" when you call.** Conference room rates are \$96 for Single or Double. Check-in time is 3:00 PM and Check-out time is 11:00 AM. There is free parking at the Williamsburg Hospitality House.

**DIRECTIONS:**

**From the Richmond Airport:** Take Interstate 64 East. Take Exit 238 and follow the signs to Colonial Williamsburg. Turn right on Route 132 (not Route 132 Y). Proceed straight through the traffic light. After crossing the railroad tracks, go through the traffic light and take the next right on Scotland Street. At Richmond Road, the Williamsburg Hospitality House will be on the right.

**From Newport News/Williamsburg Airport/Norfolk Airport:** Take Interstate 64 West. Take Exit 238 and follow the signs to Colonial Williamsburg. Turn right on Route 132 (not Route 132Y). Proceed straight through the traffic light. After crossing the railroad tracks, go through the traffic light and take the next right on Scotland Street. At Richmond Road, the Williamsburg Hospitality House will be on the right.



## *Who should attend a Triad Conference?*

*Crime Prevention Specialists*

*Senior Service Providers*

*Adult Protective Service Workers*

*Law Enforcement Professionals*

*Triad/S.A.L.T. Council Members*

*Senior Citizen Community Leaders*

*Anyone concerned with issues that affect seniors*

*We encourage law enforcement agencies that currently do not participate in Triad to send a representative to the Conference.*



## 2013 Statewide Triad Training Conference Registration

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Representing: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

*Early Registration Fee (received by March 18): \$50.00 per person  
Late Registration Fee (received after March 18): \$75.00 per person*

***Make checks payable to: "Virginia State SALT Council" and mail to:***

***Juanita Balenger, Triad Director  
Office of Attorney General Ken Cuccinelli***

***10555 Main Street, Suite 350***

***Fairfax, Virginia 22030***

***Any conference related questions?***

***Call Juanita Balenger at (703) 359-1121 or email her at***

***[jbalenger@oag.state.va.us](mailto:jbalenger@oag.state.va.us)***

# *7<sup>th</sup> Annual Statewide Triad Training Conference*



## *Tentative Schedule:*

### **Tuesday, April 9**

- 3:00 – 6:00 p.m. - Conference Check-In
- 5:00 – 7:00 p.m. - Opening Reception

### **Wednesday, April 10**

- 7:30 a.m. - Registration/ Continental Breakfast/Exhibits Open
- 9:00 a.m. - Welcome & Opening Ceremonies
- 9:30 a.m. - Opening General Session
- 10:45 a.m. - Concurrent Breakout Sessions
- 12:00 p.m. - Lunch
- 2:15 p.m. - Concurrent Breakout Sessions
- 3:15 p.m. - Break – Exhibits Open
- 3:45 p.m. - Concurrent Breakout Sessions

### **Thursday, April 11**

- 7:30 a.m. - Continental Breakfast/Exhibits Open
- 8:30 a.m. - Concurrent Breakout Sessions
- 9:45 a.m. - Concurrent Breakout Sessions
- 11:00 a.m. - Closing Session
- 12:00 p.m. - Safe Travels Home!

# TIME

Monday, Jun. 11, 2012

## The Long Goodbye

By Joe Klein

The phone call came on a cloudy morning in Iowa. I was interviewing Senator Chuck Grassley in his farm kitchen, surrounded by a sea of corn. Mom was back in the hospital again. She had pneumonia. She wasn't eating. "If we don't put in a feeding tube," my mother's internist told me, "she won't survive on her own."

Mom had always been vehement about how she wanted to go. "Just pull the plug. Let me die," she would say, with more than a hint of melodrama. "I don't want to be a vegetable." But was she a vegetable now? She had been suffering from dementia for several years and at times seemed to be living on a different, prohibitively weird planet populated by angels, murderers and secret paramours. At one point, I called from the road, and she told me she had taken a lover. He was in bed with her right now. They had made love three times. (She was 91.) "Where's Dad?" I asked. In the other room, she said. Which was true, both literally and metaphorically: Dad was also suffering from dementia but of a less florid and more truculent variety. He rattled between wild rages and utter forgetfulness; he was intermittently incoherent, having lost much of his ability to locate words.

Over time, though, Mom's angels and imaginary lovers disappeared, and an eerie dullness set in. She was rather limited in her responses now. "That's nice," she would say when I told her about my children and grandchildren. "I love you too," she would say. She never initiated conversation, but occasionally I could still make her laugh. Vegetables don't laugh.

"If we don't put in the tube, how long does she have?" I asked the doctor. He wasn't sure. He was the sort of doctor who was allergic to certainty or even to ballpark estimates. "We've taken care of the pneumonia, but she's not eating," he repeated. So weeks? Days? She needs nourishment, he said. I was in Iowa. My brother was in Asia. I didn't want to sign a death sentence without even seeing her, without giving her a chance to rally. "O.K.," I told the doctor. "Put in the feeding tube. I'll be there as soon as I can."

That was the beginning. I spent the next five months as a death panel for both my mother and my father. They passed away within a few weeks of each other last winter. The circumstances of their deaths were not

unusual; many of my friends have been through similar experiences with their parents in recent years. But we grieve in different ways, and my way, I guess, is to write about it--and also to examine the policy implications of how we treat the elderly. Because it is clear to me, after this awful winter, that there are better ways to handle the endgame. I now believe, for example, that I made a mistake when I agreed to Mom's feeding tube. I believe that because I was extremely fortunate to transfer my parents, at the end, from regular fee-for-service Medicare to a private nursing home that used the Geisinger health care system, in which--as with the Mayo Clinic and others--doctors are paid salaries and outcomes-based performance bonuses rather than by the services they perform. It is a system that many health care experts see as a model, a way to save significant amounts of money while providing better care. I can't personally attest to the savings--although, as we'll see, the statistics are impressive--but I can say that the level of candor, sanity and humanity of the Geisinger doctors I dealt with was stunningly high. They helped me through some of the toughest decisions I've ever had to make. My parents died serenely, with dignity. When you are a death panel--when the time and manner of their passing is at least partly in your hands--that is the very best you can hope for.

But humanity before policy: let me tell you a little bit about my parents. They were born within a month of each other in 1920. They met on the first day of kindergarten. At P.S. 114 in Rockaway Beach, Queens, the children were arranged by height and marched into class together in two lines. My father was the shortest boy, my mother the shortest girl. They walked into class that first day holding hands. It wasn't exactly a straight line ever after. Rummaging through their memorabilia, I found a picture of Ensign Malcolm Klein with a date at the Cocoanut Grove in Boston during the months that the U.S. Navy had sent him to Harvard Business School for advanced training as a supply officer in 1942. I found pictures of Mom with other guys as well. But Mom and Dad became engaged during the war, were married on May 13, 1945, and were inseparable after that.

Dad grew up in an upper-middle-class family; Mom was poor. Dad's father kept the books for the John F. Curry insurance agency--which meant, in effect, that he kept the books for Tammany Hall. Curry was boss during the Roaring '20s, the Jimmy Walker era. The '20s also roared for my mother's father Frank Warshauer. He was a professional musician who wrote a couple of Top 40 hits, which enabled him to buy a two-family house on the less fashionable bay side of Rockaway. (Dad's home overlooked the ocean.) The Warshauer house was my first home. If you've seen Woody Allen's film *Radio Days*, which takes place in Rockaway Beach, you get the picture: my parents and I lived upstairs; my grandparents and two maiden aunts, Rose and Madeline, lived downstairs. The aunts eventually become part of the family retinue when my grandparents passed away.

Dad's ability to provide for everyone began with an incredible piece of luck in 1942: he won the largest daily double in the history of the Suffolk Downs race track: \$1,877.40. "Ensign Klien [sic] says he will use his

winnings to purchase war bonds," the Boston Record reported. After the war, he used the money to buy a small printing company. By the time I joined the payroll at the age of 14, the company had grown to nearly 100 employees and was doing some of the finest lithography in New York.

I was extremely proud of my dad. I could see how his employees respected him. But they feared him too, and so did I. He had made an implicit deal with my mom: she was allowed to have her sisters live with us, and he was allowed to go about screaming like a banshee. He and Mom had a loving marriage, and they had fun. I have in my possession a certificate from the Irv Siegel School of Social Dancing honoring Mal and Miriam Klein for proficiency in "mambo, cha-cha-cha and merengue." But Dad was a terrifying presence in our lives. Even his fatherly duties--helping with a Cub Scout project or coaching Little League--were occasions for embarrassing rages. I mention this because his anger intensified as he began to lose his wits; it was the terrain on which I had to maneuver as I sought to make decisions regarding my parents' health and safety after they retired to State College, Pa.

Dad bought a lovely house in Brookline Village, one of those progressive-care communities that enable you to slide toward senescence from the complete independence of a single-family home to assisted living to nursing care, although Dad refused to slide. He remained flagrantly, stubbornly independent, running his household, which included my two inevitable aunts, even as his health began to decline and then plummet. All four were cared for during the day by two lovely Kazakh women whom Dad hired independently of Brookline Village, but as the years passed, it became apparent they weren't enough. Mom had gone blind--the victim of a rare form of glaucoma that wasn't detected until it was too late--and she suffered from neuropathy, which weakened her legs. Both she and Rose would fall on the way to the bathroom at night; the home health aides would find them on the floor in the morning. My brother and I suggested that he expand the home health care to a 24/7 operation--the Kazakhs had friends who would take the night shift--but Dad refused. "If he ran a nursing home with these conditions," my brother said, "he'd be arrested." (Dad relented only after a hospice worker, who would come to care for Aunt Rose as she neared death from congestive heart failure, threatened to call the authorities and have Mom and Rose removed.)

Things became impossible. Dad was going blind too, but he refused to give up his driver's license. I had to call the police to have it taken away, but he continued to drive anyway. At one point, his urologist called to tell me that Dad had driven into his parking lot and knocked down a sign: "Do you really think he should be driving?" After that, I had the Kazakhs hide the car keys. Dad followed Mom's precise path downward: his macular degeneration grew worse, he developed neuropathy, and dementia set in. He gave orders to his bookkeeper--who was now trying to keep track of the money owed six Kazakh caregivers--and his investment adviser, forgot them and then screamed. He fired the bookkeeper; the investment adviser quit. He caused a public ruckus by claiming that the manager of Brookline Village was cheating the homeowners, which made it impossible, initially, to move Rose and Madeline into either the assisted-living

or nursing-home facilities there. He became credulously obsessed with his junk mail, sending thousands of dollars in donations to "charitable" lotteries run by phony patriotic and veterans groups. I'd tell him he was wasting his money, and he'd say, "But look at the printing. It's a beautiful four-color job." He screamed at the Kazakhs, who were patient beyond imagining. He screamed at Mom when the angels and murderers hovered about; he was a bit daunted by her phantom lover though.

Rose passed away in December 2010, and Mom began to decline thereafter. The emergency runs to the hospital became more frequent. She broke her elbow, her hip. And then, finally, came the pneumonia, and the feeding tube in October 2011. By this time, I'd had private conversations with several of my parents' doctors, who agreed--informally--to allow me to exercise my medical power of attorney. (My son, a lawyer, held the financial power of attorney.) We couldn't do this formally because Dad would have taken me to court. He was infuriated with me for stopping him from driving and forcing him to have full-time home health care. The hazy legality of the situation was exacerbated by the nature of the Medicare system. There was no coordination among the flotilla of physicians taking care of my parents. There was no real supervision of their daily drug taking: Dad was in charge, and sometimes he'd screw up; it was hard for me to communicate on the phone with the Kazakhs, whose English was spotty. On several occasions, Mom was rushed to the hospital because the drugs prescribed by her various doctors had interacted poorly or Dad had given her the wrong dosage. Their internist was a sweet man, but he refused to confront my father. My brother, who was living in Asia by then, figured that only a disaster would change the situation. Instead of a disaster, though, we lucked into Geisinger.

Happily, the manager at Brookline Village was willing to forgive Dad their very public battle and let me move them into the on-site nursing home, called the Fairways. I told Dad it was necessary for Mom to go there because of the intricacies of the feeding tube, which wasn't entirely true. And then I reminded him, "You always said you wanted to be with her. Maybe you should go in too. It'll help Mom recover." He agreed, then forgot we'd had the conversation. It took three more such talks--one with their internist--to get him into the facility, and even then, Dad would try to break out. He occupied the elevator in protest one day; I had the nurses give him a tranquilizer. And I must admit, I could see his point. The nursing home was first-rate, with a wonderful staff, but it was a death factory. People went in and didn't come out. The fellow in the room next to Dad's, a stroke victim, roared and cried incomprehensibly throughout the day, a terrible sound. "Why can't we just die at home?" Dad asked. It was a fair point, but I couldn't give the real answer: because it was safer for them in the nursing home and, as I soon learned, the quality of medical care--which was provided by the Geisinger system--was much better than what they'd been receiving.

My first conversation with a Geisinger doctor, Victoria Devan, was refreshingly different in a no-bull sort of way. I told her I had mixed feelings about Mom's feeding tube, that Mom had left clear instructions against prolonging her life--but I'd been out of town, I'd wanted to see if she would recover her appetite, and I

wasn't sure how many days she'd have if we didn't put in the tube. Devan said she understood, "but we should keep a close eye on it. When they lose their appetites, they're usually telling us something." Devan also told me that Mom would have had weeks, perhaps a month, more of life if we hadn't inserted the tube. What a relief: clear, simple sentences. When I asked Devan about it later, she said she'd been relieved as well. "You got it," she said. "Sometimes the family members don't. Sometimes they want us to do all sorts of things that just aren't realistic, and we have to be very patient about walking them through the reality of the situation. You understood where it was heading."

A week later, I checked in again with Devan. Mom was eating less than 10% of her meals. "Maybe we could reduce the amount of food she's getting through the tube and see if her appetite revives?" I asked. Devan agreed but told me once again, gently, that the odds were that Mom wasn't coming back. And she was right. After another week had passed, my brother came home from Asia, and my wife and children joined me in State College for a meeting with Dr. Charles Maxin, who was Devan's senior colleague. He seemed like a figment of Norman Rockwell's imagination--calm and reassuring and flagrantly decent. Like Devan, he didn't mince words. Mom wasn't responding; we were only prolonging the inevitable. He told us her death would not be painful. I looked around at my family and asked if anyone had any objections to pulling the plug on Mom. No one did.

"There's one other thing," Maxin said. "I noticed that your mom has a do-not-resuscitate order in her file, but your dad doesn't. Should we add it on?" I told Maxin that Dad acted as if old age were a reversible condition. He probably would want to be resuscitated. "Are you sure about that?" he asked. "You know that he broke two ribs when he fell in the bathroom last week. He's very frail. If we tried to resuscitate him, we'd probably break the rest of his ribs." This was startling but undeniable. I approved a do-not-resuscitate order for Dad. It was becoming clear to me that in the gentlest possible way, these Geisinger doctors did not mess around.

The Geisinger medical center seems almost like a mirage. It is a giant, state-of-the-art medical facility plopped down amid farmland in the town of Danville, Pa. The hospital is the mother ship of an extensive network of medical practitioners tending to 2.6 million patients in 44 mostly rural Pennsylvania counties, including the doctors who took care of my parents at the Fairways. It was founded in 1915 by a widow named Abigail Geisinger and first directed by Harold Foss, a surgeon who had been an assistant to the famed Mayo brothers. Like the Mayo Clinic, it employed a team approach, with doctors, paid as employees rather than as independent operators, cooperating on patient care. "It's like hiring a general contractor to supervise the renovation of your house," says Henry J. Aaron, a health expert at the Brookings Institution. "He brings his team of subcontractors and coordinates their work. It's a lot more efficient than finding and organizing the carpenters, the electricians and the painters by yourself."

There are good contractors and bad ones. The accountable-care-organization model--which is the emerging term of art for places like Mayo and Geisinger--was emulated in all its worst aspects when health-maintenance organizations (HMOs) emerged as a cost-cutting tool in the 1970s and then became unpopular when they became synonymous with hellish bureaucratic medical rationing. But during the years that HMOs were going in and out of fashion, a quiet revolution was beginning--the computerization of medical records. And Geisinger became a pioneer in analyzing those records to find out which sorts of treatment worked and which didn't. Over time, as the data accumulated, it has become clear that quality health care can be provided in a way that makes patients happy, with a minimum of draconian bureaucracy and for less money. "Our core belief is that about 40% of what doctors and hospitals do is wasteful," says Dr. Glenn Steele, Geisinger's president. "If you can extract that percentage of crap, you can redistribute it into savings and profits but also into procedures that actually help patients."

Geisinger has found, for example, that by adding case managers--nurses who work by phone and in person from doctors' offices--to chronic elderly-care cases (like my parents before they entered the nursing home), they can give more individual attention and produce better results. The case managers call or visit the patients regularly to make sure they've taken their medication, weighed themselves (on Bluetooth scales that send the results to the Geisinger computers), are eating the right things and are aware of upcoming appointments. They are also there to listen to complaints, which, as those of us who've been through parent care know, are not infrequent. A study published in the American Journal of Medical Quality found that this system produced 18% fewer hospital visits, a staggering 36% fewer return visits and cost savings of 7%. "Geisinger has made steady progress in reducing per capita Medicare costs over the past 20 years," says Dr. Elliott Fisher of the famed Dartmouth Institute for Health Policy and Clinical Practice. "It has gone from the middle of the pack to very near the top."

Over those years, Geisinger has quantified almost every aspect of health care. A bundle of nine routine procedures has been identified to treat diabetics, for example. The bonuses that Geisinger doctors receive depend on how closely they adhere to proven procedures, as monitored by the Geisinger computers. Bonuses also depend, in part, on how the patients rate their care, and doctors--who are not always the most sociable human beings--are asked to go through a bedside-manner orientation program called Patients 101, which schools them in basic procedures like shaking hands with members of the patient's family, looking them in the eye and introducing themselves. This sort of training is especially important in a system in which doctors sometimes must try to deny care requested by patients or their families that is deemed unnecessary. "It takes more time and effort to sit down and have a discussion with the patient rather than just ordering the duplicative X-ray," says Dr. John Bulger, Geisinger's assistant chief quality officer. But the time spent on the discreet application of candor saves money and develops a deeper level of patient trust and satisfaction.

Doctors are trained to do whatever they can to save a patient, even an elderly one, and that is an excellent thing. But that Hippocratic impulse has been subtly undermined by the rewards of fee-for-service medicine and by the threat of malpractice suits, which militate in favor of ordering the extra MRI or blood test or dialysis even for a patient who probably has only weeks to live. And so it was that when my father was rushed to the Mount Nittany Medical Center suffering from acute kidney failure in late January, the immediate impulse of the doctors in the emergency room was to try to revive him by rehydrating him. "That's how they're trained," my father's urologist, Dr. Charles Dalton, told me. Dalton is a terrific fee-for-service doctor who had impressed me with his Geisinger-like candor in the past. "But [rehydrating him] was probably the wrong thing to do," Dalton went on. "Renal failure is a good way to go. You just go to sleep. Your dad's kidneys are pretty much shot. You may revive him, but he'll be back here in a month, six weeks."

My next decision seemed obvious, but it was much tougher than removing Mom's feeding tube. This was Dad. He had always haunted my dreams, and now I had visions of the Mighty Malcolm rising from his hospital bed, screaming at me for trying to kill him. But that Malcolm had disappeared after Mom passed away in November, a few weeks after the meeting with Maxin. At the end, I had fed her several teaspoons of chocolate ice cream and said, "I love you, Mom." Her last words were "I love you too." An hour later she was gone.

The next morning, I told Dad that for the first time in 86 years, there was no Miriam. "Is it definite?" he asked, crushed. His will to live vanished. He pretty much stopped eating. I tried to revive his interest in food by having the nursing home serve him more of the things he loved to eat--salads, pancakes, a glass of sweet white wine with dinner. "You did that? That's amazing," he said of the wine. "I really appreciate what you're doing. You're a good son," he said for the first time in my life. I told him he had been a great dad. "I could have been better," he replied.

But he forgot to ask for the wine with dinner. And he often forgot to eat dinner. He slept through most days. And about eight weeks after Mom died, his kidneys failed and I faced a final decision. Anil Aleti was the Geisinger doctor on call at Mount Nittany, and he was every bit as forthright as Maxin and Devan. We could keep Dad going with intravenous hydration, and he might last a month--there was no question of inserting a feeding tube--or we could stop. I called my brother and told him that I'd decided to let Dad go. He agreed, as he had every step of the way.

I sat by Dad's bedside for that final week in the nursing home. He opened his eyes a few times and tried to speak, but he couldn't. I held his hand; he squeezed mine once or twice. The morning he died, two angels from hospice care sat with my wife and me by his bedside; the nursing staff and Dr. Devan hovered about as well. Betsy Brett--the hospice supervisor who had been on the case since Rose died and had seen Dad

In my parents' case, Geisinger had worked with the nursing staff at the Fairways. I was consulted about every adjustment in medication and told about every time Dad tried to do a walkabout and inevitably fell down. By the third week, the staff and I were co-conspirators, laughing about Dad's stubbornness and trying out new strategies to make him more content. The situation was, of course, horrific--Mom and Dad were both fading away--but I no longer felt so guilty and frustrated. I was part of a team making their passage as comfortable as possible. After the struggles I'd been through with Dad, it's hard for me to describe what a relief this was.

"This is such a terrific model," says Henry Aaron. "It costs less and gives better results. In a Darwinian business system, you have to wonder why it doesn't spread." Only about 33% of Americans get their health care through organizations like Geisinger. But the model is becoming more popular, encouraged by the Centers for Medicare and Medicaid Services (CMS), which has run hundreds of pilot projects over the past six years. "If you're a group practice that joins one of the CMS pilots and prove you can improve service while cutting Medicare costs, you get to keep a portion of the savings," says Fisher. Much of the savings projected for the Affordable Care Act--Obamacare--would come from a broader application of his model.

But that's going to be a big fight and difficult to win: most doctors don't like the Mayo-Geisinger way of doing business. The culture of fee-for-service medicine, which features each doctor as the captain of his or her own ship, is incredibly powerful. "What you hear from doctors who don't like our system," says Steele, "is 'We don't want to be robots run by your computers.' But we encourage innovation if it really works." Devan says that while Geisinger doctors don't have to worry about the business hassles of running a fee-for-service practice, it isn't exactly natural for doctors to have their work under constant scrutiny by their peers. "We have monthly meetings where each patient is reviewed," she tells me. "That's a major cultural shift for most doctors."

The shortcomings of fee-for-service medicine are well known, especially when it comes to Medicare. At the age of 80, my mother insisted on having a heart-valve operation to fix a murmur she'd had since birth. "It's getting worse," she said. "I'm feeling more tired than I used to." The going rate for such operations was more than \$100,000, and Medicare paid for hers. The current system is rife with such unnecessary expenditures--"We're having a national epidemic of wrong patient operations," Fisher says--and it seems clear that a model like Geisinger's, in which doctors aren't rewarded for performing extraneous tests and operations, would be the best way to reduce the costs of Medicare. It also seems clear that asking people like my parents to make market decisions about their health care--the sort of system that Congressman Paul Ryan and other Republicans support--would be an act of cruelty and an unnecessary one at that. In the end, changing the way health care is provided rather than the way it is sold may be the most efficient way to generate savings.

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rage against his twilight--explained how it would be. His breathing would become shallower, then more intermittent, then stop. And so it went: Dad seemed to sigh at the end. He inhaled and sighed and was gone. He was not a religious man, but there was a gorgeous serenity in this moment--and there was a certain satisfaction for me too, surrounded by the caregivers who had helped me through this passage toward my own maturity, caregivers who really knew how to give care.

TO WATCH JOE KLEIN TALK ABOUT HIS STORY, GO TO [time.com/klein\\_video](http://time.com/klein_video)

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# *The Long Goodbye:*

One of the most important  
conversations you should have.

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A PRACTICAL GUIDE  
TO NAVIGATING  
LIFE'S LAST DECISIONS

MEDARVA  
THE MORTUARY

**CBS 6**

*Approaching the difficult subject surrounding the last days of a loved one's life, especially a parent, is not an easy task. As the matter is both emotional and stressful, this guide was created to help you initiate important conversations and compile the information necessary to be prepared when the time comes. It is our observation that it is better to begin these conversations when everyone is healthy.*

## The Conversation Starter

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You know almost everything you need to know about your loved ones. Where they were raised and their favorite memories from childhood. But do you know their wishes in regard to their final days? Do you know their choices in regard to different health care situations? You may think that these conversations can happen down the road, but your loved ones may reach a time in which they are no longer able to talk with you. Imagine how much less stressful and more peaceful those last days could be if you choose now to discuss health care and the future with your loved ones.

### CONVERSATION WITH YOUR FAMILY

#### **Begin the conversation:**

*"Mom, I love you dearly. I want to be able to help you as much as I can and do what you want done, but I don't really know what your wishes are when the time comes."*

Recognize that it isn't an easy conversation and not everyone is ready for it. But it is best if you start when your parents are still healthy and not in pain or fear. It is much easier than trying to guess what they want when they are actually ill.

#### **Start with basic questions:**

*"As you grow older and no longer able to care for yourself on your own, what would you like to do?"*

Depending on the situation, there are a host of options you can discuss, including having them move in with a child, at-home care, assisted living

or a nursing home. However, it's important to note that throughout these discussions, your parent should feel like he or she has a voice and is still in control of the decision-making process.

#### **Then, move to the more difficult topics:**

*"If you become very ill, what are your wishes? What health care measures do you want performed? Who do you trust to make the decisions when you can't?"*

Be prepared for a less than enthusiastic response from your parent in the initial discussion. No one likes to face the possibility of his or her life's end. However, the important point is to begin the conversation. And it may take several discussions, but with each one, you can continue to work together to obtain the information you need to be prepared.

## CONVERSATION WITH YOUR FAMILY (continued)

If you are the “parent” in this situation, or just someone who is trying to be prepared, don’t be afraid to raise the topic with your family on your own – it’s your life, keep control of it, even to the end! If your family isn’t prepared to handle the discussion, then hold the discussion with your attorney, a trusted friend or financial advisor. In fact, in some cases, it may be better to hold the conversation with an attorney who will oversee the implementation of your wishes without having to cope at the same time with the emotions of losing a loved one. In any case, be an active participant in the conversation, no matter how uncomfortable it becomes or who becomes uncomfortable with the topic.

Questions you should consider discussing include:

- 1) **Do you have an Advance Health Care Directive (also known as an Advance Medical Directive or a Living Will)?** This allows you to state what you want for your own medical care if you are unable to make decisions for yourself. (A sample Advance

Directive has been included as an addendum to this document for your reference.) You can:

- Direct that a specific procedure or treatment be provided, such as artificially administered hydration (fluids) or nutrition (feeding);
- Direct that a specific procedure or treatment be withheld; and
- Appoint a person to act as your agent in making health care decisions for you, if it is determined that you are unable to make health care decisions for yourself. This includes the decision to make anatomical gifts of a specific part or parts of your body via organ and tissue donation, or of your entire body.

- 2) **Whom would you like to designate as your power of attorney, both medically and financially?** It is important to designate a person to make medical and financial decisions if you are unable to make decisions on your own. This information should be documented in your will.

## CONVERSATION WITH YOUR HEALTH CARE TEAM

It is also important to have conversations with the physicians and nurses of your health care team, so that they too are informed of your parents’ or your wishes. If you are uncertain about the terminology, or even the consequences of the decisions that you are making, don’t be afraid to ask your physician(s):

- 1) **What are my parent’s/my options?**
- 2) **What are the consequences of the decisions we are making?**
- 3) **What are things we should be considering that we haven’t asked about already?**

Below are questions to go over with your parent(s), so these professionals will know in advance how to act and what procedures to perform, especially in critical moments:

- 4) **Would you like to be resuscitated, or would you like a “Do Not Resuscitate Order?”**
- 5) **Are there certain life-prolonging treatments you would like to avoid while allowing others?**  
If so, what treatments should be avoided?  
Respirator, CPR, Dialysis, Surgery, Antibiotic Drugs, Tube Feeding?

## HEALTH CARE DECISIONS

- Designate a Power of Attorney for Health Care  
Select a family member or someone you trust who understands and agrees with your health care preferences. This person has access to your medical records, can select a physician or other health care professional, and can decide whether you will have a specific medical treatment.
- Possess Health Insurance Account Cards  
Be sure you have possession of all health insurance cards and obtain copies for your power of attorney.
- Consider Advance Health Care Directives  
Determine what procedures are or are not allowed when end of life is nearing, such as:
  - Life Prolonging Treatments: Respirator, CPR, Dialysis, Surgery, Antibiotic Drugs
  - Pain Management
  - Tube Feeding
  - Do Not Intubate Order
  - Do Not Resuscitate Order
- Advance Directive Documents  
Kept with you in case of emergency at the hospital. Given to close family members and health care professionals. If you have to go to the hospital for tests, give the hospital a copy to keep in your record.
- Physicians Orders for Life-Sustaining Treatment (POLST)  
Unlike the Advance Health Care Directive, the POLST is signed by the patient and the physician, and moves with the patient as part of the medical record.
- Hospice Care
- Long-Term Care Insurance

Below are helpful resources available about the choices you and your family face during this time. We used these organizations and websites in gathering the information in this document:

- **National Family Caregivers Association:** <http://caregiveraction.org/>
- **National Hospice and Palliative Care Organization:**  
<http://www.nhpco.org/resources/end-life-care--resources>
- **Virginia Division for the Aging:** <http://www.vda.virginia.gov/links.asp>
- **Advance Health Care Directive:** [www.vda.virginia.gov/advmedir.asp](http://www.vda.virginia.gov/advmedir.asp)

## *Other things to think about*

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Another overwhelming task around this subject is collecting your parent's important documentation and account information. This checklist was prepared to help you organize the essentials, as well as give you an idea of the information you may need to gather for yourself one day.

### PARENT/LOVED ONE'S PERSONAL INFORMATION

- Birth Certificate
- Social Security Number
- Social Security Card
- Marriage License
- Divorce Record
- Spouse's Death Certificate
- Other (Adoption/Naturalization, etc)

### PARENT/LOVED ONE'S PERSONAL ADVISORS INFORMATION

- Physician(s)
- Nurse/Home Health Care Provider
- Religious Leader
- Attorney
- Accountant/Tax Advisor
- Bank
- Business Manager
- Insurance Agents
  - Health
  - Life
  - Home
  - Auto

### PROPERTY

For the following, gather the primary owner(s) information including titles, business license and EIN numbers.

- Residence(s)
- Business
- Other (Vacation, Rental, etc)
- Motor Vehicles

### FINANCIAL

#### **Debts and Liabilities**

- Bank Accounts
  - Checking
  - Savings
  - Credit Unions
  - Brokerage Firm(s)
- Bank Account Co-signer
- Credit Card Balances
- Home Mortgage
- Car Payment
- Bank Loans
- Any Other Debts or Loans
- Taxes

## FINANCIAL (continued)

### **Direct Transfer of Assets**

You do not need someone to be in charge nor do you need a will to designate where some finances are supposed to go, but with a Direct Transfer of Assets they will be directly payable upon death.

- Bank Accounts
- Brokerage Accounts
- Real Estate
- Retirement Accounts
- Vehicles

### **Assign Power of Attorney for Finances**

- Estate Planning
- Life Insurance

### **You may want to put the following in a Safety Deposit Box**

- Birth or Marriage Certificate
- Insurance Policies
- Rare family photos
- Irreplaceable heirlooms
- Jewelry
- Gemstones
- Precious Metals
- Marketable Securities
- Living Will

- Last Will & Testament

A legal document signed and dated in the presence of two witnesses.

- Living Trust

For larger estates with a wider range of financial vehicles and as a trustee you have control over assets. After death, assets are transferred to beneficiaries.

- Direct Transfer of Assets

These are assets directly transferred to another person without a will or living trust.

- Immediate Access to Accounts

Make sure the name of a trusted person is listed with yours on accounts as "Joint Tenants with Right of Survivorship."

### **Do not include in a Safety Deposit Box**

- Original Will
- Trust Instruments
- Powers of Attorney

Some states seal safe deposit boxes after death and prevent immediate access to documents.

## *Advance Medical Directive*

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The Advance Medical Directive for Health Care protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

The Virginia Advance Medical Directive lets you state your wishes about medical care in the event you develop a terminal condition, meaning it is probable that you will not recover from the condition and either your death is imminent or you are in a persistent vegetative state. This document also lets you name someone to make health care decisions on your behalf anytime you are unable to make your own medical decisions. This document can be used anytime during your life.

A sample Advance Directive form is provided here for your reference. *Note: This document will be legally binding only if the person completing it is a competent adult (at least 18 years old).*

**Further information and forms are available at [www.vhha.com](http://www.vhha.com) (Virginia Hospital & Healthcare Association).**

# VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE

I, \_\_\_\_\_, willingly and voluntarily make known  
Printed Name of Individual Making This Advance Directive for Health Care (Declarant)  
my wishes in the event that I am incapable of making an informed decision about my health care, as follows:

*(YOU MAY INCLUDE ANY OR ALL OF THE PROVISIONS IN SECTIONS I, II AND III BELOW.)*

## SECTION I: APPOINTMENT AND POWERS OF MY AGENT

*(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)*

### A. Appointment of My Agent

I hereby appoint \_\_\_\_\_  
Name of Primary Agent E-mail Address

Home Address \_\_\_\_\_ Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

\_\_\_\_\_  
Name of Successor Agent E-mail Address

Home Address \_\_\_\_\_ Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

### B. Powers of My Agent

*[IF YOU APPOINTED AN AGENT ABOVE, YOU MAY GIVE HIM/HER THE POWERS SUGGESTED BELOW. YOU MAY CROSS THROUGH ANY POWERS LISTED BELOW THAT YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY ADDITIONAL POWERS YOU DO WANT TO GIVE YOUR AGENT.]*

The powers of my agent shall include the following:

1. To consent to or refuse or withdraw consent to any type of health care, including, but not limited to, artificial respiration (breathing machine), artificially administered nutrition (tube feeding) and hydration (IV fluids), and cardiopulmonary resuscitation (CPR). This authorization specifically includes the power to consent to dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain. This applies even if this medication carries the risk of addiction or of inadvertently hastening my death.
2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information as necessary to carry out my directions as stated in this advance directive.
3. To employ and discharge my health care providers.
4. To authorize my admission, transfer, or discharge to or from a hospital, hospice, nursing home, assisted living facility or other medical care facility.
5. To authorize my admission to a health care facility for treatment of mental illness as permitted by law. (If I have other instructions for my agent regarding treatment for mental illness, they are stated in a supplemental document.)
6. To continue to serve as my agent if I object to the agent's authority after I have been determined to be incapable of making an informed decision.
7. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me.

9. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

10. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

ADDITIONAL POWERS OR LIMITATIONS, IF ANY:

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## SECTION II: MY HEALTH CARE INSTRUCTIONS

*[YOU MAY USE ANY OR ALL OF PARTS 1, 2 OR 3 IN THIS SECTION TO DIRECT YOUR HEALTH CARE EVEN IF YOU DO NOT HAVE AN AGENT. IF YOU CHOOSE NOT TO PROVIDE WRITTEN INSTRUCTIONS, DECISIONS WILL BE BASED ON YOUR VALUES AND WISHES, IF KNOWN, AND OTHERWISE ON YOUR BEST INTERESTS. IF YOU ARE AN EYE, ORGAN OR TISSUE DONOR, YOUR INSTRUCTIONS WILL BE APPLIED SO AS TO ENSURE THE MEDICAL SUITABILITY OF YOUR ORGANS, EYES AND TISSUE FOR DONATION.]*

1. I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover:

*[CHECK ONLY 1 BOX IN THIS PART 1.]*

- I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)
- I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)
- [YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

2. I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

*[CHECK ONLY 1 BOX IN THIS PART 2.]*

- I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)
- I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable. (OR)
- I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest \_\_\_\_\_ as the period of time after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my agent or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable. (OR)
- [YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY. THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]*

3. I provide the following other instructions concerning my health care:

[YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMSTANCES OR ANY CIRCUMSTANCES. IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE.]

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### SECTION III: ANATOMICAL GIFTS

[YOU MAY USE THIS DOCUMENT TO RECORD YOUR DECISION TO DONATE YOUR ORGANS, EYES AND TISSUES OR YOUR WHOLE BODY AFTER YOUR DEATH. IF YOU DO NOT MAKE THIS DECISION HERE OR IN ANY OTHER DOCUMENT, YOUR AGENT CAN MAKE THE DECISION FOR YOU UNLESS YOU SPECIFICALLY PROHIBIT HIM/HER FROM DOING SO, WHICH YOU MAY DO IN THIS OR SOME OTHER DOCUMENT. CHECK ONE OF THE BOXES BELOW IF YOU WISH TO USE THIS SECTION TO MAKE YOUR DONATION DECISION.]

- I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, [www.DonateLifeVirginia.org](http://www.DonateLifeVirginia.org), and that I may use the donor registry to amend or revoke my directions; OR
- I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

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**AFFIRMATION AND RIGHT TO REVOKE:** By signing below, I indicate that I understand this document and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

Date

Signature of Declarant

The declarant signed the foregoing advance directive in my presence. [TWO ADULT WITNESSES NEEDED]

Witness Signature

Witness Printed

Witness Signature

Witness Printed

*This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. For information on storing this advance directive in the free Virginia Advance Health Directive Registry, go to <http://www.VirginiaRegistry.org>. This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (June 2012, [www.vhha.com](http://www.vhha.com)) ▲\*\**

