BASIC INCOME IN SUPPORT OF THE PREVENTION OF SENIOR INSTITUTIONALIZATION

by Victoria E. Lehman, MA, JD, researcher.

Over the last decade, and particularly the past 4 years, I have been spending much of my time attending to family members and friends from their 70's to their 90's, who are resident in Personal Care Homes. These are acute care units, due to stroke, various progressive physical and mental ailments with no positive future prognoses, dementias and Alzheimer's. Apart from myself and a few other "regular attender" families, by and large the residents receive very few visitors. People with relatively good health seem either too busy, or often too fearful, to spend time with family members and friends who may not even register awareness of their surroundings, are unable to communicate or attend to their own needs, and are often thought not to benefit from the touch and presence of others. With the shrieks and moans emanating from the often parched throats of residents experiencing the terrors of dementia, family members often appear to flee as though from a zombie apocalypse. This is demonstrably wrong, of course, and ironically the symptoms they fear are often from the lack of human touch and connection, having left the residents depressed, desperate for their families and friends, and dissociated from the here and now of reality. Anxiolytic medications are rarely prescribed as they are considered to create a risk of falling and other injuries.

So the residents often experience a kind of hell in social isolation that creates a echo box of their own expressed needs, both emotional and physical, with no one to advocate for those needs, and what visitors observe is largely the consequences of this confinement. Often it is understood that the frail senior whose health declined sharply upon becoming alone and without the supports of family or friends, sometimes after a debilitating illness or injury, the death of a spouse, the passage of time as family members passed or drifted away, and the subsequent isolation. This isolation is rarely voluntary but often is experienced as shameful; it is most often thrust upon a person by time and circumstance. There may be family members in the back of the picture, but the circles of connection being increasingly drawn due to smaller family numbers and the financial necessity of earning a living, with little or no financial margin for extending hands to family members in need of support and social contact, breaks the bonds that formerly provided life and health to seniors.

And as our population, and those of many other developed countries such as Japan, have tipped demographically to where there are more people over 65 than under 14 years of age, the numbers of individuals facing life with severe decline is on the rise. It is a terrifying prospect, as most of these illnesses do not augur any hope of improvement, and most of the sufferers know that as matters decline, they will be alone and wiped out financially. Research has shown, however, that diseases like dementia progress most rapidly when people are socially disconnected and their supports, including nutritional support, are deficient. Not being able to shop for healthy food, not being interested in cooking for one, lack of hydration, and without access to services such as Meals on Wheels for daily nutrition, creates a predictable downward spiral that can have permanent consequences on overall health and function.

The age disparity of the population of developed countries has declined at such a pace that in 2016, the sales of adult diapers outsold baby diapers. And in these circumstances, approximately 25% of Texas Millenials have recently been reported in the press to be unpaid caregivers, and many have a great challenge finding productive and paying employment. The provision of basic income would provide these Millenials with the opportunity to be paid for the productive work that is now called "emotional labor", being that work necessary to support others than oneself, and to date, never paid by the receiver, though "at a cost" to the provider. Women have been considered the main providers of "emotional labor": to their spouses, immediate families, extended families, co-workers, etc., but this category also extends to others, largely in the family setting. It depends upon the availability and willingness of a family member to give up financial and social opportunities, personal comforts, and both present and future financial security, in favor of what they perceive to be the more primary concern of being a health care provider in caring for a loved one (1. Cleveland Business: "Senior living, health care providers prepare for the 'silver tsunami'" [caregiver demand is outstripping supply] March 20, 2018).

And not only is there no pay for this very real "emotional" labor, being work done for the emotional well-being of family and friends, and most often produced so silently and effectively that the recipient take the efforts completely for granted. But largely without respite as there has been no "fund" for it, this also can exact a cost in the health and both present and future finances, of the provider. In fact, there is a saying among those who provide emotional labor as caregivers to a frail senior, that they become ill or even die before the person for whom they are caring. Basic income can assist with providing respite and compensate for the expenses otherwise payable of the caregiver. (2. Jay Newton-Small: A Growing American Crisis: Who Will Care for the Baby Boomers? TIME, updated February 15, 2019)

The increasing cohort of frail seniors has become a target group for private enterprise, as the construction and development of assisted living and personal care homes has burgeoned in the past 20 years, particularly, being considered a lucrative area of investment. Thirty years ago, it was estimated that the intergenerational transfer of wealth was to be in the trillions of dollars between "The greatest generation" and their progeny, and billions of dollars has effectively been siphoned away to date in expensive senior accommodation "ghettos" that nonetheless include the full cohort of lifestyle amenities and recreational facilities for healthier living among one age-group, often apart from their family kinship circles. (3. Altus Group: "2019 Canadian Cost Guide for real estgate development and infrastfucture construction costs"; senior housing construction costs as listed for numerous Canadian cities). And even in these circumstances of relative wealth, there are still shortages (4. pricetags.ca: "Get Ready for the 'Grey Tsunami' and Seniors' Housing Shortages", Sandy James Planner, December 10, 2018)

But the concern is not that senior cohort who can afford to spend $3,500 and more per month on resort-like assisted living centers, but rather the much larger numbers of the middle-class and below, who have hereto lived in circumstances ranging from middle class comfort to relative poverty. Those previously in the middle class face poverty after the

depletion of their savings and assets, as they do not qualify for Medicaid until these assets have been depleted. And 60% of bankruptcies in the US are on account of assets and credit being depleted due to medical expenses prior to any necessity for personal care levels of frailty. This is particularly true for those who have not had access to universal health care and suffer acute debilitation at an earlier age. They have no means to afford care outside their homes, and could have been the best candidates to "age in place" had supports been present prior to tipping into the worsening of their conditions to the point of requiring institutional care. (5. GuelphMercury.com series; "longterm care system overwhelmed").

Governments in the US and Canada are being hard-pressed to develop municipal personal care housing at a rate fast enough to keep up with demand. Those who are unable to find the necessary level of housing and care are often kept in hospitals, overwhelming health care systems. But the cost per square foot of developing senior housing for acute needs can range from $100,000.00 per resident unit plus common areas and up, which has created a severe backlog, even when there is a will by government to produce. And having been on the Board of a major University for a number of years, it was made very clear to us that the capital costs are only the base for the often higher expense of ongoing staffing, programming and servicing of the physical structures. Personal care facilities also require high levels of staffing at a professional level of expertise, all working together under the expense of professional administrators.

And robots are not going to save the situation. While the media touts the rise of robotics in Japan, that solution is expensive, requires maintenance, and may be a feature of institutional care apart from acting as a medication minder and personal alarm in an individual home. As well, Japan's Shinto culture imbues even inanimate objects with "spirit" and makes interaction with appealing forms of robotics an easier sell than in the West.

But what happens when family members are too poor, or do not have the health or resources themselves to care for their frail seniors? The number of seniors being "granny dumped" in Japanese and US hospitals, marked in the press initially in 1992 (6. The New York Times: "Granny Dumping by the Thousands", March 29, 1992; also, Wikipedia survey article "Granny dumping"), has risen. These families of seniors previously living on their own and falling into frailty, could not cope or afford to care for them, particularly with the increase of joblessness and poverty caused by worker displacement from technological disruption. And some hospitals in Canada and the US, pleading a lack of institutional expertise with dementia, "granny dump" patients as well (7. The Caring Generation; Pamela Wilson: "Dementia Patients Dumped from Hospital Emergency Rooms; and American Nurse Today: "Dumped: When nursing homes abandon patients to the hospital" October, 2016, Vol. 11 No. 10). In Japan, poor families have revived the practice of "ubasute", or "granny dumping", which was done in ancient times (8. Nextshark: "Poor Japanese Families are Reviving the Heartbreaking Tradition of "Granny Dumping"; Carl Samson, January 31, 2017). Elderly seniors, isolated and with no supports, have been committing petty crime such as shoplifting, as the better alternative to the costs and loneliness of being frail and alone (9. Businessinsider.com: "Signs:japan-demographic time bomb. 2017 prisons are turning into nursing homes").

One strategy that has taken hold in Canada and the Us over the past 30 years is private and governmental "home care". Home care's intention is to assist the home resident to "age in place" and stave off the potential need for institutional care as long as possible, thus saving the capital and consequential costs of institutional care, as well as prevent hospitalizations and the burden on the health care system as the Home Care attendants are part of a team of health care professionals including supervisors, case managers, nurses (including nurse practitioners), and doctors. This is another area where entrepreneurs have found an opportunity to invest in the private sector, in developing a profit center in relation to seniors with the means to afford private, at-home care. However, private home care is not affordable to all, as with the expense of private assisted living and personal care homes.

As well, for government home care to be put into place, normally there must be a back-up plan consisting of friends and relatives, in the event that the traveling Home Care Aide is unavailable to attend. This disruption could be due to a home care attendant's illness, the attendant being kept at a previous attendance, or even due to weather. If there is no back-up plan, the home resident client may be required to change their care plan and revert to hospital, and eventually a personal care home. Again, this adds to the overwhelming of many health care systems. And this back-up plan can be required over any time in a 24 hour day, so that requires a family member or friend to be "on call", which itself may be impractical or impossible due to full-time work responsibilities, even if there is more than one person attempting to "cover". And with the demographics of family planning, often there are only one or two adult children who must bear this responsibility along with caring for their own children and working full time, sometimes being forced to work out of the jurisdiction where their parents may reside, and increasingly due to economic or technological disruption of employment.

Research has demonstrated, however, that rates of mental decline in many conditions are often responsive to the frail elderly being supported in their Community with familiar surroundings and people. The goal is to lengthen the time that it may take for recourse to institutional care, and lessen the population's need for institutional care. The hope of many is to die at home, or at least that they enjoy their life out of an institution until they may need the health care system to assist, whether in hospital or at home, in their end time. The fact of Medical Assistance in Dying (MAID) being legislated in Canada in the past few years, in which I was engaged through the Canadian Bar Association Health and Elder Committees, should not be lost on those of us who have experienced the pressing desire of those who wish to chose their own ending rather than be caught in an institutional system of end-of-life care.

Technological and economic employment disruption patterns are predicted by Silicon Valley to increase exponentially and immutably. In consideration that society is striving to ensure that the needs of the frail elderly are met, regardless of their financial means, and that they have a quality of life, basic income that would be provided to all their adult family members would have a positive impact on their circumstances.

For a family to be required to move at a time when the senior is still relatively active and

participating in family life, this often means that the adult children are forced to move hundreds of miles from their home communities. They have the expenses of setting up in a new location, disruption of children's lives and schooling, the finding and expense of day care, no "back up" when in an area where there are no family, friends or other support structures. If they fail to be able to maintain employment due to even a temporary health crisis of the adults or children, or are unable to find or maintain children in daycare, they are potentially rudderless in an effectively hostile environment with no support. They have lost the potential support of their senior family members who otherwise would both be providing supports and being actively engaged in activities that are healthful, stimulating, stave off isolation and potential ill-health, and ward off the crippling mental impacts that lead to the worst impacts of dementia.

One purpose of basic income can be to provide financial stability to the extended family by providing the opportunity to source other initially/potentially less remunerative employment upon employment disruption. Another would be by supplementing one or both adults in a household so that the "emotional labor" of caring for the generations can be afforded. There may also be benefits to smaller communities to maintain their populations when there is an economic disruption of employment by the loss of an industry, and afford "breathing room" for new industries to be sought.

This provision of basic income in keeping communities alive in times of economic trouble can also save the funding for local institutions such as hospitals, schools, businesses and infrastructure, as these are all based on service populations. Job disruption in small towns can impact on government very quickly unless there is a strategy such as basic income to hold off the depletion of populations to larger centers. This has left the frail elderly entirely stranded and at risk of worse health outcomes, including institutionalization that may not even be accessible in the area, or available at all, forcing them into what sometimes appears to be improvised or "hallway" hospital care. This is debilitating and demoralizing to the seniors, their families, and the health care providers.

Keeping communities alive and financially viable in times of economic downturn and trouble, including assisting the elder population, through a basic income-type program, has been done in China through their guaranteed farming programs, and in India. (10. Achim Steiner "What India and China have done to reduce extreme poverty; CNBC 31 May 2019). Communities that stay together are communities that maintain their elderly in their family-of-origin structures, and the need for the expense of institutional care becomes less, which in any case may be beyond these governments to provide in the numbers that would otherwise be required.

In conclusion, a basic income guarantee would support those caring for frail seniors living in their homes or with family members, so that they could avoid institutional care that may be prohibitive to them, and even to the tax base. It would also indirectly and directly provide financial support to communities threatened by economic and technical disruption, by maintaining critical infrastructure including hospitals, schools, and by directly supporting local businesses. This would also avert migration to larger centers that are already experiencing overcapacity with regard to sustaining seniors at the point of already being too frail to manage without institutional care, as well as the unemployed/insecurely employed and their families.

Eliza Jennings' Renaissance Retirement Campus features numerous amenities and cultural and dining experiences, including pig roasts, a supper club and wine pairing dinners. PHOTO PROVIDED

The population of those individuals ages

85 OR OLDER

is projected to triple

between 2015 and 2040.

— Department of Health and Human Services' Administration on Aging

Between 1946 and 1964, nearly 79 million Americans were born into a generation defined by music, culture, activism and expression. Now ranging from 54 to 72 years old, the baby boomers face another age of change. They are evaluating what the next phase of life looks like, and it doesn't necessarily equate to settling down.

By 2040, there will be about 82 million older individuals, more than double the number in 2000, according to the Department of Health and Human Services' Administration on Aging.

This so-called silver tsunami presents unique opportunities for senior living providers, which are looking to entice aging adults with a variety of amenities and outlets that emphasize wellness, living and community.

"The baby boomers aren't looking only for entertainment. They want engagement," said Diane Banning, independent living sales manager for Eliza Jennings, an Olmsted Township-based senior living provider.

Eliza Jennings' Renaissance Retirement Campus, for example, already offers a full list of cultural outings and dining options, although the organization is still considering new

offerings as it looks ahead to its future residents' expectations, Banning said.

"The baby boomers are wanting more space," she said. "Physical fitness will be important, and they will want access to a state-of-the-art fitness center. They tend to be more conscientious eaters, so they want more small plates and vegan dishes, and casual dining options instead of going to a big dining room. Baby boomers are smart shoppers. They want choices."

The leadership behind North Canton-based Danbury Senior Living has been paying close attention to the preferences and needs of current and the upcoming generation of residents since it opened its first independent senior living facility in 1997. Danbury now operates 16 properties throughout Northeast and north central Ohio, which include independent living apartments, assisted living centers and memory care facilities.

Campus-style configurations have taken hold to minimize the disruption of a move from one facility to the next, said president Brian Spring. Wellness amenities run the gamut, from access to on-site parks and walking trails for fitness enthusiasts, to pubs and bistros for social connections, and transportation for off-campus excursions (think margarita night at the local Mexican restaurant). Anytime dining between 7 a.m. and 7 p.m., versus the traditional pre-established meal times, accommodate a demand for more flexible dining.

As Danbury looks to grow its portfolio of senior living products, campuses located near top-level universities may become part of the mix.

"A lot of seniors come to us with high levels of acuity, and they are interested in lifelong learning," Spring said.

"We're committed to a well-rounded picture of wellness," added William Lemmon, CEO.

McGregor, a Cleveland-based nonprofit provider of independent and assisted living, rehabilitation care, and respite and hospice services, also is building out its mix of residential choices. Its latest assisted living facility is scheduled to open in summer 2019 and provides a more affordable alternative for cost-conscious consumers. Assisted living can cost between $3,500 and $4,500 per month, but not all individuals living on a modest budget can afford to private pay that fee.

McGregor's new 90-unit senior living facility aims to supplement pricier digs elsewhere by offering a mix of market rate and affordable units.

"Central to McGregor's mission is the commitment to support programs that allow older adults to age in place, wherever they call 'home,'" said Rob Hilton, president and CEO. "Our No. 1 priority is to build out the capacity of services that enables affordable senior housing."

FACT

14.5%

The share of the 65-plus population in **2014.**

21.7%

The projected share of the

65-plus population in **2040.**

— Department of Health and Human Services' Administration on Aging

Staying well

Maximizing the aging population's wellness is a multi-dimensional undertaking that will require more collaborations within the health care system and the surrounding community, those in the industry say. The bulging share of older adults will further strain health care providers, entitlement programs such as Medicare and Social Security, and safety net agencies.

Within Cuyahoga, Geauga, Lake, Lorain and Medina counties, nearly one-fourth of the population is 60 or older. The percentage of that population will grow over the next decade. By 2030, about 32% of the five-county region's residents will be near or beyond retirement age, according to the Western Reserve Area Agency on Aging.

Helping seniors maintain adequate nutrition and socialization are key factors of maintaining or improving wellness.

"Some of the main problems among seniors are hips, heart, depression, diabetes and dementia," said E. Douglas Beach, CEO of the Western Reserve Area Agency on Aging, which provides community-based services and supports for older adults and individuals with disabilities. Exercise slows down the onset or progression of those conditions, he said.

The Western Reserve Area Agency on Aging currently addresses seniors' wellness needs by coordinating a range of essential services, from hot meal delivery to aiding seniors in applying for money that can be used toward farmers market purchases.

New community partnerships may be necessary as the demand for health care and wellness-related services increases, he said. However, technology improvements — from wearable devices to telemedicine — buoy some of the concerns over taking care of the aging population.

"You can't assume gloom and doom. Instead of looking at this as a tsunami, it's really more like a big wave," Beach said. "Every day, you hear of new and improved advancements in Alzheimer's treatments. Automatic driving cars could help reduce isolation. Improving wellness as seniors age so they can remain independent is a doable undertaking."

FACT

The population of people ages

65 and older **is projected to nearly double**

between 2015 and 2050,

from **47.8 million** to **88 million.**

— Paraprofessional Healthcare Institute (PHI)

Caregiver demand outpacing supply

Meanwhile, a projected shortage of caregivers also is a widespread concern among the health care industry, as more people age with the desire to remain in their homes as long as possible. According to Paraprofessional Healthcare Institute, a New York-based eldercare advocacy organization, the U.S. by 2024 will need about 1 million new jobs in direct care, which includes home health aides, nursing assistants and personal care aides.

At McGregor, for instance, workforce development to serve the aging and economically disadvantaged population will continue to be a priority.

"In serving low-income seniors, there is a desperate need for workers, primarily health care workers, across the continuum of the profession, from paraprofessionals, nursing assistants, resident services coordinators all the way to geriatric physicians and those with a master's in social work," Hilton said.

To that extent, McGregor PACE offers a managed care program that provides services which address the medical, rehabilitative, social and personal care needs of older adults, so that individuals can stay in their home safely as long as possible, said Ann Conn, McGregor's chief operating officer.

"The focus of PACE is providing the right care at the right time in the right place," Conn said. "We want to support family caregivers and help manage complex coordinated care for their loved one."

The Benjamin Rose Institute on Aging also is evaluating more creative solutions to help meet the growing health care needs of the community, said Dabney Conwell, vice president and executive director of that advocacy and service provider's Rose Centers for Aging Well, which provides home-delivered meals and programming at seven area senior centers.

FACT

Ohio has the **sixth-highest population** in the nation of individuals ages 60 and older.

— Western Reserve Area Agency on Aging

"We're providing services for four generations," she said. "We have put a lot of energy and resources into serving as thought leaders on how to best provide caregiving resources for family members or friends. We can't do this alone."

Programming in the senior centers is evolving to meet the wide-ranging interests of its senior center visitors, from bingo games to fitness or courses on self-protection. But capacity is limited when it comes to connecting with aging homebound adults. Conwell wonders if there isn't more of a community-wide opportunity to interact with adults to minimize their loneliness or feeling of isolation, which can trigger depression.

"It seems like there's an opportunity to engage with the corporate world in terms of volunteer service," she said. "It could be as simple as a weekly check-in over the phone with Mrs. Smith to make sure she's OK. We can all be caregivers when it comes to taking care of individuals who are aging, and therefore support our community."

TIME

A Growing American Crisis: Who Will Care for the Baby Boomers?

Jasmin Merdan—Getty Images

BY JAY NEWTON-SMALL UPDATED: FEBRUARY 15, 2019 10:22 AM ET

IDEAS *Newton-Small, a TIME contributor, is the CEO of MemoryWell and author of Broad Influence*

Every day since her husband broke his hip, Beatrice Egger has been afraid. The 91-year-old retired teacher worries when William, 90, a retired principal, is in the shower. She worries when she is helping him get dressed and he unsteadily towers over her. And she worries when he moves from sitting to standing or from room to room. When he falls, which inevitably happens, she can call upon

aides at their Issaquah, Wash., retirement home to help get him back up. But they can't help her all the time. So she stays scared.

If they could afford it, Beatrice and William would hire a home care aide to help during the day. That would give Beatrice a safety net, a pair of younger stronger arms to steady William. They know they're lucky that their pensions afforded them life in a retirement community, food and some level of care. But they live in fear that William's next fall will prove fatal and, without his pension, Beatrice might not be able to afford her community; after a lifetime of middle-class jobs, she might be forced into Medicaid.

Beatrice is one of 43 million unpaid caregivers in America, a number poised to spike as the Baby Boomers, who comprise most of the family caregivers now, join the ranks of the oldest old. "Family caregivers make up a silent support army — without them, health and social systems within our aging societies would be absolutely overwhelmed," says Scott Williams, who oversees Embracing Carers, an international caregiving initiative for pharmaceutical company EMD Serono. The group conducted a survey of unpaid caregivers in 2017, which found that nearly half of family caregivers suffer from depression, and 45% did not have time to book or attend their own medical appointments as a result of their caregiving activities — thus putting caregivers at risk of falling ill and needing caregiving themselves. A 2002 Stanford University study found that 40% of Alzheimer's and dementia caregivers actually die from stress-related disorders before the one for whom they are caring.

Compounding pressure on this unpaid labor force is a shortage of paid caregivers to fill a growing class of jobs that are troubled by low pay and poor working conditions. The Bureau of Labor Statistics ranked home health and personal care aides as among the fastest growing occupations, with an anticipated 1.2 million new jobs anticipated between 2016 and 2026. But these are already jobs that most Americans don't want, leading to high turnover rates of 74% annually in nursing homes. So who will be filling these jobs?

America is not prepared for this coming shortage. Congress and the White House have kicked the can down the road, effectively waiting for the issue to

become a crisis before they deal with it. But caring for America's elders is the single most expensive domestic priority on the horizon, breaking the projected budgets of both Medicare and Medicaid, all 50 states and most of the middle class, and the truth is, no one is truly prepared for what is to come. And so states are beginning to take the lead to address the issue: Washington State, where the Eggers live, Hawaii and Maine are amongst the first to try to get ahead of the crisis.

For those who haven't yet dealt with this problem, here are the ground rules confronted by any elder caregiver. First, Medicare does not pay for long-term care. Period. At most it pays up to 100 days of skilled nursing per disease. Unless your loved one is among the 2% of Americans smart or flush enough to take out increasingly expensive long-term care insurance, your only recourse is paying out of pocket or, if you're anywhere near the poverty line, spending down your loved one's assets so they can qualify for Medicaid.

"No one could consider not insuring their homes against fire. But when you look at long-term care, people don't buy insurance because they can't afford it even though one out of four people are going to need it," says Rep. Drew C. MacEwen, a Republican representing Mason County, west of Seattle, who is sponsoring a bill currently before Washington State's legislature to create a state-sponsored long-term care program. "Doing a statewide program makes it affordable."

Washington State is bracing for a dual catastrophe: the anticipated 2026 insolvency of the federal Medicare hospital trust fund, which funds much of Medicare spending, and their own state's Medicaid bankruptcy. In any state, no matter how well prepared, sheer demographics will overwhelm the system. Washington in 2015 spent $1.7 billion on long-term care. By 2030 that number is expected to more than double to over $4 billion as the population ages and the number of available family caregivers declines from an average of seven today to four in 2030, according to Rep. Laurie Jinkins, a Democrat from Tacoma and the other co-author of the bill.

MacEwen and Jenkins' measure would impose a small employee tax to create a fund to help Washingtonians for care. The fund would provide a menu of benefits, from setting up a state-sponsored long-term care insurance fund that makes care more affordable to paying and training family caregivers like Beatrice, to paying up to $100 a day for in-home caregivers or for aides to visit facilities. So Beatrice could also get the aide to help with William that she needs. By helping families stretch the dollars they do have, the bill's sponsors hope they can help families like the Eggers avoid state-sponsored Medicaid down the road. The state estimates the bill will save it $37 million in 2025, the first year the fund is active, and nearly $4 billion by 2052. This would not only help state finances, though; it would also arguably improve care by allowing more people to age in place with their families, rather than in institutions that are often grim.

If passed, Washington will join only Hawaii in states that are actively preparing for the coming caregiving cliff. Hawaii in 2017 approved a measure to provide up to $70 a day to support family caregivers who also work outside the home, a benefit that can be used for a home health aide or adult daycare. But Washington would be the first state to impose a payroll tax to such an end. And passage is not a foregone conclusion. Last year, a similar measured failed, when groups such as AARP opposed some of the eligibility requirements of the measure.

Maine, the nation's oldest state, failed to pass a similar initiative in 2018. That provision would have created a home care fund through an income tax on high earners to help Maine families pay for care. It also would have increased pay for the home care workforce and allowed workers to unionize, creating a category of jobs that would enable more young people to stay and work in Maine. Currently, low wages and poor working conditions for home care workers contribute to annual turnover rates exceeding 66%.

The Maine measure had widespread opposition in the business community, with opponents questioning the proposed regulatory scheme and countering that increasing income taxes would have a negative effect on the economy.

Congress isn't totally unaware of the coming train wreck. For the 2009 Affordable Care Act, lawmakers debated the CLASS Act, a provision that would have created a national public long-term care insurance program. But it was eventually taken out in the Senate bill because it was deemed too expensive. In 2017, Congress passed the RAISE Act, which created a national panel to develop a strategy to address the issue and beefed up funding for caregiver innovation grants at the National Institute of Health and the National Institute of Aging. The first report is due at the end of 2020, and the group is expected to report biennially after that. In the meantime, Senators Susan Collins and Bob Casey have introduced the Geriatrics Workforce Improvement Act. And already, through tax breaks and incentives, lawmakers have successfully incentivized people to age at home, which is far cheaper than institutionalized care. But it is clear that much more needs to be done. With 10,000 Baby Boomers retiring every day, we are only at the beginning of this demographic danger.

Correction, Feb. 15

The original version of this story misstated Scott Williams' last name. It is Williams, not Walker.

Contact us at editors@time.com.

IDEAS *TIME Ideas hosts the world's leading voices, providing commentary on events in news, society, and culture. We welcome outside contributions. Opinions expressed do not necessarily reflect the views of TIME editors.*

PRIVATE SECTOR PRICE PER SQUARE FOOT

	BUILDING TYPE	Vancouver	Calgary	Edmonton	Winnipeg
RESIDENTIAL	CONDOMINIUMS/APARTMENTS (Excludes Parking)				
	Up to 6 Storeys (Hybrid Construction)	190 – 260	180 – 250	175 – 245	180 – 250
	Up to 12 Storeys	200 – 280	185 – 260	180 – 260	185 – 265
	13-39 Storeys	210 – 275	200 – 245	190 – 255	190 – 260
	40-60 Storeys	215 – 280	200 – 260	200 – 260	200 – 265
	60+ Storeys	245 – 310	n/a – n/a	n/a – n/a	n/a – n/a
	Premium for High Quality	90 – 220	80 – 200	75 – 200	75 – 200
	WOOD FRAMED RESIDENTIAL				
	Row Townhouse with Unfinished Basement	125 – 195	115 – 145	120 – 145	115 – 150
	Single Family Residential with Unfinished Basement	140 – 250	120 – 180	125 – 180	120 – 185
	3 storey Stacked Townhouse	165 – 225	140 – 170	145 – 175	140 – 180
	Up to 4 Storey Wood Framed Condo	180 – 240	150 – 200	155 – 205	155 – 210
	5 to 6 Storey Wood Framed Condo	200 – 265	160 – 205	160 – 205	160 – 215
	Custom Built Single Family Residential	415 – 1,050	400 – 850	400 – 850	405 – 850
	SENIORS HOUSING				
	Independent / Supportive Living Residences	205 – 300	170 – 260	175 – 265	175 – 270
	Assisted Living Residences	235 – 320	200 – 270	205 – 280	205 – 280
	Complex Care Residences	280 – 375	250 – 325	245 – 340	250 – 320
COMMERCIAL	OFFICE BUILDINGS (Excludes Parking)				
	Under 5 Storeys (Class B)	215 – 270	180 – 245	180 – 255	185 – 255
	5 - 30 Storeys (Class B)	215 – 255	180 – 250	180 – 255	185 – 260
	5 - 30 Storeys (Class A)	240 – 305	215 – 285	215 – 290	220 – 290
	31 - 60 Storeys (Class A)	255 – 360	235 – 330	235 – 330	240 – 335
	Interior Fitout (Class B)	50 – 105	50 – 85	50 – 85	50 – 90
	Interior Fitout (Class A)	100 – 190	85 – 160	85 – 160	85 – 160
	RETAIL				
	Strip Plaza	120 – 175	105 – 165	110 – 170	110 – 170
	Supermarket	180 – 230	155 – 210	165 – 215	160 – 215
	Big Box Store	170 – 230	155 – 210	160 – 210	160 – 215
	Enclosed Mall	250 – 345	205 – 280	210 – 290	210 – 285
	HOTELS (Excludes Parking)				
	Budget	180 – 235	160 – 200	160 – 210	160 – 205
	Suite Hotel	295 – 340	230 – 290	235 – 295	235 – 295
	4 Star Full Service	300 – 370	240 – 290	245 – 295	250 – 300
	Premium for Luxury	95 – 170	90 – 150	90 – 150	95 – 150
	PARKING				
	Surface Parking	7 – 25	6 – 20	6 – 20	6 – 20
	Freestanding Parking Garages (above grade)	95 – 135	75 – 100	75 – 100	80 – 105
	Underground Parking Garages	115 – 170	110 – 155	110 – 155	110 – 150
	Underground Parking Garages (Single Level, Open Cut Excavation)	90 – 125	90 – 120	90 – 125	90 – 125
	Underground Parking Garages - Premium for Unusual Circumstances	40 – 175	30 – 120	30 – 120	30 – 120
INDUSTRIAL	Warehouse	95 – 135	80 – 110	80 – 115	80 – 115
	Urban Storage Facility	95 – 140	80 – 110	80 – 115	80 – 115
	Data Centre - Tier III	595 – 975	490 – 920	490 – 945	490 – 950
	Pharmaceutical Lab	560 – 790	410 – 620	410 – 630	420 – 635
	Manufacturing Facility	300 – 395	240 – 325	245 – 340	250 – 345

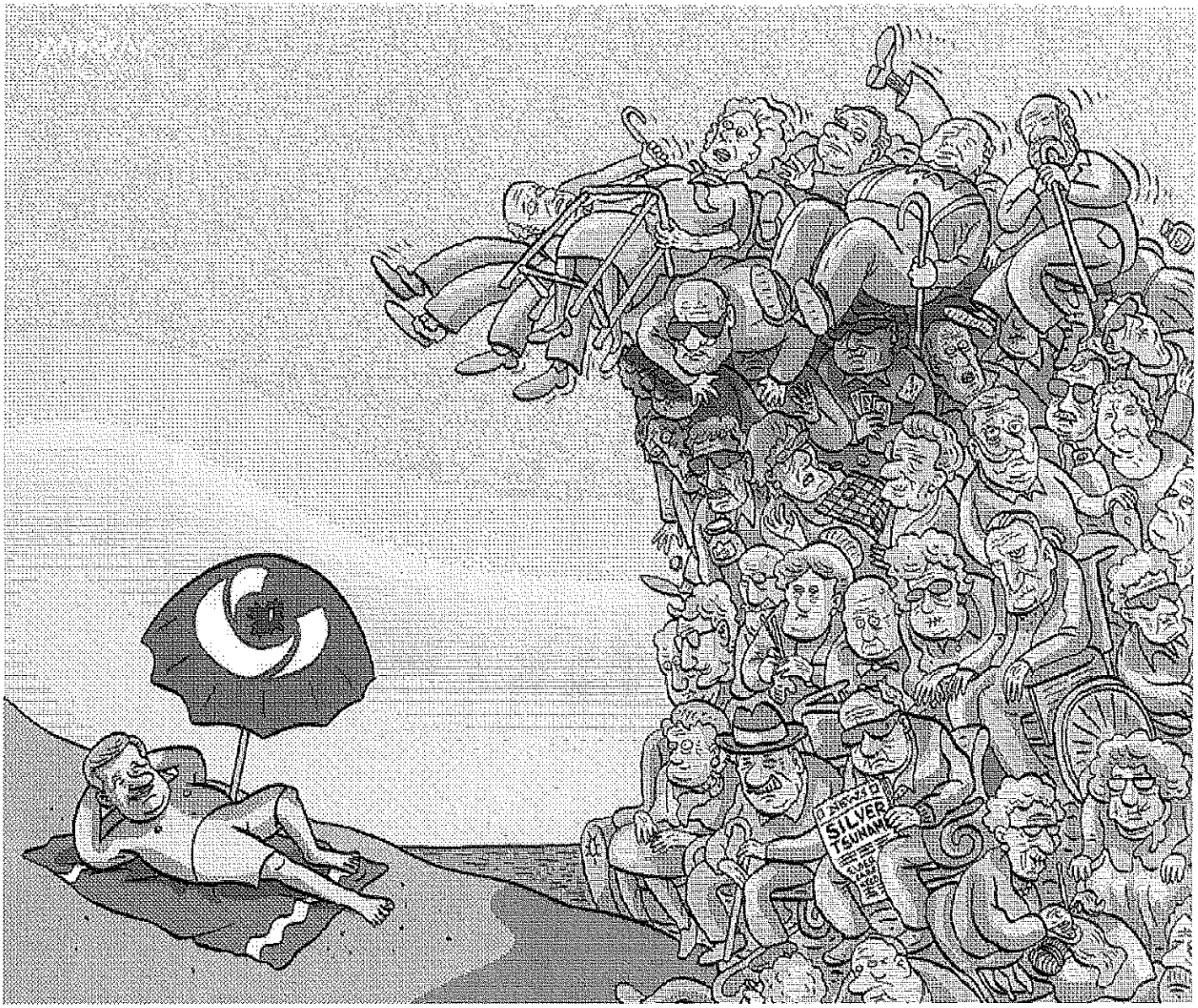
PRIVATE SECTOR PRICE PER SQUARE FOOT

	BUILDING TYPE	GTA	Ottawa/Gatineau	Montreal	Halifax	St. John's
RESIDENTIAL	CONDOMINIUMS/APARTMENTS (Excludes Parking)					
	Up to 6 Storeys (Hybrid Construction)	180 – 250	170 – 240	160 – 230	155 – 225	155 – 225
	Up to 12 Storeys	185 – 265	175 – 245	165 – 240	165 – 235	165 – 235
	13-39 Storeys	190 – 255	180 – 250	175 – 245	175 – 245	n/a – n/a
	40-60 Storeys	200 – 260	n/a – n/a	185 – 260	n/a – n/a	n/a – n/a
	60+ Storeys	225 – 280	n/a – n/a	n/a – n/a	n/a – n/a	n/a – n/a
	Premium for High Quality	75 – 200	60 – 165	65 – 175	65 – 170	65 – 170
	WOOD FRAMED RESIDENTIAL					
	Row Townhouse with Unfinished Basement	105 – 160	110 – 155	105 – 150	95 – 135	110 – 145
	Single Family Residential with Unfinished Basement	115 – 215	115 – 185	100 – 170	90 – 150	115 – 150
	3 storey Stacked Townhouse	135 – 180	145 – 175	120 – 170	115 – 165	135 – 170
	Up to 4 Storey Wood Framed Condo	150 – 200	155 – 190	120 – 180	125 – 160	130 – 170
	5 to 6 Storey Wood Framed Condo	160 – 215	155 – 190	140 – 190	125 – 170	130 – 185
	Custom Built Single Family Residential	400 – 900	430 – 890	370 – 740	250 – 500	290 – 610
	SENIORS HOUSING					
	Independent / Supportive Living Residences	185 – 270	165 – 255	160 – 255	155 – 235	170 – 240
	Assisted Living Residences	210 – 295	195 – 260	190 – 270	180 – 250	185 – 260
	Complex Care Residences	250 – 330	240 – 305	235 – 295	215 – 290	225 – 300
COMMERCIAL	OFFICE BUILDINGS (Excludes Parking)					
	Under 5 Storeys (Class B)	185 – 255	180 – 235	165 – 225	165 – 215	175 – 225
	5 - 30 Storeys (Class B)	190 – 265	190 – 245	170 – 235	170 – 240	180 – 250
	5 - 30 Storeys (Class A)	220 – 290	220 – 280	185 – 260	185 – 260	195 – 280
	31 - 60 Storeys (Class A)	235 – 340	n/a – n/a	220 – 340	n/a – n/a	n/a – n/a
	Interior Fitout (Class B)	60 – 95	50 – 85	50 – 95	50 – 90	50 – 90
	Interior Fitout (Class A)	90 – 200	85 – 150	85 – 155	85 – 145	85 – 145
	RETAIL					
	Strip Plaza	115 – 185	120 – 165	100 – 170	100 – 155	115 – 160
	Supermarket	155 – 215	155 – 190	130 – 180	125 – 190	140 – 185
	Big Box Store	145 – 200	150 – 175	130 – 180	140 – 185	140 – 185
	Enclosed Mall	215 – 295	200 – 255	195 – 270	185 – 260	200 – 250
	HOTELS (Excludes Parking)					
	Budget	160 – 210	155 – 195	150 – 205	175 – 220	155 – 190
	Suite Hotel	245 – 305	205 – 275	205 – 270	200 – 280	205 – 270
	4 Star Full Service	255 – 330	235 – 300	220 – 290	220 – 290	235 – 290
	Premium for Luxury	95 – 160	85 – 140	90 – 150	60 – 100	75 – 110
	PARKING					
	Surface Parking	8 – 20	6 – 18	6 – 16	6 – 16	6 – 16
	Freestanding Parking Garages (above grade)	75 – 110	75 – 100	70 – 100	95 – 115	100 – 130
	Underground Parking Garages	115 – 160	105 – 160	85 – 140	100 – 150	125 – 155
	Underground Parking Garages (Single Level, Open Cut Excavation)	90 – 120	95 – 130	90 – 120	90 – 125	90 – 130
	Underground Parking Garages - Premium for Unusual Circumstances	40 – 190	30 – 150	30 – 150	30 – 150	30 – 150
INDUSTRIAL	Warehouse	75 – 105	85 – 105	65 – 100	95 – 130	95 – 130
	Urban Storage Facility	80 – 105	90 – 110	n/a – n/a	n/a – n/a	n/a – n/a
	Data Centre - Tier III	550 – 1,050	525 – 900	525 – 915	n/a – n/a	n/a – n/a
	Pharmaceutical Lab	465 – 735	430 – 650	435 – 665	n/a – n/a	n/a – n/a
	Manufacturing Facility	270 – 355	260 – 340	255 – 340	255 – 335	255 – 330

December 10, 2018

Get Ready for the "Grey Tsunami" and Seniors' Housing Shortages

Sandy James Planner
(https://pricetags.ca/author/sandyjamesplanner/)



Housing issues are a real concern for young people trying to work in Vancouver and attempting to find a place to live that does not eat up everything they earn. But there is the other side of the population cohort experiencing similar pressures, seniors who are retired and on fixed income with housing that because of the real estate market is often insecure and unstable.

Dan Fumano touches on this in his article on the Grey Tsunami (https://vancouversun.com/uncategorized/staff/business-blogs/real-estate-business/dan-fumano-a-grey-tsunami-and-the-precariousness-of-aging-for-vancouver-renters) and the challenges seniors have when being asked to leave rental accommodations they have lived in sometimes for decades. Duke of Data and Simon Fraser University Director of the City Program Andy Yan observes that renters in Vancouver that are seniors "*are more likely than younger renters to face what Statistics Canada calls "core housing need.*"

With a third of Vancouver renters being senior, census data shows that 60 per cent need stable affordable housing, and are not in the position to pay more if displaced from their current tenancies. As the baby boom becomes senior citizens, Andy Yan describes the lack of available and affordable

seniors' accommodation as "*a province headed into uncharted demographic territory, with an aging tsunami barrelling toward infrastructure and housing ill-prepared for it.*"

Today there are more people over the age of 65 than there are young people under 14 years of age. That is 16 million seniors. And in just over a decade seniors will be 25 percent of all the Canadian population.

That will have profound impacts on how we design streets, parks and access to be universally useable by a geriatric generation that will need to age in place in order to keep health insurance costs low. Isobel Mackenzie, the B.C. seniors advocate is already speaking about the fact that nursing homes will not be able to accommodate the range of people needing care, and that it will be standard for people with active dementia to live and function in apartments in the downtown areas of cities.

It is important that we think of cities and spaces for everyone but especially for the elderly, and prepare for this major sea change in the services and accommodation that will need to be provided. Andy Yan calls 2016 "*an inflection year where the working population supports more people over the age of 65 than under the age of 19 — a pattern that has never occurred.*"

How do we house and how do we design space in Vancouver for the very young and the very old?

Ontario's long-term care system is paralyzed, and failing its most vulnerable residents. More than 600 government funded homes are supposed to provide high quality, round-the-clock care to the frail elderly. But Metroland's special report shows seniors stuck on record wait lists, entangled in bureaucracy and subject to pressure tactics that jeopardize their rights.

First in a Four-part series

GUELPH — Dementia robbed John Harrison, now 91, of his good nature. An unfair and under-resourced long-term care system chipped away at his dignity, his daughter Jan Graff said.

"Everybody knew my dad," Graff said during a recent interview. "He was a joker, a fun person. You never saw my father angry."

Graff, a Guelph retiree, is extremely angry over the way her beloved father, and her mother Gladys, were left in an untenable situation by a long-term care system plagued by excessive wait times — a system, she said, that appears to give unfair advantage to those who can afford private or semi-private accommodations.

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"Everybody knew my dad," Graff said during a recent interview. "He was a joker, a fun person. You never saw my father angry."

Graff, a Guelph retiree, is extremely angry over the way her beloved father, and her mother Gladys, were left in an untenable situation by a long-term care system plagued by excessive wait times — a system, she said, that appears to give unfair advantage to those who can afford private or semi-private accommodations.

Like many seniors in Ontario, Harrison, a professional photographer during his working life, lacked the financial resources to pay for anything other than basic long-term care accommodations. Consequently, said his daughter, when he needed a long-term care bed locally, one wasn't available.

"It was just an absolute nightmare," said Graff.

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The New York Times | https://nyti.ms/29b0diG

Archives | 1992

Granny Dumping by the Thousands

MARCH 29, 1992

It was a sad and troubling story. John Kingery, 82, suffering from Alzheimer's disease and wearing a sweatshirt inscribed "Proud To Be An American," was abandoned outside the men's room at a dog racing track in Post Falls, Idaho. His wheelchair had been stripped of identification and his clothing labels ripped out; he couldn't remember his own name.

Pictures of him clutching his teddy bear as attendants prepared to send him home to Oregon provoked a national wince. But what turns a wince into an ache is the sudden awareness that John Kingery is no isolated case. The American College of Emergency Physicians estimates that 70,000 elderly Americans were abandoned last year by family members unable or unwilling to care for them or pay for their care.

Social workers call this phenomenon "granny dumping." But they are reluctant to condemn those who do the dumping. Instead, they paint a harrowing portrait of millions of Americans who are near the breaking point with the burden of caring for their ill and elderly parents. One in five families now takes care of an elderly parent. Millions of American women will care for their aging parents longer than they care

Nobody yet knows all the pressures that led John Kingery's daughter Sue Gifford to check him out of a nursing home and, presumably, leave him at the track. Nor is it known whether the family first explored all avenues of financial and social assistance. But in all too many cases, the care-giving children feel overwhelmed by mounting bills, bureaucratic hassles, hopelessness. The burden falls heavily on female relatives; three of four people caring for the elderly are women.

When the illness is Alzheimer's, care-givers often veer from despair to burnout. Alzheimer's patients can live 20 years in a state of dementia. They require round-the-clock social rather than medical care. Thus, they are usually best cared for at home, by family and publicly funded care-givers. In New York State, some 40,000 older adults, many with Alzheimer's, are cared for at home with Government help. That eases the burden on care-givers without lifting it.

But until Alzheimer's is cured or a long-term health care program is available, the Sue Giffords of America will be as much the victims of an aging population as the John Kingerys.

A version of this editorial appears in print on March 29, 1992, on Page 4004016 of the National edition with the headline: Granny Dumping by the Thousands.

WIKIPEDIA

Granny dumping

Granny dumping (informal) is a term that was introduced in the early 1980s by professionals in the medical and social work fields. Granny dumping is defined by the *Oxford English Dictionary* as "the abandonment of an elderly person in a public place such as a hospital or nursing home, especially by a relative".[1] It may be carried out by family members who are unable or unwilling to continue providing care due to financial problems, burnout, lack of resources (such as home health or assisted living options), or stress.[2]

The phenomenon is not new.[3] A practice, known as *ubasute*, had allegedly existed in Japan centuries ago when senile elders were brought to mountaintops by poor citizens who were unable to look after them. The widespread economic and demographic problems facing Japan have seen it on the rise with relatives dropping off seniors at hospitals or charities.[4] 70,000 (both male and female equally) elderly Americans were estimated to have been abandoned in 1992 in a report issued by the American College of Emergency Physicians. In this same study, ACEP received informal surveys from 169 hospital Emergency Departments and report an average of 8 "granny dumping" abandonments per week. According to the New York Times, 1 in 5 people are now caring for an elderly parent and people are spending more time than ever caring for an elderly parent than their own children. Social workers have said that this may be the result of millions of people who are near the breaking point of looking after their elderly parents who are in poor health.[5]

In the US, granny dumping is more likely to happen in states such as Florida, Texas and California where there are large populations of retirement communities. Congress has attempted to step in by mandating to emergency departments requiring them to see all patients. However, Medicaid is covering less and less of medical bills through reimbursement (in 1989 it was 78% but that number is decreasing) and reduced eligibility.[6] In some cases, the hospitals may not want to take the risk of having a patient who cannot pay so they will attempt to transfer their care to another hospital. According to the Consolidated Omnibus Budget Reconciliation Act of 1985 set into place by Ronald Reagan, a hospital can transfer at the patient's request or providers must sign a document providing why they believe a patient's care should be better served at another facility. With 40% of revenue coming from Medicaid and Medicare a hospital must earn 8 cents per dollar to compensate for the loss of 7 cents per Medicaid/Medicare patients. Hospitals had to pay an additional 2 billion dollars to private payers to cover costs for Medicare/Medicaid patients in 1989.[6]

Incidents of granny dumping can happen before long weekends and may peak before Christmas when families head off on holidays. Caregivers in both Australia and New Zealand report that old people without acute medical problems are dropped off at hospitals. As a result, hospitals and care facilities have to carry an extra burden on their limited resources.[7][8]

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Select Page

7

THE CARING GENERATION®

Embracing life's transitions with dignity, clarity and stability

Hospital dumping of dementia patients is the new normal. Twice in the past 30 days I have had two clients sent to the emergency room for delusional and unsafe behavior. Both individuals had a diagnosis of dementia. Both times a medication review was requested because in addition to the diagnosed urinary tract infections both individuals exhibited generally unsafe and agitated behaviors.

One client attempted to stab a caregiver in the leg with a knife, another physically harmed a family member. With dementia these behaviors are more common than one might expect.

In prior times, geriatric psychiatry units would accept individuals with dementia for medication management that is much better implemented in a more controlled environment. Medication management means that the present prescribed medications are reviewed in addition to other medications that may be helpful in managing agitated or unsafe behaviors.

of your mind and the medical profession refuses to help you.

Today, due to insurance regulations, only individuals with mental health diagnosis may be admitted for treatment into a geriatric psychiatry unit. Individuals diagnosed with dementia who are exhibiting mental distress do not qualify for treatment under health insurance in a geriatric psychiatry unit.

One of the challenges in going back through an individual's health history, especially an older adult, is that a mental health diagnosis was viewed as a negative stigma. Thus, even if an older adult of today had mental health issues in their younger years, this rarely has been diagnosed, let along placed as a diagnosis in a medical chart. This is the question you will be asked if you attempt to have a loved one placed in a geriatric psychiatric unit - is there a diagnosis related to mental health?

The lesson: if anyone in your family experiences challenges due to mental health, have the diagnoses placed in the medical chart. If not, and this person has a diagnosis of dementia in later years, it may be difficult to receive treatment.

Medical treatment for behaviors is is a present challenge and a challenge for the future as the number of individuals diagnosed with dementia increases and behavioral challenges occur. If the medical profession refuses to treat demented individuals with behaviors who will?

Who in the insurance industry or the government decided that persons diagnosed with dementia should be DENIED TREATMENT? Who in the insurance industry or the government decided that behaviors of persons with dementia should NOT be treatable for geriatric psychiatry benefits using a health insurance benefit?

The reality is that not all medical professionals working in hospitals — or even primary care physicians — are trained to care for persons diagnosed with dementia. In one of the emergency room visits, the emergency room physician and social worker told me, *"we're not equipped to deal with this type of situation (dementia)."*

equipped to treat and respond to individuals diagnosed with dementia what does this say of the gap in healthcare today and in the future?

If the medical profession and insurance companies fail to pay attention to this segment of the population today, how will the ever increasing number of individuals yet to be diagnosed in the future with dementia receive treatment?

Will individuals diagnosed with dementia be dumped out of hospitals into the streets or into the homes of loved ones who are even less prepared to care for their family members?

A case manager at another hospital told a client that he needed to take his father home and find a care community because the hospital was unsuccessful in making this transition for the family. Again, if medical professionals in a hospital are not successful in finding a community placement for an individual, how can the hospital expect a family member with fewer skills and knowledge to be successful?

Professionals with the skill, background and ability to work with individuals diagnosed with dementia and to advise their families *represent a specialty niche of professionals within the aging industry.* If you are a person diagnosed with dementia or a family member seek out assistance rather than having your loved one being treated with less than dignity and caring. Plan ahead for expected and unexpected situations.

If you are interested in planning for your care or the care of a loved one, pick up a copy of my book, The Caregiving Trap: Solutions for Life's Unexpected Changes.

ABOUT PAMELA WILSON

PAMELA D. WILSON, MS, BS/BA, NCG, CSA helps caregivers and aging adults solve caregiving problems and manage caregiving needs through online programs, live support

Dumped: When nursing homes abandon patients to the hospital

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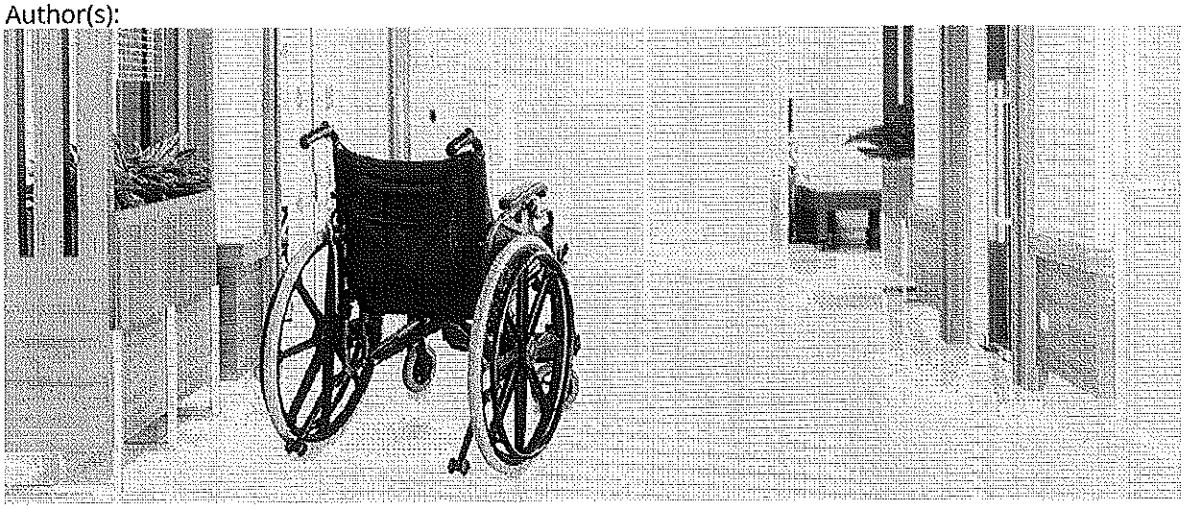
Author(s):



Margie is an 86-year-old nursing home resident who has developed a bladder infection. As is the case with many elderly women, she also is confused as a result. On her way out the door to a hospital, she struggles and yells that "they better not tell anyone else" about why she is going to the hospital. When her elderly, out-of-state family members call to check on Margie, they are told that the Health Insurance Portability and Accountability Act (HIPAA) prevents staff from saying anything.

Five days later, when Margie's fever is down and she is lucid and ready for discharge, she calls the nursing home—and is told she can't come back. She calls her family in a panic, only to learn that they had no idea where she was. Margie wasn't poor, at least not until about 2 years in the nursing home, which consumed all of her savings, including the money she realized in selling her home. Everything was gone except Social Security and a tiny pension (not enough to even begin to cover the nursing home charges).

Once Margie was hospitalized, the nursing home cleared out her room, packed her belongings, and refused to take her back, all without any advance warning. This process is as illegal as it is reprehensible. And, by the way, HIPAA was never intended to keep family members of confused patients in the dark.

An illegal practice

Unfortunately, some nursing homes regularly evict residents illegally. No illegal eviction method is more frustrating than the hospital dump. In such a scenario, a nursing home has a resident transferred to a hospital for some acute care need. Then when the time has come for the resident to be discharged, the nursing home refuses re-admittance, often claiming, "the bed is already filled."

When a hospital discharges a patient, and the nursing home won't take him or her back, it's called "hospital dumping." The dumping of mostly low-income nursing-home patients (or those who have become low-income because the nursing home has already taken all the money they have) is a growing problem, one involving a complicated interaction among nursing homes that complain of low Medicaid payments, hospitals put on the spot to find another facility to take the person, and frail elders and their families.

Here are the facts: When a nursing home resident is transferred to a general acute care hospital, federal and state rules require the bed be held for up to 7 days. If the hospitalization exceeds 7 days, the facility must nonetheless provide the resident with the first available bed in the nursing home after he or she is cleared for return.

The purpose of the legally mandated bed-hold is obvious: Residents who need to go to the hospital for acute care should not have to worry about losing their placement in their nursing home as a result. Federal law requires skilled-nursing facilities to give residents 30-days notice if they want a resident to leave.

Nursing-home administrators have various reasons for hospital dumping: perhaps the residents require more care or have behavioral issues, such as emotional agitation or abusive outbursts. One thing is sure, the residents either don't have any money—or they have run out of the money they had.

Whatever the reason, the nursing home just leaves the resident in the hospital. According to law, if a nursing home can't meet a resident's medical needs, the nursing home staff should call the state department of health and senior services. But it's quicker and cheaper (for the nursing home) to simply dump the patient on the hospital.

Nursing facilities have even told a hospital that a patient could not return because his or her cost of care was higher than the state Medicaid rate. And the nursing homes complain that they have too many of these types of residents already—if they keep every difficult low-income case, they will go broke.

Resolutions and solutions

Helping a dumped patient usually starts when a hospital social worker asks the nursing-home administrator for confirmation that a patient was given due notice; it is surprising just how many nursing home administrators are not aware that a patient *must* receive 30 days notice before being evicted. Patients who are wards of the state are among the prime candidates for getting dumped, primarily because these elders typically have no family members and often have legal guardians appointed by the state, usually attorneys. When residents go to a hospital, their guardians should be notified but rarely are.

Rules being broken without consequence

Nursing home abuse lawyers say that facilities around the country are breaking the rules when it comes to evicting nursing home residents. Those rules, as defined by the Code of Federal Regulations (CFR) 42 CFR 483, require that facilities must permit residents to remain unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
3. The safety of individuals in the facility is endangered;
4. The health of individuals in the facility would otherwise be endangered;
5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
6. The facility ceases to operate.

When one of the above occurs, federal law also requires everything to be documented to avoid foul play. Unfortunately, many facilities simply don't follow those rules and transfer or discharge patients they just don't want to care for anymore. There have been numerous reports of nursing home facilities falsely accusing residents of violence, forging documentation in order to get rid of unwanted patients or, believe it or not, dumping patients into a hospital emergency department and then refusing to take them back. Unfortunately, many patients, or their families, don't know that filing a lawsuit is an option. Not surprisingly, the patients generally are not informed of their right to the 30-day eviction notice. Nursing home residents who are transferred, dumped, or evicted from long-term care facilities are victims of nursing home abuse. These issues, which are far more common than most people think, are especially troubling because nursing home and assisted living facility residents and their families often simply don't know they have rights and *can* fight back. Nurses, as patient advocates, ought to know this—and all discharge planners need to be aware of both the practice and the patient's rights. Ultimately, the responsibility resides with the state, and until the state has been informed and other arrangements made, the patient must not, ever, just be dumped—by nursing home or hospital.

Leah Curtin is Executive Editor, Professional Outreach for *American Nurse Today* and a consultant with CGFNS International in Philadelphia, Pennsylvania.

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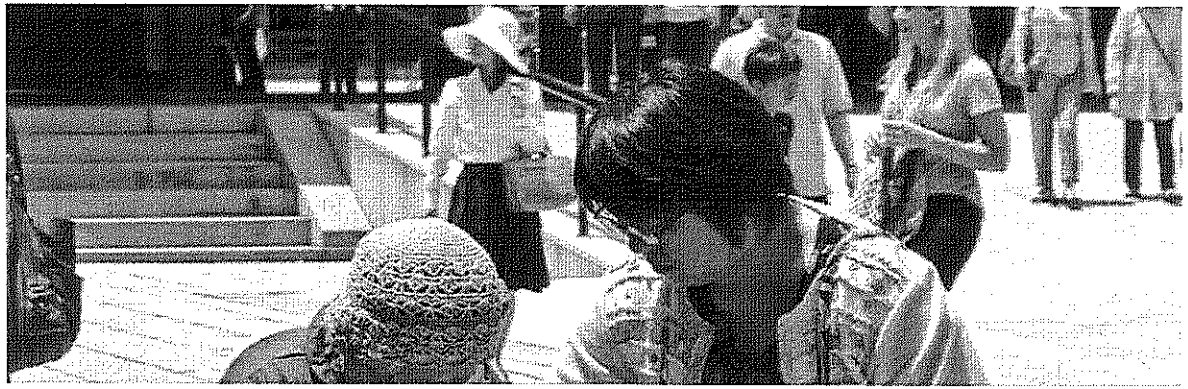
Was this error, fraud—or deliberate retaliation?

(https://www.americannursetoday.com/error-fraud-deliberate-retaliation/)

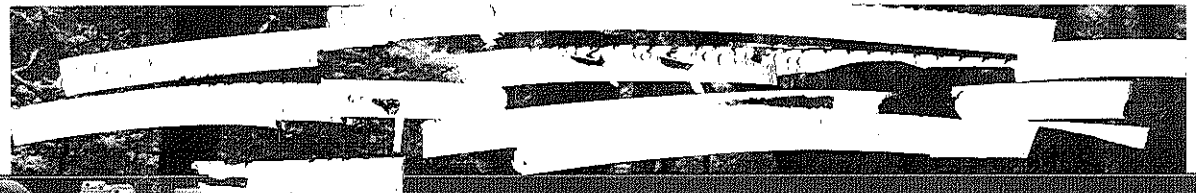
Carl Samson · January 31, 2017 · 3 min read

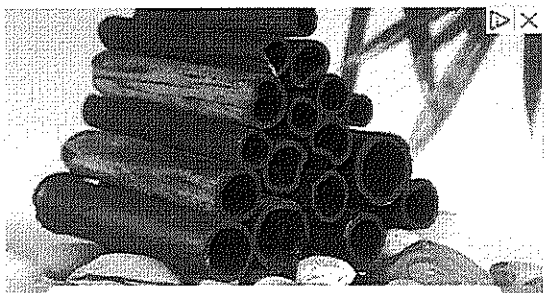
Poor Japanese Families are Reviving the Heartbreaking Tradition of 'Granny Dumping'



Poor Japanese households that can no longer tend to their elders are reviving an ancient practice called "ubasute," which means "granny dumping."

In the past, economically-disadvantaged citizens allegedly brought their elders to mountaintops and left them there to fend for themselves and eventually die.





In feudal Japan ubasute or "granny dumping" sometimes occurred in times of famine or hardship. It refers to the horrific practice of abandoning elderly relatives on lonely mountaintops. The demographic challenges the country currently faces have caused a modern revival of the practice, with some charities establishing a service called "senior citizen postbox". The charities assign elderly parents left with them to retirement homes.

The tragedy is the family members who abandon their elderly relatives are normally genuinely desperate and struggling on their own, often with a relative with severe dementia. Many are depressed as a result of the weight of the burden.

The problem comes because the number of 20- to 29-year-olds in Japan has dramatically decreased from 18.3 million to 12.8 million since 2000, according to the World Bank. By 2040 there may only be only 10.5 million. Thus cities are chasing an ever-diminishing number of young adults and children in order to support their economies and retiring populations.

A quarter of Japan's 127 million people are over 65, and there is expected to be an explosion of further pensioners around 2025 when the post-war baby boomers reach their mid-70's. At the

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9. Must we forfeit democracy to 'make war' on climate change?
10. Are married people still happier?

there may only be only 10.5 million. Thus cities are chasing an ever-diminishing number of young adults and children in order to support their economies and retiring populations.

A quarter of Japan's 127 million people are over 65, and there is expected to be an explosion of further pensioners around 2025 when the post-war baby boomers reach their mid-70's. At the same time the latest census showed that the Japanese population fell at its fastest rate since records began, decreasing by almost 300,000.

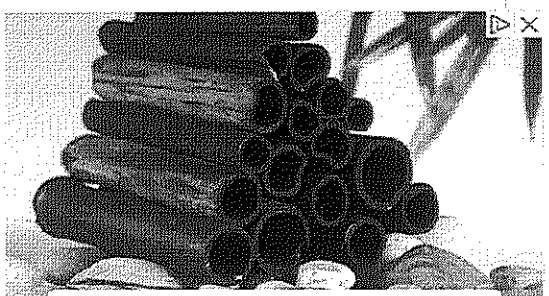
The government has made addressing declining fertility a huge priority. One important thing will be encouraging a focus on family, motherhood and time spent with children and older family instead of a focus on such long working hours. Some companies are now looking at more flexible working hours or even three days weekends, as they begin to acknowledge the excessive working culture. Flexibility is needed both to have children and to look after the growing elderly. Japan is increasingly a lesson in a corporate culture that just simply doesn't encourage life or quality of life. What is it all for?

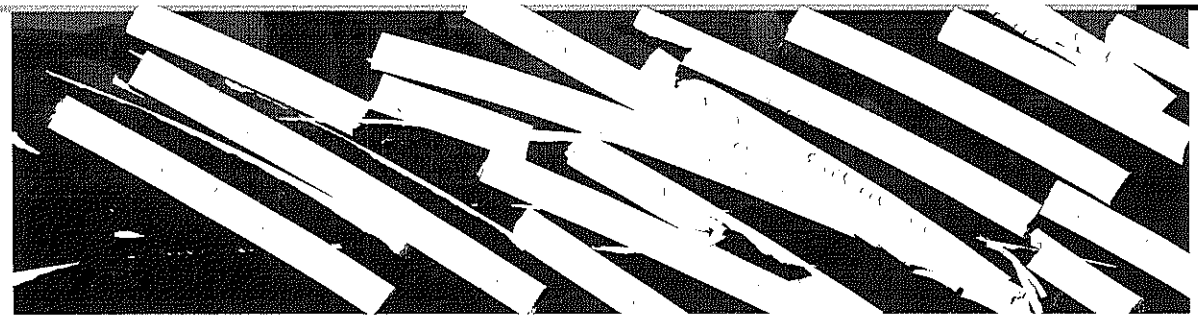
The government and business groups are also launching a Premium Friday campaign on February 24th. The campaign encourages companies to allow workers to finish early on the last Friday of every month so that they can go out and have fun. Let's hope more initiatives such as these are aimed at family time and recreation. A re-balance away from a sole career focus (with even the pressure to socialise away from family among colleagues for many Japanese employees) might make having children more attractive for Japanese couples.

Image via elminium / Flickr (CC BY 2.0)

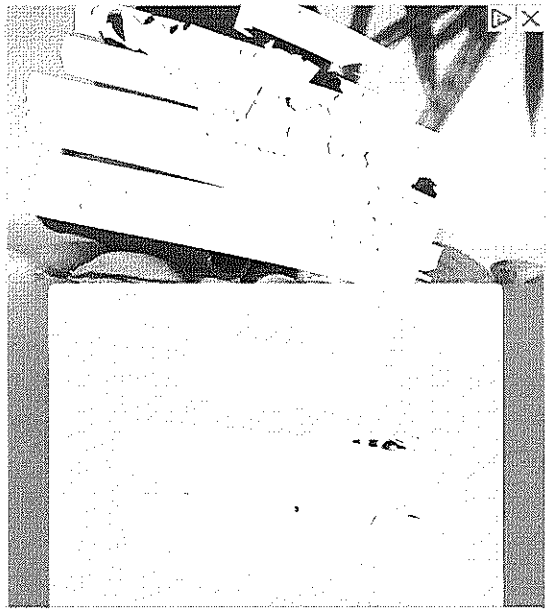
Legend has it that the Aokigahara Forest, infamous for its reputation as a suicide spot, was one site for ubasute.

Now, the practice makes somewhat of a comeback as seniors are brought to hospitals and charity offices so they can be adopted, Business Insider said. The reason for doing so remains the same, however: poverty.





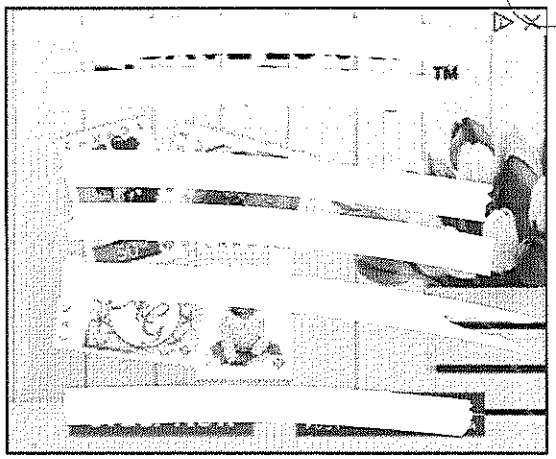
Social worker Takanori Fujita told the Times of London, **"There are a lot of people who have a certain amount of income but who still live in poverty and struggle terribly with relatives who can't look after themselves. They are reluctant to ask for help because they feel it's shameful."**



Concerned over its aging population, the Japanese government began sticking QR codes to old people in December so they can be tracked. The move attempts to address memory problems caused by dementia.

The government also works hard to save the nation from what scientists call a "demographic time bomb." Researchers from Tohoku University set the country's doomsday to August 16, 3766, when only a single Japanese person will exist (assuming no other global catastrophe occurs). The term appears to be the end-result of the aging population and falling fertility rates. Initiatives include speed-dating events, fatherhood lessons and shortening labor hours to combat the associated problem of "karoshi" or "death by overwork."

What do you think about leaving elders on hospice institutions?



Prisons are turning into nursing homes.

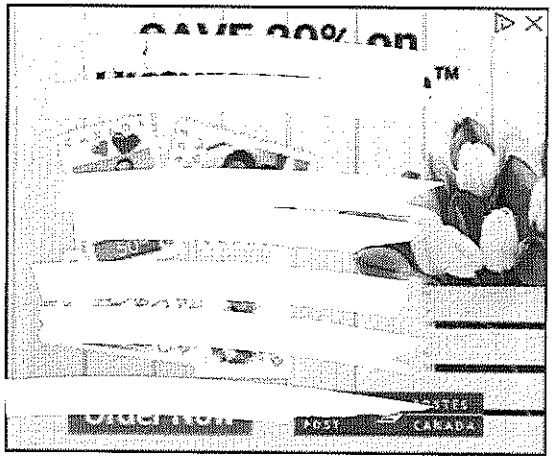
About one-fifth of all crime committed in Japan is done by the elderly. Most of it is petty theft and shoplifting.

Emmanuel Ocbazghi

As crime rates among the elderly rise, prisons have

elderly rise, prisons have effectively turned into nursing homes. Guards are made to bathe the inmates and help them get dressed, and experts say living conditions are too good to keep recidivism rates down.

Normally, younger relatives would take care of the inmates once they're released. But in some cases the costs (and loneliness) are simply too much to bear in a troubled economy, and seniors look to prison as the better alternative.



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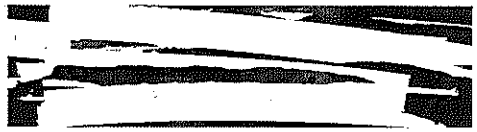
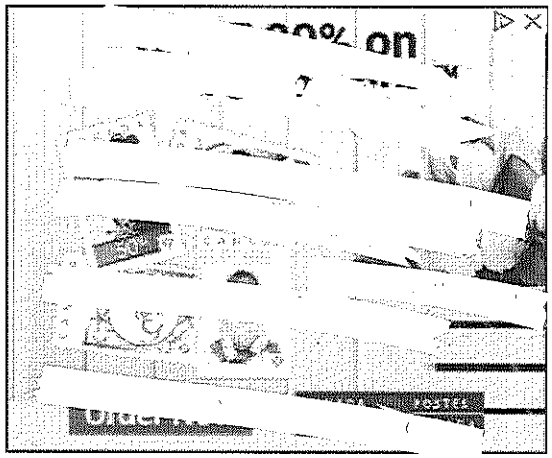
total isolation, according to a New York Times report.



Toru Hanai/Reuters



In the most severe cases, people's apartments become their tombs. Neighbors only find out they have died once the stench of death seeps through the walls. Some people have worked out pacts with their neighbors to watch out for signs they may have died, like not opening the blinds in the morning.

"If it's closed," 91-year-old Chieko Ito told the Times, referring to a paper screen on her window, "it means I've died."

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