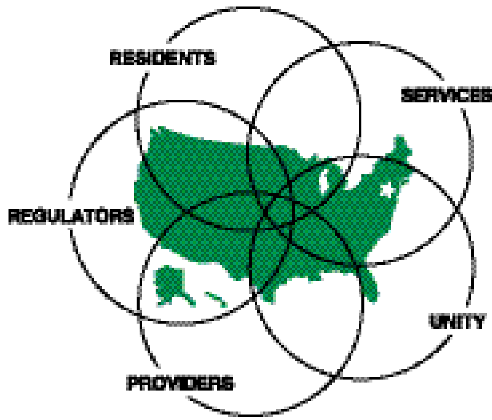

NaCCRA LIFE LINE

The Resident's Watchdog...
The Industry's Friend

National Continuing Care Residents Association

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Emerald Heights (WA) Strikes Gold!

About four years ago a group of residents from Emerald Heights, a type "A" CCRC located in Redmond, Washington, joined with other Puget Sound CCRCs in an effort to develop a residents' bill of rights for Washington. That effort fizzled out. But fortunate timing of several events re-energized the quest.

First, in August 2014 Professor Katherine Pearson from Penn State spoke to the Puget Sound group at Mirabella CCRC in Seattle. She spelled out both rights and responsibilities of CCRC residents. Professor Pearson's enthusiasm coupled with the natural exuberance of The Rev. Bob Nicholson (our local cheerleader and a NaCCRA Director) spurred us all to action. We agreed to pursue establishing a Washington State NaCCRA chapter with the long-term goal of legislation protecting independent living in CCRCs. We also agreed to work within our individual communities on a "bill of rights" tailored to each community's specific needs.

The state-level working group has met several times and developed procedures and plans for organization of a Washington State NaCCRA chapter.

The " Work Sessions" was a meeting of the representatives from local CCRCs on September 25, 2014, at Emerald Heights wherein we agreed to move ahead to seek a NaCCRA Washington and to individually pursue bills of rights. The photo shows NaCCRA Board Member Rev. Bob Nicholson making a point to the group.

At Emerald Heights, we hit the ground running. We started off with a presentation of a video of Professor Pearson's speech. The evening meeting was heavily publicized and drew nearly 200 of our 470 residents. A shortened version of the speech was shown that evening followed up by a presentation of the full speech every day for a week on our in-house TV system. Applications and encouragement for NaCCRA membership were featured.

The response was terrific! Within a few weeks membership was nearly 80! The Residents' Association Council approved the $200 dues out of their budget to establish a NaCCRA chapter at Emerald Heights.

We also started immediately on our own "bill of

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The "NaCCRA" photo is the meeting of the Emerald Heights NaCCRA chapter on January 20, 2015 to approve the Emerald Heights Residents' Association Residents Responsibilities and Rights.

rights." Draft one dated September 27th was based on the NaCCRA talking paper plus suggestions from Professor Pearson. A working group met about every two weeks to hammer out a universally acceptable version. By the time we reached Drafts three and four in October the sources had been expanded to include Leading Age's "Quality First" initiative and disclosure guidelines, the bylaws of our own Residents' Association, adopted legislation from several other states, and lots of residents' suggestions. To help keep things straight, sections in some of the drafts were color-coded by source.

Most importantly, we shared the results of our efforts with management. Development of a "bill of rights" without transparency and collaboration would lead us nowhere. We've received comments back twice and look forward to continuing discussion and negotiation. This process has been eased considerably by the fact that of the thirty-six rights specified in the Emerald Heights bill of rights, all but a handful are already enjoyed by the residents of Emerald Heights. We are truly fortunate in that.

By December, we were up to Draft 10. The title was changed to "Resident Responsibilities and Rights." We got a new dose of enthusiasm at just the right time from a speech before the neophyte Washington chapter by national NaCCRA president Dan Seeger. He emphasized the importance of a bill of rights and filled us in about CCRC experiences elsewhere. We presented a video of his speech to a large audience at Emerald Heights both in a well-attended meeting and on in-house television. We also publicized the continuing work on the bill of rights at the meeting and in our in-house newsletter. Additional meetings were held to collect resident comments and suggestions on Draft 11. Attendance was at or over 100 at every well-publicized assembly.

In January 2015, the combined Residents' Association activity committee/NaCCRA chapter approved Draft 12 unanimously and enthusiastically. This document formed the final collective expression of residents' needs and desires.

The next steps will be the expected approval by the Resident Council in February and then by the whole Association in March. In parallel we will continue our discussions with management. We expect some compromise on a few issues.

We at Emerald Heights do indeed feel that we "struck gold" with the move towards a statement of residents' responsibilities and rights—the bill of rights. We hope that the story of our efforts may serve a useful purpose to others who wish to tackle this critical issue.

Keith Gilbert, Emerald Heights (WA)

March/April 2015

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NaCCRA exists for the purpose of promoting, supporting and protecting the chosen lifestyle of Continuing Care Retirement Community (CCRC) residents in the United States. NaCCRA is the only national organization for CCRC residents and is dedicated to the promotion of continuing care resident communities as a humane, cost-effective, long-term care model for elderly individuals. Its work is conducted primarily by volunteers and support comes from dues and gifts.

The Association since October 2000 has been classified by the IRS as a tax exempt 501(c)(3) Corporation. Donors may deduct contributions as provided in section 170 for Federal estate and gift tax purpose if they meet the applicable provisions of sections 2055, 2106 and 2522 of the Code.

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What's in a Name?

Daniel A. Seeger
President, National Continuing Care Residents Association

What is a CCRC? Actually, there is really no official definition of exactly what a Continuing Care Retirement Community is. When I first became acquainted with the field, which was when my parents moved into one in the early 1990's, the definition in common usage applied to a community operated on a not-for-profit basis – a community which, in return for a non-refundable entry fee and a monthly fee which was subject only to adjustments related to inflation, would provide a resident with whatever level of care she or he needed for the remainder of their days.

Gradually, in the years since, this common understanding became blurred. Profit making corporations entered the field as providers, and various innovations were introduced, such as fully or partially refundable entry fees, and fee-for-service, or modified fee-for-service, contracts. Fee-for-service plans provide for rates to be raised according to the level of care needed, thereby eliminating the "insurance" aspect of the arrangements. (Many residents have private insurance plans to help meet the escalating costs).

There do exist various accrediting agencies that have tried to sort things out, but, as far as I can determine, there is no standard and universal definition of what a CCRC is. There are some helpful ways to categorize actors in the field: the term "life care" is usually applied to those communities following what I regard as the original concept; the term "fee for service" applies to arrangements whereby residents are charged market rates for whatever service they require; and the term "modified" is applied to arrangements where there is some defined reduction from market rates in what is essentially a "fee for service" plan.

There is now a proposal being circulated that the nomenclature "continuing care retirement community" be replaced with something more upbeat and modern. The question is whether or not a nomenclature change will clarify things for consumers, or further bewilder them. While it is fun to participate in a contest to come up with a new vocabulary, the proposal does contain the risk that there will be introduced into the marketing environment a new level of complexity that will alienate, and thereby lose, as many potential residents as it will attract.

It is thought that for baby boomers the term "continuing care" bears the connotations of "nursing home," a concept to which many potential residents are averse. Yet, the term continuing care describes exactly what most people who are realistically aware of the diminishments which age often brings are looking for. People who do not want to face reality will not be in the market for continuing care at all, and might be satisfied with simple "senior citizen" housing. But I suspect that, ultimately, as many baby boomers will be as cognizant of reality as their predecessors have been.

It is thought that for baby boomers the term "continuing care" bears the connotations of "nursing home," a concept to which many potential residents are averse.

On the other hand, there are many serious issues that might indeed deter baby boomers more than the existing nomenclature, not because baby boomers want to deny reality, but because they may be able to absorb and benefit from the experience of earlier generations. For example, baby boomers might resist the inclusion in contracts of such sentences as "The management shall have full authority to increase or decrease daily fees, and make changes in the scope of services, upon a 30 day written notice to the resident." Such sentences, standard in many contracts, essentially give providers the right unilaterally to alter the terms of the agreement upon a mere thirty days notice.

Baby boomers might also become wary of an industry where there is no standard way to assess the relative financial strength of various communities, even though they may be being asked to turn over a substantial portion of their life savings when signing a contract with a particular provider. Communities vary radically in their fiscal strength; yet there is no easy way for a consumer or potential consumer to assess where on the fiscal spectrum the community or communities they are considering falls. Sometimes the most prosperous-appearing communities are the ones most fiscally impaired precisely because they have spent too much money on looking good.

While not wishing to deny the public relations significance of a name, there are more fundamental challenges that those of us concerned with strengthening the continuing care concept need to address. In relation to contract issues and fiscal issues, "a rose is a rose is a rose" does not apply, for there are many other flowers and weeds in the garden, and, alas, not all of them smell equally sweet.

LeadingAge "Name Storm" Project

Why Do We Need a New Name for CCRCs?

The CCRC NameStorm initiative has its roots in market research that Mather LifeWays conducted in 2012. "We wanted to understand the public's perception of the CCRC category," says Brenda Schreiber, vice president of marketing at Mather LifeWays. "We found that most consumers aren't familiar with the term. But once (consumers) hear it, it carries a very strong negative connotation." The words "continuing care" were primarily to blame for the negative impression, she says. "Those words imply that you already need care," says Schreiber. "Consumers didn't see this as relevant to them, because they still perceive themselves as active and independent." The word "retirement" didn't sit well with consumers either, she says. "When lumped with 'continuing care', the word 'retirement' feels like they are literally retiring," says Schreiber. "It implies that they are losing control, and that they don't have any choices, which is exactly the opposite of what we offer." The research convinced Mather LifeWays that the CCRC term was a barrier that kept consumers from even making inquiries about the organization's communities. Eager to remove that barrier, Mather LifeWays decided to stop using the term in its marketing. Then, Mather LifeWay's President and CEO Mary Leary approached LeadingAge President and CEO Larry Minnix to see if the 2 organizations could work together to develop a name that would resonate with the next generation of older adults. CCRC NameStorm was a direct result of that conversation. "We definitely didn't want to go at this alone because this isn't about us, it is really about the consumer," says Schreiber. "We wanted a new name to reflect the lifestyle and the attitudes that people want and desire. But we also wanted that name to be accepted and adopted by not-for-profit and for-profit providers alike. That will really strengthen the offering."

Will Any Name Do?

In order to make it into the NameStorm survey, a new name had to meet certain criteria, says Alishia Parkhill, vice president of marketing for LeadingAge. Those criteria stipulated that a suggested name had to:

- Be consumer-centric: The NameStorm team was looking for names that focus on the consumer experience, rather than on the services organizations provide.
- Expand possibilities: Names could not contain words that limit a customer's perception of what they may or may not receive. Rather, the team was looking for a name that would spark a new conversation with future consumers.
- Be available to own: A trademark attorney will vet a narrow list of submissions to determine their availability.
- Be memorable and easy to say.

25% of Workers Plan to Downsize in Retirement

A recent Cassandra Dowell article in Senior Housing reported on a recent study which found that globally a quarter of working age people say they will have to move to a smaller home when they retire and more than one-third say they will have to eat out less. "A balancing act" is the newest in HSBC's "The Future of Retirement" series and includes views of more than 16,000 people in 15 counties, including US. The online poll used to collect this data was conducted in August and September 2914.

Almost two in five think their financial preparations are inadequate, similar to the opinion of retirees who say they were not prepared adequately or at all for their retirement. Many working age people are worried about running out of money (69%) and about having enough for daily living in retirement.

About a third of today's retirees say their financial situation in retirement is worse than they expected and that they should have saved more.

ASK and SHARE

Many "Asks" were presented to *LifeLine* readers in the January/February 2015 issue. My submission deadline to the editor for this current issue didn't allow a lot of time for me to receive your "Shares," but please … go ahead and submit them since topics never expire! More questions ("ASKs") have come in. Two new "ASKs" will be posed at the end of this column. I await your replies to both new and old topics. Are you a new reader of *LifeLine*? Go to NaCCRA's website to peruse past issues. The Ask & Share column started with the January/February 2014 issue.

Regarding a 2014 "Ask" about non-smoking campuses, here are some new "shares."

Village on the Green (Longwood, FL): We became 100% smoke free in 2014. Our Executive Director decided that being smoke free was desirable, announcing the start date several months in advance. This affected employees as well as residents. The large trashcans with sandy ashtrays on top were replaced with plain ones. Metal signs were posted in all buildings, stating, "This is a TOBACCO-FREE & SMOKE-FREE FACILITY. WE APPRECIATE YOUR COOPERATION." The few resident smokers made no complaint and adapted to the new rules. Information submitted by Ruth A. Stewart.

The Amsterdam at Harborside (Port Washington, NY): Our community is non-smoking in all common areas indoor and out, but smoking is permitted in resident's own apartments. This has been a source of complaint as residents can smell the smoke in the hallways. Information provided by Betsy Budne-Finnel.

Regarding a 2014 "Ask" seeking a pro/con discussion on a resident's ability to allocate an "up to" percentage of the annual Employee Appreciation contribution to specifically named employee(s):

A "con" from Tryon Estates (Columbus, NC): Although appearing to be well-intentioned, the designation of a portion of a resident's gift (columnist's note: the resident would not be identified) toward a particular employee for the annual gifting will lead to serious morale problems with the employees who are less favored. Further, many employees are "behind the scenes" such as the kitchen staff, off shift security, and off shift medical or maintenance, just to name a few. Most of these employees have limited resident contact and therefore the residents cannot judge their performance. We are not running a popularity contest. Management of the facility is charged with ensuring the performance of the employees and recognizing those that deserve recognition. Residents may and should bring to management's attention those employees who deserve special recognition. Some facilities have mechanisms for doing this, such as Star Performer Awards. The rewarding of those employees for performance "above and beyond" is best left to management. Conversely, management is charged with correction of deficient employees. Therefore, the gifting should be fair and equitable among all the employees. Information provided by Ralph Collins.

Resident Health Committees:

The Amsterdam at Harborside (Port Washington, NY): We have a "Health Issues" Committee that is a joint committee of the Residents Council, management, and the Health Center administration. It serves as a liaison between independent living residents and the Health Center. It arranges with outside agencies to perform blood pressure readings and flu immunizations. It plans educational lectures by physicians from the community. Information provided by Betsy Budne-Finnel.

And now, a new ASK regarding Residents Associations: **How is your residents' association organized and how are members chosen or elected to the association? What needs to be in place for your residents' association to be perceived as highly effective by the residents?**

A new ASK regarding surveillance cameras in nursing home rooms: **Does your community permit a family to install their own surveillance camera in their loved one's room so that the family can monitor?**

Another new ASK regarding CCRC on-campus physician service: **What is the nature and extent? Schedule? Level of satisfaction?** If you instead have another level of medical service/clinic (nurse; physician assistant, etc.), please respond to these same questions.

Readers: I am receiving more questions than answers. I need your responses. When you submit an "ASK," go ahead and provide the related "SHARE" information from your community. E-mail your comments to jenniferyoung@jenniferyoungmail.com or snail mail to 15815 Rolling Green Cove, Tyler, TX 75703. Thanks!

Resolving Conflict Senior Style

Conflict is something we all have experienced from time to time. Sometimes it is more painful than we care to remember. But even though we tend to associate conflict with negative experiences, conflict is not always bad. In fact, conflict is a natural part of life because we all see things differently. What matters when we are in conflict with another is how we deal with it.

One of the things we seniors bring to the conflict resolution table is the wisdom that we have gained from years of experience. If we are honest with ourselves, even though we know that our way of seeing is the correct way, we have to admit that maybe once or twice our way of seeing something was just plain wrong. This knowledge is key in resolving conflict.

Conflict arises when people act on their own perceptions without acknowledging that other perceptions are equally valid. Exploring perceptions takes time and may take several attempts. But just the experience of attempting to hear the other side's perceptions can tone down, if not resolve, a conflict.

The experience we bring as seniors can help us describe our perceptions based on prior life lessons, either good or bad. This neutral reference to a situation that happened in the past can allow the other side to acknowledge that perception without having to admit that theirs was wrong. Being given the opportunity to say "That sounds like a good idea, let's give it a try," is a positive way to give in without losing.

When folks on either side of a conflict feel that they have been heard, even if not agreed with, they are more willing to allow the other side to proceed. This process of sharing both sides sharing their perceptions can actually lead to growth of relationship or the discovery of truth in a situation.

Finally, remember that conflict is focused on something that has already happened. Resolution is focused on the future. Help the other side see that once perceptions are understood the goal then becomes building positive steps for the future.

ANN BARKER

One of the pioneer mediators in Tennessee, She began a private mediation practice in Knoxville in the early 90s, while writing mediation training materials and teaching conflict management and negotiation courses for the UT Center for Conflict Resolution. Ann has experience drafting and managing state and federal contracts, running small businesses, directing non-profit programs, and litigating civil matters.

Ann has served on numerous committees of the American Bar Association including the ABA Commission on Domestic Violence and as co-chair of the Litigation Section Membership, Family Law, and Children's Rights Litigation Committees. She currently on the Board of Directors of Hiawassee College and was an attendee at the LeadingAge Meeting and Expo in Nashville.

She is the mother of two children whom she adopted from Guatemala and the proud grandmother of two. Ann has been active in politics and ran for the Tennessee state legislature in 2006.

2015 Aging in America Conference

Aging in America, the annual conference of the American Society on Aging, will take place in Chicago March 23-27 and will offer five days of intensive learning, networking, and community-building. Aging in America is the nation's largest multidisciplinary conference for professionals who work with older adults, including aging service providers, policymakers, social workers, senior center professionals, healthcare providers, caregivers, and anyone with a passion for improving the lives of older adults.

Conference attendees, exhibitors, and presenters will:

- Learn about new and innovative ideas that will help you in your work with older adults;
- Discover practical solutions to the challenges you face on a day-to-day basis;
- Connect with peers and leaders who will transform the way you think about aging;
- Reach a community of professionals who collectively influence the lives of hundreds of thousands of older people through their everyday work.

Disaster Prepared CCRCs can be a Justification for Tax Exempt Status

According to IRS Revenue Ruling 69-545 charity care is not the sole justification of tax-exempt status. A tax-exempt organization can also address the needs of their communities. The Healthcare Financial Management Association in 2005 issued the following list of attributes that can be considered as evidence of community benefit. The following criteria are most often considered

- Advances medical or health knowledge
- Enhances health of the community
- Relieves or reduces the burden of government or other community efforts such as schools, charitable programs and services to veterans
- Improves access to health care services

It is advised that you have a clearly defined mission statement (values, code of ethics and conflict of interest) committing the institution to charitable endeavors including those that follow.

Examples of Community Benefit Actions and Activities:

A CCRC is urged to work with the local health department on their community needs assessment and confirm your role in the plans to prevent communicable disease.

Conduct your own Hazard Vulnerability Analysis including information from local OEM.

Provide a "dispensing site" for seasonal flu vaccinations (residents and/or family and friends).

Providing space for community health education programs (local cable TV programs viewing/discussion groups/ informative presentations).

Providing a site for fitness group/ health exercise programs.

Co-Sponsor Health Fairs.

Take a booth at community events (National Night Out, etc.)

Keeping a list of persons with disabilities in your facility who may need assistance with transportation/evacuation/ shelter-in-place.

Having direct communications checks with first responders (use the ACS electronic system).

Have an emergency preparedness planning committee and/or a resident/staff CERT FOR SENIORS team.

Train and provide for shelter-in-place to prevent unnecessary resident travel to doctors and hospitals.

Be prepared in the event of a surge of recovering or rehabilitation in-patients from a hospital. They may require temporary placement at a community-based facility. A CCRC facility can facilitate placement knowing who and what they can provide in the way of temporary shelter for feeding and temporary sleeping accommodations for hospital staff, supplies of food and water to patients and their caregivers. Note: Arbor Glen did this during Hurricane Sandy and other CCRCs in New Jersey.

DOCUMENTATION AND COMMUNICATION

Use IRS 990 filings, particularly for Medicare

Show cumulative effect of all activities, not just one event.

Establish CCRC linkage with CCRC facilities in adjacent counties.

Maintain a current list of CCRC Facility emergency contact employees (day, night, weekend, holidays) for the following essential services:

- Heating and Cooling
- Water (hot and cold)
- Medications
- Clinical supplies
- Food and related supplies
- Shelter repair and alternative sites
- Mobility equipment
- Transportation
- Telephone and computers

List of vendors for the above essential services

List of First Responder contacts in the immediate area

List of County Office of Emergency Management key staff

List of VOAD groups in the county of your facility.

Maintain the average count of open beds each month at independent living.

The above illustrates another dual benefit of having a team of residents and staff working on preparedness-response-recovery. Save your assets and protect your tax status.

THINK ABOUT IT !!!!!

Ed Peloquin, Former Director for Emergency Preparedness, LeadingAge New Jersey

How Doctors Die

(It's not like the rest of us)

Study reveals disparity between how doctors choose to die and how they treat dying patients.

In a recent survey of more than 1,000 doctors, 88 percent said they'd choose a "no code" or do-not-resuscitate order for themselves if the risks and burdens of treatment outweighed the expected benefits.

A new study about end-of-life care sheds light on a "disconnect" between what physicians say they'd want for themselves and what they're actually providing to their patients.

The study, released Wednesday by the Stanford University School of Medicine, found most physicians surveyed would choose a do-not-resuscitate or "no code" status for themselves if they were terminally ill even though they tend to pursue aggressive, life-prolonging treatment for patients facing the same prognosis.

Lead author Dr. VJ Periyakoil, a clinical associate professor of medicine and the director of the Stanford Palliative Care Education and Training Program, said the study revealed a disconnect that needs to be better understood.

"A big disparity exists between what Americans say they want at the end of life and the care they actually receive," she wrote in the study. "More than 80 percent of patients say that they wish to avoid hospitalizations and high-intensity care at the end of life, but their wishes are often overridden."

The new study, published in the journal PLOS ONE, looked at physicians' attitudes toward advance directives, which give patients more control over end-of-life decisions by communicating care preferences. In addition to assessing whether doctors' attitudes towards advance directives had changed in the last 23 years (they hadn't), researchers surveyed more than a thousand doctors in 2013 to see what their own personal choices were regarding end-of-life care.

A group of 1,081 physicians was asked to complete a web-based advanced directive form and an advance directive attitude survey. A hefty portion of these doctors -- about 88 percent -- said they would chose "no code" or do-not-resuscitate orders for themselves. The "no code" or "choice not to prolong" statement reads as follows: "I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death."

While the new study pointed out most doctors choose not to have their life prolonged if terminal, many patients are still receiving treatment at end of life.

A 2013, JAMA study of Medicare patients found that despite the fact most seniors want to die at home or in the home of a loved one, only a third actually do. Many more die in nursing homes, hospitals or intensive care units hooked to machines and feeding tubes. Of those who do make it to hospice care, one third are there for less than three days before dying. Until then, many are subjected to aggressive end-of-life treatment.

Or as the new study's conclusion put it, "dying patients continue to be hospitalized and subjected to ineffective therapies that erode their quality of life and their personal dignity" while doctors "have a striking personal preference to forego high-intensity care for themselves at the end-of-life and prefer to die gently and naturally."

Periyakoil said she understands what's behind the disparity.

"Our current default is 'doing,' but in any serious illness there comes a tipping point where the high-intensity treatment becomes more of a burden than the disease itself," she said. "[But] we don't train doctors to talk [to patients about end of life] or reward them for talking. We train them to do and reward them for doing. The system needs to be changed."

Dr. Bernardo Goulart, a lung, head and neck cancer oncologist with Seattle Cancer Care Alliance and affiliate investigator with Fred Hutchinson Institute for Cancer Care Outcomes Research (HICOR), admits talking to patients about end-of-life care is not easy.

"It's a hard topic to discuss," he said. "It involves difficult emotions for the physician including guilt, a sense of failure, a sense of abandonment. I have a lot of ambivalent thoughts when I'm having a discussion about transitioning from aggressive cancer care to palliative hospice-type care. "

Lack of training may also be part of the problem, he said.

"It's a failure of medical education on the part of physicians," he said. "We're not used to thinking that our interventions – as aggressive as they are – are limited and that death and dying is part of a process, not a failure. Palliative care is a transition of care and is also in the patient's best interest when they express interest in not pursuing aggressive measures and dying at home."

Sometimes, though, it's more emotionally comfortable for

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STATE ASSOCIATION REPORT

Public Hearing on Legislation to Increase Protections for Connecticut CCRC Residents

On January 29, six ConnCCRA officers and members testified at a public hearing before the Health Services Committee, one of two to consider House Bill 5358, An Act Establishing a Bill of Rights for Residents of Continuing Care Retirement Communities, before it goes to the State House and Senate. The sponsoring legislator, Michael D'Agostino, an attorney assisting ConnCCRA pro bono with the legislative process, also presented testimony.

The purpose of the proposed legislation is to provide greater protections for residents of continuing care retirement communities. As it is, they invest financial assets in a CCRC anticipating its sponsor will be a prudent steward of their funds. Unlike residents in nursing homes and assisted living facilities, current Connecticut laws for CCRC resident protection do not cover precarious gaps in financial disclosure.

To address this disparity, H.B. 5358 would require added reporting to residents, the Commissioner Of Social Services, and the Attorney General, if and when a CCRC falls below certain financial condition parameters which, if not appropriately addressed, could lead to financial distress and impair the ability of the CCRC to hold to its promises to residents. Additionally, the bill would amend existing regulatory legislation by including a Bill of Rights. It includes, but is not limited to, provisions requiring additional financial disclosures by CCRC sponsors, greater input from residents in the decision-making process, and additional state oversight.

Testimony on January 29 focused on financial disclosure and transparency, when refunds are paid, whether residents may form associations, and other related issues. It was noted that other states such as New Jersey and Massachusetts have enacted legislation sought by Connecticut CCRC residents.

To review a draft of Connecticut's proposed Financial Disclosure and Resident Protection Act go to naccrau.com. To explore assistance available from NaCCRA to draft a Bill of Rights for CCRC for residents in your state contact Dan Seeger, dseeger8000@gmail.com.

Joseph Walton, Seabury (CT), past NaCCRA Treasurer and Seabury Council member

How Doctors Die continued

doctors to simply dole out additional, albeit futile, treatment.

"It's a lot easier for a physician to prescribe one more line of chemotherapy than it is to have a conversation about why you're stopping therapy," he said. "I can see how a physician could postpone this conversation and go for one more line of chemo instead of taking a bigger step, doing the heavy lifting and talking about end-of-life."

Patient's families can also influence a decision to pursue aggressive treatment at end-of-life instead of opting for palliative care which focuses on managing pain, providing emotional support and end-of-life planning.

"Physicians may want to act in the best interest of the patient but many times family members have a really hard time dealing with the loss of a loved one," he said. "I had a patient just last week and we had a conversation that more treatment was not a good recommendation and hospice was best. The pushback I got was from the family, not the patient."

Goulart agreed with Periyakoil in that the system needs to change. Even practical changes, he said, might make a big difference.

"Conversations about end-of-life care take significant amounts of time," he said. "We can bill for a visit but we cannot bill specifically for an end-of-life conversation. I wonder if there should be a billing code for this. There certainly should be changes beginning with medical education and medical culture.

And changes around end-of-life conversations and care are definitely in the works.

Nine of southern California's leading health care providers, including UCLA, jointly issued a set of recommendations recently to reduce suffering and promote greater dignity for patients approaching end of life. The guidelines call on doctors and other health care professionals to work with adult patients to plan in advance for end-of-life care that respects each patient's values and goals and avoid treatments that can do more harm than good.

Diane Mapes is a staff writer at Fred Hutchinson Cancer Research Center. She has also written extensively about health issues for nbcnews.com, TODAY.com, CNN.com, MSN.com, Columns and several other publications. She also writes the breast cancer blog, doublewhammied.com.Reach her at dmapes@fredhutch.org.

ED: A recent claim by one of my personal physicians prompted my search of this topic and I was amazed to see in my Google search the number of articles sharing these same views which have appeared in very recent years in such publications as The Wall Street Journal, The New York Times, the Readers Digest, The Saturday Evening Post and in a number of medical blogs.

Florida Task Force

For over a year, a joint Task Force between LeadingAge Florida and FLiCRA worked to explore options to better protect residents if these types of scenarios arise in the future.

FLiCRA supports the Task Force Bill that will be sponsored by Representative Charles Van Zant of Palatka (Penny Farms) and Senator Thad Altman of Melbourne (Indian Rivers Estates, East and West).

The legislation contains important pro-resident language and includes the following key provisions: 1) Clarifies and strengthens the role of the Residents' Councils. Requires a facility that files chapter 11 reorganization to include with its filing, the name and contact information of a designated resident selected by the Residents' Council for consideration by the court to serve on the Creditors' Committee. 2) Requires every CCRC to provide a copy of its most recent third-party financial audit to the President or Chair of the Residents' Council within 30 days of filing their annual report with OIR. 3) Modifies Gold Seal requirements for proof of financial stability for a nursing home that is part of a CCRC to include either accreditation or the submission of information adopted by AHCA for the entire entity rather than just the nursing home as is now required in rule. 4) Provides that the facility's board of directors or governing body may add a resident as a voting member. 5) Broadens the language of 651.071 to enhance the preferred claim status of refunds owed to residents.

Support Mandatory Patient Notice of Hospital Observation Status

Hospitals are increasingly using "observations status" for emergency room patients that need more evaluation time and are not yet ready to be admitted as inpatients. A patient in observation status is cared for in a regular hospital bed and receives meals, just like a regular inpatient. For fee-for-service Medicare patients and for some Medicare Advantage and other insurance coverages, patient observation status creates a potential financial burden if they later require skilled care in a nursing home. Fee-for-service Medicare, as well as some other insurers including some Medicare Advantage Plans, require a 3-day hospital inpatient stay prior to providing skilled care benefits.

Many observation status patients are not currently being advised of their status and that it may make coverage unavailable for subsequent non-inpatient hospital care, such as therapies or nursing home based skilled care.

Four states, Connecticut, Maryland, New York, and Pennsylvania enacted laws that require hospitals to notify patients when they are in observation status. These laws mandate that hospitals advise the patients in observations status to contact their insurance carriers to determine the potential impact observation status will have on their benefits and out of pocket expenses.

Continue to Oppose any Sales Tax Reforms that Repeal Current Resident Benefits

Currently, "homes for the aged," which include continuing care retirement communities are exempt from the state sales tax if they hold a 501 (c)(3) tax-exempt certificate from the IRS. In addition, section 212.07 (7)(i), F.S., exempts residents of nursing homes, assisted living facilities (ALFs), continuing care retirement communities and other similar facilities (whether for-profit or nonprofit) from a sales tax on residents' meals. Entrance fees and monthly fees charged to residents in continuing care retirement communities and ALFs are also being excluded from the state sales tax. If the Legislature were to repeal these exemptions or exclusions, the cost to each CCRC resident is a minimum of $3,500.00 in new taxes annually. There are over 26,000 residents living in Florida's CCRCs.

Contact: Bennett Napier, CAE or Eric Thorn, Esquire 850/906-9314 or Bobby Brantley 850/521-0600 www.flicra.com

Top Ten Senior Housing Trends for 2015

In the January 19, 2015 "Senior Housing News", George Yedinak reported these upcoming trends:

1) Merger and acquisitions acceleration as efficiencies are needed for shareholder returns;
2) Senior housing marketing strategies lose the digital moniker;
3) Employee retention rise to top of the human resources challenges;
4) International senior housing grows further, faster;
5) Senior housing tech: a reality check for startups comes this year;
6) CCRC Without Walls need proximity;
7) Discretional spending in revenue models will help drive the growth;
8) Home Health Care strategy is a critical part of any plans;
9) Developers need solid foundations to achieve success in challenging locations, and
10) Aging in place as a for-profit solution via renovation and repairs.

Members since Jan/Feb 2015 *LifeLine*. . .Welcome these new members

Alabama
Redstone Village
Shirley Lotz

California
Carlsbad by the Sea
Anne Burns
Charles & Pat Killen
Mildred Wilson
Masonic Homes of California
Jerry Chandler
John Raney

Connecticut
Covenant Village of Cromwell
Jane Curtis
Carol Hamilton

District of Columbia
Knollwood
Diane Reason (LIFE)
J. Paul Reason (LIFE)
Residences at Thomas Circle
Joanna Eagle

Florida
Azalea Trace Residents Association
Bay Village
Donald & Carolyn McGarvey
Indian River Estates East
Bruna Picco
Jane Rossi
Indian River Estates West
Jesse & Gloria Burnam
David Lazer
Doreen Pinkerton
Graham & Sarah Pritchard
St. Andrews North
Hugh Strachan
Westminter Palms
Phil & Louisa Thomas
Westminster Shores
Marilyn Grunthal

Illinois
Monarch Landing
Joan Everett
James & Kay Filkins
Martin Godoy
Morton Hartman
Virginia Killiam
Carol Schultz

Maryland
Ann MacKay
David MacDowell (LIFE)
Eloise MacDowell (LIFE)
Herron Point
Fred Harmon
Carol Kerbel (LIFE)
Kent Kerbel (LIFE)
Oak Crest Village
Elizabeth Albans
Nancy Glaeser
Nancy Hoover
Ilse Harap
Vantage House
Judy Rivkin

New Jersey
Fellowship Village
Dr. Dorothy Zufall
Medford Leas at Lumberton
Maggie Heineman (LIFE)

New York
Jefferson's Ferry
Heather McManus
Forrest McMullen, Jr.

North Carolina
Deerfield
Ann Whaley (LIFE)
SearsStone
Jewel Tolan (LIFE)

Oregon
Scott Philips
Capital Manor
Darrel Dixon
Friendsview
Patricia Landis
Mary's Woods
Edward & Kathleen Allison
Terwilliger Plaza
Ron & Naomi Bloom
Narilyn Gifford
Virginia Kingsbury

Pennsylvania
Quincy Retirement Community Residents Association
Foxdale Village
Shirley Leopold
The Village at Sprenkle Drive
David McIntosh

Texas
Presbyterian Village North
Frank LaCava

Virginia
Westminster Canterbury on Chespeake Bay
Pat Arant
Janie Blassingham
Peter Bondi
John Dean
Jacklyn DeCamp
Rosalee Evans
Edgar Gerloff III
Robert & Charlotte Harrell
Willa Hurley
Loyce Jarvis
LaVerne Kennedy
Margaret McGeorge
June Myers
E. A. & Susan O'Neal
Elizabeth Pappas
Gerrie Pearlin
Betty Perry
Jack Smith
Loretta Watkins
Carlotte Wick

Washington
Ermerald Heights Residents Council
Emerald Heights
John Sr. And Donna Bailey
Warren & Glenette Bestwick
Mildred Bigfoot
Jan Brekke
Priscilla Brekke
Theodore & Shirley Elder
Craig & Lind Fetters
Karen Gilmour
Maurice Gilroy
Kathleen Hardin
Lorraine & James Husband
Violet Mar
Kathy Muir
Margaret Reynolds
Ernest Ruf
Dorothy Scholz
Robert & Colleen Sheehan
Henry Sommer
Janes & Pauline Thaidigsman
Exeter House
Lydia Balk
Horizon House
Dean & Louise Barker
Jane Commet
Constance Hellyen
Mamie Rockafellar
Mirabella
Bill Barrere
Frank & Eliabeth Bret
Nancy Cleveland
Barden & Jackie Erickson
Arnold Gaillard
Alice Hingston
Joanne Mearls
Louise Miller
Lois North
Charles & Bess Porterfield
Lynda Prindle
Mary Rogers
Gilbert Roth
Charles Sleicher
Esther Stevenson
Janet Swanson
George & Mary Jo Walker
Margaret Wells
Skyline
Jim DeMaine
Rhoda McLauchlan
Sumio Sakata
Taddeus Spratlen
Robert & Mary Terrell
TimberRidge at Tallis
Willaim Laken

We extend our sympathy to the familiy and friends of this member who has died recently:

Washington
Aljoya at Thorton Place
Elizabeth Nicholson

Membership Growth Shows Changing Pattern

Here are the states with the most individual members:

Florida: 439
Washington State: 254
Connecticut: 169
Virginia: 149
Illinois: 85
Washington, DC: 116
North Carolina: 122

Marleen Varner, Editor
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Please feel free to share your copy with a fellow resident or your administrators. Your comments, suggestions and article submissions are invited.

NaCCRA Membership Application

NACCRA Thanks You for your support • By Working Together We Can Succeed

Date ____________________________

Name of Individual: 1st Person ____

2nd Person ____

Address ____

Telephone ____

Email ____

Name of Community ____

ANNUAL DUES (FIRST) INDIVIDUAL .... $ 20.00
ANNUAL DUES (SECOND) INDIVIDUAL ...... $ 15.00
LIFETIME MEMBERSHIP (FIRST) INDIVIDUAL ... $ 200.00
LIFETIME MEMBERSHIP (SECOND) INDIVIDUAL .... $ 150.00
Annual Dues per Community Association .... **$ 200.00**
Annual Dues per State Association .... **$ 500.00**
Tax-exempt Contribution .... $_______
Total Enclosed............................... $_______________

Please make your checks to: NaCCRA
and return this notice with your check to:
NaCCRA Headquarters
325 John Knox Rd. Suite L103
Tallahassee, FL 32303
Your Check is your receipt.

NATIONAL CONTINUING CARE RESIDENTS ASSOCIATION
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