

My Aging Parents – When and How to Ask For Help.

My name is Sandra Calfo. I am with your Employee Assistance Program and I will be the facilitator for today.

May is older American's month, so it is a natural time for us to be addressing this concern. A quarter of all family households now are dealing with elder care issues. Fifty percent of women caregivers are employed. Thirty-four percent of that number full time, 16% part-time and among those employed women, 54% of them indicated that they had to take time off work during the last year to give care to a sick relative. So we are here today to address those kinds of issues and the issues that you raise through your questions in our Question and Answer Session.

The Webcast is really formatted into two parts. The first is that we have a panel of experts who will be giving you some general information. Questions and answers will follow this then and we ask you in the live audience here to hold your questions until that segment of the program. For those of you viewing us on the Web, you can e-mail questions at Senior Resources at UPMC.edu. For those of you who are in the audience today, your questions can be written on an index card that is in your packet of information and we ask you to put your e-mail address and/or phone number on those cards. We are anticipating we may not get to all of the questions today, so we want to make sure that we will be able to follow up with you. The same holds true for those of you viewing us through the Web. We will use your E-mail as the way to get back to you if your question does not get addressed today. Now that we have dealt with all of that, let's turn to our panel.

We will begin today with Greg Peaslee who is the Senior Vice-President of Human Resources. We are joined by Dr. Eric Rodriguez who is a physician specializing in work with senior adults. We also have Dr. Rick Morris who is a geriatric social worker and Mr. Cliff Cohen, who is the Clinical Director again at your Employee Assistance Program. So with that, Mr. Peaslee, let's start with you.

Mr. Peaslee – Thank you. I also would like to welcome all of you that are here today at the session of those that are viewing on the Webcast. We hope that you find this session to be informative and helpful. We do realize, as Sandra said, that our work force is no different than the statistics that she talked about. That many of us, myself included, are dealing with aging parents and aging loved ones who are in declining health and that raises a whole host of issues that many of us, as family members, are dealing with and we felt that it would be very appropriate for us to bring together a session that would have describe for UPMC employees those resources that are available within UPMC and there is a wealth of resources that are available throughout UPMC that deal with senior care issues. You will hear about quite a lot of those today and you will hear about more of those in the future. I hope you do find the session informative and helpful and please, as Sandra said, your questions are very welcome. We would appreciate those questions today. The idea is to help inform. Generally if you have a question, I guarantee there is someone else in the audience that has the question and may not just be as bold as you to ask that question, so please if you are watching on the Webcast, E-Mail your questions in and don't use this as the end-all. If you have questions after the session, you can contact any of us I am sure or any of the resources that we described today to help you deal with elder care issues as well. I would like to thank first of all everybody who has been involved with this. There is a wide range of UPMC staff who have pulled this together and I would like to thank each of them personally for their time, dedication and efforts to this. At this time, Sandra will not introduce our experts, some esteemed colleagues of ours as well and we will jump right into the session. Thank you all for attending.

Sandra - Just one comment before we get to our panel members. This Webcast is going to be achieved, so if questions are raised together or points that any of you attending want to go back to, you can, and please do tell co-workers so that we can spread this word about the resources as far and wide throughout UPMC as possible. So with that, let me turn to Dr. Eric Rodriguez who is going to be addressing today the physiology of aging and the challenges that older adults face.

Dr. Rodriguez - To judge by some of the questions that were submitted to this panel in advance of the presentation, I can take a wild guess that some of you are well involved in caring for older family members already. The questions were sophisticated and difficult. They are the sort of questions that make me wonder what kind of expert am I since I didn't have ready answers for you, but I think we can perhaps help at least bring the issues. Given that those of you attending and perhaps some of you watching already are confronting problems related to the aging of family members, my inclination was to try to give you some nuts and bolts help and the help that I intended to give you, really drives from my own experience and that is this – that when I first became interested in geriatric medicine, one of my concerns was that evaluating and managing the problems that older adults pose to the health care system is, at times, very difficult, in fact, frustrating and I learned a strategy, I guess I should say I was taught a strategy for approaching those problems, but reduced my levels of frustration and enabled me to be a little bit more effective and to demystify medicine a little bit here. Let me say that I think it is a strategy that anyone, be they a health care provider or a family member, can bring to the efforts to help older people confront the aging-related issues. This is the essence of the strategy. It is to do what geriatric medicine does all the time, which is to shift the focus of our efforts at understanding health issues in older people from a conventional medical approach, which is focused around diagnosing and treating diseases and instead, direct our efforts to observing and understanding and responding to changes in function that affect older people. Function is many things, but we often break it into subgroups. We talk about cognitive function, in other words the function of the brain or the mind and we talk about physical function, perhaps the body. Those two things are not as distinct as we might like to make them. We can add another category which probably belongs in there and that is sensory function, particularly seeing and hearing. Looking at your older family member from that perspective can help you in a number of ways to understand the impact of all their medical problems, be they acute, chronic, relapsing, on them as a person. In other words, looking at their capacity to perform these functions and I will innumerate some of the ones that we look at in just a moment. Looking at their capacity to function gives you a sense of what their disease burden is doing to them in their ability to lead an independent life.

Now what are the kinds of things that affect function? As I mentioned chronic disorders do that. Acute disorders do that. Injuries. Trauma does that. Sometimes iatrogenic harm. Harm inflicted by the efforts of the health care system itself do that. Psychiatric disorders affect function and clearly the many brain disorders to which we are all vulnerable as we age can do that. What are the sorts of functions we are talking about? Well, geriatric medicine tends to have it very well laid-out in an objective sort of way. We talk about two groups of functions. One are the instrumental activities of daily living. These refer, to simplify it, to the tasks necessary to run a household on your own. So anyone who is living independently in the community as we say is doing things like managing finances, using the phone, shopping, cooking, cleaning, to varying extents, administering medications, using transportation of various sorts. These are called IADLs – the instrumental activities of daily living. Those are higher-order functions that require a pretty intact cognition and physical capacity to perform. They tend to be in a certain order depending on what afflicts the individual, but I always ask about managing finances. Occasionally I run into people who never in their life managed their finances because somebody else did, so that is not a fair question for them, but managing finances tends to be very vulnerable

to early cognitive loss, so somebody who has had to turn over the checkbook, may be beginning to have problems with cognition.

Another very sensitive IADL is that of medication management, especially when the regimen is complex, so I ask about skipped doses, missed medications, taking things twice, etc. as another probe for the level of cognition. Things like shopping and housekeeping tends to rely, to a greater extent, on physical capacity, so I ask about those abilities as well to get a sense of physical function. As older people, who are suffering various disorders move down the functional ladder, you might say, they may begin to encounter problems with what we refer to as the basic activities of daily living, sometimes just abbreviated as the ADLs. The ADLs as opposed to the IADLs pertain to the care of yourself personally, so they are the personal care tasks and they tend to be ordered in an almost biologic hierarchy starting with the most difficult of them, which is bathing, most difficult and dangerous, I might say, getting in and out of the tub or shower, whatever arrangement on your own, followed by dressing which means selecting appropriate clothes and putting them on in an appropriate order, tends to be difficult, particularly dressing the lower extremities. Shoes, socks and pants tend to be harder for most people than shirts, blouses and sweaters. As we move down the ADL hierarchy, we run into independent mobility in other words the ability to walk from Point A to Point B, transferring, getting from say bed to chair or from a chair to a toilet, using the toilet and finally at the very bottom of that hierarchy of ADLs is the capacity to feed yourself, that is to put the spoon on the mashed potatoes and bring it to your mouth successfully.

What I am proposing to you is that if you focus on these very intuitive and obvious tasks that people need to carry out to live independently and observe changes there, losses of those abilities, you get a very strong handle on the status of your loved one and you also have something you can communicate in a very objective way to health care providers that should be meaningful to them as well. You can follow trends in these ADLs and IADLs looking for improvements in response to treatment, looking for further losses in response to progression of diseases. You can even use them to prognosticate. These functional assessments are powerful tools to guide us in knowing how long somebody might live and, in some respects, functional assessment is more powerful than a simple examination of a medical problem list. So I learned that functional assessment helped me understand and deal with my patient's real world problems more effectively at times than their medical problem list did and I advocate that you look at your family members from that perspective too and use it as a tool to help you gauge their current status and communicate it effectively to their health care providers. I am not sure if I am over my time.

Sandra – I think you did wonderfully well. Thank you so much. Terrific.

We are going to follow that wonderful introduction with Dr. Rick Morris and he is going to address the social and emotional aspects of aging and where to turn for help.

Thank you. It is actually not just aging. May is the month of Older Person's Month, but also this particular week is Aging and Mental Health Week, so it is also very appropriate to talk about this area. We talk a lot about mental health when we mean mental illness and I am going to talk briefly about both today. Mental health is very simple. It is simply our ability to cope and cope with the demands of what Dr. Rodriguez referred to as function, the demands of daily life, the activities of daily living, but in addition to that, it is also a reflection of our own sense of self esteem, our own sense of life satisfaction. Our own sense of moral. What I am going to talk about in the first part of this talk is simply some areas around mental health and about self esteem. Using self-esteem somewhat as Dr. Rodriguez used function. The literature, both clinical experience and longitudinal research experience in aging recently has been very

interesting because there has been a focus on not so much problems, disease, disorders, but there has also been a focus on who does well. Who is successful? Over time and over the life span, if you consider issues of life satisfaction, moral, self esteem, what we can say about people who do really well in those areas? And actually it is not surprising that those who age well, who age successfully have a good sense of this well being in their lives. Very simply, people that do well, that are successful late in life have done well throughout their lives. They are people who have been able throughout their lives to adapt to transition, to adapt to change without too much difficulty. To have been able to maintain throughout their life span their basic personality structure and also people that have been able in their lives to garner some sense of meaning, some sense of accomplishment, some sense of worth in their lives and as you would suspect, also able to maintain important relationships in their lives, to have a variety of activities that mean something to them and interestingly, one of the traits, in terms of successful aging, is the ability to maintain a sense of humor in the face of all changes, and also a sense of having a passion for life. This is a quick summary of people who do well, but yet, we know with age, there occurs loss. Losses occur in late life with a lot more variety than at other times of life and also with a lot more frequency and also a lot less time between losses. We understand that with aging, there is somewhat of a slowing of response time. We can also understand that the same is true psychologically, that people who suffer loss. It takes older persons somewhat longer to get over loss than it would have taken earlier in their lives. And if we think about loss, it is not just losses that you would expect as part of normal aging, some of the physical changes that occur, but in the sensory changes that occur, but if we think about it, it is also a loss of role or status. It is a loss, for some people, of self-esteem, of ownership, of loss of mental capacity, of realizing that it is taking people longer to come up with appropriate words, that their ability to think may not be the way it used to be. It also for people is losses in groups or membership, the change that they have and when they move, to relate to neighborhoods or communities. It is also when people retire, a change not only in what they do, but the change in social interaction, the change in routine.

So these losses actually can be sources of grief. They are stresses and people respond to grief by a process of grieving and in late life, what happens is when there is one loss that occurs, sometimes another loss happens before that grief of the first loss is finished. So there is this cumulative effect and sometimes a snowballing effect and sometimes what we see is that 1 and 1 and 1 are not just 3, but can be 10. The sum becomes more than their parts.

There are two major sources of perhaps stress late in life, widowhood and retirement. Most people do pretty well actually and cope well with these losses. In widowhood, though, some people that don't do well are those people that have had maybe poor marital relationships throughout their marriage, not much intimacy, an unsupportive relationship or an dependency on the other person in the marriage to provide their own identity or if the loss is very sudden instead of gradual, that can be difficult or if there is little social support, that can also be difficult. Probably one of the most significant findings since 1963 in all of the research in personality, has been the importance in human aging over time of the existence of a confidant. Someone that can be a buffer against the losses of aging. Someone that you can have intimate, stable relationships with and this is indeed true when there is a loss in widowhood. Sometimes the loss of the person that died is the confidant. Also, although the literature is not completely consistent on this, males or widowers, have a more difficult time than widows do. For retirement, it is very simply. People do well in retirement, except that they don't have enough money. People do well in retirement except that they have a poor perception of their health, which is different than their actual health. The perception of health in late life is actually a very powerful predictor of how well someone does. Finally people that have no other interests other than work. They tend not to do as well in retirement. Retirement is a change in itself. It is not the time to be getting new interests. It is a much better time to go back and have interests that have been life-long. So if

we look at these losses, if we look at successful aging, we can say maybe two or three things in summary.

We can say (1) Social support is important. Social support means that family, friends, neighbors, community, trusted community organizations provide either concrete help, tangible help or emotional assistance to someone. Appropriate social is a very good predictor of life satisfaction, a very good predictor of someone's own perception of their health. It reduces the risk of institutionalization.

The second thing we can say is that an older person needs to have a sense of control over their life. They need to be able to feel that what is happening to them in spite of these losses and with these changes that they have some say in it. That they have a sense of control. People that do that, that have that sense of control, do better.

Finally, people that have some meaning in their life also do better. I am trying to tell you in the first part of the talk that aging is a very weak variable. We cannot say a lot about a person just because they are older. We can say that in coping with the issues of aging and coping with loss, that most older adults are not pretty much the same. They are very unique. We can say that most older people do pretty well in coping with stress. They are very competent but they do well in very different ways. They are a very heterogeneous population.

Dr. Morris, I think we are going to need to, I am checking for time.

Let me also briefly talk about psychiatric problems and I can do this pretty briefly because the message is important. About 18 to 25% of older people suffer from some mental illness in later life. The trouble with mental illness in later life, it is very complicated. Dr. Rodriguez talked about function. He talked about people not being able to manage their checkbook or take their medicines and that could be a sign of cognitive loss. Certainly, it can be a sign that someone just does not have interest in doing that at all. They lack energy. They lack any desire and that could be because of depression. So the clinical presentation of psychiatric problems in late life is difficult. Sometimes people present with somatic complaints and sometimes you cannot figure out what is going on. It is very complicated. And also stereotypes make it difficult. People think, including family members, that no wonder people, they are older, they should be depressed. They are older. No wonder things are happening badly to them. As you get older, you are confused and that is not true. The stigma of mental illness is a barrier as well, but we should also know that dementia and depression are not part of normal aging.

30 seconds for Alzheimer's disease and 30 seconds for depression.

Alzheimer's disease in late life affects about 4-1/2 million people and by 2050, perhaps 14 million people. With Alzheimer's disease I think the biggest risk is advancing age. Three percent of people between the ages of 65 and 74 have Alzheimer's disease and up to 50% of those over 85. The good news is that there are available medicines that potentially improve cognitive function and potential improve the functioning that Dr. Rodriguez talked about for activities of daily living and there is very promising research now on nerve cell protection and vaccines.

In depression, the issue is, the prevalence rate is much greater than Alzheimer's disease, that older people get depression, and depression kills. Depression presents and combines with physical disorders and cost and morbidity and mortality are much greater when depression is thrown into the risks. Suicide in late life is higher than suicide at any time of life. Depression is a major risk factor for suicide. The good news is that 85% of depression is eminently treatable.

The good news is that there is a great response rate, a low rate of resistance late in life and some combination of medicine and psychotherapy seems to not only help people get better, but more importantly, help people stay better late in life.

The final panel member is Mr. Cliff Cohen who is going to address the work piece of this entitled “The Resources for Support at Work.”

We took an informal poll of our EAP clinicians, our counselors and they reported that considerably more than half of the employers that we see, who are struggling with a caregiving concern, do not say that that is the reason why they want to schedule an appointment. They call because they are having problems concentrating at work. They are feeling more irritable than usual or tearful often or they are arguing more with their spouse. Then in the counseling session, the counselor hears that one of their problems contributing to things, feeling overwhelming, is the caregiver role they are in. The EAP staff wanted to make it clear to me that the obvious two that the experience of caregiving presented to them is a very complicated and idiosyncratic one, that although caregiving can be draining and painful, it is also very rewarding and very affirming for many adults. The EAP has played a direct role with supervisors and management and with employees at UPMC and other contracting companies with caregiving. Supervisors call the EAP at times to consult about valued employees who are perhaps suddenly presenting with the kind of things I just talked about earlier. They are distracted or anxious or they are starting to miss more work than usual. They are irritable or just easily overwhelmed with the task that they have to do day-to-day and after continuing to talk to the employee or after recommending the employee consider going to EAP, the caregiver does reveal the situation they are in. Managers often ask us what they do to help basically and in turn, we usually recommend, I think, in that first conversation, the most important thing that they try to offer the employee is validation of the role that they are in. Validation of the struggle that that role is causing and empathy and also offering to try to create a work situation in which the employee can do well. Perhaps saying something like “what can I do to help?” Supervisors are then to contact HR so that time flexibility options can be a part of the conversation and we have encouraged a meeting with HR and the manager and the employee and I think on occasion, EAP has been present too to just put everything available out on the table for the employee and have an open conversation. Parallel with supervisory consults, we try to help employees in their sessions by giving suggestions offering specific ideas for rhetoric that they might use with their supervisor or by coaching them to try to stay calm when they have that conversation with their supervisor, to reveal what is going on with them. Many employees, for understandable reasons or maybe for not so understandable reasons, are hesitant to talk to their manager about their personal life. An employee was concerned that it might hurt a future promotion that she was hoping to get. I don’t know if that was true or not, but it was a real concern for her. But, I think that waiting to have these conversations is a mistake because it risks that things will just blow up when it gets to a very late stage and I think it is important that they try to have that conversation sooner than later. I think it is worse if a supervisor has no prior warning that something is going on and all of the sudden a lot of time is needed and it is better to be proactive.

The EAPs most frequent role in counseling employees and their family members is with uncomplicated grief, which is sadness. It is a lot of things. I am not going to define it, but it is a normal reaction to a loss and it is often a profound grieving experience for people to watch a parent struggle through their illness. As my Dad and I used to say, this getting old stuff is not for sissies. It was not my line, but I had heard it before, but I know he got a kick out of my saying that to him in his final months.

Off topic a bit, we counsel just so many employees with uncomplicated bereavement following the death of a parent and I know that is not exactly related, but it can be very surprising to adults at the intensity of the sadness that they experience at the death of a parent. We counsel couples who are trying to balance their marriage and parenting with caregiving. Some couples support each other so nicely through that journey and others need more coaching. We have had a couple of spouses who had promised earlier in their marriage or before they got married that their parent would not come and live with them, but sometimes that promise needs a second look I guess.

We address a myriad of extended family issues around caregiving. I have seen numerous employees with their adult siblings in the session, quite a crowded room sometimes, just to meet to discuss division of duties. Sometimes those conversations can be a little intense, but I think they have been helpful and I have met some great people doing that. We have seen some siblings, they are not fighting about division of duties, they are jealous of one another because the parent chose one sibling over another to stay with. People are interesting. We have explored with siblings the painful option that sometimes they can commit a parent against their will into a hospital for treatment. That is rare. It could be something to consider if a parent is in immediate danger. I am sure the doctor could speak to that more than I could, but they are just unable to care for themselves. I could tell you that the EAP pointing out that option has been greatly appreciated because it was hard to do at discharge, the parent was doing so much better.

We counsel employees who are caring for parents with whom they have had very conflictual relationships through their lives and which may still be very difficult and that is certainly is an added difficulty when that is the case and I think that they counseling sometimes, at least short-term, is appropriate. Sadly we consult with employees and family members to brainstorm how involved they want to do with a parent in caregiving. People struggle with that. Some employees have had parents who were abusive or they were absent or they had terrible addiction problems and we often include spouses and siblings in these discussions too. In these cases, we don't give advice. We just try to keep people thinking through their possible options and try to keep their mood pretty strong and their functioning stable. We may refer these cases for longer-term treatment to the most appropriate provider also.

So in closing I think the EAP is a good place for employees who are struggling with these issues to get started. We work closely with all of these departments, with HR, with caregiving groups in the City and if you have questions about what services are available and how you can assess or evaluate those services, we should be able to point you in the right direction.

Thank you.

The next part of the webcast is questions and answers and it is time for all of you to go to work. If you are live here, put your question on the index card and E-Mail away if you are watching up through the webcast. To get us started, we did have a few questions that came in early, so we are going to start with those.

The first one is What do I do when I feel that my parent clearly needs help or a change in living situation for their own safety, but they refuse to consider or discuss it? I am wondering Dr. Morris if we could begin with you on this one.

Actually my response would be a little bit flippant, I guess. I would ask if how do they know that the parent clearly needs a change in their living situation for their own safety and must change that living situation. Certainly a consideration in any issue of safety is trying to look at the current environment that the person is in, modifying that environment if possible to make it a

safer place. There is a tremendous amount of great advice on modification in one's environment to make it more safe. Sensory-wise to make it more safe physically and also, there is a tremendous amount of help available now in the home, through both public agencies and through private agencies. See up on the screen the phone number and the web address for the Institute of Aging. It has a listing of resources in these areas. Certainly, the other thing would be trying to sit down with other members of the family and the older person, him or herself, and discuss this and discuss the implications of why the family is concerned and what may be alternatives, other than changing the living arrangement. I think the two important principles here are as long as possible you want to keep someone in their own familiar environment if that environment is safe. You want to let the person age in place and secondly, then, if you have to make changes in living arrangement, do it in conjunction with the older person, him or herself, when you can and thirdly when you do that, the living arrangements should be the least restrictive alternative as possible. That would be one way I would approach that.

Any other panel members who would also like to follow up? I just wanted to mention that these conversations do need to happen, just to be able to discuss this with the parent can be so difficult with the actual child, that sometimes I have seen it kind of go better when it was not done by the child, maybe by the spouse of the child because the loving intensity is just less, and I see a little more willingness at times to hear it from someone other than the child, just a thought.

Another question. My mother is becoming increasingly frail and somewhat forgetful, but she is competent to make her own decisions. She refuses to give up living in her own house. I am really worried about her. What can I do?

Dr. Rodriguez, any thoughts on this one? Lots of thoughts, but probably no answers. This is something we encounter all the time, of course, and I still have not figured how to deal with it, so I would just give you maybe some dimensions of the problem to consider. I certainly do believe that from the perspective of the physician caring for the older person, my job is not to necessarily make the children happy, but rather to do what is right for my patient, the older person, him or herself, and that sometimes cannot be achieved without some discomfort on the part of the children. I would also point out, as I think Dr. Morris did, that children may not agree and actually Dr. Cohen too, you indicated that there may be divergences amongst the children of one of my patients as to what Mom or Dad needs or should do and sometimes we have to get everybody around the table to begin to get them on the same page about that. For me there are two major considerations involved in that issue that was presented. One is the competence of the older person to make their own decisions and as the physician for that patient, my inclination is to want to give them the benefit of the doubt and assume that the wish to remain in the home, let's say, might be a deeply held and consistent value that we ought to respect until we have a real good reason to assume that this person no longer understands well enough the issues to make that decision. The other axis of this problem that I run into is my own and typically the children's impulse to put safety over autonomy. We are most concerned to prevent scenarios like tumbling down the steps and spending 24 hours on the floor without assistance, and certainly that is a horrible thing, but the wish to avoid outcomes like that really has to be balanced against the wish to protect the autonomy of the older person, to give them the right to incur risks if so they choose and if they are competent to make that choice. So, when I hear this, I step back and I think about competence and I think about safety versus autonomy and I bear in mind the principle which Rick Morris and a few others at Benedum have implicated me from the beginning which is that, where there is doubt, I think we ought to error in the direction of trying to keep people in their own familiar and loved environments.

Thank you. Any follow up before we move on? OK.

My mother is 83 and still active. She still drives and is independent, but I am worried about her driving as she sometimes gets a little confused and her reflexes seem to be a bit slower. How do I check to make sure she is safe while driving without upsetting her? Dr. Rodriguez, do you want to start on this one?

The short answer is you can't do that. You can't check and not upset her. If there is something that is dearly held, after home, I think it is the car and the ability to drive and I have lots of patients who hang onto their driver's license forever as sort of a symbolic representation of the capacity to drive even when they have not done it in years. It is a very contentious issue and it is one I particularly don't like to see coming. Now in this State, a physician and here is maybe a way to get the daughter or child off the hook, the physician has a legal obligation to report a patient whom the physician considers likely to be unsafe as a driver. So once I have heard enough, I have to notify PennDot. Now let me say there is a below the radar approach to that problem too, which is to get the patient to agree to testing of their ability to drive and at this point I am not sure where that is most readily available, but over time, it has been available at the UPMC Rehab where they have a sort-of two phase testing program, sort of an in the office test which if you flunk that is the end of it. If you pass the in the office test, you move onto a road test and they tend to do a better test, probably than PennDot will do if PennDot deems it necessary to test. I often use that as kind of leverage with my patients. In other words, go through this evaluation or I am going to call Penn Dot and that tends to move them. Something we have done is to try to enforce limits on driving, daytime driving only. Short-distances only. Avoid high-speed roads, etc. I can't recommend that actually as a strategy because I think that once certain cognitive losses are incurred, even that kind of driving is not safe and I guess a fourth and very subterfugous approach as to have the family disable the car if they have real doubts and we have had to do that. It is a very difficult area and I think determining when someone can't drive is a lot more complicated. There are obviously cases where it is clear, absolutely clear, but there is a lot of shades of gray and I think not only the testing that Dr. Rodriguez mentioned, but also really seeing if the family has observed real problems or is it just the fact that now someone has reached this age of 90 and, therefore, they shouldn't drive. How can you possibly drive at 90? If you are driving on a familiar road and you are not cognitively impaired and you are driving for five minutes where you have gone before and it is daytime, you can drive. It is, I think, a very difficult area and one that I think that you need to talk about very carefully not only with other family members but potentially with the older person themselves and with the person's physician, if the person gives you permission. It is interesting to talk about because I am just glad my 16-year-old daughter is not watching the webcast because she would probably be requesting that I am confused all the time too.

Next question and here is one about fathers. The other's have been about mothers. Because my father's health is not good, I have to accompanied him to various appointments, requiring me to take time off work. I don't want to get into trouble calling off, but I need to be there for him. What do I do?

Mr. Peaslee. I think there are several things to consider in this situation which I think this is probably impacting many many people. The first thing is, which was talked about prior, you should be communicating these issues with your supervisor. You should be requesting time off, as far in advance as possible. What really gets to be an operational problem, as most of you can imagine in your areas of work, are when people are continually coming in the morning of an issue and saying "I have to take my parent to a medical visit" when in reality most medical visits are scheduled long in advance, so that there can be advanced planning. People can work around your PTO schedule. So the first thing I would tell folks is to be in a very early and regular dialog with

your management about that issue. Additionally, there are other options available to you, depending on the seriousness of the medical condition. You do have access to Federal Family Medical Leave which can give you up to twelve weeks a year of unpaid time off if you are dealing with a personal serious illness or with the illness of a family member. You would need to apply for that program in advance. You can contact any of your Human Resource professionals and your supervisor who can help you with that, but again, I would summarize the most important thing, I think, is to be in a dialog with your supervisor, so that they can help you. I think, again, as it was talked about previously, they can't help you if they don't know that you are having this problem.

Anything to add, Mr. Cohen or should we move on? My advice would be, I tell employees at times, not to expect that one conversation is going to make it all better and that your supervisor is just going to say, "great, you can have this time." It is an ongoing process, possibly it will take continual talks. If it does not go well the first time, just kind of punch verbally and get angry, but continue to act professional and maybe consult with friends or people about how you can keep wording that if it is not going so well. I absolutely think that the conversations need to occur.

My sister is 75 years old and refuses to discuss any advance plans, such as a Living Will or medical Power of Attorney. Her husband is deceased and her children seldom visit and don't really get along. To protect her from future wishes, I am trying to encourage her to create some advance plans to avoid any potential problems. Any suggestions as to how I could discuss this topic with her or where I might find some resources to assist her? Mr. Cohen, could we start with you? I am not sure that I have an easy answer for that one with someone who is refusing to talk. I think back to what I said earlier, that I think this person could really think about all of the people in the life of her sister and see if what assortment of people, a combination possibly could be used to go and talk to her and see if you could get her to think about this kind of thing. There are certainly resources for attorneys who are experts at this. You could call the EAP and we could direct you to something that would be very very inexpensive for a consultation if you just want to see what she will need, that is not a problem. I think it is a very minimal cost.

For the monthly fees, what resources could be available for someone. This is a question about resources. Are there other alternatives? What State or National agencies are available for assistance? This is a parent that lives in another State outside of Pennsylvania. I will just ask anybody on the panel.

I don't think it matters what State. The issue is that no insurance covers assisted living and most States don't supplement people going into assisted living arrangements. What many States have is the ability to qualify for Medical Assistance is that you have to spend resources up to certain limits. It is called spend-down. So if you go to a living arrangement that includes assisted living and other levels of care in that place, sometimes the facility can let you spend the resources until you qualify for what is maybe assistance in that State, if the level of care over time gets to be that close to full-time nursing. Even many long-term care insurance policies really don't cover assisted living. On the other hand, some communities have wonderful resources related to living arrangement and there are a few areas that have programs that can let a person live in the community, attend day health centers, if they qualify, attend adult day care centers and supplement that for resources, so again, if a person needs assisted living, it still would be very good to make sure that that person really needs to leave that living arrangement. In our State, for instance, Pennsylvania as opposed to many other States, there is a great array of services available in the home and including some waiver programs that can give income or give money to support more services in the home.

What is best way to help prevent further declining of physical and mental capabilities, like physical therapy and does that work and does it have to be prescribed by the primary care physician?

Dr. Rodriguez. There was just an article in the Health Section of the Post Gazette that cited research by a University of Pittsburgh researcher who had looked at senior athlete's in the context of the upcoming Senior Olympics and noted that there was a steady linear drop-off in best performance over time as people age and a particularly drop-off around age 75. Then, instead of losing seconds per mile, it became a matter of minutes per miles for populations of senior athletes, and, of course, I found that rather discouraging and thought what a bummer, but then I thought, but wait a minute, most of my patients, they are not even athlete's, or these master-level athletes. I think the counter balance to that discouraging view is that most older people are so far from utilizing their potential physically or perhaps even cognitively, that there is room for improvement, so barring the 80-year-old marathoner, almost anybody else can actually get better if they will do the right things. Just to make sure I am on firm scientific ground when I say this, I should point out there is good evidence that you can take people in their 90s and send them off to the weight room and they will build muscle and they will build strength, so I think the situation for most of us is that we, in fact, could be doing better. One of the real interesting dilemmas of geriatric medicine is how much of what we are seeing in the clinic is really an inevitable effect of aging versus a very remediable effect of inactivity and I tend to think that the bulk of what we see is the latter. That is a few words about physical function. Cognition – I think there is a growing body of evidence to the effect that if you don't use it, you will lose it phenomenon applies in cognition as well as in physical function. I certainly don't think it can hurt anybody to take up some activities that will stretch their mind a bit. One great thing to try to do is see if you can get your older folks computer savvy, but don't give them my E-Mail address. Anything that stretches the mind, I think is probably good. It probably helps build new connections between the neurons and maintain existing connections. We have some medications, the Aricept, Reminyl, Exelon and Namenda cognition enhancers. I point out that for the most part, the effect of those medications is probably to slow the progression of cognitive loss and we don't, at this point, have anything that is amazingly powerful at restoring loss of cognition. I think there is some evidence, you heard about the nun's study for Alzheimer's disease and also about the literature on successful aging actually. That indeed even exercise potentially improves cognition. There is some evidence that it does something good in the brain beyond just neuro-epinephrine and that there actually can potentially change somewhat of the structure of the brain, so there is promising things on exercise. The other things on using mental capability, I think, is problem solving and that would include using your brain. People has talked about crossword puzzles, word search puzzles, but even reading. I think the key is though using that knowledge, so if you are reading, the important thing if you go to a movie or a play or you see the news, is talking to someone about that. Exchanging information and using that information, that seems to be very helpful as well.

We have time for one, maybe two questions, so let's move on to this one. This would be directed to any and all of the panel. What do you do if you think your parent is depressed? You suggested to them to talk to somebody, but they won't hear of it?

It is actually not just about depression, but depression is probably a great question because when people are depressed, they don't feel like doing anything and they lose the initiative for doing anything. Sometimes someone's personal physician can really help in talking about issues of aging including depression, so you could encourage them at their regular check up to talk to their physician or give you permission to talk to their personal physician. Sometimes that helps. Not always, because some of our physicians are not very good at recognizing depression late in life.

Two really good questions to ask, if you think they are depressed, is actually “how are you sleeping” and “do you worry a lot.” If the answer there is “I worry a lot and I am not sleeping very well”, sometimes that is enough evidence to say you know what, this is not normal. This is not what you are usually like. Something is going on and sometimes it is helpful to point that out. Sometimes people have to get worse before they get better. When people go with depression to the personal physician and they present with their depressive symptoms somatically, saying that there are physical problems. There often is a work up that does not show anything and so then you say it’s not physical, it must be something else and sometimes that helps. What do you think.

I agree with all of that. I certainly think the current cohort of elderly are more likely to feel that anything smacking of mental illness is very stigmatizing and they are very avoidant of presenting symptoms that might suggest they are suffering an illness. So even if you manage to succeed in getting them into the office, let’s say of the PCP, forget the psychiatrist, they still may not want to talk about it there. I think all of us who work in geriatric medicine have learned work-arounds for that problem, one strategy at least involves recasting depression as a total bodily illness that results in physical symptoms, such as fatigue, poor sleep, appetite, poor energy, increased pain sensation, etc. and actually in older patients that is often what depression is. It is a physical syndrome and that way you begin to dodge a little bit the notion that maybe you are crazy, which is in the back of the minds of some of these older patients if you talk about depression. So I really think if you look for a way to talk about it that is acceptable and not stigmatizing you can bring along many of the older patients to not only an understanding that maybe they are suffering something, but actually accepting treatment for that something. Given the currently available antidepressants, I think we have got medications that are safe enough that a therapeutic trial can be recommended even when you are not entirely confident that depression is what you are dealing with, but that you have a hunch it might be. These medications are unlikely to cause, for the most part, significant side effects. Whereas I am not trigger-happy with prescribing, I am not too weary or worried about trying an antidepressant in somebody who might be suffering a depressive syndrome.

Thank you. That is our last question. Let me ask those of you watching us through the web to please fill out the evaluation. Those of you here please do the same. I will remind you that this will be achieved. You can go back to it. Please E-Mail and send us your questions. We will get back to you and thank you very much for tuning into this session today.