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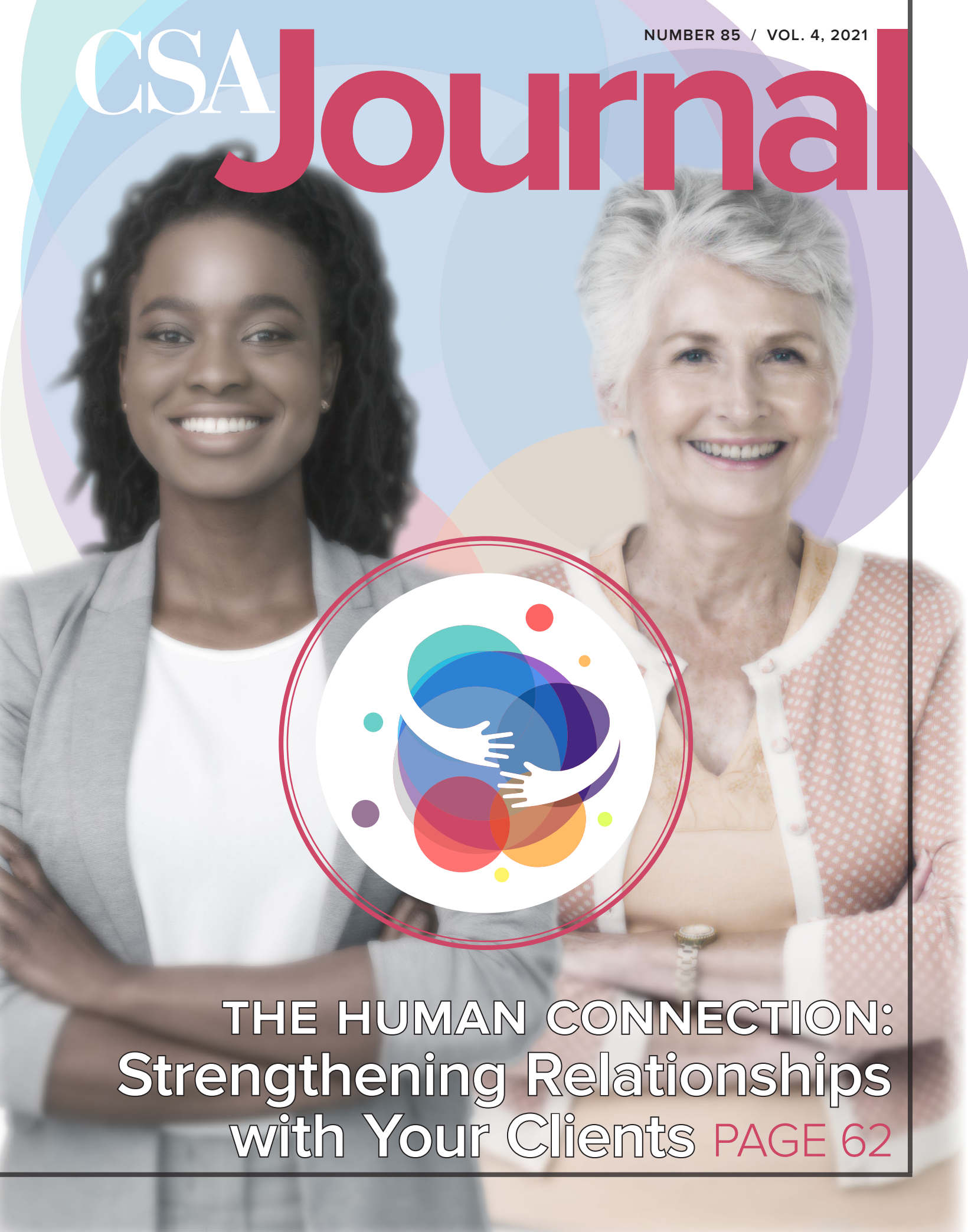

THE HUMAN CONNECTION: Strengthening Relationships with Your Clients

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Society of Certified Senior Advisors®

Society of Certified Senior Advisors® (SCSA) is the premier membership organization educating and certifying professionals who serve older adults. The Certified Senior Advisor (CSA)® credential is among only a handful that are dually accredited by the American National Standards Institute and the National Commission for Certifying Agencies. The SCSA education program, *Working with Older Adults,* uniquely covers aging and health, social, and financial issues important to many older adults. SCSA was founded in 1997.

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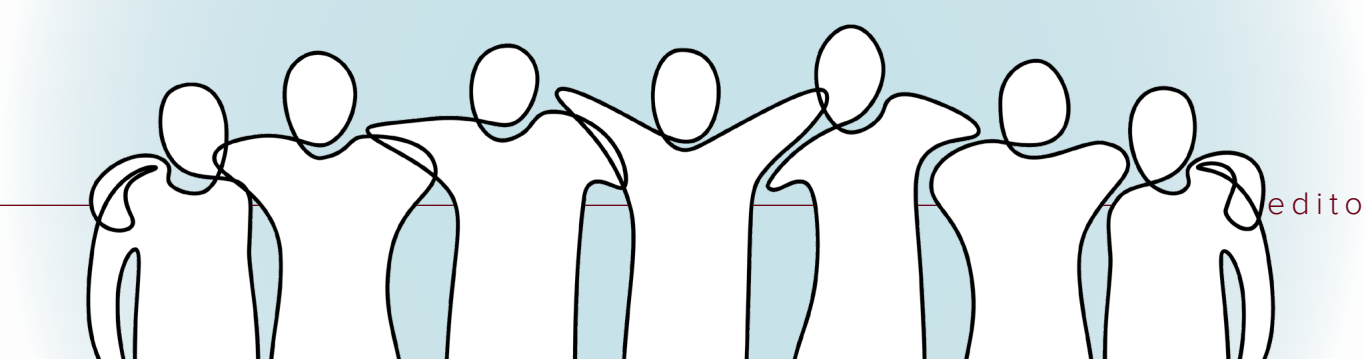


Trust … how important is this in the aging industry? It is critical for the success of our organizations. Our clients have to believe we are committed to core values which consistently and comprehensively encourage their trust. But how do we build trust among our employees and clients? Not so easily.

During the COVID pandemic, I have been visiting my sister-in-law in a skilled nursing facility. She has been dealing with multiple sclerosis (MS) and its side effects. Not an easy thing to witness! Each time I plan a visit, I call the activities director to learn the most recent protocols. Are they on lockdown or can I come visit inside? Have any of the staff or residents tested positive? My sister-in-law has had her vaccine, as have 98 percent of the residents. The staff is not required to get the vaccine so all it takes is one positive test for the residents' world to be disrupted once again. Weekly testing, protocols, documenting and updating relatives take away from time supporting quality of care. These disruptions have happened many times and, to me, seem a torturous way for people to live during the last years of their lives. Staff turnover and shortages only add to this craziness!

I have no easy answer for this issue, but I know that the leadership in this organization must be going through huge challenges building trust.

SCSA and CSAs support the need for strengthening core values and building trust with clients. In fact, that is the purpose of the SCSA organization: to facilitate high-quality standards within the aging industry. *CSA Journal* 85 exemplifies this goal by educating professionals on ways they can build and maintain trust with their clients.

The Case in Point by Amy D'Aprix is a great example. Amy's expertise in building a human connection with clients by developing stronger listening and questioning skills is unprecedented. How better to build trust and relationships with clients (and employees) than to become a *Level 3* listener? The article explains the *Three Keys to Building Trust:* 1) listening at Level 3, 2) asking high-impact questions, and 3) conveying empathy with ease.

Building trust with clients requires you to understand how to minimize their risks, whether financial- or health-related. In a two-part series, Aaron Rubin explores the top threats to successful cash flow in retirement and how seniors can position their finances to protect against them. Part One explains the effects of inflation, overspending, and underinsurance on long-term financial sustainability. J.D. Dinnocenzo clarifies how home equity conversion mortgages (HECMs) are being used in new ways to build long-lasting financial stability. Nancy Butler educates the reader on how to receive the maximum benefits from your long-term care insurance.

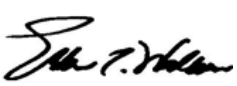
From the healthcare risk side, according to AARP, "On average, 28 percent of pre-Medicare-age adults aren't adhering to their prescriptions as written because of the high cost of medications." Richard Sagall shares resources for reducing medication costs such as patient assistance programs, rebates, discount cards, co-pays, etc. Rachel Stuck and Tracy Mitzner explain ideas for designing successful exercise classes for older adults from the perspective of fitness instructors. The authors identify ways to minimize risks and overcome physical and enrollment challenges. Elisabeth Schuler explains the difference between private patient advocates and hospital-based patient navigators.

The COVID effects on caregiver compassion fatigue have been overwhelming. How do we rebalance or harmonize the positive and negative consequences of care? E. Ayn Welleford shares how critical it is that we understand how compassion satisfaction is the antidote to compassion fatigue.

For decades, the business world has focused on advancing efficiencies along with quality through the concept of Six Sigma. Danielle Hartman guides us through the process of adapting these standards to the aging industry, applying the same principles in order to better serve our clients and build their trust.

Other articles complement the need for resilience in caregiving, supporting physical and financial independence through home design and building understanding of the purchasing power of grandparents.

The CSA Journal Board's goal is to assist you in advancing your core values and building your client's trust in your organization through increased understanding of the complex issues and needs facing older adults.



Erika Walker
Editor and CSA Journal Board Chair

Given that more people are living longer, it is not surprising that there is also a greater number of people living longer with mobility disabilities. Ambulatory disability, defined as having difficulty climbing stairs or walking, is the most predominant disability reported by all older adults aged sixty-five and older (Roberts, Ogunwole, Blakeslee, & Rabe, 2018). The percentage of older adults with mobility disability also increases with age. A full 15 percent of older adults between the ages of sixty-five to seventy-four, 26 percent between the ages of seventy-five to eighty-four, and 48 percent aged eighty-five and above have a mobility disability (Roberts et al., 2018). Having a mobility disability increases mortality risk and is related to the presence of other diseases, such as heart disease and diabetes (Fried, Bandeen-Roche, Kasper, & Guralnik, 1999), as well as lower social engagement (Rosso, Taylor, Tabb, & Michael, 2013). Engaging in exercise is important for overall wellness (Kokkinos, 2012), and is also a critical part of managing many secondary conditions (CDC, 2008). Exercise has been shown to significantly reduce fatigue as well as improve balance, muscle endurance, and quality of life (Edwards & Pilutti, 2017).

Only three out of ten older adults with a mobility impairment engage in recommended physical activity levels (Brown, Yore, Ham, & Macera, 2005). Given the low levels of engagement, one essential component is ensuring that when exercise is accessible to

Designing Successful Exercise Classes for Older Adults with Mobility Disabilities

Exercise is vital for older adults, especially those with mobility disabilities. A few tips and tricks can optimize the experience.

BY RACHEL E. STUCK, PHD
AND TRACY L. MITZNER, PHD

this population it is effective. Understanding the importance of an evidence-based exercise program, as well as how to design a class that will be successful, is essential to promote successful aging within this population.

Building a Successful Exercise Class: Insights from Exercise Instructors

Twelve exercise instructors with experience working with older adults aging with mobility disabilities were interviewed to understand what factors contributed to class successes, class challenges, and methods for overcoming the challenges. In addition, the exercise instructors gave insights into the requirements for doing an exercise program at home.

What makes a class successful?

To understand what it takes to build a useful class, it is important to understand what is considered successful. A class where there was communication and feedback between the participants and instructors was considered a marker of success. To create opportunities for feedback and communication, one instructor would:

Call their names and say, "How are you feeling?" or just in general, "Is everybody feeling this? Do you feel this like I do? How are you doing?"

Instructors also valued a positive group dynamic that created camaraderie. Providing an outlet for socialization with friends and peers was considered important for overall class success, as well. One instructor described it this way:

You're saying 'hi' to friends that you typically see on a Monday, Wednesday, and Friday. That kind of a thing. I think that really bolsters success, and it also helps with adherence because I think they know they're gonna see their friends and they look forward to that.

There are several components for class success that rely on the exercise instructor's ability and skills. The content taught in the class is, not surprisingly, a huge contributor to overall success. For example, one instructor stated:

[For] the class to be successful, [it] has to be appropriate to the people taking it. The students have to feel like they are getting something from the class and it's not too difficult for them, but at the same time … it can be challenging for them. There's good flow, nice transitions between the different types of exercises they're doing, to avoid any kind of confusion and to make them feel that it's a well put together class.

In addition to delivering appropriate content, the instructor's knowledge and experience are key. Knowledge of various adaptations and modifications to provide for varying levels of ability is especially crucial given the diverse abilities and limitations that older adults aging with mobility disabilities can face. It is important to give opportunities to allow all participants to engage, as one instructor acknowledged:

I encourage them to do what they can, regardless of what it may be. If you can't do a high knee lift, just march. If you can't do that, just lift your toes up. I try and encourage them to do something, rather than sit.

Experience with various types of limitations can also help instructors be more successful at quickly identifying potential modification needs. One instructor noted:

Ultimately the true success, the efficacy of the physical activity, has a great deal to do with the knowledge and experience of the instructor, and how they can guide the group.

Beyond the content alone, the instructors highlighted the importance of teaching with enthusiasm. The participants can help add to class success through goal setting and through their attitude toward the class. For example, if participants have intrinsic motivation for coming to class and goals that they want to achieve, the instructor will be able to better help them achieve those goals. These findings are consistent with the literature on the importance of goal setting in successful health behavior change (Bailey, 2019).

To help older adults set appropriate goals, instructors can help guide them either through a worksheet or set aside part of the class to help them identify goals. Effective goals should be: approach driven (working towards something), learning focused (improving performance or learning a new skill), difficult over easy (but must be achievable or it will decrease self-efficacy), and SMART (specific, measurable, achievable, realistic, and timed) (Bailey, 2019). For more details on how to develop SMART goals see "Writing SMART rehabilitation goals and achieving goal attainment scaling: a practical guide." The next step to setting successful goals is creating an action plan to identify the key details of how, when, and where the goals will be accomplished.

What are challenges instructors should be aware of?

The aforementioned components can contribute to making a class more successful, but there are also challenges to this ideal. The exercise space itself can pose an obstacle to the instructors and participants if there are any fall hazards, particularly if they cannot be mitigated. Any fall hazards that can be removed should be, of course. However, because not all environmental hazards can be manipulated, older adults also need to be aware of the surroundings and know where their feet are going. Exercise equipment itself can present a tripping hazard, so it is important when using such equipment to instruct participants to put it under their chair or elsewhere out of the way when not in use.

Exercise equipment can pose psychological challenges as well. The following quote exemplifies how physical challenges can be amplified because of associated emotional hazards such as performance anxiety, disappointment, and frustration:

Some of the challenges from a mobility impairment standpoint would be the utilization of adaptive equipment and some individuals feeling a little self-conscious for needing certain adaptive equipment when other participants in the class may not need it, although they have the same diagnosis.

Communication, feedback, and socialization can contribute to the success of a class, but a lack of them can cause problems. Instructors highlighted the difficulty of providing feedback when one participant may be struggling, yet the instructor does not want to single that person out in front of the class. Challenges related to socialization include instances when one or more participants feel left out of the group, such as when some participants are having a conversation in the middle of class that disrupts the overall class. Another is when there are cliques of friends that cause others to feel isolated and possibly not return to class.

Creating class content for the participants is another challenge. One instructor talked about walking this tightrope:

I have to make sure that I am creating an exercise prescription that will effectuate something but also not put [students] in a position of getting hurt or injured.

Managing this balance can be especially difficult for this population as they may be experiencing cognitive decline that impedes their ability to be aware of their balance or other physical capabilities. Instructors have to watch the participants at all times to ensure they are safe, in addition to providing instruction to the class.

Advice for Overcoming Challenges

The instructors shared strategies for overcoming many of these challenges. Instructors can mitigate environmental hazards by providing props such as chairs or balance bars. Several instructors discussed taking the time to physically remove potential hazards such as extension cords or uneven rugs. One method that was suggested for addressing environmental challenges that cannot be mitigated through props or removal was to improve participant awareness through communication:

The floor could be too slippery and unfortunately, [there is] nothing I can do about that, right? If it's a hardwood floor, what am I going to do about that? So, my goal is to point it out to them and say 'Okay guys, they must have just waxed the floor. This is really slippery today.'

Modifications to exercise are another key method that instructors discussed for addressing the variability in ability and safety concerns. Providing several levels of modifications and indicating when to do which exercise can also help. It is challenging to manage a group class with individuals who have diverse capabilities. The best outcome starts with a full understanding of who is in the class and what each of them can or cannot do. This knowledge and awareness can help the instructor provide more appropriate instruction for the whole group. For instance, one instructor asks for input from newbie class members:

I just take things as they come, and make sure that when I'm going into an exercise class, that I've taken a moment to sort of relax for a second, make sure that I am mentally clear, that I'm aware of all my surroundings. [I think to myself], who are the people in the class that I've worked with before, what are their challenges, who are the new people? And [I introduce] myself to them and find out if they have any particular challenges that I need to know about.

In sum, instructors play a key role in developing a successful class by providing safe exercise content with various adaptations for participants, awareness of participants and space, enthusiasm, and effective communication methods to ensure safety both physically and emotionally.

RECOMMENDATIONS FOR SUCCESSFUL EXERCISE CLASSES

Recommendations for Creating Successful Exercise Classes for Older Adults with Mobility Disabilities:

- **Provide time for socialization between group members, but promote inclusivity of all the members.**
- **Utilize either an exercise-based program or ensure instructors are very knowledgeable about mobility disabilities to ensure they can create a safe and effective class.**
- **Ensure the participants have time and space to allow the instructor to have a deeper understanding of their abilities and limitations.**
- **Have participants set individual goals for exercise.**
- **Ensure individuals in a group class are as close in capabilities and limitations as possible to reduce the amount of adjustments needed and the amount of mental awareness required by the instructor.**

Advice for Exercising at Home

For exercising at home, the components of success are often similar to those discussed above. First, there must be a space large enough for movement that has even flooring. Instructors recommended at least the area of an arm's width and depth. There are many effective seated exercise programs that can mitigate the risk of falling if there is not an exercise instructor or caretaker present to aid in fall prevention. Make sure that the chair is sturdy and firm to support exercising. When doing a standing workout, it is important to remove all potential tripping hazards. Many instructors expressed concern over not being able to review where a participant was working out to check for tripping or other hazards. Another key component to consider when exercising at home is what exercise has the appropriate content. There are several online resources available for older adults with mobility disability looking to exercise at home. For example, there is an online seated yoga class designed specifically for older adults and/or those with disabilities at https://adaptiveyogalive.com/. There are also many other online classes, but it is important to choose a class that is appropriate for the individual's capabilities. Goal setting is also important for at-home exercise. The resources

previously listed can help with developing a plan.

Evidence-Based Exercise Program

Safe and effective class content is a key component of successful exercise. One way to ensure the content is safe and effective is by implementing evidence-based exercise programs. These are programs that have been researched and validated to have positive exercise outcomes for various target audiences (Betz, n.d.) that have been reviewed by experts in the field. These programs have shown not only that they have positive health benefits, but that they also have high retention rates. Although many random exercises can be generated by instructors with the best of intentions, they do not have the same scientific rigor to ensure safety and effectiveness as evidence-based programs. Many of these programs also offer training for instructors and some of these are online classes.

There are several evidence-based exercise programs designed for older adults. *Enhance Fitness* is an evidence-based program designed for various levels of functionality that not only improves the physical health of the participants, but also their emotional well-being. Several evidence-based

EVIDENCE-BASED EXERCISE PROGRAMS FOR VARIOUS MOBILITY IMPAIRMENTS:

PROGRAM NAME	WEBSITE	BRIEF DESCRIPTION
AEA Arthritis Foundation Exercise Program (AFEP)	Home (aeawave.org)	Offers online videos, as well as instructor training, that target older adults with arthritis.
Enhance®Fitness	Project Enhance |	Exercise and wellness options for older adults of varying levels of functionality-though does not target older adults with mobility disability specifically.
Fit and Strong!	Fit & Strong! (fitandstrong.org)	An 8 week exercise program targeting older adults with osteoarthritis.
Stay Active and Independent for Life (SAIL)	SAIL Seminars - Stay Active and Independent for Life	Offers training for instructors in an fall prevention focused training.
Tai Chi for Arthritis	Home - Tai Chi for Health Institute	Offers a variety of classes for varying levels of functionality (including fall prevention, arthritis, rehabilitation), as well as program specific instruction videos available for purchase.
Tai Chi Quan: Moving for Better Balance (TJQMBB)	Tai Ji Quan: Moving for Better Balance (tjqmbb.org)	Offers instructor training in a class designed for older adults at risk of falling and with balance disorders.

For more evidence-based health programs, see: Title-IIID-Highest-Tier-EBPs-June-28-2018.pdf (ncoa.org)

ONLINE CLASSES FOR OLDER ADULTS WITH MOBILITY DISABILITY:

ONLINE CLASS	WEBSITE	BRIEF DESCRIPTION
Adaptive Yoga	https://adaptiveyogalive.com/	Free online class and videos with seated yoga for older adults and those with disability.
Tai Chi for Arthritis	Online Tai Chi Lessons | Tai Chi for Health | Dr Paul Lam	Online class that offers seated Tai Chi.
Silver Sneakers	https://tools.silversneakers.com/	Online and recorded classes on demand targeted at various levels of capabilities.
NCHPAD-14 Week Program	https://www.nchpad.org/14weeks/	Free personalized exercises based on an individual's capabilities.

programs specifically target fall prevention or balance. Although only a few of these offer online classes or video recordings, most provide training and certification in the program for instructors. Some of these trainings are online to make learning how to instruct an evidence-based exercise program even more accessible.

Conclusion

Older adults with mobility disabilities have higher mortality risk and face many barriers to successful aging. Through providing effective exercise instruction, the overall wellness of these older adults can be improved. It is important to understand how to provide effective exercise instruction. Using the experiences of several instructors who teach classes for older adults with mobility disability provides insight on how to create successful exercise instruction, the challenges of providing successful instruction, and strategies for overcoming those challenges. Evidence-based exercise instruction classes have been designed for older adults with and without mobility disabilities. These inclusive classes can be both engaging and effective for all ability levels at once.

To ease the process of developing successful classes and improving the health of older adults with mobility disability, a list of recommendations is provided for developing a successful exercise program. In addition, various evidence-based exercise programs that could be implemented for this population are listed in the resources. Providing effective classes for older adults with mobility disability is an essential first step in providing resources for improvement of overall health and successful aging. •CSA

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In a tangled domestic healthcare system, professional navigators and advocates have emerged to help steer patients to optimal results. Their path has been decades in the making.

BY ELISABETH SCHULER, BCPA, CSA
FOUNDER AND CEO, PATIENT NAVIGATOR, LLC

HISTORY AND TRENDS

IN THE FIELD OF HEALTHCARE ADVOCACY

"I wish I had known you when …" is how folks generally respond when I tell them that I am a patient advocate and my job is to help patients and families navigate through our healthcare system. They tell me stories about when they were overwhelmed, confused, afraid, or unsatisfied by our complicated, expensive, and often inefficient healthcare system in the United States: an aging parent receiving inadequate care, an unsuccessful emergency room visit, a new and frightening diagnosis, battles with their insurance company, the specialist merry-go-round, or dismissive doctors.

The idea that patients need support from family members or friends to help them through a crisis is not new. However, private patient and healthcare advocacy as a separate profession has gained attention in the past twelve years because it fills so many gaps in the current American healthcare system. This profession, born of necessity and nurtured by its trailblazers, now plays an integral role in helping patients and families achieve better health outcomes, save money, and reduce stress during difficult medical journeys.

Separately, some hospitals now hire clinically trained patient navigators. For example, hospital-based breast cancer navigators help patients with the administrative management of their illness within their hospital system. In the past decade, private advocates have created professional organizations to represent us, established codes of ethics, competencies and best practices, built a national credential to certify advocates, and developed directories to find and hire a private advocate. Patients can now seek out competent, compassionate advocates to guide them toward better outcomes and teach them to become their own best advocates.

What is the history of healthcare advocacy and patient navigation?

The concept of patient and healthcare advocacy in the United States gained significant attention as part of the movement for patient rights in the 1970s. The Society for Healthcare Consumer Advocacy and the first Patient Representative Department at Mount Sinai Hospital in New York were created by Ruth Ravich in 1967. In 1972, the American Hospital Association (AHA) incorporated a patient bill of rights into the accreditation standards for hospitals (AHA, 1972).

Sarah Lawrence College in New York established a master's degree program in Health Advocacy in 1980 to educate professionals to work in hospitals, community, or private settings.

While hospitals began to recognize patient rights in the 1970s and 80s, the concept of "patient navigation" was founded in 1990 by Harold P. Freeman, a surgical oncologist at Harlem Hospital, for the purpose of eliminating barriers to timely cancer screening, diagnosis, treatment, and supportive care. His program has since evolved to include the movement of an individual across the entire healthcare continuum from prevention, detection, diagnosis, and treatment to end-of-life care. As empirical evidence accrued to support his findings (Freeman, 2012), U.S. policymakers came together to support the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 (Public Law 109-18). The Act authorized $25 million over five years to develop community-based navigation programs. The Center to Reduce Cancer Health Disparities was created at the National Institutes of Health. Data from Dr. Freeman's programs began to prove how valuable navigation could be to improve cancer diagnosis and treatment outcomes. These types of positive outcomes have given rise to other community-based navigator efforts.

At about the same time, other organizations were founded to help patients improve health or aging outcomes. Members of the Aging Life Care Association (formerly known as Geriatric Care Managers and formed in 1985) are health and human services specialists who act as a guides and advocates for families who are caring for older relatives or disabled adults. The Patient Advocate Foundation (PAF), founded in 1996, is a national 501(c)(3) non-profit organization that provides case management services and financial aid to Americans with chronic, life-threatening, and debilitating illnesses. Many national advocacy groups now offer help navigating the diseases they represent, such as breast cancer or Alzheimer's disease.

It's no wonder that there is confusion about these definitions of who is an advocate or navigator, what they do, and who pays them. The evolution of navigation and advocacy has now grown to cover almost anything being done to help patients and families find their way through the maze of our healthcare system.

What are private patient advocates?

Even as the U.S. government began to address the disparities in access to cancer care among specific communities and populations in the past sixteen years, the idea of private, one-to-one patient and healthcare advocacy was born of necessity as a way to mitigate the complicated, inefficient, expensive, and fragmented healthcare delivery system. Just as many people now use a financial advisor, legal advisor, or life coach to manage different areas of their lives, Americans are learning that they can likewise hire a private healthcare advocate with insider knowledge and direct experience about how the healthcare system works. These healthcare system advisors work to improve medical outcomes, overcome obstacles in the healthcare system, and find resources in the same way that other expert advisors solve problems and avoid pitfalls in their professional arenas.

What kinds of things do private patient and healthcare advocates do?

Private patient advocates work directly for, and are paid by, individuals and families. Their only allegiance is to those individuals. Private advocacy services are not generally covered by insurance. We work with our clients and families to help them at many points along the healthcare continuum, including:

- disease research,
- insurance problems,
- finding doctors,
- understanding treatment and care options,
- preparing for and accompanying them to visits,
- serving as coach and quarterback of their healthcare team,
- facilitating communication with family members, caregivers, and doctors,
- mobilizing resources,
- managing medical paperwork,
- guiding them through aging parent transitions,
- gathering and deciphering medical records,
- serving at the hospital bedside, or
- simply offering a soft shoulder to cry on.

Many advocates do most of these things, but there is no single business model or list of services. Some advocates might only work with older adults, cancer patients, or medical billing and insurance problems. It depends entirely on the advocate's business and practice.

Who are private patient advocates and hospital-based patient navigators?

Early on, it was often nurses or social workers who started healthcare advocacy practices. Physicians are also starting advocacy businesses after having worked within the healthcare system. Additionally, advocates may come to this work because they have been through a life-changing medical event — either themselves, or

with a friend or loved one. They have learned the hard way how difficult it can be to navigate and manage a complicated diagnosis, treatment, or chronic condition. They experienced the confusion, lack of coordination, dangers, and inefficiencies in our healthcare delivery system and now they want to share both what they have learned and how to avoid missteps along the way. Some advocates are laypeople with no prior medical experience or training who come from a variety of backgrounds. Health and patient advocates are often independent, working in private practice (their own businesses) for one or more patients at a time. Each handles his or her work differently.

Some people wonder what the distinction is between private patient healthcare advocates and hospital-based patient navigators. Typically, the primary focus of hospital-based navigators (such as breast cancer navigators) is to make sure that the doctor's instructions, prescriptions, tests, and discharge orders are carried out while the patient is in treatment within the facility or hospital system that employs them. The goal is to successfully "navigate" a patient **within** that institution.

Independent, private advocates, on the other hand, only work on behalf of their clients and guide them through their medical journey and transitions of care, such as seeking out other doctors and institutions, researching treatment options, and staying with the client after discharge to the home. An advocate, when contacted by a newly diagnosed patient, might begin with, "Let's get a second opinion from an independent source." Private advocates should be able to provide credible research so that the patient, with his or her medical team, can make informed decisions and connect with community resources. However, an advocate must never make decisions for the client, cross the line into doing clinical work, or offer a diagnosis. According to our advocate code of ethics, even medically trained advocates must focus solely on representing and advocating for their clients, not practicing medicine.

How is this profession organized?

As with any new profession, it has been a process of building, growing, and professionalizing over the past ten-plus years. Advocate leaders realized early on that it was important to establish a professional organization and a code of ethics. In August 2009, the National Association of Healthcare Advocacy Consultants (NAHAC, now named the National Association of Healthcare Advocacy), was established by Joanna Smith, (LCSW, MPH), the owner of Healthcare Liaison in Berkeley, California. Founding members of NAHAC believed that individuals working as advocates needed to come together to create guidelines for this profession and to educate consumers about its existence and usefulness. Today, NAHAC is a nonprofit organization dedicated to improving patient outcomes through the promotion of the profession of healthcare advocacy through empowerment, education, and collaboration. NAHAC developed the first code of ethics and best practices for this profession, which have served as models for others.

Also in 2009, Trisha Torrey founded AdvoConnection, originally a national directory to help patients find advocates. In 2012, this directory grew into the Alliance of Professional Health Advocates (APHA), an extensive professional and support organization for private, independent patient advocates. The Alliance focuses on the business side of advocacy. Its goal is to help advocates start and grow successful practices, and to help them improve patient outcomes by maximizing their reach.

In January 2012, a group of individuals representing various advocacy constituencies came together with the goal of creating a substantive, accredited national patient advocacy credential. That effort led to creation of the non-profit Patient Advocate Certification Board (PACB).

The most recent organization created with the mission of transforming people into active participants in their care is Health AdvocateX, which grew out of the Washington State Health Advocacy Association (WASHAA) founded by Beth Droppert (BSN, RN) and Robin Shapiro in 2012. Health AdvocateX is a national, nonprofit organization that brings together health advocates, patients, caregivers, health providers, allied health businesses, communities, and educational representatives to promote health advocacy with the purpose of helping every person get the care they deserve.

What qualifications should an advocate have?

To tackle the issue of setting standards and competencies and to promote excellence in patient and healthcare advocacy, the Patient Advocate Certification Board (PACB) worked for six years to develop the Board Certified Patient Advocate (BCPA) credential. The PACB is set up to:

- manage and maintain a universally recognized certification for patient and health advocates;
- establish and maintain relevant knowledge domains, skills, ethical standards, and best practices for advocates;

- collaborate with healthcare consumers to achieve patient and family centered care;
- establish professional development for certified advocates; and
- promote and professionalize patient advocacy.

The certification examination to become a Board Certified Patient Advocate (BCPA) is now given to qualifying candidates twice a year. The first cohort of BCPA candidates was credentialed in March 2018. As of summer 2021, PACB has credentialed 889 advocates.

Currently, there is no mandatory education, experience, or qualification for a private patient or healthcare advocate. It is not yet a profession that requires licensure. Choosing an advocate with his/her Board Certified Patient Advocate credential, however, offers a competency level tested by an independent third party; accountability through ethical standards and/or a disciplinary process; and recertification requirements for continued learning and enhanced competence. Membership in a professional advocacy organization is also desirable. Since 2005, other courses, certificate programs, and university programs have been developed to educate patient advocates to work in a variety of settings (Master List — 2021).

How can I find a healthcare or patient advocate?

Consumers now have several ways to find and screen healthcare advocates. AdvoConnection offers a searchable directory of members on its website, as do the National Association of Healthcare Advocacy (NAHAC), the Patient Advocate Certification Board (PACB), HealthAdvocateX, and Greater National Advocates (GNA). Word of mouth or personal referrals are always a good way to find an advocate as well.

What questions should I ask if I want to hire someone? What should I expect? What do they charge?

You should interview an advocate the same way you would interview any other professional you would consider hiring. Among questions you could ask are:

- Have you handled other cases similar to mine before?
- What is your background and training?
- How long will it take to perform the services I need?
- What do you charge?
- Do you have client references I may contact?
- Do you provide written reports?
- Where are you located?
- What are your hours?
- How do you communicate with your clients?
- What would you typically do to help someone in my situation?

ADVOCATE DIRECTORIES

- AdvoConnection https://advoconnection.com/
- Aging Life Care Association (ALCA) https://www.aginglifecare.org/
- Health AdvocateX https://www.healthadvocatex.org/directory-professional/
- Greater National Advocates (GNA) https://www.gnanow.org/
- National Association of Healthcare Advocacy (NAHAC) https://www.nahac.com/find-an-advocate

Two regional chapters of NAHAC have also been formed:

- Massachusetts Health Care Advocates https://www.mahealthcareadvocates.org/
- Bay Area Health Care Advocates https://bayareahealthcareadvocates.org/

Working with a patient advocate is an intensely personal relationship. You must feel that you can trust and work with that person comfortably. You should expect that the advocate will respect your privacy and cultural preferences and that he or she is a good communicator. You may need to speak with several candidates before you feel comfortable hiring one.

You should also expect a written contract or agreement which specifies what the advocate will deliver to you and when, as well as a detailed explanation of his or her fees and charges. Do not rely on verbal promises or commitments; get it in writing. There is no standard fee for private advocacy services. Fees can range from $50 to $300 per hour, depending on the advocate's experience, education, niche, and location. Based on the advocate's track record, you should feel comfortable that you will be getting your money's worth just as you would with any other professional service provider.

Future Trends

It's clear that private patient and healthcare advocacy is here to stay. Patients have gravitated to our model in large part because of the allegiance factor — our

only allegiance is to the patient and family, not to a hospital system, insurance company, or other institution. Trisha Torrey, the founder of the Alliance of Professional Healthcare Advocates, coined the acronym FUDGE as another reason for the growth of private advocacy. Patients often feel **F**earful, **U**ncertain, **D**oubtful, **G**uilty, and **E**xhausted and turn to an advocate for help.

There has also been a larger awakening in the medical system to focus on patient-centered care. Over recent years there has been a move toward partnership in care, centered on a recognition of the knowledge and expertise that patients have and can contribute to the management of, and decision making about, their health (Hewitt-Taylor and Bond, 2013). This has pushed medical professionals and younger doctors to realize that the Internet and social media have empowered patients who are now better informed about their health and expect better treatment, answers, and communication.

With regard to Internet research, "apomediation" is a new socio-technological term that was created to characterize a "third way" for users to identify trustworthy and credible information and services online (Eisenbach 2008). Apo is a Latin term that means "separate, apart, or away from" and apomediation is crowd-sourcing guidance from peripheral mediators (Anderson, 2008). For example, an apomediary might be a layperson who writes a well-respected blog about a disease for which he or she has developed an expertise.

The emergence and professionalization of patient advocacy means that patients now have a lifeline when faced with a medical crisis or other obstacle in the healthcare delivery system. With a competent, compassionate advocate as a guide, they may expect better outcomes, reduce stress, and focus on healing. We will continue to build our profession, ensure that its members adhere to specific standards, ethics, and best practices, and educate consumers so that they know who we are and how we can help, and teach them to become their own advocates. •CSA

RESOURCES

Aging Life Care Association https://www.aginglifecare.org/

Alliance of Professional Health Advocates (APHA) https://www.aphadvocates.org/

Code of Conduct and Professional Standards - APHA - https://www.aphadvocates.org/health-advocate-code/

Code of Ethics - Health AdvocateX - https://www.healthadvocatex.org/code-of-ethics/

Code of Ethics - NAHAC - https://www.nahac.com/nahac-code-of-ethics

Ethical Standards for a Board Certified Patient Advocate https://www.pacboard.org/wp-content/uploads/20191115PACB-Ethics.pdf

Greater National Advocates https://www.gnanow.org/

Health AdvocateX https://www.healthadvocatex.org/

Master List of Health Advocate Programs, curated by APHA. https://www.healthadvocateprograms.com/

National Association of Healthcare Advocacy (NAHAC) https://www.nahac.com/

Patient Advocate Certification Board (PACB) https://www.pacboard.org/ Consumers can verify an advocate's certification on this website.

Patient Advocate Foundation (PAF) https://www.patientadvocate.org/

Patient Navigation Institute - Dr. Harold Freeman - https://hpfreemanpni.org/

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The medicines we have today work wonders, lessening suffering and extending lifespan. A problem many people encounter is affordability. Too many Americans either can't afford their medication costs or have to sacrifice to pay the bill.

Treatment of any problem begins with a diagnosis — and medication affordability is often an unrecognized cause of treatment failures. It's underdiagnosed for two reasons: prescribers rarely ask patients if they can afford their medications and patients are reluctant to admit they can't afford their medications.

Perhaps the saddest aspect of this problem is that a lot of help is available. It's just that patients and prescribers aren't aware of how to find the needed help. What follows is a summary of the types of help and how to find it.

The Scope of the Problem

Ask just about anyone, "How often, when your healthcare provider prescribes a new medication, are you asked if you can afford it?" Most times, the answer is, "Never has happened." Or, at a follow-up appointment, were you asked, "Did you have any problem getting the medication?"

According to a study in the Annals of Internal Medicine, 20 to 30 percent of prescriptions are never filled (Viswanathan et al., 2012). Half of the prescriptions for chronic diseases go unfilled. These unfilled prescriptions are costly to our healthcare system. The research shows that every year approximately 125,000 deaths are due to missed medications and the total cost of missed medications is between $100 billion and $289 billion.

According to AARP, "On average, 28 percent of pre-Medicare-age adults say they aren't adhering to their prescriptions as written because of the high cost of medications" (Burns, 2019). A recent survey by Bankrate reported that 32 percent of responding families delayed or deferred medical adherence in the previous year due to costs (Foster, 2020).

The sad thing about these statistics is that help is available for many of these people. There are thousands of programs that help people with health-care costs. It's just that many of those in need aren't aware of the programs.

Drugs don't work in patients who don't take them.

—FORMER U.S. SURGEON GENERAL C. EVERETT COOP, MD

HELP WITH MEDICATION COSTS

Too many patients simply forego needed medication due to cost when there is help available for almost all who need it. BY RICHARD J. SAGALL, MD

How To Find Assistance

There are many ways to search for assistance. Most people start with a Google search. One difficulty with this approach is finding the right search terms and wading through all the ads. Then you have to decide which offers are legitimate and which are come-ons from less-than-reputable sources.

Another source of information is websites devoted to a specific disease or condition.

The National Organization for Rare Disorders (NORD) has information about specific diseases, but has limited information on general help programs. Other sites may have some information, but not information on all the programs that may help.

A Solution

NeedyMeds offers "one-stop shopping" for finding programs that provide assistance (NeedyMeds, n.d.). It has information on over 30,000 programs. All the information is free and updated regularly. What follows is an introduction to the website and how to find the information you need. Please be aware that the author is the cofounder and president of NeedyMeds and his opinions may be biased.

Pharmaceutical Patient Assistance Programs

You may have heard at the end of some pharmaceutical television ads, "If you can't afford this medicine, the maker of this medicine may be able to help." What the ad is referring to is the company's pharmaceutical patient assistance program (PAP).

These programs, funded by the pharmaceutical manufacturer, provide free medications worth billions of dollars to millions of people. Currently, NeedyMeds lists nearly 450 PAPs. Each has its own eligibility criteria:

- **Income level.** Most programs use a multiple of the federal poverty levels (FPL) to determine income cutoffs. Don't let the word "poverty" mislead you. Many of these programs use 400 percent of the FPL or even more as their maximum for income (U.S. Dept. of HHS, 2021). That means a

family of four with an income of $100,000 would qualify for some programs.

- **Insurance status.** Some programs require applicants to have no health insurance, others say applicants must not have coverage for the needed medicine, and some don't care. Many of these programs won't help people on Medicare, Medicaid, or state or other federal programs.
- **Age.** Programs may limit the age of the applicant. This limitation is usually based on prescribing age limitations determined by the Food and Drug Administration (FDA).
- **Diagnosis.** Some drugs may be used to treat any diagnosis, while others are limited to FDA-approved diagnoses.
- **Residency.** Some programs only help U.S. citizens or legal residents, while others will help anyone with a U.S. address.

Each program has its own eligibility criteria, application, and application process. Sometimes different programs run by the same company have different criteria. The one thing all the programs require is the need for a prescriber. To help with that potential problem NeedyMeds has information on free/low-cost/sliding scale clinics (see below).

Unfortunately, too many people don't look further for other types of assistance. They may miss out on programs that could help them. Here's a breakdown of other types of assistance on the NeedyMeds website.

Free/Low-Cost/Sliding Scale Clinics

The first step in obtaining the medications you need is seeing a health-care professional who can diagnose and treat your ailment(s). If you can't afford to see a prescriber, you can't get the medicines you need.

Again, NeedyMeds can help. There's a listing of over 18,000 free/low-cost/sliding scale clinics on their website. There is sure to be one or more clinics near you that will adjust its fees based on your income level. Many also have pharmacies that offer low-cost or no-cost medications.

Many of these clinics offer the full spectrum of healthcare, while others may specialize in specific age groups or types of care. Most, but not all, offer general medical care. Others may provide mental health or substance abuse services. The description of each clinic lists the type of services offered.

Coupons, Copays, and Rebates

These savings options cover both prescription and over-the-counter medications and products. Some help cover insurance copays, while others lower the cost of non-drug items. This list is always changing, so it pays to check it regularly.

A BRIEF HISTORY OF NEEDYMEDS

NeedyMeds was started by Richard Sagall, MD, and Libby Overly, MED, MSW, in 1997 to help people find programs that help with medication costs. From that beginning, NeedyMeds has grown to have over 30 employees working to help people find programs that help with their healthcare costs.

The website has information on over 30,000 programs. All the information is free, easy to access, and updated regularly. The website is visited by 10,000-15,000 users daily and the helpline receives 4,000-6,000 calls monthly.

The NeedyMeds Drug Discount Card is saving people over $1.5 million monthly. Since its inception, the card has saved people over $300 million dollars. In addition to the NeedyMeds website, the organization runs a number of other websites:

- BeMedWise.org - This website has information on the proper use, storage, and disposal of medications.
- Safe Needle Disposal - This website has information on how to safely and legally dispose of home-generated sharps for every state and a compendium of over 4,000 collection sites for used sharps.
- Findcare - A place to find free/low-cost/sliding scale clinics near users.

Diagnosis-Based Assistance

This is one of the most underutilized sections of the website. It contains nearly 4,000 programs that provide help based on a diagnosis. Some of the programs are national, while others may be regional or local. Some provide free or low-cost services (transportation, house cleaning, etc.), while others offer assistance in obtaining medications, and others offer direct financial assistance. The scope of assistance is really quite remarkable. Here are a few examples:

- Local or long-distance transportation to medical facilities
- Wigs for women who lost their hair due to chemotherapy

- Diabetic supplies
- Nipple tattooing for women undergoing breast reconstruction
- Childcare while the parent is receiving treatment
- Pet care when a pet owner is hospitalized
- Hearing aids
- Glasses

As you can see, the scope of assistance is broad.

COVID-19 Services

The COVID-19 pandemic has caused severe financial hardship for many families. There are over 400 programs that specifically provide assistance for people in this category. It may offer rent or utility bill assistance, help with medications or health-care costs, or provide for daily expenses.

Medical Transportation Costs

These programs, a subset of the diagnosis-based assistance programs, help people get to their appointments. Some provide local transportation while others may cover the cost of air transportation. In addition to providing the actual transportation, some cover travel expenses with gas cards or travel reimbursements.

Retreats, Camps, and Recreational Programs

Everyone needs a break now and then. Programs in this section of the website provide free or low-cost recreational activities for people with specific diseases or their family members. These programs provide a safe and supportive, fun experience for children and adults. It's especially important for children to have an opportunity to spend time with other children experiencing the same stress and difficulties.

Scholarships

There are a large number of scholarships available for students with specific illnesses or diagnoses. These programs help with tuition and room-and-board costs for students attending college. Assistance is also available to help with the costs of special equipment or other unique needs that help these students attend college or other types of schools. Some scholarship programs even help with tuition costs for family members/caretakers of a person with a specific diagnosis.

Government Health-Care Programs

The states have a number of programs that assist people with a wide spectrum of medical programs. These include health insurance assistance, special-education

SUMMARY OF PROGRAMS ON NEEDYMEDS AS OF JUNE, 2021

PROGRAM NAME	NUMBER OF ENTITIES	DESCRIPTION
PAPs	440	Supply medications at no cost.
Free/Low-Cost/Sliding Scale Clinics	18483	Clinics that adjust their fees based on the patient's financial status.
Diagnosis-Based Assistance (DBAs)	3973	These programs provide services or financial support based on the applicant's diagnosis.
Coupons, Copays, and Rebates	2827	A list of programs that lower the cost of medications and durable medical supplies.
COVID-19 Services*	419	DBAs that specifically offer programs for people with COVID-19.
Medical Transportation*	201	These programs either provide the transportation or help cover the cost.
Retreats, Camps & Recreational Programs	2095	These programs provide a break for people with certain diseases or their family members.
Scholarships	679	Provide help with educational costs based on diagnosis.
Government Healthcare Programs	1394	Many states have assistance programs for residents with specials needs arising from illnesses.
*A subset of Diagnosis-Based Assistance (DBAs) programs		

programs, assistive technology, cancer screening programs, vaccinations, and nutrition programs.

Other information in this section includes:

- Medicare Information
- Medicaid Sites
- SHIP Medicare Counseling
- Federal Poverty Guidelines
- Tax Return Request Forms

More Cost-Saving Resources

This final section has information on the NeedyMeds Drug Discount Card, durable medical equipment discounts, and FAQs on drug discount cards and copay cards.

A few words about drug discount cards. These cards, and there are many, basically work the same way. Discounts are negotiated with the pharmacies for all the drugs available through a drug discount card. The patient presents the card to the pharmacist, who determines the discount.

Sounds simple, but there are some things to remember:

- No card offers the best discount on every drug.
- The cards can't be combined with insurance, nor with state or federal programs.
- Sometimes a card offers a better price than the insurance copay price.
- Savings vary from month to month and store to store.

The NeedyMeds Drug Discount Card differs from other cards in a few critical areas:

- NeedyMeds protects user privacy and never uses patient information for any marketing purposes. This can't be said for all drug discount cards.
- Any income derived from the drug discount card goes into funding our mission and providing free services. Most other cards' profit goes into investors' pockets.
- NeedyMeds keeps expenses low so we can pass the greatest savings on to card users.

How to Access the Help

All this information is of little value if you can't easily access it. There are two ways you can access these programs: on our website and by calling our toll-free helpline. Both services are free; we never charge individuals for using our services or looking for assistance.

The NeedyMeds Website

On average, more than 12,000 people visit our website — www.needymeds.org — every day. The website contains all the information we have on the more than 30,000 programs in our database. Researching the database is the quickest way to find programs that may help you. Click on the "Healthcare Savings" tab on the home page. This opens the links to all the information described above.

The Toll-Free Helpline

For people who, for various reasons, don't want to use our website, we offer a toll-free helpline. Our trained counselors help the 4,000 to 6,000 people who call every month find programs that may help them. The counselors provide program information and phone numbers, but it's up to the caller to take the next step.

Summary

As Dr. Koop said, "Drugs don't work in patients who don't take them." The number one reason people don't take their medications is cost. NeedyMeds can help people find ways to lessen the cost of their drugs. All the information is free, easy to access, and updated regularly. If you are having trouble paying for medications or know someone who is, then NeedyMeds may be able to help. •CSA

Dr. Sagall is the co-founder and president of NeedyMeds. He is a graduate of the Medical College of Ohio, Toledo, and the Eastern Maine Medical Center Family Medicine Residency Program. He practiced family and occupational medicine for twenty years in Bangor, Maine. He started NeedyMeds over two decades ago while in Bangor. His passion is helping people find resources to help with medication and health-care costs.

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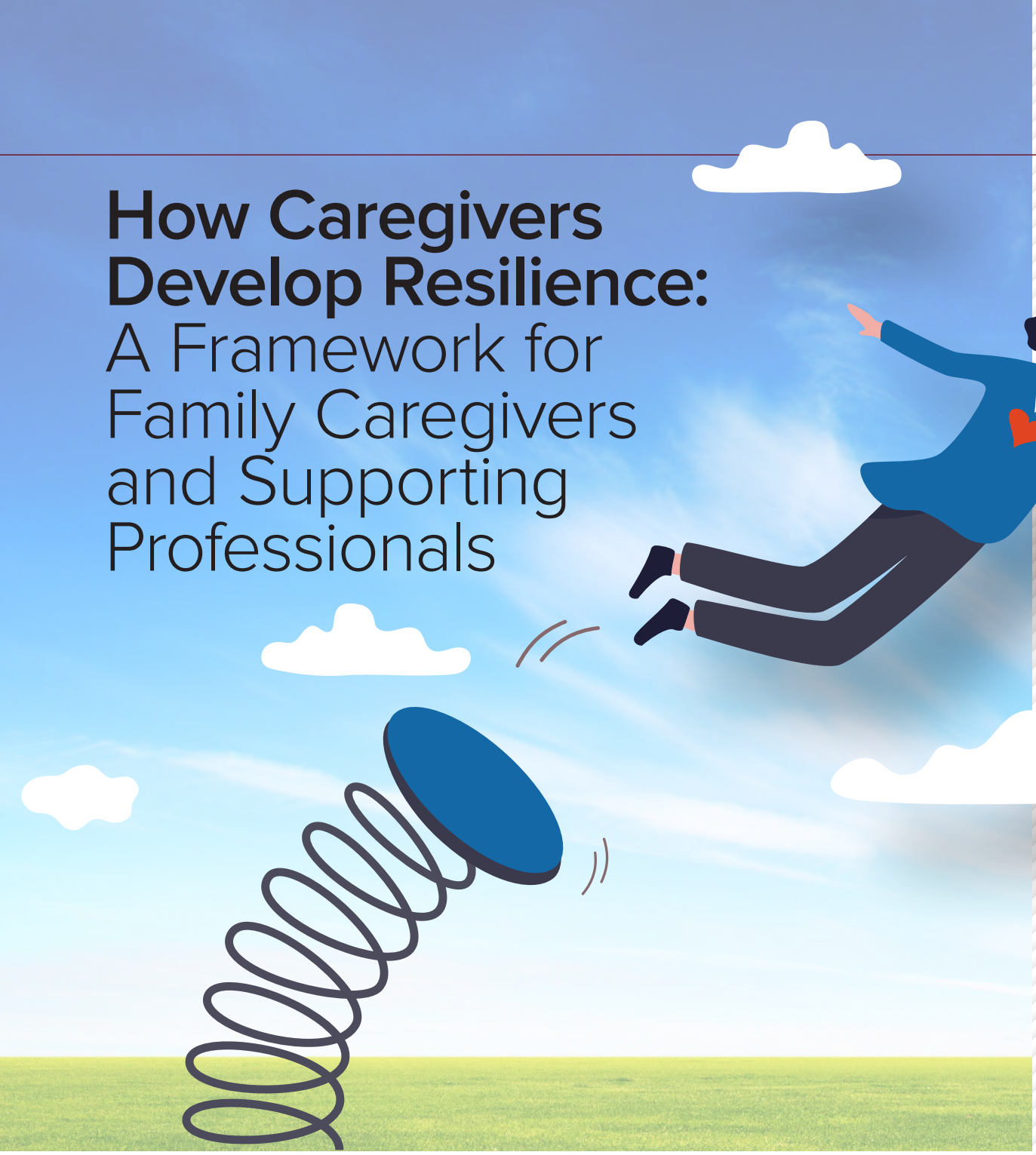
How Caregivers Develop Resilience: A Framework for Family Caregivers and Supporting Professionals



A resilient mindset can be developed systematically to help caregivers embrace the tasks at hand and recognize the gifts of caring for another. BY AARON BLIGHT, EDD

There are more than 53 million caregivers in America today (AARP & NAC, 2020). Despite the widespread prevalence of caregiving, family members who assume the caregiver role frequently find they are unprepared for the physical and emotional demands of caregiving. In contemplating the changes that caregiving has ushered into their lives and relationships, it is not uncommon for family caregivers to ask a question: *How do I keep doing this?*

Sometimes the immediate response to this question invokes a checklist of tasks. "Do these things," the suggestion goes, "and you'll get by." While caregiving

certainly encompasses a lengthy list of tasks, ceaseless checkboxes will not produce the mindset that caregivers must acquire to successfully support a loved one over the long trajectory of caregiving. Physically, caregivers can try to take care of themselves by getting plenty of sleep, exercise, and good nutrition. They should also be able to ask for help unabashedly when they need it. But even these foundations of critical preparation are often not enough to maintain a healthy outlook.

Caregivers must develop resilience — the ability to cope with difficult circumstances — in order to overcome adversity, avoid getting overwhelmed, and continue to address the evolving requirements of a loved one in need. Resilience is more than the action required to "power through" tough situations; it's a result of the belief that a person can survive, and possibly learn to thrive, in unexpected challenges. In fact, research shows that a growth mindset leads to increased psychological resilience (Boullion, Withers, & Lippmann, 2021).

Changing the mindset about caregiving can help caregivers who are struggling to build their resilience. When caregiving is viewed as a learning process that introduces change and ultimately leads to growth, a caregiver will find it easier to perform care-related tasks — not because the tasks are different but because the caregiver's mindset is different.

In light of the above, I am happy to introduce a framework that helps caregivers establish the mindset needed for ongoing care-related service to their loved ones. Caregiver resilience is developed across five domains of the care experience represented by "R" words: Roles, Relationships, Realities, Rewards, and Readiness. Let's review each of these building blocks of caregiver resilience.

Roles

Roles are positions we occupy in the social world. Roles are central to our human relationships, our place in society, and our concept of self. "Care receiver" is among life's least-coveted roles. And yet we know that caregivers don't exist without care receivers.

In Chapter Two of *When Caregiving Calls: Guidance as You Care for a Parent, Spouse, or Aging Relative* (Blight, 2020), I describe caregiving by using the metaphor of a stage play, borrowed from the seminal writings of sociologist Erving Goffman (1959). In a caregiving play:

- the care receiver is the star of the show,
- the script is written by the care receiver's health conditions, and
- the caregiver is a supporting actor.

With caregiving, nobody knows precisely how the script will unfold. Nobody knows exactly when the final curtain will fall. We do know, however, that when the show is over, the star performer may not be there to take a bow.

While every caregiving storyline is unique, the care receiver and caregiver are always, respectively, the primary and secondary roles in an unfolding drama. Understanding the nature of these roles is a foundational part of being able and willing to continue service as a caregiver.

Relationships

Caregiving changes relationships. While this can be disorienting and unwelcome, it's among the most important things for caregivers to realize as they seek to meet the ongoing needs of a loved one who is aging, sick, or disabled. By recognizing that relationships are changing, caregivers are also uniquely positioned to honor their relationships with care receivers.

Chapter Three of *When Caregiving Calls* presents research from applied gerontology suggesting that family caregiving is marked by a series of role-based transitions, which start from an initial set of family relations and change over time due to changes in the caregiving context (Montgomery & Kosloski, 2012). As the care receiver's needs become greater, the caregiver's actions must change — and this changes the caregiver's role identity within the relationship.

The relationship history between caregiver and care receiver becomes intertwined with, or perhaps subsumed by, the tasks of caregiving that are now being performed. Caregivers can reach the point where they ask themselves: Who am I now in this relationship? Amid such profound changes, the historic family relationship continues to shape the caregiver's motivation and approach to providing care. Honoring relationships is thus a critical component of caregiving.

There are three steps to honoring relationships while caregiving:

- ***Remembering*** your historic relationship with your loved one,
- ***Acknowledging*** that things are changing due to your loved one's health conditions, and
- ***Adapting*** to the terms of an emerging care-based relationship with your loved one without forgetting the history you share together.

Adapting to the terms of a new care-based relationship could involve uncomfortable topics of

conversation concerning your loved one, the performance of caregiving tasks you never had to do before, and/or spending more (or less) time together. As the needs of care receivers continue to evolve over time, caregivers must make corresponding adjustments. Through it all, family caregivers remember in their minds and hearts that the person they're caring for is special.

Realities

Family caregivers often report that caring for a loved one is among the hardest things they've ever done. Until you've assumed the responsibilities of caregiving, you're probably unaware of the multi-faceted commitment that must be made to meet the ongoing needs of a loved one who depends on you. Nevertheless, when caregiving calls, you eventually discover how the physical, emotional, relational, and spiritual dimensions of caregiving can cause deep distress and dissonance in your life.

Caregiving has a way of rudely introducing you to things you never wanted to think about. You may choose to ignore some of these things, preferring to avert your eyes from the stark view in front of you. Avoidance can become a default position because it may be more comforting to choose not to think. Denial is a related but slightly different strategy: you know what may occur but refuse to accept that it applies in your situation. Another approach is busyness, where you can be so focused on your to-do list that you don't have time to manage the tough stuff.

As difficult as it may be, the best way to handle the hard realities of caregiving is to confront them. Here are five hard realities that are commonly found when caregiving:

1. Bodies fail.
2. Sometimes the treatment is worse than the disease.
3. Caregiving causes stress.
4. Caregiving can be an emotional roller coaster.
5. Death happens.

Every caregiver will face a unique set of hard realities. However, when caregivers honestly confront the most troubling aspects of their experiences, they place themselves in positions to find support and solutions that will help them deal more effectively with their challenges.

Rewards

Caregiving offers rewards that you don't necessarily expect amid the struggle of providing daily service to a loved one. The rewards may pop up in a single moment, or they may become perceptible only after the long, arduous slog of care is over and your loved one is no longer with you. Often the hardest things to do are also the most rewarding things to do, and caregiving reflects this reality.

Unfortunately, so much of our research has focused on the hard parts of caregiving, like burden and stress, that social science has yet to develop a comprehensive and robust view of positive outcomes associated with being a family caregiver.

Are there rewards associated with caregiving? There most certainly are. Here is what three family caregivers told me about the positive dimensions of their service to loved ones:

- "Being a caregiver for my dad was the toughest job I have ever had, and yet what a privilege to be there for my parent during the last year of his life as he was for me during my first."
- "In my case, it was the fact that my mom had total confidence in me and there are no words to describe that feeling."
- "It was tough but caregiving did a lot for my soul. I was able to make sure he knew I loved him, not just in deed but in words. I was able to help him deal with his pain, and what an amazing feeling to know you have comforted someone you love. The greatest reward is being able to give back to him. He was my big brother and he did a lot for me and there is no price I can attach to how great I feel even now — that I had the opportunity to give back AND let him know I loved him so."

These heartwarming and profound thoughts are merely a sample of the responses I have received when asking family caregivers about the rewards they find in their caregiving experiences. Their insights never cease to touch me.

Caregiving is not wholly about illness, aging, disability, burden, and stress. Caregivers who persist in the role, despite its challenges, often discover the beauty from the ashes. Caregiving delivers moments you'll remember forever, lessons you'll apply to the rest of your life, and attitudes that will be permanently adjusted as a result of the experience. These are but a few of the significant rewards that caregiving offers.

Readiness

People don't receive certification or education to fulfill the family caregiver role. It's easy for caregivers to feel like they're not prepared to do what their loved one needs them to do. To improve their readiness to care,

wise family caregivers adopt a learning orientation to caregiving.

First, they seek information about their loved one's specific condition, including the diagnosis, prognosis, and potential treatment options. Such study will allow caregivers to understand what is happening to their loved one and discover what to expect over time.

Beyond the "book knowledge" that is acquired, caregivers must also learn how to handle unfamiliar challenges arising in connection with the tasks of caregiving. This can be anything — such as helping a loved one get in and out of a car, providing hands-on personal hygiene assistance, assisting with medications, or responding to dementia-induced behaviors. Often family caregivers feel most unprepared when they've never performed a care-related task before.

How do families learn to deliver the different tasks of caregiving? The answer can be found in a study of staff members working in a care facility for people with dementia. The employees who worked at the facility were unskilled, direct-care aides who had not received specialized formal schooling in managing dementia-related behaviors. Despite their lack of formal education, the aides learned ways of effectively managing these challenging behaviors through their own process of "showing, guessing, and trying" (Beckett & Hager, 2002). This three-step approach can be summarized as follows:

- ***Showing*** involves a demonstration of what must be done;
- ***Guessing*** suggests a choice that is made amid the uncertainty of alternative approaches, and
- ***Trying*** is a "trial and error" process which allows

CAREGIVER RESILIENCE

Understanding ROLES involves making adjustments to an emerging caregiving story. Resilient caregivers learn what it means to fulfill a caregiving role. They know that the care receiver didn't choose to be in this position, and they adapt to the changing conditions of their loved one.

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Honoring RELATIONSHIPS allows caregivers to nurture, and continue to be present, for the important people in their lives. While the functions of caregiving may change the nature of social interactions between participants, the historic relational bond between caregivers and their loved ones motivates resilient caregivers to continue to be there.

Confronting REALITIES enables caregivers to deal with the hard parts of caregiving. Instead of denial or discouragement, resilient caregivers realistically assess and strive to overcome the challenges they experience while caregiving. Although some things cannot be changed, acknowledging and embracing what is hard enables caregivers to endure and occasionally triumph.

Cultivating REWARDS opens the mind and heart to the good parts of caregiving. Sometimes adversity reveals unexpected blessings, such as personal growth, moments of joy, paradigm shifts, or enhanced relationships. Resilient caregivers seek and recognize the good even as they struggle with the bad.

Practicing for READINESS is how caregivers prepare themselves to offer appropriate support to their loved ones. Resilient caregivers are not innately endowed with the ability to deliver the tasks of caregiving; it is only through practice (trial and error) that they develop the sustainable capacity to do what is physically required for a loved one in need.

you to evaluate the attempted approach and gather new information about what may or may not work.

Family caregivers essentially follow the steps of "showing, guessing, and trying" to develop their readiness to perform the caregiving tasks that a loved one requires. Showing, guessing, and trying gradually teaches caregivers how to handle their own challenging care situations more effectively.

It all comes down to the proverbial saying, "Practice makes perfect." As caregivers practice performing requisite care-related tasks, they grow in their capacity to meet the needs of their loved ones — both now and in the future.

How Professionals Can Help Family Caregivers Increase Resilience

In consideration of the five domains of family caregiving described above, I created a model of caregiver resilience (see graphic on pervious page). The model serves as a tool for caregivers and supporting professionals to impose a frame onto a caregiving situation, assess the implications, and determine where adjustments can be made that will lead to greater resilience.

There is a wide range of professionals who routinely engage with families in care-related situations. Social workers, counselors, and care managers have assumed responsibility to professionally support individuals and families through challenges associated with aging, illness, and disability. Skilled medical professionals treat their patients and interact with the families of the patients. Moreover, there are other professionals — such as attorneys, financial planners, clergy, Realtors, and funeral directors — who find themselves in discussions with families struggling to care for loved ones.

The model of caregiver resilience is a handy resource that professionals can use in a problem-solving dialogue with family caregivers. Professionals may facilitate such discussions through a three-step process of framing, prompting, and thinking, as follows:

- **Framing.** The professional presents the model of caregiver resilience, explaining it within the context of the family caregiver's individual situation.
- **Prompting.** The professional asks questions and makes comments to help the family caregiver engage in thoughtful reflection.
- **Thinking.** The family caregiver and the professional "let their minds flow" about how the model can be applied in the family caregiver's situation.

Note that the professional is instrumental in not only introducing the model but also joining with the family caregiver in applying the model to the care circumstances at hand. The model thus enables the professional to: 1) use shared language to analyze the situation with the family caregiver, 2) listen to the family caregiver's thoughts, and 3) bring professional guidance to the discussion.

Both participants thereby engage in an exchange that has the potential to reshape the family caregiver's mindset about caregiving, which is the key to building resilience. An effective discussion will produce insights as to how the family caregiver could approach caregiving more effectively. In turn, actions can be taken that will ultimately make the situation better for both the caregiver as well as the care receiver. The model may be revisited again and again to evaluate progress and identify new ways to foster resilience as care-related circumstances change and evolve over time. •CSA

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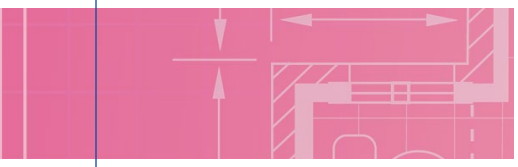
Enabling by Design: Leveraging Home Features for Physical and Financial Independence in Retirement



Older adults are unnecessarily disabled by standard design features, with some people eventually evicted from their own homes as a result of age-biased design. This is preventable and there is a solution. BY ESTHER GREENHOUSE, M.S., CAPS

The design of our homes and neighborhoods is one of the least understood factors that impacts our financial and physical independence. As a result, little is done to properly address it. The status quo of our built environment artificially creates forced frailty and dependency, increasing both the demand for caregiving and the impoverishment of families through expenditures on long-term care which could have been prevented, reduced, or delayed. Because our housing and communities are not designed and built for the expected changes that occur with aging, some people are literally *evicted from their homes by design*: after being pushed to an artificially lower level of functioning by a discriminatory standard of design, they are forced out because their new needs are not supported (AARP & NAC, 2020).

Increasingly, the response by individuals, families, and society to this common scenario is home modifications, which provide significant benefits. However, this response reflects a limited understanding of the problem's true extent and what is needed to address it. My Enabling Design Approach is a response to these issues. It builds on Universal Design while addressing gaps in its application. It is also more comprehensive considering the interdependence of societal challenges, policy, economics, and personal finance.

Universal Design and Aging In Place

Because Universal Design (UD) is inclusive of persons with disabilities and older adults, it has been misunderstood as specific to those groups of people and their needs. This leads to the misperception that UD is an add-on for accessibility, and/or a means to address accessibility in places where the ADA Accessibility Guidelines (ADAAG) do not apply, such as in single-family residential housing. These views have delayed the adoption and application of UD and weakened the impact of its benefits due to our society's discomfort with aging and disability.

Universal Design is also conflated with aging in

place, and although these concepts overlap in several key ways, they are fundamentally different. Aging in place is a lifestyle goal; Universal Design features can be a means for achieving that. My definition of aging in place — the ability to successfully live in one's home of choice through old age — can in many cases be achieved through the use of UD features in homes for people of all ages. As such, UD is a means for making aging in place a reality as one ages in the home over time. Unfortunately, failing to apply UD commonly prevents successful aging in place. Modifications to correct age-biased design often come too late, after a person has already been disabled by the design of their home.

Lack of Understanding of the Status Quo

As so few practitioners are aware of the inherent biases designed into the buildings and products that we depend on, there is a lack of understanding and appreciation of UD. If architects, designers, and builders really understood UD it would be the standard way of designing, because Universal Design is, as the name indicates, "design for all."

Making Changes Too Late

Only 1 percent of the nation's housing stock has all five key universal design features necessary for successful aging in place:

1. A zero-step entry,
2. Single-floor living,
3. Wide halls and doorways that can accommodate a wheelchair (or a walker or person assisting),
4. Electrical controls reachable from a wheelchair, and
5. Lever-style handles on faucets and doors (JCHS at Harvard University, 2016).

Because of this, successful aging in place is not possible without home modifications (Joint Center

for Housing Studies at Harvard University, 2016, p. 9). These features are necessary for the individual's functioning and well-being and also to successfully allow for at-home care provided by family and/or paid home health aides and for the provision of Home & Community Based Services (which will receive an influx of just under $10 million from ARPA and a projected $150B from the Build Back Better Act). More importantly, these features must be viewed as powerful mechanisms to *prevent unnecessary design-related physical decline.*

Unfortunately, these interventions often come too late — after a loved one has already been disabled by the design of their home. These modifications are also an expense that many cannot afford on the fixed income of their retirement years. Many won't consider aging-in-place modifications until they or their parents actually experience a need for them due to health-related functional changes or being disabled by the design of their home.

The Power to Enable

Increasing awareness of the role of the built environment on the well-being of older adults has led to programs for aging-in-place home modifications, such as the Johns Hopkins CAPABLE program and environmental modifications through the Nursing Home Diversion Waiver program, as well as incorporating built environment domains as part of the WHO and AARP Age-Friendly Communities framework. While these are positive steps forward, there are two primary issues:

1. Many people cannot access these programs because they exceed income and asset thresholds.
2. Home modification programs are accessed *after* there is a need, when the homeowner has already been disabled by design.

In response to how these previous programs fall short, I have developed a key approach that may have significant benefits to individuals, their families, and society: Enabling Design.

The Enabling Design Approach was created as a response to:

- The aging of the population
- Inappropriate design typologies
- A conflation of Universal Design with disability and frailty
- A misperception of the ADA as a complete solution
- A bias against home modifications, equating them with frailty, disability, loss of independence
- A lack of knowledge of the true impact and costs of the status quo of the built environment on individuals, families, municipalities, and society as a whole

The key components of the Enabling Design Approach are (1) Theory, (2) Fact, and (3) Solutions.

1. **THEORY**
   M. Powell Lawton's Environmental Docility Hypothesis introduces the concept of environmental fit and press. When there is **good fit between a person and his environment**, the person can function at the highest level and be as independent as possible. However, the greater the gap between the environment's demands and a person's abilities, the more the person is subject to **environmental press**, a form of stress which *pushes them to an artificially lower level of functioning and greater dependency*. This is preventable by informed design that reflects the true needs, abilities, and behaviors across the lifespan, thereby enabling independence.
2. **FACT**
   The Status Quo is Disabling and Discriminatory. Data, conventions, and codes have created built environments that are optimally designed for the average-height male with high physical, cognitive, and sensory abilities. This requires everyone else to adapt. As we age, this adaptation can create forced frailty, the functional eviction from one's home, unnecessary expenditures, and impoverishment through depletion of assets.
3. **SOLUTION**
   The Enabling Design Approach is a solution that considers design, economics, policy, urban planning, and societal trends. It does not require radical changes in our built environments but an accurate understanding of the discriminatory and costly impacts of the status quo to create small but significant changes in features, approaches, and policies. Enabling Design is a vehicle for physical and financial independence as people age. Most importantly, it enables us to age with dignity and quality of life.

The Role of Financial Planners

Financial planners can be a crucial gateway to key resources for their clients to leverage the untapped power of design to maintain or improve their financial and physical wellbeing as part of a comprehensive retirement strategy. Financial planners can inform their

clients through materials, seminars, webinars, and special events including housing summits in partnership with regional home builders associations, offices for the aging, planning departments, and other relevant organizations.

A majority (66 percent) of adult children do not stay with their parents' financial advisors once they inherit their parents' assets (Skinner, 2015). By helping older adults retain their physical and financial independence, financial planners can also play a valuable role directly for the adult children by reducing their caregiving burden. For many women in particular, this can have enormous implications not only on their current life, but on their future retirement as well.

Middle-aged women need the expertise of financial planners for their aging parents, and because their future retirement critically depends on being provided an additional strategy for independence.

Why?

- Women tend to live longer than men, a trend that will continue for the foreseeable future (Medina et al., 2020).
- Women make up 61 percent of caregivers in the U.S. (AARP, 2020, p. 11).
- Although the gender pay gap has been shrinking, in 2021 women earn 84 cents for every dollar a man makes (Barroso & Brown, 2021).
- Women are more likely than men to take time out of the workforce for child rearing, caregiving for potentially multiple parents (especially with an increasing number of stepparents), as well as caregiving for their spouse/partner.
- In 2020, over 800,000 women left the workforce due to the pandemic (Ellingrud & Hilton Segel, 2021). The resulting lost wages mean today's childcare crisis is tomorrow's retirement crisis.

Enabling Design features may reduce a woman's risk of impoverishment and dependency by:

- Reducing her caregiving burden by enabling her parents and spouse to retain greater physical independence.
- Reducing the likelihood that she will need to use her own financial resources to cover her parents' expenses should they outlive their money.
- Increasing the likelihood that she will inherit assets from her parents and her spouse.
- In her own home, helping her to maintain her own physical independence as she ages.

The Role of Communities and Municipal Agencies

When referring to older adults in relation to community services, the default view is often based on their deficits. But rather than viewing older adults as a monolithic, homogenous group, communities can widen their lens. First, it's important to recognize that there is enormous diversity of abilities, finances, lifestyles, and needs, as well as race, ethnicity, and sexual orientation among older adults. Second, communities must expand the parameters of this group to include those down to age fifty. Why? Because by the age of fifty, most people are experiencing normal age-related changes to their senses, particularly vision and hearing. In addition, the qualifying ages for retirement and benefits frequently shift as programs and policies change.

Finally, the population of Americans aged fifty and older is responsible for a massive amount of economic growth, investment, and buying power. This portion of the economy is known as the Longevity Economy, and its significance has spawned numerous in-depth studies since the early 2010s. As of 2021, research on this sector has found:

- The Longevity Economy generates $.51 of every dollar in the U.S. economy.
- If looked at independently, it would be the third-largest economy in the world, behind only the U.S. and China.
- It is currently $8 trillion annually, and projected to triple by 2050 (Accius & Suh, 2019).

Communities, particularly municipal agencies such as planning departments, offices for the aging, and economic development offices, must understand the potential of this population. If communities fail to meet the needs of this group, they will move to other locales, taking their more than $600 billion of state and local taxes with them, as well as their other expenditures.

Prepare to Leverage Federal Funds

The American Rescue Plan Act (ARPA) and the Bipartisan Infrastructure Investment and Jobs Act, and the Build Back Better Act (as of 11/16/2021), will provide funds to communities to improve, among others, transportation systems, housing, broadband, and services for older adults. These new funds will reinforce and expand the continued shift to Medicaid's Home and Community Based Services (HCBS) programs. While this not only reflects the economic advantage of providing care at less cost within a private residence

as opposed to a facility, it also supports older adults who have expressed the desire to age in the home of their choice (Binette et al., 2019).

These funds represent important opportunities for our communities, but they bring up a trio of issues that must be considered and addressed:

- How will communities effectively provide increased Home and Community Based Services when their housing stock and infrastructure work against this and artificially increase the demand for such services?
- How will home health aides and nurses provide care for residents at home if they cannot afford private transportation and the community lacks transportation options that work for people who reverse commute away from the central business district and into residential areas, and who provide one- to four-hour shifts including nights and weekends?
- How will home care be provided in housing that is not designed for the needs and abilities of older adults?

Apply the Enabling Design Approach

Communities can prepare to effectively and efficiently utilize the coming federal funds by applying the Enabling Design Approach. This involves conducting a community assessment of their built environments (especially the housing stock), services, zoning codes, and current home modification programs in order to identify existing assets as well as necessary changes. Communities must identify the home design features that they should incentivize or require to be incorporated into renovations, and more importantly, to all new construction. Communities can do the above independently, or as part of a larger Age-Friendly Community program.

Conclusion

We cannot create complete and effective solutions if we only see part of the problem. Having an accurate understanding of the status quo of housing and community design is necessary to successfully meet the needs of people as they age. The forced frailty, eviction from one's home, impoverishment, and reduced quality of life created by standard housing should not be accepted or tolerated and we have the power to address it. Financial planners and community organizations can exponentially impact their clients' and citizens' physical and financial independence in retirement by serving as a key vehicle and gateway to approaches, programs, and resources. •CSA

AMERICANS WITH DISABILITIES ACT

While the Americans with Disabilities Act (ADA) and the accompanying Accessibility Guidelines (ADAAG) have had enormous positive impacts, significant gaps remain.

- **The ADAAG does not apply to all physical spaces. Exempt places include, but are not limited to: single-family residences (where the majority of Americans live) and residential spaces with less than four multi-family units. Furthermore, many older places are "grandfathered"/exempt because modifications would constitute "undue hardship."**
- **The goals of the ADAAG are not to enable people to thrive, but to remove minimal barriers to access. While it does so to an extent, many places supposedly designed in compliance with these guidelines are still poorly designed for independence and also may be missing key features.**
- **The ADA and ADAAG minimize barriers for persons with disabilities. This is crucial but what about the millions of people who do not have defined disabilities but do not fit the parameters for which the status quo was designed?**

RESOURCES

AARP Age-Friendly Communities
Articles on aging in place, plus a link to the CAPS directory. http://www.aarp.org/livable-communities/network-age-friendly-communities/info-2014/an-introduction.htm

AARP's HomeFit Guide
A resource for evaluating your home's readiness to meet your needs as you age, and planning modifications if needed. AARP's HomeFit Guide

AARP The Longevity Economy
Overview and link to report on the economic impact of the population fifty and older. http://www.aarp.org/about-aarp/press-center/info-09-2016/aarp-announces-longevity-economy-activity-increase.html

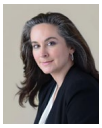
Johns Hopkins CAPABLE Program
CAPABLE is a program developed at the Johns Hopkins School of Nursing for low-income seniors to safely age in place. *https://nursing.jhu.edu/faculty_research/research/projects/capable/*

National Association of Home Builders Aging In Place Remodeling Checklist
Aging In Place Remodeling Checklist

National Association of Home Builders CAPS Directory
Use this directory to locate professionals who have achieved the Certified Aging in Place Specialist (CAPS) designation. This includes builders, remodelers, designers, architects, occupational therapists, physical therapists, realtors, and mortgage specialists. *NAHB CAPS Directory*

Nursing Home Transition and Diversion Program
A government program to keep, or return, people to aging in the community vs. in a facility.
https://www.health.ny.gov/facilities/long_term_care/nhtd/index.htm

Veterans Administration Grants
Veterans may be eligible for home modification grants. Veterans whose need is not service-related may be eligible for Home Improvement and Structural Alterations (HISA)grants of up to $2000. https://www.prosthetics.va.gov/psas/HISA2.asp
Veterans whose needs are service-related may qualify for more significant grants under the Specially Adapted Housing Grant (SAH) or the Special Housing Adaptation Grant (SHA). https://www.va.gov/housing-assistance/disability-housing-grants/



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Carers can mitigate compassion fatigue by refocusing on their passion and purpose, known as their compassion satisfaction, early and often.

BY E. AYN WELLEFORD, MSG, PHD

An Appreciative Approach to Building Compassion Satisfaction

Stories of compassion fatigue are as plentiful and unique as the professional and family carers who share them. The impact of compassion fatigue on individuals and organizations is well documented in the research literature (Figley, 1995; Stamm, 2016; Cocker & Joss, 2016; Nolte, Downing, Temane, Hastings-Tolsma, 2017; Flarity, Nash, Jones, & Steinbruner, 2016). In addition to the physical and emotional symptoms experienced at the personal and relation levels, compassion fatigue has professional and organizational ramifications, ultimately impacting quality of care. While helping professionals and family carers are not strangers to the experience of compassion fatigue, many have little familiarity with, or focus on, training to build *compassion satisfaction*, the antidote to compassion fatigue.

Sharing a Common Language Around Compassion Fatigue

Compassion satisfaction and compassion fatigue can be seen as occurring simultaneously as two sides of the same coin: the positive and negative consequences of caring (Stamm, 2016). "Compassion fatigue is defined as a state of exhaustion and dysfunction — biologically, psychologically, and socially — as a result of prolonged exposure to compassion stress and all that it evokes" (Figley, 1995, 253). Compassion stress may be felt in association with exposure to one who is suffering or experiencing trauma (Figley, 1995). Burnout and secondary traumatic stress (STS), both frequently discussed in conjunction with compassion fatigue, are two possible pathways to compassion fatigue. Either may singly or in combination result in compassion fatigue if the symptoms are not mediated through the presence of compassion satisfaction. Burnout, or chronic overload, most associated with the work environment occurs when demands exceed resources. STS is the stress felt due to caring for a traumatized person or carrying another's stress. Some researchers suggest that burnout occurs over time, while STS may come on suddenly due to exposure to another's trauma.

An important, yet infrequently discussed, component of the narrative of care is compassion satisfaction. Compassion satisfaction can be expressed as the joy, sense of purpose, and meaning derived from one's work of caring (Flarity, et al., 2016) or the emotional labor of caring. In other words, compassion satisfaction is about connecting and remaining connected to one's own unique sense of purpose, or "big why," as a helping professional or carer. Your big why, typically represented in a narrative, blends purpose and strengths. It may be a story from your past or a present day experience. As a helping professional, your big why may be the joy felt in a caring relationship with a family member or loved one, an experience with a client where you helped make a difference in that person's life, a time when you were able to bring positive change through your own skills and strengths, or the experience of gratitude expressed by co-workers.

Shirley's Story

Shirley grew up close to her grandparents. She has many fond memories of their time together and all she learned about family, tending a garden, work ethic, and most importantly, dreaming big. When Shirley's grandmother became ill, Shirley helped out in the afternoons. Their relationship grew as they spent more time together, sharing stories. Shirley enjoyed the time they spent together coming up with creative ways for her grandmother to continue to do the things she enjoyed. Shirley was compassionate, enthusiastic, and a creative problem solver. Her grandmother seemed to be comforted when they were together. Shirley felt at ease and at home.

No one was surprised when Shirley decided to become a nursing assistant. As the newest hire at the assisted living facility, Shirley frequently found herself as the "floater" caring for residents wherever staffing was required. Early on, Shirley found herself struggling to feel purposeful in her work and often felt overwhelmed. There was not time to get to know the residents and support them as she had hoped. She also felt poorly equipped to meet the diversity of needs. Spending each day with different people offered little opportunity to see the outcomes of care before Shirley moved on to a different part of the community. She never felt fully competent given the ever-changing faces. Shirley felt deflated.

Further escalating her struggles, Shirley wasn't able to connect with a consistent team of coworkers and felt she had nowhere to turn for support and guidance. Shirley knew she needed solutions but didn't know what to do or where to turn. She was beginning to feel that this wasn't her calling after all.

Compassion Fatigue: What Does it Look Like?

In Nolte's metasynthesis with nurses, the authors coalesced the lengthy lists of potential physical, emotional, and triggering symptoms into the following apt phrases of the felt experiences of compassion fatigue: the feeling of being wrung out or worn out, the feeling of walking a tightrope, and feeling alone in a crowded room (2017). Each expresses the felt and debilitating dysfunction of the negative consequences of caring that, if untended, can result in compassion fatigue.

Compassion Fatigue: Who is Most at Risk?

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet," (Remen, 1996).

It is fair to say that all who care are at risk for compassion fatigue based on the two components of empathy and exposure, as initially identified by Figley (1995). However, a deeper dive into more recent research indicates that we are not all at equal risk. The simple act of being in a relationship with another brings both positive and negative results of caring. Additionally, personal traits such as perfectionism, social isolation, low social support, and poor boundary setting may increase one's individual risk. Professional or work role factors such as having no off-switch or a tendency to put others needs first and organizational factors such as a culture of silence, lack of training, or administrative demands all fold together to create a complex recipe of risks for compassion fatigue.

Nolte shared the following reflection regarding individuals at greater risk for compassion fatigue: "There were feelings ... of not being able to identify options to deal with stress ... unable to diffuse the distress they experienced … through use of internal dialogue with self or verbalization with others — strategies believed to distance … from compassion fatigue." Those who were unable to internally dialogue regarding care provided, diffuse stress, and maintain perspective faced significant inner conflict to "opt out" (Nolte, et al., 2017, p. 4369). This speaks to what Flarity refers to as the exhaustion funnel, in which individuals with this level of fatigue have spiraled far beyond the safety of the buffering provided by compassion satisfaction, basic wellness practices, and resiliency tools to pull themselves back from the debilitation of compassion fatigue. In depleted states people do not have the best use of their existing skills and tools. They are unable to work from a place of strength. Nolte's quote alone demands that we shift the narrative about compassion fatigue. We cannot simply suggest that "people" (ourselves included) "take better care of themselves". When carers find themselves feeling wrung out, as if they are walking a tightrope, or feeling alone in a crowded room (Nolte, et.al., 2017) they have spiraled too far down the exhaustion funnel (Flarity, et al., 2016) to be able to disrupt the path to compassion fatigue with their existing personal and professional resources and tools. It is time to upskill: to reach in and to reach out.

An Appreciative Approach to Building Compassion Satisfaction

How do we rebalance or harmonize the positive and negative consequences of care? Just as the risk factors and effects of compassion fatigue are multidimensional, so are the protective factors and skills needed to rebuild compassion satisfaction (Figley, 1995; Nolte, et al., 2017; Cocker & Joss, 2016).

First, let's rethink the frequently used oxygen mask metaphor. Let's be clear: the oxygen mask only falls from the overhead when the plane is losing cabin pressure. There is obvious trouble, and the passengers are likely feeling unsettled and distressed. Is that when we want to consider measures to prevent compassion fatigue or implement basic wellness practices? Spiraling toward dysfunction: Is this the ideal time to implement effective wellness practices, reach out for support, or request institutional change? Herein lies the challenge: oftentimes when people find themselves far along the path to compassion fatigue they are unable to operate from their best selves. Building on one's compassion satisfaction and creating a climate of compassion can help mitigate the effects of compassion fatigue before dysfunction occurs.

Whether the goal is to disrupt the path to compassion fatigue for oneself, a colleague, or a family carer, embracing an appreciative mindset allows a strengths-based approach (Bloom et al., 2008) to creating a climate of compassion. Being aware that the narrative of care involves both positive and negative consequences enables helping professionals to begin to rebalance and harmonize the experiences of emotional labor. Creating a shift from a deficit- to a strengths-based mindset offers a fresh starting point for seeking opportunities to bolster self efficacy and resilience.

Reach In! Compassion Satisfaction is the Antidote to Compassion Fatigue

Building (or rebuilding) compassion satisfaction is an inside job. A daily practice of reminding themselves of their joy and sense of purpose, and of their strength stories can be a protective force against compassion fatigue. Compassion satisfaction is the joy, purpose, and meaning derived from one's work (Flarity et. al., 2016) and I would argue, the antidote to compassion fatigue. Because of the important mediating role of compassion satisfaction in reducing or preventing compassion fatigue, building resilience, self efficacy, and meaning making are essential to the transformation from negative to positive aspects of caring (Stamm, 2016, Cocker & Joss, 2016). But before people can retool and build resilience, they must connect (or reconnect) with the satisfaction derived from caring and their big why.

Disarm

Disarming is described as the use of positive, active, and attentive listening along with questioning strategies aimed at building trust and rapport with others (Bloom et al., 2008). Disarming creates a climate of compassion, nurturing and nourishing a sense of belongingness, normalizing the human experience and creating connection. This may start with awareness of the experience of compassion fatigue, normalizing the experiences, being non-judgmental, asking trauma-informed questions such as "What happened?" instead of "What's wrong with you /me?".

Creating a climate of compassion for self and others is like having a personal and/or professional forcefield of protection. Remember that the duty to self is the first layer of this forcefield.

Just as professionals would create a sense of person-centered safety and compassion for a client around respect for self, inclusivity, open dialogue, and transparency, a personal climate of compassion for self and others starts here as well. It begins with maintaining connection with one's own personhood and big why in order to harmonize the consequences of care: compassion fatigue and compassion satisfaction. While compassion fatigue may not be eliminated, maintaining a connection to compassion satisfaction is an essential antidote to altering the path to compassion fatigue.

Many people have never had an open and frank conversation with themselves about their own climate, never giving a thought to self-compassion until their metaphorical plane is in trouble. It's time to rethink that narrative.

Discover *(or Rediscover)*

Discovery is defined as connecting with strengths and skills and past successes (Bloom et al., 2008). Building compassion satisfaction begins with connecting to one's own big why. Identifying one's own big why is an ethical imperative as a helping professional. Remaining focused on one's own big why creates an alignment with how the values of helping professionals and the principles of person-centered care present in daily practice. Your big why is the first tool or guiding principle in your toolkit as a helping professional. Carers must keep this tool with them at all times, keep it polished and in good shape as a reminder of their own person-centered values. Remaining connected to one's big why will serve as a guide and protection against the ramifications of compassion fatigue. Each person's big why is the home to their own special professional

ethic and moral imperative, guiding their ethical practices as helping professionals.

Shirley's story

Shirley knew her big why was to help create solutions for people to live their best lives even in the face of illness. In her current role, she was struggling to feel self efficacy and strength; she wasn't feeling aligned with her calling. Shirley's grandmother was her inspiration. She had helped Shirley discover her purpose. How was Shirley to reconnect with her purpose now, when the setting felt so different?

Dream

Carers must encourage and be inspired by stories and dreams (Bloom et al., 2008). Sharing strength stories with trusted friends and colleagues is an important part of building compassion satisfaction, keeping it ever present by giving it voice. Collecting stories that inspire is an important step toward designing one's path. Dreams energize, inspire, and motivate carers to maintain focus on their joy and sense of purpose.

Shirley's story

One evening when Shirley was headed home, a volunteer whom Shirley had frequently seen delivering mail throughout the community stopped her to chat. Estelle, a long-time volunteer, knew all of the residents. She had heard Shirley talking with Mr. Jones earlier in the week and shared that Mr. Jones seemed noticeably cheerier for rest of the day. Thinking about her grandmother's positive attitude and resilience, Shirley told Estelle one of her many inspiring stories. The two planned to have lunch together the next day to talk more. Through this brief conversation, Shirley felt her mood shift. She finally felt as if, once again, she was making a difference in someone's day. She felt seen. She felt heard. She felt that her work mattered.

Design

Carers may co-construct an action plan to make dreams and goals a reality (Bloom et al., 2008). Creating a climate of compassion involves designing a formula for one's own basic wellness practices. As Dr. Felicia Vaughan (2020) notes, developing a daily wellness practice requires discipline and consistency. Professionals must apply the same commitment to their own wellness that they recommend to clients and patients.

Self compassion and self nurturing are more than bubble baths, a day on the golf course, mani-pedis, and shopping sprees. Self care begins with daily basic wellness practices. It is imperative that carers think about their own self-care practices as they would think of a care plan they would recommend for a client, grounded in the *big six basic wellness practices*:

- Sleep/Rest
- Diet/Nutrition
- Hydration
- Elimination of toxins
- Exercise/Mobility
- Social/Emotional Engagement

Developing one's own unique formula of basic wellness is an essential demonstration of one's own self-honoring mindset and practice around duty to self. A framework grounded in the big six basic wellness practices likely looks familiar to readers because these are the components for building any basic care plan. Designing and delivering, with discipline and consistency, one's formula for basic wellness is a direct demonstration of self-compassion. This will not occur by adding yet another task to the to-do list, but by being mindful of daily basic wellness practices. It's time for caring professionals to design a care plan for themselves for a change. Self care is only selfish if one never cares for others. For carers, self care is the foundation for providing person-centered care.

"Rest and self care are so important. When you take time to replenish your spirit, it allows you to serve others from the overflow. You cannot serve from an empty vessel." —Eleanor Brown

Deliver

Whether people are designing their own compassion satisfaction plan or supporting another in designing their own, delivery is about putting that plan into action. A strategy to follow here is one of: Stop, Start, Continue. Ask yourself the following questions:

Stop. What is one thing that you could stop doing that would make the biggest difference in building compassion satisfaction? Focus on micro-goals to build self efficacy. Choose something doable and then cut it in half. Choose the tiniest change. For example, choose to take the stairs instead of the elevator, even if just one flight. Instead of scrolling through news and social media, go to bed half an hour earlier. Instead of rushing in to the next meeting, pause and give yourself sixty seconds to breathe. Tiny changes add up over time.

Start. What is the one thing that you could start doing that would make the biggest difference? For example, drink an extra glass of water. Choose one

action that would create compassion for yourself and others. Remind yourself each morning of your big why. Tell yourself one of your own strength stories on the way to work. Ask a co-worker about his or her big why and share the inspiration together.

Continue. Ask yourself, "What is working here?" and do more of that.

Shirley's story

With Estelle's encouragement, Shirley began writing down and sharing the stories from her grandmother. She also began collecting stories from elders she met at the community. The residents enjoyed knowing that their stories were important to Shirley and they took joy in sharing new stories when they met. Sharing stories from her grandmother reminded Estelle each day of her big why. While she still felt overwhelmed from time to time, the reminder brought her joy and also bolstered her resolve to reach out to her supervisor for additional training and support. Looking back on the experience of being a "floater," Shirley realized that, while it hadn't been ideal, it was an important part of her story.

Don't Settle. There is no single magic pill for building compassion satisfaction, but you can create a formula to help harmonize the positive and negative aspects of care. Just as the risk factors for compassion fatigue are multidimensional, building compassion satisfaction involves consistent commitment to remaining aligned with your big why, creating a climate of compassion, retooling, and uptooling when necessary, embracing the positive restlessness of appreciation and a self-honoring mindset. An appreciative approach to building compassion satisfaction calls us to keep focused on strengthening our strengths.

Conclusion

"The most insidious aspect of compassion fatigue is that it attacks the very core of what brings helpers into this work: their empathy and compassion for others" (Figley, 2012, p. 4).

While more research is needed, professionals know enough to say that compassion fatigue is an occupational risk for helping professionals and family carers. As helping professionals, our first duty is to ourselves, to keep ourselves fit for duty, our skills sharp, our caring response at the ready. In addition to duty to self, we have a special professional ethic to our colleagues, interns, families, and trainees to be proactive in bolstering the positive consequences of care and to best prepare for the negative consequences (Figley, 1995). This begins by changing the narrative about the consequences of care, remaining connected to our big why, our meaning and purpose, reminding ourselves of our strength stories, and creating compassionate communities by encouraging others to do the same. •CSA

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Top Risks to Retirement Income

Part 1 of 2

Running out of money in retirement is a constant fear for most older adults.

BY AARON RUBIN, JD, CPA, CFP®

The old saying goes, "While working, it's all about building assets; in retirement, it's all about cash flow." Mismanagement of cash flow or its underlying assets, as well as externalities, can threaten an older adult's quality of life. Over two articles, we'll explore the top threats to successful cash flow and how retirees can position their finances to protect against them.

1. Inflation

Inflation is the silent killer of investment portfolios. No matter what the return on any particular investment, the true tale of performance is told by the inflation-adjusted (often called "real") return. The most common method of tracking inflation in the United States is the Consumer Price Index (CPI). The CPI is calculated by the U.S. Bureau of Labor and Statistics (BLS) and is "a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services" (BLS, 2021).

A host of categories are included in the CPI calculations, namely food, energy, and other goods and services (BLS, 2021). The "other" category includes clothing, vehicles, shelter, transportation, and medical services. Medical services are broken down into two subcategories: physician's services and hospital services (BLS, 2021). While it is a crude measure of how most people's lives are costing more over time, the CPI at least provides a starting point. From 2015 to 2019, inflation averaged 1.8 percent per year, according to Dimensional Fund Advisors (DFA, 2021). In other words, the cost of living in the U.S. was 1.8 percent more expensive every year. If investors earned less than 1.8 percent on an investment, they essentially fell behind from an inflation-adjusted perspective.

For retirement portfolios, inflation tends to be even more silent and more deadly than outlined above. The main problem with retirement portfolios and inflation is that in retirement expenditures tend not to be allocated in the same way as during a person's working years. While prior to retirement people tend to spend more on clothes and transportation, retirement curbs those expenditures and increases spending on leisure and health care.

Eventually, leisure gives way to health care as the primary focus of retirement dollars. It is here that a plan gets tripped up. BLS tracks medical care specifically and even produces the Medical Care Index (MCI) that tracks the cost of health care. According to the MCI, health-care inflation rose over 33 percent between 2011 and 2020 (BLS, 2021). This is nearly double the traditional CPI rate.

What to do about inflation, particularly medical inflation, within a retiree's portfolio is a delicate dance. On the one hand, returns in the stock market tend to perform well above inflation. The S&P 500 has returned 13.88 percent per year over the last ten years (DFA, 2021). However, market volatility can

decimate a portfolio in retirement, when funds must be withdrawn for living expenses. On the other hand, bonds probably don't perform well enough to stay ahead of medical inflation. Barclay's Aggregate Bond Index has returned 3.84 percent annually over the last ten years (DFA, 2021).

A balanced distribution portfolio should have a healthy mix of both equities and fixed income to stave off the threat of inflation, and yet also protect against market volatility. In the graph on the next page, we see two portfolios, one invested 100 percent in the S&P 500 starting out and another portfolio that is 65 percent in the S&P 500 and 35 percent in short-term bonds. If we have a set withdrawal rate of 5 percent for both portfolios and increase withdrawals by 3 percent per year, we see the 100 percent stock portfolio quickly runs out of money because of market volatility, while the one that has the bonds can sustain itself for a much longer period of time.

Those looking for adequate cash flow should also be careful with annuities. While annuities do provide needed stability for retirement cash flows, they often do not contain inflation riders, and so the inflation-adjusted benefit therefore goes down over time. Consumers and professionals should be careful around planning, and ought to price out inflation-adjusted riders, though they tend to be more expensive.

2. Overspending

It seems like a truism that overspending in retirement would lead to problems with portfolio longevity. Certainly, those that have champagne taste on a beer budget will struggle no matter how much they've saved, if they've managed to save anything for retirement at all. The question is how do we define overspending?

Many advisors are familiar with the "4 percent rule." In short, the common belief is that if retirees limit their withdrawals from a diversified portfolio to 4 percent, they have little to worry about when it comes to running out of money, even if the stock market faces a serious decline. However, the common understanding of the rule may be a bit of a misconception.

The 4 percent rule stems from an article written by William Bengen in 1994. In his article, he grapples with how to advise clients on a reasonable rate of withdrawal. He attempts to quantify what the correct rate of withdrawal might be for a retirement (or distribution) portfolio. What concerns Bengen is not the average rate of the return, which was 10.3 percent per year compounded in common stocks, and 5.1 percent per year for treasuries, but the effects of distributions on portfolios during severe market declines (Bengen, 1994).

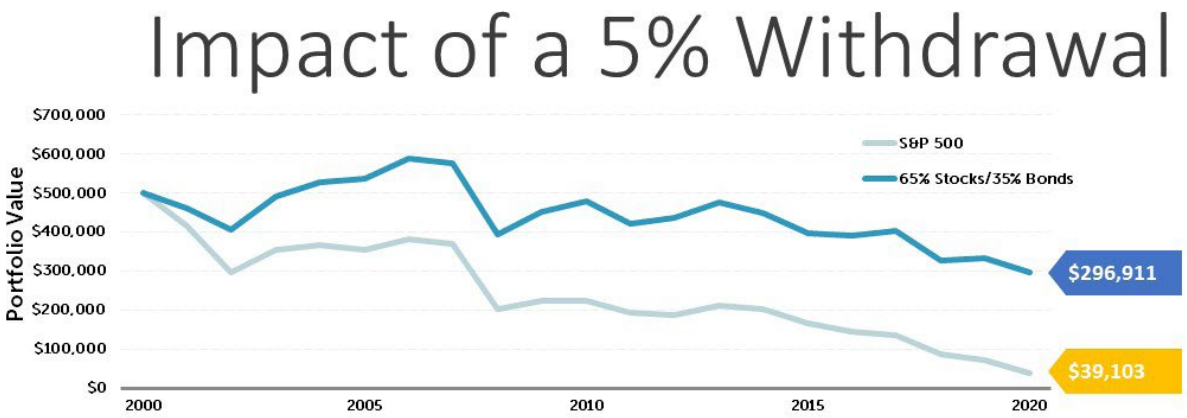
Bengen assumed that most people would have around a 30-year retirement, and based success off modeling portfolio persistence over that period of time. He demonstrated that if people had a portfolio that was 50 percent in stocks and 50 percent in bonds, they could safely withdraw 4 percent per year, even if they had started their withdrawals right before the Great Depression. However, Bengen did not preclude the possibility of taking 5 percent per year from a portfolio, only that it was riskier than 4 percent (note he called a 6 percent withdrawal rate "gambling").

But is this 4 percent rule still useful with today's markets, or have we evolved beyond that limitation? Part of the problem with Bengen's rule is that he assumed that after year one, a person would withdraw enough to compensate for inflation. Portfolio cash flow is much more nuanced. Often, the portfolio starts at a particular rate of withdrawal, and the distributions may be steady for a string of years. Then, various large-impact events (medical, housing, etc.) begin to negatively affect expenses with more frequency and it becomes clear the amount being withdrawn is no longer sufficient. The size of the portfolio relative to the new demands is re-evaluated, and the client and his or her advisor establish a new withdrawal rate.

Economist Michael Kitces self-published his own findings using a slightly different methodology. Kitces back-tested various portfolios over rolling periods of time, and found the range of sustainable withdrawals based on a portfolio 60 percent stocks and 40 percent bonds to yield between 10.8 percent to 4.4 percent with the median being 6.2 percent (Kitces, 2008). Using Bengen's methodology, this would mean the safest withdrawal rate is actually 4.4 percent. Bengen would eventually update his research to include small cap stocks and settle on 4.5 percent as an appropriate starting withdrawal rate on a 50/50 portfolio (Berger, 2020).

This is not to say that 4.5 percent is the end of the discussion; it merely sets the bar for how to think through systematic withdrawals. For many, the distribution rate is not the minimum required to make their lives run. There are a great deal of luxuries that go into a retirement budget, and a conversation that involves paring back those luxuries in falling markets can go a long way to raising the withdrawal rate. If clients do set their withdrawal at the historical median of 6.2 percent for a 60/40 portfolio as found by Kitces, there is significant peril (recall that Bengen called it gambling).

But what if there were a frank discussion with the client setting expectations up front? The advisor could tell the client that starting at 6.2 percent is fine, but should the market return 4 percent or less in a given



Source: Morningstar Direct 2021. Hypothetical value of $500000 invested on December 31, 2000 and kept invested through December 31, 2020. Withdraw is 5% of initial hypothetical value ($25,000 of initial $500,000 starting value) taken out at end of each year, growing by 3% per year. Allocation is 100% S&P 500 TR, and 65/35 Mix represented by: 0.5% (Cash), 6% (DFA Emerging Markets Value I DFEVX), 21% (DFA Five-Year Global Fixed-Income I DFGBX), 7% (DFA International Small Company I DFISX), 13% (DFA International Value III DFVIX), 5% (DFA Real Estate Securities I DFREX), 13.5% (DFA Short-Term Extended Quality I DFEQX), 10% (DFA US Core Equity 1 I DFEOX), 14% (DFA US Large Cap Value III DFUVX), 10% (DFA US Small Cap I DFSTX). The performance data quoted represents past performance. Past performance does not guarantee future results and principal value will fluctuate so that an investor's shares, when redeemed, may be worth more or less than their original cost. Indexes are unmanaged baskets of securities that are not available for direct investment by investors. Index performance does not reflect the expenses associated with the management of an actual portfolio. Portfolio returns are the weighted average returns of the respective funds, rebalanced annually. Actual rebalancing may be different. The portfolio allocations are based on a Buckingham model portfolio, which may not be suitable for all investors. It may not reflect the impact material economic and market factors might have had on decision making if clients' money were actually being managed at that time. The performance quoted reflects the reinvestment of dividends and capital gains distributions. Portfolio performance does not reflect the deduction of any fees charged by an independent investment advisor or other service provider to an individual account. Such fees, if taken into consideration, will reduce the performance quoted above.
Indices are not available for direct investment. Their performance does not reflect the expenses associated with the management of actual portfolios nor do indices represent results of actual trading. Information from sources deemed reliable, but its accuracy cannot be guaranteed. Performance is historical and does not guarantee future results. Total return includes reinvestment of dividends and capital gains.

year, the following year would have to have a reduction in spending; or, if there is a market decline of a certain severity, then there would have to be an immediate cut in withdrawal. This, along with keeping a significant cash reserve, may allow for higher rates of withdrawal than would otherwise be advisable. Of course, some retirees do not have wiggle room in their budget, and 4.5 percent may be the best option.

3. Underinsurance

One time when I started talking with a client about life insurance, he sardonically replied to me, "I want to take care of my family, but I'd like them to be sad when I die." Insurance is one of those difficult conversations that requires clients to consider themselves in a casket or in a facility. Either way, being underinsured in either life insurance or long-term care insurance can cause cash flow problems for the retiree and family members alike.

Life insurance fulfills many needs, ranging from estate creation to an estate tax tool. However, for cash flow purposes, we should think of life insurance for its income replacement properties. While we tend to think of income replacement as a problem for young families, the truth is that the income replacement function extends far beyond the working years.

When planning for cash flow into retirement, common sources include Social Security, pensions, and annuities. Social Security presents an interesting problem since when one spouse dies, the lower of the two payments will go away. This can lead to a major shortfall for the surviving spouse. Imagine a situation where one spouse was receiving $35,000 a year in benefits, and the other $30,000. The death of one of them cuts their retirement income nearly in half. It's possible that the household expenses will be reduced, but probably not to the same extent as the income lost.

Similarly, many people take annuities and pensions over a single lifetime. Joint products might be too expensive or the benefit not rich enough to support their lifestyle. To increase annual income, families may choose to take the benefit over a single lifetime. This, of course, comes with the danger that the annuitant or the pensioner dies prior to his or her spouse, and again the surviving spouse is forced to live on a reduced level of income.

To plug that hole, a couple can consider life insurance. A first-to-die policy probably makes the most sense for a Social Security situation. In that case, the income they are attempting to replace is known, and rises in the cost-of-living benefits can be estimated somewhat accurately. How many years of income to be replaced is the driving factor for determining face value. The level of risk aversion of the client, coupled with life expectancy tables, also inform on the optimal insurance value.

The annuity or pension scenario based on a single life is a better case for a single insured policy. The problems surrounding how much face value should be applied for persist. But a more risk-averse retiree, or those with perceived longevity issues, should seek additional insurance.

As with all insurance products, risk factors can make the insurance cost prohibitive. Those nearing retirement may want to consider whole life policies to be certain the coverage lasts long enough, and those in retirement may want to use longer-duration term policies to keep costs down. If necessary, the term policies should be able to convert to permanent, in case longevity becomes an issue.

Aside from losing income in retirement, a retiree must be concerned about extraordinary expenses. The average cost for a private room in a nursing center facility is nearly $9,000 per month nationally. In areas with higher costs of living, like the San Francisco Bay Area, it tops more than $15,000 per month (American Council on Aging, 2020). There are a variety of factors that go into the costs, including regional factors (the Bay Area of California is a lot more expensive than Birmingham, Alabama, for example). Either way, such expenses are a drain on resources, and for a couple can be life altering.

Many times, a family relies on home equity as a backstop against the meteoric costs related to late-life medical expenses. However, in a situation where one spouse has enough cognitive impairment to warrant, or even require, a facility, and the other still has substantial independence, covering the needs of both is a seemingly impossible task. Many times, family members may step in and offer shared living arrangements if the home needs to be sold, but this is far from ideal. Add in the fact that if one spouse uses all of the family resources, that means the other spouse may not have their needs met when their time comes.

Many retirees errantly think that if they have Medicare, they don't have to worry about these kinds of expenses. However, Medicare is vastly insufficient and most often irrelevant when it comes to living in a facility since it only covers things like hospital care, doctor services, and medical supplies. Thus, a person needs to have another plan to pick up the additional costs.

Thankfully, insurance companies offer a long-term care (LTC) product. LTC covers many of the expenses that Medicare typically does not. Limits on the policy include a daily limit and often a benefit limit as well. Advisors also must pay attention to in-home care limits and other restrictions that LTC policies often contain.

Current LTC coverage is usually a hybrid that is expressed as a rider to a life insurance policy. The benefit limit is often a multiple of the face value of the life policy. As the insured uses the LTC benefit, it decreases the face value of the life insurance. Should the insured not use the LTC rider, his or her beneficiaries end up with the whole face amount.

In managing retirement cash flow, there are many potential roadblocks and pitfalls that await the unaware retiree. Older adults would be wise to work with advisors who have expertise in cash flow management. More importantly, advisors should collaborate with experts to make sure that their clients are prepared to take on the challenges that are bound to pop up along the way. Having a strong network of investment advisors, insurance brokers, and financial planners is important to give the client the best chance of success even in the most challenging of times. •CSA

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Purchasing a Home with No Monthly Mortgage Payments—*How is THAT Possible?*

Many older adults could benefit by using this little-known, non-traditional mortgage product.

BY J. D. DINNOCENZO, MBA, CSA, CMP

Tom and Mary were thrilled to be moving to Florida to begin their retirement. They found the perfect home on a beautiful golf course and were excited about starting a new chapter in their lives. After applying for a mortgage, they were devastated when they received the phone call from their loan officer advising them their loan had been denied. Unfortunately, this scenario is all too common.

One of the biggest challenges that older adults face today when purchasing a home is that they typically do not qualify for a traditional mortgage. The primary reason for this is that their retirement income is not sufficient to meet the rigid debt-to-income guidelines set forth by Fannie Mae and Freddie Mac. So, they're forced to buy less home than they would like and/or use a substantial amount of cash reserves to purchase the home, or even possibly lose hope of being able to move at all. Fortunately, there's a solution.

Home Equity Conversion Mortgages

The Home Equity Conversion Mortgage or HECM (also known as a reverse mortgage) is often an ideal solution to help older adults purchase a home using a non-traditional mortgage product. Although the HECM mortgage has been around since 1987, it wasn't until 2009 that the Department of Housing and Urban Development (HUD) approved the use of a reverse mortgage for home purchase transactions.

So, how does a reverse mortgage work when buying a home? In a *HECM for purchase* transaction, the buyer brings an equity contribution to the closing in the form of a down payment. The down payment is about 50 percent of the purchase price and the balance of the purchase is financed using a reverse mortgage. To better understand how the transaction works, let's look at an example: a buyer is purchasing a home for $400,000. The home buyer would secure a reverse mortgage for $200,000 and bring the other $200,000 to closing to cover the down payment and closing costs and ends up with a mortgage that has no monthly payment — it's that simple!

The actual loan amount may be higher or lower depending on the borrower's age, home value, and current interest rate. Although the amount of the down payment may seem high compared to the usual 20 percent down payment in a traditional mortgage, home buyers using a HECM to purchase a home typically are selling a home that is either paid off or has a significant amount of equity, so a large down payment is not an issue.

Right-Sizing and Dream Home Strategies

There are two primary strategies where a HECM for purchase can be utilized: the right-sizing strategy, and the dream home strategy.

The **right-sizing strategy** is typically where homeowners are down-sizing from the large family home where they raised their children and want to purchase a home that better suits their current needs, such as a single-story home with less maintenance or a home in a warmer climate.

Tom and Mary decided to sell their large home in New York and move to Florida where it doesn't snow. Their New York home is worth $625,000 and they have no mortgage. Tom and Mary sell their home for $625,000 and net $600,000 after real estate fees. They find the perfect home in sunny Florida valued at $400,000. Tom and Mary could easily pay cash for their new home, but instead they decide to utilize a HECM for purchase mortgage of $200,000 and bring $200,000 cash from the sale of their New York home. This right-sizing strategy allows Tom and Mary to move into the perfect home while putting $400,000 into their savings to help fund their retirement.

In the **dream home strategy**, Tom and Mary have the same $600,000 to invest in their new home, only this time they find their dream home on a golf course and it costs $800,000. Again, they take advantage of the HECM for purchase and buy their dream home. They utilize a HECM loan for $400,000 along with $400,000 from their available funds to buy the house and still have $200,000 left over to put away for their retirement.

In both strategies, Tom and Mary have moved into a new home that better suits their needs and even saved some money to help make their retirement easier. In both scenarios, they have no monthly mortgage payment. However, Tom and Mary are still responsible for paying their annual property taxes, homeowner's insurance, homeowners association fees and routine home maintenance. Because there are no monthly mortgage payments made with a HECM loan, it is important that homeowners budget for their annual property charges when preparing their financial budget.

Other Uses for the HECM Product

While the reverse mortgage can now be used to purchase a home, traditionally the product has been used to payoff an existing "forward" mortgage. The elimination of a monthly mortgage payment can make a tremendous difference in the life of older adults who are on fixed incomes. Older homeowners are also using reverse mortgages to do home improvements, travel, pay off credit card debt, and pay for skyrocketing healthcare costs. A new and creative use for reverse mortgages involves funding for an assisted living facility.

Here is a potential scenario: Jim and Judy own their home and have no mortgage. Jim need full-time care and they decide that an assisted living facility is the best solution. Judy still wants to stay in the home. To pay for the ongoing cost of the assisted living facility,

Jim and Judy decide to do a reverse mortgage and take periodic distributions to fund the cost of the facility care. Jim is happy that he is getting the care that he needs and isn't going to be a burden to Judy. Judy is happy that she can remain in her home knowing that Jim is getting the care and attention that he needs.

How a HECM Works

We all learned in kindergarten that there's nothing in life for free, right? So, how can you have a mortgage with no mortgage payment? The HECM product is a negatively amortized loan, which means the mortgage balance goes up each month instead of going down like it does in a traditional forward mortgage. The reason the mortgage balance of a HECM increases is that an interest charge is added to the mortgage balance every month. The original loan balance, plus any accumulated interest, is paid back when the homeowner no longer occupies the home as his or her primary residence. If there is any equity remaining in the property at the time the mortgage balance is paid off, that equity belongs to the homeowner (if still living), the estate, or the heirs. If there happens to be a negative equity position, neither the homeowner, the estate, nor the heirs are responsible for any deficiency since the HECM is a government-insured loan. Any deficiency would be paid by the Federal Housing Administration's (FHA) mortgage insurance fund. With the HECM loan, homeowners never owe more than the value of the home, **regardless** of the mortgage balance.

For example, when Tom and Mary sell their Florida home, if the property is worth $600,000 and their mortgage balance is $400,000, the mortgage balance would be paid off with proceeds from the sale and Tom and Mary would keep the $200,000 of equity. However, if Tom and Mary's home declined in value and was only worth $300,000 but they owed $400,000, the shortfall of $100,000 would be paid by FHA's mortgage insurance fund. The bank will NOT ask Tom or Mary, their estate, or their heirs to pay any shortfall.

Original Reverse Mortgages

Probably one of the most misunderstood products in the mortgage industry, revere mortgages have been around for over sixty years. In the early days, the reverse mortgage product was a private loan offered by only a select number of banks. Unfortunately, these banks didn't have sufficient safeguards in place to protect homeowners and, as a result, bad things happened to good people. Reverse mortgages developed a notorious reputation over the years and became a much-maligned mortgage product. The bad reputation continued for years until finally the government stepped in. In the 1980's, HUD and FHA brought the reverse mortgage product under their oversight and created the modern-day reverse mortgage now known as a Home Equity Conversion Mortgage or HECM. Even today, misunderstandings remain about the HECM product that stem back to the original private reverse mortgages. Perhaps the biggest misconceptions are the falsehoods that "the bank owns the home" and "the bank will keep any remaining equity in the property when the home is sold." Both statements are 100 percent false! The title to the property always remains in the homeowner's name so the bank never "owns" the home. Furthermore, if there is any remaining equity in the home at the time the mortgage is repaid, that equity belongs to the homeowner, if he or she is still living, the heirs, or the estate.

Safeguards

HUD and FHA have insured the protection of older adults through a wide range of safeguards. The most significant of the safeguards is the non-recourse feature of the HECM product, which means that a homeowner can never owe more than the value of their home **regardless** of the mortgage balance. Another important safeguard that was instituted by HUD is that all homeowners applying for a reverse mortgage must attend counseling from a HUD-approved counseling agency. Counseling is intended to ensure homeowners are aware of their obligations while they have a reverse mortgage — such as paying property taxes and homeowner's insurance. Counselors also review triggers for the loan repayment — such as permanently moving out of the home or failing to pay property taxes or homeowner's insurance.

Mortgage Options

The HECM mortgage is available as a fixed or adjustable-rate loan; the product that is best for a borrower widely depends on the transaction that is being financed. The adjustable-rate product is commonly used for a cash-out refinance where the borrower has either no mortgage on the home or only a small balance that is to be paid off. The adjustable-rate reverse mortgage offers the borrower several distribution options, including cash at closing, a monthly payment for life, or a credit line that can be accessed in the future if and when funds are needed. The fixed-rate product is widely used for purchase transactions or refinance transactions where there is a large mortgage being paid off.

Some borrowers purchasing a home with a

HECM may choose the adjustable-rate HECM mortgage to take advantage of the credit line feature that the HECM offers. The adjustable-rate HECM can be paid down to free up equity and establish a credit line that is not available on the fixed-rate product. The HECM credit line is unique in that the credit limit increases over time as a function of the borrower getting older and can never be cancelled, regardless of the mortgage balance and/or value of the property. Having the credit line feature is attractive to many borrowers because it can act as an emergency fund if needed in the future.

For older adults considering a HECM mortgage, there are some basic requirements that must be kept in mind:

- The minimum age for the primary borrower is sixty-two (a co-borrower can be younger).
- The home must be the borrower's primary residence.
- Borrowers must prove their ability to pay property charges (property taxes, homeowner's insurance, and any association fees).
- The borrower cannot be delinquent on any federal debt at the time of application.
- Eligible property types include:
  - » Single-family homes
  - » Condominiums that are approved by HUD and FHA
  - » Manufactured homes built after June 15, 1976
  - » Two- to four-unit properties, as long as one of the units is occupied by the borrower

The HECM mortgage is considered an "open-ended" mortgage — the loan has a defined beginning (at closing) but doesn't have a defined ending like there is on a traditional 30-year fixed-rate "forward" mortgage. The HECM mortgage becomes due and payable when the last surviving borrower no longer occupies the home as his or her primary residence. The borrowers can live in the home as long as they wish, regardless of the mortgage balance or the value of the home. Borrowers or their heirs have up to one year to pay off the HECM loan once the loan becomes due and payable. If a borrower temporarily moves out of the home, they have up to one year to move back into the property without triggering the repayment of the loan. This feature of the reverse mortgage product is particularly beneficial to a homeowner who may need to be in a rehabilitation facility for an extended period of time.

Is a reverse mortgage right for everyone? Certainly not! Certain factors are key indicators that a reverse mortgage may not be the best solution for a client. One very important factor to consider is how long the homeowner wants to stay in the home. For homeowners that have a short time horizon, a reverse mortgage may not be the best solution since the cost/benefit ratio wouldn't be in the borrower's best interest. Those homeowners with long time horizons are best suited to consider a reverse mortgage since the cost of doing the loan is amortized over a much longer period of time. Another situation where a reverse mortgage may not be the best choice is for older adults who believe that the equity in their home is part of the legacy that they want to pass on to their children or grandchildren. For those older adults wanting to leave their homes to their heirs, a reverse mortgage is probably not a wise decision due to the diminishing equity that occurs over time. However, for those who see the equity in their home as another component of their overall retirement plan, a reverse mortgage can be an excellent way to help improve the quality of their lives and help to make retirement easier. For Tom and Mary, the HECM for purchase was the ideal solution that allowed them to purchase their retirement home. •CSA

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Strategies to Manage the Cost of Long-Term Care: Insurance and Beyond

Many retirees face the cost of long-term care when their financial situation is far from robust. These strategies can help older adults manage the added expense.

BY NANCY BUTLER, CFP®, CDFA®, CLTC®

The cost of long-term care has been steadily rising every year. While most people agree that receiving care in their own home would be preferential to receiving care in a nursing facility, few people are protected or prepared for the level of expenses associated with this care. It is important to be aware and understand the choices available and the impact they have on long-term financial security.

TYPE OF CARE	2010	2015	2020
Homemaker Services	$ 3,432	$ 3,718	$ 4,481
Home Health Aide	$ 3,623	$ 3,813	$ 4,576
Adult Day Health Care	$ 1,300	$ 1,492	$ 1,603
Assisted Living Facility	$ 3,185	$ 3,600	$ 4,300
Nursing home care – Semi-Private Room	$ 5,628	$ 6,692	$ 7,756
Nursing home care – Private Room	$ 6,266	$ 7,604	$ 8,821

Source: California Department of Insurance

The chart above shows the average monthly cost of long-term care in the United States in 2010, 2015, and 2020 according to studies done by Genworth Financial, Inc. (California Dept. of Insurance, n.d.).

Depending on where in the country a person lives, these rates can be higher or lower. These costs do not take into account many additional expenses older adults will most likely have, including medical insurance premiums and personal care such as haircuts, clothes, entertainment, newspapers, technology, medical co-pays and deductibles, telephone, and other expenses.

Although I have not found any real statistics outlining the history of premium increases on new issue long-term care insurance policies, the statistics on existing long-term care insurance premiums have been steadily increasing at amazing rates. A report by the California Department of Insurance (2018) illustrates how high these rate increases were in 2018 for existing long-term care insurance policies already in place. Three different companies in as many states hiked their rates from more than a third to nearly double the previous charge. The chart on the next page gives examples from the report.

How can anyone but the wealthiest individuals possibly manage the cost of long-term care, given these numbers? It's not easy. It depends on a careful combination of strategies to manage income, assets, and insurance to optimize each. When done correctly, these strategies can allow older adults to preserve the retirement nest egg they spent their life building so it can last longer for them and they can pass any remaining assets to their heirs in a tax-efficient way.

Many people choose to purchase a long-term care (LTC) insurance policy. The first decision when buying LTC insurance is to choose from among desired options, such as the waiting period, daily coverage amount, inflation option, number of years of coverage, and any others that may be offered. Then compare those options with each long-term care insurance provider being considered to be sure of making a like-kind comparison. Choose wisely and read the fine print; as noted above, rates can increase dramatically.

Case Study Illustrates Pitfalls

"Bonnie" was an 84-year-old widow living at Sunny Day, an assisted living facility, when she became my client. Her mind was pretty sharp, but her health was failing. She enjoyed participating in activities and being around people, especially her family. But after a bad fall a few years ago, she had trouble walking. She also had other medical issues, which is why she could no longer live alone. The assisted living facility where Bonnie lived provided entertainment almost daily, prepared all of her meals, drove her to medical appointments, and took care of other things Bonnie could no longer do herself. She wanted to stay there as long as possible and not go to a nursing center.

Bonnie had always lived comfortably, but not extravagantly. She had Social Security, a small pension from the company she worked for, and another small pension from her deceased husband. She also had a traditional individual retirement account (IRA), some non-retirement assets, and a cash reserve. She used the dividends and interest from her assets for income. She also had a long-term care insurance policy that had been purchased many years ago.

Bonnie had three major concerns:

1. She liked to keep her mind and body as active as she could. Quality of life was of utmost importance for Bonnie.
2. She was concerned about having enough money to pay for care she may need in the future and it was important to her to be able to support herself financially and not rely on others.
3. She wanted to preserve as much of an inheritance as possible for her children when she passes away.

INSURANCE COMPANY	STATE	INCREASE REQUESTED	INCREASE APPROVED	DATE INCREASE ISSUED
GE Capital Assurance	CT	41-72%	48.15%	7/30/2018
Bankers Life and Casualty	AL	35%	35%	6/10/2018
Transamerica Life Ins. Co.	CA	97%	30% - 90%	1/15/2018

Source: California Department of Insurance

Bonnie had been residing at Sunny Day Assisted Living for a few years, had made many friends and was comfortable there. Since quality of life was important for Bonnie, the goal was for her to stay there as long as possible and not be transferred to another facility, even if one could be found at a lower cost.

Following are some general guidelines on managing health costs, and how I applied them to Bonnie's situation.

If a client has long-term care insurance, use that first.

After six months, Bonnie became ill and needed hospital care. When released from the hospital a week later, she was transferred to a nursing center for rehabilitation before she could return to the assisted living facility. This is common for many older adults and many long-term care policies pay a different benefit amount when residing in a nursing home vs. an assisted living facility, and will pay no benefit when residing in the hospital. That is one reason applying early for benefits is so important. Bonnie had a LTC policy. If Bonnie had waited too long to apply, the delay would have caused the insurance company to need to verify where she had resided each day, and it would take a lot longer to receive benefits. Additionally, it is important to apply for benefits as soon as qualifying care is required so that premium payments will stop.

Improve the opportunity to receive the maximum benefits from long-term care insurance.

Long-term care insurance can be the most cost-effective way to cover the high cost of long-term care. That can be true whether care is at home, in an assisted living facility, or at a nursing center. Bonnie had a policy to help cover the cost of care but it would not fully cover all of her costs. Often, long-term care insurance benefits go unused. Here is one reason that can happen and how to overcome it.

It can be very helpful to have a knowledgeable person, such as an LTC expert, help the assisted living facility complete the paperwork to request policy benefits. Administrators sometimes do not know what to list on the form. For example, Bonnie was pretty independent. The first time she applied for benefits she had been denied. Later, a family member helped the administrator complete the form on Bonnie's behalf and she was approved. Some of the facts that should have been listed on the paperwork the first time had been omitted. For example, the administrator stated that they did not provide care for Bonnie since she had an aide living with her. That was not true. The aide assisted Bonnie with several things she could not do on her own, but she was not a nurse and was untrained and unable to provide several areas of care Bonnie required. The facility had a nurse who daily tended to Bonnie's open wounds that she often had due to a medication that thinned her skin. There were several other areas of care the facility provided that had not been listed initially.

Had the paperwork been completed correctly the first time, Bonnie would have qualified then. The family member requested the facility backdate the paperwork to the date originally submitted since her level of care had not changed and it was not Bonnie's fault that the facility completed it incorrectly. It worked, but it took over six months for Bonnie to receive all of the benefits her policy provided.

If there is no long-term care insurance in place or if it has been depleted, consider the following strategies to preserve what took a lifetime to build so it isn't lost in the last few years.

Health Reimbursement Account (HRA) and Health Savings Account (HSA)

Many long-term care expenses are qualified medical expenses. This means they are eligible for tax-free withdrawals from the member's Health Savings Account (HSA) or Health Reimbursement Account (HRA). It is important to check with a tax advisor and/or financial advisor to determine if the member's particular expenses qualify.

Federal guidelines state people can open and contribute to an HSA if they are covered under a qualifying high-deductible health plan that meets

the minimum deductible and the maximum out-of-pocket threshold for the year. They must also not be covered by any other medical plan.

For an employee's HSA, the employee, the employee's employer, or both may contribute to the employee's HSA in the same year. For an HSA established by a self-employed (or unemployed) individual, the individual can contribute. HSA funds can be withdrawn tax-free and used for care.

Income Tax Offset

In 2020, the IRS allowed all taxpayers to deduct their total qualified unreimbursed medical care expenses that exceeded 7.5 percent of their adjusted gross income if the taxpayer used IRS Schedule A to itemize deductions. This provision can save clients a lot of money, as I illustrate with Bonnie's case.

The cost of care Bonnie was responsible to pay last year at Sunny Day was estimated at $4,300 per month, or $51,600 for the entire year. Bonnie's tax advisor stated that she had approximately $54,000 in tax-deductible medical expenses for the full tax year, which included the cost of the assisted living facility, medical co-pays, deductibles, prescriptions, and other miscellaneous health expenses.

Any money withdrawn from Bonnie's traditional IRA assets (contributed pre-tax) are taxable as regular income. Also, inherited IRA assets are fully taxable (although her heirs will have ten years to withdraw the money and pay the tax).

I suggested that Bonnie consider first withdrawing $54,000 (which included her required minimum distribution) of taxable IRA assets to pay for her care. The tax can be totally offset by the medical expense deduction. If additional money was needed, she could use non-qualified assets next. All cash not needed for immediate expenses would be allocated to a non-qualified secure cash position for future expenses.

This enabled Bonnie to pay no income tax on this withdrawal and also keeps her children from paying income tax if the money is left to them. The goal is to spend taxable assets that can be offset by Bonnie's medical and other expenses, so that neither Bonnie nor her heirs will be required to pay income tax on these assets.

Bonnie's monthly income:

$ 750 Bonnie's pension
$ 800 Pension from Bonnie's husband
$1,400 Social Security (partially taxed)
$1,250 Taxable dividend and interest income
$4,200 Total monthly income ($50,400/year)

$1,700 Cost of personal care, insurance, clothes, copay, prescriptions, dental, eyeglasses, newspapers, etc.

$2,500 Net income per month x 12 = $30,000 per year available for Bonnie's care

Allocation of annual cash withdrawn:

$51,600 Cost of care
$30,000 Available from current income
$21,600 Shortage in 2020

$54,000 Withdrawn from taxable IRA account
$21,600 Needed for care
$33,600 Excess cash withdrawn to allocate for future expenses

Income Tax Rates

Some of Bonnie's taxable income was offset by her personal exemption and a portion of her Social Security was not taxable. The chart below shows that Bonnie could have a total taxable income of up to $40,525 without increasing the rate at which her income is taxed. Since implementing the previous strategy should cause no taxable income, additional money could be withdrawn if needed without causing Bonnie to be taxed at an increased rate.

2021 FEDERAL INCOME TAX RATES FOR SINGLE INDIVIDUALS (IRS, 2020):	
10%	Up to $9,950
12%	$9,951 to $40,525
22%	$40,526 to $86,375
24%	$86,376 to $164,925
32%	$164,926 to $209,425
35%	$209,426 to $523,600
37%	$523,601 or more

Remove Market Fluctuation Concerns

A solid emergency fund is an important tool in developing and sustaining financial security. Although people often hear that the rule is to have six months of living expenses set aside for a cash reserve, everyone's situation is different. For some people, that amount may not be enough to feel comfortable. On the other hand, some people feel a six-month reserve is too high.

After Bonnie consulted with her financial advisor, Bonnie's cash reserve need was determined to be $45,000.

Once the amount of cash reserve to set aside was determined, her financial advisor must calculate a reasonable estimate of the amount that will be needed from assets each year to provide for any shortage to cover Bonnie's total expenses. Then multiply that amount by three years. Add to that number a cushion for inflation and the cash reserve. For Bonnie, the numbers looked like this:

Her current annual shortage is $21,600 per year. Increase that to $25,000 for inflation and the decrease in her dividend and interest income due to liquidating assets.

$75,000 Estimated annual expense shortage for three years

$45,000 Cash reserve Bonnie agreed would be comfortable

$120,000 Total

$120,000 is the amount that should not be invested in the market and should be held in guaranteed cash accounts. Even though the return may be extremely low, no return is better than potentially losing principle due to market fluctuations.

How to Allocate the Total Cash

$120,000 Total needed

$70,000 Cash reserve and twelve-month expense shortage invested in checking, savings, and money market

$50,000 Remaining balance to apply to laddered certificates of deposit (CDs)

Laddering CDs can be a simple way to help cash reserves work harder than many checking, savings, and money market accounts. Laddering requires dividing the money into several CDs with staggered maturity dates, so that some of the cash is available to use at regular intervals. Typically, the longer the term of the certificate, the higher rate of return.

An appropriate strategy for Bonnie can be as follows:

$25,000 Twelve-month certificate of deposit

$25,000 Twenty-four-month certificate of deposit

Also research other time periods that are twenty-four months or less. Often a special rate may be available for a different time period, for example seven months or thirteen months, which could be higher than the more common six months, twelve months, and twenty-four months. This strategy can help increase the return on cash assets while allowing access without a penalty when money is needed. As each certificate matures, transfer the proceeds to the checking, savings, or money market account.

Each year, calculate a reasonable estimate of the amount that will be needed from assets to cover any shortage of Bonnie's total expenses, and transfer that amount to the plan in place for the secure assets used to maintain three years of cash needs plus the cash reserve. Keep in mind that cash can be held securely in qualified or non-qualified plans.

Reverse Mortgage

Although this strategy did not apply to Bonnie since she was living in an assisted living facility, it may be an appropriate strategy for homeowners.

Older adults living in their home who own it outright or have a lot of equity and are at least sixty-two years old can consider a *reverse mortgage*. A reverse mortgage enables money to be taken out of the value of the home in a lump sum, monthly income payments, a line or credit, or a combination of all three, all in the form of a loan. The money can be used any way the homeowner likes, including to help pay for care. The homeowner is required to keep up with property taxes, maintenance, and insurance, and cannot move into a nursing home or assisted living facility for more than a year without selling the home. It can be especially helpful for retirees with limited income and few other assets. They keep the title and the lender places a lien (or mortgage) on the home. However, if they move or if the house is sold, the loan must be repaid out of the proceeds of the sale.

Before entering into a reverse mortgage agreement, it is important to review the written estimate of the total cost, as it can be very high and varies by company. Some of the costs include:

- document preparation,
- flood certification,
- HECM counseling fee,
- mortgage insurance premium,
- origination fee,
- settlement or closing fee,
- tax payment history,
- appraisal fee,
- credit report,
- title insurance,
- recording charges, and more.

A reverse mortgage can provide cash but it can be expensive and can also complicate matters if the homeowners plan on leaving their home to their heirs. An elder law or estate planning attorney, or financial advisor, can help determine if this is a good option. I suggest reviewing all options available before applying for a reverse mortgage.

Other Important Factors to Consider

There may be a *chronic illness, critical illness, or accelerated death benefit rider* on one or more life insurance policies that are in effect. Even if the rider was not in place at the time the life insurance policy was issued, some companies have added the rider to existing policies after they were issued. This rider can provide access to a payout of the death benefit while the insured is still living if he or she is suffering from a terminal illness. Policies may have different rules and requirements to qualify under this rider, so it is important to thoroughly understand the details of the policy provisions.

If Bonnie ever needs to sell a mutual fund, stock, or most any other investments that have appreciated and are not located in a qualified retirement plan, then she will need to know the *cost basis*. Cost basis is the amount paid for a security. At the time of the sale of an appreciated security, the owner only owes taxes on the difference between the amount paid for the investment plus all reinvested earnings and reinvested capital gains (cost basis) and the value received at the time it is sold. This will be less of an issue going forward, because companies have been required since 2011 for most investments (with others added over the next five years) to keep track of cost basis for clients (Horn, 2013). For investments purchased before the law went into effect, owners will need to have a record of the cost basis.

If clients do not have the cost basis for each security, a good place to start is to ask the company that holds the investment for it. Even though investment companies and banks were not required to keep track of cost basis, they still may be able to help. For a fee, some firms will offer to provide past statements so clients or their tax advisor can calculate the cost basis. This will allow advisors to determine which security will trigger the least tax when sold and allow clients to be prepared when required to provide the cost basis when filing their tax return. Consider selling securities with a high cost basis first. This strategy can lower taxes now and at death there is currently a step-up in basis to make these securities tax-free to heirs.

When withdrawing money to pay for care, consider leaving *Roth IRA* assets for last. They will continue to grow tax free for later use or to leave to heirs, also tax free. Of course, it is important to actively manage the assets held in IRAs and all investments keeping in mind time frame, risk level, fees, and other factors.

Medicaid typically provides benefits when there are few assets and little income. Medicaid eligibility and benefits can be different based on the state clients live in. Each state has a maximum amount of assets and income the ill and well spouse can retain to be eligible for benefits. There are many eligibility requirements including U.S. citizenship, age limits, level of health care needed, and more. Each state typically has a look-back period and penalty for assets that were transferred to someone else. It may be lengthy, for example, sixty months. Adults should check with their state and an elder law attorney for guidance.

Calculating how to spend assets while needing long-term care is not easy. Most older adults require the help of a financial professional to strategize for optimal use of varied investments and income. The best time to begin is before long-term care is needed. With current information and proper professional planning, older adults will have a much better chance of paying for the care they need, maintaining their quality of life, and even being able to pass assets to their heirs efficiently, if desired. The earlier the planning begins, the better the chance to be able to cover the cost of care and meet other important goals. •CSA

During her thirty-five plus year career as a Certified Financial Planner® and asset manager, **Nancy Butler** has worked with thousands of individuals, assisting them in the financial aspects of aging, including how to pay for the care they need and preserve the assets they spent their lives building. Today, Nancy is an international speaker, award-winning author and 3-year delegate to The United Nations for The Commission on the Status of Women. Nancy also teaches insurance classes in Connecticut.

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The Purchasing Power of Grandparents

The financial generosity of grandparents, and their increasing control of America's wealth, present a unique marketing opportunity for professionals in a variety of fields.

BY HELEN KEIT, CSA, MBA

Grandparents in the U.S. spend a whopping $179 billion per year on their grandkids (O'Brien, 2019). The average annual expenditure was $2562 per grandparent (AARP, 2018). This willingness to spend presents a unique opportunity for aging-industry professionals, whether they are marketing to this group for their dollars or creating an estate plan or budget that includes spending on family. In fact, Americans over fifty control more than 80 percent of household wealth. The size of this cohort is growing as the population ages, presenting new opportunities for businesses to expand their offerings and their bottom lines, according to a recent study from Oxford Economics (2016).

Purchasing Power

What is purchasing power? It is much more than the ability to buy products and services. It depends on supply and demand, credit, inflation, housing status, region, and work status, among other factors (Eren, 2019). Most surveys referenced in this article gathered data in the decade after the Great Recession of 2007 to 2009, when the nation was recovering economically. That financial and housing crisis certainly had an impact on grandparents' purchasing power, and future studies will doubtless make comparisons with the impact of the current COVID-19 pandemic as data is collected going forward.

The number of grandparents in the U.S. has grown by 24 percent since 2001, from 56 million to 70 million (AARP, 2018). Gains in health and lifespan have allowed many more men and women to enjoy years with their grandchildren. This relatively new segment of consumers is expected to account for at least 40 percent of consumption growth between 2015 and 2030, while spending on housing, travel, entertainment, food and financial products (Irving, 2018). The baby boom generation has the power to influence the level of consumer spending for the entire nation, according to the U.S. Bureau of Labor Statistics.

With this growth in the number of grandparents over the past half century, their role in family life has become increasingly important. Because of demographic, economic, social, and technological changes, grandparents provide necessary assistance, both economic and otherwise, for many households headed by their adult children. Besides providing unconditional love, emotional support, and guidance, many grandparents help with childcare and provide financial assistance to relieve the economic, social, and personal stress on their families (Bevis, 2019).

Generosity of Grandparents

A 2012 MetLife Study on how grandparents share their time, values, and money illustrates the growing financial support older adults provide to their children and grandchildren. Fully 96 percent of grandparents said they spend money on their grandchildren for birthday and holiday gifts. Even with the impact of the financial crisis, 62 percent of grandparents surveyed provided financial or monetary assistance for their grandchildren. The average amount of annual assistance was $8,289.

According to the MetLife survey, 82 percent of grandparents provided cash, while 62 percent gave gifts and 18 percent bestowed financial products on their grandchildren. (Results do not add up to 100 percent due to individuals who gave in more than one category). The majority (81 percent) of grandparents said they gave small gifts over their lifetime, although nearly a fifth (19 percent) said it was important for them to leave a large sum as a legacy on their death.

An AARP survey of 54- to 72-year-old grandparents conducted during September of 2018 found a growing number of them were contributing cash for their grandchildren's tuition (college or other schooling), groceries, and other major life expenses. More than a quarter (26 percent) of grandparents were helping to pay for family vacations , 21 percent were helping pay for tuition, 14 percent helped buy meals and groceries, and 5 percent helped pay for rent or mortgage and medical costs. It's interesting to note that before COVID-19, a survey of millennials and Generation Zers found half of these young Americans were receiving financial assistance from parents and grandparents (Menton, 2020).

Despite past economic challenges they may have endured, grandparents continue their growing financial generosity. They often give to their children and grandchildren without worrying about, or possibly understanding, how it impacts their own financial future. These older adults said they would sacrifice on something for themselves before they would let their financial situation affect giving to their grandchildren. Many surveyed classified their spending for grandchildren into two groups: necessities (food or clothing) or non-necessities (games and toys).

Financial Giving

Older adults are willing to part with cash to help ensure a better future for their grandchildren, whether to fund general needs or education. Grandparents contribute to savings accounts, buy certificates of deposit, fund brokerage accounts, start Uniform Gifts to Minors accounts (to avoid the cost of creating a trust) or 529 savings accounts for education, to name a few. Leaving a cash-value life insurance policy is another method to help fund a grandchild's future (Nuss, 2020). Financial services companies should reach out to this market of grandparents with a variety of ways to leave a legacy for their grandchildren. Many grandparents are interested in contributing, but they need guidance on the best way to do this for their particular situation.

As a result of the COVID-19 pandemic, older employees have experienced higher unemployment rates than those in mid-career. Workers fifty-five and older were 17 percent more likely to lose their jobs than employees thirty-five to fifty-four, and rehired more slowly through 2020. This higher rate of job loss and longer length of unemployment among older

workers may affect the overall purchasing power of grandparents and their ability to provide the previous level of financial support for their grandchildren and families (AARP, 2020). Grandparents will be re-evaluating their estate plans, wills, and how they leave assets to their children and grandchildren, but they are feeling more pressure to help their grandchildren through pandemic difficulties. They will have to balance this with their own financial needs for the future.

Home Buying and Travel Trends

One of the best gifts a grandparent can provide is to help a grandchild with the purchase of a home. A home will likely appreciate and, unlike stocks and bonds, can't be easily sold by the children to buy something frivolous. A grandparent can make a gift of closing costs or help with the down payment for a house. Some grandparents want to help pay for a portion of the purchase price, but they should avoid cosigning for the loan unless they are mentally and financially prepared to find themselves responsible for the debt down the road.

A trend toward multigenerational housing has emerged, brought on by the pandemic and concern about family members being able to visit and care for elders. Many families want to purchase a home that can comfortably house the whole family – seniors, their children, and grandchildren. Before grandparents contribute to housing of any sort, they should seek advice from accountants on current rules for the annual gift tax and lifetime exemption (Carlson, 2020).

Before the pandemic derailed travel, many innovators in the industry were beginning to see a new trend in "gramping," or leaving the parents at home and having the grandparents and grandkids bond on a trip just for them. A 2019 U.S. Family Travel Survey reported that 37 percent of grandparents surveyed were planning to travel with their grandkids in the next three years, cementing this gramping movement for vacations designed to appeal to the interests of the two different generations (Shluter, 2020).

Considerations for Business Owners

Businesses looking to cultivate this large group of consumers must consider that all these potential customers fifty and over cannot be lumped into one large group. Depending on the product or service being offered, it can be beneficial to split this broad grouping into three segments: active adults, older adults, and those over ninety. Those skewing younger may be more interested in adventure, while others are seeking comfort and leisure. A wide economic moat separates those who are on a tight budget from others who can spend freely. Consider different marketing angles for these diverse economic conditions. Finally, business owners must find ways to appeal to segments of the older population with increasing spending power but varying needs and desires, such as women and solo agers.

Businesses should refine their best practices based on what is important to this grandparent segment. It is proven that those aged fifty and up look for consistency in service and like to work with those they trust more so than younger consumers. Through surveys of past customers, an innovator in this market can develop new approaches, including the right value proposition, message, print style, and design. The purchasing power of grandparents presents opportunity that today's businesses cannot afford to ignore. New products, new approaches, value offerings and top-of-the-line service should help attract customers and improve the bottom line. •CSA

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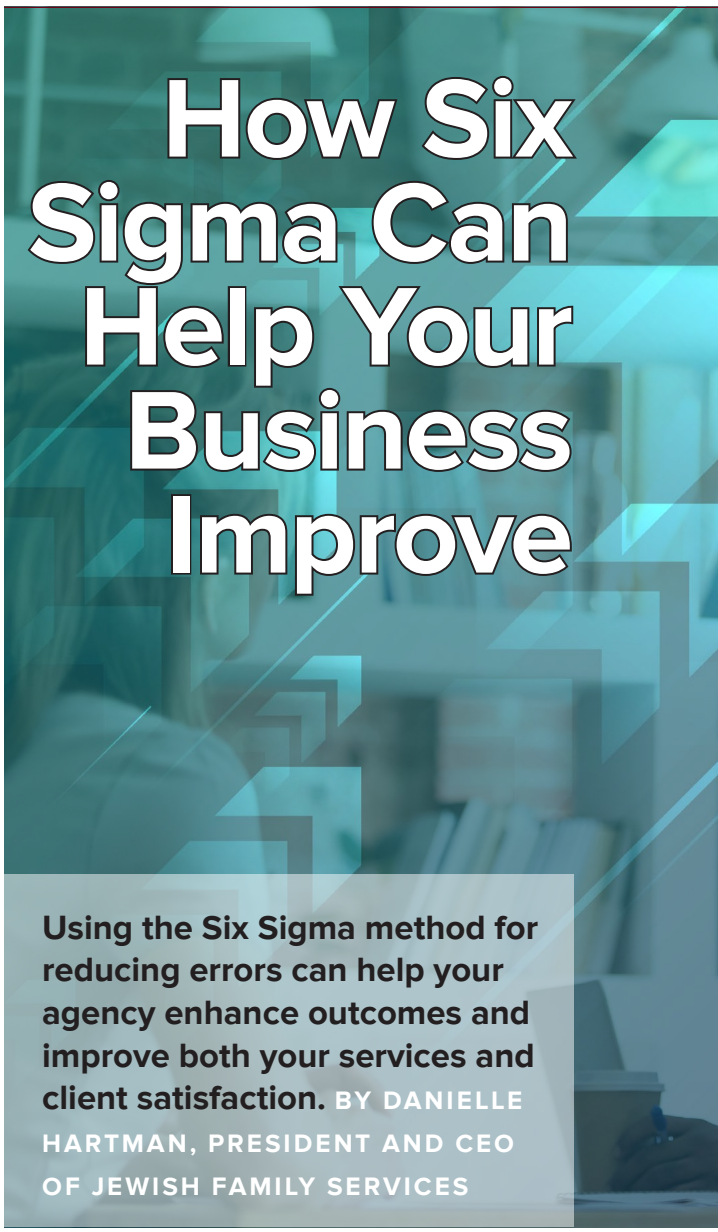


How Six Sigma Can Help Your Business Improve

Using the Six Sigma method for reducing errors can help your agency enhance outcomes and improve both your services and client satisfaction. BY DANIELLE HARTMAN, PRESIDENT AND CEO OF JEWISH FAMILY SERVICES

When I tell colleagues that I have a black belt in Six Sigma, I usually get an odd look, because most people in the nonprofit sector have never heard of Six Sigma and can't believe a job title of "Black Belt" is actually real. The typical follow-up question is, "What's that?" The simplest way for me to explain Six Sigma is that it uses a series of steps aligned with data to solve everyday business problems in order to increase efficiencies and improve the client experience. The concept was created by engineer Bill Smith in 1986 while he was employed at Motorola (Six Sigma Daily, 2020). Wikipedia (n.d.) explains it as "a set of techniques and tools for process improvement."

Any business focused on aging can benefit from understanding the fundamental concepts. This includes nonprofits, health-care entities, social services agencies, and other government organizations. The challenge for any aging-focused entity to benefit from Six Sigma is that these agencies are usually highly reliant on human capital, in which the variability is subtle and often nuanced. The challenge is to leverage the data-driven elements behind the methodology to change or adapt human behaviors. Improving patient outcomes can lead to improved patient satisfaction and a reduction in costs. An example of this is from Mount Carmel Health Systems, where they used the Six Sigma methodology to focus on operational challenges. As a result, projects focusing on six key areas generated over $3 million in cost savings (Bandyopadhyay & Coppens, 2005).

The fact that one could use math to solve business problems itself is what really piqued my interest in Six Sigma, and the reality that I was never great at statistics but so desperately wanted to be led me down the path of becoming a Six Sigma "black belt," someone who is certified to explain the method's principles and philosophies, while working for General Electric (GE) in the mid-1990s. Anyone who grew up at that time and worked in the for-profit sector is probably familiar with Chairman and CEO Jack Welch's desire to implement Six Sigma methodology throughout the corporation.

A Conversion at GE

But GE's quest for continuous quality improvement actually began before Six Sigma, when ISO9000 certification was the model to strive for. I vividly recall being in GE's management training program, working in a warehouse in Houston, and participating in the preparation for their ISO9000 audit. I found the method of merely documenting a process so that others could follow it, with little to no regard as to whether the process was even good or worth following, perplexing at best. I never really caught on to the ISO9000 standard.

Following the Six Sigma methodology establishes a culture of continuous process improvement and is applicable in both the for-profit and nonprofit sectors.

When Welch decided he would put his efforts into Six Sigma, the mandate was for all employees to go through the first level of training, and while I was in Houston I received my Six Sigma green belt certification. In Six Sigma, individuals develop expertise by earning "belts" at each level of accomplishment. The ascending order includes white, yellow, green, and black belts, culminating with the "master black belt" designation.

I recall being fascinated that one could use the Six Sigma methodology and statistical modeling to help solve common problems in our business. Those experiences of using the Six Sigma methodology followed me throughout my time at GE and culminated when I received my Six Sigma black belt during the last year of my career before leaving to raise my young children.

Using Six Sigma At Nonprofits

Even when I later transitioned to the nonprofit sector, those lessons and experiences stuck with me and influenced my management style. The tools that I learned during my time at GE have profoundly influenced how I developed a culture of continuous process improvement at my nonprofit agency, including how we solved several problems at the time using the Six Sigma tools. In my eleven years as a nonprofit CEO, I have never met another colleague with a Six Sigma background. However, I do believe that the methodology is not only appropriate but much needed in the nonprofit sector, as well as the for-profit world, to solve problems, achieve better client experiences, and to create a culture of continuous process improvement (Villanova, 2020).

What Does Six Sigma Mean?

The Six Sigma methodology strives to improve processes by reducing errors through identification of root causes, refining those processes to increase efficiencies, and then stabilizing those processes for predictable results. Following the Six Sigma methodology establishes a culture of continuous process improvement and is applicable in both the for-profit and nonprofit sectors. The name "Six Sigma" is derived from the bell curve used in statistics where one "sigma" represents one standard deviation away from the mean. The defect rate is determined to be low when the process exhibits six sigmas: three above and three below the mean (Six Sigma Daily, 2020). When a process is brought to the ultimate "six sigma" level, it means that for every one million opportunities, there will only be 3.4 errors.

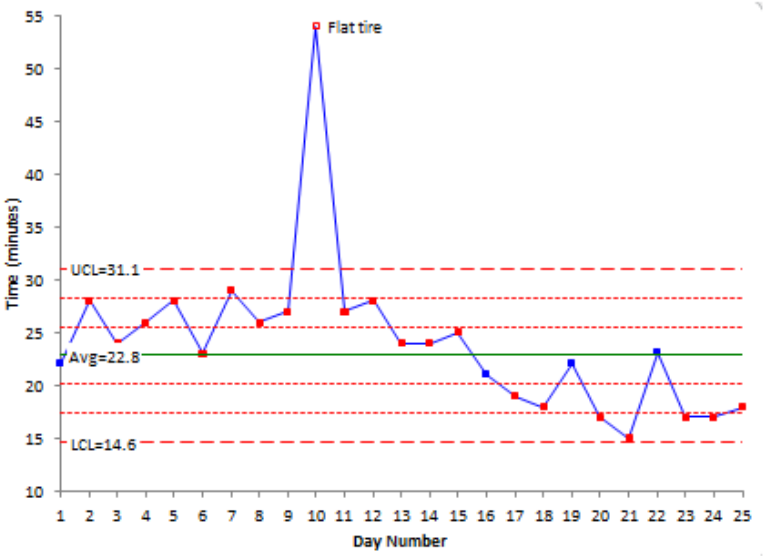
Six Sigma Concepts

The basic methodology behind Six Sigma is a process that can be summarized by the **DMAIC** acronym. Let me explain:

- **D**EFINE. At this stage you are merely defining the problem. An example in the nonprofit sector could be overspending a grant or delivering the wrong bag of groceries to a food pantry client.
- **M**EASURE. This is the data collection part of the process and is one of the most interesting steps in the methodology. In this stage, it is critical to include everyone who touches a process. This may include program staff, care managers, finance department staff, the grant manager, operations manager, or even volunteers. Some examples of the tools used for data collection include free-flowing brainstorming sessions, decision trees, and data from a client database or other data collection source. The use of statistical modeling tools may also be used here, but other platforms such as Microsoft Excel or reporting from your own database will suffice.
- **A**NALYZE. Here you are trying to drive down to the root cause of the problem, without making any changes to the existing problem. This is harder to do than say, because we often want to jump to the finish line without going through all the stages. To do this, Six Sigma uses the "5

Whys" concept to continue to ask "Why?" until you cannot ask any more. This process mimics a child who constantly asks her parents why she can't do something. A video to illustrate the point is available at Toyota 5 Whys - YouTube. The use of the "5 Whys" doesn't require sophisticated statistical modeling such as regression analysis or hypothesis testing.

- **I**MPLEMENT. In this stage, you begin making changes to processes using clear operational definitions and written standard operating procedures (SOPs). Sometimes the smallest change can have very large results, and this is all that is needed to correct or improve a process or client experience. An "operational definition" is defined as a clear and understandable description of what is to be observed, collected, or measured so that no matter who is collecting and interpreting the data, the outputs will be the same (Parker, n.d.). Let me illustrate what I mean by going back to my experience with GE. This was so impactful to me that I have never forgotten it and often use it to explain operational definitions. Each of us was shown an iced animal cracker and asked to write an operational definition that others would be able to read and understand. We were then told to exchange papers with someone else and by following their operational definition, determine what the object they were defining was. No two people described the iced animal cracker in consistently the same manner and because there was so much variability in how it was described, and no one passed the exercise. Inevitably, a key piece of information was missing, and we learned that if we did not carefully construct the operational definition, which would eventually lead to written standard operating procedures (SOPs), we were setting ourselves up for potential errors.
- **C**ONTROL. This is the final step in the process and is how people will know if their process is in or out of control. It can also help indicate if a process is about to *become* out of control (McNeese, 2011). Graphing is key to visually depict your process in the control state, and should include upper control limits (UCLs) and lower control limits (LCLs) (Taylor, 2017). In Six Sigma, the UCLs and LCLs are typically set at three standard deviations above or below the mean. However, you can adjust your control limits for your process in a different manner if it's more fitting. In the next column is an example of what a chart with standard Six Sigma control limits looks like (Ritz, 2015).



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An Example of Six Sigma Methodology Use in a Nonprofit

One of the best examples I have of how we used Six Sigma methodology in my nonprofit was related to a large grant we received to pay for a myriad of services for older adults, including private-duty home care. The challenge with the grant was managing the dollars spent on home care, the amount of which often fluctuates due to hospitalization, extended family stays, aging, etc. We needed to be able to spend down the home care dollars without spending too much, thus overspending the grant. Conversely, we didn't want to spend too little and thus underspend the grant. Both situations have consequences for business operations and client satisfaction. If we underspend the grant, then some clients may not get all the hours they really need, and future grant awards most likely will be reduced in kind. Overspending the grant likewise causes problems, since we will now need to raise the additional dollars to cover the difference, which may be significant. Client experience also will be affected by overspending the grant, because we may have to reduce hours, changing the care the client receives in turn. This grant was, and remains, difficult to manage, but with application of the Six Sigma methodology we were able to get the grant in balance and on a consistent path moving forward. Here's how we did it:

Define. Overspending or underspending grant funds restricted to pay for home care.

Measure. We had plenty of data from our software to show weekly and monthly expenditures on home care. We also used a free-flowing brainstorm session with all staff involved in the program to gather data on how the process currently worked, from receiving the

initial call to paying the invoice for services rendered. We also referenced data from the actual grant contract that specified what our required annual spending on home care had to be.

Analyze. Here we were able to drill down to see the root causes of this problem. For example, in this particular situation, we discovered that hours for home care were being approved without checking with the grants administrator to verify availability of funds. We also discovered a lag time between when a new account was established or an existing account had a change in hours, thus creating an inaccurate accounting of available funds due to a gap in time between approval and reconciliation.

Implement. Several tweaks to the process were made, such as approving home care hours only after verifying availability of funds with the grants administrator, and tightening up the time between approval and recording in the system. All of this was done under the lens of continuous process improvement. The overall client experience also improved as we had more timely and accurate information about whether or not we could afford to allocate additional hours to home care. Program staff performance also changed for the better because staff was able to spend less time correcting issues related to client care, leaving more time to spend with their clients.

Control. We created a control chart that included control limits to manage around the variability factor. The middle constant line was the average monthly spend if we were able to straight-line the funds. Here we did not use the standard three deviations above or below the line, but were able to use the average variability from our data to set the UCL/LCL. As long as the monthly spending on home care remained in control, fluctuating between the UCL and LCL, the grant was in balance and no action needed to be taken. If the spending started to consistently reach or exceed the UCL or LCL, then spending was no longer in control and further investigation and refinement were needed. Once those changes occurred, we were able to manage the home care hours of the grant better, thus reducing the cycle of overspending and underspending of the grant funds and improving the overall client and staff experience by removing stress and anxiety. Having more timely data on available unspent home care dollars made a big difference .

This is just one example of a practical application of how Six Sigma methodology could work in a nonprofit. When we were going through the process I did not specifically call the process Six Sigma, primarily because I would have had to spend an inordinate amount of time explaining what it meant, and I was more concerned about using the tools to improve processes. Our agency continues to embrace the continuous improvement culture. Many universities have courses on Six Sigma; it would be a worthwhile investment to send at least one of your staff people to obtain the green belt certification and to have that person apply the Six Sigma methodology to a problem within your business. If anything, you may find that you need to upgrade your data collection systems so that you can use the information to help you make better business decisions. At the end of the day, we must run our nonprofits in the same manner as any business, which includes continually seeking ways to improve the client experience while managing costs and increasing productivity by decreasing opportunities for error. I invite you to try it in your own organization. •CSA

Danielle N. Hartman joined Ruth & Norman Rales Jewish Family Services (JFS) as president and CEO in March 2010. She received her MS in Nonprofit Management from Florida Atlantic University in 2010 and her BS from Drexel University in 1993. Before her work in the nonprofit sector, Danielle spent seven years in the private sector as a manager of operations for GE Supply, a division of General Electric. She can be reached at danielleh@ralesjfs.org.

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CASE IN POINT

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The Human Connection:
Building Rapport With Clients for Forever Relationships

People don't care how much you know until they know how much you care. —TEDDY ROOSEVELT

Client retention absolutely depends on mastering more than the essentials. Here's how to build relationships that will last a lifetime and have others seeking your services. BY AMY D'APRIX, MSW, PHD

Trust. It's the foundation of every relationship in life and yet most people spend little time *intentionally* focused on its importance or how to build or measure it. The word "trust" is often used in marketing materials and conversations, but how much thought is given to its importance in human connection and how it can deepen professional and personal relationships?

The Importance of Trust for Connection

Jack Welch said this about trust: "You know it when you feel it." Think for a moment about a professional relationship where there is trust and it's likely that his

statement rings true. Doing business with a trusted person is enjoyable, allowing people to be open and perhaps even vulnerable. In Burke and Hung's *Financial Advice and Trust*, trust is cited as the most important factor for investors in their decisions to seek financial advice (2015, pg. 1). Trusted individuals make the people they deal with feel truly understood and valued because trust breeds feelings of safety and the comfort in knowing someone "gets" you. Clearly that is what everyone wants their clients to feel. But how to achieve that? Does getting clients a better rate of return on their investments guarantee a deeper level of trust? Perhaps it is by demonstrating a commitment to ethical behavior that will ensure clients' trust. Or perhaps, the secret sauce of trust is actually something quite different.

In 2017, personnel from Vanguard's Center for Investor Research conducted a study in which they examined trust in a financial advisory relationship. From a survey of nearly four thousand clients and eighteen in-depth interviews, they developed a model of trust with three components:

1. **Functional factors**, or the ability to do the tasks associated with being a financial advisor;
2. **Ethical factors**, or maintaining the expected conduct while running a business; and
3. **Emotional factors**, or the intangible aspects of the relationship between clients and their advisors.

All three are important and all contribute to having a trusting relationship with an advisor. However, in the research results functional factors only accounted for 17 percent of a trusting relationship and ethical factors for 30 percent. Amazingly, the emotional factors represented 53 percent of what made an advisor trustworthy. Stated differently, it appears that ethical and functional factors are "table stakes;" clients assume these are present when working with a professional advisor. Emotional factors could be the differentiator in business and a notable contributor to client retention and prospect conversion (Madamba & Utkus, 2017).

Building Trust: Start with Life Transitions

To start building emotional trust it's important to have a common point of connection. Life transitions provide that opportunity. Some transitions can be anticipated, such as retirement or grandparenthood. Other transitions are like "lifequakes" and blindside people, such as caregiving, the sudden death of a spouse, or even a global pandemic. Regardless of whether it is anticipated or a shock, every life transition has four implications: practical, emotional, family, and financial.

As explained by Dr. T.B. White in *Consumer Trust and Advice Acceptance: the Moderating Rules of Benevolence, Expertise, and Negative Emotions*, clients tend to focus on the emotional and family implications of change, especially as decisions increase in perceived difficulty (2008, p. 141). As a wealth professional, it is natural to emphasize the financial implications. After all, that is what financial professionals are trained to do. But in order to build trust, it's important to begin with what is important to the client. A good mantra is: "The only things that matter are the things that matter to my client." Discovering what is most important to clients and responding to that requires an ongoing commitment to focus on and enhance the skills that are foundational to connecting with people and building emotional trust.

Advisors of every profession, particularly financial advisors, have to rise to the challenge of focusing on the emotional aspects of their relationships with clients, not just on financial or business issues. Most professionals already know that clients want their advisor to understand them beyond their money, yet it can be more comfortable to discuss finances in isolation, not intricately tied to the rest of the client's life. In order to be the trusted advisor of choice, the one a client will turn to at every stage and change in life, there has to be a conscious shift in focus and a deepening of emotionally based skills. White explains that emotional investment in the welfare of the client is one of the greatest pathways for building trust with clients (2008, p. 142). Now, instead of simply being money managers the most successful advisors will view themselves as "life transitions managers" and focus on enhancing the emotional skills needed for deeper relationships.

Three Keys to Deepening Trust and Connection

All people, including clients, have a need to feel heard and understood. As stated, it's foundational for trust and connection in both professional and personal relationships. Yet, in this busy world, how many people really feel they are deeply heard?

The good news is that the skills required for clients to feel deeply understood and valued can be learned relatively quickly and implemented immediately. This is done by working on the three fundamentals of communication:

1. Improving listening skills;

2. Changing the kind of questions typically asked; and
3. Learning to convey empathy with authenticity and ease.

Listening in a New Way

The first step in deepening relationships is to work on listening. Many people have been taught about active listening: the importance of leaning forward, making eye contact, and not talking while others are speaking. These are vital aspects of listening. However, in order to improve the ability to connect, it is helpful to think about listening in terms of three levels.

The first level is listening to reply, and this is very common for professionals to do because they are keen to demonstrate their value by offering solutions. After all, clients seek out professionals to help enhance planning and to solve problems. There is nothing wrong with offering solutions; it is just that clients need to feel that you truly understand them and their unique situation before they will be fully open to your input. When someone listens at level 1, they are apt to jump into the conversation rather than first stepping back and listening in a manner that allows for true understanding. The only way to achieve that is to move to a higher level of listening.

Level 2 listening is listening to understand. This means slowing down, pausing, asking clarifying questions, and being present to the conversation. It's easy to recognize when someone is focused elsewhere or not really attending to what is being said.

Level 3 listening is where the magic occurs. This is listening to what isn't being said, the emotion or feelings beyond the content. Added to level 2, this means also watching body language, asking better questions, and being aware of what might be going on for the person as she shares information. The case study illustrates the notable difference between level 2 and level 3 listening. Clearly, the goal is to move to level 3 listening as often as possible.

The good news is that practicing the skill of listening reaps immediate rewards. Not just client relationships, but relationships with colleagues, friends, and family will likely shift in a positive direction.

Asking High-Impact Questions

The second key component of deepening relationships is asking high-impact questions. These are questions that demonstrate a real interest in learning more about clients and their lives. It's common to utilize close-ended questions as a way to confirm facts since they elicit yes or no answers. The other type of question, open-ended questions, work well to get and keep a conversation going. High-impact questions are very effective in seeking out what is most important to clients, and providing more useful information for an advisor tailoring financial planning to their clients' deepest needs and desires.

High-impact questions allow clients to step back and pause, reflect, and evaluate. These questions are helpful in ranking what is most important to them, based on their perspective and opinions. In addition to providing richer information to the advisor, they often cause clients to learn something about themselves.

> Advisors of every profession, particularly financial advisors, have to rise to the challenge of focusing on the emotional aspects of their relationships with clients.

During discovery, advisors often ask clients to "tell me about your family." The problem with that request is that there is no context for what information the advisor is seeking. What specifically should the client share about his or her family? Turning this into a high-impact question creates context and elicits the information most relevant to the discussion. It also addresses assumptions that the only important people in the clients' life are the usual suspects: the immediate family. The high-impact version of this question is: "Who are the most important people in your life that you want us to consider when doing financial planning?" Two other high-impact questions that can be asked in every client meeting and that will ensure the client's needs are being met are: "What is the most important thing for you that we cover in our meeting today?" and "What was the most important takeaway for you from our meeting today?" High-impact questions will convey the advisor's genuine concern and demonstrate a desire to truly understand clients and their unique situations.

Expressing Empathy with Ease

For many people, the third key component, expressing empathy, feels the most challenging. However, with a better understanding of the steps involved as well as a commitment to practice, conveying empathy will become more natural and less intimidating.

Expressing empathy demonstrates an under-

standing of the experience of another person. In order to be empathic, advisors have to be willing to step out of their own perspective and consider a situation from their client's point of view. Simply put, it is about "standing in someone else's shoes."

In order to understand what someone else is going through, curiosity is essential. And being curious means utilizing the skill of asking high-impact questions, and then listening at level 3 to fully understand what another person is thinking AND feeling. Thus, being empathic builds on the first two key components already discussed.

After demonstrating curiosity and listening, the third step in empathy is actually conveying it to the client. Remember, the purpose of empathy is to communicate "I get you." This can be accomplished by acknowledging the difficulty in a client's situation or validating his experience. The advisor needs to find empathic statements that feel authentic and fit the advisor's style. Often short sentences do this the best. For example, "I'm so sorry you are going through this" or "Wow, you have so much on your plate, I can't even imagine how you are juggling it all" are excellent empathic statements. When caught off guard, stating something such as, "I don't even know what to say right now, I just want you to know how sorry I am" is a genuine way to connect with someone.

There are a couple of empathy pitfalls that are important to avoid. One of them is saying, "I know just how you feel." The truth is, we never know how someone else feels and rather than connecting us to the other person, it often makes someone feel a bit defensive. Instead, "I can't even imagine how you feel right now" is much more effective. It is also important to delay problem solving until after expressing empathy. People are not as open to hearing solutions until they know that the listener truly understands what they are going through. Problem solving will follow, but remember: empathy first.

These three simple things — improving listening skills, changing the kind of questions typically asked, and learning to convey empathy with authenticity and ease — will build trust and connection with clients. As White (2008) explains, such trust building lends to a sense of emotional support which investors are proven to value more than perceived expertise in the field (p. 143). The good news is that they are things that can be learned and improved upon and take very little time to employ in any practice. Implementing these three things will also allow advisors to build more holistic financial plans, increase client retention, and make them more referable!

SCENARIO

MARTA IS A SEASONED AND SUCCESSFUL WEALTH advisor who is working with a business coach to help elevate her business to the next level. Her coach asked to sit in on a few client meetings to observe how Marta interacts with clients. In their coaching sessions they are focusing on increasing client retention, especially widows, who frequently leave advisors in the first year after their husbands die. They are also looking at ways to help Marta become more "referable." Her coach has noted that many advisors focus more on asking for referrals than on making themselves a "referral magnet."

Marta has gotten permission from a longtime client, Ingrid, to have the coach join them for their next meeting. Ingrid is a 73-year-old retired lawyer. She was a partner in a prestigious law firm in her city and only retired four years ago. She has been working with Marta for twenty years, and has always been engaged in managing her finances. Ingrid has been widowed for several years, and has two adult daughters. She is now dating someone and it has become quite serious, and she anticipates they will move in together in the near future. She often says this is one of the happiest times in her life.

Marta started the meeting by casually chatting with Ingrid and getting caught up with what is going on in her life and the life of her daughters, whom she has never met. She was happy to hear that Ingrid's grandchildren were all doing well. The coach noted they have a very comfortable rapport. Marta clearly knew a lot about Ingrid's life and they had a very easy conversation. He sensed a genuine warmth between them, which likely contributes significantly to their long professional relationship.

After the initial chatting, Marta then gently shifted the conversation to the review of Ingrid's financial plan and portfolio. She did not, however, ask the high-impact question that is an important start to the business side of the meeting: "What is most important to

you that we discuss today?" Instead, she reviewed the agenda she had prepared ahead of time, asked Ingrid if that was acceptable to her, and jumped right into reviewing her financial plan.

As the meeting progressed, it was apparent that Ingrid was clearly knowledgeable about her financial situation but, as the coach observed, Marta didn't pause at all to do check-ins with Ingrid to see if she had any questions or if there was anything she wanted her to elaborate on. And she didn't tie the financial plan directly to aspects of Ingrid's life, such as the transitions and possible changes that might lie ahead. She also didn't start the financial plan review by checking to make sure that all of the most important people in Ingrid's life were considered in the plan. For example, she could have asked something like, "Are there any changes in whom you want to consider in your financial plan?" Instead, she simply reviewed numbers and talked about how long Ingrid's money was likely to last if she lived to different ages. A couple of times the coach recognized a look of thoughtfulness on Ingrid's face, and once or twice Ingrid appeared to tune out of the conversation. Marta didn't notice because she was busy discussing the reports. There was a lot of information to cover and Marta was conscious of the time.

When they had completed the agenda items, Marta moved to wrap up the meeting and then asked, "Do you have any questions about anything we just discussed?" When Ingrid indicated she did not, Marta began putting away papers and asking Ingrid about her plans for the summer. Ingrid shared that she was going to Germany to see her mother. Marta enthusiastically replied, "Oh, that's great. Have a wonderful trip, I look forward to hearing about it when we meet again."

The coach noticed that Ingrid looked a bit sad when she talked about the trip and wondered how old her mother was, given that Ingrid was seventy-three. Marta had another client meeting and got up to say goodbye but the coach asked Ingrid how her mother was doing. Ingrid shook her head and said, "Not very well. She has Alzheimer's disease and I'm not sure she is going to recognize me on this trip. I'm guessing this might be my last time seeing her." The coach said, "I am so sorry, I can't even imagine how hard this will be for you." Ingrid said that she felt grateful there were so many good things happening in her life, but this trip was going to be a very tough one. They chatted briefly and everyone left the meeting.

Discussion

Although Marta is a seasoned and successful wealth advisor, she makes a number of very common mistakes. The most glaring is that she overestimates the importance of the numbers in both the portfolio review and the review of the financial plan. Of course the numbers matter; that is why someone seeks the guidance of a financial professional! However, people's financial life and non-financial life are intricately woven together. As mentioned in the article, every life transition, event, or "lifequake" has four implications: practical, emotional, family, and financial. The financial discussion would have been more relevant to Ingrid if Marta had connected it to those non-financial impacts.

Marta also missed opportunities to ask high-impact questions that should be part of every client meeting. Those questions include: "What is most important thing to you that we discuss today?" And, at the end of the meeting, "What was the most important takeaway to you about today's meeting?" Advisors who start and end their meetings with these types of questions learn a great deal about how to better tailor their service to that particular client.

Marta also became so focused on the reviews that she often wasn't listening at level 3. Overall, she did listen at level 2, to the content of what Ingrid

was saying, but level 3 requires someone to be fully present to what is going on for the other person. As the article suggests, this means being aware of body language, tone of voice, and the likely emotions that someone is feeling. Ingrid missed the notable facial expressions that the coach picked up on during the review: thoughtfulness and loss of interest. If Marta had simply paused at various intervals and said something such as, "This is a lot of information we are reviewing in a short time. Is there anything you'd like me to elaborate on, or anything that isn't as clear as you'd like it to be? I'm happy to answer any questions," this would have kept Ingrid more engaged and ensured she got the information she needed.

Probably the biggest opportunity that Marta missed was at the end of the meeting. When Ingrid mentioned she was going to Germany to see her mother, Marta had mentally already left the room. For her, the agenda was complete and she was likely thinking about the next meeting. Her response to Ingrid mentioning she was going to Germany was a level 1 response, listening to reply. If she had been at level 3, she would have noticed the sad facial expression and the look of concern. And she would have been present enough to know that the mother of a 73-year-old woman would be quite old and likely having some health issues. Imagine how it would have made Ingrid feel if Marta, rather than the coach, had simply asked, "How is your mom doing?" The response to this question allowed the coach to offer a genuinely empathic statement and create a connection with Ingrid. If Marta had done this, it undoubtably would have deepened the relationship. Now imagine that Marta took it one step further and took the time to send Ingrid something small for the trip. She could have given her a book to read on the plane, or gifted her something small to demonstrate she understood how difficult this trip was for Ingrid. If Marta makes these few small changes to client meetings, she is likely to increase retention and become more referable. The most successful advisors know that "all that matters is what matters to your client." They listen at level 3, ask high-impact questions, and demonstrate genuine empathy! •CSA

RESOURCES

Become a Trusted Advisor of Choice with Dr. Amy
Dr. Amy's Trusted Advisor of Choice is a practice elevation program and game-changer for financial professionals. Discover how to forge deeper, more authentic relationships that will keep you top-of-mind and take client trust, loyalty, and referrals to a whole new level. https://www.dramy.life/trusted-advisor

Empathy: The Essential Skill To Survive The Robo-Planner Threat
This article emphasized the importance of "empathy training" for financial advisors as empathy remains the primary advantage of working with people rather than AI. https://www.kitces.com/blog/empathy-training-to-survive-the-robo-planner-threat/

Five Ways Advisors Destroy Empathy
This article details mistakes that can be made in relationship building with clients. In recognizing and understanding the way in which clients can be alienated, a pathway to building greater empathy and thus stronger client relationships becomes clear. https://www.wealthmanagement.com/client-relations/five-ways-advisors-destroy-empathy

Four Reasons Why Empathy is Good for Business
This article details the way in which empathy and compassion make for more success in running a business emphasizing the importance of "soft skills." https://www.entrepreneur.com/article/322302

Soft Skills Can Make Hard Conversations Much Easier
This article identifies listening and empathy as something which sets financial advisors far ahead of AI within the field. Listening intently and asking thoughtful questions lead to greater client loyalty and security. https://www.investors.com/financial-advisors/good-listening-skills-key-to-human-financial-advisors-beating-robots/

The Best Financial Advisors Cultivate And Harness The Power Of Empathy
This article notes that empathy is essential to building strong relationships with clients. As is indicated, strong listening skills on the part of the advisor becomes a key element in the cultivation of such empathy with a client. https://www.investors.com/financial-advisors/best-financial-advisors-cultivate-empathy/

Life Transitions by **Dr. Amy** was founded with the vision of changing the way people think, talk, and act when navigating life transitions, particularly in their last third of life. For over thirty years, Dr. Amy D'Aprix has consulted extensively in the financial services and health caregiving industries, where she's renowned for providing down-to-earth, practical, and professionally informed guidance, educational programs, and coaching that deliver ROI. Contact her at dramy@dramycaregiving.com.

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