A GUIDE TO
Healthy Aging

Encompass Health
Rehabilitation Hospitals

A LETTER FROM DR. LISA CHARBONNEAU

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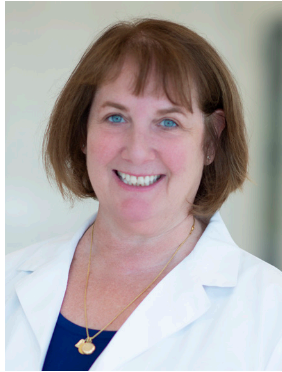

Healthcare is complicated. At Encompass Health, we understand that and want to make it a little less complicated. In this guide we want to equip you with the information and tools you need to make the best decisions for your health as you or a loved one ages.

In this two-part guide you will find information to help you make the most of the care you receive. From understanding Medicare and finding the best plan for you or your loved one to knowing your rights as a patient.

We also want to help you and your loved ones plan for the unexpected. Talking about end-of-life planning and wills and trusts are not easy family conversations, but they are necessary ones. We hope our tips help make these discussions a little easier.

Yes, healthcare can be complicated, and it tends to get more complicated as you age, but a little knowledge and some advanced planning can go a long way in navigating you or a loved one's care in your 60s and beyond.

Dr. Lisa Charbonneau, Chief Medical Officer

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Understanding **your choices** as a **patient**

During a medical emergency, there might not be time to determine your options for care, but once that emergency is stabilized, your physician or case manager could recommend you transition to another care setting as part of your recovery. These settings—known as post-acute care—include home health, inpatient rehabilitation, skilled nursing homes and long-term acute care hospitals.

Your care team could refer you to one of these settings based on your abilities and goals, but as a patient, you have a choice in selecting which facility you go to. In fact, it is your right as a patient. The Center for Medicare/Medicaid Services refers to this as patient choice.

Compare providers near you with this tool from Medicare.gov

What is patient choice

In 2019, the Center for Medicare/Medicaid Services updated its discharge planning rules to require providers to inform you of your choices when it comes to your post-acute care options.

Your referring clinicians—typically a physician and/or a case manager—are required to inform you of the different care settings available in your area that are appropriate for the level of care you require. They also have to tell you if they or their organization have any financial ties to those listed and to share information from those providers, so you can make an educated choice.

The information they share should be related to your recovery goals. Depending on the setting of care, some of that information could include data surrounding rehospitalization (the need to transfer back to the acute care hospital) and patient satisfaction scores, as well as return to community rates.

While all this information can be empowering, it can also be overwhelming, especially if you are not familiar with the different settings of post-acute care.

Know your options before you need them

As defined by the Medicare Payment Advisory Commission, post-acute care is rehabilitation or palliative care that a patient receives after a stay in an acute care hospital, or in some instances, in lieu of a hospital stay. That care can take place in the home or in a facility, depending on the patient's needs. Medicare recognizes four primary types of post-acute care:

HOME HEALTH: Home health is care that is provided in the home to help you recover after an illness or injury. Your doctor or other provider can refer you to home health and work with you and the agency to determine how many visits you are eligible to receive each week. Home health is designed to meet you where you are. If you're recovering from a surgery or a recent hospital stay or managing a disease or injury, home health provides care in the comfort of home. Home health services include nursing, therapy, nursing aides and social workers.

INPATIENT REHABILITATION: Inpatient rehabilitation provides a hospital level of care with intensive therapy to help you regain your independence and ultimately return to your community after an illness or injury. While at an inpatient rehabilitation hospital, you will receive three hours of therapy a day, five days week. You will also have frequent visits from a rehabilitation physician and other physicians, depending on your needs. Nursing care is provided around the clock, and a multi-disciplinary team that includes rehabilitation physicians, nurses, therapists, dietitians, pharmacists and case managers will design a unique care plan to fit your goals. Conditions commonly treated at rehabilitation hospitals include stroke, head or spinal cord injuries, neurological disorders such as Parkinson's and multiple sclerosis, amputation and hip fractures.

SKILLED NURSING FACILITY: At a skilled nursing facility, you will receive therapy and nursing care. However, unlike inpatient rehabilitation facilities, there are no legal requirements mandating the number of hours of care per day that must be provided. Physician visits are not as frequent, either.

LONG-TERM ACUTE CARE HOSPITAL: If you or your loved one has had a particularly extended and medically complex hospital stay, a long-term care hospital may be recommended. At a long-term care hospital, you will receive nursing and rehabilitation care for an extended period of time. Many patients referred for this level of care are not yet able to participate actively in rehabilitation and may require assistance breathing.

Will my insurance cover it?

That depends on your insurance and your coverage. You do have to meet certain medical requirements for the different settings of care to receive Medicare coverage. Also, some Medicare plans, such as Medicare Advantage ones, limit you to providers within their network. Work with your care team or primary care physician to determine if you meet the requirements of a particular setting. Make sure to discuss your goals, so they can fully understand your long-term needs and the setting that will best help you meet them. In some circumstances, you can consult with your preferred provider to see if they can work with your insurance to help you receive coverage.

Do your research

Your care team is required to provide you and your loved one with data regarding the quality of care of providers in your area, but take time to do a little research yourself. Look at patient reviews on websites. Ask family and friends with similar conditions who have had good outcomes and experiences. Where and who you receive care from matters, so take time to look around and find the best provider to help you reach your recovery goals. Perhaps a family member can tour a facility you are considering or take a virtual tour online. By understanding the different settings of care now, you are already taking a step in the right direction.

UNDERSTANDING MEDICARE AND the **best plan** for **you**

If you or a loved one are nearing the Medicare age but are unsure what this benefit provides or the plan that is best for you, we are here to help you understand your options. Medicare is the national insurance program for adults age 65 and older. It's also a benefit most working adults pay for throughout their lifetime.

Throughout the years, Medicare has evolved and extended the amount of plans available. Understand your options now, so you can pick the best plan for you or your loved one when the time comes.

What is Medicare?

The concept of federally funded health insurance dates back to the days of President Harry Truman, who pushed for a national health insurance plan for all qualifying Americans. His push failed, and it would take another two decades for Congress to adopt a national healthcare insurance plan. This one would be solely for older adults, setting the Medicare eligibility age at 65. The first American seniors began receiving Medicare in 1965.

Initially, Medicare started under the Social Security Administration, but the program is now run by the Centers for Medicare/Medicaid Services and is funded primarily through tax dollars in the form of a payroll deduction.

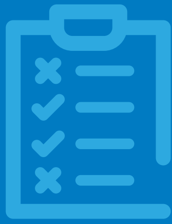
When Medicare first began, it was exclusively for those 65 and older and only included parts A and B. Over time, the program was extended to individuals under the age of 65 with certain disabilities and anyone with end-stage renal disease. Supplemental plans were also added for Americans to choose from. According to CMS, more than 62 million Americans received health insurance through Medicare in 2020.

QUICK TIP

Consider these two things when enrolling in a Medicare plan:

Your **income** and your **ability to choose** your provider.

Traditional Medicare can get expensive as you add plans; however, Medicare Advantage plans limit you to providers in their network.



While Medicare was designed primarily for older U.S. adults, Medicaid is not age specific. Instead, it is designed for those needing financial assistance with their healthcare. Both are government programs overseen by CMS but unlike Medicare, Medicaid coverage is dictated by each state, following federal guidelines. Though it does vary, coverage and eligibility are usually dictated by your income and liquid assets.

Depending on your plan, you may have to pay some deductibles and other costs under Medicare. With Medicaid, you typically don't have to pay anything for covered healthcare expenses. Some of the covered benefits under Medicaid include inpatient and outpatient hospital services, physician services, laboratory and X-ray services and home health services.

If you are on Medicaid when you turn 65, you may be eligible to receive coverage from both Medicare and Medicaid. This is called dual eligibility. Call your State Medical Assistance (Medicaid) office for more information to see if you qualify.

What to consider when picking a Medicare plan

When it comes to deciding between a traditional Medicare plan and a Medicare Advantage plan, consider two things: your income and your freedom to choose your provider. As you add supplemental plans to traditional Medicare, it can cost more than Medicare Advantage plans. However, with traditional plans, you have the freedom to choose any Medicare-approved, certified provider anywhere. Most Medicare Advantage plans require you to see a provider within their network and may require prior approval or a referral for certain procedures or healthcare services

If you're still searching for answers on what the best plan is for you, Medicare offers these seven things to consider when selecting your Medicare coverage.

1	**COST**	What are the premiums and deductibles and other costs? What do doctor appointments and hospital stays costs?
2	**COVERAGE**	Does the plan cover the services you need?
3	**YOUR OTHER COVERAGE**	If you have other health or prescription drug coverage, understand how these would work with Medicare.
4	**PRESCRIPTION DRUGS**	Do you already have a prescription drug plan or do you need to join a Medicare one? Compare and contrast the drug cost under each plan.
5	**DOCTOR AND HOSPITAL CHOICE**	Do your doctors accept this coverage? Can you choose your healthcare provider or do you have to choose from an approved network of providers?
6	**QUALITY OF CARE**	The quality of care and services offered can vary, so make sure you are satisfied with yours.
7	**TRAVEL**	Do you frequently travel outside of the U.S.? Make sure your plan covers this or make sure you purchase a supplemental plan.

How do I enroll?

You are automatically signed up for Medicare at age 65. However, if you want to select a Medicare health or drug plan, you have a seven-month period around your 65th birthday to sign up for one. This is called the initial enrollment period, and it:

- Starts three months before you turn 65; if a plan is selected during this period, it will go into effect the first day of the month you turn 65.
- Includes the month you turn 65; if a plan is selected during this period, it will go into effect the first day of the month following your 65th birthday.
- Ends three months after you turn 65; if a plan is selected during this period, it will go into effect the first day of the month after you enroll.

If you later decide to change your plan or join a plan after that seven-month period has closed, enrollment is open each year from Oct. 15 to Dec. 7. Changes or enrollment during this time period will go into effect the following January.

What are the different plans?

In general, there are two types of Medicare plans: traditional Medicare and Medicare Advantage.

Traditional Medicare

Traditional Medicare includes Parts A and B. Part A is automatic and includes hospital insurance, which covers hospital stays, as well as skilled nursing facilities and hospice. Part B is optional and is deducted from your Social Security should you enroll. It includes medical insurance, which covers outpatient services, as well as some physician visits and preventative care. Other supplemental plans can be added through private insurance companies; these are paid for out-of-pocket.

Medicare Advantage

Also referred to as Medicare Part C or MA plans, Medicare Advantage is an all-inclusive plan that includes both parts A and B, as well other coverage such as prescription drugs, dental and more, depending on the plan. These plans are offered through private Medicare-approved companies. If you join a Medicare Advantage plan, you will likely be required to choose healthcare providers that participate in your plan's network.

There are a variety of Medicare plans out there today, so as you near the Medicare age of 65, start researching your options to find the one that best meets your needs.

Cutting through the medical jargon

Sometimes, interpreting a doctor's medical jargon can feel like trying to understand a foreign language.

Most patients and families, don't want to admit they don't understand when a doctor begins explaining a complicated illness or condition, and instead sit quietly nodding in affirmation.

Jargon is pervasive in all professions, but it has its greatest impact when doctors try to communicate with patients. People's lives are at stake. Healthcare professionals have their own verbal shorthand that may be highly effective when they speak to each other but causes confusion when used with laymen.

The use of jargon begins in medical school. A medical student can quickly rattle off that, "Mrs. Jones had a syncopal episode last night without any evidence of arrhythmia. I don't think it was vagal but I ordered a 2D echo and holter. I still can't rule out a vertebrobasilar event." Everyone wearing a white coat understands this secret language, but as a patient lying in the bed, you may feel terrified and confused.

Medical jargon is everywhere

The average American reads and speaks at an eighth- or ninth-grade level, yet doctors assume that their patients will understand their obscure communication.

Multiple studies have looked at the use of jargon by doctors and the failure of patients to understand them. One study of 249 emergency room patients reported that 79% did not know that the word hemorrhage was the same as bleeding and 78% did not know that a fracture was a broken bone. In case you think these were illiterate, underprivileged people, 45% of the people in the study

QUICK TIP

Use the Ask Me 3 technique when talking to your doctor:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

were college educated. We cannot assume that the lawyer or English professor has any more understanding than someone with less education.

What can you do to interpret the medical speak?

There are some steps that you and your families can take so you don't fall into the same trap that so many do. One simple program is the "Ask Me 3" program that provides you with three questions to ask your doctor.

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Unfortunately, you may still get jargon-packed answers. So, here are a few more tips to make sure you walk away with a clear understanding of your problems.

- If you do not understand what your doctor is saying, immediately stop them and ask them to use simpler language. Don't pretend that you understand when you do not.
- Tell the doctor what you think they said to be certain that you understood them. This is called a "teach back."
- If you feel you need more time, ask to schedule another visit in the near future. This may be a telehealth visit and you will have the opportunity to have others listen in and help you.
- If the doctor is busy, ask if there is a nurse or assistant who can answer your questions.
- Take a trusted friend with you for another set of ears and even to take notes.
- Ask who you can call if you still have questions when you get home.

HEALTHCARE SCREENINGS in **your 60s** and **beyond**

One of the best ways for you to protect your health as you age is through health screenings. Identifying health problems in the earliest stages allows for prompt treatment and offers the best chance for a positive outcome. While some health screenings are suggested for both sexes, others are specific to men or women.

It is no secret that your body changes as you age. Physiological changes such as hormonal levels, cell function and loss of bone density all increase health risks. But diet, lifestyle and activity level also play a role. Prioritizing health in your later decades is one way to stay on top of changes and get the jump on issues that can turn serious if ignored.

Healthcare screenings in your 60s

As you enter your sixth decade, making time for these important health checks can be lifesaving. Many of the screenings you had in your 50s carry into the next 10 years.

For women:

- Mammograms – Women should continue regular mammograms every two years, as in the previous decade.
- Pap smear/HPV testing – Until age 65, pap smears should be done every three to five years, following the same guidelines as in your 50s. Starting at age 65, the USPSTF no longer recommends pap smear screenings in women who have had routine pap smears in the past and are at no increased risk for cervical cancer.
- Bone density screening – Starting at age 65, the USPSTF recommends routine bone scanning for women. Estrogen plays an important role in maintaining bone mass. After menopause, estrogen levels drop sharply, and bone mass loss increases. Throughout the first decades of life, bone tissue is naturally regenerated. Old bone tissue is broken down in the body and replaced by new. Bone mass stops increasing around age 30. Over the next decades, bone loss outpaces bone growth, making bones more fragile and prone to injury. By the time you

reach your 60s, if you haven't had a bone density screening, now is a good time to start. The most common test to check for signs of low bone mass or osteoporosis, is a dual-energy X-ray absorptiometry (DEXA) scan. However, according to American Bone Health, if your DEXA scan shows a T-score of -1.0 or higher, testing is needed only every 15 years unless you are at high risk of osteoporosis. Some risk factors for osteoporosis include low body weight, long-term low-calorie intake, previous fractures, family history of osteoporosis, dementia, alcoholism, history of falls and lack of physical activity.

For men:

- **Prostate cancer screening** – Men should continue prostate cancer screenings following the same protocol as in the previous decade. Yearly testing is suggested if PSA levels are above 2.
- **Aneurysm screening** – Abdominal aortic aneurysm (AAA) is a concern for men who smoke or who have smoked in the past. Between the ages of 65 to 75, the USPSTF recommends a one-time ultrasound screening. Since male smokers are in the highest risk group, the test is not routinely recommended for other groups. An aortic abdominal aneurysm is caused by a weakening in the main artery (aorta) that moves blood from the heart to the lower body. A bulge develops at the weak spot in the blood vessel and can rupture without warning, leading to life-threatening complications.

For men & women:

- **Self-skin screenings** – Women and men should continue self-skin examinations, watching for new or unusual growths. Areas of concern should be examined by a healthcare professional.
- **Colorectal cancer screenings** – Using the same guidelines as in your 50s, colorectal cancer screenings should continue through stool tests, colonoscopy or sigmoidoscopy.
- **Heart health screenings** – It is important that heart screenings continue as in the previous decade. Changes in physical health could dictate the type and frequency of screenings. In healthy adults in their 60s, blood pressure checks should be done every three years, cholesterol screenings every five years and weight checked at your annual examination.

Healthcare screenings in your 70s

Surprisingly, some routine health screenings you committed to in past decades are no longer recommended after age 70. It is important to understand, however, that general screening recommendations are based on the benefit they provide to the entire population. They are simply guidelines and do not take into consideration your personal health or physical status. For this reason, in your 70s, it is more important than ever to establish a relationship with your health provider and discuss which options are right for you.

For women:

- **Mammograms** – Routine mammograms should continue until age 75. After this point, there is no longer sufficient evidence that the screening test is beneficial to most women. Your overall health and specific needs should determine whether routine mammograms are right for you.
- **Pap smears** – The USPSTF guidelines do not recommend this screening test for women over 65. As with most screening test guidelines, any concerns you have should be addressed by a healthcare professional.

- **Bone density screening** – Since bone health is extremely important in your 70s, you should continue bone density screening. For women who are taking medications for osteoporosis, the National Osteoporosis Foundation recommends a screening scan be done every one to two years.

For men:

- **Prostate cancer screenings** – Most healthcare organizations do not recommend prostate cancer screening past age 70 if you are symptom-free with a life-expectancy of less than 10 years. If you are over 70, your overall health will play an important role in your physician's determination of whether or not prostate screening is necessary.
- **Osteoporosis screening** – The American College of Physicians recognizes the risk of osteoporosis that can lead to bone fracture in elderly men as well as women. While women lose bone mass quickly in the first few years after menopause, bone loss in men continues at a much slower pace. By age 65 to 70, the rate of bone mass loss is actually about the same in men and women. Men 70 and over who are considered at risk of osteoporosis may benefit from osteoporosis screening. Risk factors include low activity level, low body weight, low calcium or vitamin D levels, current smoker and those who drink three or more alcoholic drinks a day.

For men & women:

- Colorectal screening – Until age 75, the USPSTF continues to recommend colon and rectal cancer screening for women and men. Stool testing every one to three years, sigmoidoscopy every five years, and colonoscopy every 10 years remain the best tools for detecting colon cancer. Testing for colorectal cancer is not recommended for men or women after age 75, but if you are in good health with a life expectancy over 10 years, your physician may opt to continue screening tests.
- Heart health screening – Blood pressure, cholesterol, blood sugar and body weight continue to require monitoring. Although the USPSTF doesn't provide guidance on optimal screening intervals, screening frequency will likely be based on your overall health and whether you fall within the normal range for these tests.
- Depression screening – Although many look forward to their golden years and imagine them to be carefree and relaxing, some elderly adults suffer from depression and unhappiness. Everyone gets the blues occasionally or experiences sadness at the loss of friends and loved ones, but true clinical depression is a medical condition that requires diagnosis and treatment. Older adults are at increased risk of depression and are frequently misdiagnosed or undertreated. Depression is more common in older adults with one or more illnesses, such as heart disease or cancer. According to statistics from Mental Health America, the second highest suicide rate in the country occurs in those 85 and older. If you notice changes in yourself or a loved one, seek help from your medical provider right away. Depression can be identified and treated using methods such as the Geriatric Depression Scale.

Why **you need** a **crisis file** now

It is not uncommon to talk about what you might do if a particular health or life situation were to occur. However, what may be an abstraction can become a reality in a matter of seconds.

If an emergency were to occur, would your loved ones have access to information, such as your insurance cards and medications? A crisis file can be a place to store all this information, so in the event of a medical emergency, your loved ones can easily get pertinent information for your health and more.

What is a crisis file?

Each family is different, and for some their crisis file will be extensive, while for others it may be limited. Your crisis file can live on your computer or be stored safely in the cloud where you can access it from your devices and share with trusted loved ones. Once you compile the right information for yours, share it with a trusted loved one and make sure to keep it updated annually.

Here is a list of what could be included in your crisis file.

- ☐ ***Insurance cards:*** You can take a photo of the cards with your smartphone or record the information.
- ☐ ***Lawyers:*** The names and address of any lawyers that would have your important information like wills, deeds, etc.
- ☐ ***Power of Attorney and Medical Directives:*** Scan in actual copies of the documents and place them here.
- ☐ ***Accountant:*** This person probably has a copy of your last tax return. If you do not use an accountant, then scan in your most recent tax return.
- ☐ ***Bank accounts:*** Record the names and account numbers of all bank and checking accounts.
- ☐ ***Credit Cards:*** The names and numbers of all your credit/debit cards.
- ☐ ***Birth certificates:*** Scan copies or list where you keep them in your house or safety deposit box.
- ☐ ***Safety deposit box or home safe:*** Where are the keys or what is the combination to your safe?
- ☐ ***Passwords:*** Where do you keep your passwords? Do you have a program like "mSecure" that stores all your passwords?
- ☐ ***Physicians:*** The names, specialty and phone numbers of all your physicians.

You will undoubtedly think of other things that belong on this list, but it is a start. For a bit more information read the National Institute on Aging's "Getting Your Affairs in Order."

HOW TO TALK ABOUT **end-of-life planning**

An unexpected illness or injury can change your family's lives in less than a second. In the event this occurs, medical professionals have to ask your family to make decisions on how much care should be provide and what you would or wouldn't want done.

When these sudden illnesses or injuries occur, often families must not only absorb all of the new information about their loved one's condition, but also are left guessing what their loved one would want them to do. Unfortunately, many have never talked with their loved one about such a difficult situation.

These may only seem like hypothetical questions to discuss at a cocktail party with a drink in one hand and an hors d'ourve in the other. How many times have you said, "I would never want to live if…"? But, at 2 a.m. in the ICU, unconscious, on a ventilator and surrounded by your children and husband, it is no longer a party exercise — it is real. You need to have a serious discussion with your family about your wishes before they're faced with making those choices themselves. If you don't, they will wish you had.

It's not just for the elderly

We tend to think that end-of-life planning is primarily for the elderly or for those with cancer. Yes, they need to plan, but this is directed at the rest of you who have ignored this issue. You don't think it will happen to you, but you may find yourself at age 40, 50 or 60 in an ICU, your family unprepared and in a state of shock.

Right now, it is not too late. If you think this is going to be a difficult discussion in the comfort of your home, it will be far more difficult at 3 a.m. in a hospital waiting room.

QUICK TIP

Ellen Goodman and her colleagues created the Conversation Project to help you become better prepared for these types of events. You can go online and print off a "starter kit" that works for all ages, from the able bodied and the disabled to the eager and the reluctant participants.

'This is What I Want Done If …'

You may want to use the entire Conversation Project kit, but for now, sit down and get started by asking each other:

- Under what circumstances would you want life sustaining measures discontinued? While you may only be able to speak in generalities, it is a start.
- Try to give your family some guidance on what you consider "quality of life." This varies greatly for each person and certainly by age group. Younger people tend to invest a great deal of value in physical abilities, while those of us with a fair amount of "seasoning" realize that physical abilities are elusive and our cognitive abilities have much more value.
- If you did not have cognitive awareness or were severely cognitively impaired would that impact your decision on how much care you would want?
- Would you want a feeding tube or water (hydration)? If you wouldn't, put it in writing since some doctors and facilities may have a problem with this.
- Is your will up to date? I cannot tell you how many patients I have treated who were in a coma only to find out that the last time they updated their will or power of attorney was decades ago when they had their first child.
- Finally, most importantly, have you said all the things you need to say to each other and your children—now, while you are cognitively intact? Families without "loose ends" are able to make the difficult medical decisions much more easily. Every doctor has a dozen stories of dealing with a family that seems to be in agreement on what to do for their loved one, when a daughter or son from Cleveland shows up and tosses an "emotional grenade" in middle of the room.

Advanced directives, wills and trusts

Preparing for the future is one of the best gifts you can give yourself and your loved ones, but most Americans fail to take the necessary steps to ensure their medical and financial wishes are legally protected. A 2020 Gallup poll reveals only 45 percent of Americans have a living will and a poll conducted by the same organization the following year found that only 46 percent of adults in this country have a will to handle their property and legal affairs.

While it is not a pleasant topic, incapacitation or death can occur at any age, sometimes suddenly. Having the proper legal documents in place takes the burden off family members and helps your family and physicians clearly understand your medical wishes. It also gives you control over important medical and legal decisions. Unfortunately, a single document isn't enough to fully protect you. Learning about these essential legal documents is the first step in planning for your future.

Incapacity planning

If the time comes when you are unable to make decisions about your financial or healthcare needs, it is important that you have designated someone who can represent you in these matters. From a financial standpoint, there are documents that are essential in protecting your assets and giving decision power to someone you trust.

Financial incapacity planning

- Financial Power of Attorney – this authorizes an individual of your choosing to handle your financial affairs when you are unable to do so. There are two types of power of attorney, or POA. A durable POA is effective immediately after the document is signed. This means the appointee can act on your behalf even when you are not incapacitated. The second type of POA is called a springing POA and is effective only after you have been declared mentally incapacitated. Many states offer their own POA form, which can easily be found by

searching POA forms along with your state name. The typical requirement is that the agent acting on your behalf be eighteen years of age or older and of sound mind. Often, this form must be signed in the presence of a notary public. Without this legal document, should you become incapacitated, the courts may appoint a guardian to make these decisions for you.

- **Will** – this legal document becomes active upon your death. It designates exactly who you wish to receive your property. Without a will (or trust), state law will determine how your assets are distributed. Should you die intestate (without a will), typically the estate is passed to the surviving spouse and children, but stepchildren, friends, or charities will not be included. While having a will usually isn't enough to avoid probate (a court process to determine the validity of a will), it often speeds the probate process. A will can also minimize estate taxes, allows you to determine exactly who inherits specific assets, and puts you in charge of appointing a trusted individual to act as executor of your estate. Even if you establish a trust, many legal advisors recommend also completing a will.
- **Revocable Living Trust** – this is an estate planning document that authorizes another party to make decisions about your money or property should you die or become unable to manage your affairs. It also designates the person or persons who will receive your assets upon your death. A living trust simply means the trust is set up while you are living, and the term revocable means you can make changes in the document as you wish. By transferring properties and assets into a revocable living trust you can avoid probate, which is something you cannot do with a will. Your information remains private since the trust does not require the court's approval. Although a revocable living trust is the most common type of trust, there are many other forms of trusts, including testamentary trusts (a specific trust that goes into effect upon your death) and irrevocable trusts (an unchangeable trust that gives ownership and control of the trust to trustees). The size of your estate and your specific needs play a role in determining which trust is best for you.

Medical incapacity planning

Advance Directives are legal instructions that outline your health care wishes. Several documents fall under this term, including a medical power of attorney and a living will. While you may have discussed your desires with family or friends, it is important that these wishes be recorded in writing. Advance directive forms and requirements vary from state to state. Typically, you can complete these documents without the help of an attorney, although you may want to include them as part of your estate planning.

- **Medical Power of Attorney** – also known as a health POA, this document gives an individual of your choosing the authority to make medical

decisions for you should you be unable to do so. Under a medical POA, the individual, or agent, you select can only make healthcare decisions. This person may also be known as your patient advocate. This document does not authorize the agent to make financial decisions for you.

- Living Will – a written legal document that outlines the medical steps and treatments you want, or do not want, to be implemented for end-of-life care. These measures include cardiopulmonary resuscitation (CPR), mechanical ventilation, dialysis, tube feeding, organ or tissue donation, and more. Religious preferences may also be included.

Once your advance directives are complete, retain a copy for yourself and share a copy with your doctor and your patient advocate. You may also keep a copy in your medical records.

Medical orders

Seriously ill or terminal patients may translate their wishes into medical orders known as Provider Orders for Life-Sustaining Treatment (POLST) or Medical Orders for Life-Sustaining Treatment (MOLST). Unlike advance directives, these documents require physician's approval. Such patients may also opt for a DNR (do not resuscitate) order, which also require physician sign-off. A conversation with your doctor can help in determining which of these options may be appropriate for you.

Some online services offer estate planning kits that include the various forms discussed in this blog, but it is imperative that you understand the significance of these documents. There are many state and federal laws to consider. If you have questions or concerns, it is worthwhile to consult with an estate planning attorney who can explain the various options and provide any necessary legal advice.

Glossary: common healthcare terms and conditions defined

Healthcare can be confusing. When you add in all the medical jargon and acronyms, it can be difficult to decipher. But you don't need a degree to understand some of the common healthcare terms. We're here to help.

The following are some of commonly misunderstood medical terms simplified for you.

Acute – A sudden onset of a medical condition

Acute care – A setting of care for treatment of short-term needs, such as a hospital or urgent care facility

ADLs – Activities of Daily Living such as grooming, dressing and personal hygiene

Ambulation – The act of walking

Aspiration – The breathing in of a foreign object, such as food or liquids, into the lungs

Chronic – A condition or illness that lasts or reoccurs over time

CMS – Center for Medicare/Medicaid Services

Comorbidity – additional medical conditions that are not the primary reason for treatment

Continence – The ability to control the bladder and bowels

CVA – Cerebrovascular Accident, commonly called a "stroke"

DVT – Deep Vein Thrombosis is a blood clot occurs deep within the vein**s**

Dysphagia – Difficulty swallowing and moving food and liquids from the mouth to the stomach

Glucose – A simple sugar often a component of carbohydrates that serves as an energy source

HDL – High-Density Lipoprotein, also known as "good" cholesterol

Hypertension – Also known as high blood pressure, is when the pressure of blood flow is too high, causing the heart to work harder

Hypotension – Also known as low blood pressure, is when the pressure of blood flow is too low

Incontinence – The inability to control the bladder and bowels

Inpatient – A setting where a patient stays overnight at the hospital or facility while receiving treatment and recovering

LDL – Low-Density Lipoprotein, also known as the "bad" cholesterol, forms plaque in the blood vessels, which can lead to health concerns such as heart attack and stroke

Left neglect – A deficit or impairment in awareness of the left side of the body caused by an injury or condition in the right side of the brain

Length of stay – The time a patient stays in a setting of care

LPN – Licensed Nurse Practitioner

Morbid obesity – Having a Body Mass Index (BMI) of 40 or greater or weighing 80 to 100 pounds over normal weight

Myocardial infarction – The medical term for a heart attack

Outpatient – When a patient receives treatment, but is not admitted to the hospital or facility

OT – Occupational Therapist

PCP – Primary Care Physician

Prognosis – The likely course or progression of a disease or condition

Premorbid – Occurring or existing before the onset of a disease or illness

Post-acute care – A setting of care where patients receive care after or in lieu of an acute care stay, such as inpatient rehabilitation hospitals, home health and skilled nursing facilities

PT – Physical Therapist

Readmission – When a patient returns to the hospital after a prior stay within 30 days

RN – Registered Nurse

SLP – Speech Language Pathologist, or speech therapist

Sliding scale insulin – The sliding scale takes into account that glucose levels can vary before and after meals, so the dose of insulin is adjusted accordingly

Spasticity – Abnormal muscle tone that prevents normal movement

Transfers – Movement of a patient from one surface to another, such transitioning from the bed to a wheelchair

TIA – Transient Ischemic Attack, also known as a mini-stroke, is a brief interruption of blood flow to the brain or spinal cord, which causes temporary symptoms similar to a stroke

Other resources:

AARP

Alzheimer's Association

American Society on Aging

Connect with Encompass Health

Eldercare Directory

National Council on Aging

National Alliance for Caregiving

National Institute on Aging

Our purpose

We serve our patients and communities through customized rehabilitation that exceeds expectations. Our care teams are committed to achieving the best possible outcomes and getting patients back to what matters most.

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