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fifty plus advocate

39th year

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Health care professionals and others finally address elder bullying. p. 4

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Health care, law professionals turn attention to elder bullying

By Brian Goslow

Three years ago, the marketing director of a small residential assisted living community in a western suburb of Boston contacted Marcia Frankel, clinical director of senior services for the Jewish Family and Children's Services of Greater Boston, to ask if she would come and talk to the staff about bullying that was going on at the facility.

The nation's attention had recently been grabbed by the suicide of South Hadley teenager Phoebe Prince, who had emigrated here from Ireland and took her own life after being taunted and bullied at school, but Frankel hadn't thought about bullying among seniors until that call.


Frankel

"Afterward I started looking into bullying in the senior community and speaking with colleagues around the country and trying to develop some strategies for effectively intervening," said Frankel. "I absolutely think this wouldn't have gotten the attention it has if it hadn't been for the concerns about teen bullying and with even younger children."

According to the Administration on Aging, "Hundreds of thousands of older persons are abused, neglected and exploited (each year). In addition, elders throughout the United States lose an estimated $2.6 billion dollars or more annually due to elder financial abuse and exploitation. These are funds that could have been used to pay for basic needs such as housing, food and medical care."

The abuse occurs in every demographic. "It's still very early in being researched, but most people give figures of about 20 percent of elders encountering some level of bullying at some point in their life," Frankel said.

Frankel created a PowerPoint presentation that is being adapted by organizations in Massachusetts and throughout the United States looking to address the issue. "Is it Bullying? Strategies for Assessing and Intervening with Older Adults" identifies bullying as a "type of aggressive behavior" in which "someone is trying to gain power over another person." It can be verbal, physical or the act of isolating the individual from others.

A controlling spouse, relative or roommate who wasn't physically abusive earlier may become so when the pair is older, living in close quarters and spending more time together.

"Now they're in their late 70s, early 80s, and they're together 24/7," Frankel said. "It certainly can take its toll. Unfortunately, bullying can escalate and it can go from verbal bullying to actual physical instances of assault."

Dealing with bullying becomes much more difficult if the "bully" is suffering from Alzheimer's or dementia. They may say — or do — something for which it's human nature to respond in kind. Frankel was called to assist at one senior facility where residents were insulting some younger staff members, which made for an uncomfortable climate for everyone there.

"The wait staff in assisted living are often high school students and some of them speak in a way that can be challenging for seniors who have hearing loss," she said. Some residents called the teen workers stupid and said derogatory things about them. "The staff didn't know how to respond to these elders who were scaring them," explained Frankel.


Ebacher

Most health care and residential living facility staffers are instructed how to respond if confronted in this fashion. "Most of them have gotten pretty thick-skinned about responding and that is discussed with them," Frankel said. "One of the things I try to make a big point about and that I think is crucial is that all bad behavior isn't bullying and you have to differentiate when people are expressing things and are 'disinhibited,' as we say, because of dementia or other mental illnesses. It becomes very challenging when it's somebody with Alzheimer's who is not screening what they're saying."

Seniors are also known to bully each other. Frequently, abusive arguments break out at senior living facilities or senior centers over bingo, lunch or event seating. This form of bullying can cause someone to stop participating in activities, potentially leading them to withdraw socially, feel rejected, and become anxious and/or depressed and even suicidal.

Frankel has talked to administrators about people who take over and make what's intended to be public space into their "private" space. "There are certain places people gather and those are heightened places where social bullying goes on," she said. "Near the mailboxes is a very big area as are front lobbies and in nice weather, often where people sit outside on benches and chairs."

As more administrators began to recognize that bullying was indeed going on at their facilities, they began to seek ways of addressing it. Jason R. Ebacher, assistant superintendant and director of training, staff development and TRIAD (a program in which seniors and law enforcement works together to address issues of concern) for the Essex County Sheriff's Department, has been getting a growing number of requests to speak on the issue at senior centers in his region.

"One particular senior center called me and said they'd like me to give a talk because they need to put their foot down," Ebacher said. The center staff had recognized that when they failed to intervene in aggressive situations, some had taken it as a sign that it was OK to act that way. "They had some seniors that were not going to the senior center anymore out of fear of being bullied or harassed by other

BULLYING page 10

Clinton Youth Council on Aging supports Elder Abuse Awareness Day

By Brian Goslow

June 15 is the eighth annual World Elder Abuse Awareness Day. The event was created by the International Network for the Prevention of Elder Abuse and the World Health Organization at the United Nations to provide an opportunity for communities around the world to promote a better understanding of abuse and neglect of older persons by raising awareness of the cultural, social, economic and demographic processes affecting elder abuse and neglect.

Students from Clinton High School in Central Massachusetts have asked their town to officially recognize the day with the hope of encouraging citizen participation in the event; their actions eventually led to the entire Commonwealth recognizing the day.

Kathi Bailey, director of the Clinton Council on Aging and Senior Center, formed the Clinton Youth Council on Aging (YCOA) two years ago as a pilot program she calls, "a community and economic development tool with an aging lens." She said she recognized that much of the public policy regarding the aging population at the community level was not well understood.

"I thought the best place to start would be with the kids in the high school, to pull them together, much like a model United Nations," Bailey said. "We'd have this Youth Council on Aging that would talk about aging issues, global to local, and the economics of it all relative to public policy. Every couple of months, we'd tackle a different problem."


Clinton Youth Council on Aging members hold their proclamations at April 17 Clinton selectman meeting

Over the past two years, the YCOA, a joint program of Clinton High School and the Clinton Senior Center, have tackled accessibility issues, why women age into poverty at a greater entry rate then men and the Affordable Care Act. The group also participated in an AARP talk on Social Security and Medicare and attended last fall's Massachusetts Council on Aging conference — the first high school youth group ever to do so. The American Society on Aging Conference nominated the program as one of the most innovative projects in the country.

This semester, YCOA has dedicated itself to having Elder Abuse Awareness Day recognized by their town selectmen. Prior to their April 17 appearance in front of the board, they prepared a thorough presentation to accompany their request, which included a video and talk by each YCOA member.

"I tell them they're the experts on aging in the community," Bailey said. "When they made their presentation to the selectmen, they talked about the correlation between abuse and poverty and the correlation between abuse and alcoholism and drug addiction. They talked about violence against women around the world and then linked it all to a natural progression to elder abuse and defined it and talked about what should done about it."

Along with the June 15 designation, the YCOA also requested that funds be provided for a town employee to be trained in recognizing signs of and preventing elder abuse to be shared with other professionals in the town. Bailey noted that Boston University offers a course in "Elder Abuse, Neglect and Exploitation."

After their presentations, the Clinton selectmen approved their requests and YCOA members received a series of proclamations from local and U.S. officials, including Sen. Elizabeth Warren and State Sen. Harriette Chandler (D-Worcester), thanking them for their efforts.

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Facebook posters say nasty things about older people

By Sondra Shapiro

Just My Opinion

I am a Facebook user. Mostly I post for this publication's page. Occasionally I share a photo or two of my cats or peruse the pages of high school classmates and long lost friends. Facebook appeals to my nosey nature.

Until recently, I assumed Facebook was the great generational equalizer. While ageism has been found in the workplace, media and other institutions, my experiences led me to believe the social networking site was a place where young and old come together in age neutral territory.

As I skim posts, it is clear that young and old are often "friends" — meaning they are members of the same Facebook group. I often notice exchanges between grandparents and grandkids. Groups that represent older Americans such as AARP have Facebook pages. In fact, a 2012 Pew Internet research study found that as of December 2012, 52 percent of Internet users between the ages of 50 and 64 were using social networking sites such as Facebook and 32 percent of Internet users age 65 and older were doing so. These facts made me feel Facebook went against the societal norm.

Then my naïve assumptions were quashed after reading the results of a Yale University study that revealed ageism is commonplace on Facebook — a hard fact for this poster to swallow. Facebook is being used to perpetuate rather than halt aging bias. Researchers analyzed 84 groups that included about 25,000 members. The sites were created by people between the ages of 20 and 29. Using 75 search words such as senile, decrepit, old, aged, retired and experienced, the researchers found only one group that didn't include a negative stereotype — that belonged to individuals dedicated to the *Lord Of the Rings* character Gandalf.

"Facebook has the potential to break down barriers between generations; in practice, it may have erected new ones," observed study leader Becca Levy, Ph.D., associate professor and director of the Social and Behavioral Sciences Division at the Yale School of Public Health,

The study was recently featured in the online version of *The Gerontologist*. Researchers from the University of California in Berkeley, Hopkins School in New Haven and Hunter College in New York co-authored the study with the Yale investigators — the first of age stereotypes that appear on social-networking sites.

Often posters described older people — anyone over age 60 — as being "mental" and/or "physically incompetent." In some cases, executing the aged was proposed such as this one post that suggested anyone "over the age of 69 should immediately face a firing squad."

Another poster wrote, "I hate everything about them, from their hair nets in the rain to their white Velcro sneakers. They are cheap, they smell like (expletive deleted) ... they are senile, they complain about everything, they couldn't hear a dumptruck ..."

According to the study's summery, 74 percent of the groups excoriated older individuals, 27 percent infantilized them and 37 percent advocated banning them from public activities, such as shopping and driving.

Levy stated that Facbook officially forbids hate speech in its Community Standards list that includes mentions of race, ethnicity, national origin, religion, sex, gender, sexual orientation and disability and disease. But, it does not include hateful words against older people.

In response to the Yale study, Facebook delivered the following statement: "Direct statements of hate against particular communities violate our Statement of Rights and Responsibilities and are removed when reported to us. However, groups that express an opinion on a state, institution or set of beliefs even if that opinion is outrageous or offensive to some do not by themselves violate our policies."

There are millions of Facebook groups so the groups analyzed represent only a fraction of Facebook's global user base. But unless the researchers had the bad luck to study the few groups that show age bias, it's not a stretch to conclude that ageism is the norm.

With so many older people posting these days, what's to keep a senior from stumbling upon one of these hateful sites? Perhaps the posters don't care that their words can be hurtful. I am not suggesting we limit free speech, but social networking has become a common way for individuals to socialize. Its users should show better manners. It is up to Facebook to act responsibly by adding older people to its Community Standards list.

Sondra Shapiro is the executive editor of the Fifty Plus Advocate. Email her at sshapiro.fiftyplusadvocate@verizon.net. And follow her online at www.facebook.com/fiftyplusadvocate, www.twitter.com/shapiro50plus or www.fiftyplusadvocate.com

Long-term care: Not for me, poll says

WASHINGTON —

We're in denial: Americans underestimate their chances of needing long-term care as they get older — and are taking few steps to get ready.

A new poll examined how people 40 and over are preparing for this difficult and often pricey reality of aging and found two-thirds say they've done little to no planning.

In fact, 3 in 10 would rather not think about getting older at all. Only a quarter predict it's very likely that they'll personally need help getting around or caring for themselves during their senior years, according to the poll by the AP-NORC Center for Public Affairs Research.

That's a surprise considering the poll found more than half of the 40-plus crowd already have been caregivers for an impaired relative or friend — seeing from the other side

POLL page 21

Promises, promises: Social Security pledge at risk

By Stephen Ohlemacher

The issue:

As the population gets older, Social Security, Medicare and Medicaid are eating up more and more of the federal budget, squeezing the ability of the government to pay for other programs. Today, the three massive benefit programs account for 44 percent of federal spending. Left unchanged, they will account for more than 60 percent in 25 years, according to the Congressional Budget Office.

Unless Congress acts, the trust fund that supports Social Security is projected to run out of money in 2033. At that point, the retirement and disability program would collect only enough in payroll taxes to pay about 75 percent of benefits.

Medicare's hospital insurance fund is in worse shape. It is projected to run out of money in 2024. At that point, it would only be able to pay 87 percent of costs, according to projections by the trustees who oversee Medicare and Social Security.

The campaign promise:

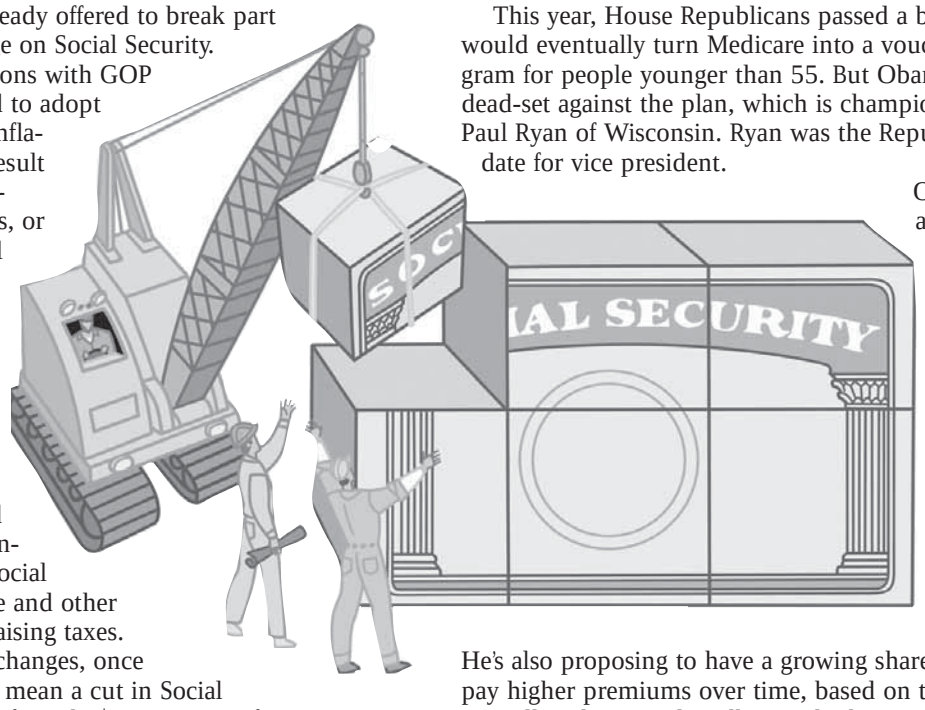
Obama rarely mentioned Social Security during his 2012 re-election campaign. Four years earlier, he was more forthcoming.

In a 2008 speech to AARP: "John McCain's campaign has suggested that the best answer for the growing pressures on Social Security might be to cut cost-of-living adjustments or raise the retirement age. Let me be clear: I will not do either."

On Medicare, Obama told the Democratic convention on Sept. 6, 2012: "Yes, we will reform and strengthen Medicare for the long haul, but we'll do it by reducing the cost of health care, not by asking seniors to pay thousands of dollars more."

The prospects:

Obama has already offered to break part of his 2008 pledge on Social Security. Twice in negotiations with GOP leaders, he agreed to adopt new measure of inflation that would result in smaller cost-of-living adjustments, or COLAs, for Social Security recipients. Both deals fell apart. But now Obama has put forward the idea in his own proposed federal budget. If adopted, it would gradually trim benefit increases in Social Security, Medicare and other programs while raising taxes.



His proposed changes, once phased in, would mean a cut in Social Security benefits of nearly $1,000 a year for an average 85-year-old, $560 for a 75-year-old and $136 for a 65-year-old.

Obama and Republican leaders in Congress have held off-and-on talks about possible changes to entitlement programs since 2011, as part of their efforts to reduce government borrowing. But a deal remains elusive. Republicans insist any agreement must include deep spending cuts, while Obama says any deal must include more tax revenue. And many Democrats in Congress are protective of the entitlement programs that Obama now is willing to touch.

This year, House Republicans passed a budget that would eventually turn Medicare into a voucher-like program for people younger than 55. But Obama says he is dead-set against the plan, which is championed by Rep. Paul Ryan of Wisconsin. Ryan was the Republican candidate for vice president.

Obama's approach to Medicare savings, known during the campaign, is different. He'd cut payments to drug companies, hospitals and other service providers. He's also proposing to have a growing share of seniors pay higher premiums over time, based on their incomes. As well, richer people will pay a higher Medicare payroll tax.

On Medicaid, though, the government has offered to foot more than 90 percent of the bill for states that expand the program to bring in millions of uninsured low-income adults. States worry Washington might shift costs back to them later.

For years, budget hawks have insisted that huge entitlements must be on the table for meaningful fiscal discipline to be achieved in Washington. Whether the effort to rein in their spending succeeds or fails, it's clear they're on the table now. — AP

Dems, GOP talk up deficit reduction, but don't act

By Charles Babington

WASHINGTON —

Liberals' loud objections to White House proposals for slowing the growth of huge social programs make it clear that neither political party puts a high priority on reducing the deficit, despite much talk to the contrary.

For years, House Republicans have adamantly refused to raise income taxes, even though U.S. taxes are historically low, and the Bush-era tax cuts were a major cause of the current deficit.

And now, top Democrats are staunchly opposing changes to Medicare and Social Security benefits, despite studies showing the programs' financial paths are unsustainable.

Unless something gives, it's hard to see what will produce the significant compromises needed to tame the federal debt, which is nearing $17 trillion.

There was nothing surprising about Republican denunciations of Obama's proposed tax increases, which he wants to combine with spending cuts to reduce the deficit.

The newer wrinkle was the left's sharp criticisms of his proposals to slow the growth in Medicare and Social Security benefits, provided Republicans agree to new revenues. Obama has offered Republicans such a deal before. But this month's budget proposal gave it a new imprimatur.

Sen. Bernie Sanders, a liberal independent from Vermont, led a petition drive opposing "any benefit cuts to Social Security, Medicare or Medicaid." The deficit, his letter says, "was primarily caused during the Bush years by two unpaid-for wars, huge tax breaks for the rich and a prescription drug program" for Medicare, funded through borrowing. He suggests that higher taxes on the wealthy are the fairest way to tackle the deficit.

Democrats cite several reasons to raise taxes on high-income households. Obama campaigned for such tax increases in 2008 and 2012 but accomplished them only partially with the "fiscal cliff" resolution of Jan. 1.

Major tax cuts in 2001 and 2003 played big roles in turning a federal budget surplus into soaring deficits, according to research by the Congressional Budget Office (CBO) and others. And by many measures, the U.S. tax burden is near historic lows.

Households earning roughly the national median income paid, on average, 11.1 percent of their income in total federal taxes in 2009, the most recent year for such data. That's the lowest level in more than 30 years, the CBO reported.

Nonetheless, House Republicans have placed their highest priority on refusing to raise income tax rates, effectively ranking it above all other goals.

If it's easy to make a case for higher revenues, the same is true for slowing the growth of Social Security and Medicare benefits. For decades, studies have warned of approaching trouble in these popular but costly programs, as health care costs rise and baby boomers

DEFICIT page 8

Entitlements' unimpeded growth is boon to seniors

By Charles Babington

WASHINGTON —

With Congress increasingly unable to resolve budget disputes, federal programs on automatic pilot are consuming ever larger amounts of government resources. The trend helps older Americans, who receive the bulk of Social Security and Medicare benefits, at the expense of younger people.

This generational shift draws modest public debate. But it alarms some policy advocates, who say the United States is reducing vital investments in the future.

Because Democrats and Republicans can't reach a grand bargain on deficit spending — with mutually accepted spending cuts and revenue hikes — Social Security, Medicare and Medicaid keep growing, largely untouched. Steady expansions of these nondiscretionary "entitlement" programs require no congressional action, so they flourish in times of gridlock.

Meanwhile, many discretionary programs are suffering under Washington's decision-by-indecision habits, in which lawmakers lock themselves into questionable actions because they can't agree on alternatives.

The latest example is $80 billion in automatic budget cuts, which largely spare Medicare and Social Security. Growth in these costly but popular programs is virtually impossible to curb without bipartisan agreements.

Instead, the spending cuts are hitting the military and many domestic programs that benefit younger Americans. They include early education initiatives such as Head Start, and scientific and medical research.

This shift in public resources is dramatic and growing. While 14 cents of every federal dollar not going to interest was spent on entitlement programs in 1962, the amount is 47 cents today, and it will reach 61 cents by 2030, according to an analysis of government data by Third Way, a centrist-Democratic think tank.

"Entitlements are squeezing out public investments" in education, infrastructure, research and other fields that have nurtured future prosperity, the study said. "The only way for Democrats to save progressive priorities like NASA, highway funding and clean energy research is to reform entitlements."

But Democrats won't consider entitlement cuts until Republicans agree to increase taxes for the rich. And Republicans, who control the House, refuse to do that.

The Third Way study was written 10 months ago. Since then, partisan clashes that produced the "fiscal cliff" and the automatic cuts have made matters even worse, said the group's vice president, Jim Kessler.


Kessler

"The foot is on the accelerator with entitlement programs, and it's on the brakes on investments," Kessler said. "And this country needs more investments."

Society must care for the elderly and needy, Kessler said, "but we can't do that at the expense of young people and new ideas."

With baby boomers retiring in huge numbers, total benefits for seniors are bound to grow. "But over the course of decades, Medicare and Social Security spending generally grow faster than inflation, per beneficiary," Kessler said. That squeezes nearly everything else.

According to White House budget records, discretionary spending comprised two-thirds of total federal outlays in 1968 and mandatory spending made up 27.5 percent. The estimate for 2018 has those shares nearly reversed: discretionary programs will consume 27.5 percent of total federal spending, mandatory programs will consume 62 percent and interest on the debt will take about 10 percent.

"Costs linked to the retirement of the baby boom generation," the nonpartisan Congressional Research Service said in a recent report, "are a major cause of rising mandatory spending." The current trajectory of federal health care spending, the report said, "appears unsustainable and could place heavy fiscal burdens on younger generations and generations not yet born."

Congress set the sequester cuts into motion as a self-imposed prod in 2011, when the parties deadlocked on how to address deficit spending. The across-the-board cuts were supposed to be so distasteful that both parties would reach a budgetary compromise to avoid them.

It didn't happen, and the cuts began taking effect last March.

They include a $1.6 billion reduction in the $30 billion budget for the National Institutes of Health (NIH), the world's largest supporter of biomedical research. NIH Director Francis Collins said the cuts will delay the start of hundreds of medical research projects.

Those paying the price, Collins said, are "ultimately patients and families who are counting on us to find those next promising cures and treatments." — AP

PRIDE comes in all ages: LGBT community needs help, support

By Michael E. Festa

The early days of June are always a wonderfully vibrant time in Boston. It's when we celebrate PRIDE week. AARP staff and volunteers proudly participate in the annual festival, providing resources and information to older lesbian, gay, bisexual and transgender (LGBT) residents.

And now, more than ever, the needs of this aging demographic are at the forefront of our minds.

AARP and You

The Administration on Aging reports that between 1.7 to 4 million Americans age 60 and older are LGBT. This demographic is more likely to live alone. They are more likely to have no children. And, they may have less-than-close relationships with their families. Small wonder many older gay men and women feel isolated.

The fact remains that many LGBT seniors, fearing discrimination, do not come out to caregivers. Still others opt to go without help — even when ill — rather than seeking assistance from service providers. According to a recent report, "Disparities and Resilience among Lesbian, Gay, Bisexual and Transgender Older Adults" (Fredrickson-Goldsen, 2012), more than 20 percent of LGBT older adults do not disclose their sexual orientation or gender identity to their physician. Of those surveyed, 68 percent reported that they experienced verbal harassment and 43 percent experienced physical violence.

Recognizing the need to look closer at the issues facing senior LGBT residents, the Massachusetts House has proposed a special commission to investigate and study the health, housing, financial, psycho-social and long-term care needs of older LGBT adults and their caregivers. The goal: to identify ways to meet the needs of this vulnerable and often invisible aging population.

Once approved, The LGBT Aging Commission, to which AARP has been named, will report on the funding and programming needed to enhance services to the growing LGBT population and examine best practices for increasing access, reducing isolation, preventing abuse and exploitation, promoting independence and self-determination, strengthening caregiving, eliminating disparities and improving quality of life.

It's no secret that we are facing a coming age wave, a demographic shift that will have a profound impact on the Bay State. The time is now to prepare for the future. The time is now to make sure that the supports and services that help seniors remain in their communities are strong and inclusive of all.

The Administration on Aging reports that between 1.7 to 4 million Americans age 60 and older are LGBT.

Services that help our older residents remain independent and in their communities as they age are important for all — and should be available to all.

Visit aarp.org/ma for more information about AARP Pride, including resources, events and information for LGBT seniors and their families.

Attending the Boston Pride Festival on Saturday, June 8? Stop by the AARP table and say hello.

Michael E. Festa is the state director of AARP Massachusetts, which represents more than 800,000 members age 50 and older in the Bay State. Connect with AARP Massachusetts online at www.aarp.org/ma; Like us at www.facebook.com/AARPMA and follow us on www.twitter.com/AARPMA.

Beware of the one-legged stool, it isn't enough to live on

By Al Norman

In 1934, when President Franklin D. Roosevelt first pitched the idea of a Social Security program to Congress, he referred to "three principles" of the program:

- Non-contributory old-age pensions for those who are now too old to build up their own insurance;
- Compulsory contributory annuities, which in time will establish a self-supporting system for those now young and for future generations;
- Voluntary contributory annuities by which individual initiative can increase the annual amounts received in old age.

Social Security was never meant to be the sole source of support in retirement. As Roosevelt said when he signed the program into law: "None of the sums of money paid out to individuals in assistance or in insurance will spell anything approaching abundance. But they will furnish that minimum necessity to keep a foothold; and that is the kind of protection Americans want."

Push Back

FDR years later depicted Social Security as "only a base upon which each one of our citizens may build his individual security through his own individual efforts."

As of 2012, 77 years after the passage of Social Security, the average monthly Social Security benefit for a retired worker was roughly $1,230. That's $14,760 a year. The federal poverty level that year for one person was $11,170. So Social Security is just enough to stay above poverty — but $40.44 a day is not what FRD called "abundance."

When I was in college, we were told that the three legged stool was made up of Social Security, pensions and private savings. But since the 1970s, many employers shut down their defined benefit pension plans, which gave retirees a guaranteed monthly payment based on years of service and salary.

For low- and middle-income workers, the three legged stool became a one legged pole.

Instead, employers began offering defined contribution plans, which shifted the pension burden from the employer to the employee, leaving it up to workers to finance their future alone. For low- and middle-income workers, the three legged stool became a one legged pole: they made too little to save, and their employer pension was gone.

To stimulate more private savings, the White House is now proposing automatic IRAs, which would be funded by workers. President Obama's 2014 federal budget includes a proposal to require small employers (those with less than $20 million in annual payroll) and with 10 or more workers and no retirement plan, to automatically enroll employees in an IRA, from which they could opt out. "About half of American workers have no workplace retirement plan," the president said. "Yet fewer than one out of 10 workers who are eligible to make tax-favored contributions to an (IRA) actually do so." The president's new treasury secretary said automatic IRAs would help people "get in the practice of saving for their retirement."

But this is the same administration that just proposed cutting the Social Security cost of living adjustment, which would take $130 billion out of retirees' pockets over the next decade. Instead of putting more burden on cash-strapped workers, the White House should drop the chained CPI proposal, and impose higher Social Security payroll taxes on people earning more than $113,700. Congressman Bernie Sanders (I-VT) has proposed raising the FICA tax on salaries over $250,000.

One thing is certain: most workers don't earn enough to put much away. If we are down to a one-legged stool — it's better to shore up the Social Security leg, than to expect workers to "automatically" finance their own retirement.

Al Norman is the executive director of Mass Home Care. He can be reached at 978-502-3794, or at info@masshomecare.org.

➤ *Deficit*

Cont. from page 6

begin to retire.

If lawmakers are to preserve the programs for future retirees, they will have to accept much more political pain than officials endured during a 1983 overhaul that included several extremely controversial measures, said Social Security trustee Charles P. Blahous.

Obama has proposed an often-discussed step, which deals with government accounting in general, not just entitlement programs. If Congress agrees to higher tax revenues, the president said, he would back a slower growth calculation for cost-of-living increases for Social Security benefits, plus higher Medicare premiums for higher-income seniors.

Interest groups have criticized both ideas. AARP calls the slower cost-of-living formula a "harmful change," and urges seniors to oppose it.

American voters can largely blame themselves when Congress is more talk than action on deficit reduction. Americans routinely say they want a smaller federal debt, but not at the cost of programs they hold dear — including Social Security and Medicare. — AP

No one fix to slow hospital readmission epidemic

By Lauran Neergaard

WASHINGTON —

More than 1 million Americans wind up back in the hospital only weeks after they left for reasons that could have been prevented — a revolving door that for years has seemed impossible to slow.

Now Medicare has begun punishing hospitals with hefty fines if they have too many readmissions, and a top official said signs of improvement are beginning to emerge.

"We're at a very promising moment," Medicare deputy administrator Jonathan Blum told The Associated Press.

Nearly 1 in 5 Medicare patients is hospitalized again within a month of going home, and many of those return trips could have been avoided. But readmissions can happen at any age, not just with the over-65 crowd who are counted most closely.

Where you live makes a difference, according to new research that shows how much room for improvement there really is. In parts of Utah, your chances of being rehospitalized are much lower than in areas of New York or New Jersey, according to a report from the Dartmouth Atlas of Health Care.

The AP teamed with the Robert Wood Johnson Foundation to explore, through the eyes of patients, the myriad roadblocks to recovery that make it so difficult to trim unneeded readmissions.

The hurdles start as patients walk out the door.

"Scared to go home," is what Eric Davis, 51, remembers most as he left a Washington hospital, newly diagnosed with a dangerous lung disease. His instructions: stop smoking. He didn't know how to use his inhaler or if it was safe to exercise, until a second hospitalization weeks later.

There is no single solution. But what's clear is that hospitals will have to reach well outside their own walls if they're to make a dent in readmissions.

Otherwise a slew of at-home difficulties — confusion about what pills to take, no ride to the drugstore to fill prescriptions, not being able to get a post-hospital check-up in time to spot complications — will keep sending people back.

"This is a team sport," said readmissions expert Dr. Eric Coleman of the University of Colorado in Denver. It requires "true community-wide engagement."

Pushed by those Medicare penalties, hospitals are getting the message.

"It's made hospitals go, 'Oh my gosh, just because they're outside my door doesn't mean I'm done,' " said nurse practitioner Jayne Mitchell of Oregon Health & Science University, who heads a new program to reduce readmissions of patients with heart failure.

In a pilot test, her hospital is sending special telemedicine monitors home with certain high-risk patients so that nurses can make a quick daily check of how these patients are faring in that first critical month.

Too often, families don't realize that many readmissions can be prevented.

NO page 10

Tips to help avoid a preventable hospital return

Patients too often leave the hospital without knowing how to care for themselves, leading to a preventable return. Here are tips to improve your chances of a successful recovery at home:

•Be sure you understand your illness and the care you received in the hospital.

•Ask if you will require help at home. Can you bathe yourself? Climb stairs? Will you need bandages changed or shots? If so, do you have a caregiver to help, or will you need to arrange for a visiting nurse?

•Repeat back your care instructions to be sure you understand them.

•Ask for a written discharge plan that lists your medical conditions, your treatments and the plan for your ongoing care.

•Get a list of all medications, how to use them and what to do if you experience side effects. Be sure to ask whether to continue medications you were taking before this hospitalization.

•Ask what symptoms suggest you're getting worse and what to do if that happens, especially at night or during the weekend.

•What follow-up appointments will you need and when? Ask if your hospital will make the appointments for you, and send your records.

•Do you have transportation home to follow-up appointments and to the drugstore?

•If you have a regular physician, make sure the hospital sends a report of your hospital stay.

•If you are uninsured or will have difficulty affording prescriptions, a hospital discharge planner or social worker may be able to link you to community resources that can help.

•Get a name and number to call if questions about your hospitalization or discharge arise. — AP

Sources: Dr. Eric Coleman, University of Colorado in Denver; Robert Wood Johnson Foundation; Journal of the American Medical Association.

➤ No

Cont. from page 9

In Fort Washington, Md., Reggie Stokes started asking questions after his 84-year-old stepmother was hospitalized four times in a row for transfusions to treat a rare blood disorder. He found a specialist in another city who said a bigger dose of a common medication is all she needs.

The hospital "could have helped her and saved money" by doing that legwork, Stokes said. His advice: "You have got to go out and do research for yourself."

That's hard when you're feeling ill, said Lincoln Carter, 50, of New York, who didn't think his pneumonia was under control when the hospital discharged him.

But, Carter said, "I didn't even really know the questions to ask." Nor could he get to his regular doctor's office. When "you can't breathe, the last thing you want to do is sit on the subway." A few days later, he was back in the hospital.

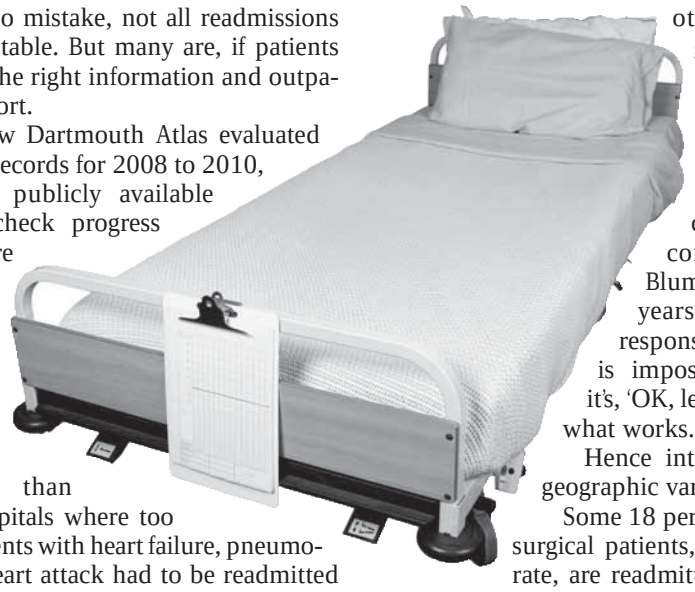
Patients don't have to be powerless, and the Robert Wood Johnson Foundation has started an effort called "Care About Your Care," which offers consumers tips to guard against unnecessary readmissions.

"Everyone has to understand their role in improving the quality of care, including families," said Dr. Risa Lavizzo-Mourey, the foundation's president. "This could be a time when we turn the corner."

Rehospitalizations are miserable for patients, and a huge cost — more than $17 billion a year in avoidable Medicare bills alone — for a nation struggling with the price of health care.

Make no mistake, not all readmissions are preventable. But many are, if patients are given the right information and outpatient support.

The new Dartmouth Atlas evaluated Medicare records for 2008 to 2010, the latest publicly available data, to check progress just before Medicare cracked down. In October, the government began fining more than 2,000 hospitals where too many patients with heart failure, pneumonia or a heart attack had to be readmitted in recent years.



"Change is hard and comes slowly," said Dartmouth's Dr. David Goodman, who led the work.

Of seniors hospitalized for nonsurgical reasons, 15.9 percent were readmitted within a month in 2010, barely budging from 16.2 percent in 2008. Surgery readmissions aren't quite as frequent — 12.4 percent in 2010, compared with 12.7 percent in 2008. That's probably because the surgeon tends to provide some follow-up care.

Medicare's Blum told the AP that the government is closely tracking more recent, unpublished claims data that show readmissions are starting to drop. He wouldn't say by how much or whether that means fewer hospitals will face penalties next year when the maximum fines are scheduled to rise.

But by combining the penalties with other programs aimed at improving these transitions in care, "we have now changed the conversation," Blum said. "Two years ago, the response was, 'This is impossible.' Now it's, 'OK, let's figure out what works.' "

Hence interest in the geographic variation.

Some 18 percent of nonsurgical patients, the highest rate, are readmitted within a month in the New York City borough of the Bronx. Rates are nearly that high in Detroit, Lexington, Ky., and Worcester, Mass.

Yet the readmission rate in Ogden, Utah, is just 11.4 percent. Half a dozen other areas — including Salt Lake City, Muskegon, Mich., and Bloomington, Ill. — keep those rates below 13 percent.

For surgical patients, Bend, Ore., gets readmissions down to 7.6 percent.

Some studies suggest part of the variation is because certain hospitals care for sicker or poorer patients, especially in big cities. Yet Minneapolis, for example, has readmission rates just below the national average. Goodman said whether local doctors' stress outpatient care over hospitalization, and how many hospital beds an area has, play big roles, too.

Readmissions don't always happen because the original ailment gets worse. It could be a new problem — the pneumonia patient who's still weak and falls, breaking a hip.

Yale University researchers recently reported in the *Journal of the American Medical Association* that people face a period of overall vulnerability to illness right after a hospitalization, because of weakness, sleep deprivation, loss of appetite and side effects of new medications.

But ask returning patients what went wrong, and Coleman, the readmissions expert, said nonmedical challenges top the list.

New York's Montefiore Medical Center now sends uninsured patients home with two weeks' worth of medication so they don't have to hunt for an affordable place to fill a prescription right away, said Dr. Ricardo Bello, a cardiac surgeon.

In the nation's capital, Dr. Kim Bullock recalled her frustration with a diabetic hospitalized nine times in one year in part because of transportation. He felt too lousy to ride two buses and the subway to the nearest Medicaid clinic for regular care.

"Start from their reality," said Bullock, an emergency room doctor and family physician. Without the right community connections, "they will just stumble along."

Another hurdle: The Dartmouth study found fewer than half of patients saw a primary care doctor within two weeks of leaving the hospital. — AP

Online: Care About Your Care, www.careaboutyourcare.org; Care Transitions, www.caretransitions.org; Dartmouth Atlas of Health Care, www.dartmouthatlas.org.

➤ Bullying

Cont. from page 4

seniors," said Ebacher.

He said there's a fine line between abuse and bullying. "A lot of times, I'll get questions when I'm giving a talk like, 'Geez, this has happened to me or this has happened to me' and a lot of times it's actually more of an abuse situation, whether it's physical, emotional, mental — in those times, I say, if it's an abuse situation, you contact the local law enforcement authorities and handle it that way. Or you contact your senior center or you let somebody know."

Frankel said bullying is a form of abuse that involves an attempt to exert power/control over another person.

Instead of clearly defining the two, Ebacher preferred to give their differences:

• Violence (abuse) has generally been decreasing in America, bullying has not.

• Violence is against the law, while bullying generally isn't unless it crosses the line into harassment or assault.

• Violence is generally seen as an unacceptable type of behavior; (while) more people accept bullying as a normal part of life.

Ebacher credits Frankel's research and her "Is it Bullying" presentation as providing a guideline to address bullying issues. The main objectives of the program is to identify key characteristics of social bullying among older adults in a variety of settings; distinguish between bad behavior and bullying; and learning how bystanders can help reduce bullying behavior.

Bystanders sometimes remain silent when they see bullying, be it because "it's none of my business," they fear getting hurt or becoming the next victim or feel powerless to intervene and don't know what to do. However, studies show getting involved makes a huge difference. When someone speaks up, the bullying stops 50 percent of the time, usually within 10 seconds.

During one of Ebacher's talks, he overheard an older person bullying another older person. So he stopped talking and told the audience, " 'You know what? It's all about respect. Have respect for your other elders that are in the senior centers and act like an adult.' "

He has found that if during his talks, an individual has repeat questions, they're usually about the person's own personal situation. He usually asks to speak to the person after the event. Oftentimes, he finds out the "bully" is a family member or person entrusted to look after a loved one whose physical or mental state is in decline. "It could be anybody. Anybody could be somebody's power of attorney or somebody's guardian. Unfortunately, the majority of times, it's the immediate family, a loved one," said Ebacher.

"Neglect is huge. Some of the seniors don't have food in their house and the person that's responsible for doing that is not going out and getting the things they need to live." The worst level of abuse occurs when someone with the power of attorney is stealing money from a person.

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UGANDA, a different kind of life

By Victor Block

UGANDA — Enjoying a hot shower, buying meat at a market or strolling through a village may seem like commonplace occurrences. But in the African country of Uganda, these experiences are likely to be unlike life as you're used to living it.

The shower is water poured into a rooftop tank, which drips through holes in a bucket onto the bather below. Meat is body parts of animals, some unidentifiable, strung up in an outdoor marketplace. And many villages are mud-brick huts with thatch roofs and dirt floors.

Child at well

(photos by victor block)

One impression of Uganda during my recent visit was how much diversity is squeezed into an area about three times the size of Maine. Broad plains and lush rain forests cover much of the country. One-quarter of the landlocked nation is under water, including Lake Victoria, the second largest freshwater lake in the world after Superior.

Most people visit Uganda to observe a Noah's Ark variety of wildlife in its natural habitat. Our itinerary included visits to two major gathering places of elephants, and sightings of herds of zebras. We observed giraffes browsing on tender leaves at the top of tall trees as powerful cape buffalo wallowed in mud nearby.

Uganda offers a Noah's Ark variety of wildlife.

Hippos immersed in rivers, baboons congregating alongside dusty roads and wart hogs with faces only another wart hog could love also caught our attention. Birders delight at spotting some of the 1000-plus species of resident and migratory winged life.

Several lion sightings were among the highlights of our game drives. A rare treat was a visit to one of only two places in the world where the big cats spend part of the day sprawled over tree branches.

Another special experience was trekking for mountain gorillas. Of the estimated 880 of those magnificent creatures in the world, about 400 live in Uganda's aptly named Bwindi Impenetrable Forest.

The narrow trail up steep hillsides soon disappeared and our guide cut a shoe-wide path with his machete. Slippery ground and unbreakable vines that clutched at our feet added to the challenge.

When we finally located our prey, several peered down from tree branches where they were chomping on leaves, while others enjoyed their meal on the ground. When the silverback, the large dominant male, growled and began to advance toward us, our guide waved his machete and the hulking animal turned away. Guides also carry an AK-47, which, they assured us, would be used to frighten away an animal, not shoot it.

Along with the fascinating array of wildlife in Uganda, I found life of another kind to be equally intriguing. Many of Uganda's 35 million people are among the poorest in the world, yet they retain a lust for life and amiable demeanor.

Women tilling the soil on steep hillsides, some with a baby in a sling on their back, often chat and laugh with friends toiling in adjacent fields. Wide smiles adorn the faces of children, who wave to passing vehicles transporting visitors.

I still picture lines of women and children walking beside roads that are more pothole than pavement, balancing a variety of bundles on their head. They included bunches of bananas, laundry just washed in a stream and heavy five gallon plastic containers of water pumped from the village well.

Deo Karegyesa, a farmer with whom we visited, explained that he sleeps near his sweet potato crop to keep foraging bush pigs away. He proudly pointed to a deep trench that he and other villagers had dug to prevent elephants from destroying their crops.

Mountain Gorilla

As we chatted with a traditional healer named Alfonse Bifumbo in his thatch-roof hut, chickens pecked at the dirt floor. He described herbs he uses to treat ailments that range from malaria to ear, eye and nose problems, and to drive away evil spirits that he said sometimes possess people.

The adrenaline rush of a charging mountain gorilla and stately beauty of lions sprawled over tree branches are but two memories of Uganda that linger in my mind. Equally fascinating were encounters with people whose culture and lifestyle are very different from mine, and that provide even more reasons to visit that fascinating country.

Women and children walk beside roads that are more pothole than pavement.

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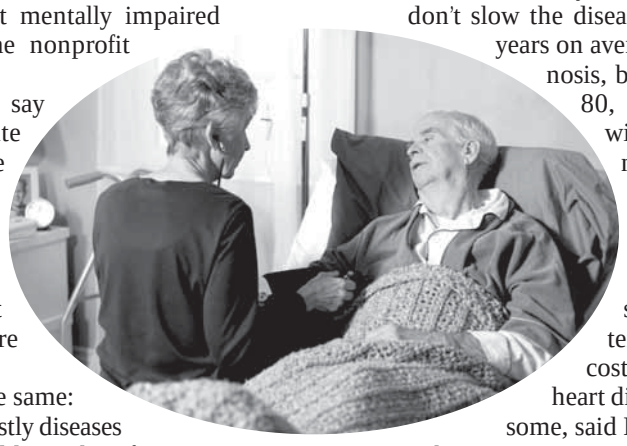
Dementia tops cancer, heart disease in cost

Cancer and heart disease are bigger killers, but Alzheimer's is the most expensive malady in the U.S., costing families and society $157 billion to $215 billion a year, according to a new study that looked at this in unprecedented detail.

The biggest cost of Alzheimer's and other types of dementia isn't drugs or other medical treatments, but the care that's needed just to get mentally impaired people through daily life, the nonprofit RAND Corp.'s study found.



It also gives what experts say is the most reliable estimate for how many Americans have dementia — around 4.1 million. That's less than the widely cited 5.2 million estimate from the Alzheimer's Association, which comes from a study that included people with less severe impairment.

"The bottom line here is the same: Dementia is among the most costly diseases to society, and we need to address this if we're going to come to terms with the cost to the Medicare and Medicaid system," said Matthew Baumgart, senior director of public policy at the Alzheimer's Association.

Dementia's direct costs, from medicines to nursing homes, are $109 billion a year in 2010 dollars, the new RAND report found. That compares to $102 billion for heart disease and $77 billion for cancer. Informal care by family members and others pushes dementia's total even higher, depending on how that care and lost wages are valued.

"The informal care costs are substantially higher for dementia than for cancer or heart conditions," said Michael Hurd, a RAND economist who led the study. It was sponsored by the government's National Institute on Aging.

Alzheimer's is the most common form of dementia and the sixth leading cause of death in the United States. Dementia also can result from a stroke or other diseases. It is rapidly growing in prevalence as the population ages. Current treatments only temporarily ease symptoms and don't slow the disease. Patients live four to eight years on average after an Alzheimer's diagnosis, but some live 20 years. By age 80, about 75 percent of people with Alzheimer's will be in a nursing home compared with only 4 percent of the general population, the Alzheimer's group says.

"Most people have understood the enormous toll in terms of human suffering and cost," but the new comparisons to heart disease and cancer may surprise some, said Dr. Richard Hodes, director of the Institute on Aging.

"Alzheimer's disease has a burden that exceeds many of these other illnesses," especially because of how long people live with it and need care, he said.

For the new study, researchers started with about 11,000 people in a long-running government health survey of a nationally representative sample of the population. They gave 856 of these people extensive tests to determine how many had dementia, and projected that to the larger group to determine a prevalence rate — nearly 15 percent of people over age 70.

Using Medicare and other records, they tallied the cost of purchased care — nursing homes, medicines and other treatments — including out-of-pocket expenses for dementia in 2010. Next, they subtracted spending for other health conditions such as high blood pressure, diabetes or depression so they could isolate the true cost of dementia alone.

"This is an important difference" from other studies that could not determine how much health care cost was attributable just to dementia, said Dr. Kenneth Langa, a University of Michigan researcher who helped lead the work.

Even with that adjustment, dementia topped heart disease and cancer in cost, according to data on spending for those conditions from the federal Agency for Healthcare Research and Quality.

Finally, researchers factored in unpaid care using two different ways to estimate its value — foregone wages for caregivers and what the care would have cost if bought from a provider such as a home health aide. That gave a total annual cost of $41,000 to $56,000 per year for each dementia case, depending on which valuation method was used.

"They did a very careful job," and the new estimate that dementia affects about 4.1 million Americans seems the most solidly based than any before, Hodes said. The government doesn't have an official estimate but more recently has been saying "up to 5 million" cases, he said.

The most worrisome part of the report is the trend it portends, with an aging population and fewer younger people "able to take on the informal caregiving role," Hodes said. "The best hope to change this apparent future is to find a way to intervene" and prevent Alzheimer's or change its course once it develops, he said.

Online: Alzheimer's information: www.Alzheimers.gov; National Institute on Aging: www.nia.nih.gov.

Palliative care improves quality of life

By Judith Boyko

More than 1.5 million people in our country die each year as a result of chronic illness. According to "America's Care of Serious Illness," a report published by the Center to Advance Palliative Care and the National Palliative Care Research Center, "most people living with a serious illness experience inadequately treated symptoms, fragmented care, poor communication with their doctors and enormous strains on their family caregivers."

Baby boomers are aging at an unprecedented rate. Coupled with increased life expectancies, which will result in more people living longer with at least one chronic illness, the need for palliative care is both understandable and imperative.

Although the number of palliative care programs has significantly increased over the last decade, there are still misconceptions about what it is.

Myth: Palliative care is terminal care.

Truth: Palliative care is focused on improving a patient's quality of life through pain relief and symptom management.

For many people battling diseases like cancer, end-stage congestive heart failure, ALS (Lou Gehrig's disease), or end-stage Chronic Obstructive Pulmonary Disorder, palliative care is often the best plan and may be delivered simultaneously with curative treatments.

For example, patients undergoing chemotherapy may experience such side effects as nausea and vomiting, breathing problems, loss of appetite and pain. Palliative care may help to relieve those symptoms and potentially prevent re-hospitalizations.

Colleen E. Gallagher BSN, RN, CHPN, director of special programs and clinical nurse manager at the Natick Visiting Nurse Association, said, "Not only does palliative care provide the comfort a patient requires during an extremely difficult time, but it also reduces the cost of care for patients with chronic or life-limiting illness."

Caregiving Tips

Myth: Palliative care and hospice care are the same thing.

Truth: Although palliative care and hospice care are both focused on care, there are differences in their delivery.

While palliative care is focused on providing relief from stress and symptoms during serious illness, hospice prepares the patient — and the family — for death.

Typically, hospice care is delivered after a patient has been given a prognosis of less than six months to live and is no longer receiving curative treatments. The focus of hospice care is to enable patients with a terminal illness to experience the end of their lives with dignity, as fully as possible.

Myth: I have to be in the hospital to receive palliative care.

Truth: Palliative care can be delivered/administered where the patient chooses to receive it: at an assisted living facility, nursing home, hospital, doctor's office, a clinic

PALLIATIVE page 16

Stay alert and be cautious to avoid scammers

By Brenda Diaz

Gladys received a telephone call from a telephone number she did not recognize. When she answered, the caller asked if she was a senior. Gladys said "yes." The caller asked her to confirm her full name and address. Gladys confirmed the information. At that point the caller then rattled off a series of numbers and asked Gladys to confirm this was her bank routing number. Gladys hung up the phone. This was the best thing she could have done. Gladys was in the process of being scammed.

Unfortunately, seniors are a major target of scamming. Currently, there is an unfortunate trend of scammers using Healthcare Reform as a way of getting into a senior's retirement fund. Whether it is a person or a group of people targeting seniors, seniors must be savvy to avoid a scam. In 2012, The federal government received 83,000 complaints, up 12 percent from 2011.

Medicare discount cards cannot be sold over the telephone. Contact Medicare directly to enroll in their programs at 800-MEDICARE.

Seniors may also be vulnerable to big return investment scams, fraudulent lottery winnings or reverse mortgage opportunities. Never make a limited-time offer decision. If you are being pressured over the telephone, chances are they are not who they said they were.

Lenny was at home watching television, when he heard a knock on his front door. When he went to his door, a local contractor was offering him free estimates on any work he needed done at home. Lenny let the gentleman in and started explaining how many things he needed done around the house. Lenny thought he was getting a great deal and the contractor was just what he needed. Unfortunately, Lenny gave the contractor a check for the supplies and the contractor did not return to perform the services. Never hire anyone who comes to your door without you initially contacting them.

Caregiving Tips

Please remember this golden rule, any opportunity that sounds too good to be true, most likely is.

Five tips to avoid a scam:

- Never give any personal or financial information.
- Register your telephone number with the Do Not Call Registry by calling 888-382-1222.
- Ask many questions. And make sure you get answers from a company you can trust and verify is legitimate.
- Take all the time you need to make a sound decision.
- Carefully read all the fine print on written correspondence stating any lottery or travel winnings.

Brenda Diaz is the director of community relations at Wingate Healthcare. She can be reached at Wingate of Needham or Wingate of Sudbury, 781-707-6106. Visit their website at www.wingatehealthcare.com and wingatehealthcare.com/location_needham. Archives of articles from previous issues can be read on fiftyplusadvocate.com.

One in 3 seniors dies with, not of, dementia

By Lauran Neergaard

WASHINGTON —

A staggering 1 in 3 seniors dies with Alzheimer's disease or other types of dementia, says a new report that highlights the impact the mind-destroying disease is having on the rapidly aging population.

Dying with Alzheimer's is not the same as dying from it. But even when dementia isn't the direct cause of death, it can be the final blow — speeding someone's decline by interfering with their care for heart disease, cancer or other serious illnesses. That's the assessment of a recent report by the Alzheimer's Association, which advocates for more research and support for families afflicted by it.

"Exacerbated aging," is how Dr. Maria Carrillo, an association vice president, terms the Alzheimer's effect. "It changes any health care situation for a family."

In fact, only 30 percent of 70-year-olds who don't have Alzheimer's are expected to die before their 80th birthday. But if they do have dementia, 61 percent are expected to die, the report found.

Already, 5.2 million Americans have Alzheimer's or some other form of dementia. Those numbers will jump to 13.8 million by 2050, the report predicts. That's slightly lower than some previous estimates.

Count just the deaths directly attributed to dementia, and they're growing fast. Nearly 85,000 people died from Alzheimer's in 2011, the Centers for Disease Control and Prevention estimated in a separate report (CDC). Those are people who had Alzheimer's listed as an underlying cause on a death certificate, perhaps because the dementia led to respiratory failure. Those numbers make Alzheimer's the sixth leading cause of death.

That death rate rose 39 percent in the past decade, even as the CDC found that deaths declined among some of the nation's other top killers — heart disease, cancer, stroke and diabetes. The reason: Alzheimer's is the only one of those leading killers to have no good treatment. Today's medications only temporarily ease some dementia symptoms.

Carrillo

But what's on a death certificate is only part of the story.

Consider: Severe dementia can make it difficult for people to move around or swallow properly. That increases the risk of pneumonia, one of the most commonly identified causes of death among Alzheimer's patients.

Likewise, dementia patients can forget their medications for diabetes, high blood pressure or other illnesses. They may not be able to explain they are feeling symptoms of other ailments such as infections. They're far more likely to be hospitalized than other older adults. That in turn increases their risk of death within the following year.

"You should be getting a sense of the so-called blurred distinction between deaths among people with Alzheimer's and deaths caused by Alzheimer's. It's not so clear where to draw the line," said Jennifer Weuve of Chicago's Rush University, who helped study that very question.

The Chicago Health and Aging Project tracked the health of more than 10,000 older adults over time. Weuve's team used the data to estimate how many people nationally will die with Alzheimer's this year — about 450,000, according to the report.

That's compatible with the 1 in 3 figure the Alzheimer's Association calculates for all dementias. That number is based on a separate analysis of Medicare data that includes both Alzheimer's cases and deaths among seniors with other forms of dementia.

Last year, the Obama administration set a goal of finding effective Alzheimer's treatments by 2025, and increased research funding to help. It's not clear how the government's automatic budget cuts, which began earlier this year, will affect those plans.

But the new report calculated that health and long-term care services will total $203 billion this year, much of that paid by Medicare and Medicaid and not counting unpaid care from family and friends. That tab is expected to reach $1.2 trillion by 2050, barring a research breakthrough, the report concluded. — AP

➤ *Palliative*

Cont. from page 15

or in their own home.

Myth: I don't have a say in the type of care I receive.

Truth: As a specialty, palliative care is delivered by a diverse, interdisciplinary team of professionals — including physicians, nurses, certified home health aides, social workers, physical therapists, spiritual or religious counselors, occupational therapists, pharmacists and music and art therapists.

They work closely with the patient's primary doctor, with each other, with the patient and with the patient's family to ensure that the care begins at the appropriate point of illness and addresses the patient's physical, emotional and spiritual needs and well being.

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Scooter ads face scrutiny from government

WASHINGTON —

TV ads show smiling seniors enjoying an "active" lifestyle on a motorized scooter, taking in the sights at the Grand Canyon, fishing on a pier and high-fiving their grandchildren at a baseball game.

The commercials, which promise freedom and independence to people with limited mobility, have driven the nearly $1 billion U.S. market for power wheelchairs and scooters. But the spots by the industry's two leading companies, The Scooter Store and Hoveround, also have drawn scrutiny from doctors and lawmakers, who say they create the false impression that scooters are a convenient means of transportation rather than a medical necessity.

Members of Congress say the ads lead to hundreds of millions of dollars in unnecessary spending by Medicare, which is only supposed to pay for scooters when seniors are unable to use a cane, walker or regular wheelchair. Government inspectors say up to 80 percent of the scooters and power wheelchairs Medicare buys go to people who don't meet the requirements. And doctors say more than money is at stake: Seniors who use scooters unnecessarily can become sedentary, which can exacerbate obesity and other disorders.

"Patients have been brainwashed by The Scooter Store," said Dr. Barbara Messinger-Rapport, director of geriatric medicine at the Cleveland Clinic. "What they're implying is that you can use these scooters to leave the house, to socialize, to get to bingo."

The scooter controversy, which has escalated with a recent government raid on The Scooter's Store's New Braunfels, Texas, headquarters, underscores the influence TV ads can have on medical decisions. Like their peers in the drug industry, scooter companies say direct-to-consumer advertising educates patients about their medical options. But critics argue that the scooter spots are little more than sales pitches that cause patients to pressure doctors to prescribe unnecessary equipment.

The Scooter Store and Hoveround, both privately held companies that together make up about 70 percent of the U.S. market for scooters, spent more than $180 million on TV, radio and print advertising in 2011, up 20 percent since 2008, according to advertising tracker Kantar Media. Their ads often include language that the scooters can be paid for by Medicare or other insurance.

"The fact that 87 percent of the persons who seek power mobility products from The Scooter Store under their Medicare benefits are disqualified by the company's screening process is powerful evidence of the company's commitment to ensuring that only legitimate claims are submitted to Medicare," the company said in a statement.

Insurance executives say doctors who don't understand when Medicare is supposed to pay for scooters are partly to blame for unnecessary purchases.

Scooters — which are larger than power wheelchairs and often include a handlebar for steering — are covered by Medicare if they are prescribed by a doctor who has completed an evaluation showing that their patient is unable to function at home without a device.

The doctor fills out a lengthy prescription form and sends it to a scooter supplier that delivers the device to the patient and then submits the paperwork to Medicare for payment. Medicare pays about 80 percent of that cost. Supplemental insurance or the government-funded Medicaid program often picks up the remainder for low-income and disabled Americans.

But Dr. Stephen Peake, medical director for the insurer Blue Cross Blue Shield in Tennessee, said doctors can often be as uninformed about the appropriate role of scooters as patients.

One reason for the confusion? Doctors say scooter companies are just as aggressive with health professionals as they are in marketing to their patients.

Allegations of Medicare fraud within the industry go back nearly a decade.

In 2005, the U.S. Justice Department sued The Scooter Store, alleging that its advertising enticed seniors to obtain power scooters paid for by Medicare, and then sold patients more expensive scooters that they did not want or need. The Scooter Store settled that case in 2007 for $4 million.

As part of the settlement, The Scooter Store was operating under an agreement that made the company subject to periodic government reviews between 2007 and last year. In 2011, the latest review available, government auditors estimated that The Scooter Store received between $47 million and $88 million in improper payments for scooters.

In recent months Sen. Richard Blumenthal, D-Conn. and other members of the Senate Aging Committee have pushed Medicare to recover the millions of dollars spent on unnecessary scooters each year. Those purchases totaled about $500 million in 2011, the latest year available, according to a report by the Department of Health and Human Services' inspector general.

Medicare, which said that it does not have control over how companies market chairs, launched a pilot program designed to reduce wasteful spending on scooters.

Under the program, government contractors in seven states review patients' medical documentation to make sure they need a wheelchair or scooter before approving payments for a device. The program is being tested in a small number of states — including Florida, California and New York. — AP

Fee costs come down again, but is it enough?

By Mark Jewell

BOSTON —

It's easy to overlook what's important when it comes to saving money. Many people would sooner clip a coupon for shampoo than review the expenses they're paying to invest in mutual funds.

Cost is hardly the only consideration because a fund charging above-average fees may generate larger returns than a low-cost fund. But more often than not, any performance edge that a fund manager achieves is erased by the fees that are shaved off investors' returns.

The bottom line: Fees matter, especially when it's a product like mutual funds, which most investors will own for decades as they save for retirement.

The good news is that costs continue to come down. Fund expenses fell slightly last year, extending a long-term trend, according to an annual update from the Investment Company Institute (ICI), a trade organization.

Yet the findings show there are plenty of areas where the industry could be doing more to reduce the costs that investors pay.

Stock fund investors paid an average expense ratio of 0.77 percent last year. In dollar terms, that's $77 shaved from the return earned by a $10,000 investment in a fund. That's down from 0.79 percent in 2011 and 0.83 percent in 2010. Going back further, the progress has been even more impressive. Expenses averaged 1.07 percent in 1993.

Those are the ongoing expenses paid out of the fund's assets to cover operating costs, expressed as a percentage of total assets. Each shareholder indirectly pays a proportional share of overall costs via the expense ratio, with the amount paid based on average fund assets over the course of a year. The size of the expense ratio determines how much money an investor earns from a fund's investment returns.

To calculate average fees across thousands of funds, the ICI compared each fund's expense ratio with its end-of-the-year asset total. The averages are asset-weighted. That means expenses at funds with large asset totals, and therefore lots of investors, count more toward the averages than expenses at smaller funds.

In addition to stock funds, expenses declined at bond funds and mixed-asset funds that invest in stocks and bonds. But it's clear the industry needs to do more to keep investors' costs down. Here are four areas meriting special attention:

1. Little progress for bond funds: Average expenses at bond funds slipped to 0.61 percent from 0.62 in 2011, and 0.64 in 2010. Ten years ago, the average was 0.83 percent. Although that's a positive trend, the decreases in recent years have been surprisingly small, said Todd Rosenbluth, a fund analyst with S&P Capital IQ.

Go back to 2008, and bond fund expenses averaged the same 0.61 percent that they did last year. Yet since then, bond funds have attracted more than $1 trillion in cash, as anxious investors pulled money out of stock funds and invested in the relative safety of bonds. In fact, assets in bond funds have more than doubled since 2008, to about $3.5 trillion.

Yet it's unlikely that costs to manage those funds have doubled. As with many industries, size counts with mutual funds. It doesn't cost twice as much to manage a fund with $2 billion in assets than it does to run a $1 billion fund. The larger the fund's asset total, the larger the revenue from fees. The more profitable a fund is to run, the easier it is for its management company to cut fees without hurting the bottom line.

Rosenbluth suspects that one reason that bond fund expenses have declined more slowly than stock fund fees in recent years is that bond funds typically charge less than stock funds. As a result, there's less room for bond funds to reduce fees, without potentially cutting so much that the fund is only marginally profitable.

2. Slowing rate of improvement: Last year's 0.02 percentage point decline in the average stock fund expense was just half the size of the 0.04 point decreases in 2011 and 2010.

The ICI said it's difficult to make sweeping conclusions about expense trends over a few years because each year's figure is an average that's rounded off. A relatively small difference in expenses from one year to the next can look big or small when it's rounded.

One reason progress has been slow is that investors have been withdrawing more cash from U.S. stock funds in recent years than they've deposited into them.

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Doing your will online could be dangerous

By Linda T. Cammuso

Thousands of individuals sidestep using an estate planning attorney to create their wills and other estate planning documents. Instead, they turn to online "will kits" in the belief that the overall cost is less. While the desire to save money is understandable, in the end, this choice can be far more costly than paying an attorney. .

Legal Briefs

As an estate planning tool, a will ensures that your wishes are carried out regarding the inheritance of your assets and who will be in charge of your estate. However, estate planning is not just about a set of documents, it is about decisions and advice that are particular to your situation. The process can involve complex issues that may not be apparent at first glance.

There are many reasons for working with an estate planning expert to prepare your will, including:

•Compliance with state laws: Often when people use online forms they make inadvertent mistakes. Massachusetts law is specific about formalities regarding signing documents — witnesses, notary publics, etc. Even minor mistakes can invalidate your entire will or certain provisions within it.

•Personal credibility: In creating a will, the person must be of sound mind and under no outside influence. If it is later suspected that he/she was not mentally competent when the will was created or if another person was influencing the provisions, the document could be challenged. Signing with an attorney and professional witnesses ensures that there is an objective record of the document execution.

•Capturing all your assets: The fact is that a will only applies to certain of your assets — do you know which ones? It's unlikely an online do-it-yourself kit will be able to properly guide you. An estate planning attorney can help you understand which assets need to be handled outside your will.

•Taxes: Estate planning attorneys understand state and federal tax laws (estate, gift and income) and the consequences of lifetime gifts as well as transfers at death. Without that knowledge, your estate or heirs could face unnecessary tax liabilities.

•Online wills lack flexibility: The online forms are fairly standardized and restrict your choices to tailor your wishes.

•Gifting: Gifting is an important estate planning tool. Failing to consult with an attorney before making a gift or adding someone's name to your assets could have devastating consequences such as rendering a loved one with disabilities ineligible for public assistance or a college-bound grandchild ineligible for a scholarship, or inadvertently excluding other family members.

•Ownership of a business or other unique asset.

Lifestyle situations also play an important role in this discussion. For example, if you have a so-called "blended family" (married with children from prior relationships), are in a non-traditional relationship or are divorced or widowed, each of these situations demands special planning considerations. Additionally, circumstances regarding your children may warrant specific attention — for example, if any children are minors, disabled or non-biological.

Do-it-yourself estate planning is just not worth the risks. Many estate planning attorneys offer free consultations, so it will only cost you time to become educated on whether your situation could benefit from working with a professional.

Linda T. Cammuso, a founding partner at Estate Preservation Law Offices and an estate planning professional, has extensive experience in estate planning, elder law and longterm care planning. She may be reached at www.estatepreservationlaw.com or by calling 508-751-5010. Archives of articles from previous issues may be read at www.fiftyplus advocate.com.

Market rebounds, not retirement confidence

Workers appear to have little faith that the economic recovery and the stock market's climb have left them better-prepared for retirement.

Confidence in the ability to afford a comfortable retirement remains at the same record low level recorded in 2011, and is slightly lower than last year, according to the Employee Benefit Research Institute (EBRI), which has conducted the study the

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➤ Fees

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With cash flowing out, it's hard to cut fees.

Yet that impact would have been greater if not for the market rally that started in early 2009. Investment gains increase the amount of assets in funds, allowing a fund to be run more efficiently.

3. Slow progress for managed funds: A key reason that investors have been pulling cash from managed stock funds in recent years while adding to index funds is the cost differential. Managed stock funds charged an average 0.92 percent last year, or nearly seven times more than the 0.13 percent average for index funds.

The gap has been widening in recent years, as costs at index funds have come down more rapidly than fees charged by managed funds. A decade ago, managed stock funds charged an average 1.10 percent. Last year's average is down just 16 percent from 2003.

In contrast, the average index fund charges nearly half of what it did in 2003, when the average was 0.25 percent.

4. Many funds remain pricey, despite size: The ICI's report doesn't offer specifics on individual funds, but research by S&P Capital IQ identifies several large funds that continue to charge above-average fees, despite the cost-efficiency one might expect. Rosenbluth found 17 funds, most of them stock funds, with more than $5 billion in assets that have expense ratios of at least 1.0 percent. These funds are charging above-average fees, yet rank among the largest 10 percent of funds based on size.

"These should be more efficient to run, and they could be sharing some of those benefits to fund shareholders through fee reductions," Rosenbluth said. — AP

Suicide rate rises among middle-aged in the U.S.

NEW YORK —

The suicide rate among middle-aged Americans climbed a startling 28 percent in a decade, a period that included the recession and the mortgage crisis, the government reported.

The trend was most pronounced among white men and women in the 35 to 64 years old age group. Their suicide rate jumped 40 percent between 1999 and 2010.

But the rates in younger and older people held steady, the Centers for Disease Control and Prevention (CDC) found.

Why did so many middle-aged whites take their own lives?

One theory suggests the recession caused more emotional trauma in whites, who tend not to have the same kind of church support and extended families that blacks and Hispanics do.

The economy was in recession from the end of 2007 until mid-2009. Even well afterward, polls showed most Americans remained worried about weak hiring, a depressed housing market and other problems.

Another theory notes that white baby boomers have always had higher rates of depression and suicide, and that has held true as they've hit middle age. During the 11-year period studied, suicide went from the eighth leading cause of death among middle-aged Americans to the fourth, behind cancer, heart disease and accidents.

"Some of us think we're facing an upsurge as this generation moves into later life," said Dr. Eric Caine, a suicide researcher at the University of Rochester.

One more possible contributor is the growing sale and abuse of prescription painkillers over the past decade. Some people commit suicide by overdose. In other cases, abuse of the drugs helps put people in a frame of mind to attempt suicide by other means, said Thomas Simon, one of the authors of the CDC report, which was based on death certificates.

People ages 35 to 64 account for about 57 percent of suicides in the U.S.

The report contained surprising information about how middle-aged people kill themselves: During the period studied, hangings overtook drug overdoses in that age group, becoming the No. 2 manner of suicide. But guns remained far in the lead and were the instrument of death in nearly half of all suicides among the middle-aged in 2010.

The CDC does not collect gun ownership statistics and did not look at the relationship between suicide rates and the prevalence of firearms.

For the entire U.S. population, there were 38,350 suicides in 2010, making it the nation's 10th leading cause of death, the CDC said.

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➤ *Market*

Cont. from page 19

past 23 years.

Nearly half of workers surveyed in January had little or no confidence that they'll have a financially comfortable retirement, EBRI said. Twenty-eight percent were not at all confident — the highest level recorded since the survey began in 1991 — with 21 percent saying they were not too confident.

About 13 percent were very confidant and 38 percent somewhat confident, figures that weren't substantially greater than the record lows in the 2011 survey.

The survey also shows how many workers live on the edge, with little savings besides the equity they may have if they own a home, and besides any expected income from a pension. Fifty-seven percent said the total value of their household savings and investments was less than $25,000, excluding any home equity and pension benefits. Among that group, nearly half had less than $1,000 saved.

If there's any positive takeaway, it's that researchers believe workers who are the least prepared for retirement have become increasingly aware that they need to save more.

In 2007, for example, confidence numbers were substantially higher before the economy sank into a recession. Seventy percent were either somewhat confident or very confident that year.

The decline in confidence in recent years suggests "a much higher degree of realism" about the need to increase savings rates, said Jack VanDerhei, EBRI's research director, and co-author of the report.

That could explain why confidence remains low, despite the economy's gains since the recession and the recent market rally.

Despite the realization that they're not saving enough, short-term financial needs are so pressing that long-term goals become secondary.

In addition to worrying about their retirement savings, workers "lack confidence in their ability to pay for medical expenses, and even basics such as food, clothing and shelter," VanDerhei said.

The researchers concluded that fewer than half of workers appear to be taking basic steps needed to prepare for retirement. For example, 46 percent of those surveyed reported that they or their spouse had tried to estimate how much they'll need to save by retirement to ensure that they could live comfortably. The rest made no such calculation.

Two percent of workers and 4 percent of retirees said that saving or planning for retirement was the most pressing financial issue that most Americans face. Both groups were most likely to identify job uncertainty as the most pressing concern (30 percent of workers and 27 percent of retirees) followed by meeting day-to-day needs (12 percent for each group).

Participants cited the cost of living and daily expenses as the key reasons why workers either don't contribute to workplace savings plans such as 401(k)s or don't contribute enough.

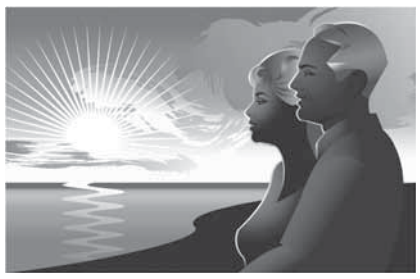
Fifty-five percent of workers and 39 percent of retirees reported having a problem with their debt levels. About half said they could definitely come up with $2,000 if an unexpected need arose within the next month. — AP

➤ Poll

Cont. from page 5

the kind of assistance they, too, are likely to need later on.

"I didn't think I was old. I still don't think I'm old," explained retired schoolteacher Malinda Bowman, 60, of Laura, Ohio.



Bowman has been a caregiver twice, first for her grandmother. Then after her father died in 2006, Bowman moved in with her mother, caring for her until her death in January. Yet Bowman has made few plans for herself.

"I guess I was focused on caring for my grandmother and mom and dad, so I didn't really think about myself," she said. "Everything we had was devoted to taking care of them."

The poll found most people expect family to step up if they need long-term care — even though 6 in 10 haven't talked with loved ones about the possibility and how they'd like it to work.

Bowman said she's healthy now but expects to need help someday from her two grown sons. Prompted recently by a brother's fall and blood clot, she began the conversation by telling her youngest son about her living will and life insurance policy.

"I need to plan eventually," she acknowledged.

Those family conversations are crucial: Even if they want to help, do your relatives have the time, money and know-how? What starts as driving Dad to the doctor or picking up his groceries gradually can turn into feeding and bathing him, maybe even doing tasks once left to nurses such as giving injections or cleaning open wounds. If loved ones can't do all that, can they afford to hire help? What if you no longer can live alone?

"The expectation that your family is going to be there when you need them often doesn't mean they understand the full extent of what the job of caregiving will be," Susan Reinhard, a nurse who directs AARP's Public Policy Institute, said. "Your survey is pointing out a problem for not just people approaching the need for long-term care, but for family members who will be expected to take on the huge responsibility of providing care."

Most people who have been caregivers called the work both worthwhile and stressful. And on the other end, those who have received care are less apt to say they can rely on their families in times of need, the poll found.

With a rapidly aging population, more families will be facing those responsibilities. Government figures show nearly seven in 10 Americans will need long-term care at some point after they reach age 65, whether it's from a relative, a home health aide, assisted living or a nursing home. On average, they'll need that care for three years.

Despite the "it won't happen to me" reaction, the AP-NORC Center poll found half of those surveyed think just about everyone will need some assistance at some point. There are widespread misperceptions about how much care costs and who will pay for it. Nearly 60 percent of those surveyed underestimated the cost of a nursing home, which averages more than $6,700 a month.

Medicare doesn't pay for the most common types of long-term care. Yet 37 percent of those surveyed mistakenly think it will pay for a nursing home and even more expect it to cover a home health aide, when that's only approved under certain conditions.

The harsh reality: Medicaid, the federal-state program for the poor, is the main payer of long-term care in the U.S., and to qualify seniors must have spent most of their savings and assets. But fewer than half of those polled think they'll ever need Medicaid — even though only a third are setting aside money for later care, and just 27 percent are confident they'll have the financial resources they'll need.

In Cottage Grove, Ore., Police Chief Mike Grover, 64, says his retirement plan means he could afford a nursing home. And like 47 percent of those polled, he's created an advance directive, a legal document outlining what medical care he'd want if he couldn't communicate.

Otherwise, Grover said he hasn't thought much about his future care needs. He knows caregiving is difficult, as he and his brother are caring for their 85-year-old mother.

The AP-NORC Center poll found widespread support for tax breaks to encourage saving for long-term care, and about half favor the government establishing a voluntary long-term care insurance program. An Obama administration attempt to create such a program ended in 2011 because it was too costly.

The older they get, the more preparations people take. Just 8 percent of 40- to 54-year-olds have done much planning for long-term care, compared with 30 percent of those 65 or older, the poll found.

Mary Pastrano, 74, of Port Orchard, Wash., has planned extensively for her future health care. She has lupus, heart problems and other conditions, and now uses a wheelchair. She also remembers her family's financial struggles after her own father died when she was a child.

Still, Pastrano wishes she and her husband had started saving earlier, during their working years. — AP

➤ Suicide

Cont. from page 20

The overall national suicide rate climbed from 12 suicides per 100,000 people in 1999 to 14 per 100,000 in 2010. That was a 15 percent increase.

For the middle-aged, the rate jumped from about 14 per 100,000 to nearly 18 — a 28 percent increase. Among whites in that age group, it spiked from about 16 to 22.

Suicide prevention efforts have tended to concentrate on teenagers and the elderly, but research over the past several years has begun to focus on the middle-aged. The new CDC report is being called the first to show how the trend is playing out nationally and to look in depth at the racial and geographic breakdown.

Thirty-nine out of 50 states registered a statistically significant increase in suicide rates among the middle-aged. The West and the South had the highest rates. It's not clear why, but one factor may be cultural differences in willingness to seek help during tough times, Simon said.

Also, it may be more difficult to find counseling and mental health services in certain places, he added. — AP

Decorating tips for making a rental space your own

By Melissa Rayworth

It's yours, but it isn't. A rented apartment or house can be a wonderful place to live, and a challenging place to decorate.

The restrictions are many: Landlords often want their white walls to stay white. Many won't let you do even the most minor construction. Some even ask renters not to nail anything to the walls.

Complicating things further, many rental properties have small rooms and no-frills, builder-grade light fixtures, doors and cabinetry with little personality.

How can you inject some of your personality into a rented space without enraging your landlord?

The first step is to go all in.

"So often people think of their rental as not theirs, and therefore go through life not creating a beautiful home or nest," said designer Kyle Schuneman, author of *The First Apartment Book: Cool Design for Small Spaces* (Potter Style, 2012). "Life is too short to not create a sanctuary that represents your unique vision."

Home decorating blogger Wanda Hoffs gives the same advice to her readers at recreateanddecorate.com. As an Army wife, Hoffs has lived in many rental properties around the country and has learned to decorate each one as if it were truly hers.

Here are five ideas from Hoffs and Schuneman that can help you embrace your rented space.

"Usually rentals are small, and I am a firm believer in function before form," Schuneman said. "Sometimes it's a puzzle piece to get those 'must haves' into your space — the desk, the bed, the couch."

He suggests using old items in new ways: Does the desk become a footboard? Should a small bookcase from your old living room be tucked into the corner of your new kitchen?

If your current furniture doesn't fit well into a rental, Hoffs suggests spending wisely on new items. Rather than buying an expensive new piece that fits your rental perfectly, "use thrift store furniture and paint it yourself," she said.

Used furniture can be "so inexpensive that you can sell it at a yard sale if need be" when you decide to move out of the rental. "It's not about where you buy it," Hoffs likes to tell her blog audience. "It's how you use it."

"Wallpaper used to be only for the homeowner crowd," Schuneman said, "but now with companies like Tempaper, you can put up temporary wallpaper that peels on and peels back off when you're ready to move."

Hoffs suggests using wall decals, which now come in a huge range of styles and sizes, or even duct tape.

"It comes in many great colors and patterns," she said, "and can be used on a wall in many different patterns, such as the trending chevron pattern, stripes or even to create a border around a wall grouping."

If you want to do just a bit of painting that could be easily repainted before you move out, Hoffs and Schuneman both suggest painting a stenciled design on one wall. Or paint a band of bold color along the top of your walls.

To make the eventual repainting easier, Hoffs said, "always know the original color and brand of paint."

"If you're afraid to touch your walls or have a really difficult landlord," Schuneman said, "bring in the color through fabrics and textures around the room. If you leave your walls white, hang a bold curtain on the windows and a coordinating couch that really pops."

Hoffs agrees: "Fabric can be a great, inexpensive way to add color, pattern and texture to a room. It can be framed or stapled to a large art canvas to be hung on the walls," to add a burst of color. You can also attach fabric temporarily to a wall using spray starch.

Lush plants are another option: "Bring in plants to add life, color and to warm up your home," Hoffs said. Even if you're not a gardening expert, "there are many low-maintenance ones for those who do not have a green thumb." When it's time to move, they're easy to take with you.

"Your floors are a blank slate for design," Schuneman said. "Treat it as your fifth wall and find a beautiful rug to ground the whole space."

Schuneman is a fan of FLOR carpet tiles, which can be arranged to make what appears to be a rug of any size. "I love using FLOR tiles for rentals because they can be put together in different configurations when you move and can be personalized, so only you have that certain pattern that represents your style," he said.

Although you can't change the cabinets in your rented kitchen or bath, Hoffs points out that you can swap out the hardware on doors and drawers at a very small cost.

"You can always change these back to the original ones when you start to move," she said, as long as you remember where you've stored the originals.

The same goes for light fixtures. A change of lighting can add "instant drama" to your home, Hoffs said, so consider swapping out the current fixtures with ones that reflect your taste. Just be sure to store the landlord's fixtures carefully and reinstall them properly before moving out. — AP

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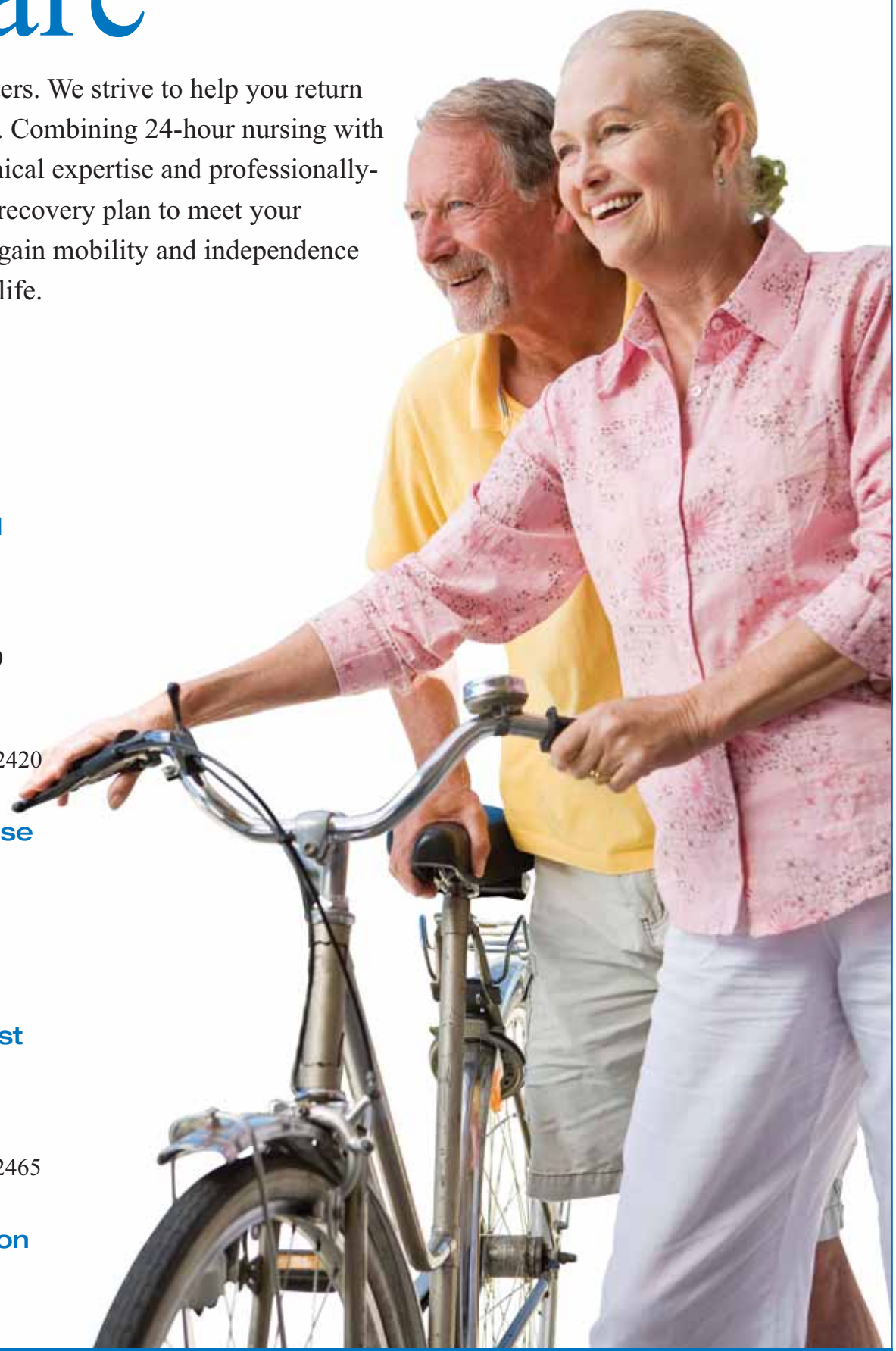

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hage, disability, status as a Vietnam era veteran, qualified special disabled veteran, recently separated veteran, or other protected veteran, or source of payment. GLS-06867-11-IE