A crisis looms in long-term care as boomers enter retirement years

A great many older Canadians may be in for a shock when they're faced with care costs in their final years. A recent poll commissioned by the Canadian Life and Health Insurance Association found that 56% of Canadians aged 60 and older do not know what the costs of long- term care are in their province, and two- thirds – 67% of them – have not made plans to cover the costs of possible ongoing long- term care. "We have a problem," Stephen Frank, Toronto- based vice president, policy development, at CLHIA, said in an interview. "We're facing a looming crisis with Canada's nine million baby boomers entering retirement. The reality is that 17% to 20% of them will need long- term care at the end of their lives."

The poll also shows that 70% of women do not have plans in place to cover care costs, compared with 62% of men. "This is particularly troublesom**e," noted Heather Clarke, vice-**president of insurance services at Investors Group in Winnipeg, "because women have longer life expectancies than men."

Some Canadians assume that LTC is entirely government- subsidized. But care in LTC facilities, often called nursing **homes, is only partly subsidiz**ed by provincial governments. The fees paid by residents differ from province to province, and do not include personal expenses such as chiropractic work. According to Manulife Financial figures, a private room in an Alberta home now costs $1,627.50 a month. A private room in Ontario is $2,166.58 a month, and $1,637.40 in Quebec. Nova Scotia has a daily rate of $94.75, which comes to $2,842.50 for a 30- day month. Semi- private rooms are a few hundred dollars less, and in many provinces, those who can't afford the standard rate can apply for further subsidization.

"In Manitoba where I live, provincial subsidies are generous," Ms. Clarke added. "Costs run from $31.30 a day to a ceiling $73.40 depending on after- tax income, so a wealthy resident would pay the same amount as a person who's less wealthy." And LTC f**acilities are entirely subsidiz**ed in the Northwest Territories, Yukon and Nunavut.

"The big question is whether governments can continue subsidizing elder care for the huge baby-boomer group," Ms. Clarke said. The number of Canadians aged 65 and older is now about 15% of the population. By 2031, it will rise to 25%. One in every four Canadians will be 65 and older.

Last year, the CLHIA compiled a policy paper that examined the cost and viability of LTC over the next 35 years as the boomers pass through old age, and found that immediate action needs to be taken to ensure they'll have access to the care they'll need. "We looked at the costs, and came up with the conservative figure of $1.2 trillion – assuming an inf**lation rate of 3% – to subsidiz**e nursing home care, home care and hospital care," Mr. Frank said. "There is currently $600 billion in government funding in place for this. That means a $600- billion shortfall."

And that $1.2 trillion, he added, does not include building LTC facilities and training health- care professionals. "It assumes that nursing homes are in place, and doctors and other professionals are on the job. We need private sector involvement to build new facilities, and we need more health- care professionals. There are currently about 200 geriatric medicine specialists practising in Canada. In contrast, Sweden, with a population less than a third the size of Canada's, has about 500 geriatricians. The shortage will intensify in coming years."

Governments need to take a leadership role and signal to Canadians that they have to take responsibility for their later years, Mr. Frank said. “We’ve sent copies of the paper, and have had dialogues with all the provincial health ministers and the federal minister of health, and we’re starting to see some progress. Some provinces have put more money into home care. But the magnitude is enormous and structural reforms are needed to address the shortfall.”

One of the paper’s recommendations calls for creation of tax credits for the purchase of LTC insurance, and an LTC savings vehicle, modelled on the registered education savings plan. It noted that, as of 2010, only 385,000 Canadians had LTC coverage. “Long- term care insurance has been a more popular product in the U.S. than in Canada,” Ms. Clarke said. “We have a stronger social safety net here, and some assume government will take care of their LTC needs.

“LTC insurance is also fairly expensive, partly because few people buy it. Those who can afford it may not need it,” she added**. “And people often only realiz**e the need for such coverage when they’re older and premiums are more expensive.” She gave the example of one LTC product that pays a maximum weekly benefit of $500, depending on cost of care, for a maximum of 250 weeks. At the age of 50, a single male would pay $1,000 in annual premiums. At age 60, he would pay about $2,000 a year.

But Ms. Clarke noted that the insurance industry is coming up with innovations to fill the looming need, such as products with convertible features. “Some critical illness and disability policies can be converted into LTC coverage if the policyholder hasn’t claimed CI or disability benefits by a certain age.”

And shared LTC coverage for couples is another way to bring down costs, she added. “The probability of both spouses needing LTC is low, so premiums for shared coverage are less expensive than if each spouse took out single coverage.”

Structural changes

The paper cited a number of structural changes that would reduce care costs throughout Canada and could generate savings of $140 billion. One is to eliminate the backlog of Canadians in acute- care hospital beds who are waiting for admission to LTC facilities. “There are currently about 7,550 of these individuals across Canada,” Mr. Frank said. “A hospital bed costs the system about $800 a day instead of about $120 a day in an LTC facility.”

The paper also recommended moving 20% of residents of LTC facilities into home- care settings. “A Toronto Balance of Care project,” the report noted, “concluded that 37% of those on the Toronto Central LTC waiting list could be supported safely and cost- effectively if they were to receive care in their own homes…We know the vast majority of Canadians would prefer to receive care in their homes rather than in institutional settings.”

By Rosemary McCracken - 2013-06-18

Source: insurance-journal.ca/2013/06/18/a-crisis-looms-in-long-term-care-as-boomers-enter-retirement-years/

Long Term Care

Most people buy health insurance and insurance for home, car and other property replacement. However, fewer people buy long-term care insurance, either not thinking about it or hoping that their savings will be sufficient to meet any associated expenses.

In fact, **long-term care can be very expensive** and can deplete a lifetime of savings within a few years. (Long-term care in nursing homes can cost an individual more than $40,000 per year.)

Who Needs Long-Term Care

Long-term care is typically needed by the elderly, but it is also required by anyone with a debilitating illness or injury who needs assistance to perform what we consider everyday functions, such as feeding oneself, bathing and getting dressed.

Like other services covered by insurance, long-term care insurance must be purchased before the insured requires the services covered under the policy. This means that many individuals will purchase the policy and never benefit from it. The likelihood of this happening is greater among younger individuals, whose chances of requiring long-term care are lower. Consequently, some financial professionals recommend that only individuals closer to ages 50 to 65 purchase long-term care insurance, as these individuals are more likely to benefit from the purchase of a policy.
If you are employed, you may want to check with your employer regarding coverage, as some employers provide long-term care insurance for their employees, and some will even extend coverage to parents of their employees. If you are already covered under an employer-sponsored policy, then you may not need to purchase a separate policy until after you retire.

Cost of Long-Term Care Insurance

The cost of long-term care insurance is usually determined by factors such as the type of policy, the age of the insured and the time period the policy covers. Naturally, policies that provide coverage for an unlimited period will cost more than policies that provide coverage for a limited period. Policies purchased at an early age are less costly than policies purchased later, because a younger person is more likely to pay premiums for a longer time. The cost of the policy may also be affected by the preferred location of the service - whether in-home, at a nursing home or at some other facility providing professional care - and whether the coverage is comprehensive or basic, as defined by the policy.

Things to Look for in a Long-Term Care Policy

When you purchase long-term care insurance, you must pay attention to what the policy covers. For instance, the definition of disability may differ among plans: it can vary from a condition that makes an individual unable to perform simple everyday functions, such as getting dressed, to certain medical problems as defined by the policy. Here are some other features you should consider before you choose your long-term care insurance:

Inflation protection - Does the policy include an inflation protection feature? This ensures premiums do not increase, or at least limits the rate at which they do increase, even if the cost of long-term care increases.
Deductible - Does the policy include a deductible, and if so, how does it define it? The definition of deductible may include dollar amounts and/or a period of coverage. For instance, the insured may be required to pay expenses out of his or her pocket for a certain number of days, as defined by the deductible.
Coverage - Coverage is the amount of expenses covered by the policy. Some policies will pay up

to a certain amount per day. This could affect the type of care you choose - whether in-home or at a professionally-run facility - and the care provider you choose, depending on their fees. Higher coverage usually means a higher premium. Whatever the costs involved, you need to be aware of coverage so there are no surprises when you need the benefits.
Period of coverage - A plan may limit coverage to a certain number of years. Additional coverage may require additional premiums.

Benefits of Purchasing Long-Term Care Insurance

If the need for long-term care arises and you don't have insurance, the associated costs may have to be paid out of personal savings or financed by loved ones. If you are unable to afford the cost of hiring care providers, family members may be required to assist you, which means they may have to take unpaid leave from work. By purchasing long-term care insurance, you help to ensure that any costs associated with your care are covered, thereby lessening the financial burden on yourself and your family.

Conclusion

It may be beneficial to purchase your long-term care insurance at an early age, as the premiums are usually lower for younger individuals. However, remember that long-term care insurance is not for everyone and is usually purchased by younger individuals only when they have a history of family illness that are covered under these policies. Bear in mind that coverage may be denied if the potential insured is already at a stage that requires long-term care.

For example, if someone already has Alzheimer's disease, he or she may no longer be eligible for long-term care insurance. Finally, remember that paying premiums is less costly than paying long-term expenses out of your pocket. Before purchasing a policy, be sure to compare rates, features and benefits offered by different insurance companies, independent brokers and so on.

Not all Long Term Care insurance policies are the same.

Before choosing any Long Term Care insurance policy, it is important to seek professional advice and guidance to ensure that you choose the best available policy for your situation.

Contact our office for more information about **Long Term Care insurance.**

Source: http://www.chappellandstone.com/insurance/long-term-care

Judy Southon placed her late husband in a long-term care facility after the stress of caring for him became too much. CHRIS YOUNG FOR THE GLOBE AND MAIL

HEALTH

Home care's shortcomings

Ailing seniors too soon pushed into nursing homes, leaving caregivers stressed, Health Council says

ANNE McILROY OTTAWA
TAMARA BALUJA TORONTO

As more and more Canadians find themselves caring for an elderly relative at home, new research shows that supports by provincial governments fall way short of what families require.

And the more severe the illness – for example, seniors with dementia and other complex medical problems – the less likely that adequate, publicly provided home care will be supplied. In fact, people with the most complex diagnoses often receive only a few more hours of home care a week than those with more moderate needs.

For the health system, it means that patients end up in hospital beds or nursing homes – far more expensive alternatives – when they could still be at home, says John G. Abbott, chief executive officer of the Health Council of Canada, which will release its comprehensive report on Monday.

On a more personal level, family caregivers are taking on heavier burdens, reporting high levels of stress and depression, the report says.

It's a situation that Judy Southon knows all too well. She realized she was in a crisis when she started self-medicating with sedatives meant for her ailing husband.

"My chest was so tight and I was so wired ... I would give him two pills because he would be so agitated, and then one for myself," Ms. Southon said.

Her husband Vic was diagnosed with dementia in 2007 and Ms. Southon looked after him at their Toronto home for two years. She had caregivers help out for a few hours weekly, while she worked a contract job at a bank. She had to maintain their large home, cook meals, shovel snow – things her husband normally helped out with – and dipped into their savings to make ends meet.

"My evenings, my weekends, and all those other times when the caregivers weren't there, they were all devoted to him," she said. "It was work and then take care of him. I felt trapped."

When she could no longer manage, she made the difficult decision to put him in a long-term care home, where he died in September. "I felt inconsolably sad for him, but it had to be done or I would fall sick too," she said. "It was about self-preservation."

Provinces pay for home-care programs, with providers visiting patients' homes for a wide range of services – from bathing patients and looking after their personal care, to providing medical services, like administering injections. Home-care workers are supports for family caregivers, to give them a much-needed break.

The report found that over the past decade, provincial governments have significantly expanded home care and the number of recipients has grown by 51 per cent.

But it's not enough, especially for high-needs seniors.

In Ontario, for example, most clients can get only 14 hours of home care a week, Mr. Abbott said.

"The vast majority of cases are getting 14 hours, maybe 15 and 20 hours," he said in an interview. "There are not sufficient hours, for what would be now the new typical case."

The report, released Monday, recommends a system that regularly assesses the needs of seniors and their family caregivers, one that would offer them more support as it is needed. Home care should be more integrated in the health-care system, the report says, with family physicians taking part in the home-care team.

Compared to many other countries, Canada invests more in long-term care facilities than home care.

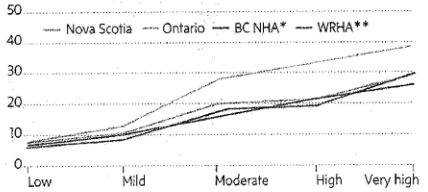
Governments need to consider shifting that pattern of spending, the report says.

Ms. Southon wishes she could have looked after her husband at home for longer, something that a more advanced home-care system could have provided.

"But at some point, you have to take care of yourself, or you'll have caregivers who are sick, and then you'll have two sets of people who need help."

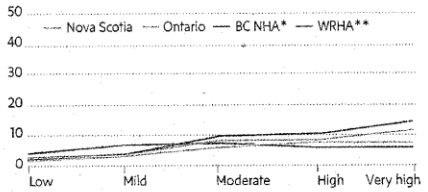
As seniors' needs increase, so do the caregivers' hours of support

Average hours of family caregiver support in a week



As seniors' needs increase, hours of home care increase very little, if at all

Average hours of homecare services in a week



*Northern Health Authority in British Columbia (2010 data), ** Winnipeg Regional Health Authority in Manitoba (2007 data). Note: Ontario data was from 2010 and Nova Scotia data was from 2007.

CARRIE COCKBURN/THE GLOBE AND MAIL » SOURCE: HEALTH COUNCIL OF CANADA

Screen Capture

Scott Knight
Executive Director
The Hemisphere Centre for Mental Health & Wellness

Konstantine Zakzanis
Associate Professor
Department of Psychology
University of Toronto

The population is aging, fuelling the debate over the reliability of senior motorists. The situation has revealed looming challenges that North American auto insurers need to address with regard to underwriting, rating and claims management of drivers who have pre-existing cognitive impairments.

A "74-year-old driver plowed his SUV through a crowded intersection and into a group of people waiting for the bus in Montreal… killing two bystanders and sending pedestrians hurtling through the air 'like bowling pins'"… an "87-year-old man drove his car through a crossed street market in Santa Monica, California, killing 10 people…"

News stories like these seem to be occurring more frequently, sparking renewed debate over whether or not North America's aging population poses a public-health hazard on the roads. Transportation statistics, based on a variety of reports, indicate that seniors, those aged 65 and older, have a higher annual fatality rate than younger drivers and, measured by distance driven, these older drivers are involved in accidents out of proportion to their numbers.

The debate over the reliability of aging motorists usually includes discussion about the diseases and other health issues that are often part of the aging process. In particular, dementia is cited as a growing concern.

In an insurance role, whether it be as an underwriter or adjuster, understanding dementia/cognitive impairments and how to assist clients who may be suffering from dementia is likely to become more pertinent.

For the North American auto insurance industry, there are looming challenges to be addressed on the underwriting, rating and claims management of drivers with pre-existing cognitive impairments. However, there is a lack of data available to insurers from which to base rating and underwriting decisions.

Without family doctors and health care professionals proactively and reliably documenting their own files, there is insufficient information on which claim personnel may form decisions. Notwithstanding the missed opportunities

Illustration by Dave Whamond/threeinabox.com

with respect to rating and underwriting, this lack of information on a single claim may cost an insurer upwards of $1 million to $2 million on an alleged catastrophic injury claim.

RISING INCIDENCE OF DEMENTIA

The population continues to age. By 2011, the oldest baby boomers, those born in 1946, had reached age 65 and the proportion of people that age and older had started to increase rapidly. This shift in the population size of the elderly will have far-reaching effects, especially on the health care system.

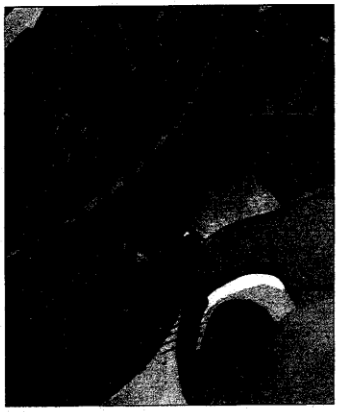
A major issue will be the incidence of dementia: more than 50% of the residents in nursing homes are affected by dementia; one in every 13 seniors over the age of 65 has Alzheimer's disease, the most common form of dementia; and one-third of seniors have some form of dementia by age 85, while more than half do by age 95.

A joint report released last April by the World Health Organization and Alzheimer's Disease International, *Dementia: A Public Health Priority*, indicates a global time bomb that needs to be addressed statistically:

- there are in excess of 10 million cases of dementia globally;
- there are 7.7 million new cases of dementia per year globally;
- there are 5.4 million people in the United States with Alzheimer's disease, 2.3 million with other dementias and almost 11 million with other cognitive impairment disorders; and
- there are 7.9 million licensed drivers over the age of 80 in the U.S.

The prevalence of cognitive impairment disorders is expected to increase by 50% in the next 20 years with the "greying" of the U.S. population. Here at home, findings of a Canadian Psychiatric Association research paper from 2004, *Driving and Dementia in Ontario: A Quantitative Assessment of the Problem*, include the following:

- the number of drivers 65 years or older will increase from slightly less than 500,000 in 1986 to almost 2.5 million in 2028;
- there will be almost 100,000 drivers with dementia in Ontario by 2028;
- most drivers with dementia will continue to drive as the disease progresses, increasing the likelihood it will eventually affect their driving ability; and
- The Ministry of Transportation does not require any remedial driver testing until age 80, and testing does not screen for dementia deficits related to driving or screen any population exhibiting possible deficits under the age of 80.



In North America, the prevalence of dementia alone in the +65 years population group, excluding cognitively impaired not dementia, approaches 25%. For those older than 65, the annualized incidence rate of undiagnosed cognitive impairment is 2%.

EFFECTIVE SCREENING ESSENTIAL

The findings also recommend the risks associated with the dramatically increasing number of drivers with dementia demand a psychometrically sensitive and efficient screening procedure. An effective approach in guiding decision-making related to dementia is the use of neuropsychological testing, which offers an understanding of the progressive nature of dementia and highlights the importance of early intervention.

In North America, the prevalence of dementia alone in the +65 years population group (excluding cognitively impaired not dementia, or CIND) approaches 25%. Research indicates that within the older than 65 age group, the annualized incidence rate of undiagnosed cognitive impairment is 2%.

The Alzheimer Society cites research documenting early-onset dementia occurring as early as 45 years of age, and when considered with advancing research on concussions/post concussive syndrome, there are serious implications with which to contend.

UNDERSTANDING DEMENTIA

Dementia is an acquired condition of intellectual impairment produced by brain dysfunction. It can be defined as an acquired persistent impairment of intellectual function that affects at least three of the following areas of mental activity: language; memory; visuospatial skills; emotion/personality; and cognition (i.e. abstraction, calculation, judgment, executive function, etc.)

Depending on the type of dementia, cognitive deficits in the early stages may vary. However, regardless of the specific type, it is important to note that all are progressive.

A prerequisite for driving is the integration of high-level cognitive functions with perception and motor function. Aging, *per se*, does not necessarily impair driving or increase the crash risk. But medical conditions, such as cognitive impairment and dementia, become more prevalent with advancing age and may contribute to poor driving and an increased crash risk.

The extent to which driving skills are impaired depends on the cause of dementia, disease severity, other co-morbidities and individual compensation strategies. Dementia often remains undiagnosed and, therefore, general practitioners (GPs) can find themselves in the difficult situation to disclose a suspicion about cognitive impairment and queries about medical fitness to

drive, at the same time. In addition, the literature suggests that cognitive screening tests, most commonly used by GPs, have a limited role in judging whether or not an older person remains fit to drive.

EARLY IDENTIFICATION AND INTERVENTION

Early identification is the best way to prevent harm and reduce risk (literature further suggests that pharmacological strategies, namely use of medications, can slow the progression of dementia). Early intervention also helps to ensure the individual is brought to the attention of the appropriate health care practitioner as soon as possible so that he/she may immediately begin appropriate treatment.

Dementia is identified by neuropsychological testing, which evaluates/tests disturbances in the various areas of mental activity. The testing is a specialized sub-discipline of psychology that focuses on the relationship between brain and behaviour by way of formal standardized paper and pencil measures.

Unfortunately, full neuropsychological assessments are not only very expensive (these cost an estimated $3,500 to $6,000) and time-consuming, limitations exist on accessibility and language barriers of assessors within a multicultural context, meaning this cannot be considered a practical solution.

Looking to clear these obstacles, Konstantine Zakzanis, Ph.D., a professor at the University of Toronto, has developed a 15-minute, patent-pending test sensitive to cognitive disorder secondary to numerous disease states or injury. These include the early stages of Alzheimer's disease and other dementia syndromes; post-concussive syndrome; attention deficit disorder; or other disease processes affecting brain function. Dr. Zakzanis's test, called Brainscreen, demedicalizes the screening process. The screen, costing about $25 apiece, can be completed without the aid of an administrator on various mobile and personal computing devices.

TEST AT POLICY ISSUANCE

Rafts of research confirm the correlation between cognitive function and driving, creating an opportunity for insurers to deploy a cognitive screening tool at the time of policy issuance. If the test in question does not require special training or administration, costs could be lowered since an applicant could access the tool in the home, direct via the underwriter or via the broker/agent network. All results and data could be instantaneously delivered to the insurer and its approved designates.

Early identification is the best way to prevent harm and reduce risk. Early intervention also helps to ensure the individual is brought to the attention of the appropriate health care practitioner as soon as possible so treatment can begin immediately.

Insurers could use the test on suspected traumatic brain injury claims and validate a client's cognitive decline relative to his or her scores at the time of policy issuance — this would be similar to baseline scoring as might be employed for concussion management programs. Immediately following submission of a claim, a case manager or adjuster could "administer" the test to validate or compare any cognitive deficits from policy issuance to claim.

Even without a pre-test, administering the screen following the submission of a claim will help validate any cognitive deficits relative to the normative population as well as assist in determining whether or not to employ full neuropsychological testing and, possibly, identifying what specific test batteries ought to be used in the assessment.

A report published in the September 2012 issue of the *New England Journal of Medicine* indicated a proactive reporting system associated with fitness to drive, with study authors estimating annual savings to the Province of Ontario of approximately $7 million through crash prevention (the figure does not take into account the additional savings for auto insurers). For their part, consumers would be better served with rating and underwriting specific to their own unique risk factors.

With the large aging cohort moving forward and research expanding on cognitive awareness/function impacted by trauma and pharmacological contraindication, serious significant ramifications abound. The advantages to be had as a result of cost-effective and accessible early screening — not only from the public safety perspective, but also from that of an insurer considering underwriting and claims — outweigh any disadvantages.

Over the past seven years, there has been ongoing research that directly links cognitive function to driving abilities across all age groups. Industry stakeholders should be working together to champion a policy of cognitive screening for the benefit of their customers and society.

Society will benefit through access to a health care tool that ought to form part of every annual check-up, while insurers and consumers benefit through more exacting underwriting and rating. This will be reflected in more accurate premium calculations at policy inception and renewal, and help to drive down injury assessment costs on claims. ≡

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brighter life

Sharing ideas about money, health and family

Family

Getting the best out of life with your partner, kids and parents

Elder care and the five stages of aging

By Sheila Avari, BrighterLife.ca

August 23, 2011 | **Topics:** Family, Health, Retirement | Comments (3)

These days, everyone has a story about caring for an elderly family member. From waiting with Dad at the doctor's office, to staying overnight to administer Mom's medication, to visiting your spouse at the long-term care home, the spectrum of care is broad. Elder care is posing mounting pressure on family caregivers, who are contributing billions of dollars worth of unpaid care each year.

People are burning out from taking care of a sick or elderly family member, says Dr. Mark Frankel, president and CEO of Taking Care Inc., an organization dedicated to helping caregivers navigate the elder-care system. Its self-service website and call centre receive a combined 20,000 to 30,000 inquiries annually. "We get most calls from family members carrying the load, caring for a parent or spouse," says Frankel. "They're frustrated, exhausted and stretched, and they need support."

Going into long-term care is not an isolated event; it is usually a gradual process with many stops and bumps along the way. As people age, they may experience chronic health problems resulting in a variety of functional challenges or disabilities. They and their family caregivers shift from one strategy to another, coping with what can be a trying experience. As the stages of care progress, the choices and sources for that care become more complex, and often more expensive.

To help families understand and be better prepared for the main needs and issues along the long-term care continuum, Frankel has developed the following five-stage framework:

Stage 1

Seniors are still self-sufficient and able to manage chronic health problems and disabilities. Usually they don't require or even accept special support from family members, preferring to be as independent as possible.

Stage 2

Independence turns to interdependence. Seniors begin accepting care from family members with cooking, house cleaning, shopping and banking, but are reluctant to accept formal care just yet. "Seniors often see formal caregivers as a beginning in the decline in their independence," Frankel explains. During this stage, Frankel often advises families to begin considering seniors' residences designed for independent living, which feature 24-hour security, suites, meal plans, cleaning services and laundry.

Stage 3

Seniors become more dependent on others for practical chores such as meal preparation, cleaning, shopping and transportation. They may also begin to need some limited direct help or stand-by assistance with personal care items such as dressing, bathing and grooming. There are a wide variety of care options; live-in and live-out personal support workers provide one-to-one care. Assisted living or retirement homes become options if both personal care and social activities, such as group dining or recreation programs, are desired.

Stage 4

The responsibility for providing care at home can send some families into an exhausting spiral of crisis management. "Families call us saying they went to Mom's fridge and all the food was rotten, or Dad's been leaving the stove on," says Frankel. "The health and personal care needs of a senior can outstrip the family's capacity to help. Formal home care may be insufficient or too expensive and the family goes from crisis to crisis."

Stage 5

Frankel's final stage of long-term care occurs when families are forced to admit their elder family member into a nursing home. Skilled nursing care and extensive personal care help the senior continue to live with dignity and allow the family to continue providing social and emotional support, while still tending to their own responsibilities.