Seán Collins (00:01):
We're calling this episode the challenge of Staying Home. It's where most of us are most comfortable, where most of us feel we fit in, and where we can relax and be ourselves. In 1939, a pretty famous movie made the point of reinforcing an old cliche,

"The Wizard of Oz" excerpt (00:24):
Yes, I'm ready now. Then close your eyes and tap your heels together three times and think to yourself, there's no place like home. There's no place like home. There's no place like home...

Seán Collins (00:44):
On today's program. The benefits of staying home and the barriers people face when they grow older or when they're living with a disability.

Dr. Maureen Nash (01:02):
Americans by overwhelming majorities really prefer to stay in their homes as they age.

Seán Collins (01:17):
Survey after survey, between 75 and 90% of people say they want to stay in their own home.

Dr. Maureen Nash (01:23):
People who are able to stay in their own home, live longer. They tend to be in better financial condition, and they tend to be overall more healthy with less evidence of cognitive decline and less evidence of dementia.

Seán Collins (01:39):
People of all ages who live with a severe disability also say that they prefer to be in their own homes.

Dr. Lisa Iezzoni (01:47):
People who need activities of daily living supports are people who have the greatest challenges. We still need human assistance to be able to do basic activities of daily living, you know, feeding, bathing, dressing, toileting, and basic mobility.

Seán Collins (02:03):
On today's program, the challenges of staying home from two perspectives, people with disability and people wanting to age in place on the Hear Me Now podcast. I'm Sean Collins. Please stay with us.

(02:16):
(music Ends)

(02:25):
We have two interviews to share with you today with two physicians who think about not only how people live, but where people live. And like Dorothy Gale of Kansas, they've learned that there's no place like home in a bit. We'll hear from Dr. Maureen Nash about aging in place. Dr. Nash has recently been named a distinguished fellow of the American Association for Geriatric Psychiatry. She's the medical director of Providence Elder Place in Portland, one of the programs of all inclusive care in Oregon. But we're going to begin on the other side of the country with a conversation with Dr. Lisa Iezzoni, professor of Medicine at the Harvard Medical School. Dr a's research has focused on people with disability and how they interact with the people who provide healthcare, and in a broader sense, how they get the help they need to live lives that are full and unencumbered by barriers. Dr. Iezzoni joins me now from Cambridge, Massachusetts. Welcome back to the podcast Dr. A.

Dr. Lisa Iezzoni (03:40):
Thank you so much for having me, Sean.

Seán Collins (03:43):

So give us an overview of the situation that people with disability face in being able to stay in their communities and to stay in their homes. What are the obstacles that make that choice difficult?

Dr. Lisa Iezzoni (03:56):
Numerous. I think that that is a flip answer, and it totally depends on the level of functional abilities of people. People who need activities of daily living supports are people who have the greatest challenges, because even though I saw a talk a while back about a robot feeding a person <laugh>, it still is, you still need human assistance to be able to do basic activities of daily living. You know, feeding, bathing, dressing, toileting, and basic mobility. And so that requires kind of having a human interface where one human helps another human. And we know that about 75% of that caregiving support is provided by what is kind of scratch your head for why it's called this, but it's called informal caregiving. Informal caregivers. And these are family members who often have given up their own careers and their own kind of work life to be able to stay at home, be around when their loved one needs them to be able to provide that kind of activities of daily living supports.

(05:18):
But about 15 to 25% of people don't have that type of informal caregiving network, and they need to go into the paid personal assistance services field area to try to get that kind of support. It's what I call PAS -- Personal Assistance Services, paid personal assistance services. And that is very challenging on many, many levels. I think the very first level is cost. Even though these are workers who are low wage workers, often these individuals who provide these types of services have to have two to three jobs themselves to be able to make ends meet for their families. So even though the workers themselves are earning just low wages that are not even vaguely livable for an individual with a disability, and we know that the vast majority of people with disabilities are not high income, many are on fixed incomes, that being able to afford these services is the biggest challenge. And a lot of people think that insurance like Medicare, which is insurance, federal insurance for older and disabled people covers

paid personal assistance services, but it doesn't accept in very unusual circumstances, and neither does private health insurance. And so people can be stuck not having the money to pay for these services unless they get onto Medicaid, which as you know, is a state federal health insurance program for people who are low income or meet other qualifications.

Seán Collins (07:14):
So the the practical side of that is an individual would have to pauperize themselves before they become eligible for that Medicaid assistance.

Dr. Lisa Iezzoni (07:24):
Yes, the technical term that they use is spend down <laugh>. You know, they'd have to spend down their income and they can only have certain assets that are available to them. But the point that I'd like to make here is that Medicaid, again, is a joint federal and state program, and states vary widely in terms of how generous they are for personal assistance services and how easy it is to get onto Medicaid. As, you know, part of the Affordable Care Act that Obama signed back in 2010, one of the ways that they were gonna try to expand healthcare to make it available to every American was by expanding Medicaid. But a lot of states chose not to expand Medicaid, and there still are states out there that have not expanded Medicaid. And so it's very difficult for many people around the country to get onto Medicaid.

Seán Collins (08:25):
Perhaps one of my least favorite phrases that I've heard in the course of doing this podcast on healthcare is the phrase 'kinless' or 'friendless' to describe individuals who don't have a social safety net among friends or children or rel close relatives. And I will self-disclose to you that I'm skinless and have all sorts of comorbid conditions. And I'm, I'm frankly, terrified of what happens in the next 15, 20 years. You know, I, I'm not sure what I'll do when I can't live independently any longer. And this is something that's faced by people with disability at a much earlier age. I'm looking at it as someone

who's aging, but it, it's a terrifying situation to think that there is no place for you to live.

Dr. Lisa Iezzoni (09:22):
It is terrifying. And that's why my reason fuck about this topic ends unsatisfactorily <laugh> by saying that this is gonna become an even more acute problem with the aging baby boomer generation and all of us competing for this scarce resource of people who are willing to work these low wage jobs and provide in-home supports for us. And so it is terrifying, and it is also almost like a full-time job right now to even organize that kind of care, because especially, I mean, the pandemic has exacerbated all sorts of societal ills. And one of them is receiving and finding this kind of support because a lot of the people who used to be willing to provide this kind of support in the home now can go down the street and earn more at, you know, the local fast food restaurant.

(10:40):
And so it's even more difficult now than it was even, you know, two and a half years ago when it was getting increasingly difficult to find these kind of supportive people who can provide these kind of supportive services. Yeah. And, and so I'm sorry, Sean. I mean, I, I'm not helping with your terror at all, but I think that this is why it's really important for people to just understand what they might be confronting and think about, okay, how can I maybe plan ahead in some sort of way to make this a situation that might be doable for me if I become increasingly functionally impaired?

Seán Collins (11:36):
I guess one of the questions I have is staying in your community, staying in your home is often a goal for people, and it's an understandable goal. I guess I'm wondering how important is it that it actually be your longtime home and, and is what's really important that you are able to stay connected to a circle of people that you, you socialize with and you're familiar with the environment? Like is it important that people stay in their own home or is it, could it be just as important to create a housing situation that's less

institutional? Maybe more along the lines of co-housing where you have people sort of sharing some common services and space, but having their own private apartments could that serve the same purpose as staying in your own home?

Dr. Lisa Iezzoni (12:34):
This is going to be an intensely individual choice and decision. I simply cannot answer the question as you phrased it, because it will depend on what you or I like. We are gonna have very different preferences. A survey found a number of years ago that only 4% of Americans would wanna go into nursing homes if they become so disabled that living at home would be very difficult. Let me just say again about the pandemic is the pandemic showed us that nursing homes were killing fields. That is where the vast amount of mortality, especially early in the pandemic was happening. And so until we figure out how to have more communal settings that are pandemic proof <laugh> or or really can allow people to have a sense of dignity, a sense of choice, a sense of control, a sense of agency, all the kind of independent living principles, I really think that the dignity of risk principle, if they choose to stay at home that we need to think about how to allow that to happen.

(14:10):
And so, for example one of the people who I interviewed for my book was a guy who all called Matt, and he lives in a high rise apartment building that was constructed for older people. And so a lot of older people live in this building. He moved into it when he was a younger person, so it's not only older people. There are people with disabilities, but a number of the people in that building use the same PCAs and personal care assistance. And so my friend Matt might need six hours of PCA care a day and get six of PCA care, but he had a friend with Ms who actually lived a couple of floors below him, who sometimes because of flares or exacerbations, would need more time than she was being given with her PCAs. And so Matt would have his PCA go down when he'd finished with his PCA to care for his friend, a couple floors below. And so if we could have situations where PCAs were caring for people across floors in the same building, for example, they could be more available and more kind of aware of what a

particular person needed on a particular day. If they happen to be sick with a cold that day, they might need more or they might need less on a different day, that there could be arrangements of flexibility that could allow and facilitate something like that happening.

Seán Collins (15:43):
This seems like a situation that is ripe for creative legislative intervention.

Dr. Lisa Iezzoni (15:51):
It is if we change the societal norms that have governed America since the founding of the country. And let me say why I say it that way. From the very founding of the United States, there were laws that required ship captains to return people who were disabled back to their home countries, which was like primarily England. We're talking about going back to, you know, the 16 hundreds and 17 hundreds because our country didn't want to have people with disabilities here. It was a rugged country. They didn't wanna have to care for them. And in fact, there were laws put in place, you know, or understandings in communities again, that it was the family that had to care for the patient or, or the person with a disability. Otherwise there might be s houses that they could go to where, and again, infection was rampant and there was, you know, in some of AL'S houses, you know, 30% mortality in a given year.

(17:08):
And so I think that there was not a social contract in our country from the earliest founding that society needed to support the dignity of people throughout the lifespan. You know, other countries, there are some other countries that have more of that perspective, that older people are to be respected and to support their dignity. You provide these kind of supportive services in the home or in a place that that person finds comfortable. Our society has never been like that. And so there actually have been historians of long-term in the United States who have made that exact point that this has been a health policy dilemma that has actually confronted us for centuries. And it would take a huge and massive rethinking of how we want to spend our societal

resources, especially when we think about intergenerational spend expenditures right now, that's a huge issue that I'm just not sure how politically we would get to a point where we are able to actually support people with dignity in their homes.

Seán Collins (18:32):
Are you familiar with the PACE programs?

Dr. Lisa Iezzoni (18:35):
I am familiar with PACE.

Seán Collins (18:37):
What do you think of them and their, that model for this care?

Dr. Lisa Iezzoni (18:44):
Okay, so in the book, I talk about a man named Michael, who I, I extensively talk about him, actually. I dedicate the book to him. He's a really, he's my best friend, and I dedicate the book to him and his longest serving personal care assistant, a woman named Nita, who is an immigrant from Haiti. And Michael Michael had a very bad experience with Pace. I had actually recommended pace to Michael because Michael, when I first met him, I met him in 2009. And at that point he was trying, he has primary progressive ms and he still had a tiny residual bit of right hand function although he was left-handed. And so he could do a tiny bit, but he basically behaved, his body behaved like a transected spinal cord. He behaved, he couldn't move any part of his body at all volitionally.

(19:51):
And so he could only afford three hours of TCA care a day. He could afford an hour and a half in the morning, and then an hour and a half in the evening. And so I said to him, and he would often spend the rest of the day, you know, between seven 30 in the morning and nine 30 at night, he would spend it without food or water because he couldn't get it. And so I suggested that he joined pace because I think that it is

conceptually a very nice model. But what I didn't realize about the PACE model was that it really is driven by the interdisciplinary team, that it's the healthcare professionals, and it's the people who are employees of pace, who make the decisions about many of the aspects of people's lives and people's care. It's a very agency driven model for personal care assistance, for example.

(20:50):
Mm-Hmm. <affirmative>, it's not a consumer directed model, which has, you know, it's pluses and minuses. People will have different preferences about that. But Michael unfortunately ended up in a pay program that where his, the assigned PCP against his will kept him in a nursing home put him into a nursing home to treat a very small pressure injury by frequent turning. And when it was treated, the P C P refused to return Michael's 10 p c a hours a day that were supporting him at home. She said, I'm not gonna let you go back home. I'm not gonna reinstate the PCA hours. And so Michael was forced to go to Medicaid adjudication and Medicare adjudication actually for pace. And the adjudicator came back and said, pace, you need to reinstate these hours. PACE appealed the adjudicator, and by that point, the nursing home, which had initially treated Michael's pressure injury was not caring for him.

(22:02):
And he developed a very severe illness and almost went into acute renal failure, at which point I was able to get him out of the nursing home. And when he got to a hospital to be treated for his infection, and the nurses turned him over, his entire back of his body was covered with with a, a, you know, skin abrasions. He, he had developed complete you know, abrasions all over his back of his skin because they hadn't turned him. And so at that point, he was gonna have to go back into the nursing home because during the medicated during the Medicare adjudication from pace, they were not going to again, return the PCAs to him. And so he just quit pace. And several months later, the adjudicator came back and said, you should have reinstated the PCAs. So again, you know, this is probably an unusual story, but it's a story that is a warning story. You know, it's a canary in the coal mine story that it can happen even in

pace, that if patients are not the ones in control of what's going on, that they can be at risk.

Seán Collins (23:18):
It's so tragic.

Dr. Lisa Iezzoni (23:19):
Yeah. And, and this, this happened in 2017 and Michael's never recovered, and he was somebody, you know, who was a very active wheelchair user, would be out in his wheelchair, you know, at least five miles a day. Yeah.

Seán Collins (23:40):
Does anything give you hope here?

Dr. Lisa Iezzoni (23:42):
I know that we probably shouldn't be talking politics now, but, you know, one of the build back better aspects of Joe Biden's plan was to try to provide extra funding for for basically home supports to increase the wages of people who are providing these common supports. Because we need to have a workforce. And without the higher wages, we just simply don't. And there's 800,000 people right now in the country on Medicaid waiting lists for home and community based services that aren't counting them. And so I think that, again, this is a political question. It's a question of values, it's a question of our society. It becomes also an intergenerational question. Because I think that if we provide the resources that are required for baby boomers to be able to live at home with dignity, with the supports that they need it could be a intergenerational amount of money shift that our society may not be willing to spend.

(25:01):
So I remain kind of I'm willing to consider the possibility that this might happen, but I think that it's gonna take a lot of work. Understanding, again, we need to respect the dignity of the workforce. We need to respect the dignity of the people who need these

services. And let me also say, however, that it's not simply older people who need these services. In fact, for my book, I made a point not to focus on people who are over 70 <laugh> because I wanted to, you know, include people in their forties. And, and my final two chapters are actually a man who's 20 years old, who was born with a disability that has required him to use a wheelchair his entire life, and to just think about what that's gonna mean for him over time. So I think that this is something that, again, the historians of long-term care in the United States have said, we have not cracked this nut. We haven't figured it out. And and so it will take some serious societal thinking before we finally do.

Seán Collins (26:18):
Thank you so much for taking the time to talk with me today,

Dr. Lisa Iezzoni (26:22):
And thank you for having me. Sean.

Seán Collins (26:23):
Dr. Lisa Iezzoni, professor of medicine at the Harvard Medical School. She researches the nexus of disability and healthcare at the Health Policy Research Center — the Mongan Institute at Massachusetts General Hospital. Her book, "Making Their Days Happen" explores paid personal assistance services supporting people with disability living in their homes and communities.

(26:53):
Now, let me introduce you to our second guest today. Dr. Maureen Nash is a geriatric psychiatrist and the medical director of Providence Elder Place in Portland. It's one of the PACE programs in the state of Oregon. PACE refers to the federal program of all-inclusive care for the elderly. Dr. Nash was recently named a Distinguished Fellow of the American Association for Geriatric Psychiatry, and she's on the line with me now from Portland. Dr. Nash, welcome back to the podcast.

Dr. Maureen Nash (27:25):
Well, thank you. I am happy to be here. Talking about older adults

Seán Collins (27:31):
In general, what do we know about the wellbeing of people who are able to stay in their homes as they age?

Dr. Maureen Nash (27:40):
So, Americans by overwhelming majorities really prefer to stay in their homes as they age. Survey after survey, you know, between 75 and 90% of people say that they want to stay in their own home if you ask them. And it definitely helps w with many things, including people who are able to stay in their own home, live longer. They tend to be in better financial condition, and they tend to be overall more healthy with less evidence of cognitive decline and less evidence of dementia. Some of that is, of course, always a little, you, you do have to wonder about the chicken in the egg because people who develop a severe cognitive decline may not be able to live at home. Right. So it's a little bit of both, I think, but Americans strongly prefer to age in place.

Seán Collins (28:49):
And the fact that you're, you're identifying Americans as a group here, is it, is it a cultural thing do you think, or pension for independence, for instance?

Dr. Maureen Nash (29:01):
Well, I think I definitely think different cultures think about it differently. You know, most of the data that I have seen has been on Americans. I think generally Europeans as well. I'm, I'm less sure if, if sort of cultures where they have much smaller living situations, you know, where you, if you have a small village and your extended family is all right there, like moving in with your extended family may, you know, may not be seen the same way it would be in the United States.

Seán Collins (29:41):

Yeah. So if someone wants to stay home but isn't able to any longer, what are some of the issues that families face in either convincing or conjoling or forcing someone to move into an assisted living situation or some place where they're gonna be able to get more care than they can get at home?

Dr. Maureen Nash (30:07):
Yeah, that is a typical challenge when people think somebody needs to move, but the person themselves either doesn't think they need to move or doesn't want to move. You know, aging in place has, has a definition, a federal definition, and it's having the health and social support so that you are able to live safely and independently in your home and community for as long as you wish. Right. So that is apparently the f federal official definition of aging in place. And what I think the difference here is, so the federal and all of us in healthcare, et cetera, that word live safely is very prominent. But when you talk to older adults, I think they move that down. Not everybody, but most people I talk to, they are less concerned about their safety when it comes to that. But people's children, or their spouse or their neighbors or their, you know, extended family or friends may be much more worried about a person's safety than they themselves are. So it definitely can be a challenging conversation and one that is probably best done with lots of time and the least amount of pressure possible.

Seán Collins (31:35):
Yeah, yeah.

Dr. Maureen Nash (31:36):
You know, when we talk about people not driving any longer what we talk about now is retiring from driving. Hmm. So we don't talk about giving your license up or giving your car up, which is definitely associated with independence for many people. But we talk about retiring from driving and that sort of language is much more palatable and, and more humane. Hmm. I think for people, the challenge with aging in place is that even though nearly everyone says they want to do that, most people do not modify their homes so that they can age in place. And that was really highlighted in a number of

different articles. People don't think about modifying their homes until after they develop disabilities or, or health needs. And then, you know, it's really hard to do a several month long remodel when you actually need the changes right now.

(32:44):
Right. And there, there just aren't enough housing units that, besides individual homes in the United States for all the people who are aging. So we would definitely be better off if people thought about aging in place in their thirties, forties, and fifties whenever they go to remodel. You know, making sure that they can get everything on the same floor, making sure they can get into and out of a bathroom and they can bathe without having to step over things, et cetera. There are lots of things we can do, and that is a modifiable area that we need to talk about more. Hmm.

Seán Collins (33:28):
I, I know that you have special expertise in taking care of people with dementia, and as that becomes an issue for someone, not that it becomes an issue for everyone, but should it become an issue, it begins perhaps to cloud judgment, and so someone may think that they're perfectly safe and minimize the danger that they're in. Right. It's not just my kids think I'm not safe. In fact, you may not be processing the information completely.

Dr. Maureen Nash (34:02):
Right. And that gets to the issue of capacity. You know, does the person have the ability to understand the risks, benefits, and alternatives to moving? And if a person has capacity and is willing to accept risk, that is one thing. And if a person doesn't actually have the ability to understand the safety issues, that's when healthcare powers of attorney or healthcare representatives the term is different state to state or even a guardianship might come into play. But one of the things when I have diagnosed somebody with dementia early, which is starting to happen more and more, I think as people sort of hear about trials of new medications, and there's a lot of hope that someday we'll be able to really modify the path for somebody who has a diagnosis of

dementia. And so when I talk to people with a new diagnosis one of the things to explore with the person and their natural supports is really what is what is gonna be really important to you in the long run?

(35:17):
And do you have other health conditions that might, you know, lead you to have a shorter life? Or are you really going to be ending up living with dementia for 15 or 20 years? In which case, you know, it might be a very prominent part of the end of your life. Not a hard discussion to have, but it's an important discussion. But way back then, at the beginning, what I suggest to people is considering either moving into a senior living community or an assisted living early while you're still able to form new memories and learn some things and make relationships or else waiting a long, long time. What I have seen clinically is a lot of people are in the middle of, but they're impaired enough that they, they cannot learn a new environment mm-hmm. <Affirmative>. And so they're doing okay in their home, but they move into an assisted living, and all of a sudden they have huge problems because they can't learn.

(36:28):
They can't learn a different kitchen layout, they can't learn a different schedule. They get confused about where they are and who is this person entering my home. And so I think that it's really important to, to look at, am I the kind of person who's who, who wants to be doing lots of activities with lots of other people every single day and eating with large, larger groups of people, you know, is that something I enjoy or am I really, does that not factor in as a part of the way I live my life and, and would see a high quality of life? And I think those kind of considerations need to be done early. And, and again, I think it, it's, it's very difficult because it's just like remodeling your home before you need it to be remodeled. Mm-Hmm. <affirmative>, it's a lot of pre-planning when sometimes it's easier not just to just not think about these things until they, we absolutely have to.

Seán Collins (37:39):

Avoidance is a kind of natural fallback for a lot of us, I think. Dr. Nash, you talked about having these conversations early. In some families' experiences. Are you present for those early conversations? Do you find yourself acting as a mediator in some way or a, an observer or as a participant, or, or is that something that families do by themselves or with a social worker? How does how does that conversation get started?

Dr. Maureen Nash (38:09):
Great question. And like everything else, it depends on the family a little bit. But when I diagnose somebody with dementia, it's one of the things that I think about. And because I'm not being presented with this major life-changing diagnosis, you know, I'm not in the sa same state of perhaps surprise or distress that, that a person and their family may be when they get the news. So I'm in a little bit different place, and I like to after we discuss the diagnosis and sort of work out, you know, next steps in the short term, one of the things that I like to do in a, in a follow up conversation close to that, is to start to look at some of these longer term issues. You, you know, it doesn't make sense to do that when somebody's having a crisis or, or after they've just had some, you know, earth shattering diagnosis disclosed to them.

(39:13):
That's not the right time, but that's a good time sort of after somebody gets used to the idea a little bit or comes to accept that, oh, that really does explain things. And then I have helped people that I see, but most people don't see a geriatric psychiatrist. There aren't that many in the United States, frankly. And so a lot of people will work with a, a geriatric case manager, which could be a social worker or a nurse. That's a great source of assistance. And even if you don't need a case manager on a regular basis, having a consult with a geriatric case manager in your community can be very helpful reaching out to your network of people to find out what has been helpful for others in your circles. Because, you know, it's not the kind of thing people are necessarily gonna talk about unless you bring it up. Hmm. And so I think there are a lot of people struggle alone when there are many people they know who have faced similar challenges. And most of us benefit when somebody asks us for advice or asks

us for input or, you know, it's, it's kind of a compliment when somebody seeks your point of view. Sure.

Seán Collins (40:46):
Dr. Nash, earlier we heard Dr. Azzoni talk about some of the barriers that exist for people with disabilities, e even younger people being able to stay in their homes. And one of the, the hallmarks there was cost. And how do you afford to bring people in to provide services for you really necessary services. Does that become any easier if you're elderly, or does that economic burden persists for families?

Dr. Maureen Nash (41:18):
Great question. And I think we have particular challenges for the middle class in this country. People who have lots of financial resources are not gonna be limited by that. And people who have very, very little often qualify for Medicaid and Medicaid services really can provide in-home supports. Every state structures it a little bit differently, but the amount of support that people get from Medicaid is really amazing. That's actually one of the main ways that people come to PACE programs for people who are very frail, but people who are not necessarily frail but are older in need assistance. There's the Villages movement, I don't know if you're familiar with that, but started in Europe and exists around different parts of the US and it's really a community of people, older adults who take care of each other and do things for each other.

(42:25):
And then they maintain a list of contractors who they vet so that you're not just hiring anybody off the street. And they do social activities and often share some meals. There's also senior centers and places like that where you can get information on what is available, but the people who are sort of in that middle class area do struggle in our country. And what does sometimes happen is people have to like, use up their resources and then they do qualify for Medicaid. And so that is something that senior law attorneys sometimes get involved with helping people figure out. I think a, again, a geriatric case manager could probably also help with that kind of an issue.

Seán Collins (43:20):
Yeah, it is, it is a peculiar fact of the way things are set up, that the middle, the people in the middle are the ones who are finding it most difficult to find services and afford services. I mean, sometimes there's real sticker shock when you get in touch with a assisted living facility and talk about, you know, what's it gonna cost?

Dr. Maureen Nash (43:43):
Oh, yes. $60,000 a year. $80,000 a year. Absolutely. But I just to put all that in context I mean, yes, people in the middle class do struggle, but prior to social security, prior to Medicare, everybody who wasn't wealthy struggled. So I would say the middle class is the group of people who are at the least ability to, to do things at the moment. But that is a much smaller group than what it used to be. Yeah. And in the states that have expanded Medicaid, you know, I think there, there are lots more resources for people.

Seán Collins (44:28):
Yeah, absolutely. I think in those days before social security, there were probably more intergenerational family arrangements too. I mean, grandma might be living with you to begin with.

Dr. Maureen Nash (44:40):
Yes. And those intergenerational relationships are really very important. Actually, one of the things that helps older adults stay resilient is having contact with children. Course it does depend on the child a certain amount, but there, there is, there is a lot to be said for socialization with people of various ages.

Seán Collins (45:04):
Yeah. One of my favorite architectural stories involves building in the suburbs of Paris where the upper floors are senior living and the ground floor is a daycare center, so that there's constant interaction between toddlers and older folks, like outside in the yard, in the playground area in the building itself. And it, it speaks to this, what you just said,

that there's real benefit on both sides for the kids and for the older adults to have that interaction.

Dr. Maureen Nash (45:43):
Yes.

Seán Collins (45:45):
I want to ask you one really practical question about a benefit of staying at home. And that's familiarity of surroundings. You know, your neighbors, you know, you have interactions with the grocer, the layout of the neighborhood, all of that would seem to add to the stay at home side of the ledger that leaving that would be hard.

Dr. Maureen Nash (46:10):
I think familiarity and a place where you have been and where you have a sense of belonging is very advantageous for people who are able to do that. And I, it's a, it's a number of different things. For one thing, moving takes a lot of energy. Making an entirely new group of friends and acquaintances takes lots and lots of energy. And some of us are better at that than others. And then there's the cognitive aspect, because I can function fairly well in my home where I've lived for 40 years, but once I move learning a new stove, learning a new system for heating, learning new locations for things, that takes a lot of cognitive capacity. And so the capacity to operate at a safe level is higher. When you're in a familiar place, you can be more impaired, but still be able to do well or all right. And once you move to a brand new place, people look often look much more impaired than they looked when they were at home. Like, I just saw you three weeks ago and you didn't look like this at all. Well, three weeks ago, I wasn't living in a new place where I don't know where anything is. Right. And I don't have any friends, and I don't have ways to contact people.

Seán Collins (47:50):
Dr. Nash, thank you for taking the time to talk with me today. I always really enjoy our conversations.

Dr. Maureen Nash (47:57):
You're very welcome and have a great day. Sean,

Seán Collins (47:59):
Maureen Nash is medical Director of Providence ElderPlace in Portland, one of the PACE programs in the State of Oregon. Dr. Nash was recently named a Distinguished Fellow of the American Association for Geriatric Psychiatry.

(48:15):
Earlier we heard from Dr. Lisa Iezzoni of the Health Policy Research Center, -- the Mongan Institute -- at Massachusetts General Hospital, Dr. Iezzoni is professor of Medicine at the Harvard Medical School. She's the author of "Making Their Days Happen: Paid Personal Assistance Services, Supporting People with Disability, Living in their Homes and Communities."

(48:40):
Both docs have appeared on the Hear Me Now podcast before you'll find links to those previous appearances on our website, along with links to articles about aging in place and the barriers that people with disability face as they try to stay in their homes. Find all of that at www.hearmenowpodcast.org. The Hear Me Now podcast is a production of a Providence Health System and its family of organizations.

(49:12):
Find us on the web at Hear Me Now, podcast.org. Our program is produced by Scott Acord and Melody Fawcett. We have research help from medical library staff, Carrie Grinstead, Basia, Delawska-Elliott, Sarah Viscuso, and Heather Martin. Our theme music was written by Roger Neill. The executive producer is Michael Drummond.

(49:34):

Join us in two weeks when our guest is Dr. Titilope Fasipe, co-director of the Sickle Cell and Thalassemia program at Texas Children's Cancer and Hematology Center. She'll be bringing us up to date on some of the groundbreaking developments in the treatment of sickle cell disease. If you haven't already, subscribe to the podcast and the episode with Dr. Fascipe will automagically appear on your phone the day it's published. I'm Sean Collins. Thanks so much for listening today. Be well.