

Medicare

New Doughnut Hole Calculator Steers Part D Enrollees to Less Expensive Medications

By Sally Hurme, J.D., and Jane Lincoln, MSW

Late summer is the time of year when many people in Medicare Part D fall into the infamous “doughnut hole.” The doughnut hole is the coverage gap in the Medicare Part D benefit that requires enrollees to pay all of their medication costs. For some, the added costs are unexpected or unpredicted; for many, being in the doughnut hole is simply unaffordable.

As one senior, Alice W. from Columbia, Kentucky, said:

Part D Medicare helps with my prescription drugs. This year I got in the doughnut hole in November with three prescriptions that had to be refilled. They cost more than \$200. I had to make a choice—get the medications or groceries. I had one of the prescriptions filled and left off the two others I have to take every day. Since they are preventive medications, it didn’t take but less than a week until I was getting sick. There was not enough money to buy all the medications and feed our family.

The doughnut hole need not be as burdensome as before, thanks to AARP’s new Doughnut Hole Calculator. This online interactive tool at www.aarp.org/doughnut-hole guides consumers to options to reduce their Part D spending by identifying less costly generic or therapeutically similar alternatives.

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Sally Hurme, J.D., is a senior project manager, and Jane Lincoln, MSW, is a project manager, at AARP in Washington.

Elder Abuse Prevention

Failing to Report and False Reporting of Elder Abuse: Penalties Under State Adult Protective Services Laws

By Laura Remick

This article examines penalties for failing to report elder abuse and for knowingly making a false report of abuse under the adult protective services (APS) laws that exist in each state, the District of Columbia, and three territories (referred to generally as “states”). The information is based on corresponding charts, which provide more information about the laws, including relevant statutory provisions. The charts are available on the elder abuse Web page of the ABA Commission on Law and Aging.¹

This article discusses provisions of APS laws in effect as of December 31, 2008. The APS regulations were not reviewed. There may be other state or federal laws or regulations that address these issues.

Following an overview of elder abuse, the role of APS, and reporting, this article discusses the array of penalties set forth in the laws and recent legislative trends. The goal of this paper and the charts is to provide information to state and federal legislative staff, other policy makers, program administrators, practitioners, educators, researchers, reporters, and others.

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Laura Remick is the ABA Commission on Law and Aging’s 2009 Coleman Summer Intern. She is currently a third-year law student at the University of Pittsburgh School of Law, enrolled in the health law certificate program.

**Coverage of Brooke Astor Case Draws Ink, Ire of ABA Commission Senior Attorney
Lori Stiegel, see page 9.**

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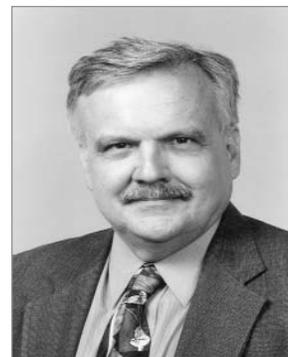
ABA Commission Welcomes Distinguished New Members, Liaison

The ABA Commission on Law and Aging is composed of fifteen members who are appointed on an annual basis by the president of the American Bar Association. As a multi-disciplinary group, the commissioners represent aging experts from a broad spectrum of professions, including law, health care, social work, gerontology, advocacy, and public service. The fundamental diversity of the group ensures a stimulating forum for discussion of the law-related issues facing older Americans. Cooperative efforts between the commissioners and staff have produced numerous publications, as well as research and demonstration projects of considerable value to the public at large. To provide our readers with a view into the strengths and expertise of our commission, each fall issue of BIFOCAL provides abbreviated profiles of the most recent distinguished appointees.

JEFFREY J. SNELL, chair, practices in the area of elder law, estate, probate, and real estate law as a solo practitioner. Within the ABA, he is a member of the Committee on Scope and Correlation of Work, the Standing Committee on Technology and Information Systems, and the ABA Museum of Law. Mr. Snell has served on the ABA Board of Governors and was one of the first “young lawyers” to become a member of the Senior Lawyers Division under their new elder law category. Mr. Snell is licensed to practice in both Ohio and Florida.



DAVID M. ENGLISH is the William Franklin Fratcher Endowed Professor of Law at the University of Missouri-Columbia. Within the ABA, professor English has dedicated a considerable amount of work to aging and disability issues. This includes presidential appointments to the Commission on Law and Aging (2001-2004); the Special Committee on Bioethics and the Law (2004-2007); and the Commission on Mental and Physical Disability Law (2007-2009). He has held numerous leadership positions in the Section of Real Property, Trust and Estate Law. Currently, professor English represents the section in the House of Delegates and is a member of the section’s executive committee. He was previously a member of the section council and group chair in charge of the elder law and disability group of committees. Professor English has spoken fre-



quently to the House on resolutions sponsored by the commission. As a Uniform Law Commissioner for the state of Missouri, he was involved in the drafting of numerous uniform acts directly relevant to the legislative projects and educational work of the commission, including the 2007 Uniform Adult Guardianship Jurisdiction Act (reporter), the 2000 Uniform Trust Code, and the 1993 Uniform Health-Care Decisions Act. He was a member of the drafting committee on the Uniform Power of Attorney Act, the Uniform Anatomical Gift Act, and an advisor on the Uniform Guardianship and Protective Proceedings Act. In his current position as executive director of the Joint Editorial Board for Uniform Trusts and Estates Acts, professor English has oversight responsibility for all uniform legislation relating to aging and disability issues.

MARIA GREENE is the director of the Georgia Division of Aging Services. She is responsible for the statewide administration of services for older adults and vulnerable adults, including the Community Care Services Program, home- and community-based services, Long-Term Care Ombudsman Program, Adult Protective Services, Elderly Legal Assistance Program, Alzheimer’s services, senior employment services, caregiver services, kinship care, and health and wellness activities. Ms. Greene leads the state aging services network, comprised of twelve Area Agencies on Aging, and more than five hundred providers. She is the direct supervisor of ten leadership team members and provides guidance for approximately 340 state staff. Ms. Green has held multiple appointed positions, including delegate to



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the White House Conference on Aging, and member of the Governor's Blue Ribbon Commission on Home- and Community-Based Services.

ALISON HIRSCHL is an attorney at the Michigan Poverty Law Program, where she advocates on behalf of low-income elderly clients. Her practice includes legislative and administrative advocacy, litigation, and training both consumers and professionals. Ms. Hirschel also is a Public Interest /Public Service Fellow at the University of Michigan Law School, where she has taught elder law since 1998. She is



counsel to the Michigan Campaign for Quality Care, the Michigan State Long-Term Care Ombudsman Program, and recently completed her term as president of the National Citizens' Coalition for Nursing Home Reform in Washington. Ms. Hirschel was a delegate to the 2005 White House Conference on Aging and has received numerous awards, including the 2003 National Aging and Law Award.

ROBERT L. ROTH is a partner in the health care law group at Crowell & Moring in Washington. He began practicing privately in 1993 following an 11-year career in government, at both the state and federal levels, serving as a senior attorney with the Office of General Counsel of the U.S. Department of Health and Human Services (representing the Health Care Financing Administration (renamed the Centers for Medicare & Medicaid Services)), as an assistant attorney general representing Maryland's Dept. of Health and Mental Hygiene, and as counsel to the Maryland General Assembly. Mr. Roth served as chair of the ABA's Health Law Section for 2001-02. In January 2002, he was a member of the ABA's Joint Leadership Educational Delegation to the U.N. Offices in Geneva, Switzerland, in meetings with the World Health Organization and other U.N. agencies. Mr. Roth is active in several professional associations and has been teaching legislation at the University of Baltimore School of Law since 1984.



HON. JOHN M. VITTONI has been the chief administrative law judge for the U.S. Department of Labor since 1995. Before joining the Department of Labor, Judge Vittone was a judge with the U.S. Department of Transportation and the Civil Aeronautics Board. Judge Vittone also served on the staffs of the U.S. Department of Justice and the Federal Trade Commission. Within the ABA,



among other positions, he has been a member of the board of governors, chair of the ABA Justice Center, chair of the Judicial Division's Conference of Administrative Law Judges, a member of the Commission on Diversity in the Profession, and a member of the House of Delegates. Judge Vittone currently serves as a member of the House of Delegates on behalf of the Administrative Law Section.

CHARLES E. ENGLISH is the Commission's liaison from the ABA Board of Governors. He is the senior partner in the Bowling Green law firm of English, Lucas, Priest & Owsley, LLP. His practice encompasses civil litigation, corporate banking, and trust and estates matters. Mr. English is a past president and member of the board of governors of the Kentucky Bar Association. In 1999, he was awarded the Kentucky Bar Association's Outstanding Lawyer Award. Mr.



English is a fellow of the American College of Trial Lawyers and the American Academy of Appellate Lawyers, an advocate of the American Board of Trial Advocates, a member of the American Law Institute, and a life member of the Judicial Conference for the U.S. Court of Appeals for the Sixth Circuit. He was elected by his alma mater, the University of Kentucky College of Law, to the law school's hall of fame. Mr. English also is a Life Fellow of the American Bar Foundation. Within the ABA, he has served as Kentucky's state delegate in the House of Delegates, and as a member of the standing committees on the federal judiciary and lawyers professional liability.



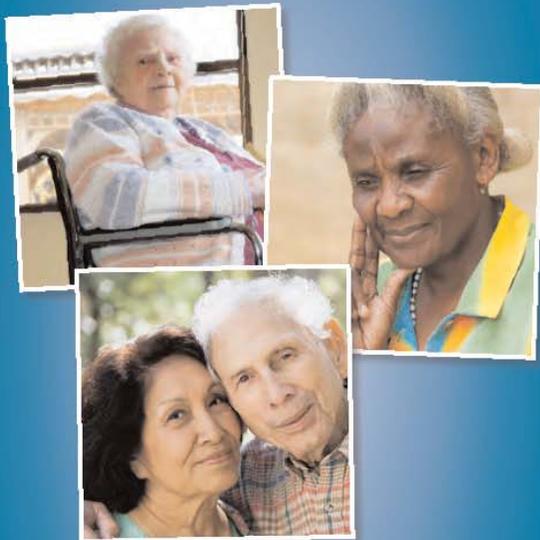
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Doughnut Hole Calculator Steers Part D Enrollees to Less Expensive Medications

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About one in every four Part D enrollees not enrolled in low-income subsidies, who filled one or more prescriptions in 2007 (some 3.4 million people), fell into the doughnut hole, according to a Kaiser Family Foundation report. On average, patients' out-of-pocket drug spending doubles when they reach the doughnut hole. Sixteen percent of the people

in the coverage gap stopped taking medications or reduced their use of important medications after they reached

Access the calculator at www.aarp.org/doughnuthole

the coverage gap. Generalized to the entire population of Part D enrollees, Kaiser's research suggests that 14 percent reached the gap. However, only four percent climb out of the doughnut hole to reach catastrophic coverage.

Developed with DestinationRx, the company that developed Medicare's online Drug Plan Finder, AARP's Doughnut Hole Calculator allows people to find cost savings based on the actual drugs they take and the specific Medicare Part D plan in which they are enrolled.

The less expensive medication options generated by the calculator are created using a number of widely respected scientific sources, such as the Oregon Health and Science University's Drug Effectiveness Review Project and peer-reviewed journal articles. The users of the calculator do not need to register their personal information and their self-entered medication data are not saved—assuring privacy.

"The best part of the tool is how easy it is to use," said David Gross, a manager with AARP's Education and Outreach group, which developed the calculator in collaboration with health policy and pharmacy experts. Just fill in your zip code, list your drugs, and choose your health plan from the list that comes up. You'll find out how long your initial coverage will last before you hit the doughnut hole.

For many medications, the tool provides up to three less expensive, but equally effective, alternatives you can discuss with your doctor. Lipitor, for example, has no generic version available. However, three other cholesterol-lowering drugs might be options for the patient to discuss with her doctor: lovastatin, pravastatin sodium, and simvastatin. One of the most useful features of the calculator is that it prints letters that enrollees can take to their doctor for each prescription medication that has less expensive alternatives.

How It Works

1. **Select Plan.** The user types in a zip code and the calculator lists all the possible Part D plans that serve that zip code. The user chooses his or her plan.
2. **Enter Drugs.** The user types in the exact name of the drug (either the brand or generic name) and selects the relevant dosage. When their "Medicine Cabinet" contains all the prescription medications they take routinely, the user clicks "NEXT."
3. **View Report.** The report produces a graph that shows when the patient may hit the doughnut hole, what the annual costs are broken down by the month and by medication, and what the premium, deductible, initial coverage, and catastrophic coverage looks like.
4. **See Options.** This is where the user can explore whether there are any other options to save money for each medication. If there is, up to three options are shown. The user can print out a letter for the doctor that lists the original medication, the less expensive options, and all the other medications that the user listed.

The calculator recalculates the medication expenses each time the user selects a less expensive medication (by clicking on "View Total Savings"). Sometimes, if therapy changes are made, the user can avoid the coverage gap altogether! The tool is also useful for people who aren't at risk of hitting the doughnut hole by making it possible for them to find ways to reduce their out-of-pocket expenses through less expensive generics or therapeutically similar choices.

A Unique Tool

Because AARP worked with DestinationRx, the designers of the Medicare.gov plan finder, the Doughnut Hole Calculator draws the drug pricing information directly from the Medicare.gov database, with the permission of the Centers for Medicare & Medicaid Services. This allows for as close to accurate pricing as possible. This calculator also provides more than generic substitutions: for many prescription medications that are not yet available as generics, the tool generates therapeutically similar alternatives, a unique function among online tools.

This calculator may not close the coverage gap, but it will inform Part D participants of options when available, and gives them the tools they need to pursue them.

Failing to Report and False Reporting of Elder Abuse

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Elder Abuse

Defining what constitutes elder abuse is challenging; practitioners, researchers, policy makers, and others have been trying to do that for decades.² The result is a growing body of literature on the topic of definitions.³ This article, however, only highlights the generally recognized types of elder abuse and briefly discusses the diversity in state statutory definitions. Each state has a different definition to govern the authority of APS agencies to take and investigate reports and to provide protective services. Therefore, it is not necessary to explore the complexities of defining elder abuse other than to point out that most APS agencies serve adults, not just older persons, and, thus, this paper uses the term to mean both elder abuse and adult abuse, unless otherwise indicated. Also, this paper refers generically to the types of elder abuse as “abuse” and to victims as “abused” unless otherwise indicated.

According to the National Center on Elder Abuse, there are seven types of elder abuse. These include:

- (1) physical abuse: the use of physical force that may result in bodily injury, physical pain, or impairment;
- (2) sexual abuse: non-consensual sexual contact of any kind with an elderly person;
- (3) emotional or psychological

The ABA Commission has added a new set of statutory analysis charts to its elder abuse Web page:

- **Penalties for Failing to Report Elder Abuse: Comparison Chart with Provisions from Adult Protective Services Laws, by State**
- **Penalties for Making a False Report of Abuse: Comparison Chart with Provisions from Adult Protective Services Laws, by State.**

The charts were prepared by Laura Remick. To view these charts, as well as others, go to www.abanet.org/aging and select the Elder Abuse link from the Resources menu bar.

—Lori A. Stiegel, Senior Attorney
ABA Commission on Law and Aging

abuse: the infliction of anguish, pain, or distress through verbal or nonverbal acts; (4) neglect: the refusal or failure to fulfill any part of a person’s obligations or duties to an elder; (5) abandonment: the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder; (6) financial or material exploitation: the illegal or improper use of an elder’s funds, property, or assets; and (7) self-neglect: the behavior of an elderly person that threatens his or her own health or safety.⁴

Although these seven types were derived from an analysis of all state APS laws, the reality is that “statutes differ significantly in the ways in which definitions are organized, the types of abuse defined, and the wording of the definitions.”⁵ Research conducted by the ABA Commission on Law and Aging demonstrates that most states do not have all seven of the NCEA categories. Sometimes states simply don’t include a category. Other times, a category is included, but it is subsumed in another definition. And, of course, the words used in the definitions vary widely, too.⁶

The definitions of “abuse” used in Delaware and South Carolina provide a good example of these differences. Both states use that term to mean two types of elder abuse—physical abuse and psychological/emotional abuse—but that is where the similarity ends. South Carolina defines abuse, generally, as “physical abuse or psychological abuse.”⁷ Delaware defines abuse more specifically as

- (a) physical abuse by unnecessarily inflicting pain or injury on an infirm adult; or
- (b) a pattern of emotional abuse, which includes, but is not limited to, ridiculing or demeaning an infirm adult, making [sic] derogatory remarks to an infirm adult, or cursing or threatening to inflict physical or emotional harm on an infirm adult.⁸

To see other state definitions of elder abuse, visit the “Types of Abuse: Comparison Chart of Provisions in Adult Protective Services Laws, by State” and “Types of Abuse: Provisions and Citations in Adult Protective Services Laws, by State” charts, available on the Web site of the ABA Commission on Law and Aging.⁹

Adult Protective Services

Role and Services Provided

According to the National Research Council, APS is the “backbone of community-based efforts to respond to elder

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Let the ABA Commission On Law and Aging Help You in Your Work

The ABA Commission on Law and Aging provides valuable professional and consumer resources, technical assistance and legal education, and research on a wide-range of critical issues affecting older persons, including:

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- Elder Abuse
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- Professional Ethical Issues
- Housing Options and Needs
- Health and Long-term Care Quality, Planning, and Decision-making
- Social Security, Medicare, Medicaid, and Other Public Benefit Programs

The ABA Commission on Law and Aging provides a forum for legal professionals to communicate and share ideas on two active listserves—**Elderbar** and **Collaborate**—and distributes a bimonthly e-journal *Bifocal*.

Find up-to-date and practical information on the Commission's publications Web page, which offers an extensive catalog of professional and consumer resources on a wide range of issues of concern to elder law practitioners, advocates, and older persons.

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Failing to Report and False Reporting of Elder Abuse

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mistreatment.”¹⁰ The goal of APS agencies is to “reduce or eliminate the abuse, exploitation, and neglect of elderly and vulnerable adults.”¹¹

Adult Protective Services agencies seek to fulfill this goal by receiving and investigating reports of suspected elder abuse.¹² If abuse is substantiated or, in some states, the victim is at risk for future abuse, APS professionals may offer or arrange for an array of protective services. These may include economic, emergency, health care, housing, legal, mental health care, and other supportive services.¹³ Abused elders who have decision-making capacity have the right to choose whether to participate in an APS investigation and whether to accept or reject any services offered to them.¹⁴ If APS professionals question whether an older person has the capacity to consent to or refuse services, then APS will seek to have a capacity assessment conducted or take steps to have a court determine whether the person has capacity.¹⁵

Eligibility for Services

In addition to defining what constitutes elder abuse, state APS laws also provide eligibility criteria for services. These criteria determine what reports may be taken and investigated and who may receive protective services. Like the definitions of elder abuse, these eligibility criteria are diverse. Research by the ABA Commission on Law and Aging demonstrates that the criteria fall into six categories: (1) age, (2) condition, (3) ability to function, (4) living situation, (5) whether the victim is receiving other services, and (6) whether the victim has a guardian or conservator.¹⁶

Reporting to Adult Protective Services

Adult Protective Services interventions begin when the agency receives a report regarding suspected elder abuse.¹⁷ Victims can self-report, but the APS laws, like the child protective services laws from which they are derived, focus on reporting by professionals or other individuals whose contact with older persons allows them to recognize signs of possible abuse.¹⁸

A person only needs a reasonable suspicion of abuse to report.¹⁹ Many state APS laws provide that persons who make abuse reports in good faith will be immune from liability.²⁰

Until recently, the reporting provisions of APS laws could be classified, generally, as either mandatory or voluntary. Mandatory reporting states require designated professionals or individuals to make a report to APS if they suspect that an older person is being or has been abused.²¹ Voluntary reporting states encourage, but do not require, reporting to APS.²² A third classification—limited mandatory reporting—requires reporting only under specified circumstances when a victim cannot choose for himself or herself whether to report or authorize someone else to make a report.²³ Each of these reporting schemes is explained more fully below.

Mandatory Reporting

To increase reports and interventions, hopefully thereby decreasing elder abuse, the laws in all but five jurisdictions require reporting of suspected elder abuse to APS by designated professionals or individuals. Research by the ABA Commission on Law and Aging demonstrates that the APS laws in these states fit into the following four categories: (1) mandatory reporting by designated professionals or individuals, (2) mandatory reporting by any person, (3) mandatory reporting by any person with qualifications or circumstances, and (4) limited mandatory reporting.²⁴

A majority of states fit into the first category. Their APS laws list specific professionals or individuals as mandatory reporters. Examples of categories of professionals that may be mandatory reporters include: physicians, practitioners of the healing arts, dentists, surgeons, pharmacists, nurses, emergency medical technicians, nursing home administrators, health care facility administrators, employers or employees of certain entities, caregivers, guardians, social workers, clergy, police officers, firefighters, and lawyers.²⁵

The second category is for states that require any person who suspects elder abuse to report. Seventeen states—Delaware, Florida, Indiana, Kentucky, Louisiana, Mississippi, Missouri, New Hampshire, New Mexico, North Carolina, Oklahoma, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, and Wyoming—require any person to report.²⁶ A few of those states—Delaware, Florida, Puerto Rico, and Texas—fit into both the first and second categories; they require any person to report, but also list certain professionals as mandatory reporters.

Three states are in the third category. Guam, Iowa, and South Carolina²⁷ classify any person who meets certain qualifications or circumstances as a mandated reporter.²⁸ To illustrate, in South Carolina any person who has “actual knowledge” of the abuse is a mandatory reporter.²⁹

The fourth category—limited mandatory reporting—is found in three state laws. Pennsylvania, Illinois, and Wisconsin require reports only under narrow circumstances defined by the state statute.³⁰ In Pennsylvania, reporting is only required if the suspected abuse victim is “an individual who

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Elder Abuse/In the News

Coverage of Brooke Astor Case Draws Ink, Ire of ABA Commission Senior Attorney Lori Stiegel

In a letter to the editor titled “Playing Down Elder Abuse” (*Washington Post*, Oct 16, 2009) **ABA Commission on Law and Aging Senior Attorney Lori Stiegel** took *The Washington Post* to task for relegating coverage of the guilty verdict in the criminal trial of Anthony Marshall for stealing from the estate of his mother, philanthropist Brooke Astor, to a “few lines in the gossip page.”

Ms. Stiegel cited U.S. Senate and MetLife studies indicating the staggering numbers of elders experiencing abuse and the costs of financial exploitation each year. She suggested that this lack of news coverage in Washington contributed to the fact that “the Elder Justice Act, the first comprehensive federal legislation on elder abuse, has languished in Congress since 2002.”

To read the complete letter to the editor, go online to <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/16/AR2009101603232_3.html>

[Note: Ms. Stiegel wrote this letter on personal time and was not speaking for the American Bar Association.]

In more press, **Ms. Stiegel** was quoted in a blog article published in *The New York Times* titled “Abuse Experts Heartened by Astor Verdict” (*NY Times, The New Old Age*, Oct 10 and *NY Times, Postings*, Oct. 13). As the trial inched forward and the sensational headlines ebbed, prosecutors, experts, and other professionals involved in the field of elder abuse—including ABA Commission on Law and Aging Senior Attorney Lori Stiegel—were still very much following the case. As Ms. Stiegel speculated in the article:

If the prosecutors, including the head of the Manhattan District Attorney’s pioneering elder abuse unit, had failed to win a conviction . . . it could have been perceived as reinforcing the notion that these cases are just too difficult to bring and that juries will have trouble understanding the issues.

Ms. Stiegel added that the guilty verdict sends a strong message to prosecutors that they can “successfully bring these complex and challenging cases.”

To read the complete article, go online to <<http://newoldage.blogs.nytimes.com/2009/10/10/abuse-experts-heartened-by-astor-verdict/?scp=1&sq=Stiegel&st=cse>>

Look for the November-December issue of *Bifocal* for more on the Astor case.

—Jamie Philpotts

Failing to Report and False Reporting of Elder Abuse

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receives care, services, or treatment in or from a facility.”³¹ In Illinois and Wisconsin, mandatory reporting is required only when a suspected abuse victim is unable to seek help or make a self-report to APS.³²

Voluntary Reporting

Voluntary reporting states encourage, but do not mandate, any person to report elder abuse to APS. Therefore, all reports are voluntary. Colorado, New Jersey, New York, North Dakota, and South Dakota are voluntary reporting states.³³

Controversy Surrounding Reporting

Reporting is a controversial topic. This article does not take a position on the merits of mandatory versus voluntary reporting. Instead, it briefly discusses the controversy because of its relevance to penalties for failing to report and for making false reports. The National Research Council’s Panel to Review Risk and Prevalence of Elder Abuse and Neglect illuminated the long-standing controversy as follows: “The ongoing debate concerning mandated reporting raises many empirical questions about the effects of these laws on the behavior of mandated reporters and about the consequences of reporting on the lives of people affected by them.”³⁴

Although “virtually no research has been conducted”³⁵ on the impact of mandatory reporting laws, there is research demonstrating that elder abuse is underreported.³⁶ The elder abuse literature provides numerous reasons why victims, professionals, and other individuals fail to report even when mandated to do so. Unlike children, older adults with decision-making capacity have the right to decide whether to self-report or whether to authorize someone else to report.³⁷ Victims often do not report abuse because they fear the report will lead to increased abuse, loss of independence, imposition of a guardian or conservator, or placement in a long-term care facility.³⁸ Victims may not want to see their abuser get in trouble.³⁹ Victims and others may fear retaliation by an abuser, or the social stigma attached with such reports.⁴⁰ Professionals, family members, neighbors, and friends of older adults may fail to report because they are following the victims’ wishes.⁴¹ They may also be unaware of or may

choose to overlook the signs of abuse.⁴² Family members are cautious and often do not file reports if the abuse occurs in the older adult’s home⁴³ in order to avoid personal accusations and family issues. Professionals may fear that reporting will destroy their relationship with the victim, leaving the victim even more vulnerable.⁴⁴ Professionals often say that they do not report because nothing happens when they do.⁴⁵

Penalties for Failing to Report

Only states with mandatory reporting laws provide penalties for failing to fulfill the legal obligation to report, and those penalties fall into three categories: (1) civil penalties against mandatory reporters, (2) criminal penalties against mandatory reporters, and (3) penalties against third parties who have responsibility for or involvement in a person’s failure to report. Each category is discussed in more detail below.

Civil Penalties

Civil penalties are prevalent among provisions for the failure to report abuse. Penalties authorized include administrative and civil fines, civil liability for damages resulting from the failure to report, and notifications to appropriate licensing entities or employers about non-compliance with a legal responsibility.

States that authorize administrative fines include Pennsylvania and Vermont. The states that have civil fines are Guam, Maine, Massachusetts, Michigan, New Mexico, Pennsylvania, Rhode Island, Virgin Islands, and Virginia. California law authorizes civil fines against officers and employees of financial institutions who fail to report financial abuse; as indicated below, however, it authorizes criminal penalties against other mandated reporters who fail to report

In Arkansas, Iowa, Michigan, and Minnesota, mandated reporters may face civil liability for the damages incurred by victims due to their failure to report.

Some states require that a licensing agency be notified when a professional, such as a physician or dentist, violates the reporting provisions. These states include Alaska, District of Columbia, Illinois, Maine, Mississippi, New Mexico, and South Carolina.

Criminal Penalties

The APS laws authorize an array of criminal penalties against mandated reporters who fail to report. These penalties include misdemeanors, criminal fines, and imprisonment.

Thirty-two states provide that an individual who fails to report abuse is guilty of a misdemeanor. These states are:

Alabama, Alaska, Arizona, Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Guam, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Washington, West Virginia, and Wyoming.

Criminal fines are authorized in the laws of these thirteen states: Alabama, California, Connecticut, District of Columbia, Louisiana, Mississippi, Missouri, Oklahoma, Pennsylvania, South Carolina, West Virginia, Wisconsin, and Wyoming.

Ten states authorize time in jail for failure to report. Those states are: Alabama, California, Louisiana, Mississippi, Oklahoma, Pennsylvania, South Carolina, West Virginia, Wisconsin, and Wyoming.

The APS laws of Montana and Oregon both express that a failure to report abuse constitutes an offense or violation, but neither specifies the nature of the offense (*e.g.*, misdemeanor) or the punishment. The APS statute in Montana states that a person who “purposely or knowingly fails to make a report is guilty of an offense,” and references Montana’s criminal code for a punishment instead of indicating one in the statute.⁴⁶ In Oregon’s statute, “a person who violates ORS 124.060 commits a Class A violation,”⁴⁷ but it fails to define a “Class A violation.”

Penalties Against a Third Party

Eight states that authorize penalties against people who fail to report abuse also authorize penalties against third parties who impede a mandated reporter in fulfilling his or her obligation. Those states are California, Florida, Hawaii, Iowa, Kansas, New Mexico, Pennsylvania, and West Virginia. Seven of these states impose the same penalty for failing to report abuse and for preventing, impeding, or interfering with a report. Iowa is the only state that has different penalties for individuals who interfere with the making of reports and for individuals who fail to report abuse. In Iowa, a person who knowingly fails to report commits a simple misdemeanor, but a person who knowingly interferes with the making of a report of elder abuse may be held civilly liable for the damages proximately caused by the failure to report.⁴⁸

Idaho enacted a provision that differs from any other state. It says “[i]f an employee at a state licensed or certified residential facility fails to report abuse or sexual assault that has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult,” the facility is held vicariously liable for the failure to report and will face

Continued on page 12

Important Notice on Social Security Class Action

Notice of Preliminary Class Action Settlement—Persons who have been denied payments of Social Security retirement, disability, SSI or SVB (Special Veterans Benefits) because of outstanding felony warrants may be entitled to relief as a result of a class action case litigated by the National Senior Citizens Law Center.

For more information, visit online: www.nslc.org/areas/social-security-ssi/Martinez-Settlement

State Emeritus Pro Bono Rules

Updated Chart Outlines State Emeritus Pro Bono Practice Rules

Emeritus pro bono practice rules encourage retired and inactive attorneys to volunteer to provide pro bono assistance to clients unable to pay for essential legal representation.

At last count 32 jurisdictions have adopted emeritus pro bono rules waiving some of the normal licensing requirement for attorneys agreeing to limit their practice to volunteer service.

The ABA Commission on Law and Aging maintains a chart of states and jurisdictions that have enacted emeritus pro bono rules. It features essential details of each state’s rules and contact information.

Access the chart, updated to August 2009, from www.abanet.org/legalservices/probonoemeritus.html.

The ABA Commission also distributes a brochure designed to help states successfully recruit emeritus pro bono attorneys to provide critically-needed legal services to vulnerable seniors and low- and moderate-income individuals who are now facing their legal problems on their own. The ABA Commission encourages state bar groups interested in establishing an emeritus pro bono program to reprint and distribute the brochure to its members. Download the brochure from www.abanet.org/legalservices/probonoemeritus.html.

For more information on state emeritus pro bono attorney rules, contact David Godfrey at Godfreyd@staff.abanet.org.

Failing to Report and False Reporting of Elder Abuse

Continued from page 11

penalties, including revocation of license, closure, bans on admission, denials of payment, or monetary penalties.⁴⁹

Recent Legislation

Three states made relevant changes to their APS laws between 2007 and 2008. New Mexico amended its law in 2007 by adding a civil penalty, which is not to exceed \$10,000.⁵⁰ The same year, Rhode Island amended its law by reducing its penalty from imprisonment to a fine up to \$1,000.⁵¹ In 2008, Louisiana added a provision that authorized penalties of a misdemeanor, fines up to \$500, and imprisonment.⁵²

Penalties for Making False Reports

Both mandatory and voluntary reporting states authorize penalties for making false reports to APS. Such penalties are meant to discourage and punish reporting for fraudulent or malicious purposes. This policy recognizes that false reports may be made for reasons such as retaliation or personal issues with the alleged victim or the alleged abuser, and that false reports can lead to an unwarranted invasion of the alleged victim's privacy.⁵³ This policy also recognizes that investigating false reports costs money that could be better put toward investigating good faith reports and serving actual victims.

Fourteen states authorize either civil or criminal penalties against a person who files a false report. Three of those states also authorize penalties against third parties who advise someone to make a false report or who cause a false report to be made. Five states provide that someone who makes a false report will lose immunity for civil or criminal liability for having made a report (commonly referred to as "good faith immunity") or lose the protection against retaliation by an employer for having made a report. These penalties are discussed in more detail below.

Civil Penalties

There are eight states that authorize civil penalties in their state provisions. Civil penalties include fines, civil liability for damages, payment of attorney's fees, and notification to a licensing entity.

Florida authorizes a civil fine against individuals who make false reports to APS.

Six states authorize civil liability for damages incurred by the subject of a false report. Those states are Colorado, Idaho, Minnesota, Mississippi, North Dakota, and Oklahoma.

Two states, Idaho and Minnesota, provide that an individual who knowingly makes a false report is responsible for the payment of attorney's fees that result from the false report.

The District of Columbia is the only jurisdiction that authorizes notification to a licensing agency as a penalty for making a false report. The provision only applies to health-care administrators and health professionals.⁵⁴

Criminal Penalties

The APS laws of ten states authorize criminal penalties for making a false report. Criminal penalties can include a misdemeanor, felony, criminal fine, or time in jail.

An individual who makes a false report may be charged with a misdemeanor in nine states: Arkansas, Colorado, District of Columbia, Louisiana, North Dakota, Texas, Virginia, Washington, and Wyoming.

In Arkansas and Florida an individual may be charged with a felony.

Three states—District of Columbia, Louisiana, and Wyoming—authorize a criminal fine.

Individuals in Louisiana and Wyoming may face time in jail for making false reports.

Penalties Against a Third Party

Three of the states that authorize penalties against individuals who make false reports also authorize the same penalties against third parties who advise someone to make a false report or who cause a false report to be made. These states are Florida, North Dakota, and Virginia. Florida authorizes a penalty against any person who advises another person to make a false report.⁵⁵ North Dakota's law includes a penalty for anyone who provides false information to another person and causes a false report to be made.⁵⁶ Virginia has a provision that includes a penalty for any person who causes a false report to be made.⁵⁷

Loss of Immunity or Other Protections

Some states provide that someone who makes a false report will lose immunity for civil or criminal liability for having made a report (commonly referred to as "good faith immunity"⁵⁸). Those states are: California, Montana, Nebraska, and

Wyoming. Massachusetts takes a different approach, providing that a person who makes a false report will lose the protection against retaliation by an employer for having made a report.⁵⁹

Recent Legislation

Only one state made a relevant change to its APS law between 2007 and 2008 regarding false reporting. Louisiana, in 2008, added a provision that included penalties for knowingly making a false report. Those penalties include a misdemeanor, a fine up to \$500, and imprisonment.⁶⁰

Conclusion

A majority of states have penalties for the failure to report elder abuse, although only a minority of states have penalties for knowingly making a false report of abuse. State provisions authorize penalties against individuals who fail to report abuse that they reasonably suspect or know is occurring and against individuals who file false reports with information they know to be incorrect. The policy behind these penalties is to encourage more people to report abuse and to deter the filing of false reports.

Nine states lack any provisions that authorize penalties against mandatory reporters for failure to report and against either mandatory or voluntary reporters for knowingly making false reports. These states are Delaware, Indiana, Maryland, New Jersey, New York, North Carolina, Ohio, Puerto Rico, and South Dakota.

Despite the fact that most state APS laws authorize these penalties, there has been no research about whether their existence alone is effective at deterring false reporting and whether they are even enforced. Such research could help inform policy makers and program administrators regarding the controversy about mandatory versus voluntary reporting and help them to better protect the health and safety of older adults.

Notes

1. American Bar Ass'n Commission on Law and Aging, <www.abanet.org/aging/elderabuse.shtml> (2009).
2. Bonnie Brandl *et al.*, *Elder Abuse Detection and Intervention* 17 (Springer 2007).
3. Nat'l Research Council, *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America* 19 (Richard J. Bonnie & Robert B. Wallace eds., 2003).
4. Nat'l Center on Elder Abuse, *Major Types of Elder Abuse*, <http://www.ncea.aoa.gov/NCEARoot/Main_Site/FAQ/Basics/Types_Of_Abuse.aspx> (2007).
5. Lori Stiegel & Ellen Klem, *Explanation of "Types of Abuse: Provisions and Citations in Adult Protective Services Laws, by State"* chart and "Types of Abuse: Comparison Chart of Provisions in Adult Protective Services Laws, by State" <<http://www.abanet.org/aging/about/elderabuse.shtml>> (2007).
6. *Id.*

7. S.C. Code Ann. § 43-35-10 (West 2008).
8. Del. Code Ann. tit. 31 § 3902 (West 2008).
9. American Bar Ass'n Commission on Law and Aging, *supra* n. 1.
10. Nat'l Research Council, *supra* n. 3, at 124.
11. Brandl *et al.*, *supra* n. 2, at 79.
12. *Id.* at 79-80.
13. *Id.* at 80.
14. *Id.*
15. *Id.* at 82.
16. Lori Stiegel & Ellen Klem, *Age Threshold Eligibility for Adult Protective Services: Comparison Chart of Criteria, by State* <<http://www.abanet.org/aging/about/elderabuse.shtml>> (2007).
17. *Id.*, *supra* n. 3, at 124.
18. *Id.* at 13.
19. *Id.* at 122.
20. Lori Stiegel & Ellen Klem, *Explanation of the "Immunity for Good Faith Reporting: Provisions and Citations in Adult Protective Services Laws, by State"* and "Immunity for Good Faith Reporting: Criteria in Adult Protective Services Laws, by State" charts <<http://www.abanet.org/aging/about/elderabuse.shtml>> (2007).
21. Lori Stiegel & Ellen Klem, *Explanation of the "Reporting Requirements: Provisions and Citations in Adult Protective Services Laws, by State"* and "Mandatory Reporters: Comparison Charts of Categories in Adult Protective Services Laws, by States" <<http://www.abanet.org/aging/about/elderabuse.shtml>> (2007).
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*, "Mandatory Reporters: Comparison Charts of Categories in Adult Protective Services Laws, by State."
26. *Id.*, *Explanation of the "Reporting Requirements: Provisions and Citations in Adult Protective Services Laws, by State."*
27. Stiegel & Klem, *supra* n. 21.
28. *Id.*
29. S.C. Code Ann. § 43-35-25 (West 2008).
30. Stiegel & Klem, *supra* n. 21.
31. Pa. Stat. Ann. tit. 35 § 10225.103 (West 2008).
32. Stiegel & Klem, *supra* n. 21.
33. *Id.*, *Explanation of the "Reporting Requirements: Provisions and Citations in Adult Protective Services Laws, by State."*
34. Nat'l Research Council, *supra* n. 3, at 123.
35. *Id.*
36. Brandl *et al.*, *supra* n. 2, at 75.
37. *Id.* at 61.
38. *Id.* at 52-57 for a discussion of barriers to reporting elder abuse.
39. *Id.* at 52.
40. *Id.* at 75.
41. Stiegel & Klem, *supra* n. 38.
42. *Id.* at 61-62.
43. *Id.* at 75.
44. James G. O'Brien, *Abuse, Neglect, and Exploitation of Older Persons* 52 (Lorin A. Baumhover & S. Colleen Beall eds., 1996).
45. *Id.*
46. Mont. Code Ann. § 52-3-825 (West 2008).
47. Or. Rev. Stat. § 124.990 (West 2008).
48. Iowa Code Ann. § 235B.3 (West 2008).
49. Idaho Code § 39-5303(2) (West 2008).
50. N.M. Stat. Ann. § 27-7-30(D) (West 2007).
51. R.I. Gen. Laws § 42-66-8 (West 2007).
52. La. Rev. Stat. Ann. § 14:403.2 (West 2008).
53. *Id.*, *supra* n. 2, at 75.
54. D.C. Code Ann. § 7-1912 (West 2008).
55. Fla. Stat. Ann. § 415.111(5) (West 2008).
56. N.D. Cent. Code § 50-25.2-10(1), (2) (West 2008).
57. Va. Code Ann. § 63.2-1606(G) (West 2008).
58. Stiegel & Klem, *supra* n. 20.
59. Mass. Gen. Laws Ann. 19C § 11 (West 2008). This law is applicable only to persons with disabilities. Massachusetts has separate laws and programs for elder protective services and adult protective services. For more information, please see the Threshold Eligibility Charts available at <http://www.abanet.org/aging/about/elderabuse.shtml>.
60. La. Rev. Stat. Ann. § 14:403.2 (West 2008).

Book Review

**Nasty, Brutish & Long:
Adventures in Old Age
and the World of Eldercare**

By Ira Rosofsky (Avery, NY, 2009. \$25)

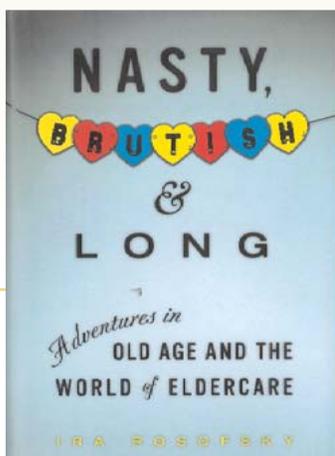
Review by David Godfrey, Senior Attorney
ABA Commission on Law and Aging

Nasty, Brutish & Long offers a rare and unblinking glimpse into the psychosocial issues facing the elderly population living in nursing homes. The author weaves stories collected from his professional experience as a psychologist treating (mostly) elderly patients in nursing homes, assisted living facilities, and other institutions, with his personal experience surrounding the decline and death of his father.

The book provides a compassionate, yet unsparing, examination of the lives of the nursing home residents he meets. He describes the psychological impact both of the physical and mental decline of his patients and the various effects of institutionalization.

This book is not an academic study or a research report; it has a narrative style that is punctuated with humorous asides and wry commentary. In parts, the book would have benefited from stronger editing. In particular are his comments regarding Medicaid rules, which vary widely from state to state and can change rapidly.

The book is easy to read at 210 pages. It would be useful for anyone interested in a deeper understanding of the psychosocial issues of residents of nursing homes and other long-term care institutions.



In the News

**Administration on Aging Awards
\$1.1 Million to States to Help Older
Americans Access Legal Services**

**Coordinated Approaches Will Help Older
Americans Remain Independent**

Grants totaling nearly \$1.1 million were awarded to eleven states to help at-risk older Americans better access legal services. The grants, announced September 18 by HHS Assistant Secretary for Aging Kathy Greenlee, are intended to bring together the aging and legal service delivery systems, and improve states' efforts to protect the independence, health, and financial security of older adults.

Awards of approximately \$100,000 each were made to California, Louisiana, Maine, Missouri, Nebraska, North Carolina, Ohio, Rhode Island, South Carolina, Utah, and Vermont to promote the continued development of statewide legal service delivery systems that coordinate efforts of senior legal helplines, legal services providers funded through the Older Americans Act, pro-bono attorneys, law school clinics, and self-help sites to ensure maximum impact from limited resources.

Through the "Model Approaches to Statewide Legal Assistance Systems" program, the Administration on Aging assists states in integrating helplines and other low-cost legal assistance mechanisms as critical, permanent, and sustained components of comprehensive legal services delivery programs across the country. The target populations of the Model Approaches program are underserved seniors, with particular emphasis upon low-income, minority, rural, homebound, Native American, and limited-English speaking older individuals.

The Administration on Aging currently funds 13 Model Approaches projects, six of which are now completing their three-year cycle: Alabama, Idaho, Iowa, Maryland, North Dakota, and Virginia. The remaining seven were recently awarded continuation funding for their third and final year: Connecticut, Florida, Kentucky, Michigan, Nevada, New Hampshire, and Pennsylvania.

Upon completion of the three-year grant period, the Model Approaches projects will present cost-effective examples of well-integrated legal services delivery systems and strategies that increase overall service access for elders.

For more information about AoA services and programs, go to www.aoa.gov.

Pennsylvania SeniorLAW HelpLine Reaches Out Through Electronic Newsletter

By Sue Wasserkrug, J.D.

An electronic newsletter is a great way to provide timely information to a large audience. As the Baby Boomers are beginning to cross the 60-year mark, more and more “seniors” are using computers. Similarly, nearly all members of the aging services network have e-mail and can benefit from an electronic newsletter.

To expand its outreach to both clients and providers, the SeniorLAW Center publishes a quarterly electronic newsletter that contains easy-to-read news and information about legal issues that affect senior citizens in Pennsylvania.

The *SeniorLAW News* is distributed to an ever-growing list of seniors, their families, and members of the aging services network. The distribution list includes staff at all 52 Area Agencies on Aging in Pennsylvania and at hundreds of community-based senior centers across the state, as well as health care providers, legal services providers (including volunteer attorneys, paralegals, and students), and elected officials and their staff.

Staff ask everyone who calls the HelpLine if they have an e-mail address and, if so, whether they would like to receive the newsletter. Staff also encourage readers who are

Sue Wasserkrug, J.D., is the director of the Pennsylvania SeniorLAW HelpLine. The HelpLine provides free and confidential legal information, advice, and referrals to more than 1,500 older Pennsylvanians per year. The HelpLine is a project of the SeniorLAW Center, a nonprofit organization that has been protecting the legal rights of older Pennsylvanians for more than 30 years.

service providers to share the newsletter with the seniors they serve.

Each issue of *SeniorLAW News* contains three or four short articles that cover any of a broad range of legal issues that affect older people. Since its inception in 2007, topics have included grandparents’ rights; newly enacted state legislation (one recent law provides protections against unscrupulous home repair contractors, while another deals with living wills); protections for purchasers of hearing aids; pension rights; proposed federal legislation, such as the Elder Justice Act; initiatives, such as the Elder Economic Security Index; and mediation.

Issues also highlight benefits and resources, such as the economic stimulus payments for seniors, Pennsylvania’s property tax and rent rebate program for seniors; expanded food stamp eligibility for seniors; and resources for assistance with the high cost of home energy bills.

In each issue, we try to include as many links to additional resources as possible. When appropriate, we also include “Save the Date” notices of upcoming events and fundraisers at the SeniorLAW Center.

The SeniorLAW News is distributed to an ever-growing list of seniors, their families, and members of the aging services network.

While most articles are written by SeniorLAW Center staff, volunteers and student interns also are invited to contribute. Occasionally, articles contributed by other organizations in Pennsylvania are published, as well. Above all, in each issue, the SeniorLAW Center strives to disseminate legal information important to older Pennsylvanians in a way that is accessible to a broad readership.

If you are interested in receiving the most recent issue of our electronic newsletter, send an e-mail to swasserkrug@seniorlawcenter.org.

If you are interested in subscribing, send an e-mail to the helpline@seniorlawcenter.org.

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Inside the Commission

Summer 2010 Law and Aging Legal Internship Opportunities

The ABA Commission on Law and Aging offers two summer internship opportunities:

- (1) The Borchard Internship, funded by the Borchard Foundation Center on Law and Aging.
- (2) The Coleman Internship, created in honor of Nancy Coleman, the founding director of the ABA Commission, and supported by an ABA Fund for Justice and Education endowment.

Both internships aim to provide law students—especially those who may be interested in pursuing a career focusing on law and aging issues—with experience in a nationally known organization in that field.

Each intern will be assigned to produce at least one major publishable product (a report, article, analysis, bibliography, etc.) under the supervision of a staff attorney. In addition, the intern will assist staff attorneys in researching or monitoring other legal/policy developments or in working on an identifiable component of a larger research or writing project.

The core focus for summer 2010 will be chosen from among several current priorities of the Commission, which include: nursing home/long-term care access and quality issues; Medicare/Medicaid coverage issues; health care decision-making developments; state guardianship law reform; elder abuse; international perspectives in elder rights.

For statements by past ABA Commission legal interns about their summer experiences, see the “Law Students” section of the Web page of the ABA Commission on Law and Aging at: www.abanet.org/aging.

Qualifications

- Completion of the second year of law school
- Good research and writing skills
- Public interest orientation, especially in the field of law and aging
- Self-initiative, intelligence, good interpersonal skills, and a willingness to learn and work under supervision.

Hours and Compensation

The internship will last 10 to 12 weeks, May - July/August, and pay a \$4,000 stipend. Start and end dates will be negotiated with the applicant. Normal ABA working hours consists of a 37½-hour work week with flex-time scheduling.

Application

Send resume, contact information for three references, a brief writing sample, and a cover letter explaining your interest to Sonia Arce, Office Manager, ABA Commission on Law and Aging, 740 Fifteenth St., NW, Washington, DC 20005, or e-mail to: sarce@staff.abanet.org.

Deadline

Applications must be received by November 5, 2009.

Questions?

Contact Sonia Arce, Office Manager, 202-662-8695, e-mail: sarce@staff.abanet.org, or Erica Wood, Assistant Director, 202-662-8693, e-mail: ericawood@staff.abanet.org

Funding Opportunity

The National Institutes of Health has announced the availability of \$30 million provided by the American Recovery & Reinvestment Act of 2009 to support the development of partnerships between academic research centers and community-based organizations.

This funding opportunity, developed in collaboration with the Administration on Aging, supports the development of infrastructure and staff for productive and sustainable academic-community research partnerships. The goal is to accelerate the pace, productivity, dissemination,

and implementation of research translation in community-based settings by strengthening and transforming relationships between academic centers and community organizations.

These grants give special attention to projects that involve partnerships with HHS-funded networks, including the AoA supported Aging Services Network.

Letters of intent are due November 12, 2009, and the application due date is December 11, 2009.

For a copy of the grant announcement, go to: <http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-09-010.html>

Tips for Providing Services on American Indian Reservations: An Individual Approach Works Best

By Alex Ward

This is, by no means, a complete treatise on working in Indian country. Much of the following knowledge comes from my personal experience working with individual tribal organizations. Because there are 562 tribes recognized in the United States, each experience will be different.

American Indians, as a population, are often misunderstood by others. Even what to call them is sometimes not clear. I once attended a tourist seminar presented by a Blackfeet Indian named Curly Bear. He began his presentation by saying: “You all are Native Americans. I’m an American Indian. Do you want to know why I’m an American Indian? It’s because Columbus was looking for India. I’m sure glad he wasn’t looking for the Virgin Islands.”

Because tribes from different regions are unique, they are also unique in how they identify themselves and how they want others to identify them. If you want to be correct, ask them what they wish to be called. In the Plains region, it is most correct to refer to the name of the tribe, such as Blackfeet, Crow, Northern Cheyenne, etc., or simply by the term American Indian. Other tribes may prefer the term Native American or Alaska Native.

When a non-Indian group decides to provide services on Indian reservations, there are several important things that should be established. First and foremost is making contacts and getting to know some people on the reservation.

Following are examples of some of the typical approaches taken when working on Indian reservations and suggestions for alternate approaches that may prove more productive.

Non-Tribal Encroachment on Reservations

If a person takes into account the bad track record “non-Indian” organizations have had on reservations, one would be hard pressed to not understand why tribes are reluctant to

embrace each new group intent on providing services. On some reservations, states have come to the tribes with grant money without even talking with the tribes beforehand. In many of those cases, the result is a grant designed in such a way that the delivery system won’t work on the reservation.

The correct approach when applying for a grant to provide services in Indian country is to work with the tribal organizations beforehand. It is very important for providers who wish to work in Indian country to recognize that once they cross the border onto a reservation they are no longer the “expert on outreach.” If the tribal partner is consulted on matters, such as outreach on the reservation, and involved in preparing the application for the grant, the provider organization is more likely to be successful in its efforts.

There are 562 distinct and federally recognized Indian tribes in the United States. Each tribe has a unique history and, in many cases, a different culture.

Another thing to consider is that it is important to learn a little of the background and culture of the tribe. For example, one issue that often leads to misunderstandings with Indian people is the matter of “eye contact.” Non-Indians look people in the eye and assume that if a person won’t look you in the eye they are being dishonest or, if in a classroom, not paying attention. In reality, they may be from an Indian culture that believes it’s rude to look people in the eye.

In many Plains tribes, it is rude not to accept food that is offered. I learned that lesson early on and have, on occasion, accepted food that I didn’t want because I knew I would offend the person if I didn’t take it.

Similarly, some words can be taken as offensive. The word “squaw” is derogatory and should never be used. Once, during a planning committee conference call, one of the participants asked if we should take “Indian time” into account and start the programs later. The person who had used that phrase was “educated,” after the call, on how offensive the term was to American Indians. Sometimes, as with the concept of “Indian time,” it’s O.K. for a person who has worked with a tribe for a long time to allude to the term. My advice is to err on the side of caution and not use such phrases unless it’s brought up by another tribal member.

Another mistake people make is to assume that American Indians are all the same, no matter which tribe they are part of. In reality, there are 562 distinct and federally recognized Indian tribes in the United States. Each tribe has a unique history and, in many cases, a very different culture. A

Continued on page 18

Alex Ward is active in the Montana SMP program and an adopted member of the Blackfeet tribe.

American Indian Outreach

Continued from page 17

good example of how some provider organizations fail to recognize this critical aspect is in the production of materials to be used in Indian country. Some organizations have put valuable information together in a product and then filled it with photos of random “Indian” images. I’ve seen pamphlets distributed to Plains tribes with distinctly Navajo or Pacific Coastal imagery. These are very recognizable to the individual tribes.

Many American Indian meetings begin and end with a prayer from a tribal elder. It is customary to present a gift to the elder for his participation. Many tribes’ culture dictates gifts of tobacco, sage, or sweet grass to the elders you visit, especially if you are asking them to do something. Again, it is important to find out what the specific tribe expects.

How is one to learn all this? Get to know your tribal partners socially so you feel comfortable asking for their input on the things you are doing.

I’ve seen pamphlets distributed to Plains tribes with distinctly Navajo or Pacific Coastal imagery. These are very recognizable to the individual tribes.

In my own experience, I was given an Indian name by Chief Earl Old Person of the Blackfeet Tribe. This single event was a special learning experience for me. The name was a very small part of the ceremony—but a very great honor. It meant that I was actually being adopted into the Blackfeet Tribe. Since this was done at the Blackfeet Powwow there was an honor song and I danced (not well) around the arbor with many of the people who had been instrumental in getting me named. Then there was a giveaway that I took part in; many items were given to people who were important to me in my days on the reservation. Finally, there was a feast that was hosted by the Eagle Shield Senior Center and about 100 people were fed. Indian people are typically very generous. They see everything much different than we do. Even poverty is something that isn’t seen the same. The poorest Indian people share what they have with their family and friends.

Many provider organizations have so many projects going on that they can only focus on one area for a short time. This approach is deadly in Indian country, because that has been their history with off-reservation orga-

nizations. The providers come in and work hard for a year or two and then leave with the tribal partner holding the bag on a program that they might not be able to carry on, especially at the level they were when the organization and grant money were present.

Successful casinos are often pointed to by non-Indians as the solution to Indian problems and a reason not to support their initiatives. However, most successful casinos are in urban areas where there are large numbers of people to gamble and make money for the tribe. The more successful ones have convention centers and hotels with them. Often they are also in states where casino gambling is only allowed on reservations or where the types of games are different in the Indian casinos than those off the reservations. On other reservations where there are casinos, there is little to draw non-Indians and so they just rearrange the money that is already there, rather than bringing in additional money for the tribe to use to improve its situation in the area. In truth, there is conflict on reservations as to whether casinos are the right solution to their funding problems. Many Indian people don’t support using casinos to make money for the tribe. Indian tribes that do have successful casinos often do things like enrolling all their people 65 or over in Medicare or using the money to support other needs in the community. Again, all tribes are different and tribal councils are as different as governments in our own communities.

Healthcare and Indian Country

Healthcare is a sore point for American Indians. A good primer for this is *Broken Promises*, which is a U.S. Civil Rights Commission Study of Healthcare on Indian Reservations that was released in 2004 (*Broken Promises: Evaluating the Native American Health Care System*. U.S. Commission on Civil Rights. Washington, DC. 2004). The primary health system for American Indians is the Indian Health Service (IHS), which is grossly underfunded (about 55 percent of need in the Billings, Montana, Area).

The IHS has a policy of not requiring those 65 or over, who would have to pay premiums, to enroll in Medicare. This is most likely because there are two very different views of healthcare by Indians—those who are considered “traditional” and those who are more “progressive.” Traditional Indians feel that the United States government has treaty obligations to provide health care to all Indians and that obligation is found in Indian Health Services. They are concerned that the efforts to get Indian people enrolled in other insurance is an effort to further erode the underfunded system and a way to eventually get rid of IHS in favor of more costly private insurance, including Medicare. Many tradi-

tionalists are tribal health directors or have influence on tribal councils, which make those tribes reluctant to enroll their members in private insurance.

One other issue around Medicare is that many traditionalists have not enrolled and are old enough that their premiums are cost prohibitive because of the penalty for enrolling too late. This is reversible for those who are QMB eligible, but not for others. I have actually encouraged the Senate Finance Committee chair to have the new health care reform exclude Indians from the penalties (or say that IHS is creditable coverage, as is done in Medicare D). Unfortunately it's an issue that should be corrected, but the Indian Health Care Improvement Act hasn't been passed for 10 years.

On the other hand, many progressives would like to see all eligible tribal members enrolled in Medicare to help take the pressure off the limited Contract Health funds that IHS has to use for people who have needs requiring off-reservation medical attention. I have been working in Browning, Montana, and other locations with IHS, charged with enrolling qualified tribal members in benefits such as Medicare Savings. Some traditionalists understand that they need to work on getting people enrolled to increase their quality of life in the short term, until the U.S. government actually faces up to its responsibility.

Summary

Working with American Indians is a very interesting and rewarding experience. I have become not only friends with my Indian partners, but they have become family. That is the greatest reward that can be bestowed on a person who is not connected to the reservation.

American Indians have a great sense of humor and events I've been involved in on reservations in Montana have been some of the most fun I've ever had.

There often are stereotypes that have to be dealt with before each of us can work productively with people from different communities than our own. I, for one, was raised in a border town where there was racism directed towards Indians. It's easy to see people who meet our stereotypes if they stand out because of their race; it's not as easy to see the people who are college graduates (in Browning, Montana, often with degrees from schools like Harvard) who have decided they want to use their education to help their tribe, or the people with high school or less education who are doing things that people with Ph.D's aren't accomplishing outside of Indian country.

In the process, don't forget that people are people and there are all types in all cultures. Curiosity, dedication, and a true determination to accomplish things is what is required for successive partnerships with American Indian tribes.

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Elderbar gives you the opportunity to communicate across the boundaries of the law and aging networks and the public and private legal sectors. Share ideas and information about programs, bar section and committee activities, and learn how others are responding to the increasing demand and finite funding for legal services for seniors.

Elderbar is a project of the ABA Commission's National Legal Assistance Support Center as part of its role in the National Legal Resource Center, funded by the Administration on Aging. It is a closed list; messages can only be posted and read by members.

To get connected to **Elderbar** send your name, e-mail address, and professional affiliation to David Godfrey at Godfreyd@staff.abanet.org.

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Alzheimer's Disease, Dementia, and the SSDI Process: "Passage of Time Is Not Your Friend"

By Leslie B. Fried, J.D.

Improving the Social Security Disability Insurance system is a particularly worthwhile effort given the delays that can occur when a person applies for benefits. For persons with Alzheimer's disease and other dementias, these delays are problematic because dementia causes a considerable loss of executive function early in the disease and seriously compromises the ability of these individuals to work.

The Alzheimer's Association has increased its advocacy efforts during the past several years to improve the SSDI system for individuals with young-onset (under age 65) Alzheimer's disease and related dementias. On several occasions, the Alzheimer's Association submitted written comments to the Social Security Administration to revise the listings to better address the diagnostic and functional impairments of this population.

In Fall 2007 the Alzheimer's Association submitted comments on why young-onset Alzheimer's disease, and related dementias, is appropriate for inclusion in the Compassionate Allowance Initiative. On July 29, 2009, Commissioner Astrue and the SSA held a one-day outreach hearing in Chicago to hear testimony on the issue. While a decision is not expected for several months, it is hoped that continual education and persistent advocacy will address some of the problems for this population within the SSDI claims system.

Leslie B. Fried, J.D., is a senior attorney with the ABA Commission on Law and Aging and is the director of the Alzheimer's Association Medicare Advocacy Project. The Medicare Advocacy Project is a collaborative effort between the Alzheimer's Association and the ABA's Commission on Law and Aging. It was established in 1998 by the Alzheimer's Association to address Medicare coverage issues for people with Alzheimer's disease and to respond to Alzheimer-related Medicare inquiries from local Alzheimer's Association chapters throughout the country.

This article was first published in the NOSCCR Social Security Forum, Vol. 31, No. 8, August 2009. Established in 1979, the National Organization of Social Security Claimants' Representatives is an association of over 3,900 attorneys and other advocates who represent Social Security and Supplemental Security Income claimants. Reprinted with permission.

Background

Over the past few years, as Alzheimer's Association representatives sought information about people under age 65 with Alzheimer's disease and other dementias, they were shocked and saddened by the stories they heard. People under age 65 with Alzheimer's and other dementias often lose their jobs—they are fired or forced to retire—even before they are diagnosed. Some, who are aware of their increasing problems at work, seek a diagnosis and are fired when they tell their employers. Others decide to resign when they learn the diagnosis and recognize that they cannot fulfill their responsibilities to their employers, even though it likely means they will not be able to fulfill their responsibilities to their families. Many try to find another job that they will be able to manage. Some succeed in finding such work for a time, only to be fired or forced to retire again when it is clear that they cannot learn new skills and work routines.

Like many applicants for SSDI, benefits are very important to the young-onset population who are often initially denied benefits but usually win on appeal. Under the Compassionate Allowance Initiative, SSA will find individuals with certain diseases or conditions eligible for SSDI benefits by the nature of the disease and expedite the processing of their claims. While applicants would still have to meet most of the SSDI criteria, when it comes to the disability criteria, they would be considered eligible by virtue of the disease. Because of the degenerative nature of Alzheimer's disease, by the time someone has gone to the doctor and been properly diagnosed, the individual is already experiencing functional loss that impacts his or her ability to maintain "substantial gainful employment."

Why Alzheimer's Disease?

People with Alzheimer's disease and other dementias demonstrate observable symptoms in the early stages of their condition. Those with mild Alzheimer's have clear deficits in recent memory and at least one other cognitive domain. They have an inability to complete familiar tasks and functions, difficulty handling finances, and challenges with geographi-

cal orientation in their homes or businesses. Changes in personality occur frequently, including apathy, depression, and disinhibition.

As their disease progresses, individuals with moderate Alzheimer's are dependent on others for instrumental activities of daily living, such as using the telephone and shopping. Many do not remember to take care of daily activities, such as bathing and dressing. They may not recognize familiar people and can no longer safely operate motor vehicles, lawn mowers, and other machines. Most are no longer able to operate common equipment, such as computers or stoves. Irritability, paranoia, and disrupted sleep are common in moderate dementia.

Alzheimer's disease is a progressive, degenerative, and terminal illness. There is no treatment that stops or delays the progression of the disease. The few drugs currently approved only treat the symptoms. For about half of the individuals who take them, these drugs offer a modest, temporary delay in the worsening of cognitive symptoms. However, they do not stop or even slow the progression of the disease from early memory loss through complete bodily dysfunction, on the way to death.

The Alzheimer's Association frequently hears from individuals under age 65 with Alzheimer's disease and other dementias that they are denied SSDI benefits upon initial application, but they ultimately receive benefits at some level of the appeals process. It is because of the disease progression and lack of treatment to slow or prevent the course of the disease, that individuals with Alzheimer's disease rarely lose their appeals before an Administrative Law Judge. Yet, some individuals are forced to wait one, two, or even three years before they receive their benefits, which are then retroactive to their initial date of application. The emotional and financial costs to these individuals and their families are preventable.

A Breakthrough

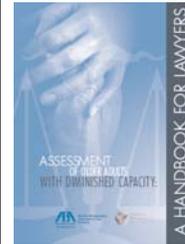
In July 2008 I was contacted by a senior staff person at SSA and informed that they were reviewing the medical criteria and expected to work quickly on proposed new criteria on Alzheimer's disease and related dementias. We were invited to meet with the SSA staff who were working on the listings for Alzheimer's disease and other dementias. In addition, three medical professionals—Dr. Laurel Coleman, an internist from Maine; Dr. Jenny Moye, a psychologist from Boston; and Dr. Dan Marson, a neuropsychologist from the University of Alabama-Birmingham—agreed to participate in the meeting.

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The ultimate resources on capacity assessment of older adults—for lawyers, judges, and psychologists. Developed by the experts at the ABA Commission on Law and Aging and the American Psychological Association.

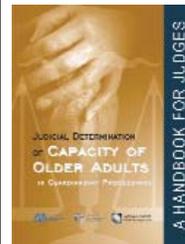
Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers

While most older adults will not have impaired capacity, some will. Obvious dementias impair decision-making capacity—but what about older adults with an early stage of dementia or with mild central nervous system damage? This book offers elder law attorneys, trusts and estates lawyers, family lawyers, and general practitioners a conceptual framework and a practical system for addressing problems of client capacity, in some cases with help from a clinician. \$25.



Judicial Determination of Capacity of Older Adults in Guardianship Proceedings

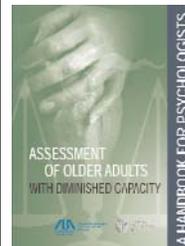
A user-friendly handbook written especially for judges, it provides a quick guide to the “six pillars of capacity assessment,” essential to a full and accurate assessment of capacity; a practical explanation of the “five key steps in judicial determination of capacity”; and links to expanded information, work sheets, model forms, and fact sheets available online at no charge.



\$25. *An online, expanded version of the book is offered on the Web site of the ABA Commission on Law and Aging at <http://www.abanet.org/aging/publications>.

Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists

This handbook is designed for psychologists evaluating civil capacities of older adults. The specific goal of this handbook is to review psychological assessment of six civil capacities of particular importance to older adults, namely, medical consent capacity, sexual consent capacity, financial capacity, testamentary capacity, capacity to drive, and capacity to live independently. Relevant literature, suggestions for assessment tools, and case examples are provided throughout. \$25.



Purchase from the Web site of the ABA Commission on Law and Aging at www.abanet.org/aging/publications

Alzheimer's Disease and SSDI

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During that two-hour meeting, we urged SSA that Alzheimer's disease and other related dementias be considered for the Compassionate Allowance Initiative. We emphasized that, by definition, individuals with Alzheimer's disease can no longer maintain employment. We discussed at length short-term memory and functional impairments associated with Alzheimer's disease and their impact on vocational function. Dr. Moye and Dr. Marson provided in-depth descriptions of how Alzheimer's disease affects function.

We were encouraged in December 2008 when SSA announced its initial list of 50 conditions for the Compassionate Allowance Initiative. The conditions were limited to cancers, "rare" conditions, and brain injuries/stroke. This initial list included two "rare" dementias—frontotemporal dementia (FTD) and Creutzfeldt-Jakob disease. We considered this an important first step. By including these two dementias, SSA acknowledged that individuals with diminished cognitive impairments can quickly reach a point where they can no longer maintain gainful employment and deserve a prompt disability determination.

Commissioner Astrue's Outreach Hearing

In April 2009 we were informed that Commissioner Astrue decided to host an outreach hearing on young-onset Alzheimer's disease and related dementias. The hearing was scheduled for July 29 in Chicago. The SSA requested the Alzheimer's Association's assistance with themes and witnesses for the panels. Commissioner Astrue, SSA deputy commissioners and the regional commissioner for the Chicago SSA Region (Region V), and the deputy director of the National Institute of Aging, heard testimony from and asked questions of three panels of expert witnesses. The witnesses provided an overview of Alzheimer's disease and related dementias, showed images of the brain, and discussed the disease progression. Of great significance was the testimony on the impact of the disease on an individual's executive function during the earliest stages. Yet, it was the final panel, comprised of individuals and family members with early-onset dementia, that provided some of the most powerful and poignant testimony of the day. Each discussed the personal impact of the disease, as well as its effect on their family lives. They told of the varying degrees of difficulty and humiliation of the SSDI application process. They described how their families struggled while they awaited a favorable determination. As one spouse noted, "the passage of time is not a friend to people with terminal illness."

The final decision as to whether to include Alzheimer's disease and related dementias in the Compassionate Allowance Initiative is expected to be made within the next few months. It is hoped that due to the terminal nature of Alzheimer's disease, the disabilities that prohibit work in even the early stage of the disease, and the lack of a disease modifying drug, persons with young-onset Alzheimer's disease and related disorders receive expedited consideration in whatever ways are possible during the SSDI determination process.

Guardianship Resource: UAGPPJA

The ABA Commission on Law and Aging has just posted a PowerPoint presentation template titled "**Why States Should Enact the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act (UAGPPJA)**" for use by presenters at national, state, or local conferences or meetings and at state legislative hearings.

The presentation template and ten tips for using it can be downloaded for free from the Commission's Guardianship Jurisdiction Web page at: www.abanet.org/aging/guardianshipjurisdiction (if that link breaks, go to the Commission's home page at www.abanet.org/aging and select Guardianship Jurisdiction from the Resources menu on the left side of the page).

The presentation template and tips were developed for the Commission's Joint Campaign for Uniform Guardianship Jurisdiction, intended to educate about and promote support for state enactment of the UAGPPJA. The Joint Campaign was funded by the ABA Section of Real Property, Trust and Estate Law; the American College of Trust and Estate Counsel Foundation; and the Uniform Law Foundation.

There are numerous other resources on the Guardianship Jurisdiction Web page, including a link to an archived Webcast that uses the PowerPoint presentation, an article on the nine ways in which the UAGPPJA may reduce elder abuse, charts on cases and stories related to multi-state guardianship jurisdiction, and links to the UAGPPJA and legislative advocacy materials.

We hope you will find these materials to be useful.

—Lori A. Stiegel, Senior Attorney
ABA Commission on Law and Aging