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In the summer of 2003, Sarah B. Richardson1 penned an article on guardianship entitled “Health Care Decision Making: A Guardian’s Authority,” which was published in Volume 24 of the Commission on Law and Aging’s Bifocal. Richardson’s article provided a fifty-state examination on the relationship between patient-appointed health care agents and court-appointed guardians, and whether one appointment statutorily trumps the other appointment.2 As one would expect, the twelve years that have passed since Richardson’s examination have necessitated a new inspection.

While the definition varies from one state to the next, capacity in health care decision-making may be described as “the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.”3 When an individual’s ability to make health care decisions begins to diminish, an advance directive becomes an effective tool for providing informed consent for medical treatment. An advance directive is an expression of personal preferences created prior to incapacity, which can dictate health care instructions or appoint a health care agent to make appropriate decisions when necessary.

On occasion, the incapacitated individual’s voice may be drowned out by a court’s appointment of a guardian. Guardianships occur when a court has deemed that an individual is incapacitated and appoints a decision-maker to act on behalf of the incapacitated individual in one or several areas of decision-making.4 When dealing with health care decisions, an incapacitated individual’s health care agent is often the presumptive guardianship nominee since the individual has already placed his or her trust in someone willing to undertake the task.5 However, courts still might choose another candidate if there is evidence of abuse, failure to act, or a decision that is beyond the scope of the health care agent’s powers under the advance directive.

On those rare occasions when an incapacitated individual has both a health care agent and a guardian, confusion as to the authority of the health care decision-makers may emerge.6 Most states have recognized that the competing voices of a guardian and a health care agent must fall to the clarity of a single authority. By 2003, 34 states acknowledged

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1 Sarah Beth Richardson was a summer intern at the ABA Commission on Law and Aging in 2003.
4 See Richardson, supra note 2, at 1 (pointing out that courts appoint guardians by the duration and the extent of duties after a screening process that weighs evidence presented by an individual’s physicians and other parties).
5 See, e.g., Minn. Stat. Ann. § 145C.07, Subd. 3 (West 2007) (“Unless the principal has otherwise specified in the health care directive, the appointment of the health care agent in a health care directive is considered a nomination of a guardian.”).
6 See Richardson, supra note 2, at 5 (making light of the infrequency of such an occurrence).
the possible conflict of dual appointments and had created statutes granting authority over health care decisions to just one of the appointees. In 2003, 28 states recognized that the authority of health care agents to make health care decisions trumped the guardian’s authority. As of 2015, that number has expanded to 35 states and the District of Columbia. Interestingly, by 2003, six states had determined that the court-appointed guardian’s authority to make health care decisions trumped the health care agent’s authority. That number has now risen to 12 states.

Although the expansion of states adopting statutes that grant health care decision-making authority to a single appointee provides clarity, only health care agents preserve the true voice of the incapacitated individual. Since a guardian is a court-appointed official, a guardian may not be familiar with the incapacitated individual’s personal values and preferences. The same cannot be said for a health care agent who had been personally chosen by the individual prior to incapacity.

The problem presented by giving priority to guardians rather than health care agents may be mitigated to an extent by statutes incorporating some form of a guardianship decision-making standard. Decision-making standards are instrumental in attempting to align the guardian’s health care decisions to what the individual would have wanted. In 2003, 22 states had statutes incorporating a decision-making standard for guardians. Currently, that number has risen to 37 states and the District of Columbia.

Both the Uniform Health-Care Decisions Act (UHCDA) and the Uniform Guardianship and Protective Proceedings Act (UGPPA) advocate the inclusion of a decision-making standard that generally follows a three-step hierarchy in decision-making: (1) in accordance with the explicit instructions of the individual, (2) in accordance with the personal values and preferences of the individual, or (3) in accordance with the best interests of the individual. As of 2015, only 21 states and the District of Columbia have statutes granting trumping authority to health care agents.

7 See id. (pointing to the dual appointments as room for “confusion”); see also id. at 9 nn.10-11 (listing the states that have granted authority to guardians and health care agents, respectively).
8 See id. at 9 n. 11 (noting that Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, New York, North Dakota, Oregon, South Dakota, Tennessee, Vermont, Virginia, West Virginia, and Wyoming had statutes granting authority to health care agents).
10 See Richardson, supra note 2, at 9 n. 10 (noting that Alabama, Alaska, Kansas, North Carolina, Texas, and Wisconsin had statutes granting trumping authority to guardians).
11 See Who Makes the Decision?, supra note 9, at 1-11 (illustrating that, by 2015, Alabama, Hawaii, Idaho, Kansas, Louisiana, Minnesota, Missouri, Montana, Nevada, Pennsylvania, South Carolina, and Washington all had adopted statutes granting trumping authority to guardians).
12 See Unif. Health Care Decisions Act § 2(e) (1994) (defining the decision-making standard as acting in accordance with the incapacitated individual’s health care instructions and wishes, if known, or, at the very least, making decisions in the individual’s best interest); Unif. Guardianship Protective Proc. Act § 314(a) (1997) (defining the decision-making standard as following the desires and personal values of the incapacitated individual, to the extent known, or acting in the best interest of the individual).
13 See Richardson, supra note 2, at 12 n.51 (highlighting Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Mississippi, Nebraska, New York, Ohio, Pennsylvania, South Carolina, South Dakota, Virginia, and West Virginia as states with substitute decision making statutes in 2003).
15 See supra note 12 and accompanying text.
states have adopted a decision-making standard that follows the UHCDA and UGPPA format;\(^\text{16}\) the majority of the remaining states only follow either one or two of the decision-making steps.\(^\text{17}\) National standards for guardians internalize the importance of maintaining the incapacitated individual’s voice by giving priority to the individual’s explicit instructions, values, and preferences.\(^\text{18}\)

As the issues facing incapacitated individuals’ gain momentum in the eyes of our society,\(^\text{19}\) the remaining states may recognize the need for adopting statutes addressing the relationship between patient-appointed health care agents and court-appointed guardians.\(^\text{20}\) While states granting authority to guardians rather than health care agents provide clarity, only statutes allowing health care agents to trump guardians provide progress.

The tables referenced in this article can be found on the Commission’s Health Care Decision-Making Resources webpage at [http://ambar.org/healthdecisions](http://ambar.org/healthdecisions).

\(^\text{16}\) See *What is the Decision-Making Standard?,* supra note 14, at 1-19 (illustrating that California, Colorado, Georgia, Hawaii, Illinois, Kansas, Maryland, Massachusetts, New Jersey, New Mexico, North Dakota, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Virginia, Washington, West Virginia, and Wisconsin have decision-making standards that generally follow the three-step format).

\(^\text{17}\) For instance, Arizona, Minnesota, and Vermont have statutory language demonstrating the adoption of a decision-making standard that is in accordance with an incapacitated individuals expressed instructions and personal preferences. *See id.* On the other hand, Delaware, Indiana, Louisiana, Missouri, and Rhode Island have statutes only incorporating the best interest standard. *See id.* Similarly, Connecticut, Florida, Indiana, Nebraska, and Nevada only have statutes adhering to the explicit wishes and instructions of the individual. *See id.*


\(^\text{20}\) As of 2015, only Oklahoma, Rhode Island, and Texas have not adopted statutes granting authority over health care decisions to either health care agents or guardians. *See Who Makes the Decision?,* supra note 9, at 1-11.

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**Upcoming Commission Webinar**

**VA Pension: Income Security for Veterans and Their Family**

- Register and learn more at: [http://bit.ly/1IGENlC](http://bit.ly/1IGENlC)
- November 17, 2015
- This webinar will cover eligibility of veterans and their dependents for VA pension.

Panelists will discuss how to get the best results for a client looking to obtain a VA pension. Practical pointers on obtaining the highest amount for pension will be discussed, as well as how a client can keep that amount each year. Practice tips on dealing with a VA debt—due to an overpayment issue related to a VA pension—will also be provided. This presentation will give practitioners an understanding of the law and provide practical tips on how to work within the confines of the VA.
Suppose your 90-year-old mother was seriously injured or sexually assaulted as a result of poor care in a certified nursing home. You seek redress in court, only to be told that trial by jury is barred because upon admission two years ago, she signed a contract that included an arbitration clause. You will have no day in court, and the case will never be brought to public scrutiny.

If this scenario troubles you, now is the time to make your voice heard. The Centers for Medicare and Medicaid Services (CMS) have issued a comprehensive proposed rule on Reform of Requirements for Long-Term Care Facilities (Federal Register, Vol. 80, No. 136, July 16, 2015). The proposed rule includes conditions on use of arbitration clauses, and invites comments on “whether binding arbitration agreements should be prohibited.”

Arbitration is a method of dispute resolution in which a neutral decision-maker selected by the parties, rather than a judge or jury, makes a decision about a dispute. In an arbitration agreement, a party agrees voluntarily to waive the right to trial by jury, in return for a speedy and cost-effective settlement. Since the 1925 enactment of the Federal Arbitration Act (9 U.S.C. §2), court decisions have affirmed the broad reach of the Act.

While arbitration in some contexts may have significant advantages over costly litigation, it is fundamentally unfair for nursing home residents if the agreement is made before any dispute arises—that is, if it is “pre-dispute” arbitration. Post-dispute arbitration clauses in many circumstances can be advantageous, and residents should continue to have the choice to use it to resolve issues that already have arisen. However, residents and families faced with pre-dispute clauses are forced to make a critical decision without knowing anything about the occurrence at hand. They have a “take it or leave it” situation in which any semblance of true informed consent is lacking.

When entering a facility, the resident and family are not thinking of litigating poor care. They cannot envision they may be involved in disputes about pressure sores, choking, dangerous bedrails, dehydration, sexual
assault, or even death. Yet the arbitration agreement covers every aspect of their care and lives in the facility, and bars a hearing a court of law, no matter how egregious the actions.

Moreover, the resident and family may not understand the agreement, which is generally couched in legal phrases and included in a confusing array of papers required at the time of admission. Prospective residents are frail, have chronic health conditions, and are frequently coming directly from the hospital. They and their families are usually under extreme pressure to be admitted. There is generally no time to seek the advice of a lawyer, and there may be no other beds available for the same level of care and payment source within the geographic area.

Indeed, residents and families often feel compelled to sign, and this would likely continue to be so even with the conditions proposed in the rule—that the facility explain the agreement and that the explanation be acknowledged by the resident, that it be voluntary, that it provide for selection of a neutral arbitrator and convenient venue, and that admission not be contingent on signing the agreement. The conditions, while theoretically useful, are not enough to create a fair and balanced bargaining opportunity, and in fact may actually worsen the situation by allowing facilities to use the rule as a shield for actions for which they should be liable. CMS should recognize that truly informed and voluntary consent to a binding arbitration agreement is rarely, if ever, possible in the highly charged context of nursing home admission.

A strong and welcome theme throughout the proposed rule is resident-centered care and maximizing the voice of the resident. Yet the proposed arbitration provisions would directly contravene this emphasis, continuing to allow forced choices without genuine consent that will undercut the very quality of care and quality of life requirements the rule highlights.

In 2009, the American Bar Association adopted policy that “opposes the use of mandatory, binding, pre-dispute arbitration agreements between a long-term care facility and a resident of such facility or person acting on behalf of such resident.” We suggest that the proposed CMS rule should simply prohibit pre-dispute agreements for binding arbitration with its residents.

If you have views on—or specific cases about—the use of arbitration in nursing home admissions contracts, consider commenting by September 14.

See the proposed rule at: https://www.federalregister.gov/articles/2015/07/16/2015-17207/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities#h-159.

Erica F. Wood is Assistant Director at the ABA Commission on Law and Aging in Washington, DC.

“CMS should recognize that truly informed and voluntary consent to a binding arbitration agreement is rarely, if ever, possible in the highly charged context of nursing home admission. . . . We suggest that the proposed CMS rule should simply prohibit pre-dispute agreements for binding arbitration with its residents.”
On August 21, 2015, the U.S. Court of Appeals for the District of Columbia Circuit, in the case Home Care Association of America v. Weil, reinstated regulations that will allow some 2 million home care workers to qualify for minimum wage and overtime protection. The rule which was originally slated to go into effect at the beginning of 2015 is now expected to be effective by January 2016.

Understanding this change of status of home care workers requires a little trip through history.

In 1974, the Fair Labor Standards Act expanded its minimum wage and overtime requirements to cover employees engaged in domestic services. This was a major expansion of workers' rights. The regulations defined domestic services as services performed by employees such as:

- companions
- babysitters
- cooks
- waiters
- butlers
- valets
- maids
- housekeepers
- nannies
- nurses
- janitors
- laundresses
- caretakers
- handymen
- gardeners
- home health aides
- personal care aides
- chauffeurs . . .

However, the Act specifically exempted companions from these new protections, defining companions as:

any employee employed on a casual basis in domestic service employment to provide babysitting services or any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary);

In addition, an exclusion from only the overtime pay requirements of the Act was provided for:

any employee who is employed in domestic service in a household and who resides in such household.

Thus, your live-in butler (a domestic worker) would have been entitled to minimum wage but not entitled to overtime, which pays workers 150% of pay for working over 40 hours per week. But, your live-in companion, would have been entitled to neither. The rules also provide guidelines for distinguishing work hours versus free time periods for live-in workers.
Regulations promulgated under the 1974 Act defined companionship services as:

services which provide fellowship, care, and protection for a person who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs. Such services may include household work related to the care of the aged or infirm person such as meal preparation, bed making, washing of clothes, and other similar services. They may also include the performance of general household work: Provided, however, That such work is incidental, i.e., does not exceed 20 percent of the total weekly hours worked.5

As applied historically, this definition covered a broad swath of home care workers. The regulations specifically provided that third-party employers could claim the companionship services exemption or live-in domestic service employee exemption.6 In other words, the exemptions applied regardless of whether you personally hired the individual worker or you contracted with an agency that provided the worker.

Since 1974, the home care industry has undergone tremendous change resulting from a dramatically aging society and huge increases in home care services utilizing health aides and personal care services for persons with multiple medically complicated, chronic conditions. Most direct care workers today do far more than provide companionship. They assist consumers with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as bathing, dressing, toileting, preparing meals, and household management. They often provide paramedical care, such as managing medications, wound care, or tracheostomy care.

Yet, most of these workers have not had a right to be paid minimum wage or overtime. In addition, the home care industry has become a major economic presence in health care services with many more workers dependent on it today for their livelihoods.

The Department of Labor’s 2013 revision of the rule was intended to address these societal changes in a realistic way, balancing the need for this growing workforce to be treated equitably with the challenges chronically ill or disabled individuals and their families face in maintaining a good quality and affordable life.

The new rule made three substantive changes:

1. The rule revised the definition of “companionship services” to clarify and narrow the duties that fall within it.

Companionship services were narrowed primarily to the provision of fellowship and protection:

The provision of fellowship means to engage the person in social, physical, and mental activities, such as conversation, reading, games, crafts, or accompanying the person on walks, on errands, to appointments, or to social events. The provision of protection means to be present with the person in his or her home or to accompany the person when outside of the home to monitor.7

Companionship could also include the “provision of care” but only if it did not exceed 20% of the total hours worked. The provision of care means:

...to assist the person with activities of daily living (such as dressing, grooming, feeding, bathing, toileting, and transferring) and instrumental activities of daily living, which are tasks that enable a person to live independently at home (such as meal preparation, driving, light housework, managing finances, assistance with the physical taking of medications, and arranging medical care).8

The new provision also made clear that companionship services do not include domestic services performed primarily for the benefit of other members of the household or the performance of medically related services. The determination of whether services are medically related is based on whether the services typically require and are performed by trained personnel, such as registered nurses, licensed practical nurses, or certified nursing assistants.

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5 29 CFR § 552.6 (as in effect prior to January 1, 2015).
6 29 CFR § 552.109 (as in effect prior to January 1, 2015).
7 29 C.F.R. § 552.6.
8 Id.
2. The rule limited who could claim the exemption for “companionship services” to the individual, family, or household using the service. Thus, home care agencies employing companions could no longer claim an exemption, even if the worker’s services fell within the new narrower definition of companion.9

3. The rule limited who could claim the exemption for “live-in domestic service” to the individual, family, or household using the service.

So, if you hire a live-in worker to help your mother with activities of daily living, you will have to pay minimum wage, but you will not have to pay overtime. An agency employing the worker to do these services will have to pay both.10

On June 6, 2014, a number of trade associations who represent businesses employing home care workers filed suit against the Department of Labor in the D.C. Circuit Court. The associations argued that the Department of Labor ignored congressional intent when revising the rule, because Congress explicitly intended to exclude home care workers from receiving minimum wage and overtime pay.

In late 2014, the District Court vacated the revised third party regulation because the Department of Labor exceeded its authority and bypassed Congressional intent by singling out groups of employees who do not fall within the exemption based upon their employers. The District Court also noted that Congress has revisited the Fair Labor Standards Act of 1974 a number of times since its creation, but has not altered any exemptions that are at issue.

In a separate ruling in early 2015, the District Court overturned the Department of Labor’s redefinition of the companionship exemption. However, on August 21, 2015, the U.S. Court of Appeals for the District of Columbia reversed the lower court’s rulings and upheld the new rules.11 Whether an appeal to the U.S. Supreme Court will occur or be successful is unknown at this writing.

The impact of the new rule is clearly positive for direct care workers who have been providing personal care, homemaker, and home health aide services. The Bureau of Labor Statistics puts full-time personal care workers and home health aides near the bottom of the earnings scale at about $20,000 per year, yet it projects a growth rate of these occupations at nearly 50% between 2012 and 2022.12 Not surprisingly, this tracks the growth of the aging population and expanded need for long-term supportive services in the community.

Nevertheless, some predict negative consequences. The National Federation of Independent Business issued a statement saying:

Requiring overtime pay threatens to put the small firms which provide companion care out of business and jeopardizes the level of care their clients currently enjoy. By ending the companionship exemption, DOL has effectively mandated home care providers work in shorter shifts with reduced hours. At the same time, those who rely on these services can expect less personal care coupled with significantly rising prices.13

The plaintiffs in the law suit made similar claims in arguing that the rule as applied to third-party employers was an unreasonable interpretation of the Act. However, the Department of Labor noted that 15 states already provide minimum wage and overtime protections to all or most third party-employed home care workers, and another six states and Washington, D.C., mandate minimum wage protections. The Department argued that there was no evidence in those states that the extension of those protections cause any decline in access to or quality of home care services. In fact, in the comments to the new rule, the Department had pointed out:

Low wages and long, irregular hours may contribute to the high turnover rate in the industry, resulting in low continuity of care. For instance, the turnover rate (those leaving and entering home care work) for workers in the home care industry has been estimated to range from 44 to 65 percent per year. Other studies have found

turnover rates to be much higher, up to 95 percent and, in some cases, 100 percent annually . . . . 

Application of the FLSA's minimum wage and overtime compensation protections may reduce turnover rates. Frequent turnover is costly for employers in terms of recruitment costs and training of new direct care workers and also in terms of the likelihood of a reduction of quality care or not being able to provide care at all. The employee turnover rate in this industry is high because of low wages, poor or nonexistent benefits, and erratic and unpredictable hours.14

Some of the states that already offer these protections filed amicus briefs in support of the Department of Labor, including New York, Illinois, Massachusetts, and Maryland. But a group of other states filed a joint brief for the opposition, arguing that the rule will increase state Medicaid costs, expose states to an unfunded liability, and possibly lead to higher rates of institutionalization. 15

While there is still a remote possibility of the case going to the Supreme Court, the real focus of everyone's efforts will be on adapting to the rule, which is now expected to go fully into effect January 2016. The Department of Labor provides guidance on the rule for workers, consumers, and employers at http://www.dol.gov/whd/homecare. And, the National Resource Center for Participant-Directed Services (NRCPDS) publishes a free FLSA Home Care Rule Toolkit, available at http://www.bc.edu/schools/gssw/nrcpds/tools/flsahomecaretoolkit.html. Home care has finally come of age as an occupation.

Charlie Sabatino is the Director at the ABA Commission on Law and Aging in Washington, DC.

Caroleigh Newman is graduate of George Mason University School of Law and was a 2015 Spring semester intern at the ABA Commission on Law and Aging. Ms. Newman received her B.A. in history and political science with honors from Bridgewater College.

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14 78 Fed. Register 60543 (October 1, 2013).
15 The states are Arizona, Georgia, Kansas, Michigan, Nevada, North Dakota, Tennessee, Texas, and Wisconsin.

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Discussion Lists
The Commission provides a forum for legal professionals to communicate and share ideas on two active discussion lists:
- Elderbar, an open discussion list for professionals in law and aging, and
- Collaborate, a discussion list on aging, disability, and dispute resolution.

Visit the Commission’s homepage for more information on how to sign up.

Media Requests
The Commission provides background to the media on a range of issues relating to law and aging, including:
- Guardianship and conservatorship
- Elder abuse, neglect, and exploitation
- Mental capacity, aging, and surrogate decision-making
- Health care decision-making and advance directives
- Medicare, Medicaid, and long-term care
- Elder Law and the delivery of legal assistance to older persons

Contact the Division for Media Relations and Communication Services for expert contacts at abanews@americanbar.org or (202) 662-1090.
This year marks the 50th anniversary of the Older Americans Act (OAA), 42 U.S.C. §§ 3001 et seq. The goal of the OAA is to improve the lives of older Americans. The OAA was first passed in 1965 and has been periodically reauthorized over the decades.

**Older Americans Act in Your Neighborhood**

Senior centers are the most visible presence of OAA programs and services in your neighborhood. Senior centers are important gathering places, where people participate in educational, nutrition, social, and cultural programs, as well as in physical activities, health education, and health screenings. Senior centers connect people and programs and services at the local grassroots level. Senior centers vary widely in form and function, but all serve as community centers bringing together older adults and critical programs and services.

**OAA Health and Wellness Programming**

Under the theory that an ounce of prevention saves a pound of cure, the OAA promotes health and wellness by providing health education, screening, nutrition assistance, and chronic disease management assistance. Health education and screening empower older Americans to seek diagnosis and treatment at the right time for the right reasons. Health education includes helping people understand the differences between normal age-related changes and those caused by disease or illness that may be treatable or curable. Health screenings, such as blood pressure monitoring or blood sugar testing, help people spot changes so they can seek medical advice before a crisis occurs.

A frightening percentage of low-income older Americans are food-insecure, and senior centers provide low-cost meals and access to other nutrition assistance programs. The nutrition programs go far beyond senior centers, with low-cost “congregate” meals funded in part by the OAA available in a variety of faith- and community-based settings, and home-delivered meals most commonly known as “meals on wheels” being delivered to thousands of homebound people each day. For many homebound persons, the meals on wheels driver and the home healthcare worker made possible by OAA programs may be the primary contact with the outside world.

**Caregiver Support Programs**

The vast majority of long-term care is provided by friends and family in home and community-based settings. The OAA supports caregivers by providing access to training, advice, equipment, supplies, visits by trained home healthcare workers, and replacement caregivers (also known as respite care providers). These important services prevent or shorten millions of nursing home stays.

Many OAA programs also operate Aging and Disability Resource Centers (ADRC) as part of a “no wrong door” concept to help connect older adults and adults with disabilities with important programs and services. ADRCs are staffed by information and referral specialists trained to help identify and solve problems to empower people to remain in the community.

**Protecting the Most Vulnerable**

The National Center on Elder Abuse, http://www.ncea.aoa.gov, is funded through the OAA and provides research, advice, and technical assistance on elder abuse prevention, detection, and intervention. The Elder Justice Act passed five years ago as part of...
the Affordable Care Act includes significant additions to elder abuse programing under the OAA.

The Long-Term Care Ombudsman (LTCO) program is part of the Older Americans Act. LTCOs provide important information, assistance, and advocacy for residents in long-term care settings. Ombudsmen are essential to empowering and providing a voice of advocacy for the most vulnerable members of a community.

**National Centers of Expertise**

The OAA creates national centers of expertise on over two dozen issues ranging from Alzheimer's disease to women's retirement, http://www.aoa.acl.gov. Important to the ABA is the National Legal Resource Center (NLRC)—the Association has been a part of the NLRC and its predecessor programs for over 25 years. As a part of the NLRC we provide training and expert advice on elder abuse, advance planning, supported decision making, and guardianship, and maintain content on the NLRC website. The NLRC, http://nlrc.acl.gov, offers guidance to programs providing important legal assistance to low-income and at-risk seniors in every community. Modest funding for legal assistance for at risk seniors is provided through the Older Americans Act.

**State and Regional Agencies**

The majority of funding for OAA programs flows from the federal to the state level and from there to the local level. All states have a state-level office on aging; most states have regional programs known as Area Agencies on Aging (AAAs). State and local government have a meaningful (but not unlimited) flexibility in designing OAA programs and spending resources to meet the most important needs in the local community.

**Touching the Lives of Every Older American**

Older Americans Act programs and services touch the lives of every older American in one way or another. Some impact is direct while other impact is indirect, but everyone's life is touched by important OAA programs and services.

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**David M. Godfrey** is a Senior Attorney at the ABA Commission on Law and Aging in Washington, DC.

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**Commission Research Effort**

**Emeritus Pro Bono Practice Rules Survey**

The ABA Commission on Law and Aging in collaboration with the ABA Center on Pro Bono is researching what works when recruiting volunteers, placing cases, and data on closed cases with Emeritus Pro Bono Practice Rules. These rules waive some of the licensing burden for attorneys who agree to limit practice to Pro Bono cases only and exist in 38 jurisdictions.

Please take a few moments to complete the survey at bit.ly/1f5OM8p.

**The Survey will remain open until September 1, 2015.**

If you are interested in offering extended feedback on these rules, please include your name and contact information in the survey, or email David.Godfrey@americanbar.org and he will contact you in September.

If you are reporting on more than one state, please complete the survey once for each state.
2015-2016 Commission on Law and Aging

Each September 1, a new roster of commissioners is appointed by the ABA president. Most commissioners serve for multiple years with a handful of new faces starting in any given year. This year, we have a new Chair and six new commissioners; you will find them to be a diverse and highly expert group in their individual disciplines. The full roster of this year’s Commission is below. The next issue of Bifocal will provide short biographies of our new additions.

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Legal and Political Counselor of the Mission of Panama to the OAS
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Benjamin Rose Institute on Aging
Cleveland, OH

Jean Callahan
Brookdale Center for Healthy Aging
New York, NY

Ricker Hamilton
Maine Department of Health & Human Services
Augusta, ME

William E. Hopkins
Husch Blackwell LLP
Austin, TX

Keith L. Morris
Elder Law of Michigan
Lansing, MI

Stephen B. Rosales
Rosales & Rosales LLC
Belmont, MA

Bruce S. Ross
Holland & Knight
Los Angeles, CA

Robyn S. Shapiro
Drinker Biddle & Reath LLP
Milwaukee, WI

Susan P. Shapiro
American Bar Foundation
Chicago, IL

Patricia D. Struck
DFI Division of Securities
Madison, WI

Hon. Katherine Tennyson
Multnomah County Circuit Court
Portland, OR

Carole L. Worthington
Law Office of Carole Lynch Worthington
Knoxville, TN

The mission of the ABA Commission on Law and Aging is to serve as a collaborative, interdisciplinary leader of the Association’s work to strengthen and secure the legal rights, dignity, autonomy, quality of life and quality of care of aging persons.

What We Do:
- Research emerging issues
- Monitor state and federal legislation in priority areas
- Develop policy in areas of concern to older people
- Provide technical assistance
- Foster improved access to legal services for older persons
- Educate lawyers, other professionals and the public

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AMERICAN BAR ASSOCIATION
Commission on Law & Aging

CHANGING LIVES THROUGH RESEARCH, EDUCATION & ADVOCACY

Help us continue to improve the lives of older Americans.

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Your contribution is tax-deductible.
We are honored to be here with Attorney General Herring today. The work he is doing to protect Virginians—especially older Virginians—sets a great example for other states to follow. I also want to thank the Greenspring community for hosting us, the Virginia Department for Aging and Rehabilitative Services, and the Virginia Academy of Elder Law Attorneys for all their help in informing our work to protect older Virginians and older Americans.

Thank you very much Kristin for sharing your story with us today. At the Consumer Financial Protection Bureau, we believe the best way to inform our work is to hear directly from the people we work for—American consumers. Stories like yours are vivid for us and they help us understand what needs to be done to protect all consumers.

Greenspring is the perfect venue to kick off the second phase of our initiative we call “Managing Someone Else’s Money.” Today, we are launching a series of tailored state guides to help further educate and empower consumers and their caregivers to make informed financial decisions to protect their loved ones.

When Congress created the Consumer Bureau in the Dodd-Frank Wall Street Reform and Consumer Protection Act just five years ago, it saw the need to protect older Americans against financial exploitation.
and promote economic security later in life. With that in mind, Congress required us to create an office exclusively dedicated to working on behalf of older Americans.

Our Office for Older Americans focuses on improving the financial lives of consumers across the country. Each day, more than 10,000 Americans turn 62. And each day, they join 55 million more others who face financial issues that can be perilous if they are not adequately prepared.

To support our loved ones who raised us, protected us, and guided us into adulthood, we must ensure that their caregivers have the know-how. Making sure that happens is of great importance to many of us. My own father is now 97 years old. He grew up during the Great Depression, and the tough economic circumstances of his childhood has affected his outlook on financial matters all his life. But like anyone else, my father now needs some help from time to time.

As the years have gone on, the role our family plays as his caregiver has grown. Like many other children of aging parents, that has meant making sure he has the information, the tools, and the support he needs to make the best financial decisions for himself.

For some caregivers though, their role goes beyond just advice and help. Sometimes caregivers have to step in to make financial decisions for a family member or friend who is unable to do so.

It could be a daughter who was appointed by a court to serve as conservator for her mother with Alzheimer’s disease. It could be a young man serving as agent under a power of attorney for an autistic brother unable to live on his own. Or it could be a friend who handles payments from the Department of Veterans Affairs on behalf of a brother-in-arms wounded in combat. For these and many other reasons, an increasing number of Americans, young and old, are now acting as fiduciaries by managing money or property for a family member or friend.

Managing someone else’s money can be a daunting and sensitive task. Most financial caregivers have the best of intentions, but may not fully understand their duties as a fiduciary or know the best ways to go about helping another person successfully navigate their financial matters.

After listening to older Americans and financial caregivers speak about their lives, we realized the need to provide guidance for people undertaking this important duty. So we have released plain-language guides for lay fiduciaries all over the country, and in the past two years, we have distributed over 600,000 printed copies. Consumers tell us the guides have proved invaluable in providing plain-language help that they can translate into action and good decision-making.

But because people’s powers and duties as a fiduciary vary from state to state, we have learned

“Following the release of the Virginia guides today, the Bureau plans to follow up with similar guides for five other states: Arizona, Florida, Georgia, Illinois, and Oregon.”
that more was needed than a one-size-fits-all guide. That is why today we are launching the second phase of this initiative. Virginia is the first of six states with large populations of older people that will be receiving specially adapted versions of the Managing Someone Else’s Money guides.

These new guides are for four types of fiduciaries. The first guide is for people who are granted power of attorney to make decisions about money and property for a loved one. The second guide is for people appointed by a court as guardians or conservators of property. The third guide is for those who have been named as trustees under revocable living trusts. In these cases, the beneficiary has transferred ownership of some or all of their money and property to a trust, and the person named as trustee has the power to decide how to manage that money. The fourth guide is for those appointed by a government agency to manage someone else’s income benefits, such as Social Security or veterans benefits.

The guides walk fiduciaries through their duties in managing someone else’s money. They provide tips and answers to everyday questions people may have about managing someone else’s bank account, applying for federal benefits, and sharing information with family members. The guides also make sure that caregivers are prepared to protect their friends and loved ones against financial scams and abuse. Unfortunately, all too often we have seen seniors with diminished decision-making capacity targeted remorselessly and effectively by predators in disguise.

Because states have unique laws and practices, our state guides provide specific information about what fiduciaries need to know. For example, the Virginia guide for conservators explains that they must file annual reports with the court-appointed Commissioner of Accounts. The power-of-attorney guide explains when the agent may use the money to make gifts. All four guides have a “where to go for help” section at the back that lists Virginia agencies and service providers that can offer timely assistance for caregivers when they need it.

Following the release of the Virginia guides today, the Bureau plans to follow up with similar guides for five other states: Arizona, Florida, Georgia, Illinois, and Oregon. We intend for these guides to serve as templates for other states to adopt similar resources going forward.

We are especially pleased to see many of our community partners at today’s event. We hope that you will help us get these guides into the hands of caregivers across Virginia. Hard copies of all our guides are available free and in bulk, as well as on our website at consumerfinance.gov.
Virginia Residents: There’s a Guide for You!

The CFPB has released a set of Managing Someone Else’s Money guides specific to the state of Virginia. This state guide will make it easier for caregivers to follow Virginia’s unique rules and to find help close to home.

The Virginia guides are easy-to-understand booklets for different kinds of caregivers.

There are guides for:

• Agents under powers of attorney
• Court-appointed guardians
• Trustees
• Government fiduciaries (Social Security representative payees and VA fiduciaries.)

The guides help you to be a financial caregiver in three ways:

• They walk you through your duties—and give you tips on Virginia laws and procedures.
• They tell you how to watch out for scams and financial exploitation, and what to do if your loved one is a victim.
• They tell you where you can go for help from agencies and service providers in Virginia and elsewhere.

To download PDF versions or to order free print copies of the guides, please visit: http://www.consumerfinance.gov/blog/managing-someone-elses-money-virginia/.

Get Connected, Stay Connected, on Elderbar

Join Elderbar, the discussion list that brings together public and private sector legal advocates and the aging network.

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.

To get connected to Elderbar send your name, e-mail address, and professional affiliation to david.godfrey@americanbar.org.
Across the United States, an estimated 5.1 million people age 65 and older are living with Alzheimer’s disease, the most common form of dementia, and the number is expected to reach 7.1 million in the next decade. Nearly 60% of people with dementia live in their own communities, and one in seven live alone, creating an urgent need for communities to support people with dementia and their caregivers.

In a groundbreaking national effort, communities across the United States—from cities, to counties, to an entire state—are heeding that call and have announced that they will become “dementia friendly.” A dementia friendly community is defined as one that is informed, safe and respectful of individuals with dementia and their families, provides supportive options, and fosters quality of life.

“Alzheimer’s disease and dementia can be devastating to American families, but we are not powerless to support those living with the disease, their caregivers and loved ones,” said Senator Bill Frist, national spokesperson for Dementia Friendly America. “Starting in these communities, we’re building a nationwide effort to educate Americans about dementia, equip business owners and first responders to recognize and assist those with memory loss, and empower people with Alzheimer’s and dementia to engage independently and safely in community life for as long as possible.”

The communities include: Tempe, AZ; Santa Clara County, CA; Denver, CO; Prince George’s County, MD; Knoxville, TN; and the state of West Virginia.

Led by the Dementia Friendly America initiative (DFA), the communities are taking action by leveraging tailored resources in business, community-based services and supports, faith communities, health care communities, legal and financial services, local government and residential settings. The work toward dementia friendliness will involve:

- Having supportive options that foster quality of life
- Supporting caregivers and families touched by the disease
- Promoting meaningful participation in community life
- Reaching those who are underserved

DFA is building on the leadership of ACT on Alzheimer’s and 34 communities in Minnesota actively working to become dementia friendly. The model employed in Minnesota includes a rigorous, community-based process that brings people together to help a community create a supportive environment for people with dementia. More than 50 organizations—including AARP, the Alzheimer’s Association, CVS/Caremark, the International Association of Chiefs of Police, the National League of Cities, and USAgainstAlzheimer’s—have joined forces to make dementia friendly communities a reality across America through DFA, with the goal of piloting 15 communities by 2016.

DFA is set to launch a web-portal in late summer, which will include sector-specific tools and resources for those interested in working toward dementia friendliness. Those interested in learning more about the initiative are encouraged to visit the website, www.dfamerica.org, which will be updated on an ongoing basis as the tools and resources are being developed.

The Dementia Friendly America initiative (DFA) is a cross-sector, national effort leveraging tailored resources and tools to equip all community sectors to support those with dementia and their caregivers and families. By 2016, the Dementia Friendly America initiative will pilot 15 dementia friendly communities across the nation.
Free Webinar

The Fine Art of Balancing Protection with Self Determination

Sep 22, 2015 • 2:00pm

Register now! https://attendee.gotowebinar.com/register/8352458040898429186

Research shows that empowering individuals to actively participate in personal decision making improves life outcomes and can reduce the risk of abuse and exploitation. There is a risk of abuse and exploitation in all models of decision making for persons with differing abilities. An overly protective response to situations where a person with varying levels of capacity may be at risk can stifle self-determination and empowerment. Protection needs to be carefully balanced with protecting human and constitutional rights. Adults have a basic right to make choices, good or bad, and determine the course of their lives. An overly aggressive, or inappropriate protective response to limited capacity can itself be a form of abuse. This session will talk about recognizing the signs and signals of abuse, neglect (self-neglect) and exploitation, tools to maximize communication with persons with differing abilities, and promoting self-determination and choice through supported approaches that mitigate against risk and empower individuals. The session will explore the application of the Supported Decision Making model to assist persons in making choices, increase access to positive life outcomes, and reduce the risk of harm.

Presenters: David Godfrey (Senior Attorney, ABA Commission on Law and Aging) and Jonathan Martinis (Legal Director, Quality Trust for Individuals with Disabilities)

If you have questions, email trainings@nclc.org.

New Resource from Justice in Aging

Toolkit on Design and Implementation: Outreach and Enrollment Materials in States Implementing a Dual-Eligible Demonstration

Today, over 10 million low-income individuals, known as dual eligibles, receive care and services under both Medicare and Medicaid. In 2010, under a provision of The Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) created a new office to focus exclusively on coordinating the two programs. The new entity, the Medicare-Medicaid Coordination Office, began working with states across the country to better align Medicare and Medicaid benefits through state-run dual eligible demonstrations. Five years later, states and CMS are in the early stages of evaluating the demonstrations and also looking at mid-course corrections and improvements based on experiences to-date. At the same time, advocates and policymakers are contemplating future health care delivery system reforms, as part of a broader reform effort to pay for value and outcomes, instead of volume.

To contribute to these efforts, Justice in Aging has created a toolkit of design and implementation resources. The toolkit consists of:

- A new tool for advocates comparing different state outreach and enrollment materials to highlight effective models to use when reaching vulnerable populations.
- Resources on appeals procedures, designing enrollment notices, care continuity, and ensuring consumer protections in integrated models.

**2015 Solo & Small Firm Summit**

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When you register by August 26

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**KEYNOTE SPEAKER JUDY SMITH**
America’s #1 Crisis Management Expert and Co-Executive Producer of ABC’s *Scandal*

As the founder and president of Smith & Company, Judy Smith’s work in crisis management inspired ABC’s hit political thriller series *Scandal*.

Ms. Smith served as a consultant for some of the most high-profile and sensational events our history including the Iran Contra investigation, the prosecution of former Washington D.C. Mayor Marion Barry, the 1991 Gulf War, the Los Angeles riots, the Supreme Court confirmation hearings of Justice Clarence Thomas, the President Clinton scandal involving Monica Lewinsky, the congressional inquiry of Enron, and the United Nations Foundation and World Health Organization response to the SARS epidemic.

Ms. Smith will deliver the keynote address at the Difference Makers Awards Luncheon on Friday, September 25. She will sign her book, *Good Self, Bad Self: How to Bounce Back from a Personal Crisis*, immediately following the program.

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Other highlights include these exciting CLE:

**Law Firm Marketing Strategies**

**STEPHEN FAIRLEY**
CEO, The Rainmaker Institute, LLC

Learn secrets about law firm marketing and business development strategies particularly for solo or small firm attorneys. Stephen Fairley is the CEO of the nation’s largest law firm marketing company specializing in lead conversion for small to medium size law firms.

**Essential Technologies Leveraged by Successful Firms**

**DEBBIE FOSTER**
Partner, Affinity Consulting Group

You will be able to cut through the flood of tech decisions as a solo or small firm attorney and learn the five essential technologies that will help make your life easier: practice management software; document automation software; legal specific time/billing/acct software; document management/search software; and finally, utility software.

**Rise of Elder Abuse, Neglect, Exploitation and Clients with Dementia**

**LORI STIEGEL**
Senior Attorney, ABA Commission on Law and Aging

Using prominent cases of elderly being exploited, Lori Stiegel will focus on ethical issues that may arise with greater frequency as the U.S. population lives longer and faces an increased likelihood of diminished capacity. Additionally, GPSolo Chair, Stephen Rosales, will illustrate why this issue is important to solo and small firm practitioners.

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For more information and to register today, visit: [www.ambar.org/summit](http://www.ambar.org/summit).

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Ethics Brochure Updated and Available in Print or PDF

**Understanding the Four C’s of Elder Law Ethics**

This consumer-friendly brochure explains the “Four C’s” of elder law ethics—client identification, conflicts of interest, confidentiality, and competency. It helps family members understand the relationship between a lawyer and an older client.

- Free PDF download
- Purchase hard copies

To learn more, use the links above or visit the Commission’s website at http://www.americanbar.org/groups/law_aging/publications/ethics_pubs.html.

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### National Aging and Law Conference

October 29–30, 2015

[www.ambar.org/NALC](http://www.ambar.org/NALC)

#### Conference attendees will enjoy:

- Low registration rates and a two-day agenda to minimize travel time and costs
- An anticipated 4 plenary sessions and 24 workshops
- A focus on core substantive legal issues affecting older Americans with the greatest economic and social needs
- Programming on legal service development and delivery
- High-quality written materials

#### The 2015 Conference hotel boasts:

- Direct access to the Ballston Metro Station with restaurants and shopping within walking distance
- Larger space to accommodate more attendees, sessions, and faculty than last year
- On-site hotel rooms, with a negotiated room rate (limited in quantity)
- Learn more at: [www.hiltonarlington.com](http://www.hiltonarlington.com)

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Staff contact: David Godfrey
[David.Godfrey@Americanbar.org](mailto:David.Godfrey@Americanbar.org)