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Bifocal
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Guardianship practice in Maryland is undergoing big changes with major court rule amendments effective January 1, 2018. The rule and accompanying resources were prompted by an active judicial group called the Guardianship/Vulnerable Adults Workgroup of the Maryland Judicial Council’s Domestic Law Committee. This interdisciplinary Workgroup is a guardianship reform court-community partnership similar to the WINGS (Working Interdisciplinary Networks of Guardianship Stakeholders) groups that have emerged in 25 states (see http://ambar.org/wings).

In this Bifocal interview, Hon. Karen Murphy Jensen, who chairs the Workgroup, and Nisa Subasinghe, Esq., who staffs it on behalf of Maryland’s Administrative Office of the Courts, describe the Workgroup and implementation of its recommendations.

**Bifocal:** Tell us a little about the Workgroup and its ingredients for success.

**Judge Jensen:** The Workgroup is a multidisciplinary group working primarily to reform guardianship court practices in Maryland. Judges, court staff, private attorneys, Department of Aging and Adult Protective Services staff, executive branch representatives, and legal service providers are all active participants. We also have a public guardian program.
The Workgroup’s main ingredient for success is the unwavering support of Mary Ellen Barbera, Chief Judge of the Maryland Court of Appeals, and her administration. Before Chief Judge Barbera’s appointment, there was a small group of dedicated practitioners and judges studying current court guardianship practices and suggesting reforms; they laid a lot of the groundwork for this Workgroup. But Chief Judge Barbera’s decision to make this issue a priority really highlighted the need for change, and the project gained a lot more momentum. What this Workgroup has accomplished in a relatively short time demonstrates how committed this administration is to the cause.

Another ingredient is the people. The Workgroup’s members are passionate about this work and have been generous with their time, resources, and expertise.

**Bifocal:** What prompted the Workgroup’s May 2016 Report and Recommendations?

**Judge Jensen:** As noted by Chief Judge Barbera, the senior population is expected to increase precipitously in the next few years, and the demands on the courts in elder-law-related cases is also anticipated to increase. There was an opportunity to re-evaluate the qualifications of attorneys appointed to represent what Maryland law calls "alleged disabled persons" in guardianship proceedings. Additionally, in anticipation of a significant increase in that specific population, a review of how the courts select and support guardians of the person and guardians of the property, including effective monitoring of the guardianship estate, was necessary, in order to best protect vulnerable Marylanders moving forward. As a result, the Workgroup was asked to make recommendations

**Bifocal:** What was the Workgroup’s process for developing its recommendations?

**Judge Jensen:** The Workgroup’s charge was daunting, and I knew we needed an organized plan. I decided to divide the Workgroup into three subgroups, each led by one of the judges on the Workgroup. One was tasked with outlining recommendations to address the concerns about court-appointed attorneys, another focused on guardians of the person, and the last on guardians of the property.

**Nisa Subasinghe:** Before each subgroup met, they reviewed guardianship practices in the other states as well as best practice literature including resources developed by the American Bar Association, the National Association for Court Management, and the National Center for State Courts. The National Probate Court Standards were particularly helpful. When those materials highlighted states with especially innovative or helpful strategies, we reached out to them for more information. We also posted requests on guardianship and elder law listserves to find examples of training and eligibility standards and curricula for guardians and attorneys. After reviewing this information, the subgroups met to discuss best practices which could be implemented in Maryland.

**Judge Jensen:** In addition to the subgroups’ focus areas, there were also ancillary issues to which the literature offered promising solutions, such as the development of resources for guardians, training and guidance for judges, and the expansion of alternative dispute resolution in guardianship cases. We added these initiatives to our recommendations. In May 2016, the Workgroup’s 25 recommendations were unanimously approved by the Judicial Council and the Workgroup was charged with implementing them.

**Bifocal:** In your view, what are the three most significant Workgroup recommendations?
Judge Jensen: First, the training and eligibility standards for court-appointed attorneys. They play an important role in protecting the rights of vulnerable Marylanders and these standards help ensure that their clients have a voice, that guardianship is imposed only if necessary, and if needed, that the right person is appointed. Second, the orientation and training requirements for guardians. We want to encourage family members and those closest to the alleged disabled person to serve as guardians, but problems can arise if they are unclear of their role, powers, and duties. The Workgroup thought it was important to empower them with information and resources to be successful. Third, the training and resources for judges. The court is the ultimate guardian and it is imperative that judges have the tools to manage and monitor guardianship cases effectively.

Nisa Subasinghe: While guardianship is a mechanism to stop or prevent abuse, neglect, and exploitation, it can also create opportunities for bad actors. The overarching goals of the recommendations are to promote guardianship as a last resort and, where appropriate, to make sure the right person is appointed guardian...

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Nisa Subasinghe: The new certificates allow healthcare practitioners to provide better information about their patients’ functional abilities and limitations. This information is important to have when deciding what powers to grant a guardian or if one is needed at all. We also developed forms to help guardians take certain actions such as filing proof they opened a restricted account, resigning, terminating the guardianship, and we created a general motion for appropriate relief. Many guardians do not have attorneys and fail to take certain actions simply because they do not know how to carry them out. These forms will help.

Judge Jensen: The Maryland Judiciary is committed to promoting access to justice and, like many states, has a variety of resources for self-represented litigants. Since the court is the ultimate guardian, there is a responsibility to support guardians appointed by the court. To that end, the Workgroup created a subgroup to focus on the development of guardianship forms...
and make sure they meet the Judiciary’s plain language standards.

**Bifocal:** Talk about the new training requirements and resources for guardians.

**Nisa Subasinghe:** Before appointment, guardians must watch a brief orientation video program that covers the role and responsibilities of guardianship. The video provides a realistic idea of what being a guardian entails. After appointment, guardians must complete a training program that provides specific information on their role and responsibilities, how to make certain decisions, how to identify and respond to signs of abuse, neglect, and exploitation, and available community resources. The Workgroup developed templates courts can adapt for local in-person training programs, but we recognized that not all courts can host regular live programs, and they may not be easily accessible to guardians.

To address this reality, the Workgroup developed video versions of the training programs guardians can watch and file a certificate of completion. These are posted on the Judiciary’s website. In the near future, we will replace the videos with more engaging interactive online courses that will include a series of video clips on some of the more complex topics such as decision-making standards and financial exploitation. A guardianship webpage is now up and running replete with checklists, forms, and links to resources.

**Bifocal:** Tell us about the new requirements for attorneys.

**Judge Jensen:** Court-appointed attorneys must be members in good standing of the Maryland bar, demonstrate financial responsibility, and unless waived by the court, be trained in certain aspects of guardianship law and practice. The training must cover fundamentals of guardianship law and practice, manifestations of mental disease and disabilities, the role of counsel, ethical considerations, and signs of abuse, neglect, and exploitation. The training requirements help increase attorneys’ ability to advocate zealously for their clients.

**Bifocal:** What challenges do you foresee in implementing the new requirements?

**Judge Jensen:** These are big changes and courts, attorneys, and guardians need time to navigate them. Maryland’s circuit courts are not uniform and the changes will affect each court differently. Guardianship attorneys need to familiarize themselves with the new requirements and procedural changes. The orientation and training requirements add a step to the process that may overwhelm some prospective guardians and each individual court will have to respond to that reality. Along the way, the Workgroup consulted with and got feedback from judges, court staff, private attorneys, public agencies, and other service providers outside of the Workgroup. It was clear that the Workgroup would need to provide ongoing technical assistance and develop resources to help everyone navigate these changes once in effect. While sensitive to the impact on family guardians, we believe it is important for guardians to understand what is expected of them and know what tools are available upfront, and for courts to screen out those unable to take on the responsibility.

*There is still a lot of work ahead of us, but we have the leadership, resources, and support we need to get things done.*

-Nisa Subasinghe
Nisa Subasinghe: We knew there would be a transition period and were encouraged by what we learned from other states with similar requirements. Once systems are in place, courts have more information and are able to make better-informed decisions about who needs a guardian and how to appoint, one if necessary. Guardians also have more support and courts can better monitor the individuals and estates under guardianship. We also knew it was important to implement these changes now. With the anticipated increase of the population of Marylanders age 65 and older, the courts need to be ready to handle more guardianships.

Bifocal: What advice do you have for other states forming interdisciplinary working groups, or WINGS, on guardianship reform and promotion of less restrictive options?

Judge Jensen: Get the support of your chief judge, the judicial leadership, as well as court administration. When Chief Judge Barbera made guardianship reform a priority, many internal and external collaborations were established and driven by her support. I also suggest dreaming big but setting attainable goals and realistic timeframes. Try to anticipate barriers; there will be many. Think creatively, expect to pivot, and run ideas by practitioners outside of your core working group. You also need the right people. Get as many perspectives as possible, but find people who are able to set aside their individual agendas, rally around shared goals, and work collaboratively. Our Workgroup is filled with hardworking professionals with demanding full-time jobs who have volunteered countless hours to attend meetings, join conference calls, and respond to the hundreds of e-mails circulated among the members. They do this work because they care.

Nisa Subasinghe: I recommend seeing what other states are doing and taking advantage of the experts from and resources developed by the American Bar Association’s Commission on Law and Aging, the National Center for State Courts, and the National Association for Court Management. I am so proud of what Maryland is doing, but much of what we did was adapt established best practices. I also recommend finding the right leader. The minutes of a Workgroup meeting held in 2015 reflect that Judge Jensen did, in fact, tell Workgroup members to dream big. She set the Workgroup’s vision, keeps members focused and motivated, and is an incredible advocate. There is still a lot of work ahead of us, but we have the leadership, resources, and support we need to get things done.

Editor’s Note: The Maryland Guardianship/Vulnerable Adults Workgroup is listed on the ABA Commission’s website profiling Working Interdisciplinary Networks of Guardianship Stakeholders (WINGS), as a state entity similar to WINGS. See http://ambar.org/wings.

About our interviewees:

The Hon. Karen Murphy Jensen is chair of the Guardianship/Vulnerable Adults Workgroup of the Maryland Judicial Council’s Domestic Law Committee. Judge Jensen served as an Administrative Judge on the Caroline County Circuit Court from 1999-2016. In the early 2000s, she started a problem-solving court beginning with a juvenile program and transitioning to an adult program serving those with mental illnesses and drug addiction issues. She also was a founding member of Mid-Shore Pro Bono. Prior to that, she served as Assistant County Solicitor for Anne Arundel County, MD. She has a JD degree from the University of Maryland.

Nisa C. Subasinghe is an attorney with the Department of Juvenile and Family Services at the Maryland Judiciary’s Administrative Office of the Courts, where she serves as a subject matter expert on guardianship and related matters. She staffs the Maryland Judicial Council’s Guardianship/Vulnerable Adults Workgroup and coordinates and manages its ongoing projects. She also serves on the Council’s Domestic Law Committee and on several of its workgroups. Prior to joining the Maryland Judiciary, Ms. Subasinghe was a crime victim advocate. She is a graduate of The Catholic University of America’s Columbus School of Law.
In lockstep with the nursing home industry, the Trump Administration is rapidly dismantling the regulations and guidance that have been developed over the past 30 years to implement and enforce the federal Nursing Home Reform Law. Until the Christmas Eve 2017 report in The New York Times, these devastating changes, often made without any public notice or comment, received no public attention.

The single deregulatory issue in the nursing home area that attracted any public concern was the Trump Administration’s proposed rule that would reverse the Obama Administration’s 2016 final rule prohibiting nursing homes from using pre-dispute mandatory arbitration provisions in their admissions contracts with residents. The Trump rule has not yet been issued in final form.

Although litigation is an important tool when residents are seriously harmed or killed by poor care, the regulatory system is intended to prevent avoidable bad outcomes in the first place. It is the regulatory system, and particularly, at this time, the enforcement system, that is under severe attack.

The 1987 Nursing Home Reform Law, signed by President Reagan as part of the Omnibus Budget Reconciliation Act, has three broad components. First, it sets federal standards of care, called Requirements of Participation, for skilled nursing facilities and nursing facilities

1) 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.
5) Kizer v. City of San Mateo, 806 P.2d 1353 (1991) (rejecting the claim that a personal injury lawsuit is an adequate substitute for pre-injury enforcement by a public agency and describing the state police power to protect public health).
that voluntarily choose to participate in (and receive reimbursement from) the Medicare and Medicaid programs. Second, it establishes a survey system with unannounced on-site visits by trained health care professionals to determine compliance with those standards. And third, it establishes a range of intermediate sanctions, or penalties, that may be imposed when a facility fails to meet the standards of care for any, some, or all residents. Most of the remedies are discretionary.

Through subregulatory guidance – that is, guidance below the level of regulations that is implemented without notice and comment rulemaking under the Administrative Procedures Act – the Centers for Medicare & Medicaid Services (CMS) has essentially eviscerated the enforcement system.

In July 2017, CMS issued guidance to surveyors that reduced the amounts of civil money penalties (CMPs) that could be imposed against facilities, expressely replacing guidance issued by the Obama Administration in 2014. The 2017 guidance makes lower per instance CMPs the default, rather than higher per day CMPs; it discourages the Regional Offices (ROs) that officially impose remedies from starting per day CMPs before “the start date of the survey” (a change that especially affects problems identified as a result of complaint surveys); it requires CMS’s Central Office to review CMPs exceeding $250,000; and it expands facilities’ ability to describe CMPs as unaffordable, among other changes that reduce CMP amounts.

On October 27, 2017, CMS proposed repealing and replacing surveyor guidance that the Obama Administration issued in July 2016. Remarkably, the American Health Care Association (AHCA), the large nursing home trade association, had explicitly requested replacement of the Obama guidance, which it identified by number, in its December 2016 letter to President-Elect Trump. AHCA repeated the request in a March 9, 2017 letter to then-HHS Secretary Tom Price. The proposed 2017 guidance calls for limiting the imposition of CMPs for immediate jeopardy deficiencies (the highest of four levels of severity by which deficiencies are classified) that reflect a “one-time mistake” or that do not reflect “intent” to harm; prohibits imposition of CMPs for “past noncompliance;” uncouples scope and severity of deficiencies from particular remedies; and reduces enforcement against the one or two worst facilities in each state that are designated as Special Focus Facilities.

Other changes to enforcement are planned. CMS officials told state survey agency directors in August 2017 that CMS is evaluating additional regulatory policies, including “[m]ultiple tags for same noncompliance (AKA ‘stacking’)” – that


is, citing a single deficiency rather than multiple deficiencies when multiple systems fail in a facility – and “[e]xploring improving care through other remedies (e.g., DPOC [directed plans of correction])” – that is, using remedies other than financial penalties, even when deficiencies are cited.

As dismantling of the enforcement system continues, CMS is also delaying enforcement for certain standards of care that were promulgated by the Obama Administration in 2016 as so-called Phase 2 requirements, ended a five-year initiative to reduce the inappropriate use of antipsychotic drugs, solicits changes to revise federal standards of care, and announces plans to revise the requirements in order to reduce provider burden.

This is a very dangerous time for residents.

Residents’ advocates must remain vigilant and vocal.

About the author:

Toby S. Edelman has represented older people in long-term care facilities since 1977. As a Senior Policy Attorney with the Center for Medicare Advocacy since January 2000, Ms. Edelman provides training, research, policy analysis, consultation, and litigation support relating to nursing homes and other long-term care facilities. Ms. Edelman has a J.D. from the Georgetown University Law Center and is a member of the Washington, D.C. Bar.


14) CMS, “Revised Federal Oversight Support Survey (FOSS) Process National Pilot,” Admin. Info. 18:06-NH (Dec. 22, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/ Downloads/Admin-Info-8-06.pdf (advising that deficiencies identified in federal surveys will not be cited unless they reflect substandard quality of care, harm, or immediate jeopardy that were not identified by the state survey agency’s survey).


The demographic bulge known as the Baby Boom cohort is now more than half way through the life continuum. A growing portion of this group is composed of “solos.” These are individuals who cannot/do not rely on family to help navigate life events and make health decisions. Recent research by Dr. Maria T. Carney suggests that some 23% of older adults are at risk for becoming “elder orphans” (solos). This includes not only people who have no children, but those who are estranged from family, or whose family members cannot provide assistance for various reasons.

A New Kind of “Solo”

One of most overlooked reasons for “solo-ness,” however, is the degree to which choice is becoming a major factor. Boomers prefer to rely on themselves rather than institutions and even other individuals. Solos of this generation, in particular, have spent their adult life funding their own mortgages, and getting themselves to the airport. Interviews with solos conducted over the past two years reveal the same independent streak as they think and talk about aging. Many are electing to limit the involvement of family and friends when support is needed, or not to involve them at all, even when relationships are solid. This generational preference alongside of the sheer number of older adults is creating new challenges when it comes to planning for long term care and the end of life.

The most obvious challenge is that the traditional model of having a family member to coordinate care and serve as a health care agent is not workable for solos. While some solos can rely on a close friend as a substitute for family, many more cannot. Close friends may be in the same age group and dealing with their own health and care issues. Just as likely, friends and acquaintances are simply not willing to take on the responsibility of making health decisions for someone who is not family. Unfortunately, too many existing laws, policies and practices related to late life support and decision making are still laced with assumptions about the availability of family and loyal friends.

In the absence of a single close friend to serve as a supporter and surrogate, solos are beginning to explore a multi-person strategy. Some are creating “teams” of supportive friends and acquaintances to be advisors and helpers, though not necessarily “deciders.” Others are piecing together a collection of volunteers and paid professionals. Still other solos, with adequate resources, are seeking out paid professionals to meet all needs, from home care to health decision surrogates. And, sadly, there are still far too many solos who doing nothing — assuming “there is still time” or “the system” will take care of things. This does not bode well for the already overburdened public “safety net.”

The transition from the traditional family-linked older adult population to one that is more multi-dimensional, highlights the need to look critically at the tools, laws, and past practices associated with later life and end-of-life health decision making. Does what we have in place serve people with family and solos...
equally well? A few examples deserving attention include the following.

**Default Surrogate Laws**

About three quarters of all states have adopted statutes to assist medical professionals in dealing with unrepresented individuals who lack capacity. Typically, these “default surrogate” laws contain a hierarchy of people who can be consulted, and most often family members are prominent in such a hierarchy. Recently, however, states have begun to modify their statutes to create more choices and greater flexibility. Further review seems warranted in view of the new solo population.

**Liability/Fear of Litigation**

A common theme emerging from conversations with solos and those who might support them is worry over liability. Organizations, such as faith communities, are often reluctant to go beyond offering Advance Care Directive workshops. They are concerned about the potential consequences of taking on a deeper level of support. Similarly, individuals decline to serve as health decision surrogates because they “don’t want to get sued.” Are these fears valid? What is possible? Can any improvements be implemented to make more “free” resources available to solos?

**Emergence of/Demand for Paid Health Care Surrogates**

Overall, today those age 60+ are more accustomed to using paid expertise than the older adults of the past. Boomers have dropped their children off at day care, sent their taxes to accountants, paid people to deliver their groceries, and have interacted with consultants in the workplace. Such a history may be one of the reasons solos are expressing interest in and willingness to consider hiring a health decision surrogate. Currently there aren’t many to be found, but this may change as demand increases in the future. Would more professional health “fiduciaries” be a good thing? What issues might be created and need to be addressed for this to be a solid option for those who can afford to pay for resources?

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**Roles and Structures**

Historically one or more family members have managed both short-term and long-term care for parents and other older relatives. Over time, though, families and solos alike have begun to look to professional care managers and health care advocates to serve in the coordinator role. In the future, solos who chose this option, may find that their care manager and/or advocate is the person who is most familiar with their values and preferences. Consequently, that trusted professional may well be the person best qualified to serve as the health care surrogate. Is it possible for a professional to play a dual role under existing statutes? Is it desirable? If the manager/advocate is one of several employees in an organization, can the organization be named as the proxy or must a specific individual be named? Are changes needed?

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Starting the Conversation

Readers who would like to participate in the discussion around these and other “solo aging” issues, are invited to join the ABA’s new Aging Solo e-mail discussion list – **COLA-AgingSolo**. The list is scheduled to launch by March 1. This on-line group will focus exclusively on topics related to those who qualify as solo older adults, including solos with capacity and those who lack capacity. Participants will be invited to post questions and responses, share information, and help craft solutions. To be added to the list send an e-mail to **COLA-AGINGSOLO-request@mail.americanbar.org**.
Early January, 2018 saw the launch of Connect2Affect, a nationwide online network intended to raise awareness of social isolation and loneliness among older adults. The Connect2Affect network, which is sponsored by the AARP Foundation, enables users to assess their level of loneliness and to network with other lonely people.

Also in January, British Prime Minister Theresa May appointed Tracey Crouch to be the U.K.’s first Minister for Loneliness. Though the post initially sounds like something out of Monty Python, it addresses a critical need. It was created in response to a 2017 report published by the Jo Cox Commission on Loneliness which reported that more than nine million Britons say that they often or always feel lonely. Two-hundred thousand older people reported that they had not had a conversation with a friend or a relative in more than a month.

This is your opportunity to submit a proposal for a workshop at the 2018 National Aging and Law Conference (NALC) October 25-26, in Alexandria, Virginia.

We’re looking for speakers to present workshops on issues such as:
- Elder Justice
- Medicare/Medicaid/other health and long-term care
- Guardianship, alternatives, supported decision making
- Abuse, Neglect and Exploitation
- Disability
- Serving diverse clients
- Ethics and civility
- Housing, consumer law,
- House, nutrition and other safety net benefits
- Other ideas?

Submission deadline: Friday, March 2, 2018
Submit proposals as Word Documents by e-mail to David.Godfrey@Americanbar.org.

We are unable to accept pdfs or handwritten proposals.

For further details, visit the NALC web site.
The Perils of Serving as a Financial Caregiver

by Katherine C. Pearson

The facts set forth in a 2015 decision by the Arizona Court of Appeals present a cautionary, modern tale on the perils of becoming not just a personal caregiver, but also a “financial caregiver” for an older person. The father, a widower, was 80 years old, and needed increasing assistance in his daily life, including help managing his finances. For ten years — from October 2001 until his death in January 2012 — his adult daughter and her husband provided that help. Caregiving relationships undoubtedly begin every day across the U.S., in much this fashion.

The couple assisted the father in moving into their home in New Jersey, and in moving a second time, with them, to Arizona in 2008. Throughout this time, they helped with his transportation to doctors’ appointments and assisted him with medications; they shopped for him and facilitated “all of his social and recreational activities,” including caring for his dog. Indeed, they lived together for 120 months, and only in his last two months did the father move to a residential nursing or assisted care facility. It was undisputed that the daughter took good care of her father. At one point, the daughter left her job completely to be of more help, although she later returned to work.

From 2002 until he died, the daughter managed her father’s finances, which included savings, proceeds from sale of a house, and a monthly pension and Social Security; she used her authority as an agent, designated by her father’s signature on a Power of Attorney.

The father also had two adult sons. The appellate record is silent on their roles, at least until after their father’s death. After their father’s death, one of the two sons was appointed personal representative of his father’s estate. In that capacity he filed a complaint against his sister and brother-in-law, alleging they violated Arizona’s Adult Protective Services law, breached their fiduciary duty, converted the father’s funds and enriched themselves with the father’s assets. After a one-day bench trial, the Arizona trial court ordered the daughter and son-in-law to reimburse the deceased father’s estate $15,527, plus $35,000 in attorney’s fees incurred by the estate.

1) In the Matter of the Estate of Domingo A. Rodriguez, Case No. 1 CA-CV 14-052, 2015 WL 6698535 (Ariz. Ct. App. Nov. 3, 2015). The author has also used Findings and Conclusions of fact and law from the trial court’s final order, dated April 10, 2014, a copy of which is in the possession of the author. Quotations used in this article when describing the history of this case are from the appellate decision. This appellate opinion is also available at http://www.azcourts.gov/Portals/0/OpinionFiles/Div1/2015/1CA-CV14-0562.pdf

2) The other son “did not believe [his sister] should have to reimburse the estate any funds,” according to the trial court’s Findings and Conclusions, filed as a final order on April 10, 2014.
The focus of the trial court's decision, affirmed on appeal in a non-precedential opinion, was on the couple's failure to "keep an accounting" of use of the father's funds. Several key events appear to be at the heart of the courts' rulings. The couple reportedly sold the father's house in 2002 and "used a portion of the proceeds to expand their home to accommodate" the father and "to make other improvements." They later sold their own home in New Jersey and purchased a new home in Arizona. Although at trial they provided "some evidence of the value of their services and the amounts they spent" for the father's benefit, the court found they had not shown that the father "received goods and services equal to the full value of the money they received from him."

The dollars involved in the various transactions handled by the daughter or her husband are not spelled out in the appellate decision. The trial court's order attempted to reconstruct the financial history over ten years, crediting the couple with the right to certain reimbursements for expenditures most clearly made to benefit the father. The trial court also assigned values for the costs of room, board and care provided by the couple, before awarding the estate less than $16k. The award of $35k in attorney's fees from the trial proceedings, and an unspecified additional amount of attorney's fees for the father's estate as the prevailing party on appeal, were the most significant consequence of the failure of the couple to have full and accurate financial records and to keep the father's money and bank accounts separate from their own.3

In 2009, Arizona adopted a strict standard of care for those assisting vulnerable adults.4 Prior to the change, Arizona's Adult Protective Services Act required a person in a position of "trust and confidence to a vulnerable person" to act for the adult's benefit to the same extent as a trustee, a reference to the "prudent person" standard of Arizona trusts and estates law.5 The 2009 change framed the mandatory command as a duty to use "the vulnerable adult's assets solely for the benefit of the vulnerable adult and not for the benefit of the person who is in the position of trust and confidence." The appellate court rejected the defense that the "sole benefit" standard was wrongly applied in a retroactive manner to financial decisions made before the statute's change. Instead, the appellate court focused on the "failure to keep clear and accurate records, commingling of funds and engaging in [self-benefiting] transactions," concluding that such actions violated even a "prudent person" standard.

At one time, courts were often loath to second-guess family caregivers’ decisions.6 High profile modern cases of abundant greed — such as manipulation of

3) In 2001, the father signed a power of attorney (POA) that provided legal authority for the daughter to engage in transactions on her father's property in his name. The courts did not provide details about the scope of the POA in their opinions. It appears the Court of Appeals discounted the significance of the POA, because the daughter "selected" the attorney who drafted and witnessed the POA. The potential for unclear lines about whom an attorney represents – the daughter or the father or both — and the possibility of "conflict of interest" in such transactions can negate an argument about "independence" of legal advice, for either party. See e.g., Katherine C. Pearson, The Lesson of the Irish Family Pub, 40 STETSON L. REV. (No. 1), 237 (Fall 2010). Compare Maine's Improvident Transfer of Title Act, 33 M.R.S.A. §§ 1021 et seq., discussed by Sally Wagley, Maine's Improvident Transfers Act: A Unique Approach to

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5) Compare language from the UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT (1997/1998), at Sec- tion 5-314 on “Duties of a Guardian” which provides, “A guardian at all times shall act in the ward's best interest and exercise reasonable care, diligence and prudence.” See also UNIF. POWER OF ATTORNEY ACT (2006), Section 114(a), providing in part that “Notwithstanding provisions in the power of attorney, an agent . . . shall (1) act in accordance with the principal's reasonable expectations to the extent actually known by the agent and, otherwise, in the principal's best interest” and at (a)(6) “An agent that acts with care, competence, and diligence for the best interest of the principal is not liable solely because the agent also benefits from the act. . . .”

6) Russ ex rel Schwartz v. Russ, 734 N.W.2d 874 (Wis. 2007) (discussing precedence from several states regarding commingling of funds, joint accounts, and powers of attorney in a family caregiving fact pattern that lasted 9 years, and asking “how is a well-intentioned agent supposed to behave?” but ultimately rejecting breach of fiduciary duty arguments).
New York heiress Brooke Astor by her son Anthony to gain control over assets before her death — have sharpened scrutiny of financial transactions made in the name of older individuals, especially those deemed vulnerable because of disability, mental incapacity or mere age. Banks, financial management and service companies, law enforcement agencies and the courts are now more attuned to instances of financial abuse and exploitation, exhibiting greater willingness to examine the actions of family members, “befrienders,” or court-sanctioned fiduciaries.

On the one hand, much of this scrutiny is well deserved and overdue, as demonstrated in abundance by recent efforts in Nevada, Florida and New Mexico to curb abuses by personally-designated agents, as well as by court-appointed agents, such as guardians, conservators or other fiduciaries who are directly subject to some level of court-oversight. In fact, the Arizona legislature adopted the “sole benefit” standard following an investigative series of detailed media reports on mismanagement of wards’ funds.

At the same time, the greater scrutiny raises the stakes for every well-meaning person serving as a caregiver. The modern trend heightens the importance of practical education for caregivers. In some jurisdictions, such as Colorado, state bar associations have crafted brief educational materials for current or prospective agents. Experienced attorneys can — and should — play important roles as counselors at law, by explaining, highlighting and reinforcing “financial caregiving” education. [Editor's Note: See the CFPB series Managing Someone Else’s Money which sets the standard for such instructional guides, https://www.consumerfinance.gov/consumer-tools/managing-someone-elses-money/]

At a minimum, the players, including principals (or the courts) who designate financial caregivers, and those assuming financial caregiving roles as agents, guardians or custodians, may be well-advised to consider the following questions:

1. What is the financial sophistication of the proposed agent? It is often worth a conversation with the individuals about their past experiences managing money, accounts and other assets.

2. What is the size of the estate in question? It helps to know this before someone agrees to serve as an agent. The unfortunate truth in life is the larger the estate, the greater the peril for financial caregivers.

3. What are the family dynamics? Will appointment of one individual create a trap whereby an overlooked or disgruntled offspring, sibling or spouse demands an accounting? Even successful defense against a weak claim will involve costs to the financial caregivers and to the principal's estate. Family dynamics can also change over time, especially as feelings of resentment, guilt or denial begin to color relationships. Consider whether


greater transparency within the family at all phases of the relationship involving handling of financial matters may deter later problems.

4. What advance planning documents are going to be used — and why are they necessary — to support the financial caregiver? Many “canned” powers of attorney or other estate planning documents, even those available from the most carefully designed “alt-lawyer” internet websites, involve nuanced decisions about whether to authorize “gifting” powers, fees for services provided, or unlimited authority to transact in the principal’s name. Here again is the important role for the experienced attorney, as counselor at law.

5. Is the proposed agent fully aware of what it means to:
   a. Act as a fiduciary for the principal. A “best interest” standard can mean agents forego any advance of their expected inheritance. Even in states that use a “prudent person” or similar standard to evaluate the duties of a financial agent, transactions that have any odor of “self-dealing” can be scrutinized.
   b. Keep the principal’s money separate from the agent’s money and to document any reimbursements carefully.
   c. Keep detailed and accurate records of financial transactions, including cash or ATM transactions.
   d. Deal with other family members in a way that reduces, rather than increases, the potential for a belated claim of breach of fiduciary duty.
   e. Plan for the possibility that the vulnerable person may need third-party care, which may trigger demands for detailed accounting of the principal’s financial and medical history, especially if there will be a claim for benefits through insurance policies, Medicaid or the Veterans Administration.
   f. Understand that financial caregiving roles may last indefinitely, even longer than the role of health-related caregiver. Many individuals start the journey of caregiving assuming or hoping it is a temporary mission as a “Good Samaritan.” Opting out is not easy to do without consequences, including legal consequences.

6. And finally, if the financial caregiver will be paid for services as provided, or will pay others for services to the principal, what are the plans for the state and federal income tax consequences of such employment?

Thomas J. Murphy, an experienced Arizona attorney in Estates and Elder Law, explained his take-away message from cases such as the one described above, commenting that with the increasing importance of accountability for financial caregiving, “the caregiver child often has an even greater need for an attorney than the parent who is incapacitated or deemed vulnerable.”

The final words of the Arizona trial court also serve as a warning: “Although [the daughter] was not a good accountant, bookkeeper, or records keeper, her actions do not rise to the level of warranting double damages, forfeiture or sanctions. She took care of her father for over 10 years and provided him with a home, care and companionship of the final years of his life.” As affirmed on appeal, that wasn’t quite enough.

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14) Interview with Thomas J. Murphy, December 28, 2017, Phoenix Arizona (notes in possession of author).
15) In the Matter of the Estate of Domingo A. Rodriguez, Findings and Conclusion of Law No. 24, Ruling, April 14, 2014, in PB 2012-001760, Superior Court of Arizona, Maricopa County, Arizona.
From 2016 through 2017, the following states adopted legislation creating, modifying, and amending rights and procedures affecting health care decision-making:

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The legislation affects advanced directives, default surrogate laws, Physicians Orders for Life-Sustaining Treatment (POLST), and registries. These summaries are intended to offer selected highlights and do not fully describe the laws in their entirety.

Each piece of legislation is coded to indicate the potential areas of health care decision making affected by the statute. The coding system is:

- **AD** = Advance Directives
- **DNR** = Do Not Resuscitate Orders
- **DS** = Default Surrogate
- **POLST** = Physician’s Orders for Life Sustaining Treatment, or its variants (e.g. MOLST, POST, MOST, and others).
- **PAD** = Physician aid in dying legislation (also called physician-assisted suicide)


**Alabama**

(DNR)

Approved March 18, 2016. Effective June 1, 2016.
Authorizes Portable Physician Do Not Attempt
Resuscitation (DNAR) Orders, adding definitions and procedures to the state’s advance directive statute. The DNAR form must be approved by the State Board of Health. The Act also provides statutory immunity for health care providers or facilities that issue or comply with a portable DNAR.

(PAD)

2017 Alabama Laws Act 2017-231 (H.B. 96). Approved May 4, 2017. Effective August 1, 2017. This bill established the Assisted Suicide Ban Act, prohibiting a person or a health care provider from providing aid in dying under certain conditions and provides civil and criminal penalties for violations of the Act.

Arizona
(Registry)

2017 Ariz. Legis. Serv. Ch. 154 (H.B. 2076) (WEST). Approved April 17, 2017 amending Arizona Revised Statute Sections 363295 and 36-3296, relating to the health care directives registry. Directs the Secretary of State to establish a process for health care providers to access the advanced directives central registry. Expanded the definition of “health care providers” to include emergency medical service providers and emergency service technicians providing emergency medical services.

Arkansas
(AD, DS)

2017 Arkansas Laws Act 974 (S.B. 676). Approved April 7, 2017. Effective July 31, 2017. Combines three advance directive statutes into two laws — the existing Health Care Decision Act (Ark. Code Ann. §§ 20-6-101 to -118 ) and the existing Rights of the Terminally Ill Act (§§20-17-201 to -218), by repealing the separate Durable Power of Attorney for Health Care Act and merging its key elements into the Health Care Decisions Act and amending and conforming other provisions of the original acts. Among the revisions, the Act:

- Adds “durable power of attorney for health care” to subchapter definitions. Defines “durable power of attorney for healthcare” as a written advance directive that identifies an agent who is authorized to make healthcare decisions on behalf of the principal.
- Adds “Living will” to subchapter definitions. “Living will” means a written advance directive describing the principal’s individual instructions for health care to be provided or withheld if the principal subsequently lacks decision-making capacity.
- Provides a single uniform process for executing any form of advance directive – notarization or witnessing by 2 adults not related by blood, marriage, or adoption, and not entitled to any portion of the estate of the principal upon the principal’s death.
- Replaces the requirement that a principal may only revoke the designation of an agent by a signed written statement or by personally informing the supervising healthcare provider with a more flexible requirement that a principal make revoke all or part of an advanced directive, living will, durable power of attorney for healthcare, or other document, at any time and in any manner that communicates an intent to revoke.
- Requires a healthcare provider, agent, guardian, or surrogate who is informed of a revocation promptly communicate the revocation to the supervising healthcare provider and any healthcare institution at which the patient is receiving care.
- Makes minor changes in the process for identifying a surrogate in the absence of an authorized decision-maker, and adds to the priority list of surrogates a close friend, defined as any adult who: (1) Has exhibited special care and concern for the principal; (2) Is familiar with the principal’s personal values; (3) Is reasonably available; and (4) Is willing to serve.
- If no one is available to serve as surrogate, the existing law that permits the designated physician (now called supervising health care provider) to make decisions for the patient under specified criteria is modified slightly to require consultation and approval from either an institution’s ethics officer or ethics committee.
- Adds that a default surrogate may make decisions regarding withdrawal of artificial nutrition and hydration if the action is authorized by a living will or other written advanced directive, or if certain medical criteria are certified by the supervising health care provider and a second independent
physician.

(POLST)

- The General Assembly found that the physician order for life-sustaining treatment form is a complement to an Advanced Directive, if existing, by taking an individual's intentions and converting them into a medical order.
- Provides that the standardized form is to be prescribed by the State Board of Health and outlines the elements of the form.
- Outlines the hallmarks of the POLST form, provides guidance on how to complete the form on behalf of patients who lacks capacity and the process for reviewing and revising an executed POLST form.
- Indicates the relationship the POLST form is to have with Advanced Directives – the POLST form does not replace an advanced directive and a good faith effort must be made to locate and incorporate an advanced directive into the form. Outlines steps to be followed when the advanced directive and POLST form conflict with one another.
- Provides that healthcare providers, facilities, and their agents are not subject to civil or criminal liability for complying with a POLST form or failing to comply where good faith determinations are made under enumerated circumstances. Provides religious and moral exceptions to compliance.
- The signing of a POLST form is voluntary. A person or entity cannot require an individual to execute a POLST form as a condition of being insured for, or receiving, healthcare services.
- Creates criminal penalties for failing to act in accordance with certain requirements of the chapter (e.g., “undue influence” by providing financial incentives for completing the form).
- Provides the form that the State Board of Health is to adopt.

Colorado
(PAD)

Modeled upon the Oregon Death with Dignity law, the law:

- Establishes process by which competent, terminally ill (6 month prognosis) adult resident of Colorado can obtain a physician's prescription to end their life, based upon an informed and voluntary decision.
- Requires confirmation that the individual is not suffering from psychiatric or psychological condition causing impaired judgment.
- Requires (1) an initial oral request, followed by (2) a written request on an approved form witnessed by 2 qualified witnesses, and then (3) a 2nd oral request (no sooner than 15 days after the first).
- Provides for counseling of patients requesting aid in dying.
- Authorizes dispensing the prescription either directly to the patient by physician, or through a pharmacy. Both have reporting requirements to the department of public health.
- Defines its effect on contracts, wills, insurance and annuity policies and requires that they not be conditioned upon or affected by the making or rescinding of a request for medication or by a patient ingesting covered medication.
- Establishes terms for immunity from criminal and civil liabilities.
- Establishes penalties and provides an opt-out provision for health care providers.
- Provides for claims by the government against the individual's estate if costs are incurred from a patient terminating his or her life pursuant to the legislation in a public place.

(DS)
for Medical Treatment Article, §15-18.5 of Colo. Rev. Statutes to add a medical decision-making procedure for patients with no available proxy decision-maker. The law provides that an attending physician may designate another willing physician to make health care treatment decisions as a patient’s proxy decision-maker if:

- After making reasonable efforts, the attending physician or his or her designee cannot locate any interested persons, or no interested person is willing and able to serve as proxy decision-maker;
- The attending physician has obtained an independent determination of the patient’s lack of decisional capacity by another physician; by an advanced practice nurse who has collaborated about the patient with a licensed physician either in person, by telephone, or electronically; or by a court;
- The attending physician or his or her designee has consulted with and obtained a consensus on the proxy designation with the medical ethics committee of the health care facility where the patient is receiving care; and
- The identity of the physician designated as proxy decision-maker is documented in the medical record.

The law also specifies decision-making criteria and procedures, including ethics committee concurrence and/or a second consulting physician concurrence for certain decisions.

**Connecticut**

(POLST)


- Provides that the Commissioner of Public Health shall establish a state-wide program to implement the use of medical orders for life-sustaining treatment by health care providers. Patient participation in the program shall be voluntary.
- Establishes a MOLST advisory council. The advisory council shall meet at least annually to be updated on the status of the program and advise the department on matters related to improving the program.
- The Commissioner of Public Health shall adopt regulations for the program to ensure that:
  - MOLSTs are transferrable among, and recognized by, various types of health care institutions subject to any limitations set forth in federal law;
  - Any procedures and forms developed for recording MOLST require the signature of the patient or the patient's legally authorized representative and a witness on the MOLST and the patient or the patient’s legally authorized representative is given the original order immediately after signing such order and a copy of such order is immediately placed in the patient’s medical record;
  - Prior to requesting the signature of the patient or the patient’s legally authorized representative on such order, the physician, advanced practice registered nurse or physician assistant writing the medical order discusses with the patient or the patient’s legally authorized representative the patient’s goals for care and treatment and the benefits and risks of various methods for documenting the patient’s wishes for end-of-life treatment, including medical orders for life-sustaining treatment; and,
  - Each physician, advanced practice registered nurse or physician assistant that intends to write a MOLST receives training concerning: (A) The importance of talking with patients about their personal treatment goals; (B) methods for presenting choices for end-of-life care that elicit information concerning patients’ preferences and respects those preferences without directing patients toward a particular option for end-of-life care; (C) the importance of fully informing patients about the benefits and risks of an immediately effective MOLST; (D)
awareness of factors that may affect the use of MOLST, including, but not limited to, advanced health care directives, race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness and geographic area of residence; and (E) procedures for properly completing and effectuating MOLST.

**District of Columbia**

*(PAD)*


- Establishes process by which competent, terminally ill (6 month prognosis) adult resident of DC can obtain a physician’s prescription to end their life, based upon an informed and voluntary decision.
- Requires confirmation that the individual is not suffering from psychiatric or psychological condition causing impaired judgment.
- Requires (1) an initial oral request, followed by (2) a written request on an approved form witnessed by 2 qualified witnesses, and then (3) a 2nd oral request (no sooner than 15 days after the first).
- Provides for counseling of patients including the importance of family notification.
- Authorizes dispensing the prescription either directly to the patient by physician, or through a pharmacy. Both have reporting requirements to the department of public health.
- Defines its effect on contracts, wills, insurance and annuity policies and requires that they not be conditioned upon or affected by the making or rescinding of a request for medication or by a patient ingesting covered medication.
- Establishes terms for immunity from criminal and civil liabilities.
- Establishes penalties and provides an opt-out provision for health care providers.
- Provides for claims by the government against the individual’s estate if costs are incurred from a patient terminating his or her life pursuant to the legislation in a public place.

**Idaho**

*(AD)*


- Revises provisions regarding revocation of an advance directive. Adds that an advanced directive may be revoked by any other action that clearly manifests the maker’s intent to revoke the advance directive. Provides the maker of the revoked living will and durable power of attorney for health care advance directive is responsible for notifying his health care provider of the revocation. A health care provider who does not have actual knowledge of the revocation is entitled to rely on an otherwise apparently valid advance directive as though it had not been revoked.
- Revises provisions regarding suspension of an advance directive. Provides that a suspension may be accomplished by any other action that clearly manifests the maker’s intent to suspend the advance directive. Provides that a health care provider who does not have actual knowledge of the suspension is entitled to rely on an otherwise apparently valid advance directive as though it had not been suspended.
- Revises provisions regarding presumed consent to resuscitation. Provides that there is a presumption in favor of consent to CPR unless: (a) CPR is contrary to the person’s advance directive and/or POST; (b) The person’s surrogate decision-maker has communicated the person’s unconditional wishes not to receive CPR; (c) The person’s surrogate decision-maker has communicated the person’s conditional wishes not to receive CPR and those conditions have been met; (d) The person has a proper POST identification device; or (e) The attending health care provider has executed a DNR order consistent with the person’s prior expressed wishes or the
directives of the legally authorized surrogate decision-maker.

**Maryland – AD, Registry**


- Provides an important patient’s rights clarification that, “Notwithstanding any other provision of law, in the absence of a validly executed or witnessed advance directive, any authentic expression made by an individual while competent of the individual’s wishes regarding health care for the individual shall be considered.”

- The Act provides a repeal and restructuring of the Maryland Advance Directive Registry system.

- To facilitate the use of cloud-based technology for electronic advance directives, the Department of Health and Mental Hygiene (Department) is required to contract with an electronic advance directives service to connect with health care providers at the point of care through the State-designated health information exchange. The electronic advance directives service must be approved by the Maryland Health Care Commission and the Department and meet the technology, security, and privacy standards set by the Maryland Health Care Commission. Also see 2017 enactment below: 2017 Maryland Laws Ch. 667 (H.B. 188).

- Allows the State-designated health information exchange to accept as valid an unwitnessed electronic advance directive in the form of a video record or file if the video record or file is dated and stored in an electronic file by an electronic advance directives service recognized by the Maryland Health Care Commission.

- Requires the Maryland Health Care Commission to develop criteria for recognizing electronic advance directives services that are authorized to connect to the State-designated health information exchange. The State-designated health information exchange must ensure that electronic advance directives services do not have access to information stored on the State-designated health information exchange.

- Requires the information sheet on advance directives (that the Department produces under
current law) to also include information to:
(i) Educate the public on the use of electronic
advance directives; (ii) Encourage the use of
electronic advance directives; (iii) Provide
information about developing an electronic
advance directive; (iv) Describe how electronic
advance directives are made available at the
point of care; (v) Indicate that the use of an
electronic advance directive is not required;
and (vi) Indicate that individuals do not have
to pay to have their electronic advance direc-
tives honored.

• Requires the State-designated health informa-
tion exchange to include the advance directive
information sheet in the exchange's consumer
publications, on its website, and to provide it
at the request of an applicant.

• The Department is also required to:
(1) Encourage the use of electronic advance
directives; (2) Carry out appropriate
educational and outreach efforts to increase
public awareness of electronic advance
directives; and (3) Encourage the following
persons and entities to engage in outreach
efforts regarding electronic advance directives:
  o The Maryland Department of Aging;
  o County ombudspersons;
  o Local health departments;
  o Senior living facilities;
  o Academic institutions;
  o Religious organizations;
  o Hospitals; and
  o Other similar persons or entities.

Maryland
(AD)
2017 Maryland Laws Ch. 657 (H.B. 498). Approved
amending the Health Care Decisions Act - Advance
Directives and Surrogate Decision Making -
Disqualified Individuals.

• Disqualifies individuals from acting as health
care agents if (1) they are the subject of any
protective order for which the declarant is a
subject of relief under that order, or (2) they
are the spouse of the declarant and there is an
executed separation agreement or a filed ap-
lication for divorce (unless the declarant has indicated otherwise).

(AD)
2017 Maryland Laws Ch. 667 (H.B. 188). Approved
amending the Health Care Decisions Act relating to
electronic advanced directives.

• Provides that a witness is not required for an
electronic advance directive if the declarant's
identity has been authenticated in accordance
with guidelines specified by the National Insti-
tute of Standards and Technology.

• Provides that an individual shall submit an
electronic advance directive that is not wit-
tnessed to an electronic advance directives ser-
vice that is recognized by the Maryland Health
Care Commission.

Missouri
(Registry)
2017 Mo. Legis. Serv. S.B. 50 (VERNON'S) (West's
No. 40) and S.B. 501 (VERNON'S) (West's No. 51).
Approved July 10 and 14, 2017. Effective August
28, 2017. Authorizes a state “Advance Health Care
Directives Registry” to be created by contract with a
third party.

• Any document and any revocation of a docu-
ment submitted for filing in the registry must
be submitted electronically at an intake point
(defined as any licensed health care provider
or licensed attorney) and signed electroni-
cally with a unique identifier, such as a social
security number, a driver's license number, or
another unique government-issued identifier.
Submission requires a fee not to exceed ten
dollars.

• The Department of Health and Senior Services
is authorized to promulgate regulations
regarding access and other matters.

Montana
(DS)
2017 Montana Laws Ch. 285 (S.B. 92). Approved and effective May 4, 2017. An act allowing for appointment of proxy decision-makers for adult patients who lack decisional capacity related to medical treatment and have no appointed or otherwise authorized decision-maker.

- Requires the provider to make reasonable efforts to locate and notify as many interested persons as practicable to inform them of the patient's incapacity and ask that a lay proxy decision-maker be selected for the patient.

- “Interested persons” are defined as: (a) spouse; (b) parent; (c) adult child, sibling, or grandchild; or (d) close friend.

- Interested persons who are informed of the patient's lack of decisional capacity must make reasonable efforts to reach a consensus as to who among them will make medical treatment decisions on behalf of the patient.

- An attending physician may designate another physician or advance practice nurse to make health care treatment decisions as a patient's proxy decision-maker if:
  - no interested person is willing or available to serve as proxy decision-maker;
  - the lack of decisional capacity has been confirmed by a 2nd health care provider;
  - a medical ethics committee approves the designation;
  - the designated proxy is documented in the medical record.

- Specifies decision-making criteria and procedures, including ethics committee concurrence and second consulting physician concurrence for certain decisions.

Nevada (AD)

2017 Nevada Laws Ch. 154 (S.B. 50). Approved and effective May 26, 2017. An Act establishing a procedure for a person to execute an advance directive for psychiatric care to direct any provider of health care on how he or she wishes psychiatric care to be provided if he or she is incapable of making decisions concerning such care or communicating such decisions. (Appointment of a agent is already available under the existing statute).

- “Psychiatric care” is defined as “the provision of psychiatric services and psychiatric treatment and the administration of psychotropic medication.”

- Provides a sample form that may be used by a person wishing to execute an advance directive for psychiatric care.

- The directive must be signed by the principal, or another at the principal's direction, and attested by two witnesses. Neither of the witnesses may be:
  - The attending physician or provider of health care;
  - An employee of the attending physician or provider of health care;
  - An owner or operator of a medical facility in which the principal is a patient or resident or an employer of such an owner or operator; or
  - A person appointed as an attorney-in-fact by the advance directive.

- The directive becomes effective upon execution and remains valid for a period of 2 years after the date of its execution unless revoked.

- Implementation requires a finding by the principal's attending physician or a licensed psychologist and by another physician, a physician assistant, a licensed psychologist, psychiatrist, or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing that the principal's ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that s/he lacks the capacity to refuse or consent to psychiatric care.

- Provides that an advance directive for psychiatric care validly executed pursuant to the laws of another state is valid in this State.

- Outlines the circumstances under which a physician or other provider of health care may decline to comply with an advance directive.
for psychiatric care and in such cases requires the provider to “take all reasonable steps as promptly as practicable to transfer the psychiatric care of the principal to another physician or provider of health care.”

- Includes immunity provisions and the opportunity to register such an advance directive with the Secretary of State for deposit in the Registry of Advance Directives for Health Care.

**Nevada**

(POLST, DS)

2017 Nevada Laws Ch. 104 (A.B. 199). Approved May 24, 2017. Effective July 1, 2017. Amends the state’s Physician Orders for Life-Sustaining Treatment law to:

- Authorize physician assistants or advanced practice registered nurses to make certain determinations related to a POLST and to sign it.

- Changes the name of the form from “Physician Orders…” to “Provider Orders for Life-sustaining Treatment.”

- Provides for consent to POLST forms by default surrogates in a priority order similar to the existing default surrogate provision in the state’s living will statute (§449.626) but adds close friend to the list of surrogates as follows:
  - Spouse
  - Adult child
  - Parent
  - Adult sibling
  - Nearest adult relative
  - “An adult who has exhibited special care or concern for the patient, is familiar with the values of the patient and willing and able to make health care decisions for the patient.”

- Amend existing provisions regarding certain conflicts between a POLST form and DNR identification bracelets by requiring the health care provider to honor a POLST form ordering the provision of life-resuscitating treatment if the POLST form is executed after a DNR identification was issued to the patient.

**2017 Nevada Laws Ch. 318 (S.B. 227).** Approved June 2, 2017. Effective January 1, 2018. Authorizes an advanced practice registered nurse to sign medical orders, certifications, and verifications that require physician signature, if he or she is qualified to do so; and requires the State Board of Nursing to adopt regulations specifically providing for when an advanced practice registered nurse is qualified to provide his or her signature. The provision affects multiple situations from certification of death or disability and competency to stand trial, to certification of terminal condition and decisional incapacity for purposes of implementing an advance directive and signing of Physician Orders for Life-Sustaining Treatment.

**North Dakota**

(AD)

2017 North Dakota Laws Ch. 189 (S.B. 2151). Approved April 4, 2017. Effective August 1, 2017. Minimally edited the optional health care directive form to replace “doctor(s)” with “health care provider(s).” Edited the making an anatomical gift section by providing an “opt-out” section.

**Oregon**

(AD)


- Specifies case manager’s duties if they receive notice that person for whom case manager provides services will have life-sustaining procedures withheld or withdrawn.

- A case manager shall provide any information in the case manager’s possession that is related to the principal’s values, beliefs and preferences with respect to the withholding or withdrawing of life-sustaining procedures.

**Pennsylvania**

(AD)

• Expands the range of decisions over which an
agent under a health care power of attorney
has authority by adding to the definition of
“health care decision” at § 5422:
  o Admission to a medical, nursing,
residential or similar facility, or
entering into agreements for the
individual’s care.
  o Making anatomical gifts, or after the
death of the individual, disposing of the
remains or consenting to autopsies.
• Clarifies that a health care power of attorney
cannot be revoked by a guardian of the person
unless the court authorizes the guardian to
revoke.

**Texas**

(AD)

2017 Tex. Sess. Law Serv. Ch. 995 (H.B. 995)
(VERNON’S). Approved June 15, 2017. Effective
January 1, 2018. An Act relating to the form and
revocation of medical powers of attorney.

• Expands the revocation by “divorce” provision
of the medical power of attorney to include
revocation if the agent’s marriage to the
principal is “dissolved, annulled, or declared
void.” Existing law that allows the principal
to provide otherwise in the medical power of
attorney remains unchanged.
• Moves the separate mandatory Disclosure
Statement that the principal was required
to sign into the statutory medical power
of attorney form itself, so that a separate
signature is not needed.

**Vermont**

(DS, DNR, POLST)

2016 Vermont Laws No. 136 (S. 62). Approved
a “surrogate” (interested persons) to make decisions
about DNR orders and Clinician Orders for Life-
Sustaining Treatment” (DNR/COLST) when the
patient lacks decisional capacity and there is no
authorized guardian or appointed agent. COLST is
Vermont’s version of POLST.

• “Interested individual” is defined as:
  (A) the principal’s or patient’s spouse, adult
child, parent, adult sibling, adult grandchild,
or clergy person; or
  (B) any adult who has exhibited special care
and concern for the principal or patient and
who is personally familiar with the principal’s
or patient’s values.
• A surrogate can be designated by the patient
by personally informing the patient’s clinician
who must document the designation in the
medical record.
• If the patient cannot designate a surrogate,
then the patient’s clinician must make a rea-
sonable attempt to notify all reasonably avail-
able interested individuals of the need for a
surrogate to make a decision regarding DNR/
COLST. The group of interested individuals
must agree on who will act as surrogate.
• The surrogate must be willing to provide or
withhold informed consent for a DNR/COLST
order for the patient in accordance with the
patient’s wishes and values, if known; and will-
ing and available to consult with the patient’s
clinician
• If the interested individuals are unable to agree
on the designation of a surrogate, an interested
person may file a petition for guardianship.
• A surrogate cannot act if the patient objects,
“even if the patient lacks capacity.”

**Virginia**

(DNR, POLST)

2017 Virginia Laws Ch. 179 (H.B. 2153). Approved
February 23, 2017. Effective July 1, 2017. An Act
to amend and reenact § 54.1-2987.1 of the Code
of Virginia, relating to Durable Do Not Resuscitate
Orders and Reciprocity.

• Added a new provision that provides a Durable
Do Not Resuscitate Order or other order
regarding life-prolonging procedures executed
in accordance with the laws of another state
in which such order was executed shall
be deemed to be valid and given effect as
provided in this article.

- Defines “qualified advance directive facilitator” as a person who has successfully completed a training program approved by the Department of Health for providing assistance in completing and executing a written advance directive.
- Establishes requirements for training programs for qualified advance directive facilitators.
- Provides that distribution of a form for an advance directive that meets the requirements of § 54.1-2984 (“Suggested Form of Written Advance Directives”) and the provision of ministerial assistance to a person regarding the completion or execution of such form shall not constitute the unauthorized practice of law.

ABA House of Delegates Approves Resolution on Representative Payee Safeguards

Last week the ABA passed Resolution 104, which urges Congress and the Social Security Administration to strengthen the safeguards and protections for all individuals receiving benefits via the representative payee program, including, but not limited to, appropriate eligibility determinations, improved monitoring and training of payees, access to accounting for beneficiaries, and the appointment of an interim payee when a payee is removed.

The [resolution](https://shop.americanbar.org/eBus/publications.aspx), which was introduced by the Commission on Law and Aging, expands the ability of the ABA to comment on the representative payee program. The Commission on Law and Aging looks forward to the opportunity to work on matters pertaining to this program, which affects the income of millions of elderly individuals and people with disabilities.

In the ABA Store


Healthcare decisions cover more than just living wills. National Healthcare Decisions Day educates people across the U.S. on the value of advance healthcare planning. Its goal is to demystify healthcare decision-making through a 50-state annual initiative.

On Healthcare Decisions Day stakeholders throughout the nation organize events that provide clear, concise, and consistent information on healthcare decision-making to both the public and providers/facilities. The emphasis is to make simple, free, and uniform tools (not just forms) to guide the process available to all.
Come Meet Us at the 2018 Aging in America Conference!

Members of the Commission on Law and Aging’s staff will be presenting at the Aging in America Conference. The Conference, which will be held from March 26-29 in San Francisco, CA, annually attracts almost 3,000 professionals in the field of aging issues.

The Aging in America Conference features a multi-disciplinary approach that covers the full spectrum of legal, health and social issues associated with aging.

Topics include:
- Elder Mistreatment and Elder Justice
- Diversity and Cultures of Aging
- Age-Friendly Communities
- Brain Health Across the Spectrum
- Policy and Advocacy
- Technology and Aging
- Managed Care
- Caregiving
- Health and Wellness
- Lifelong Learning and Engagement
- Mental Health
- Religion, Spirituality and Meaning

Because it is not narrowly focused on a single discipline, the Aging in America Conference gives participants opportunities to broaden their knowledge of aging issues, to network with a wide range of professionals, and to gain new perspectives that will enable them to better serve their clients.

Visit www.asaging.org/aia to learn more. To contact ASA directly to request a conference brochure, call 1-800-537-9728 or email jutkam@asaging.org.

Xiaomeng Zong, the Commission’s 2018 Intern

Few of our interns have brought as wide a range of international legal experience to the Commission as Xiaomeng Zong. She has broad academic training and work experience in the legal systems of the U.S. and the People’s Republic of China. Xiaomeng is a native speaker of Mandarin who speaks and writes English fluently.

She is currently enrolled in Georgetown University’s Master of Laws program and expects to graduate in May 2018. Prior to registering at Georgetown Law, she received a Bachelor of Laws Degree from Nanjing University in China. She graduated in the top 5% of her class and received numerous scholarships and awards. She also was an exchange student at the University of California, Berkeley, and she received a thorough grounding in the legal aspects of securities, exchanges and corporations as an intern in the Nanjing office of Dentons, a multinational law firm.

The realization that China, like the U.S., faces the challenges of an aging population sparked Xiaomeng interest in working at the Commission on Law & Aging.
National Law Day, 2018

Law Day is held on May 1st every year to celebrate the role of law in our society and to cultivate a deeper understanding of the legal profession.

About the 2018 Law Day Theme: Separation of Powers: Framework for Freedom

The U.S. Constitution sets out a system of government with distinct and independent branches—Congress, the Presidency, and a Supreme Court. It also defines legislative, executive, and judicial powers and outlines how they interact. These three separate branches share power, and each branch serves as a check on the power of the others.

“Ambition must be made to counteract ambition,” James Madison explained in Federalist 51. Why? Madison believed that the Constitution’s principles of separation of powers and checks and balances preserve political liberty. They provide a framework for freedom. Yet, this framework is not self-executing. We the people must continually act to ensure that our constitutional democracy endures, preserving our liberties and advancing our rights.

The Law Day 2018 theme enables us to reflect on the separation of powers as fundamental to our constitutional purpose and to consider how our governmental system is working for ourselves and our posterity. Law Day often has an Elder Law component. In some communities, the bar association, agencies on aging and other partners have collaborated to plan presentations by lawyers on the legal rights of older persons.

To learn more about Law Day and to view a video of ABA President Hilarie Bass's Law Day 2018 Message, visit the ABA website [https://www.americanbar.org/groups/public_education/initiatives_awards/law-day.html]

Join the ABA and enjoy discounted dues!

Discounted Dues

Some lawyers qualify for discounted dues based on practice setting, employment status or years of practice.

ABA offers a discounted dues rate to judges or licensed U.S. attorneys who work as lawyers in a government or legal/public service organization. To learn more, visit our membership site.

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Our mission is to serve as the collaborative, interdisciplinary leader of the American Bar Association’s efforts 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
- Develop policy
- Provide technical Assistance
- Foster better access to legal services
- Educate lawyers, other eldercare professionals and the public

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