



# Journal of Geriatric Care Management

VOLUME 23  
ISSUE 1  
SPRING  
2013

Published by the  
National  
Association of  
Professional  
Geriatric Care  
Managers

3275 West Ina Road  
Suite 130

Tucson, Arizona  
85741

520.881.8008 / phone

520.325.7925 / fax

[www.caremanager.org](http://www.caremanager.org)

## Legal Issues in Geriatric Care Management

Guest Editor's Message .....2  
*Emily Reese, MA, CMC, CDP*

Spousal Protection Trusts = Living Choices + Protection-In-Case-  
of-Emergency Trusts .....3  
*Renée C. Lovelace, MBA, JD, CELA and Leah Cohen, LCSW, ACSW, TxG, CCM, NG, CHCQM*

On Competency and Capacity of Older Adults to Make Decisions .....8  
*Donald Freedman, JD*

So the Neighbors are Nosy and the Friends are Pushy, What Does  
That Mean for the Geriatric Care Manager?.....12  
*Lance M. McKinney, JD, CELA*

Mars, Venus, and Multi-Disciplinary Rules of Ethics .....15  
*Rachel A. Kabb-Effron, JD, CELA*

# Guest Editor's Message

*Emily Reese, MA, CMC, CDP*

This edition of the *GCM Journal* explores client legal issues which are woven into the care management process. From the first phone call questioning whether the caller has legal authority to act on behalf of prospective client, to assessment, questioning what advance directives are in place, through client's diminishing capacity, a GCM is often proacting and reacting to legal concerns. We may view law as a set of rules on which we expect to provide clarification, guidance, direction, or parameters in complex situations, but sometimes we are surprised to find the "law" is another layer in the complexity of a case.

Renee Lovelace, MBA, JD, CELA, of The Lovelace Law Firm, P.C. and Leah Cohen, LCSW, ACSW, TxG, CCM, NG, CHCQM, founder of arrangeCARE, Inc., Austin, Texas,

provide in "Spousal Protection Trusts=Living Choices + Protection-In-Case-of-Emergency Trusts" a planning tool that GCMs can add to their repertoire of resources for clients. The article provides the framework and benefits of such trusts with considerations for the GCM who will be involved.

Donald Freedman, JD, a founding partner of Rosenberg, Freedman & Lee LLP, of Newton, Massachusetts, provides an insightful look into the issues of autonomy and capacity in his article "On Competency and Capacity of Older Clients to Make Decisions." The article delves into the perspective of the capacity spectrum relative to the weight of a decision with a common sense approach to supporting the autonomy of an elder client.

Lance McKinney, JD, CELA, of Osterhout & McKinney, P.A., Fort

Myers, Florida, illustrates with two case studies the other side of the coin when there is lack of capacity and the unexpected challenges that can arise for legally designated decision-makers in his article, "So the neighbors are nosy and the friends are pushy, what does that mean for the geriatric care manager?" The article illustrates an instrumental role the GCM can provide in these conflicts that may not be readily apparent to those involved.

Rachel Kabb-Effron, JD, CELA, of The Kabb Law Firm, Beachwood, Ohio, provides a light-hearted delivery of a difficult topic – competing ethics in a new paradigm of Elder Law called "Life Care Planning." In her article, "Mars, Venus, and Multi-Disciplinary Rules of Ethics," she sheds some light on navigating ethical "clashes" for the GCM employed inside a Law Firm or working with a Law Firm on behalf of a client.



# Journal of Geriatric Care Management

Published by the:

**National Association of Professional Geriatric Care Managers**

3275 West Ina Road, Suite 130, Tucson, Arizona 85741 • [www.caremanager.org](http://www.caremanager.org)

© Copyright 2013

The *Journal of Geriatric Care Management* is published two times per year as a membership benefit to members of the National Association of Professional Geriatric Care Managers. Non-members may subscribe to *Journal of Geriatric Care Management* for \$95.00 per year. Send a check for your one-year subscription to: Subscription Department, NAPGCM, 3275 West Ina Road, Suite 130, Tucson, Arizona 85741.

## EDITORIAL BOARD

**Rona Bartelstone, LCSW, CMC, C-ASWCM**  
*Fort Lauderdale, FL*

**Phyllis Menseh Brostoff, CISW, CMC**  
*Milwaukee, WI*

**Cathy Cress, MSW**  
*Santa Cruz, CA*

**Lenard W. Kaye, PhD**  
*Orono, ME*

**Karen Knutson, MSN, MBA, RN**  
*Bryn Mawr, PA*

**Betty Landreaux, MSSA, LCSW, CMC, NCG**  
*Metairie, LA*

**Emily Saltz, MSW, LICSW, CMC**  
*Newton, MA*

**Jennifer Pilcher Warren, MS, PhD, CMC**  
*Lincoln, MA*

**Monika White, PhD**  
*Santa Monica, CA*

## EDITOR-IN-CHIEF

**Suzanne Modigliani, LICSW, CMC**  
*Brookline, MA*

## GRAPHIC DESIGN

**HagerDesigns**  
*Dallas, Texas*

# Spousal Protection Trusts = Living Choices + Protection-In-Case-of-Emergency Trusts

*Renée C. Lovelace, MBA, JD, CELA and Leah Cohen, LCSW, ACSW, TxG, CCM, NG, CHCQM*

*Mr. and Mrs. Brown have been married for 57 years. They lived together in their long-time family home until last year, when a botched back surgery landed Mrs. Brown in a nursing home. It has been devastating for both of them. Mr. Brown visits his wife every day. He plans to be there every day in the future as well, so long as it is possible for him to get there.*

*Mr. Brown worries about what would happen if he dies before his wife. Who would be Mrs. Brown's daily companion, care monitor, and advocate? The kids would visit (at least son, James would; the others, he is not so sure), but no one has the time to be a companion and to live daily life with her.*

*Mr. Brown has visited with a care manager about services that would help them, but has not yet hired someone to help them plan and carry out their plans.*

*Mr. and Mrs. Brown saved for retirement all their lives. They believed they had a nice "nest egg" to supplement Social Security and retirement checks. But their savings were no match for the cost of nursing home care. With Mr. Brown keeping what the law allows, they have depleted their other resources on Mrs. Brown's care costs, with Mrs. Brown then qualifying for Medicaid. Mr. Brown's attorney has told him that he should prepare a new will, leaving his property to his children rather than to Mrs. Brown, so that if he dies first, Mrs. Brown will not lose Medicaid eligibility by inheriting property that is now in his name.*

*That does not sit right with Mr. Brown. He wants their money used*

***Across the country, thousands of couples deplete their resources and depend upon Medicaid to pay medical and support costs at the end of their lives. This is a long-time and ongoing national problem intertwined with complex medical, financial, and public policy conundrums.***

*for Mrs. Brown's comfort and care, not for new cars for the grandkids, even though he and Mrs. Brown love them dearly. He is looking for better options that will protect Mrs. Brown if he dies before her.*

**A**cross the country, thousands of couples deplete their resources and depend upon Medicaid to pay medical and support costs at the end of their lives. This is a long-time and ongoing national problem intertwined with complex medical, financial, and public policy conundrums.

For each individual who is alone in a nursing home, however, the problem is tragically personal. Nursing home residents who are impoverished and without frequent visitors often face loneliness and neglect during a time of life when they treasure companionship and concern. Some residents have no visitors at all or may have in-and-out visits so brief and cool that they feel worse than no visits, serving only to remind individuals that they are no longer part

of their communities. Even nursing homes that provide high quality care may not provide some of the things that residents value most.

Although individuals experience profound grief over the loss of independent life when moving to a nursing home, individuals with spouses are more likely to have daily companionship and sometimes even a "new normal" with different but interesting events and/or routines that couples share. A companion spouse may not aggressively seek to manage care, but his or her daily presence often ensures that the nursing home spouse is not shortchanged on medical and care attention. While the visiting spouse does not provide basic care, he or she may provide services that make the difference between living and merely existing for the spouse in a nursing home.

Imagine the changes in a nursing home resident's life when a spouse dies before him or her. The nursing home spouse loses his or her primary advocate and companion at the same time life

*continued on page 4*

## Spousal Protection Trusts = Living Choices + Protection-In-Case-of-Emergency Trusts

*continued from page 3*

fills with grief. Sometimes children step in, but fill the void only a little. Even when children are active in a nursing home parent's life, becoming advocates for the parent, they rarely become companions. At the same time, the parent, sensitive to the demands faced by children who are taking care of their own families and jobs, may not ask for more attention or let them know when there is a problem.

Now, imagine for a minute that an experienced care manager could design a services plan to help fill some of the gaps left by the death of a nursing home resident's spouse. The care manager's fees could be paid by a trust that is permitted by federal law and that is not a disqualifying asset for Medicaid.

We are not talking about Medicaid loopholes here; also, we are not talking about someone shifting their personal costs to taxpayers by using legal tricks. The spousal protection trust, as permitted by federal law, may protect individuals who are otherwise at risk. Even where government assistance is not involved, spousal protection trusts may be essential when a caregiving spouse wants to ensure that the nursing home spouse receives superior care.

In the remaining portion of this article, we briefly address:

- What is a spousal protection trust?
- Possible benefits
- Federal law permitting such trusts
- How the trusts work
- Key factors and circumstances
- Why these trusts are not used more often
- What can go wrong and derail the benefits
- Working with other special needs trusts and plans
- Essential care management

strategies

## What Is a Spousal Protection Trust?

Attorneys often provide nicknames for trusts used for various purposes. One would think there were hundreds of different types of trusts, given the wide variety of trust names. In this article, what we refer to as a "spousal protection trust" is similar to a trust that has commonly been used for tax purposes over the years and which may be referred to as an "A-B" trust plan, a "bypass trust," an "exemption equivalent trust," or any of a number of other names. The basic plan is this: rather than leaving assets outright to the surviving spouse, the first spouse to die leaves his or her assets in a trust for the surviving spouse.

The intention of this article is not to address estate taxes, which may be of little concern to most individuals<sup>1</sup>. Rather, the goal is to point out that the legal structure with a spousal protection trust is similar to the more common tax-based trust structure, and thus it may be confusing to those (including some attorneys) who are telling spouses that they no longer need trusts for each other due to changes in the tax laws. With a spousal protection trust, the trust terms emphasize living choices and care—not tax savings<sup>2</sup>.

In addition to protecting choices and care, so long as the trust complies with federal and state laws and regulations, a spousal protection trust may be exempt from counting as a disqualifying asset for purposes of Medicaid eligibility.

## Possible Benefits

The owner of property (the trust grantor) decides on the terms and provisions of a trust. Thus the grantor may state in a trust that the grantor wants trust property used for non-support purposes such as hiring care managers and others who will enrich the spouse's life. It will make a world of difference in a nursing home resident's life to have funds for advocates, companions, social activities, and other goods and

services not covered by basic medical and support programs. Years ago, an attorney in Virginia proposed that we could think of a trust designed to protect care and enjoyment as a "daughter-in-case-of-emergency" trust<sup>3</sup>. While no one could replace a devoted spouse, having a trust that makes distributions to enrich one's life will come closer than having no such trust in place, especially for spouses with modest resources.

## Federal Law Permitting the Trusts

In 1993, Congress adopted the Omnibus Budget Reconciliation Act, which attorneys frequently refer to as "OBRA 93." That was the famous law that closed many of the Medicaid eligibility "loopholes" for those who would set aside their own funds while seeking to qualify for Medicaid. However, OBRA '93 specifically acknowledged that trusts created for one's spouse by will are not automatically included with trusts that disqualify individuals for Medicaid<sup>4</sup>. Key statutory provisions include:

(1) An individual usually cannot transfer his or her own assets to trusts and qualify for Medicaid<sup>5</sup>.

(2) Medicaid rules define an individual's "assets" as "all income and resources of the individual and of the individual's spouse. . ."<sup>6</sup>

(3) Medicaid generally treats trusts created by an individual or that individual's spouse for such individual's own benefit as a countable resource (and hence potentially disqualifying for Medicaid) if the trust is established by the individual's spouse "other than by will."<sup>7</sup>

While the spousal protection trust option bears further examination in many cases, it is useful to keep in mind that many legal strategies are more complex than they should be in a reasonably fair world. Using reasonable and protective strategies often requires that one navigate through a myriad of laws and rules with exceptions and exceptions to exceptions. In many states and situations, for example, the spousal protection trust is not funded "off the top" of the deceased spouse's estate.

*continued on page 5*

Instead, this trust may receive funding only after the deceased spouse's probate estate first satisfies certain creditor claims and the possible requirement that the surviving spouse elect to receive certain estate assets outright<sup>8</sup>. Further, there may be other approaches that offer greater levels of protection for some individuals and couples, which is why experienced elder law attorneys may be necessary in order to help create more effective plans.<sup>9</sup>

### How Spousal Protection Trusts Work

At the death of the first spouse, a probate will usually be necessary in order to fund a spousal protection trust. As noted above, property used to fund the trust must not be subject to a higher claim, such as the claims of certain creditors. In other words, the property needs to be unencumbered when passing to the trust. The executor or administrator of the first spouse's estate will establish the trust and the person or entity named as trustee will then administer the trust.

For trusts that are modest in size, it may be helpful to distribute the trust assets (of a trust created by will) to a sub-account in a pooled trust managed by a nonprofit organization.<sup>10</sup> Again, care managers may want to locate experienced elder law attorneys to help

clients design plans that consider the wide range of available options.

### Key Factors and Circumstances

Spousal protection trusts will not work in all situations. Spouses must have assets to fund the trust<sup>11</sup>, an attorney who understands the state laws and rules to draft the trust, a devoted and knowledgeable trustee to

administer the trust, a certified care manager to design and/or coordinate a care plan, and other advocates and providers of services. Many experienced trustees will develop trust distribution budgets using the care plans designed by independent care managers (who may not provide other services and therefore do not propose excessive services) in order to make the most of available trust funds. One trustee noted that using care managers gives trust beneficiaries "more bang for the buck."

Spousal protection trusts may be an ideal supplement to long-term care insurance that pays basic food and shelter costs, but which will often provide no extra funds for care management or caregivers.

### Why These Trusts Are Not Used More Often

Oddly, the spousal protection trust option has been clearly set out in federal Medicaid statutes as an available option for 20 years. Hurdles include the complexity of the option and a general dearth of awareness of

to save estate taxes. When the attorney explains that the trust's purpose is to protect living choices and long-term care options, the confusion will continue if other advisors have never heard of such a thing.

There is also a concern that any trust will potentially cause problems with Medicaid eligibility, even though federal law clearly states that a trust created for a spouse by will is not automatically a countable resource. As is so often the case, what one law giveth, another may take away. There will almost certainly be problems with Medicaid eligibility if the trust is not drafted in a manner that is accepted in one's state; for example, the surviving spouse serving as trustee leaves that spouse (who is now the trust beneficiary) in control of the funds, which will likely bring an otherwise non-countable trust back into countable territory. The state-to-state differences in laws have caused some attorneys to give up on presenting the trusts as an option to clients, especially those who are anticipating a state-to-state move.

Another blockade to using spousal protection trusts is the common, basic, pervasive, and ongoing lack of planning for incapacity among all of us who really do not want to picture ourselves aged and alone.

Ultimately, however, the primary "deal-breaker" for many clients is the fact that the spouse may not be able to serve as trustee of the trust, at least

not when otherwise eligible for and needing Medicaid. When clients hear about the requirement that someone else be trustee, they may not be interested in hearing about any of the advantages.

### What Can Go Wrong and Derail the Benefits

Shakespeare is noted as saying

*continued on page 6*

***There is also a concern that any trust will potentially cause problems with Medicaid eligibility, even though federal law clearly states that a trust created for a spouse by will is not automatically a countable resource. As is so often the case, what one law giveth, another may take away.***

this approach.<sup>12</sup> Thus clients rarely ask attorneys for these trusts and attorneys rarely offer clients these trusts as an option.

Even when attorneys have worked with clients who decide to use spousal protection trusts, some have reported receiving distressed calls from accountants, children, or other friends and/or advisors, pointing out that the client had "no need" for a spousal trust

## **Spousal Protection Trusts = Living Choices + Protection-In-Case-of-Emergency Trusts**

*continued from page 5*

“first kill all the lawyers.” While the intrusion of legalese into our lives is disturbing, trust drafting is not the time to say what one means without complying with technicalities. Finding the right attorney is a challenge; many attorneys refer to themselves as elder law attorneys when they do not know the Medicaid rules, just as many individuals refer to themselves as care managers although they are not certified and experienced.

In addition to developing a customized plan and having documents drafted to give effect to the plan, clients need to identify an experienced trustee to implement the plan. A trustee should be skilled and concerned. While individuals may automatically presume their children will be ideal trustees, they are often wrong. A child as trustee may make mistakes that result in costly disputes; even when a child serving as trustee does not make mistakes, other children may accuse a devoted caregiving child of errors in judgment, with the dispute diverting time and energy from the parent and harming the caregiver child as well.

Further, even where there is no dispute, the mechanics of trust administration will be time-consuming. A more protective option in many cases will be to use corporate trustees or nonprofit pooled trusts, with trusted family or friends serving as advisors and/or holding the power to change trustees.

## **Working with Other Special Needs Trusts and Plans**

Spousal protection trusts may work well with a variety of other trusts, especially for other family members with disabilities. For example, a trust for a nursing home spouse could, if funds remained at

the individual’s death, pour over to trusts for other family members with disabilities<sup>13</sup>.

There are many family situations where plans that include spousal protection trusts could turn cases from conflict to cooperation. Spouses often believe that a more expedient option is to give money to their children to use for a surviving parent’s benefit. However, transfers of property create penalties for Medicaid eligibility in some cases. More importantly, it is difficult to predict where money and other property will end up in families where there are long-standing conflicts, multi-generational care objectives, multiple marriages, behavioral health problems, late (or extra-late) onset of responsible adulthood for the children, children who have always relied upon a coming inheritance as their own retirement plans, etc. A coordinated plan will avoid some of the otherwise costly risks.

## **Essential Care Manager Strategies**

Certified and experienced care managers are uniquely situated to help couples make and implement decisions that will improve long-term care after a caregiver spouse has died. Spousal protection trusts will help care managers implement superior care plans.<sup>14</sup> In using a spousal protection trust effectively, care managers must be:

- #1 Advocates who help clients develop compassionate long-term care plans designed to provide what clients value
- #2 Sensitive to the fact that there are many options available to both customize and enrich the care of an individual who happens to reside in a residential long term care facility
- #3 Understanding of their client’s role within the client’s family
- #4 Able to educate others, including some family members, who may believe that individuals in care facilities are not capable of appreciating choices in their daily lives and therefore do not

need supplemental funds available for their benefit

- #5 Familiar with financial and legal strategies, including public benefits such as Medicare, Medicaid, and community programs
- #6 Savvy about estate planning that includes more than powers of attorney, medical directives, and wills; special needs trusts and spousal protection trusts may be essential components in multi-faceted and accountable long term care plans, even where clients have modest amounts of money
- #7 Comfortable addressing mental capacity when clients are considering complicated legal strategies
- #8 Flexible in creating customized, person-centered, and accountable care transition plans
- #9 Sensitive to managing expectations in multi-generational, high conflict, or multiple marriage cases where the spouses’ primary objective is protecting each other even when they love other family members and want to make provisions for them, if possible
- #10 Able to incorporate a vast array of relevant information into care plans
- #11 Adept at recognizing their own abilities as well as the skills and experience levels of other providers such as elder law attorneys, financial advisors, and trustees
- #12 Willing to insist upon respecting the client’s choices and values in planning for that client’s future and with that client’s property

## **Conclusion**

Including a spousal protection trust in planning is not a simple one-step option. Further, these trusts will not work in every case. There are, however, many situations where spousal protection trusts could be close to magical, making a world of difference in protecting a spouse otherwise left alone. The most important planning step is to consider the option. A process in which clients and planners consider more of the

*continued on page 7*

planning options available is likely to result in a customized care plan that replaces future loneliness with opportunities for companionship, care protection, and even enjoyment. As Pogo told us: “We are confronted with insurmountable opportunities.”

**Renée C. Lovelace, JD, MBA, CELA**, is an Austin, Texas attorney with a J.D. from the University of Texas and M.B.A. from the University of Chicago. She is Certified as an Elder Law Attorney by the National Elder Law Foundation as authorized by the American Bar Association, a member of the National Academy of Elder Law Attorneys (NAELA), an Emeritus Member of the Special Needs Alliance, and the 2011 recipient of the Theresa Award. *Texas Monthly* has named her as a Super Lawyer in elder law from 2007 through 2012.

**Leah Cohen, LCSW, ACSW, CCM, TxG, NG** is the founder and principal care manager with arrangeCARE, Inc., an Austin-based care management company. Leah brings over 30 years of experience to her cases, working with both families and professionals such as attorneys and trust officers to provide customized plans of care to individuals with disabilities across the lifespan. She received an Administration on Aging Fellowship and was a Chicago Community Trust Finalist. She serves as vice-chair of the Texas Guardianship Certification Board and is Treasurer of the South Central Chapter of the NAPGCM.

## References

1 Throughout most of 2012, the country watched as the federal estate tax exemption level teetered on the brink of slipping back down to one million dollars per person. Legislation adopted put the exemption level over five million dollars per person, removing federal estate tax concerns for all but the most wealthy Americans.

2 Spousal protection trusts need not cause the loss of tax exemptions, but tax considerations are beyond the scope of this article.

3 See “Using Trusts to Protect the Affluent Client in the Event of Incapacity”, *The ElderLaw Report*, Vol. 7, No. 6 (Jan 1996), page 1, by Janet L. Kuhn. An article by Ms. Kuhn that updates the 1996 article, and which looks at how some of these trusts have worked over the last 20 years, was recently published in the Dec. 2012 issue of *The ElderLaw Report*. The same strategies proposed by Ms. Kuhn for affluent clients work well for clients of modest means when a spousal protection trust is available.

4 See 42 U.S.C. § 1396p(d)(2)(A).

5 See 42 U.S.C. § 1396p(d)(1), (2), (3), and (4). For exceptions, see 42 U.S.C. § 1396p(d)(4).

6 See 42 U.S.C. § 1396p(h)(1).

7 See 42 U.S.C. § 1396p(d)(2). There are exceptions to many laws, as there are in this case.

8 Often called “widow’s election” laws, these laws vary from state to state.

9 There is a wide range of exemptions and strategies available to help individuals who are vulnerable and who have limited access to long-term care funds. Many of such exemptions and strategies are rarely discussed in general literature and are almost unknown even to experienced attorneys outside the elder law field, including exempt transfers (or estate recovery exemptions), depending on the specific facts, for children with disabilities, caregiver children, siblings with an equity interest in one’s home, spouses, etc. Most of these exemptions and strategies have technical requirements and, unfortunately, vary from state to state. Just as with care managers, the larger the knowledge base, skill set, and commitment the attorney brings to clients, the more useful a plan is likely to be.

10 Pooled trusts are generally thought of as trusts created pursuant to 42 U.S.C. § 1396p(d)(4)(C), but the provisions of that statute which could require that Medicaid be paid back from funds remaining at a beneficiary’s death (often called “payback” provisions) need not apply to spousal protection trusts. Some nonprofit organizations have pooled trusts created by one party for another (so-called “third-party” trusts) which do not require

a Medicaid payback. The goal in spousal protection trust cases could be to fund a third-party pooled trust sub-account using two steps: first, creating a trust by will, and, second, distributing trust assets to a pooled trust sub-account. For a discussion of such trusts and examples, see *Pooled Trust Options*, published by the National Plan Alliance and available at [www.NationalPlanAlliance.org](http://www.NationalPlanAlliance.org), or search the Internet using “pooled trust” and “third-party trusts,” or, for general information, search “pooled trust” with “WisPACT,” “Arc of Texas,” or “Centers for Special Needs Trust Administration.”

11 Attorneys will advise on funding steps; for example, even where property interests are substantial, there may be little available to fund a trust if asset ownership passes to a joint account holder or by beneficiary designation. In such cases, assets may need to be re-titled and/or new beneficiary designation forms completed so that property will pass to a trust.

12 Author Lovelace notes that Congress adopted OBRA ’93 the same year her youngest child was born. Over the years since 1993, that child has grown from babyhood to adulthood and is now a college engineering student. Over those same years, spousal care trusts as a care-focused option have languished and continue to be almost unknown outside of a relatively small contingent of elder law attorneys.

13 If Medicaid is involved, certain types of trusts require a “payback” to the State for Medicaid services. A spousal protection trust should not require a payback.

14 As noted earlier, there are chicken-and-egg problems that prevent spousal protection trusts from broader use, despite the potential benefits. Few people know about them, they are not always simple, individuals may not ask attorneys to consider the option, and attorneys may not know about or present the option. Should care managers be on the leading edge of a legal strategy? Care managers may become a dynamic factor in consideration of this strategy since care managers are in the trenches and deal daily with the negative consequences that individuals face when there are no funds for care coordination. One attorney advocate has noted: Who better than care managers to sound the alarm bell?

# On Competency and Capacity of Older Adults to Make Decisions

Donald Freedman, JD

## Summary

*Maintaining personal autonomy is important for most elders. We exercise autonomy through making decisions. For decisions to have personal or legal significance, however, the individual must have the capacity to decide. This article provides guidance to geriatric care managers working with elders whose capacity for decision-making is to some extent diminished by cognitive or emotional factors, in the making of informal determinations of capacity in the course of their work. It also suggests ways to enhance the capacity of persons with diminished capacity to participate in the decision-making process.*

**“People do not consist of memory alone. They have feeling, will, sensibility, moral being. It is here you may touch them, and see a profound change.”<sup>1</sup>**

Personal autonomy is a foundational American value, and making choices is the experience of autonomy, in matters every-day or life-defining. Whether expressed in the language of lawyers as informed consent, autonomy, and self-determination or in the language of human services professionals as a component of person-centered planning,<sup>2</sup> the right to make decisions about our lives, to exercise control — about where and how we live, with whom we form professional and personal relationships, what help we accept or reject from medical and social

services providers, how we spend our time and money — is held dear.

For a decision to have personal, legal, or ethical significance, however, the individual must have the capacity to decide. Capacity in this sense refers to the individual’s functional ability to understand the significance for himself of making a particular decision, with or without extra help. For the GCM to take a client decision as the basis for services or advocacy, he or she must be confident that the decision is the result of the client’s application of reason and discretion.

A word on terminology. Legal competency usually refers to the client’s status as either being or not being under guardianship by decree of a court. The terminology, and the distinction, is useful only to an extent. First consider the false negative cases. A person with a clinically diagnosed condition warranting guardianship may not be under guardianship for many reasons unrelated to capacity. Initiating the process requires volunteers to petition the court and to serve as guardian. The process is inherently adversarial, and there is concern about the impact of the process of appointment may have on the ongoing relationships of the people and agencies involved. Alternatives to guardianship, particularly in a durable power of attorney and health care proxy, coupled with present formal and informal supports, may be deemed adequate. The process is time consuming and costly.

Next, consider the false positives. Being under guardianship does not equate to incapacity to make a particular decision or type of decision. Plenary guardianship, where the person under guardianship retains no

area of autonomy in decision-making, is now the exception under the Uniform Probate Code and the laws of most states. Instead, the individual may be permitted to retain rights in areas where essential life interests are not at risk. Limited guardianship has become the norm. Formal guidance of the Massachusetts probate courts suggests that, in appropriate cases, the person under guardianship might nonetheless retain the right to determine her residence, to drive, to seek and obtain employment, to plan a schedule of daily activities, to choose home health providers, to choose a long-term care facility, and so forth.<sup>3</sup> A common formulation involves empowering the guardian to make decisions about medical treatment only. The extent of the guardian’s authority should be spelled out in the decree issued by the court, which are usually matters of public record.

In real life, the spectrum of capacity ranges from those whose capacity is taken for granted, to those altogether lacking in the capacity to make or communicate any decision of significance. Many reflected a capacity that is diminished to a degree, to the point where at least on initial reflection we lack confidence in the decision at hand. The confidence problem is compounded by the fact that deficiencies in capacity are often not global. The question is not, “is she competent?” but, “is she capable of making the particular decision to be presented to her?” Sign a health care proxy? Sign a durable power of attorney? Hire me as a care manager? Live independently at home? Admit herself to an assisted living facility? Drive a car? Transfer assets to another family member? Apply for

*continued on page 9*

government benefits? The same individual may be capable of making decisions autonomously in some domains, capable only with assistance in others, and incapable altogether in yet others. For example, an individual may be able to manage day to day with most requirements for daily living, but not have the ability to make meaningful decisions about his or her medical care. An individual may be incapable of making decisions on alternative treatments for cancer, but understand enough of what is involved to execute a health care proxy. So, in assessing capacity, we have to begin with a specification of the nature of the decision to be made, and then identifying and evaluating functional elements constituent to the capacity. Some examples follow.

Having a durable power of attorney may be critical in protecting the decision-making rights of the older client facing the risk of future incapacity to decide matters on her own. Therefore, the question of the client's capacity to make a durable power of attorney deserves special attention. It generally involves:

1. An understanding of the general nature of a durable power of attorney, which is to say, that it is a written legal document:
  - a. By which one person (the principal) names and authorizes another person (the attorney-in-fact) to perform certain legal and financial functions listed in the document on the principal's behalf.
  - b. In which the authority conferred continues notwithstanding the subsequent disability or incapacity of the principal.
  - c. In which the principal is free to revoke or modify the arrangement, including changing the person named, at any time.
  - d. Which terminates at death.
2. A general understanding of the individual's personal and financial circumstances.
3. A knowledge of the persons related to her by ties of family, personal friendship, or professional acquaint-

tance who would be the usual persons to be considered as attorney-in-fact.

Note that the functional capabilities required to sign a durable power of attorney do not include the capacity for the actual management of legal and financial affairs. An individual may well be incapable of the latter while capable of the former.

Similarly, having a health care proxy safeguards medical decision-making by allowing the selection of a trusted substitute decision-maker and providing guidance on treatment preferences. The standard of capacity to make a Health Care Proxy is also much lower than capacity to make medical decisions themselves. It is defined as requiring:

1. An understanding of the general nature of a Health Care Proxy, which is to say, that a HCP is a written legal document by which one person (the principal) names and authorizes another person or persons (the health care agent and any alternates) to make health care decisions on the principal's behalf, in the event that the principal becomes unable to make or communicate health care decisions for himself.
2. A knowledge and general appreciation of the persons related to him by ties of family, friendship, and professional acquaintance who would ordinarily be considered as health care agent.

This is a lesser standard than that involved in the making of a decision about medical treatment, or informed consent. Informed consent requires the capacity to appreciate one's current medical status, the likely course if the treatment is refused, and the risks, benefits, and uncertainties of alternative treatments.<sup>4</sup>

Determining capacity to self-admit to an assisted living facility or nursing home raises a host of complex issues. An admission agreement is a form of legal contract. Capacity to contract is not uniformly defined in state law, but generally involves consideration of whether the individual can appreciate the personal and finan-

cial significance of the basic mutual obligations involved in the admission. However, under the Americans with Disabilities Act, such facilities have a corresponding responsibility not to discriminate by refusing admission and deny services on the basis of incapacity. This obligation may arguably extend to proving accommodations consisting of special assistance to the applicant in the admissions process.<sup>5</sup>

The capacity to drive a car involves, aside from physical skills, complex decision-making on many levels, taking into account the rules of the road, road and traffic conditions, evasive maneuvering, short-term memory, attention, and processing speed.<sup>6</sup>

A formal assessment of capacity may be necessary in close, contested, or high-risk situations, but may involve cost, delay, confrontation, and embarrassment.<sup>7</sup> As a practical matter, dealings with older clients by professionals of all sorts – social workers, nurses, lawyers, accountants, financial planners, bank officers – must be informed by informal "field" assessments of capacity in the course of everyday interaction. This paper is intended to provide a basis for GCMs and other elder service professionals to do informed but informal assessments in the field.

What should we consider in thinking about a client's capacity? Consider his or her:

- Understanding of his role in the decision-making process; that is, that he has a choice.
- Possessing the requisite basic cognitive skills to receive, store, recall, and process information necessary for meaningful decision-making in the context at hand.
- Capacity to appreciate the likely results of a decision, as well as less-likely but possible results.
- Understanding of the implications of alternative courses of action for his objective future well-being, as well as his individual goals and values.

*continued on page 10*

## **On Competency and Capacity of Older Adults to Make Decisions**

*continued from page 9*

- Ability to weigh the advantages and disadvantages of alternative courses of action.
- Ability to maintain stable choices long enough for them to be effectively implemented.
- Capacity to formulate short-term and long-term objectives in relation to the matter at hand.
- Ability to distinguish between immediate and long-term needs, and to plan accordingly.
- Ability to remember and apply past experience to new situations.
- Capacity to recognize the general quality of personal relationships, e.g., in distinguishing between relatives, friends, strangers.
- Ability to communicate decisions effectively whether through nonverbal or verbal means.

Many of these functional capacities depend on cognitive

strengths that are in-born or at least persistent. They represent the “nature” of the “nature-nurture” formulation of the role of biology and environment on personal development, the “trait” of the “trait-state” formulation. However, in thinking about capacity, we must also take into account the mitigating or qualifying impact of transitory or remediable factors, especially those that we can affect in our design of the circumstances of the decision-making opportunity. An individual in familiar surroundings may be able to function adequately in decision-making, whereas the same individual, newly admitted to a hospital or nursing home, may be utterly confused. Capacity is not static, over the course of time or even the day – for many people, the difference in functioning between mid-morning and late-afternoon is substantial. If current functioning may be affected by fatigue or a recent stressful or unpleasant event, consider rescheduling. Consider the impact of untreated

mental illness, the side-effects of appropriately prescribed and administered medications, and the potential effects of medications that are inappropriately prescribed or unevenly administered. More broadly, consider individual differences in education, socio-economic background, life experiences, background knowledge, and cultural and ethnic traditions.<sup>8</sup> Plan to accommodate any physical constraints on vision, hearing, or communication.

By recognizing and dealing flexibly and creatively with such mitigating factors in the planning and execution of the decision opportunity at hand, the individual’s capacity can be effectively enhanced. At the same time, we will be addressing our legal responsibility to take affirmative steps to facilitate participation -- to make, in the terms of the Americans with Disabilities Act, “reasonable accommodations” to the individual’s areas of incapacity.

Don’t equate compliance with capacity. Passive compliance may or may not reflect consent or agreement. While we are naturally more concerned about the client whose incapacity is backed up by oppositional behavior, the incapacitated client who is passively compliant is really no less at risk of our overreaching and infringing on personal rights.

Don’t assume that the person designated under a power of attorney or health care proxy has the authority to

### **NATIONAL ACADEMY OF CERTIFIED CARE MANAGERS**

*Striving to certify knowledgeable, qualified,  
ethical professional care managers*

***Come grow with us .... earn your CMC !***

- Go to [www.NACCM.net](http://www.NACCM.net) today to review the eligibility criteria
- Order your Candidate Handbook and Application online
- Complete the Application Forms and send to NACCM
- Fees can be paid via PayPal or sent with application

***Next exam window is October 1 – 31, 2013***

***Applications due no later than July 31, 2013***

***Have questions? Contact us at 800-962-2260***

***Or [naccm@snet.net](mailto:naccm@snet.net)***

***PO Box 170 Colchester, CT 06415-0170***



*continued on page 11*

make a particular decision in place of the principal. Powers may be limited by the instrument. More basically, a power of attorney or health care proxy is basically a designation of an agent or representative. Signing a power of attorney is not ordinarily the relinquishment of ultimate authority in the principal. In many states, the authority of the health care agent does not begin until a written determination is made by the attending physician that the individual lacks the capacity to make or communicate health care decisions.<sup>9</sup>

Don't equate bad decisions with incapacity. An older client's decision to remain at home rather than go into a nursing home may be unreasonable and impractical, but it is the client's decision to make if she understands the decision and its possible consequences.

Don't underestimate capacity based solely on advanced age or diagnosis, including that of Alzheimer's Disease or mental illness. Despite the presence of a condition impacting memory or concentration, the individual may yet have the residual functional capacity to make meaningful decisions affecting his life, and to communicate them if not verbally, then by expression, motion, and emotion.

Do not overestimate the impact of expectations. Treatment with dignity enhances self-respect and confidence, enhancing participation in decision-making. Not treating the client as the responsible decision-maker assures that he won't be.

As a practical matter, take the nature and degree of risk involved in the decision into account in assessing capacity. The greater the risk, the greater the care that is warranted. We certainly do this in the context of informed consent, differentiating between low-risk preventative care and high-risk surgery. The case might similarly be made that greater care is warranted the farther the decision strays from substantive fairness and reasonableness, or the more inconsistent the decision with

the individual's known long-term commitments and values.

Ultimately, your legal and ethical responsibility is to assist the client to appreciate the objective and subjective factors weighing on a given decision, and to assist the client to participate in the process as meaningfully as possible.

*An attorney in practice for 39 years, Donald Freedman is a founding partner of Rosenberg, Freedman & Lee LLP, of Newton, MA, where he concentrates his practice in elder law, work- and entitlement-related legal problems of adults with disabilities, special estate planning for families with children with disabilities and other special needs, and advising trustees, guardians and other fiduciaries on most appropriately meeting their responsibilities. He has served as board chair of the Massachusetts Alzheimer's Association and a member of the Massachusetts Governor's Commission on Mental Retardation. He is co-editor of the three-volume treatise, Estate Planning for the Aging or Incapacitated Client in Massachusetts. In January 2009, he was chosen by Massachusetts Continuing Legal Education, Inc. as a recipient of its Scholar-Mentor Award for "outstanding contributions to legal education."*

## References

1. Neurologist A.R. Luria, from *The Man Who Mistook His Wife for a Hat and Other Clinical Tales*, by Dr. Oliver Sacks.
2. "Person-Centered planning" as defined by the Centers for Medicare and Medicaid "is a process, directed by the participant, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the participant." <http://www.medicaid.gov/mltss/docs/PCP-CMSdefinition04-04.pdf>.

3. Massachusetts Probate Court Form 903B. <http://www.mass.gov/courts/courtsandjudges/courts/probateandfamilycourt/documents/mpc903b-limitations-to-guardianship-and-conservatorship-for-judges-attorneys.pdf>
4. Practical Guide to Health Care Decision-Making, by Betsy Johnson, in *End of Life Care for Children and Adults with intellectual and Developmental Disabilities*, Copyright 2010 by the American Association on Intellectual and Developmental Disabilities.
5. Kim Thrasher, *Admission to Nursing Facilities for Persons Who are Isolated and Incapacitated*, March 27, 2012. <http://www.ltombudsman.org/sites/default/files/norc/mn-memo.pdf>
6. O'Connor, M.G., Kapust, L.R. & Hollis, A.M. (2008). *DriveWise: An Interdisciplinary Hospital Based Driving Assessment Program*. *Gerontology & Geriatrics Education*, 29(4), 351-362.
7. For those seeking guidance on the formal assessment of capacity, and on deciding when formal assessment may be warranted, see "Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologist." Copyright (c) 2008 by the American Bar Association and the American Psychological Association, hereinafter "Handbook." Available as a free download. <http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf>
8. "Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers" p. 16-17. Copyright (c) 2008 by the American Bar Association and the American Psychological Association. Available as a free download. <http://www.apa.org/pi/aging/resources/guides/diminished-capacity.pdf>
9. MGL c. 201D, s. 6.

# So the Neighbors are Nosy and the Friends are Pushy, What Does That Mean for the Geriatric Care Manager?

*Lance M. McKinney, JD, CELA*

## Summary

*This article gives two examples of friends or caregivers who interfere with the care of an impaired individual as well as the role of the geriatric care manager to address the issue. It discusses involving the court system to file guardianship or conservatorship. If the court gets involved, the geriatric care manager can provide observation and proof of trying to resolve the issue. It is important to have advanced plans such as Powers of Attorney and Healthcare Surrogates in place, in order to avoid having disputes between family members, nosy neighbors, and caregivers in the future.*

In our society we have long espoused the ideals of “live free or die” or “don’t tread on me.” We have a long history of individualism and respecting independence. As geriatric care managers, you are well aware of the reality that due to aging or other causes, some people lose their ability to protect themselves and to make informed decisions. As a result, every state has forms of advanced planning such as Powers of Attorney, Healthcare Surrogate, Trusts, or in the event of no planning some form of guardianship or conservatorship. Some states use the term conservatorship to refer to authority over the property and guardianship for decisions over the person. Florida uses the term guardianship for both aspects of the person’s life. Each

***We have a long history of individualism and respecting independence. As geriatric care managers, you are well aware of the reality that due to aging or other causes, some people lose their ability to protect themselves and to make informed decisions.***

state uses its own terminology, but generally these instruments or court processes, in some form, are present in every state.

One of the problems in the circumstance of declining ability is that one or more persons who surround the impaired individual may have disagreements as to how that impaired individual’s care should be undertaken, as well as who should have the authority to be in that role. Advanced planning alone does not prevent these disputes from arising. This article will discuss two circumstances where the very active caregivers or long-term friends were in disagreement about who and how care should be provided to the impaired individual. The purpose of this article is to lay out some of the basic authorities and legal issues and then briefly discuss how a geriatric care manager can be instrumental in resolving these issues in both the legal and practical context.

## Case Study One

Betty is a recent widow who has sufficient resources. Prior to her spouse’s death, he had provided a Trust and the direction to support his surviving wife. The deceased husband employed around-the-clock caregivers for several years prior to his death. Caregivers provided care for both the physically infirm husband and the completely mentally impaired wife. Prior to their engagement the caregivers had no personal

relationship with the clients, but they became emotionally attached to the deceased husband and the surviving wife. The Trustee has employed 24/7 care for the surviving wife in her own home and after months of trying to resolve conflict between the previously established caregivers and the new caregivers there continues to be dispute between these caregivers. There is a geriatric care manager who is also employed to provide monitoring of care and supervision of the caregivers. Unable to resolve the dispute between new and old caregivers, the old guard is fired because of disruptive behavior. These disgruntled caregivers file a guardianship and seek to be rehired.

## Case Study Two

Fred is a highly capable business leader with a long string of successes. Until very recently he was living in

*continued on page 13*

his own home and driving. These activities recently changed because of significant wandering that put Fred at risk and a major auto accident related to his impairment. Fred has no spouse but his children are appropriately attentive at a geographic distance. Distance has led to the inability to see some of the decline until these recent significant events. Fred has lived in a small community and has some very empowered and motivated friends. He was recently placed in an assisted living facility dedicated to memory impairment. Although Fred had some difficulty adjusting, with skilled redirection and reassurance, he settles into the assisted living facility routine and has become a significant volunteer and leader within the resident community. Fred's friends believe that his children are not the best choice as caregivers because of Fred's previous verbal comments to these friends; however, the children were named in all of the advanced planning documents as the caregivers and money managers for Fred. The friends do not understand why Fred cannot be maintained in his own home even if it requires 24/7 supervision, as they believe Fred has sufficient resources. The good friends file a guardianship to determine Fred's capacity and request that a professional guardian be appointed to take away the authority of the children as appointed by Fred himself, because of perceived overly protective care decisions. The friends are barred from visiting Fred as they are creating agitation with Fred by discussing the need for Fred to return home and because of their filing of the guardianship.

### Legal Parameters

Every state has a mechanism for people to appoint their own advocates with documents such as Healthcare Surrogate Proxies and Powers of Attorney. The purposes of these documents are to give the individual the right to control who their advocates are, as well as avoid the unnecessary cost of the court system. These advocates are not supervised by anyone, such as a judge; and there is limited room for holding people accountable or to have real insight in what actions are being taken by these

advocates. We've all seen abuses by these advocates, so it is not surprising that we have a legal mechanism to step in and stop or interfere with abusive practices. This is often a guardianship or conservatorship proceeding depending on the state's statutory language. Often these fights occur between family members, but on occasion there are non-family members who are motivated to take legal action.

The court system determines who can appear or enter into any particular dispute. In Florida, that

### How does the GCM fit in to these circumstances?

The geriatric care manager is uniquely situated to provide assistance in resolving these disputes. Care guidance and negotiating appropriate care is nothing new to the experienced geriatric care manager. In the first case, the employment of a geriatric care manager to provide objective feedback to the decision maker regarding appropriate care needs and the performance of various caregivers is critical for that Healthcare Surrogate

*Every state has a mechanism for people to appoint their own advocates with documents such as Healthcare Surrogate Proxies and Powers of Attorney. The purposes of these documents are to give the individual the right to control who their advocates are, as well as avoid the unnecessary cost of the court system.*

person is "any interested person," which is determined on a case-by-case basis and not limited to family. In the first case study, one might ask what right does a prior caregiver or service provider have in determining the well being of their former client? Certainly, if the established advocates under the Trust and Healthcare Surrogate are abusing or neglecting the ward, then as a society we would congratulate the Good Samaritan who interfered with that abuse. However, we all get equally frustrated with the paid employee who was terminated because of their own inability to get along with the other caregivers and then interfere where they don't belong. But which is which? Ultimately, the courts provide a forum to have each case individually decided as to who is treating the incapacitated person correctly. In the absence of wrong doing by those appointed in the advanced documents, those advanced plans will and should continue in accordance with the plan.

or Trustee who was appointed in advance. If early intervention is made, the dispute may be resolved in a positive way. Even if the dispute cannot be resolved by keeping all interested persons focused on providing the best care for the incapacitated, then the dispute can be resolved by removing the real problem. If that disgruntled former caregiver seeks court review, the geriatric care manager provides critical objective observation and testimony. The geriatric care manager also provides a layer of objectivity for the existing decision-maker. If the existing Trustee, Healthcare Surrogate, or Power of Attorney is able to point to a systematic method of decision-making, which includes objective feedback, he or she is able to refute any claims of self-interest, motivation, or emotional decision-making. The geriatric care manager provides the existing decision-maker with a mantle of credibility that would otherwise be nothing more than a partisan point of view.

*continued on page 14*

## **So the Neighbors are Nosy and the Friends are Pushy, What Does That Mean for the Geriatric Care Manager?**

*continued from page 13*

In the second case scenario, the employment of a geriatric care manager can be an aid for litigation, other than an observer and director of care. The geriatric care manager can teach or coach the well-intended but blundering friends how they can better enjoy the relationship and provide a better social environment for their very close incapacitated friend. If a nosy neighbor is unteachable or uncooperative, then the geriatric care manager has established the proof and the process that a court can focus on. Before a trusted friend is barred from interaction from the impaired ward, every effort and step is considered and taken. This is another form of insulating the original decision-maker. It helps the alleged incapacitated person to have better informed friends who can add value without distraction to the patient. The worst case scenario is that it will provide more complete proof for the judge, if so required.

The geriatric care manager is more likely to be seen by the friends as a more objective source of information.

This author is not suggesting that the geriatric care manager divide his or her loyalties between the client and the nosy neighbor when serving as a mediator or facilitator. Your loyalty is to your client. Arguably, these interveners either were part of the client's system or could be a healthy part of the client system. It takes a knowledgeable and patient advocate to build those bridges. The opposing side will often view the geriatric care manager as someone they can convince as to the righteousness of their intervention and in that process will be more willing to be open minded and counter positions can be exchanged. An experienced geriatric care manager is and should be an essential part of resolving any disputes in care whether it's with a provider, another family member, or the nosy neighbor. These circumstances beg for the employment of a geriatric care manager at almost any cost as it will always be less expensive than three lawyers and a judge.

*Lance McKinney practices in the area of elder law, including probate, probate litigation, guardianship, estate planning, and special needs and long-term care planning. He is certified as an Elder Law Attorney by the Florida Bar. Since 1998, he has been a speaker for the Professional Guardianship Course that is mandated by the State of Florida. He is a member of the Special Needs Alliance, a national network of attorneys dealing with special needs trusts and disability issues. He is Immediate Past President and Director of NAMI Lee County, Inc., serving in a leadership capacity since 2006. The National Alliance of Mental Illness (NAMI) is a non-profit, self-help support and advocacy organization of consumers, families, and friends of people with severe mental illnesses. He is the current President and a Director of the Florida State Guardianship Association (FSGA), a group dedicated to the protection of the dignity and rights of incapacitated persons throughout the state.*

***An experienced geriatric care manager is and should be an essential part of resolving any disputes in care whether it's with a provider, another family member, or the nosy neighbor. These circumstances beg for the employment of a geriatric care manager at almost any cost as it will always be less expensive than three lawyers and a judge.***

# Mars, Venus, and Multi-Disciplinary Rules of Ethics

*Rachel A. Kabb-Effron, JD, CELA*

## Introduction

*Ethical dilemmas have been considered for thousands of years. The earliest biblical scholars, through the Greek and Roman eras, and into our modern times have been trying to set rules about human relationships. What were the ten commandments, if not an early code of ethics? They included rules like: Don't kill one another, don't covet the neighbor's wife. All rules in some way are trying to manipulate and make better the human relationship. Without rules, anarchy and selfish, self-seeking behavior would rule and we would collectively destroy our society.*

*Ethics involve concepts, like morality, values, and the determination of what is right and wrong. Ethics tries to write rules to govern that which is somewhat ungovernable. Nothing is completely right or completely wrong. Even a rule like "No Killing" is not so easy to determine. There are numerous gray areas.*

**W**hen we deal with families with an elder in some type of crisis, we are called upon to solve their problems within the bounds of our professional ethics. Many times we wear many hats that require an analysis of multiple layers of ethics.

I am an attorney in a life care planning practice. I employ three full-time social workers and two support staff. We have two attorneys and a dog, Jake. The only one with the easy ethics is Jake. Life care planning is not care management with a lawyer. Life care planning is a more holistic form of elder law. The social workers

or nurses on the staff of life care planning firms help to triage and refer clients to the right resources, including care managers, to manage clients' place on the elder care continuum.

Source: <http://www.lcplfa.org/about-life-care-planning>

Our care coordination services are designed to help the attorney plan appropriately for the legal and financial needs of the elder. Inevitably the family is facing crises. The care coordinator stays involved initially to get the client stable, and then if the situation cannot be handled by the family within a month or two, the professional GCM is brought in.

Ethics in the Life Care Planning (LCP) Law Firm is a tricky area. Not only do you have legal ethics to consider and work around, but now the LCP Law firm has deliberately added a new employee who is bound by their own Codes of Ethics. This paper will attempt to lay out the different paradigms, so that lawyers, social workers, nurses, and professional geriatric care managers can understand the respective ethical boundaries that each professional brings to a client situation.

## What are Ethics?

The field of ethics (or moral philosophy) involves systematizing, defending, and recommending concepts of right and wrong behavior. Philosophers today usually divide ethical theories into three general subject areas: metaethics, normative ethics, and applied ethics. Metaethics investigates where our ethical principles come from, and what they mean. Are they merely social inventions? Do they involve more

than expressions of our individual emotions? Metaethical answers to these questions focus on the issues of universal truths, the will of God, the role of reason in ethical judgments, and the meaning of ethical terms themselves. Normative ethics takes on a more practical task, which is to arrive at moral standards that regulate right and wrong conduct. This may involve articulating the good habits that we should acquire, the duties that we should follow, or the consequences of our behavior on others. Finally, applied ethics involves examining specific controversial issues such as abortion or euthanasia.

Source: <http://www.iep.utm.edu/ethics/>

## Why are Ethics Necessary?

Relationships are complicated. Whenever two people attempt to navigate communications between one another, relationships are treading on shaky ground. In order to set boundaries and expectations in professional relationships, codes of ethics are developed for professions. Within the elder care continuum professionals encounter underlying ethical duties for nurses, social workers, care managers, doctors, and attorneys. Understanding the interaction of these duties helps all of us understand the conflicts we must navigate. Like the title suggests, as men and women seem to come from a different planet, so too, do professionals often feel like we come from different planets. The primary ethical differences involve confidentiality and its intersection with autonomy and self neglect.

*continued on page 16*

## Mars, Venus, and Multi-Disciplinary Rules of Ethics

continued from page 15

### Confidentiality Rules

Confidentiality should seem to be an area upon which all professions could agree. In the age of HIPAA (Healthcare Information Portability and Accountability Act), there seems to be nothing which is not confidential. However, when we are discussing professional ethical rules, there are specific rules pertaining to specific professions. Even when we have such rules, situations facing our elderly clients complicate even the clearest of ethical duties. Take for example attorneys, Rule 1.6 states:

- (a) A lawyer shall not reveal information relating to representation of a client unless the client consents after consultation, except for disclosures that are impliedly authorized in order to carry out the representation, and except as stated in paragraph (b).
- (b) A lawyer may reveal such information to the extent the lawyer reasonably believes necessary:
  - (1) to prevent the client from committing a criminal act that the lawyer believes is likely to result in imminent death or substantial bodily harm; or
  - (2) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of a client.

Source: [www.americanbar.org/groups/professional\\_responsibility/publications/model\\_rules\\_of\\_professional\\_conduct/rule\\_1\\_6\\_confidentiality\\_of\\_information.html](http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_6_confidentiality_of_information.html)

Contrast that with the pertinent provisions of the social worker rule 1.07:

#### 1.07 Privacy and Confidentiality

- (a) Social workers should respect clients' right to privacy. Social

workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

- (b) \*\*\*
- (c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.
- (d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

\*\*\* through (r)

Source: [www.socialworkers.org/pubs/code/code.asp](http://www.socialworkers.org/pubs/code/code.asp)

For Nurses:

Rule 3.1 – The Nurse safeguards the patient's right to privacy. The need for health care does not justify unwanted intrusion into the patient's life. The nurse advocates for an environment that provides for sufficient physical privacy, including auditory privacy for discussions of a personal nature and policies and practices that protect the confidentiality of information.

Source: <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf>

Geriatric Care Managers:

### Standard 3

The GCM should respect the client's right to privacy and, when applicable, that of the client system. The limits of confidentiality should be clearly explained to the client or designated decision-maker.

### Rationale

The GCM frequently needs to share information with others in order to fulfill his/her responsibilities. The GCM utilizes knowledge of the client's physical and mental status, financial and legal affairs, and family and community supports to achieve maximum well-being for the client. Due diligence must be exercised at all times to protect the privacy of this information.

### Guidelines

- A. The GCM should consider all information in the client's records confidential. This pertains to active and inactive clients as well as closed cases.
- B. The GCM has a responsibility to be knowledgeable of, and abide by, all applicable state and federal laws and regulations regarding confidentiality and the client's right to privacy.
- C. The GCM should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.
- D. The GCM should maintain a valid authorization to release information.
- E. The GCM should act judiciously when sharing client information with others.
- F. The GCM should not disclose identifying information when

continued on page 17

discussing clients for teaching or training or consultation purposes unless the client has consented to disclosure of confidential information.

- G. The GCM should ensure that all communications are conducted in a manner that allows for the maximum amount of privacy.
- H. The obligation of confidentiality may be waived in circumstances when the care manager believes it is necessary to protect the client from harming him/herself or others.
- I. The care manager has a responsibility to abide by the laws of their state relating to vulnerable adults including the reporting of abuse, neglect and exploitation as required in that state.
- J. The GCM should take reasonable precautions to protect client confidentiality in the event of the GCM's termination of practice, incapacity, or death.

Source: <http://www.caremanager.org/about/standards-of-practice/>

To the naked eye, it seems that all the professional standards make confidentiality important. This is definitely true. However, when the attorney ethics use the word “shall” the instruction is meant to be the most strictly held. That means that the attorney cannot disclose that confidential information without an informed waiver unless there is a reasonable belief that the breach of confidentiality will prevent “imminent death or substantial bodily harm.” This rule was not drafted to deal with the elderly client, it was largely written to help the criminal lawyer determine when to report his own client’s imminent criminal behavior.

When the legal confidentiality standard is contrasted with the social work or GCM standards of “should” which when applied in the legal ethics means it is more of a guide than a directive. Of course if a social worker or GCM had a strict directive to never disclose confidential information without a specific waiver from a

client, it would hinder the ability to get the job done.

For nurses, the duty of confidentiality is very strict and perhaps even more strictly written than the lawyer’s duty. The standard clearly envisions only the scenario that the nurse is working in a clinical setting. So if the nurse is acting in a law firm or as a GCM, the guidelines are not all that helpful. It is helpful to know the nurses’ standard so that we understand, especially in light of HIPAA, why confidentiality of the patient is highly guarded regardless of whether it is helpful to the patient or his family.

The GCM standard allows the GCM to effectively waive confidentiality for the client when the GCM believes the waiver will protect the client from harm to himself or others. This standard is in direct conflict with the attorney confidentiality rules. A lawyer is effectively bound to wait until the threat to the client rises to the imminent death or substantial bodily harm.

When these competing rules come into play is when the different professionals encounter an elder at risk or self harm. The lawyer’s duty to the client requires that unless there is a statutory duty to report abuse or neglect, confidentiality shall not be waived. Professionals need to be aware of the mandatory reporting statutes in their state.

See <http://rainn.org/pdf-files-and-other-documents/Public-Policy/Legal-resources/2012/Mandatory%20Reporting%20Elders%20and%20Disabled%20Summary.pdf> for a state-by-state listing of Mandatory Reporting statutes.

Given the patchwork labyrinth of reporting laws particularly for attorneys, the social worker or GCM is left wondering why the attorney has decided not to report a case. Perhaps a real case study will shed light on the different approaches:

### Case Study

Take a client who comes to the attorney for help in caring for his elderly wife with dementia. The gentleman is overwhelmed and has

a stated need of getting help with Medicaid. His unstated needs include help with the entire long term care maze including legal, care, and financial needs. We can assume that he has power of attorney for his wife and wants to keep her home until the end of her life. Midway through the representation he discloses to the care coordinator within a law firm and his GCM that his wife has wandered from the house three times this month. He refuses the home care arranged by the GCM, perhaps due to his own cognitive issues.

In this case, the GCM would look at the case and make recommendations to keep the wife safe. The social worker at the home care agency might call in adult protective services (APS) because the refusal of services is seen as abusive or neglectful. The attorney without a duty to report neglect is unable to breach the duty of confidentiality unless the neglect would lead to imminent death or substantial bodily harm. If everyone agreed that substantial bodily harm would result from the neglect, then perhaps APS and a guardian would be appointed (which may or may not be in the client’s best interests). While the best option is to have the husband accept the right amount of care for his wife, which is easier said than done, and the client must live with his choices and the consequences.

The lawyer in the above case study, without a duty to report neglect cannot report anything, and other than a stern warning to the client about his behavior, nothing ethically permits the lawyer to disclose the neglect. Meanwhile, the social worker in the law firm is duty-bound to report or face the risk of losing her license. The GCM can at least disclose the situation to the home care agency and talk to family members with or without a waiver to help facilitate a safe outcome.

There are no easy answers to ethical dilemmas within the elder care field. Like the case study, elders and their families present with a myriad of issues that are effectively dropped into the laps of professionals with differing

*continued on page 18*

## **Mars, Venus, and Multi-Disciplinary Rules of Ethics**

*continued from page 17*

ethical and moral duties. Interpreting the ethics of different professionals is like looking at an elephant at close range, the person looking at the trunk thinks it is a tree, the person at the tail sees a whip, and the person in the middle sees a wall. Understanding the different ethical duties helps us all to take a step back to see the whole elephant and deal effectively with the multiple disciplines in any case affecting the elderly.

Although the elephant is difficult to deal with, here are some tips for all of us:

- 1) Utilize the team. Don't go it alone.
- 2) Be aware of other team member ethical obligations/paradigms.
- 3) Professionals in a life care practice may be bound by the attorney ethics first.
- 4) Regardless of profession, the Nurse/SW should not jeopardize their licensure.
- 5) Balance Beneficence, Justice, Autonomy, and Non-Maleficence for client-related decisions whenever possible.
- 6) Before reporting abuse etc., the entire team should be consulted.
- 7) Obtain and use releases about issues relating to Confidentiality and Conflicts of Interest.
- 8) When in doubt prepare a letter to the client/ family from all professionals to protect the professionals.
- 9) Remember who the client is. When in doubt, keep this in mind.

*Rachel A. Kabb-Effron, Esq., CELA, is the owner of the Kabb Law Firm in Beachwood, Ohio specializing in Elder law. Ms. Kabb-Effron is a Certified Elder Law Attorney by the National Elder Law Foundation and is recognized as a specialist by the State of Ohio Supreme Court. Ms. Kabb-Effron has been representing elderly and disabled clients since 1998. She helps clients with Care Advocacy and public benefits eligibility planning involving Medicaid and the VA. She has been practicing Life Care Planning since 2006.*

*Ms. Kabb-Effron is a past-president and current Board member of the Life Care Planning Law Firms Association. She is a past president of the Ohio Chapter of the National Academy of Elder Law Attorneys. Ms. Kabb-Effron has been an active member of the National Academy of Elder law attorneys, serving on numerous national committees. She is a member of the Ohio and Cleveland Metropolitan Bar Associations. She is a member of the William K. Thomas American Inn of Court, a law honor society.*

**Interpreting the ethics of different professionals is like looking at an elephant at close range, the person looking at the trunk thinks it is a tree, the person at the tail sees a whip, and the person in the middle sees a wall.**

# Unlock Inner Strength

# FOX



Fox is a professional private practice of full-time physical, occupational and speech therapists specializing in geriatric rehabilitation. We believe older adults deserve the best life possible regardless of past and current medical conditions. Fox collaborates with Geriatric Care Managers to ensure successful outcomes. Our clinicians treat your clients in the comfort of their own homes while providing proactive, evidence-based clinical care to work with the body, encourage the spirit, and restore their lives.

Fox has developed customized services for care managers and their clients including:

- > Individualized therapy services under Medicare Part B
- > Dementia management programs for patients and caregivers
- > Adaptive equipment education and environmental modifications
- > Home assessments and fall risk reduction programs
- > Driving rehabilitation

**Why settle for “some improvement” when your clients can regain more of the life they love? For more information on how you and your clients can benefit from a partnership with Fox, please call 1 877 407 3422, visit us at [foxrehab.org](http://foxrehab.org), or email [GCMpartnership@foxrehab.org](mailto:GCMpartnership@foxrehab.org).**



# NAPGCM 2013 WEBINAR SCHEDULE

All Webinars held 4:00-5:30 pm ET | FOR MORE INFORMATION go to [www.caremanager.org](http://www.caremanager.org)

## June 24, 2013

— SPECIAL EVENT —

### Managing Difficult Dementia Behaviors with Dementia Care and Training Expert

**Teepa Snow, MS, OTR/L, FAOTA**

Special Price of \$25 Member or Nonmember

**REGISTER TODAY** [http://www.caremanager.org/ai1ec\\_event/napgcm-clinical-webinar-managing-difficult-dementia-behaviors/?instance\\_id=770](http://www.caremanager.org/ai1ec_event/napgcm-clinical-webinar-managing-difficult-dementia-behaviors/?instance_id=770)

Registration closes June 17, 2013

## September 11, 2013

### What You Don't Know CAN Hurt You – Streamlining & Perfecting the Hiring Process

**Business Webinar**

**Liz Barlowe and Mary Scott**

Sponsored by



## October 16, 2013

### Allowing Natural Death

**Clinical Webinar**

**Robin Taft**

Sponsored by



#### **CE Webinar Fees:**

FREE for Certified Members  
\$59 for NAPGCM Members  
\$99 for Nonmembers

#### **Business Webinar Fees:**

\$29.95 for NAPGCM Members /  
\$69.95 for Nonmembers  
[www.caremanager.org](http://www.caremanager.org)

#### **NAPGCM WEBINARS** **A Primer on How to** **Participate**

A webinar is an online, interactive seminar or workshop. All you need in order to participate is a computer, Internet access, and a phone line.

NAPGCM webinars last approximately 1 hour with 30 minutes of Q&A. A speaker will first present the subject and then participants will have the chance to interact “in real time” with questions. This is as easy as “emailing or chatting-on-line.” The Web Host will ask participants for questions -- a box will be available on your computer screen to post the questions to the group (or privately to the host).

After completion of the webinar, you will also have access to the documents (usually a PowerPoint), and the audio files. This is helpful if you want to review a key point after the “real time presentation.”

You may register for an upcoming Webinar through the NAPGCM “Events” page. Once registration is complete, an invitation (or link) will be sent by GoToWebinars. They will also send you a reminder email a few days prior to the event. It is a good idea to log-on through the link provided to you about 10- 15 minutes prior to the start time of the Webinar Event.

Once logged-in, the webinar technology will phone you – providing the audio portion of the presentation.

For up to 4 webinars each year, NAPGCM will apply for 1 CE contact hour from NACCM, NASW, CCMC and the California Board of Registered Nursing.

If at any time you have questions, you may call the NAPGCM staff. We will gladly assist you. NAPGCM is excited about the ability to offer CEs and vital business Information to our membership through the webinar technology. It may be one of the easiest ways to earn CEs!