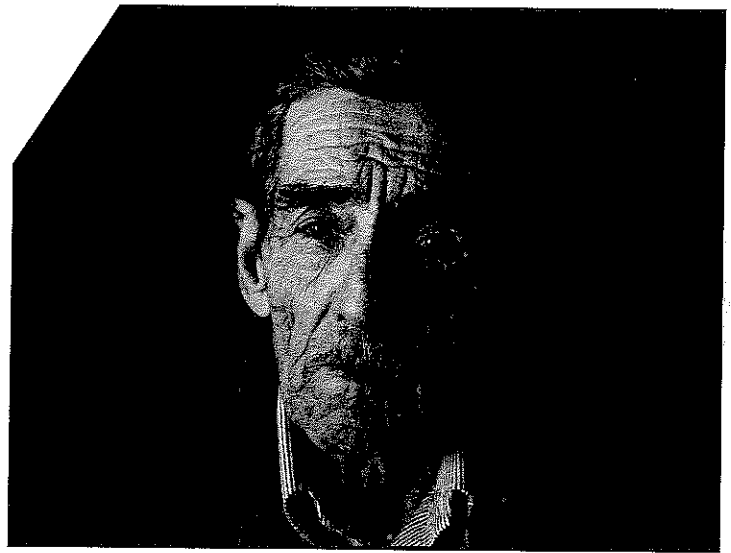


Expanding elder law practice beyond the traditional, narrow Medicaid asset-focus to the elder-centered law practice model



An Elder-Centered Approach to the Practice of Elder Law

by: Timothy L. Takacs

Fifteen years ago I decided to devote my professional life to being an elder law attorney. I learned that elder law was largely synonymous with Medicaid planning. After I tried this asset-focused practice for a while, I was not satisfied because I could not answer the questions of our client families about the long-term care system they were thrust into:

- The skilled nursing facility is telling us Momma needs this therapy and not that one—which one should we choose?
- What are Dad's residential options?
- How do we care for Mom during the day while we work?
- My husband has been diagnosed with X. Can I take care of him at home? What support services are available?

These aren't legal questions, but as an elder law attorney who aspired to a holistic approach, I needed to do better than reply "I can't help you with that ... but I can help you save the money from the nursing home."

I had to change the way I thought about the practice of elder law. Instead of Medicaid planning, I began to think about my practice as "life care planning." I began to learn more about aging and long-term care and what I call the elder care continuum, a timeline on which the client-elder is along toward the end of life.

I describe life care planning as discovering the client-

elder's place on the continuum and figuring out what we need to do to identify, access, and pay for good care for the client, now and in the future.

Our clients need to get good care when and where they need it, know how to pay for it, and be informed, activated patients. Helping clients manage their long-term care needs requires expanding our elder law practice beyond the traditional, narrow Medicaid asset-focus to what I call the elder-centered law practice model.

What Families Really Want

The question that typically brings many elders and their families into the elder law attorney's office is "How do we save Mom's money from the nursing home?" Despite their concerns about saving money, however, almost without exception the families tell us their primary goal is to promote the health, safety, and well-being of their loved one, at home or in a nursing home.

Actually, they usually just say, "We want to take care of Mom." They just don't know how to do that. They have experienced firsthand the deficiencies in care that exist and don't know what to do when they find themselves in the long-term care system. To whom can they turn for help in taking care of their loved ones?

Our philosophy elevates the elder-client's quality of life

and care above all other aims of the planning process.¹

Out of this model of practice comes patient-centeredness, or elder-centered planning, which focuses on the process and relationship with the client-elder instead of attaining a specific goal such as Medicaid eligibility. We develop a life care plan tailored to each client's needs.

Not many elder law attorneys include as a part of their fee-generating services "locating the appropriate type of care" and advocating—and intervening, if necessary—to "ensure the client's right to quality care."² Few are equipped by virtue of education and experience to ascertain what long-term care is appropriate and what care services are available in their communities, recognize deficiencies in care, and understand how to advocate for good care.

Instead, we need to hire people who specialize in the long-term care of older persons. This person might have been a registered nurse in a home health care agency, an assisted-living facility administrator, a long-term care ombudsman, a hospital discharge planner, or a social worker—in short, anyone who has the education, experience, and passion to serve older persons and can work independently to help clients and their families access resources and solve health care and long-term care problems.

In our office, we call our care specialists "Elder Care Coordinators." An ECC is assigned to each of our life care planning clients. The ECC conducts a care assessment in the client's home to identify care-related problems and assist in solving them, which might include arranging in-home help or other services or coordinating health care and long-term care providers.

When our ECCs visit clients, the nursing homes or assisted-living facilities know that we are all in the same business: helping families take care of someone's

mother, father, spouse, or other loved one. Because the long-term care community knows we are serious about promoting the good health, safety, well-being, and quality of life of our clients, we get results when it is necessary for us to advocate on behalf of a client for good care.

We do not provide hands-on care; nor are we licensed to provide health care. Instead, we represent the patient in the health care and long-term care system. There is a social work aspect to our practice, but there is more. We help our clients find, get and pay for good care. Indeed, we are counselors and advocates for good care for our clients—advocacy is what lawyers do and that is what we do!

Plainly, the problem our clients hire us to solve is more than just "How do we keep the nursing home from getting all of our money?"

The Need for Long-Term Care

As people age, they must prepare for the likelihood of future impairment and their need for long-term care. Loss in a person's ability to function daily is a natural part of the aging process, and those losses become more severe as people get older. Of the one in five elders who attain age 85, more than half are impaired and need long-term care—the personal assistance that enables them to perform daily routines such as eating, bathing, and dressing.³

The prevalence of physical and mental disability among the elderly is growing rapidly along with America's aging population. The number of Americans who will suffer functional disability due to arthritis, stroke, diabetes, coronary artery disease, cancer, or cognitive impairment is expected to increase at least 300 percent by 2049.⁴

The challenge for our society is how we are going to manage the care of these increasing numbers of elderly persons with disabilities. About 85% of elders who need long-term care receive it from family and friends; few receive assistance from paid

professionals or aides because of quality or financial concerns.⁵ Caregiving is now viewed as an unpaid extension of the public health system.

Shirley Loflin, a caregiver quoted on the Rosalynn Carter Institute for Caregiving Web site, writes, "Caring for another's every need, making life or death decisions, being on call 24/7, and dealing with many unknowns is a tough, demanding, and, in some instances, an isolated, thankless job."⁶

What can be done to help elders and their caregivers?

In its *Quality Chasm Report*, the Institute of Medicine has called for a transformation of the U.S. health care delivery system to correct the deficiencies in the current management of persons who suffer from chronic illnesses, including rushed practitioners not following established practice guidelines, lack of care coordination, lack of active follow-up to ensure the best outcomes, and patients inadequately trained to manage their illnesses.⁷

The report concluded "The current delivery system responds primarily to acute . . . health care problems. . . . Those with chronic conditions are better served by a systematic approach that emphasizes self-management, care planning. . . , and ongoing assessment and follow-up."

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive—responding mainly when a person is sick—to one that is proactive and focused on keeping a person as healthy as possible: patient-centered care, rather than diseased-focused.⁸

There is a growing consensus among healthcare providers that patients have a more active role to play in defining health care, particularly in chronic disease management, where patients provide the majority of care in daily management of their illness.⁹ According to the Chronic

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Care Model,¹⁰ to improve chronic care outcomes it is critical to engage the “informed, activated patient” with the motivation, information, skills, and confidence necessary to make decisions about and manage his health.

Unfortunately, patient and consumer health education is nearly nonexistent, says Dr. Edward Wagner, director of the Center for Health Studies, adding, “With appropriate public and consumer education, we can get consumers to be more demanding of high quality care, and become thereby, collectively, change agents.”¹¹

Elder-centered law practices will assist their clients and families in becoming the “change agents” for transforming the health care system to one that is patient-centered.

Is Medicaid Planning Ethical?

For most of our clients, Medicaid planning makes good financial sense. Why should the client and his family pay the nursing home when the cost or risk can be transferred, legally, to the state Medicaid program?

In Tennessee, there is very little difference between the quality of care the client is likely to receive in a nursing home that accepts Medicaid and one that is strictly private pay. In our experience, a primary determinant of whether a client gets good care is the family’s continuing interest and involvement in that care. So if there is no difference in quality of care, why not shelter one’s own assets and instead shift the cost of the nursing home to the state Medicaid program—the taxpayers?

Needless to say, not everyone agrees. Chuck Jones, director of Pennsylvania’s Third Party Liability division, which oversees the state’s Medicaid Estate Recovery Program, told the *Pittsburgh Tribune-Review*, “You’ve got to realize the Medicaid program was not put in place to ensure people leave inheritances to their children

or grandchildren. The money has to come from somewhere.”

Medicaid planning may be legal, but is it immoral or unethical?

Elder law attorneys advance a number of arguments for why Medicaid planning is not immoral or unethical, perhaps most often the “diagnosis unfairness” argument. If an elderly patient suffers from heart disease or cancer, Medicare will pay for virtually all the care required. Medicare doesn’t cover any significant cost of the care for persons with dementia, however—and that is unfair (or so the diagnosis unfairness argument goes). The Medicaid system therefore should be available to help equalize that fundamental unfairness—and patients should not have to impoverish themselves before the government will step in and help. While this argument and others have some appeal, they don’t get to the heart of the issue.¹²

For public policy and fiscal reasons, the government has chosen to pay for some diseases and not others. There is nothing inherently unfair about this.

In our view, Medicaid planning can be justified ethically only by placing it within the context of the economic system in which it takes place. Within the United States free market system, no one has a right to basic health care and long-term care. Instead, both are commodities that are bought and sold. Better care goes to the individual who has the means to pay for better care.

Where the market permits planning that results in a reduced net price, a purchaser cannot be faulted for availing himself of the lower price even if he could pay more. In a health care system in which the commodity known as *health* is bought and sold, there is no reason why any market participant should value another person’s property (health) more than his own. Until the United States elevates health care

to a moral right instead of a property right, Medicaid planning is morally and ethically justified.

Indeed, the individual whose dire health care needs force him to “spend down” to Medicaid benefits loses his ability to pay for other basic needs (food, shelter, and clothing as well as other healthcare and long-term care goods and services). Within this system, Medicaid planning is not only ethically justified but imperative to the individual’s survival.

The moral justification for Medicaid planning becomes particularly compelling when planning for spouses, one of whom needs nursing home care. The federal and state governments have put in place “default” rules to protect the spouse at home from impoverishment; however, like all such rules, exceptions should be made. For example, a spouse with high medical needs at home might need more money than the default rules allow her to keep.

In some instances, a couple who have been married for 50 or more years could face the prospect of getting a divorce rather than leaving the spouse at home with little or no income and resources. When done appropriately, Medicaid planning protects the spouse at home from impoverishment. ■

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(Endnotes)

¹ See Timothy L. Takacs, *The Life Care Plan: Integrating a Healthcare-Focused Approach to Meeting the Needs of Your Clients and Families Into Your Elder Law Practice*, NAELA QUARTERLY (Winter 2003); Timothy L. Takacs, *The Life Care Plan*, THE ELDERLAW REP. (Feb. 2004).

² See *What Is Elder Law?*, National Academy of Elder Law Attorneys, http://www.naela.org/Public_WhatsElderLaw.aspx.

³ Congressional Budget Office, *Financing Long-Term Care for the Elderly* (Apr. 2004).

⁴ See National Center for Health Statistics, *Tables on Trends in Health and Aging*, <http://209.217.72.34/aging>; AHRQ Research in Action, *Preventing Disability in the Elderly with Chronic Disease* (Apr. 2002)(citing

C. Boulton, M. Altmann, D. Gilbertson, et al., *Decreasing Disability in the 21st Century: The Future Effects of Controlling Six Fatal and Nonfatal Conditions*, AM. J. PUB. HEALTH 86(10): 1388-93 (1996).

⁵ K. Donelan et al., "Challenged to Care: Informal Caregivers in a Changing Health System," HEALTH AFFAIRS (July/Aug 2002).

⁶ See Shirley Loflin, *The Face of Caregiving*, <http://rci.gsw.edu/shirleyloflinindex.htm>.

⁷ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001 (<http://books.ap.edu/books/0309072808/html>).

⁸ See Improving Chronic Illness Care program of the Robert Wood Johnson Foundation, <http://www.improvingchroniccare.org>; U.S. Agency for Healthcare Research and Quality, *2004 National Healthcare Quality Report*, <http://www.qualitytools.ahrq.gov/qualityreport/documents/nhq2004.pdf>.

⁹ From Improving Chronic Illness Care, "Tools for Improvement: The Patient Assessment of Chronic Illness Care (PACIC)," available at <http://www.improvingchroniccare.org/tools/pacic.htm>.

¹⁰ For a description of the Chronic Care Model, developed by Dr. Edward H. Wagner at the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative, see *Improving Chronic Illness Care* at <http://www.improvingchroniccare.org>; E. H. Wagner, *Improving Chronic Illness Care: Translating Evidence into Action*, HEALTH AFFAIRS (Nov./Dec. 2001); and E. H. Wagner, *Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?*, EFFECTIVE CLINICAL PRACTICE 1:2-4 (Aug.-Sept. 1998), available at www.acponline.org/journals/ecp/augsep98/cdm.htm.

¹¹ *Improving Care of the Chronically Ill*, 2004 Epidemiology, Biostatistics, and Clinical Research Methods Summer Session cosponsored by the Seattle Veterans Affairs Epidemiologic Research and Information Center (ERIC) and the University of Washington; <http://researchchannel.org/program/displayevent.asp?rid=2390>.

¹² Timothy L. Takacs & David L. McGuffey, *Medicaid Planning: Can It Be Justified? Legal and Ethical Implications of Medicaid Planning*, 29 WILLIAM MITCHELL LAW REVIEW 111 (2002); Timothy L. Takacs & David L. McGuffey, *Revisiting the Ethics of Medicaid Planning*, NAT'L ACAD. ELDER LAW ATTYS. QUARTERLY (Summer 2004).

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