RACHAEL A. CABRAL-GUEVARA

STATE SENATOR • 19TH SENATE DISTRICT

Testimony before the Senate Committee on Health

Senator Rachael Cabral-Guevara

February 14, 2024

Thank you committee members for allowing me to testify on Senate Bills 1027, 1028, and 1029, an important package of bills that will help address the growing problem of complex patients finding the proper setting for care.

Complex and post-acute care has been a challenge for both hospitals and long-term care facilities alike. Hospitals have the ability to provide the care, but are often not properly reimbursed for it. Long-term care facilities often do not have the staff needed to properly care for these types of patients.

This package of bills attempts to start addressing three of the issues surrounding these complex patients: discharging complications from hospitals, making sure beds are available for them, and setting up a complex patient pilot program. It also includes an appropriate level of funding to ensure we are adequately executing on these pilot programs for patients, providers, and health care facilities.

Without delivering on the key components of this legislation, we risk continuing the unreimbursed care of patients that should be in different settings. It is inappropriate for people to unnecessarily remain in a hospital for weeks on end because of the inability to discharge to a more appropriate, longer-term care setting. It also is not right to force these patients into understaffed facilities. That is why this package is so critical: we need to see what works, what does not, and find a solution by testing this pilot program.

I look forward to continuing discussions around what we can do to improve this package and sincerely hope to finalize it this session. Thank you again for allowing me to testify on these critical bills and I am hopeful you will support them.

P.O. Box 7882 • Madison, WI 53707-7882 • (608) 266-0718
Sen.Cabral-Guevara@legis.wisconsin.gov

PATRICK SNYDER

STATE REPRESENTATIVE • 85th ASSEMBLY DISTRICT

Testimony in Support of Assembly Bills 1086, 1087, and 1088

Assembly Committee on Family Law
February 14th, 2024

Chairwoman Rozar and members of the Committee:

Thank you for taking the time to allow me to testify on these three important bills that are the result of many conversations and negotiations with our hospital and long-term care partners. Together these bills address concerns we've heard from these providers in ensuring patients with complex needs receive the care they need in the most appropriate settings. This is a shared problem in Wisconsin and I believe that this legislation will be the solution by encouraging everyone in the sector to work together in collaboration on behalf of patients with complex needs.

I am going to start with AB 1088. This legislation makes changes to the surrogate decision-making process that this Committee has previously discussed. This issue has long been on my radar since one my constituents, an attorney, first explained the complexities of moving some of these patients out of hospitals in a timely matter. This legislation will ensure that incapacitated patients not requiring hospital care can be moved to more appropriate facilities in a timely fashion by clarifying that the surrogate-decision making process applies to admissions from hospitals but without the time restrictions or the required filing of a petition for guardianship or protective placement. It is important to note this legislation maintains all current protections under s. 50.06.

The bill also requires the Department of Health Services (DHS) to release 250 nursing home beds to providers who will prioritize admissions of patients with complex needs who have been unable to find appropriate placement at another facility.

Finally, the package expands the $5 million complex care pilot program that was passed in the budget. The goal of this pilot program is to help spur development of innovative partnerships between nursing homes and hospitals in providing care to patients with complex needs in the most appropriate setting. In addition finding innovative ways to provide care to these complex patients in the most appropriate settings, the pilot will help us better identify the characteristics and needs of these patients to inform our policy making decisions in the future.

To that end, AB 1086 and 1087 use one time money to address this crisis by:

- An additional $10 million GPR to expand funding for the complex patient pilot program to a total amount of $15 million. This will enable more pilots to be created throughout the state to better serve these complex patients.

P.O. Box 8953 • Madison, Wisconsin 53708-8953 • (608) 266-0654 • Toll Free: (888) 534-0085
Rep.Snyder@legis.wi.gov

- $20 million GPR for supplemental hospital payments to help hospitals that care for patients that are ready to be discharged but stranded at a hospital because they are unable to be discharged to a more appropriate setting
    - AB 1087 requires DHS to distribute quarterly payments from this fund to hospitals based on the number of delayed discharge days.
- $10 million GPR for enhanced payments to nursing homes for bariatric patients and patients with complex wound care if they were transferred directly from a hospital. Bariatric needs and complex wound care are two conditions identified by long-term care and hospital partners that can create added complexities in providing care.

Please be aware that we are working on an amendment to increase reporting requirements on these significant investments. I want to stress that in many ways this entire legislative package is a pilot program to work together and address the needs of patients requiring complex care in our State. Too often the nature of these needs causes these patients to be left behind. It is my hope that this package incentivizes all providers to work together in getting them the treatment that they need.

I am happy to answer any questions you may have.

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5510 Research Park Drive
Fitchburg, WI 53711
608.274.1820 | FAX 608.274.8554
www.wha.org

February 14, 2024

To: Senate Committee on Health

From: Laura Leitch
Policy Counsel

Subject: WHA testimony in support of SB 1027, 1028, and 1029

Every day in Wisconsin hospitals, there are about 500 patients who are ready to be discharged but remain in the hospital awaiting a post-acute care placement. The 500 avoidable hospital days each day have a significant impact not only on those patients whose post-acute care is being delayed but also on the health care system broadly.

According to a report written by Baker Tilly for DHS, in 2022, there were about 177,000 avoidable hospital days statewide. Baker Tilly estimated the cost to care for the patients waiting for discharge to be about $485 million. In addition to the costs, the avoidable patient days also affect hospital capacity. The 177,000 avoidable hospital days are 177,000 days that are not available to care for other patients who need hospital-level services.

Although the number of delayed discharges increased during the pandemic, exceeding 700 patients a day during the Covid surges, the number has remained stubbornly high.

There are a variety reasons for the delayed discharges from hospitals and, unfortunately, there isn't one solution. The package of policies in SB 1027 and 1028 are targeted at specific causes of delayed discharges identified by the acute and post-acute care communities and we are hopeful that they would have a substantial impact on the issues:

1. **Patients remain in the hospital due to guardianship delays.**

In Wisconsin, an incapacitated patient's family members, the next of kin, can consent to an admission directly from a hospital to a nursing home or CBRF. Before admission, however, a petition for guardianship of the incapacitated patient must be filed with the court and the patient's stay in the facility without a guardian is limited to 60 days (s. 50.06). But it often takes months for the guardianship process to come to a resolution. Further, the guardianship process is a significant emotional and financial burden on families and patients.

According to a report from the American Bar Association, at least 45 states explicitly recognize next of kin authority for some type of surrogate decision-making. In Wisconsin, in addition to

the limited authority in s. 50.06, there is next-of-kin authority for organ donation (s. 157.06) and hospice care (s. 50.94).

The bill would extend the next of kin's authority to consent to the admission to and care in a nursing home or CBRF for their incapacitated loved one beyond the current 60 days and without first filing a petition for guardianship. The bill also maintains and adds patient protections.

2. There are too few providers who will accept patients who have complex conditions.

a. Relax the nursing home bed cap.

Since the mid-1980s, the number of nursing home beds has been capped at around 52,000 beds. DHS, however, has administered the cap as a moratorium, not approving additional beds to replace beds that close. In 2018, around 30,000 licensed nursing home beds remained. According to Baker Tilly, there were fewer than 26,000 licensed nursing home beds in 2022, a decrease of about 4,000 beds in 4 years.

Further, the nursing homes that remain continue to limit the number of Medicaid patients they accept. The number of Medicaid patients in nursing homes is expected to drop from 6,500 to 5,400 in the current biennium, which will make it even harder for hospitals to place patients with complex health care needs who are often on Medicaid.

In an effort to expand the state's nursing home capacity available for high-acuity patients, the bill would allow organizations to apply for and require DHS to approve 250 additional nursing home beds:

- The facility with the new beds would prioritize the admission of patients with complex care needs and patients who have not been accepted by other facilities.
- DHS could approve an applicant's request for up to 50 beds.
- The facility with the additional nursing home beds would need to meet current licensing standards and be certified as a Medicaid provider.

b. Complex Patient Pilot.

The nursing home associations requested support for a complex patient pilot in the most recent state budget. According to DHS:

- The pilot seeks innovative approaches to enable these patients to get the care they need by transitioning from inpatient to post-acute settings in a timely way.
- DHS plans to award the funds through a competitive grant application process to select hospital and post-acute facility partnership groups.

3. The high costs associated with delayed discharges affects health care capacity and access to care.

a. Supplemental payment to hospital.

As previously mentioned, the 177,000 avoidable days and the $485 million in costs to care for the patients impact hospitals' ability to care for other patients. To recognize a portion of the hospitals' staffing and other costs associated with avoidable days, the proposed supplemental payment pool would be distributed to hospitals quarterly based on the number of qualifying avoidable patient days at each hospital.

- Qualifying avoidable patient days would be days after a high-acuity patient has been ready for discharge for more than 7 days but the hospital has not been able to locate a place to discharge the patient.
- High acuity patients are patients with conditions such as obesity, a non-ambulatory disability, a mental illness, high behavior needs, need for wound care, substance use disorder, or require dialysis. Hospitals struggle to locate nursing homes and CBRFs that are willing to accept high-acuity patients because of the significant staffing and other costs to care for them.
- According to the Kaiser Family Foundation, the average cost of caring for a hospital inpatient in Wisconsin is about $2,700 a day. The distribution of the $20 million supplemental payment pool is expected to recognize a small, but important portion of those costs.

b. Enhanced complex patient rate for nursing homes.

A significant number of the patients ready for discharge from the hospitals and awaiting placement in a nursing home are bariatric patients and patients with wounds. The staffing and other costs dedicated to caring for patients with these conditions is substantial and, thus, nursing homes indicate they are reluctant to admit the patients.

To encourage nursing homes to accept these complex patients by recognizing the higher costs, the bill would provide funding for an enhanced Medicaid rate for nursing homes caring for non-ambulatory bariatric patients and patients needing significant wound care.

Hospitals estimate that around 25 percent of the high-acuity patients pending a post-acute care placement are bariatric patients or patients with significant would care needs. A significant percentage of those patients are on or have applied for Medicaid. Encouraging nursing homes to accept the patients from hospitals could open hospitals beds for patients needing hospital-level care.

Thank you for the opportunity to testify in support of SB 1027, 1028, and 1029. WHA appreciates the bills' authors, other legislators, hospitals, members of the post-acute care community, and many others who have been working to address these challenges.

bellinhealth GUNDERSEN HEALTH SYSTEM.

Date: **February 14, 2024**

To: **Senate Committee on Health**

From: **Bellin and Gundersen Health System**
Collin Bowman, MD – Palliative Medicine

Re: **Senate Bill 1027**

Chair Cabral-Guevara and members of the Senate Committee on Health, thank you for allowing me to testify today in support of Senate Bill 1027. I would like to share my concerns about the current process of transferring medically incapacitated patients, whom do not have advance care planning document(s), from hospitals to nursing homes, and how this legislation would help patients and families.

Bellin and Gundersen Health System is an integrated care delivery system providing services to over 600,000 patients throughout 35 counties in Wisconsin, Iowa, Minnesota, and Michigan's UP. Our system provides patients and communities with access to top-tier care at 11 hospitals, 100+ local clinic locations via more than 1,400 providers.

Wisconsin's current process of transferring medically incapacitated patients, whom do not have advance care planning documents, is harming patients and families. It is taking away patient's ability to choose their desired path of future medical care. It is impeding the ability of healthcare professionals to do right by patients and families. It is causing increased suffering by trapping patients and families in hospitals while they wait for the guardianship process to unfold. We can and must do better. All patients deserve the same standards of care.

An example that will highlight this suffering is John (pertinent identification and medical information will be omitted in accordance to HIPPA). He was admitted to the hospital with a heart attack. This emergent situation required open heart surgery that saved his life. Subsequently, he suffered multiple serious health complications that resulted in loss of his medical capacity. He had no advance care planning documents and denied to fill them out in the past. The guardianship process was started given concerns about future need for nursing home placement. The family felt that we were taking away both John's and their ability to make medical decisions on his behalf. The therapeutic doctor-patient relationship had been shattered. Trust had been lost. When this happens, emotions heighten and suffering for both John and his family increased. John's medical situation was already traumatizing and scary. Unfortunately, our current system only worsened John's situation.

This story demonstrates how providers hands are tied by the current dynamic and patients think it is hospitals doing this to them, not the limitations in state law. This legislation would fix those limitations and is squarely aimed at reducing suffering for patients and families. It eases the mostly unnecessary process of seeking guardianship by allowing patient's families, the ones

bellinhealth GUNDERSEN HEALTH SYSTEM.

who know the patient's goals and values the best, to be their voice. It preserves patient's autonomy to make their own medical decisions despite being medically incapacitated. It allows medical providers to do right by patients instead of holding them in the hospital against their will. It improves the quality of care we give.

Thank you for your time and consideration of our testimony. We respectfully ask that you support Senate Bill 1027.

Sincerely,

Collin E. Bowman, MD

Collin Bowman, MD
Palliative Care Physician at Bellin Health in Green Bay, Wisconsin

LeadingAge™ Wisconsin

Better Services for Better Aging

Date: February 14, 2024
To: Chair, Vice Chair, and Members of the Senate Committee on Health
From: Rene Eastman, VP of Financial & Regulatory Services, LeadingAge Wisconsin
Subject: Senate Bill 1027, 1028, 1029: Complex Patient Legislation

Thank you for this opportunity to provide testimony on the legislation intended to address post-acute care discharges.

LeadingAge Wisconsin represents hundreds of senior living providers across the state. The shared mission of our largely non-profit members is to provide exceptional quality care to their residents and to serve their communities.

While we continue to serve as many Wisconsinites as possible by constantly seeking innovative solutions to workforce, reimbursement, and regulatory challenges, we recognize that the combination of these factors and the aging demographics of the state have resulted in the unfortunate situation where it may be difficult for a patient to find a timely and appropriate post-acute care placement.

We look forward to continuing to problem solve these challenges with the members of this committee and the legislature as a whole, and we appreciate the leadership of Speaker Vos in convening a workgroup of interested parties to make progress on that issue this session. We were promised at the outset that there would be some things in the legislation that we would like and other things that we would live with and that is indeed the case.

We know that innovative approach to addressing challenges will need to continue and that's why we fully support the complex patient pilot, which will draw grant applications from partnerships of hospitals and post-acute facilities who know the issues on the ground the best and will inform future policy solutions.

We know that paperwork can be burdensome and that situations exist where it doesn't make sense to hold up an admission for a guardianship proceeding when there is a clear next of kin to approve a patients' move to a more appropriate setting. This could allow for more peaceful end-of-life care.

While we have reservations about new nursing home bed licenses being issued, we recognize there are significant challenges intermingling some identified complex care populations (such as younger residents with severe behavioral health needs) with traditional nursing home residents and we welcome facilities dedicated to specializing in this type of care.

We look forward to continuing to identify solutions that allow residents to be served in the most appropriate settings across our continuum of long-term care services. We believe that nursing homes are the appropriate regulated setting for bariatric patients requiring extensive assistance with activities of daily living and for patients requiring specialized wound care. These specialties both require a greater number of staff and staff with more specialized training, as well as equipment and supplies. Transferring

bariatric residents requires multiple staff being available, even on nights, and comes with higher risks of staff injury or regulatory risk when a lift/transfer is not completed correctly. With workforce challenges increasing past a crisis level, it is not surprising that residents with these higher care needs are waiting longer to access skilled nursing beds.

If providers are resourced to be able to step forward, it would be a no-brainer to improve Medicaid fiscal sustainability and free hospital capacity by providing more bariatric and wound care in the skilled nursing setting, as an enhanced daily nursing home rate would still cost less than the daily cost of a hospitalization.

Should any committee members or other stakeholders have questions on this legislation or on any long-term care issues in the future I can be reached at (608) 400-5051 or reastman@leadingagewi.org. Thank you.

WHCA / WiCAL

Wisconsin Health Care Association Wisconsin Center for Assisted Living

Wisconsin Long-Term Care Providers: Supportive of Complex Patient Bills

The Wisconsin Health Care Association/Wisconsin Center for Assisted Living (WHCA/WiCAL) represents more than 400 long-term care providers across the Badger State. We are pleased to join you today to share our support for SB 1029/AB 1086, SB 1028/AB 1087, and SB 1027/AB 1088.

Post-hospital placement challenges for complex patients have existed across the country for many years. The COVID-19 pandemic further exacerbated this problem. This is a complex issue, and barriers to placement exist for a myriad of reasons: the complex medical and/or behavioral needs of a patient; challenges surrounding guardianship; and lack of payor source; among other challenges. The package before you today is a meaningful and thoughtful effort to help address the issue here in Wisconsin.

The bills today aim to address some of the challenges to hospital discharge, as well as create new opportunities for hospitals, post-acute providers, and other stakeholders to work together to find solutions for this complex patient population with the ultimate goal of providing the right care at the right time in the most appropriate setting. Ultimately, we want patients to receive the best care possible in the most appropriate setting based on their needs.

- **SB 1029/AB 1086 & SB 1028/AB 1087:** These bills together would create funding mechanisms to establish new enhanced rates for two complex patient profiles: bariatric patients and patients in need of complex wound care. Both complex wound care patients and bariatric patients require higher staffing needs and specialized equipment. The legislation would also appropriate an additional $10 million GPR to the complex patient pilot program, which was signed into law as part of the current biennial budget, to allow more health care partners across the state to find innovative solutions to help facilitate hospital transfers to appropriate post-acute settings.

- **SB 1027/AB 1088:** This bill seeks to address challenges related to placing complex patients by:
  - Creating new decision-making processes when an incapacitated patient ready for discharge does not have a guardian in place, while also balancing the future decision-making needs of the patient and allowing for important checks and balances to the process;
  - Allocating up to 250 total nursing home beds meant to be limited-use for purposes of placing complex patients when a hospital has been unable to find post-hospital placement; and
  - Building out the complex patient pilot which will allow acute- and post-acute health care partners to collaborate on finding provider-driven, patient-centered solutions to placing complex patients.

Long-term care providers have appreciated the opportunity to share our perspective and input on these issues. Providers are committed to working with their health care partners, with state policymakers, and with other stakeholders to address complex patient transfer challenges.

Thank you for the opportunity to share our support for these bills.

FOR MORE INFORMATION, CONTACT:

JIM STOA
VP of Government Relations and Regulatory Affairs
Wisconsin Health Care Association
Wisconsin Center for Assisted Living
jstoa@whcawical.org

RICK ABRAMS
CEO
Wisconsin Health Care Association
Wisconsin Center for Assisted Living
rick@whcawical.org

Testimony to the Senate Committee on Health
Support for Senate Bills 1027, 1028, & 1029 – Post Acute Legislation
Sarah Becker, Social Service Director, Wisconsin
February 14th, 2024

Thank you to the committee chair and members of the committee. I appreciate you holding a hearing today on this important legislation. I am Sarah Becker, Social Service Director in Wisconsin for Aurora Health Care.

Over the last couple of years I've had the opportunity to work with WHA, legislators and other stakeholders on ideas to address the problems my team and I see every day when it comes to delayed discharges from our hospitals. I am happy to see this work coming to fruition and support all three of the bills before you today.

Right now there are approximately 50 patients in Aurora hospitals across Wisconsin who should not be in the hospital. This number fluctuates, sometimes it reaches double the current amount. But really it is a revolving number because as we discharge some of these patients, every day we have more patients who come to our facilities, some of whom will also be very difficult to discharge. At the same time, hospitals continue to struggle with capacity issues. The end result is patients having to wait for a bed to become available in order to move to nursing unit where they will receive their specialty care.

Of these patients who are waiting to leave our hospitals, approximately one-fourth are stuck due to a need for guardianship. In these instances, we invoke the provisions of 50.06 and seek a petition for guardianship and protective placement in order to facilitate the patient being able to move to post-acute care settings. However, this is not an immediate remedy.

Patients who do not have a Power of Attorney for Health Care document which empowers their agent to be able to admit them to a nursing home or group home are typically people with limited socio-economic resources who have never had cause to meet with an attorney for any reason. When their family members are approached about needing to hire an attorney to petition for guardianship of the person and protective placement, they are first incredulous that as a family member, they do not have the power to consent to their loved one's admission to the next level of care and they are then bewildered about how to go about finding, hiring, and paying for an attorney to assist them with this process.

In all too many cases, the process becomes overwhelming and the family is unable to move forward, sometimes even choosing not to step into the role of becoming a guardian. As a last resort, hospitals are using our own legal representation to file petitions in order to facilitate getting the patient to the appropriate level of care. While there is a guardian ad litem appointed to look out for the legal rights of the patient, and while the hospital has legal representation, families are left without anyone to represent their interests in the guardianship process.

Some of our patients cross the Wisconsin/Illinois border to receive their acute care in our state, but then return to Illinois if they need post-acute care. When these patients become incapacitated and require nursing home placement, they are at an advantage because Illinois allows for family members in a hierarchy to admit them to a facility even in the absence of having a Power of Attorney for Health Care document. Patients in this circumstance can move to the appropriate level of care as soon as a skilled nursing facility is identified that can meet their needs. This is the standard in the vast majority of other states as well. Now it is time to make a similar change here in Wisconsin, by passing SB 1027. This will empower families to get their loved ones into a more appropriate setting for care, more quickly.

That said, the problem of difficult-to-discharge patients is more complicated than just solving the issue of who can consent to nursing and group home admissions. That is why we also support the other bills at this hearing.

Among the remaining patients who are unable to leave the hospital timely are the patients who are so complex that we are unable to find a skilled nursing facility that is willing to accept them. With dwindling nursing home beds available, the incentives favor taking patients who are more likely to have a short stay with limited needs. Allocating additional skilled nursing facility beds, while recognizing the need for those beds to be used for complex patients as outlined in SB 1029, is one more piece of the puzzle to solving the problem of difficult-to-discharge patients.

Finally, we also support SB 1028, which provides reimbursement to hospitals for avoidable patient days. Among our patients awaiting discharge are those who will likely never be accepted in traditional skilled nursing facilities, even with the other changes in today's legislation. This is often due to high-risk behaviors that would make the post-acute care environment unsafe for staff and other residents. Patients in that circumstance remain in a hospital setting until something about their situation changes, which would allow placement elsewhere. Without this funding pool, hospital care that these patients receive is largely uncompensated even though the patient and family have no realistic alternative options for care.

The problems we are facing with discharge delays are complex, and so there is no simple solution. However, this committee has before it legislation that will take a big step toward addressing the underlying issues. Therefore, I ask for your support of all of these bills, to allow my social service colleagues and I to help more patients and families gain access to the care settings they need.

Thank you for your time today, we would be happy to answer any questions.

Ascension

Wisconsin Senate Committee on Health

Testimony of Jamie Gill, RN,
Director of Case Management and Post Acute Strategy Ascension WI
Public Hearing on SB1027 and SB1028
February 14, 2024

Madame Chair and Members of the Committee:

Thank you for the opportunity to provide testimony on SB1027 and its proposed changes to the guardianship process for patients awaiting discharge from Wisconsin hospitals to the next level of care.

My name is Jamie Gill, and I am a registered nurse and the Director of Case Management and Post Acute Strategy for Ascension Wisconsin. Ascension Wisconsin is a faith-based health care organization committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. Serving Wisconsin since 1848, Ascension Wisconsin operates 17 hospital campuses, more than 100 related healthcare facilities and employs more than 1,100 primary and specialty care clinicians from Racine to Appleton. We provide over 1.8 million patient visits annually. During our last fiscal year, Ascension Wisconsin provided over $250 million in community benefit services to our communities.

I'm here today to support SB1027 and share how it can help address the ongoing challenges that have blocked incapacitated patients from receiving the most appropriate care through timely admission to skilled nursing facilities. Currently, in instances where incapacitated patients have not identified their healthcare power of attorney, the patient's next of kin or representative must go through a lengthy and costly legal proceeding to obtain guardianship status. If the guardianship process hasn't been completed, skilled nursing facilities typically will not admit the patient. This has had profound impacts on inpatient capacity in hospitals across the state. The guardianship requirement – and delays in that process – have resulted in patients staying longer in Wisconsin hospitals, even after they are medically ready to move to a post-acute, long-term care facility that is better suited to provide them with care. While these delays have a negative impact on our hospitals, their most significant cost is to patients and their families who must wrestle with complexity and delay at a moment of vulnerability and distress. It's too much to ask of them.

The average hospital inpatient stay in Wisconsin is approximately 5 days. Following treatment, that patient can be discharged home or to a more appropriate setting, allowing the hospital to operate more efficiently to serve acute public health needs. However, if an incapacitated patient must remain in the

hospital for two or three months simply because of the guardianship process requirement, the hospital may be precluded from providing acute care to a dozen or more other patients. This scenario is counterproductive for everyone.

Ascension WI tracks excess length of stay or "excess days" for patients who have completed their care with us but can not be discharged to the next level of care for a variety of reasons, including awaiting guardianship proceedings. In 2023, we attributed 483 excess patient days to delays related to pending guardianship cases. This means there were nearly 500 days when a patient was not receiving the needed therapy and level of care to continue their healing. This number does not account for patients having difficulty with discharge planning due to complex medical, behavioral health and substance use disorder needs, insurance coverage, and a variety of other complexities impacting transition of care.

The proposed legislation would ensure that the most vulnerable person in these scenarios, the incapacitated patient, is appropriately discharged and gets access to the same quality of care that other patients who have capacity to consent to post-acute care themselves or patients who have an appointed healthcare power of attorney are able to receive .

As we work with families, they often express frustration that the existing system prevents them from moving quickly to meet the needs of their incapacitated loved ones. The current requirements inflict significant emotional and financial burden on families who are coping with a loved one's condition by forcing them also to navigate the complex guardianship process. This process is drawn out and often finally concludes with an appointment of a guardian who was recognized from the start as the patient's next-of-kin decision-maker.

Furthermore, the long-term hospitalization of incapacitated patients in the inpatient hospital setting causes significant capacity constraints that lead to longer wait times and fewer available beds for other patients seeking care for acute medical needs. As hospital beds are held for those awaiting discharge, a secondary disparity is created for patients coming into the hospitals through the emergency department who are awaiting often urgent and acute medical inpatient care.

I want to be clear, there is no clinical benefit to patients staying in inpatient hospital settings longer than medically indicated; there are only delayed therapies, added health risks, family frustrations, unreimbursed costs and delayed access for new patients needing inpatient care.

We support SB1027 because it achieves three important patient-centered objectives:

- It streamlines the current costly and complicated process to allow the next-of-kin representative to make a timely decision for their loved one to receive appropriate care in the most appropriate setting, while also ensuring other family members are informed.
- It preserves the guardianship petition process to protect the rights of patients and family members. This allows any party to petition the court to review whether the decision is appropriate and, if not, whether to reverse it.
- It maintains the guardianship process requirement in instances involving a patient who does not have a next-of-kin representative available to make appropriate care decisions.

I would also like to express our support and appreciation for the proposed addition of 250 nursing home beds within skilled nursing facilities that prioritize admissions of patients with complex needs and admissions of patients who have been unable to find appropriate placement at another facility. This

provision addresses our patients with the most complex and critical health needs, including those with complex medical needs, memory care needs, bariatric care needs, and those with histories of behavioral health diagnoses and substance use disorders, who are often denied admission to post-acute facilities even when their conditions are well managed. Skilled nursing facilities serve a vital and very different role than their hospital counterparts, and we are grateful for their service and collaboration in ensuring quality long-term care for our patients. Hospitals are unable to offer the hours of therapies and daily enrichment programming to support patients' long-term psychological and rehabilitative needs, as skilled nursing facilities do.

We recognize this is a very sensitive and complex issue, and we appreciate Rep. Snyder and Sen. Cabral Guevara, and also Reps. Wichgers and Ortiz-Velez, for their efforts to address this important matter. We believe SB1027 strikes the right balance to protect patients and their families, improve the healthcare delivery system and help reduce the guardianship caseload in local courts.

For these reasons, we thank you for considering this critical legislation that will support appropriate transitions of care for patients needing discharge, as well as those needing hospital beds. We urge the committee to support this important measure.

Testimony to the Senate Committee on Health
Support for Senate Bills 1027, 1028, & 1029 – Post Acute Legislation
Carrie Killoran, President- Greater Milwaukee Area & Aurora St. Luke's Medical Center
February 14th, 2024

Thank you to the Committee Chair and members. My name is Carrie Killoran, President of Aurora Health Care's Greater Milwaukee Area and St. Luke's Medical Center. I am here today with my colleague Sarah Becker to speak on behalf of Aurora in support of Senate Bills 1027, 1028 and 1029, which will help address a problem that continues to plague Wisconsin hospitals: delayed patient discharges to post-acute care.

Located in Milwaukee, St. Luke's is the largest hospital in Wisconsin and licensed for 938 beds. We are consistently recognized as a destination medical center for everything from cardiac care to organ transplants.

But the problem of delayed discharges is felt across each of our 16 Aurora hospitals in Wisconsin. Internally, we have a daily tracking of our patients awaiting post-acute placement. Just yesterday we had over 50 such patients in our hospitals. But this number varies – and within the past year we have seen it up to nearly 100 people across our system. These are patients who are essentially stuck in a hospital when they no longer need hospital level care.

These discharge delays negatively impact us as an organization, our employees, and most importantly, also our patients and their families. Patients who are in a hospital have increased risk of exposure to disease, may not receive needed rehab, and may be less accessible to family and friends. On the operations side, these "stuck" patients decrease critical bed availability, increase demands on staff, and contribute to financial losses at a time when many hospitals are struggling to keep up with increasing costs.

Unfortunately, a patient may experience a delayed discharge for a variety of different reasons. However, one of the most challenging is caused when a patient is non-decisional and there is no health care Power of Attorney authorized to step in and consent to admission to post-acute care. The only option is then a court-order guardianship, a process that can take weeks – all the while the patient must remain in the hospital. As I am sure you are aware, our court system is quite overloaded. As a result, it can take 6-8 weeks to get a hearing scheduled. While we are waiting for this, the patient remains with us in the hospital, taking a bed that is then not available for a patient who has true acute needs.

I have also seen this issue from a different angle. Prior to my role in health care administration, I was a practicing attorney who worked on these guardianship cases. In the vast majority of these cases, we were petitioning to have the next of kin named as guardian. This was a necessary legal step that was required in the absence of a power of attorney. The next of kin was always our preferred candidate for guardianship as they were the best positioned to know the desires of the patient. It is only if no next

of kin were available would we pursue a corporate guardian. It is notable that in the vast majority of these cases, they proceeded with no objection and the next of kin is named guardian. We ended up in the same result as we would have if the next of kin were allowed to act as surrogate decisionmaker as this bill would permit, with the notable difference that the family involved incurred not insignificant legal expenses to get there.

For these reasons, as both a hospital leader and attorney who handled these cases, I'd like to thank the bill authors for introducing this legislation and ask this committee to support the bills. Thank you, I will now turn it over to Sarah who will speak to her experience on the social service side of this issue.

SSMHealth.

Through our exceptional health care services, we reveal the healing presence of God.

Senate Committee on Health

2023 Senate Bill 1027

Relating to consent to admissions to certain healthcare facilities by patient representatives, allocation of nursing beds for patients with complex needs, and a complex patient pilot

February 14, 2024

Good afternoon, Chair Cabral-Guevara and members of the Senate Committee on Health. My name is Kyle Nondorf and I serve as the Regional Vice President of Acute Care Operations for SSM Health here in Wisconsin. On behalf of SSM, I would like to thank the committee for allowing us the opportunity to testify in support of Senate Bill 1027, which does a variety of beneficial things to assist with transfers from hospitals to post-acute or long-term care facilities.

This proposal would allow for next-of-kin to consent to admission to certain facilities for patients, and it would allow for an increase in nursing home beds for patients with complex care needs and create a pilot program to assist with resources needed to provide that care. We appreciate you holding a hearing on this important bill related to delays in transfer and discharge that impact patients, their care, and the healthcare community. We also want to thank Senator Cabral-Guevara and Representative Snyder for all their work on this topic and for authoring this proposal.

SSM Health is a Catholic, not-for-profit health system that serves four states across the Midwest and employs approximately 14,500 employees and physicians in Wisconsin. Our footprint in the state includes seven hospitals, ten post-acute care facilities, and more than 85 physician offices and other outpatient care sites. Our network of hospitals is comprised of facilities in Fond du Lac, Janesville, Baraboo, Madison, Monroe, Ripon, and Waupun.

Delays in the patient discharge process to post-acute settings can severely impact a patient's ability to receive the most appropriate care in the correct setting. These delays can also affect a hospital's operations and lead to "avoidable days," which are days in inpatient hospital care when a patient is stabilized and ready to be discharged but is unable to be. Because of state law, the guardianship process is one cause of these delays that impacts our patients more in Wisconsin than in our other states.

In fact, across our seven hospitals in the State of Wisconsin we saw nearly 1,550 avoidable days in 2023 due to reasons related to guardianship and more specifically the inability of families and loved ones to make timely discharge decisions for patients who are incapacitated. As a more specific example, of these days, nearly 500 occurred at our hospital in Fond du Lac. These occurrences take time, energy, resources, and oftentimes money for families to work through. This is further reinforced by the fact that because of the complexity of the guardianship process our own Legal Department had to hire outside counsel to assist in almost 60 of the cases we have experienced over the past two years.

SB 1027 endeavors to address burdens the guardianship process places on patients and their families by allowing a "patient's representative" to make certain discharge or transfer decisions without petitioning the court and without the 60-day time limit that currently exists and has the effect of freezing out admissions to nursing homes and community-based residential facilities (CBRFs). These representatives are already defined in order of priority and are often more simply thought of as the patient's next-of-kin.

(OVER)

This commonsense reform is a benefit to patients, their loved ones, and hospitals as it would help alleviate process-related delays that are outside of anyone's control. We do not want to see patients unable to access the best setting for care because of lengthy and unnecessary court procedures.

However, issues that result in delayed discharge for patients are not one dimensional. Our organization has additionally seen over 7,700 avoidable days due to lack of skilled nursing facility (SNF) bed space. Long-term or post-acute care placement seems to be an omnipresent challenge.

Other aspects of SB 1027 will help with addressing these issues, too. It would implement a mechanism to create much-needed, new nursing home beds at a time when we have seen decreases in the statewide number of these beds. And it would create a pilot grant program to help assist partnerships around caring for patients with complex needs who may require specialized and costly care.

It is important to highlight that delays in discharge and transfer do not just affect the immediate patient and their families. These delays also have serious impacts for patients who are seeking care at hospitals that might not have the space to admit them. Conservatively, we estimate that SSM Health hospitals could not accept at least 1,074 transfer requests to our facilities in 2023 due to limited bed space. Nearly 50 of these transfer denials were at St. Mary's Hospital – Janesville in just the last six months of the year. By helping patients get placed in an appropriate post-acute facility in a timely fashion, and thereby lessening the avoidable days at hospitals, community members presenting to hospitals with acute hospital clinical needs will also have greater access to inpatient beds across the state.

Hospitals and healthcare are seemingly facing an ever-growing number of challenges to care for the patients and communities we serve. Problems like workforce shortages and increasing costs are compounded by things such as our state's aging demographics. Because of these mounting challenges hospitals need to practice stewardship and provide the most appropriate care to patients in a timely manner. SB 1027 would reduce delays related to a complicated and lengthy court process and set up a system to provide great access to long-term care facilities in Wisconsin. These would be much appreciated changes.

SSM Health is committed to the health of our patients and the entire communities we serve. And we are grateful that the Legislature is focusing on this important topic and the challenges causing and being created by delays in discharge to nursing homes.

Thank you again for the opportunity to testify in support of Senate Bill 1027 and we respectfully request that the Committee acts to pass this proposal. I would be happy to answer any questions you may have now, otherwise please feel free to reach out at any time to SSM Health's Director of Government Affairs, Ben Van Pelt, at benjamin.vanpelt@ssmhealth.com.

Date: February 14, 2024
To: Senate Committee on Health
Re: Opposition to AB 1088/SB 1027 – consent to admission to certain health care facilities by patient representatives

The Elder Law and Special Needs Section (ELSN) of the State Bar of Wisconsin is opposed to Assembly Bill 1088 and Senate Bill 1027. The section is very concerned by how quickly these legislative proposals are moving and are still reviewing them for specific issues. For 50 years, Wisconsin has struck a careful balance between providing necessary care and protection for people who are incapacitated, protecting people from being placed into nursing homes against their wills, and ensuring that people are in the least restrictive environment. AB 1088 would destroy those protections for people without guardians or health care agents coming out of hospitals, with no provision for what comes next for those people.

Current Law: With certain limited exceptions, placement to a nursing home of a person incapable of consent requires court finding of incompetence and risk of harm justifying a protective placement. The person's incapacity must relate to specified permanent conditions. The individual has a right to both appropriate care and placement in the least restrictive environment needed and to annual review of the placement. The individual also has a guardian authorized to make health care decisions the person cannot make.

A person found incompetent by a court may be admitted by a guardian under Wis. Stats. Sec. 55.055, without protective placement, but the admission may be for no more than 90 days, must be for recuperative care, and the guardian must make placement to the least restrictive environment needed. For the placement to continue beyond 90 days, it must be court ordered as a protective placement. If the person protests, APS must visit, and court-ordered protective placement is required to continue residence if the objection persists.

A person who has appointed an agent under a power of attorney for health care must give specific authority for nursing home admission. The decision is then made by a person chosen, and trusted, by the person. Even then, the person can object to a decision by the chosen agent, and/or revoke the appointment.

Wis. Stats. sec. 55.06(2) is specifically designed to provide a surrogated decision-maker to admit a person to a nursing home if the person does not have a guardian or authorized agent if the person is being transferred from a hospital. Again, there are protective limits on the surrogate's authority. 55.06(2) cannot be used if the person has a developmental disability or mental illness. It cannot be used if the person objects to the placement. It cannot be used unless a court process is begun for ongoing guardianship and protective placement, so that there is a court review of whether the admission is appropriate and in the least restrictive setting, and whether the surrogate is appropriate to be long-term guardian.

Proposed changes made by AB 1088/SB 1027:

Nursing Home Admissions: This bill would allow a person (patient representative), not chosen by a hospitalized incapacitated person, and not determined able or competent by a court or anyone else to send the hospitalized person to a nursing home of the patient representative's choosing; and make medical and financial decisions for the person while in the nursing home. AB 1088 covers the same ground as existing 55.06(2) without all the protections. It would allow admission with no obligation by the patient representative to consider least restrictiveness, with no court finding of incompetence or review of the appropriateness of placement, and with no person with ongoing authority to make health

P.O. Box 7158 | Madison, WI 53707-7158 5302 Eastpark Blvd. | Madison, WI 53718-2101
(800) 728-7788 (608) 257-3838 Fax (608) 257-5502 www.wisbar.org service@wisbar.org

care decisions after the admission. This could happen based on a physician's finding of incapacity, even if the person's incapacity is due to a temporary condition, and there is no provision for what must happen if the person regains capacity. The length of a nursing home stay is unlimited in time, meaning the length of time the decisionmaker has authority to bind the person's finances is also unlimited in time, at the rate of several thousands of dollars every month, with no court oversight or accounting requirement whatsoever.

Individual's Lack of Agency Over Choice of Patient Representative: The bill assigns a hierarchy of potential patient representatives with limited regard to the individual's wishes and no regard whatsoever to the suitability of the listed individuals to serve.

For these reasons, ELSN opposes AB 1088 and SB 1027, but would welcome the opportunity to work to find reasonable and workable solutions that both protects individuals and their rights. If you have any questions, please contact Cale Battles, Governor Relations Coordinator at the State Bar of Wisconsin, at cbattles@wisbar.org or (608) 250-6077.

The State Bar of Wisconsin establishes and maintains sections for carrying on the work of the association, each within its proper field of study defined in its bylaws. Each section consists of members who voluntarily enroll in the section because of a special interest in the particular field of law to which the section is dedicated. Section positions are taken on behalf of the section only.

The views expressed on this issue have not been approved by the Board of Governors of the State Bar of Wisconsin and are not the views of the State Bar as a whole. These views are those of the Section alone.

Wisconsin BPDD
Wisconsin Board for People With Developmental Disabilities

February 14, 2024

Sen. Cabral-Guevara, Senate Health Committee
State Capital, Rm 323 S
Madison, WI 53707

Rep. Rozar, Assembly Committee on Family Law
State Capitol, Rm 13 W
Madison, WI 53708

Dear Sen. Cabral-Guevara, Rep. Rozar, and members of the committee:

The Wisconsin Board for People with Developmental Disabilities (BPDD) and other aging and disabilities advocates met with hospital advocates last spring and expressed our deep concerns about their surrogate decision-making, now called patient's representatives', proposal. We have significant concerns that **this legislation does not resolve the issue it seeks to address, and it creates new legal and operational issues, and risks for patients and families**.

SB 1027/AB 1088 would broadly apply to all patients over the age of 18 who do not have a health care Power of Attorney or do not have a court appointed guardian of the person. SB 1027/AB 1088 establishes a statutory hierarchy that would determine who—based on an arbitrary position in the list—would make decisions for a medically incapacitated person.

While we have had just over 24 hours between when the proposal was released and public hearing announced, our brief review has identified the following concerns:

1. **The bill bypasses the existing guardianship and protective placement process indefinitely**. This allows a patient's representative tremendous authority without any review or due process and to continue indefinitely.

2. **It appears the authority of a patient's representative to make health care decisions and authorize expenditures related to health care under the bill ends only if a court appoints a guardian to make such decisions.** That may mean that the authority of the patient's representative continues indefinitely, without any due process for the patient or any of the statutory requirements and court oversight of guardians of the person or estate that is intended to remedy abuse and neglect. The bill is silent about ending the authority of a patient's representative in other circumstances, including when the individual regains capacity or the patient's representative conduct is financially exploitative. It is unclear how an individual can contest an ongoing finding of medical incapacity. It is unclear how the individual can contest admission or continued residency.

3. We note that many people can clearly express preferences and make many decisions even with significant medical challenges. In our experience, once a third party has been allowed to make decisions there is often resistance to relinquishing that authority. **There appears to be no process for resolving the incapacitation or contesting the appointment of a family member whose wishes and priorities don't align with those of the individual, which is common.**

4. **This bill allows the patient's representative expenditure authority equivalent to a guardian of the estate, which is an expansive power.** Guardians of the estate may take possession of real and personal property, income, and benefits accruing from the property, and of any proceeds arising from the sale, mortgage, lease, or exchange of the property. They may distribute, sell, or invest assets. Guardians of the Estate also have specific statutory duties and their conduct is overseen by a court, which may remove them if financial or other abuses are discovered. Guardians of the Estate must provide an inventory and annual accounting to the court. Patient's Representative have no such court oversight, and it is unclear how comprehensively "authorizing payments" should be interpreted. Would patient's representative allow withdrawal of liquid assets, what if there are joint accounts and the other account holder is not the patient's representative? Would this allow liquidation of investments, retirement accounts, property, receiving of annuities or other benefit checks? Individuals could wake up, discover an unknown patient's representative has placed them in a facility, and has sold their property and spent their money. What rights do individuals have to contest, stop, or recover funds that have been spent?

5. The hierarchy outlined appears in other sections of the state statutes, however we believe it **prudent for the legislature to review and place some safeguards to govern these hierarchies to ensure patient protection**. Family structures are complex, and a familial relationship does not necessarily equate to a close or positive relationship with the patient. **This legislation does not require any sort of screening of potential patients' representatives**—such as whether there is a temporary or permanent restraining order in place, reports or charges of abuse or neglect against the person, pending legal proceedings including divorce, people with clear conflicts of interest or motives to do actual harm—that would exclude individuals in the hierarchy from being a surrogate decision maker. It is unclear how individuals in the hierarchy who have cognitive impairments that interfere with decision making (dementia, are under guardianship themselves) or are estranged from family members would be treated in the hierarchy if they were willing to be a surrogate decision maker.

6. **This bill absolves hospitals of any notification or coordinating responsibilities.** The patient's representative is responsible for notifying the family of their new authority. The bill does not require anything more than the attestation the patient's representative they did provide notice, and it does not require the patients' representative to confirm there is no health care POA or guardian of the person, and it does not specify that the patient's representative's authority is nullified if there is a health care POA or guardian of the person.

7. The Board of Aging and Long Term Care houses the State Long Term Care Ombudsman Program (LTCOP) for people age 60 or older. It is unclear what the notification to BOALTC is intended to achieve, there are no duties, responsibilities, or enforcement authority specified in the bill nor does the LTCOP have the capacity to manage these notices or follow up once received. The LTCOP functions under the mandates of the Older Americans Act and operates by client consent

and client direction. It is unclear what happens if individuals who have been placed in facilities want to contest their surrogate decision makers action, wish to have them removed or wish to contest their placement. **People under age 60 could easily find themselves in this kind of situation, and there are no notification requirements to any entity if that's the case.**

8. The bill gives the courts a new layer of oversight over patient's representatives if a petitioner feels they are behaving inappropriately. It's a due process step that doesn't involve the individual's rights and is unconnected to a guardianship process. It feels like a dispute resolution step between two parties external to the individual. The court isn't given many things it can do (although some are like guardian oversight, restricting a patient's representative's decision-making authority or ability to spend). **It does not give the court the ability to remove the patient's representative or that the incapacitated individual must be evaluated for legal competency within a certain timeframe. This does not give much due process to the individual.** There is no appointment of a GAL or adversary counsel and no annual reviews of the appropriateness of the placement (WATTS reviews). The individual's ability to access the courts is already going to be limited.

Alternative approaches

1. We suggest there are other legislative approaches that would better address discharge and placement concerns without circumventing the rights of the patient, including **adjusting the existing temporary guardianship process to accommodate this special circumstance within a specific time-frame** and ensuring patients have recourse if they object to a placement.

2. **We recommend hospitals be required to establish standard intake protocols that ask who patients want to make health care decisions for them in the event they become medically incapacitated**. This would allow patients to self-identify an individual in their record; the person they choose might be very different than who would be assigned in the automatic surrogate decision making hierarchy proposed in the bill. Hospitals and clinics commonly assist patients in completing Power of Attorney and other advance directives, which are available for free on the Department of Health Services and Wisconsin Medical Society websites.

3. Patients may have Health Care POAs or guardianship orders associated with their patient records, however records are not always transferred or shared between clinics and hospitals—especially if the patient is receiving care outside their normal clinic. This could result in a surrogate decision maker being used when the patient or court has authorized a specific individual to make medical decisions. **Improving record sharing and requiring hospitals to confirm there are no authorized decision makers is important to honor patient's advance directives.**

Wisconsin BPDD
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4. Wisconsin's Guardianship Support Center is an important resource for all Wisconsinite on advance directives, including POAs. Expanding the capacity of the Guardianship Support Center to provide training and technical assistance has been an important disability and aging priority and could increase the number of prospective patients who have POAs in place.

Further, **an existing process exists within state law to allow for the transfer of incapacitated patients into care facilities.** Under Wis. Stats. §§ 50.06(2-5), a family member or close friend may consent to admitting the incapacitated patient for post-inpatient recuperative care and continue to make health care decisions to the same extent as a guardian of the person and authorize expenditures related to health care to the same extent as a guardian of the estate. Wis. Stats. 50.94 allows incapacitated patients to be admitted into hospice.

We also remind the legislature that **the guardianship process is not an administrative tool, and it is not a barrier to hospital discharge.** The courts are correctly focused on evaluating whether an individual is legally competent—using the criteria outlined in Wis. Stats. Ch 54—to make fundamental decisions about their own lives.

The gravity of a judicial declaration of legal incompetency cannot be understated. Wis. Stats. Ch. 54 reflects the serious impact appointment of a guardian may have on an individual's life, freedom, and decision-making autonomy. There is no decision more consequential for an individual as to whether they keep their civil rights and authority to make their own decisions. The guardianship process is focused on the civil rights of the individual, not facilitating administrative expediency for hospitals, nursing homes, and other care facilities.

These are important issues that require the engagement of all stakeholders and advocates and deliberation by the legislature. We do not find it prudent to advance this bill at this late hour in the session, but welcome working with the legislature on these issues next session.

BPDD is charged under the federal Developmental Disabilities Assistance and Bill of Rights Act with advocacy, capacity building, and systems change to improve self-determination, independence, productivity, and integration and inclusion in all facets of community life for people with developmental disabilities[1].

Thank you for your consideration,

Beth Swedeen

Beth Swedeen, Executive Director,
Wisconsin Board for People with Developmental Disabilities

[1] More about BPDD https://wi-bpdd.org/wp-content/uploads/2018/08/Legislative_Overview_BPDD.pdf .

disabilityrights WISCONSIN
Protection and advocacy for people with disabilities.

To: Senate Committee on Health
From: Disability Rights Wisconsin (Contact: Lisa Hassenstab, Public Policy Manager, lisah@drwi.org)
Date: February 14, 2024
Re: SB 1027 - relating to: consent to admissions to certain health care facilities by patient representatives, allocation of nursing beds for patients with certain complex needs, and a complex patient pilot program.

Disability Rights Wisconsin (DRW) is the federally mandated Protection and Advocacy system for the State of Wisconsin, charged with protecting the rights of individuals with disabilities and keeping them free from abuse and neglect. With this responsibility, DRW offers the following comments on SB 1027.

DRW recognizes the challenges facing our health care and other systems when attempting to address the needs of individuals whose care needs may not require an acute care/hospital setting but for whom another care site is not immediately available due to varying circumstances; we hear from individuals and families regularly who are caught in these complex and frustrating situations. The desire to address these challenges is evident in this legislation, but DRW does not believe the changes proposed in this bill will address these challenges in a way that will meet the needs of all involved in these processes, particularly the individual for whom decisions would be made.

Of primary interest to DRW, the rights of the individual patient are not adequately addressed in SB 1027. This bill would establish a decision-making process which would circumvent processes which are currently available (but not always utilized), potentially involve decision-makers who would be unaware or not interested in the individual's health care wishes or priorities, and does not outline a process for an individual to resolve a determination of incapacitation, reclaim their own decision-making power, or contest the appointment of a particular representative.

DRW's position and comments on this bill are aligned with our partners at the Board for People with Developmental Disabilities (BPDD), and we encourage you to strongly consider the concerns and suggestions laid out in their testimony as you determine your position on this bill.

Thank you for your consideration of these comments, and please don't hesitate to reach out with any questions.