WISCONSIN LEGISLATIVE COUNCIL

LEGAL INTERVENTIONS FOR PERSONS WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

Room 411 South
State Capitol

November 14, 2012
10:00 a.m. – 4:00 p.m.

[The following is a summary of the November 14, 2012 meeting of the Special Committee on Legal Interventions for Persons With Alzheimer's Disease and Related Dementias. The file copy of this summary has appended to it a copy of each document prepared for or submitted to the committee during the meeting. A digital recording of the meeting is available on our Web site at **http://www.legis.wisconsin.gov/lc**.]

Call to Order and Roll Call

Chair Knodl called the committee to order. The roll was called and staff noted that a quorum was present.

COMMITTEE MEMBERS PRESENT:	Rep. Dan Knodl, Chair; Rep. Penny Bernard Schaber, Vice Chair; Sens. Neal Kedzie and Robert Wirch; and Public Members Suzanne Bottum-Jones, Kathi Cauley, Tom Hlavacek, Gina Koeppl, Robert Lightfoot, Rob Mueller, Wanda Plachecki, Brian Purtell, Tom Reed, Kenneth Robbins, and Chrystal Rosso.
COMMITTEE MEMBER ABSENT:	Public Member William Hanrahan.
COUNCIL STAFF PRESENT:	Mary Matthias, Senior Staff Attorney and Brian Larson, Staff Attorney.

Approval of the Minutes From the October 18, 2012 Meeting of the Special Committee

Tom Hlavacek moved, seconded by Chrystal Rosso, to approve the minutes of the October 18, 2012 meeting. The motion passed on a unanimous voice vote.

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Discussion of Committee Assignment

WLC: 0018/3, relating to authorization of an agent under a power of attorney for health care to make certain decisions related to care and treatment of dementia

Mr. Larson described WLC: 0018/3, relating to authorization of an agent under a power of attorney for health care (POAHC) to make certain decisions related to care and treatment of dementia. He explained that the provision regarding involuntary administration of psychotropic medications was removed from the draft at the request of the subcommittee.

Mr. Larson asked whether the authority of an agent to consent to the admission of a principal to certain facilities for the care and treatment of dementia and related conditions should be limited to those facilities defined as "inpatient facilities" under WLC: 0017/4. The committee discussed this option and whether there are sufficient safeguards under current law to prevent inappropriate admissions, or if a special court procedure to review certain admissions should be created. It was suggested that court review could be required when a principal has made a "continuous and valid" or "consistent and sustained" protest to admission, or that a procedure modeled after s. 51.10 (4m), Stats., be developed. Mr. Reed stated that for inpatient psychiatric admissions, there should be some form of court review if the principal shows significant resistance beyond the routine types of protests made by individuals with dementia.

Mr. Larson explained that under WLC: 0018/3, if the principal chooses to opt-in to the provisions related to care and treatment of dementia, he or she may invalidate the POAHC instrument, and revoke the POAHC, only at a time when he or she does not have incapacity. The committee discussed whether this is appropriate. Concerns were expressed that this limitation could increase the risk of elder abuse, if, for example, a POAHC has been improperly activated and the principal is unable to revoke. Mr. Larson told the committee that Carol Wessels suggested that, in lieu of altering the current standard for capacity to revoke, the draft should simply require that if the principal chooses to opt-in to the provisions related to care and treatment of dementia, the POAHC may be revoked by the principal only in writing.

Mr. Reed commented that it is important to strike an appropriate balance between allowing a principal to grant decision-making power to an agent and ensuring that there are some protections in place to address occasions when an agent abuses that power.

The committee discussed the provisions of the draft that would allow a principal to specify that protests made by the principal, when incapacitated, do not invalidate the directions to the agents set forth in the document. It was suggested that this provision be modified to specify that protests that are consistent and sustained may not be ignored. Ms. Bottum-Jones stated that, from a provider perspective, this standard would be difficult to implement because it will fall on providers to try to figure out what consistent and sustained actually means, and whether a protest should be honored or ignored will always be open to question.

Mr. Purtell stated his concern that if this provision were to become law, it might have the unintended effect of implying that any protests made by an incapacitated principal who is not covered by this new provision is a "direction" to the principal within the meaning of s. 155.20 (5), Stats., and thus supersedes the desires of the principal as expressed in the POAHC instrument. He said it is not the case

currently that all such protests are considered to be directions to the principal. This may be problematic if s. 155.25 (3), Stats., were to apply only to individuals with dementia. Mr. Purtell asked whether it might be preferable to have this provision apply to all principals, not only those with dementia, and to apply retroactively.

It was determined that the subcommittee will further discuss these issues at its next meeting.

WLC: 0017/4, relating to inpatient psychiatric treatment for individuals with dementia, and Memo No. 3, Physical Separation Requirement in WLC: 0017/4

Ms. Matthias described the draft, noting the alterations and additions made in response to discussions by the subcommittee.

Definition of inpatient facility and physical separation requirement; collection of data. The committee discussed issues related to the definition of "inpatient facility" on p. 16, ll. 8 to 11, and the requirement that under the new procedures created in the draft, an individual must be placed in a unit or setting that is physically separate from any unit or location in which acutely mentally ill individuals are located. The committee reviewed the suggestions set forth in Memo No. 3, *Physical Separation Requirement in WLC: 0017/4*, November 12, 2012 (Revised November 13, 2012).

There was consensus among the committee members that some ch. 51 treatment facilities are not appropriate for individuals with dementia and that it is very important that the committee work product delineate the types of facilities that are appropriate and prohibit placements in inappropriate facilities. It was agreed there is a need to develop greater capacity throughout the state to ensure there are appropriate facilities and settings for psychiatric and behavioral treatment for individuals with dementia, but given the current limitations, options for this type of inpatient treatment must nevertheless be provided.

The committee agreed with suggestions made by Mr. Hlavacek that the draft be revised to add a procedure for public input into the designation of "inpatient facilities" by counties under s. 55.02 (2) (b) 5., Stats., as created in the draft. The committee also agreed to add a requirement for counties to collect data regarding the capacity of counties to provide appropriate facilities and settings for psychiatric and behavioral care for individuals with dementia, and to provide this data to the Department of Health Services for the purposes of long-term planning and capacity building.

Dr. Robbins said psychiatric units are not segregated by diagnosis and therefore it would not be possible to meet the "separate unit" requirement in the draft. Mr. Reed suggested that placement facilities be required to provide an appropriate therapeutic environment. Several committee members commented that the lack of "aftercare" placements is a barrier to treatment facilities accepting patients with dementia.

The committee gave preliminary approval to the following language, to replace par. (e) on p. 21, ll. 22 and 23, of the draft, and par. (h) on p. 31, ll. 11 and 12, of the draft:

> The placement for medical, behavioral, and psychiatric needs of a dementia patient shall be in an inpatient facility that has a unit or part of a unit that provides an appropriate therapeutic environment which includes a setting designed to minimize mental and physical harm.

Length of initial placements. The committee discussed whether initial placements in inpatient facilities under the emergency protective placement and transfer procedures created in the draft should be limited to 45 days, as set forth in the draft, or shortened to 30 days. Ms. Koeppl and others stated that 30 days is typically adequate time to stabilize a patient. Concerns were raised that if a placement period of 45 days is allowed, that will become the default length of placements even for individuals who may not need that length of treatment, especially in light of the difficulty in finding a permanent placement upon discharge. On the other hand, it was pointed out that there is a strong financial incentive for inpatient stays of this type to be no longer than absolutely needed. After discussion, the committee decided to gather more information on average lengths of stay, prior to the *Helen E.F.* case, of dementia patients for psychiatric treatment before making a final decision on this issue.

Deadline for filing a petition for extension of placement in an inpatient facility. The committee directed staff to specify in the revised draft that a petition for extension of a placement in an inpatient facility, through either of the procedures created in the draft, must be filed no later than 10 days prior to expiration of the current placement order, and that in an emergency, a petition may be filed up to 72 hours before expiration of the current order.

At Mr. Mueller's suggestion the draft will be revised to provide a deadline for examiners to submit their reports related to a petition for an extension of placement in an inpatient facility.

Transfer to inpatient facilities. Ms. Cauley discussed difficulties counties encounter when trying to return individuals to their original placements after they have been transferred to a different facility for treatment. After discussion, the committee directed staff to make the following changes to this portion of the draft: (a) on p. 29, l. 16, add the phrase "or appears to have dementia"; (b) revise the sentence on p. 31, ll. 3 and 4, to read as follows: "The protective placement facility has a plan in place for the individual upon discharge from the inpatient facility;" and (c) at the time of transfer of an individual to an inpatient facility, require the transferring facility to provide written criteria under which it will allow the individual to return to the facility.

Medical clearance prior to emergency placement in or transfer to inpatient facility. The committee discussed medical clearance procedures and directed staff to amend the draft as follows: (a) on p. 21, l. 10, require the examining physician to document in writing that it has been determined with reasonable certainty that the behavior is not caused by a physical condition or illness that could be treated in a setting other than an inpatient facility; and (b) on p. 21, l. 11, after "treated" insert "safely and appropriately." These changes will also be made to the corresponding language regarding transfers to inpatient facilities.

WLC: 0015/2, relating to involuntary administration of psychotropic medication as a protective service to a person with dementia

Ms. Matthias described the draft. Mr. Hlavacek pointed out that prescribing psychotropic medications for individuals is controversial and there are federal-level initiatives underway to reduce the inappropriate use of these medications among the elderly. He said that the Psychotropic Medications Work Group of the Alzheimer's Challenging Behaviors Task Force has been discussing this issue and will release a report soon.

Dr. Robbins said it is important to recognize that the use of anti-psychotic medications in particular, not the use of all psychotropic medications, is controversial and that the use of psychotropic medications can be beneficial for individuals with dementia when used consistent with treatment guidelines. He suggested that the standard for involuntary administration of psychotropic medications (IAPM) be the same as the standard for involuntary hospitalization.

The committee agreed with Mr. Mueller's suggestion that the draft be amended to require a petition for guardianship to accompany a petition for IAPM as an emergency protective service, and to require the court to appoint a temporary guardian at the time it issues an order for IAPM as an emergency protective service (if the individual does not already have a guardian).

Mr. Mueller suggested that the physician referred to on p. 7, l. 1, of the draft, should be actively engaged in the treatment of the individual. Dr. Robbins said that typically there would be two physicians involved: one who performs the physical examination to rule out medical issues and a psychiatrist who prescribes psychotropic medications. Ms. Plachecki said that based on her experience, it seems unlikely that a psychiatrist would state, in many situations, that if medications are not administered immediately the patient will be put at risk. There was some consensus that although the 30-day timeline for obtaining an order for IAPM under current law [s. 55.14, Stats.] may be too long in some situations, it may not be necessary to permit immediate IAPM, as is provided in the draft. It was stated that facilities may not clearly understand the options currently available to them regarding administration of psychotropic medications.

Other Business

There was no other business brought before the committee.

Adjournment

The meeting was adjourned at 4:00 p.m. The next meeting of the committee will be on ***Monday, December 17, 2012, at 9:30 a.m., in the Legislative Council Large Conference Room, One East Main St., Suite 401, Madison***. Meetings of the subcommittee were subsequently scheduled for ***December 5th and 6th at 10:00 a.m., in the Legislative Council Large Conference Room, One East Main St., Suite 401, Madison***.

MM:ty