WISCONSIN LEGISLATIVE COUNCIL
STAFF MEMORANDUM

Memo No. 5

TO: MEMBERS OF THE SUBCOMMITTEE OF THE SPECIAL COMMITTEE ON LEGAL INTERVENTIONS FOR PERSONS WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

FROM: Brian Larson, Staff Attorney

RE: Summary of Remaining Issues in WLC: 0018/3

DATE: November 30, 2012

This Memo describes several issues that remain open for consideration by the subcommittee in connection with 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. The issues are organized under the following headings:

- New Option for Dementia Care
- Admission of the Principal on an Inpatient Basis to a Facility
- Revocation Under the New Standard for Dementia Care

The Memo is intended as a basis for further discussion by the subcommittee at its meetings on December 5 and 6, 2012. Please note that some of the options described below may contradict one another, and although an attempt has been made to organize and merge similar issues, some overlap remains.

New Option for Dementia Care

Under current law, a health care agent must "act in good faith consistently with the desires of the principal as expressed in the POAHC instrument **or as otherwise specifically directed by the principal to the health care agent at any time**" (emphasis added). [s. 155.20 (5), Stats.] This standard may limit the ability of an agent to act in certain circumstances. For example, when a principal has dementia, he or she may exhibit challenging behaviors that include objections to care or treatment. In that case,

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notwithstanding the general expression of authority in the POAHC instrument, one or more decision-makers may conclude that the agent does not have the ability to contradict the objection of the principal and, as a result, may refuse to honor the POAHC.

1. Optional Provision for Decision-Making Under POAHCs

Background: WLC: 0018/3 attempts to address this issue by creating a new statutory subsection, s. 155.25 (3), Stats., which is referred to as "sub. (3)" in the remainder of this Memo.[1] This subsection would establish a new option for decision-making under POAHCs such that, in cases where a principal has included this provision in his or her POAHC instrument, statements made by the principal at a time when he or she has incapacity would not be considered directions to the agent.[2] Under the draft, this optional provision would only apply to decisions related to care and treatment of dementia, or any behavior or condition substantially related to dementia, and the agent would be required to consult with appropriate care providers regarding the principal's prognosis and acceptable alternatives for care or treatment of dementia, or any condition or behavior substantially related to dementia.

Issue: Should the provision creating sub. (3) remain in the draft?

2. Exception to Optional Provision for Decision-Making Under POAHCs

Background: It was suggested that sub. (3), if it is included in the draft, include an exception in cases of consistent and sustained statements by the principal. Under the exception, consistent and sustained statements would be considered directions to the agent, even if all of the other requirements of sub. (3) have been met.

Issue: Should the proposed exception to sub. (3) for consistent and sustained statements be added to the draft? How should the terms "consistent" and "sustained" be defined for purposes of the exception? Also, should the provision include additional procedures specifying who will be empowered to determine when the exception applies?

3. Application of New Provision for Decision-Making to All POAHCs

Background: Some members of the committee expressed concern that if sub. (3) were to become law, as currently drafted, it might have the unintended effect of implying that any protest made by an incapacitated principal who is not covered by the new provision is a "direction" to the agent within the meaning of s. 155.20 (5), Stats. Under sub. (3) as currently drafted, a principal would not be covered by the new provision for purposes of a decision that does not involve care or treatment of dementia, or any behavior or condition substantially related to dementia, or if they do not include the new provision in their POAHC instrument.

Therefore, it was suggested that sub. (3) be expanded to apply to all decisions under a POAHC, rather than just those relating to dementia. That is, no statement made by a principal at a time when he

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[1] Page 5, ll. 20 to 22, and p. 6, ll. 1 to 4, SECTION 5, WLC: 0018/3.

[2] "Incapacity," for purposes of ch. 155, is defined in s. 155.01 (8), Stats., as the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions.

or she has incapacity would be considered a direction to the agent within the meaning of the statute. Specific authorization in the POAHC instrument would not be required in order for the provision to take effect, and the provision would apply to any type of decision made by an agent under a POAHC. Also, this provision would not create a specific statutory provision requiring the agent to consult with specific care providers.

Issue: Should sub. (3) be expanded to apply to all decisions under a POAHC, as described above? If so, should the draft authorize a principal to opt out of the provision if desired?

Admission of the Principal on an Inpatient Basis to a Facility

Under current law, an agent is prohibited from consenting to admission of the principal on an inpatient basis to one of a variety of facilities identified in ch. 155.[3] This provision sometimes prevents individuals from obtaining certain care and treatment of dementia, or conditions or behaviors substantially related to dementia, on a voluntary basis with the assistance of an agent under a POAHC.

1. Exception to Prohibition on Agent Consent to Inpatient Admission

Background: WLC: 0018/3 would create an exception that would allow an agent to consent to the admission of a principal with dementia to a facility for certain purposes. The draft creates this exception in s. 155.25 (4), Stats., which is referred to as "sub. (4)" in the remainder of this Memo.[4] Under sub. (4), an agent may consent to admission of a principal to a facility identified in ch. 155 if the POAHC instrument contains the required authorization. Subsection (4) would only apply to admissions made for purposes of care or treatment of dementia, or any condition or behavior substantially related to dementia. Also, sub. (4) would require a principal to consult with appropriate care providers regarding the principal's prognosis and acceptable alternatives for care or treatment of dementia, or any condition or behavior substantially related to dementia. Also, sub. (4) would require a physician from the facility to certify in writing that reasonable efforts have been made to address or accommodate the behaviors or conditions for which care or treatment in the facility is sought and the proposed admission will allow the principal to receive care or treatment more appropriate to the principal's needs.

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[3] Section 155.20 (2) (a), Stats., reads as follows:

155.20 (2) (a) A health care agent may not consent to admission of the principal on an inpatient basis to any of the following:

1. An institution for mental diseases, as defined in s. 49.43 (6m).

2. An intermediate care facility for persons with an intellectual disability, as defined in s. 46.278 (1m) (am).

3. A state treatment facility, as defined in s. 51.01 (15).

4. A treatment facility, as defined in s. 51.01 (19).

Under s. 51.01 (15), Stats., a **state treatment facility** means any of the institutions operated by the department for the purpose of providing diagnosis, care, or treatment for mental or emotional disturbance, developmental disability, alcoholism or drug dependency and includes, but is not limited to, mental health institutes; and under s. 51.01 (19), Stats., a **treatment facility** means any publicly or privately operated facility or unit thereof providing treatment of alcoholic, drug dependent, mentally ill, or developmentally disabled persons, including, but not limited to, inpatient and outpatient treatment programs, community support programs, and rehabilitation programs.

[4] Page 6, ll. 5 to 12, SECTION 5, WLC: 0018/3.

Issue*:* Should the provision creating sub. (4) remain in the draft?

2. Narrowed Exception to Prohibition on Agent Consent to Inpatient Admission

Background: It was suggested that sub. (4) be narrowed to only allow consent to admission to a facility specializing in care and treatment of dementia, such as an "inpatient facility" as defined in WLC: 0017/5. All other provisions of sub. (4) would remain the same.

Issue: Should sub. (4) be narrowed to only allow consent to admission to an "inpatient facility" as defined in WLC: 0017/5?

3. Additional Safeguards for Agent Consent to Inpatient Admission

Background: It was suggested that sub. (4) be modified to include additional safeguards that would apply to an admission consented to by a health care agent. The safeguards would be modeled, in part, after the provisions in chs. 51 and 55 related to voluntary admissions.[5] Under this option, sub. (4) would be modified to require a physician from the facility to certify in writing that the physician has advised the principal both orally and in writing of the following:

- The general right of a principal to revoke his or her POAHC under ch. 155 and any exceptions that may apply or appear to apply in this case.

- The benefits and risks of care or treatment of dementia, or any condition or behavior substantially related to dementia.

- The principal's right to the least restrictive form of care or treatment appropriate to his or her needs, and the responsibility of the facility to provide the principal with this care or treatment.

In addition, sub. (4) would specify that upon the principal's admission to the facility, the treatment director of the facility or his or her designee must provide notice of the admission to the county department for the county in which the principal is living. Representatives of the county department would be required to visit the principal as soon as possible, but no later than 72 hours after notification, to confirm that there has been compliance with specified provisions of ch. 155.

Also, currently, ch. 155 includes mechanisms to allow a petitioner to obtain a court order monitoring or limiting the powers of an agent or revoking, limiting, or rescinding a POAHC.[6] Under the proposed modification, sub. (4) would specifically authorize the treatment director, his or her designee, or the county department to serve as petitioner in any of these proceedings.

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[5] See s. 51.10, Stats. (voluntary admissions), and s. 55.055, Stats. (admissions initially made without court involvement).

[6] Sections 155.60 (1) and (2), Stats., allow for a determination of incompetency and appointment of a guardianship for an individual who is a principal under a POAHC, and for revocation or limitation of the POAHC for good cause shown. Section 155.60 (4), Stats., allow for court oversight of the agent or rescission of the POAHC if the agent is not performing his or her duties in accordance with the terms of the POAHC instrument.

Issue: Should the above proposed additional safeguards for sub. (4) be added to the draft? Should different safeguards be considered?

Revocation Under the New Standard for Dementia Care

Under current law, a principal may revoke his or her POAHC and invalidate the POAHC instrument at any time. The statutes permit a principal to revoke his or her POAHC through numerous means, including by defacing the instrument, by signing a written revocation, or by verbally expressing the intent to revoke the instrument.[7] The statutes do not limit the right to revoke to a time when a principal has the capacity.

1. New Standard for Revocation of POAHC with Dementia Care Provision Based on Capacity to Make Health Care Decisions

Background: WLC: 0018/3 would limit the right of a principal to revoke a POAHC in certain cases. It creates s. 155.25 (5), Stats., which is referred to as "sub. (5)" in the remainder of this Memo.[8] Subsection (5) would establish a new standard for revocation of POAHCs that contain an authorization for the dementia care provision under sub. (3), discussed above. Subsection (5) would specify that a POAHC containing the dementia care authorization may not be revoked by a principal at a time when the principal has incapacity.[9] Put another way, sub. (5) would specify that a POAHC containing the dementia care authorization may not be revoked by a principal at a time when the POAHC is activated.

Issue: Should the provision creating sub. (5) remain in the draft?

2. New Standard of Revocation for POAHC with Dementia Care Provision Based on "Sound Mind" Standard

Background: The current standard for execution of a POAHC is that the principal must be of sound mind. It was suggested that sub. (5) should provide that a POAHC containing the dementia care

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[7] Section 155.40, Stats., concerning revocation of a power of attorney for health care, reads as follows:

155.40 (1) A principal may revoke his or her power of attorney for health care and invalidate the power of attorney for health care instrument at any time by doing any of the following:

(a) Canceling, defacing, obliterating, burning, tearing or otherwise destroying the power of attorney for health care instrument or directing another in the presence of the principal to so destroy the power of attorney for health care instrument.

(b) Executing a statement, in writing, that is signed and dated by the principal, expressing the principal's intent to revoke the power of attorney for health care.

(c) Verbally expressing the principal's intent to revoke the power of attorney for health care, in the presence of 2 witnesses.

(d) Executing a subsequent power of attorney for health care instrument.

[8] Page 7, ll. 1 to 3, SECTION 5, WLC: 0018/3.

[9] "Incapacity," for purposes of ch. 155, is defined in s. 155.01 (8), Stats., as the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions.

authorization may be revoked by a principal only at a time when the principal is "of sound mind" rather than only at a time when he or she does not have incapacity. All other provisions of sub. (5) would remain the same. This standard would create a lower threshold for the capacity to revoke, because it is possible for an individual to be of sound mind but to have "incapacity" with respect to health care decisions. Therefore, a standard prohibiting revocation by a principal who is not "of sound mind" would prohibit fewer principals from revoking their POAHCs than a standard prohibiting revocation by a principal who does not have incapacity.

Issue: Should sub. (5) provide that a POAHC containing the dementia care authorization may be revoked by a principal only at a time when the principal is "of sound mind"?

3. Exception to New Standard for Revocation of POAHC With Dementia Care Provision

It was also suggested that sub. (5) include an exception for consistent and sustained acts of revocation by a principal. Under the exception, these acts could trigger a revocation of the POAHC, even if the principal has incapacity and all of the other requirements of sub (5) are met. This exception would apply under either standard for revocation contemplated above (i.e., "incapacity" versus "not of sound mind").

Issue: Should the proposed exception to sub. (5) for consistent and sustained acts of revocation be added to the draft? How should the terms "consistent," "sustained," and "act of revocation" be defined for purposes of the exception? Also, should the provision include additional procedures specifying who will be authorized to determine when the exception applies?

4. New Standard of Revocation for POAHC With Dementia Care Provision Based in Writing

Background: Finally, as an alternative to all of the above suggestions regarding revocation, it was suggested that sub. (5) simply specify that a POAHC containing the dementia care authorization may not be revoked by a principal except in writing. It was suggested that this would remove the question of revocation from most types of interactions involving individuals with dementia in which protests and behavioral challenges arise, provided that the provision clearly specified what revocation "in writing" meant under the circumstances (for example, whether this could include defacing the instrument or whether a separate writing would be required). On the other hand, it would preserve the individual's ability to rationally express his or her desire to revoke a POAHC instrument. As under current law, this would avoid any need to assess the capacity or ability of the principal to revoke the POAHC.

Issue: Should sub. (5) be modified to simply specify that a POAHC containing the dementia care authorization may not be revoked except in writing?

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