WISCONSIN HOSPITAL ASSOCIATION, INC.

December 17, 2012

To: **Members of the Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias**

From: **Matthew Stanford, Wisconsin Hospital Association, Vice President Policy & Regulatory Affairs, Associate**

Cc: **Mary Matthias, Senior Staff Attorney, Legislative Council**
Brian Larson, Staff Attorney, Legislative Council

Re: **Recommendation for significant additional review and changes before the drafts are introduced as legislation**

The Wisconsin Hospital Association recommends that WLC 0061/1 and WLC 0018/4 not be introduced as legislation without significant additional review, consideration, and changes.

The provision of care for individuals with degenerative brain disorders, mental illness, developmental disabilities, and alcohol and substance abuse problems is both medically, legally, financially and logistically complex and involves multiple stakeholders including law enforcement, county agencies, the judicial system, acute care facilities, long-term care facilities, physicians, nurses, and most importantly, individuals and their families. Because multiple stakeholders are involved in the provision of care for vulnerable individuals with degenerative brain disorders, mental illness, developmental disabilities, and alcohol and substance abuse problems, and because of the potential for statutorily-created disruptions to the care for this vulnerable population, comprehensive changes to this complex area of medicine and law require a longer process for consideration than is typically necessary to change to other laws.

Just over 2 months ago, on October 15, the full Special Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias (Special Committee) received the first drafts of the bills being considered today. Prior to today's meeting, the full Special Committee has met only twice, on October 18 and November 14 to consider the drafts. WHA has also been engaged in the process, offering a road map of key questions and principles for the Special Committee to consider in a memo to the Special Committee on July 31, providing a proposal prior to the Special Committee prior to the November 14 meeting that directly addressed the impact of the Helen EF Supreme Court decision by creating a simple and temporary change to Chapter 51 that would sunset to allow for a thorough and comprehensive review and reform of Chapter 55, providing a list of questions regarding the drafts to the Special Committee prior to the November 14 meeting, attending and providing input during subcommittee meetings of the Special Committee, and sharing concerns and suggestions informally with members of the Special Committee, legislators, and their staff.

To help further illustrate why significant additional discussion is needed before these drafts are introduced, WHA has also attached examples of several problems with WLC 0061/1 that have not been fully discussed by the full committee. Further, in a separate memo to the Special Committee, WHA also offers specific opposition to provisions in WLC 0061/1 that would discourage hospitals from providing inpatient psychiatric care for individuals with dementia by giving county government regulatory authority over hospitals approved and regulated by the Department of Health Services.

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 P (608.274.1820) F (608.274.8554) wha.org

While the study committee has made significant progress in a short amount of time in working through this complex area of medicine and law, we cannot say that the study committee has been able to fully consider the full impacts of these complex changes to a complex area of medicine and law. **In short, given the complex and fundamental changes in how individuals with dementia will access, receive, and direct their care, significant additional review, consideration, and modification to the drafts is necessary to ensure a comprehensive, sustainable, long-term legal framework that best ensures individuals with dementia can get the right care at the right time.** While we cannot support the introduction of the draft bills without additional stakeholder review, we look forward to working with the legislature, stakeholders on the committee, and other stakeholders to address the important and pressing issues raised by the committee.

Examples of Issues in WLC 0061/1 Needing Further Discussion and Changes Before Introduction as Legislation

The items below provide examples illustrating why significant additional discussion and changes are needed before WLC 0061/1 is introduced. The list below is not intended to be a comprehensive identification of all problems, whether high level or detailed and technical, with WLC 0061/1.

The draft is unnecessarily complex and prescriptive, and will result in inconsistent application and implementation of the law with disparate treatment for individuals in need of emergency care.

The Supreme Court's interpretation of Wisconsin law in the Helen EF decision was based on a false premise that the lives of individuals with Alzheimer's Disease and dementia cannot be improved through care provided by an inpatient psychiatric unit. Rather than directly addressing that false premise by directly addressing the language in s. 51.01 and s.51.20 (the mental health statutes) and relying upon the existing safeguards (and accepted interpretations) in chapter 51, informed consent statutes, guardianship statutes, medical malpractice laws and standards, and hospital and physician licensure laws, the current draft unnecessarily attempts to recreate those existing safeguards in duplicative ways that will require patients, families, health care providers, county agencies, and law enforcement throughout 72 counties to spend scarce resources to develop new processes and interpretations and to train and consistently apply those new processes and interpretations. In short, to accomplish the goal of "fixing" Helen EF in a way that minimizes unnecessary disruption to appropriate care and increases the likelihood of consistent application of ch. 51 and 55, additional time is needed to more carefully identify existing safeguards and rely on those safeguards to create a draft that is simpler and easier for care providing stakeholders to implement and consistently apply.

Concerned that the provision extends Helen EF to patients with a Dual Diagnosis.

Helen EF explicitly stated that it was not ruling on whether an individual with a dual diagnosis of mental illness and Alzheimer's Disease could be committed under ch. 51. The draft however addresses this dual diagnosis issue and provides that no dual diagnosis individuals should be emergently detained or treated under ch. 51. Thus, this provision does not "fix" a problem created by Helen EF, but instead creates a new problem explicitly not addressed by Helen EF. What this means is that all individuals with dementia, whether the dementia is the primary or tertiary diagnosis must be treated using the protective placement and services system rather than the ch. 51 system. Not all counties and caregivers interpret the Helen EF decision in such a manner and for good and reasons continue to use ch. 51 to provide necessary and appropriate psychiatric care to individuals with dementia. The draft would now prohibit such use of ch. 51 and substitutes a similar, but different process that as discussed below contains barriers to individuals getting care that they currently could receive under ch. 51.

Further, under current law at s.55.15(1), an "individual may not be transferred, *under the protective placement order*, to any facility for which commitment procedures are required under ch. 51." (emphasis added) Thus, while

an individual that has a protective placement order that has developmental disabilities, drug or alcohol dependency, or mental illness (including individuals with a dual diagnosis of mental illness and degenerative brain disorder) cannot be transferred under the ch. 55 order to an inpatient psychiatric unit, such an individual may be admitted to an inpatient psychiatric unit under ch. 51. It is not uncommon for an individual to have both a ch. 55 order and a ch. 51 order at the same time. Section 20 appears to unnecessarily change this current practice for individuals with a dual diagnosis and possibly for individuals that do not have dementia.

Dementia is a medical diagnosis, not a behavior.

The draft will prohibit law enforcement from taking an individual into custody under the emergency detention statute if "based on observation and currently available information" the individual has or appears to have dementia. A law enforcement officer does not have the training to determine whether an individual does NOT have "appear to have" "organic brain disease," that is "not capable of being reversed and from which recovery is impossible." It is unclear how law enforcement could consistently make this determination, thus this provision is likely to create inconsistent practice across Wisconsin.

The draft creates 72 new unnecessary and redundant hospital regulatory bodies.

Hospitals and their psychiatric units are already regulated and monitored by state and federal agencies. The draft will create a patchwork of new and redundant hospital regulations varying by county as it gives 72 county governments regulatory authority to determine whether hospitals that provide care to individuals with dementia meet qualifications and competencies determined by county governments. New county regulation of hospitals is wholly unnecessary given the existing regulation of hospitals, and will likely result in reduced access to beneficial psychiatric care for individuals with dementia by discouraging hospitals from creating or maintaining inpatient psychiatric units that will provide services for individuals with dementia.

The draft appears to permit a county to require a hospital to accept an individual with dementia on to their psychiatric unit under an involuntary protective placement regardless of whether the hospital is willing and able to accept the individual.

The "designation" provisions of the draft appear to be a significant deviation from ch. 51 which explicitly provides that hospitals that provide psychiatric services are not required to admit an individual under an emergency detention or involuntary commitment unless the hospital agrees to detain the individual. Further, permitting a county to involuntarily designate an inpatient facility would also give an inpatient facility no bargaining power with the county to ensure that the county provides adequate reimbursement to the inpatient facility for individuals protectively placed at the inpatient facility. Again, this would will likely result in reduced access to beneficial psychiatric care for individuals with dementia by discouraging hospitals from creating or maintaining inpatient psychiatric units that will provide services for individuals with dementia under a protective placement.

The inpatient facility "designation" mechanism also does not provide flexibility for situations in which a sole designated facility is at capacity or is unable to safely care for an individual due to their acuity.

It is not unusual for an inpatient unit to be full or be unable to admit a patient whose acuity is such that the unit could not safely care for the individual. If the county's only designated inpatient facility or facilities are unable to admit a patient with dementia in need of psychiatric care, the draft appears to make no provision for how such individual could receive care elsewhere.

The definition of "inpatient facility" appears to prohibit the use of non-hospital units that many counties are using to provide involuntary services in a less restrictive environment.

As a means to reduce the cost of care and to provide care in the most appropriate and least restrictive setting, some counties are utilizing non-hospital facilities such as community based residential facilities (CBRFs) for involuntary services under chapter 51. These facilities are not commonly considered "inpatient facilities" and it appears the draft precludes the use of facilities such as CBRFs.

The definition of "inpatient facility" may exclude stand-alone psychiatric hospitals or units.

The definition of "inpatient facility" requires competency in *medical* care to individuals with dementia. Given that the definition makes a distinction between "medical, psychiatric and behavioral care," it is not clear whether a psychiatric hospital or a psychiatric unit would meet the definition of competency in *medical* care and thus meet the definition of inpatient facility.

The definition of "inpatient facility" appears to be internally inconsistent.

The definition of "inpatient facility" requires that the facility must be "qualified and equipped to provide, and competent in providing…*medical, psychiatric and behavioral care."* However, the definition also provides that "medical facilities need not be on the premises." These two statements considered together are likely to create confusion and inconsistent interpretation.

To reduce the likelihood of the need for a temporary or permanent protective placement, the "72 hour clock" should start when the individual arrives at the hospital's inpatient psychiatric/dementia department.

The draft states that an "individual is considered to be detained when he or she arrives at the inpatient facility." It is not clear if this means that detention begins when the individual arrives at an emergency department of a hospital that has a unit appropriate for the individual or when the individual actually arrives at the hospital's inpatient psychiatric/dementia department. While some would advocate that the 72 hour clock start earlier, this will increase the likelihood that the individual will move to the probable cause hearing for protective placement since that individual received less time receiving care that could potentially address the issue that caused the dangerousness. If the 72 hour clock starts when an individual arrives at the inpatient unit, that will give the

individual more time to receive care that could address the issue that caused the need for emergency protective placement and thus increase the likelihood that the individual could be released without the need for temporary or permanent protective placement.

The draft contains provisions and requirements "borrowed" from chapter 51 that make little practical sense in the context of an individual that, by definition, is incompetent.

For example, the newly created inpatient emergency protective placement procedure at s. 55.59 requires a hospital to inform, orally and in writing, the individual with dementia being detained of their rights to contact an attorney and to have an attorney provided at public expense pursuant to s. 55.105. However, unlike individuals under chapter 51 which are not presumed incompetent, the definition of dementia in the draft only includes individuals that are not competent. In the context of an emergency protective placement, requiring a hospital to provide an *incompetent* individual a written notice of rights regarding the provision of an attorney makes little practical sense.

The new provisions of the draft address situations that are also addressed by ch. 51, existing provisions of ch 55 and other laws. Additional work needs to occur to make sure these provisions do not conflict or interfere with each other in a way that prevents timely and necessary care for vulnerable individuals and that the draft does in fact articulate the intent of the committee. One example is provided below.

Newly created 55.59(4) requires that when an individual with dementia is detained for psychiatric care in an inpatient facility as an emergency protective placement, the person making the emergency protective placement must immediately file a petition that meets the requirements under existing s. 55.08(1). Pursuant to s. 55.08(1), the person making the emergency protective placement must allege that the following are true:

- The individual "has a primary need for residential care and custody,"
- The individual "has been determined to be incompetent by a circuit court," and
- The individual "has a disability that is permanent or likely to be permanent."

While each of these requirements, may make sense for purposes of a traditional protective placement, they do not make sense for the purposes of getting individuals with dementia necessary, emergency psychiatric care. For example, while an individual with dementia being cared for at home may need emergency psychiatric services, that individual would not necessarily have a primary need for residential care and custody and thus could not receive emergency psychiatric care under this provision. Also, this provision would appear to prohibit individuals that have become incompetent and meet the new definition of dementia in the draft, but have not yet been judicially declared incompetent, from receiving involuntary emergency psychiatric care. Further, the committee has not discussed whether dementia is to be considered a permanent disability. Would such a designation have implicate other laws not considered?