

The Guardian is a quarterly newsletter published by the Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR) Wisconsin Guardianship Support Center (GSC).

The GSC provides information and assistance on issues related to guardianship, protective placement, advance directives, and more.

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What Guardians & POA Agents Should Know About Marketplace Subsidies

by Kyle Lawrence, Elder Healthcare Advocate, GWAAR Elder Law & Advocacy Center

Many people who have a guardian or Power of Attorney (POA) agent can still take advantage of the health care Marketplace and the subsidies it provides. Individuals that do not have a disability determination, are waiting for a government program to begin, or who have no access to government health insurance can use Marketplace plans to bridge the gap until coverage begins or as their primary health insurance if no other insurance is available. Along with these plans, beneficiaries may receive subsidies that reduce premiums and out-of-pocket costs associated with individual health insurance plans. Guardians or POA agents should be aware of these subsidies and the opportunities the Marketplace presents in the light of other available health insurance coverage.

Guardians and POA agents have good reason to be confused when faced with obtaining health insurance for their principal. Obtaining individual health insurance is hard on its own; having to navigate another person into coverage while abiding by the terms of a guardianship or POA can be an even more complicated ordeal. A guardian or POA agent who has no use for individual health care (that is, they already have employer coverage or Medicare) may even find themselves trying to obtain individual health insurance for the first time, all while responsible for making the best decisions regarding someone else's health care. This article will hopefully help allay some of the confusion and equip guardians and agents with the information needed to make rational health insurance coverage choices for their principals.

Duties of Guardians and Agents in Obtaining Health Insurance

Under Wis. Stats. § 244.50, an agent appointed under a Power of Attorney for Finances (POA-F) that contains a general grant of power may apply for, modify, or terminate insurance plans, as well as pay the premiums the premiums in place of the principal. While the POA-F agent may apply for an insurance plan on the principal's behalf, working with the Health Care Power of Attorney agent is recommended to ensure an appropriate choice is made.

Guardians of estate handle obtaining insurance for the ward in a similar way as POA-F agents. The guardian of estate is responsible for the principal's funds and making sure that those funds are used to meet the principal's needs, to preserve the funds from waste or exploitation by others, and to man-

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What Guardians, POAs Should Know About Marketplace Subsidies, continued from page 1

age and invest the funds in a responsible way. Paying for needed health insurance may seem to fall under a guardian of person's duty to obtain health care for the ward; however, it is actually only the guardian of estate that may use the ward's funds to sign up for health insurance.

The Marketplace

Guardians and POA agents should look into all healthcare options for the individuals they assist such as Medicare, Medical Assistance (Medicaid), disability insurance benefits, and others before looking to the Marketplace. Individual health insurance plans can be used to bridge the gap before coverage begins under state and federal benefit program, or if there are no other options, they can be used as the individual's primary insurance. Open enrollment for health insurance both on and off the Marketplace begins November 15, 2014, and ends February 15, 2015. The Marketplace can be an ideal option for individuals that are below 400% of the federal poverty level (FPL) – \$46,680 annually for a household size of one – and are currently without health care coverage. Having income under 400% of the FPL may qualify the individual for subsidies to help cover the cost of premiums through premium tax credits (PTCs) and out-of-pocket expenses through cost-sharing reductions (CSRs).

While there is much more information that is pertinent to what the agent or guardian should be familiar with before enrolling an individual in the Marketplace, having a grasp on what Marketplace subsidies are available and how they can help decrease the cost of the individual's health insurance is a valuable tool. Below are the forms of subsidies available to Marketplace enrollees.

Premium Tax Credits (PTC)

Premium tax credits are based on the individual's income. If the individual's income is less than 133% of the FPL (\$15,521 annually per the 2014 FPL guidelines)¹, the individual will only need to contribute 2% of his or her income to the payment of their premium. The rest is covered by the federal government in the form of a tax credit that can be taken

monthly or at the end of the year while filing taxes. Consumers between 300% and 400% of the FPL (\$35,010 and \$46,680 respectively) will have to pay 9.5% of their annual income on monthly premiums with the rest being covered by the federal government.

It is very important that consumers report their income changes throughout the year if they are receiving the advanced premium tax credit. This will allow the Marketplace to track their income and adjust their credit accordingly.

Cost-Sharing Reductions (CSR)

Cost-sharing reductions only apply when a silver plan is selected. There are two types of cost-sharing subsidies: a monthly reduction in out-of-pocket costs and an annual cap on maximum out-of-pocket costs. Individuals may receive both by meeting their respective eligibility requirements.

The monthly reduction is available for individuals with income below 250% of the FPL (\$29,175) and reduces out-of-pocket costs like deductibles, copayments, or coinsurance, but not premiums.

The annual cap on maximum out-of-pocket costs will reduce the total amount an individual is required to pay for out-of-pocket services. This subsidy is available to individuals up to the 400% of the FPL. People with incomes between 100% and 200% of the FPL will have a two-thirds reduction in out-of-pocket liability; those between 201% and 300% of the FPL would receive a one-half reduction in out-of-pocket liability; and those between 301% and 400% of the FPL will have a one-third reduction in out-of-pocket liability.

Enrolling in a plan through the Marketplace is to be done during the open enrollment period (SEP) between November 15, 2014 and February 15, 2015. There are multiple SEPs available to people that have experienced "qualifying life events." A sudden illness or disability, such as the kind that would invoke a POA or the appointment of a guardian, may be enough to trigger an "unexpected circumstances" SEP.

To see if there are any applicable SEPs or if you have any questions, contact a navigator near you or the Marketplace call center at (800) 318-2596.

¹All FPL figures are based on a household size of one. For larger households, consult the federal poverty level tables.



***In the Matter of the Mental Commitment of Sondra F.:
Price County Department of Health and Human Services v.
Sondra F.***

2013 AP 2790
(May 28, 2014)

Summary: An individual in mental health commitment appearing by video teleconference rather than in person must affirmatively object to the use of videoconferencing. If an individual objects to the use of videoconferencing and wishes to be present, the individual's due process rights might be affected if the court proceeds over the objection.

Case Detail: Sondra F. (hereafter *Sondra*) was involuntarily committed under a Ch. 51 mental health commitment in Price County. For the final hearing, Sondra appeared from Winnebago Mental Health via videoconferencing. The court did not conduct a colloquy with her regarding the use of videoconferencing technology nor did Sondra object to appearing by videoconferencing.

Sondra brought a post disposition motion arguing, pursuant to Wis. Stat. § 885.60(2), she was required to be physically present in the courtroom unless the requirement was affirmatively waived. The circuit court determined it erred by failing to engage Sondra in a colloquy, but the error was harmless.

On appeal, the parties agreed that Sondra was required to be physically present at the final hearing, that Sondra was required to affirmatively waive her right to be physically present, and that the failure to obtain waiver was an error. Because the court of appeals is not required to accept parties' conclusions of law, it rejected the assertion that Sondra's physical presence was required at her final hearing.

Sondra provided two main arguments to support her position:

- 1) Relying on Wis. Stat. § 971.04(1), she argued the requirement that a criminal defendant be present in the courtroom also applies to Ch. 51 commitments. She further argued that relying on *State v. Soto*, 2012 WI 93, 343 Wis.2d 43, 817 N.W.2d 848, to relinquish the right to be present in the courtroom, the respondent must affirmatively waive the right.
- 2) Wis. Stat. § 51.20(5) provides that Ch. 51 hearings "shall conform to the essentials of due process." She argued that the right to be present is an essential element of due process and should apply equally to mental health commitments and criminal defendants.

The County stated that Sondra is "entitled to be physically present" at her final hearing pursuant to Wis. Stat. § 885.60(2), but failing to obtain a waiver was harmless error.

The court of appeals found that Wis. Stat. § 971.04(1) and *Soto* do not apply to Sondra's case. Wis. Stat. § 971.04(1) only applies to criminal defendants. Sondra is not a criminal defendant. *Soto* required a criminal defendant to provide "intentional relinquishment of a known right." However, because the statutory requirement only applies to criminal defendants, this rule does not apply to Sondra. Although Wis. Stat. § 885.60(2) entitles Sondra to be physically present at her final hearing, it does not require it. Sondra presented no legal authority requiring her physical presence at the final hearing. Wis. Stat. § 885.60(2)(d) requires an individual to object to use of videoconferencing for mental commitment hearings or to request to be physically present. Had there been an objection to the use of videoconferencing and the court had continued the hearing, Sondra's due process rights may have been implicated. However, Sondra never objected to the use of videoconferencing and she forfeited her rights to later object to the use of videoconferencing technology. The circuit court did not err in failing to obtain a waiver of Sondra's right to appear in person because the option to appear in person is not required. The commitment order was affirmed.

***In the Matter of the Mental Commitment of Jeffrey J. T.:
Portage County v. Jeffrey J. T.***

2013 AP 2481
(June 26, 2014)

Summary: Jeffrey J. T. appealed an order extending his involuntary commitment. He argued the court did not have the competency to extend his commitment and there was insufficient evidence to support the court's involuntary medication order. The Court of Appeals affirmed the circuit court's involuntary commitment extension finding that the circuit court was competent to hear the case, and that evidence provided in the doctor's report was substantial enough to meet the strict statutory requirements.

Case Detail: Jeffrey J. T. has been under a court-ordered commitment since June 2009. He did not dispute that each prong for an involuntary commitment was shown by clear and convincing evidence, but Jeffrey challenged the circuit

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Supported Decision-Making

The concept of supported decision-making is fast becoming a frequently discussed topic in the area of decision-making. In the last decade, many countries and several U.S. courts have adopted supported decision-making principles and models. Proponents of supported decision-making often value its emphasis on all individuals' autonomy, and some believe supported decision-making models will eventually replace guardianship. But what is this concept gaining popularity? How is it different than guardianship? Will it replace guardianship? This article will explore what is supported decision-making, where examples of it can be found, and what its benefits and drawbacks are.

What Is Supported Decision-Making?

Supported decision-making is a "series of relationships, practices, arrangements and agreements, of more or less formality and intensity, designed to assist an individual with a disability to make and communicate to others decisions about the individual's life." Dinerstein, Robert D. "Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making," Human Rights Brief 19, no. 2 (2012): at 10.

In short, supported decision-making is a process that allows for the individual to make his or her own decisions and provides the individual with a support system meant to assist him or her in making those decisions. The individual is still the ultimate decision-maker.

Supported decision-making is a both a process and a shift in thinking. Many principles shape this concept, but there are at least two central principles. First, the concept is firmly rooted in the idea of autonomy and one's right to direct his or her life. It also considers the idea that independent decision-making is a myth. Individuals, regardless of competency, often make important decisions considering the input and guidance of others. Carter, Barbara. "Supported Decision-Making," Office of Public Advocate (November 2009), found at: www.publicadvocate.vic.gov.au/file/file/Research/Discussion/2009/0909_Supported_Decision_Making.pdf (last visit-

ed July 25, 2014). For example, a young adult trying to make an important life decision might consult with his or her parents, other family members, friends, etc. before making that decision. Other concepts, such as the right to take risks and to learn from those risks taken, are prevalent as well. *Id.*

How Is This Different From Substituted Judgment or the Best Interest Standard?

The most striking difference between the three concepts is who the decision-maker is. In supported decision-making, the individual is the decision-maker and is in control of his or her own choices. With substituted judgment or the application of the best interest standard, the surrogate is the decision-maker and not the individual.

With substituted judgment, the surrogate decision-maker is required to make decisions reflective of what the individual would have chosen if he or she were able to, but the surrogate decision maker makes the decision in the end.

Under the best interest standard, the standard required to be followed by Wisconsin guardians, the surrogate decision-maker is required to make decisions reflective of what is in the individual's best interest. This also means the decisions may or may not be what the individual would have chosen or wants now; the decision-maker chooses what he or she determines to be in the individual's best interest.

Where One Might Have Heard of Supported Decision-Making

The concept of supported decision-making has significantly increased in popularity in the last ten years. From the United Nations and now to certain U.S. courts, the concept is being adopted throughout the world.

UN Convention and Other Countries

One of the most prominent examples of the adoption of supported decision-making occurred when the United Nations adopted the Convention for Rights of Peoples with Disabilities (CRPD) in 2006. This convention was ratified

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court's competency to extend his commitment in 2013. Jeffrey argued the circuit court lost competency to extend his commitment because his 2012 commitment order had expired on June 4, 2013, prior to the recommitment hearing on June 17, 2013. However, the court found the 2012 recommitment order expired on June 18, 2013, not June 4th.

Jeffrey also challenged the sufficiency of evidence supporting the circuit court's order for involuntary medication. He argued the county failed to prove under Wis. Stat. § 51.61(1)(g)(4) that he was not competent to refuse medication. Under *Melanie L.*, 2013 WI 67, 349 Wis.2d 148, the language of a testifying doctor must strictly adhere to the language in the statute. Jeffrey argued that the County's sole witness Dr. Seshadri did not explain to Jeffrey the alternative treatments available or the advantages and disadvantages as required by statute. Instead, Jeffrey claimed Dr. Seshadri testified that he explained to Jeffrey how Dr. Seshadri believed the medication was helping him and/or was not needed.

However, the court of appeals found that Dr. Seshadri's testimony was sufficient evidence to meet the statutory requirements. The court of appeals will affirm a circuit court unless the findings are clearly erroneous. A circuit court's findings are not clearly erroneous if they are supported by any credible evidence. In Dr. Seshadri's report, he stated he explained the advantages, disadvantages and alternatives to Jeffrey but, "[Jeffrey] is incapable of expressing an understanding of the advantages and disadvantages and alternatives to accepting this particular medication or treatment, or is substantially incapable of applying an understanding." The court found the evidence in the report sufficient enough to affirm the circuit court decision.

***In the Matter of the Mental Commitment of Kathleen H.:
Waukesha County v. Kathleen H.***

2014 AP 90

(June 25, 2014)

Summary: The Court of Appeals reversed a Waukesha County decision to order the involuntary medication and treatment of Kathleen H. The court found that the County did not meet the burden of proof that, by clear and convincing evidence, Kathleen did not understand the advantages, disadvantage and alternatives of a particular medication. The

County provided testimony that did not strictly adhere to the specific statutory terms, to prove Kathleen received an adequate explanation, as required by *Melanie L.*

Case Detail: In 2004, Waukesha County ordered Kathleen H. to a mental health commitment and involuntary medication order. The court extended these orders several times. However, in February 2013 Kathleen wrote the court requesting to cancel her recommitment order because she could no longer take her medication. The circuit court entered an order for involuntary medication finding that Kathleen was "incapable of expressing an understanding of the advantages and disadvantages as well as the alternatives" of her medication. Kathleen appeals this order arguing the county did not meet the burden of proving she was incompetent to refuse medication.

To meet the burden of proof, the county had to show that due to mental illness "after the advantages and disadvantages of and alternatives to accepting the particular medication or treatment have been explained to the individual," the individual is either "incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment," or is "substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness . . . in order to make an informed choice as to whether to accept or refuse medication or treatment." Wis. Stat. § 51.61(1)(g)(4). The county had to prove the statutory elements by clear and convincing evidence.

However, before a court can even examine whether an individual has the proper understanding of medication or treatment, the court must determine whether the individual received an adequate explanation to make an informed choice. In *re Melanie L.*, 2013 WI 67, 349 Wis.2d 148. *Melanie L.* requires strict adherence to specific terms of the statute. The testimony of the medical professional must closely follow the statutory terms so that the court does not need to speculate about the reasonableness of the explanation.

The Court of Appeals found that Dr. Cahill's testimony did not show by clear and convincing evidence that Kathleen received a reasonable explanation of the advantages, disadvantages and alternatives to her proposed medications. The court stated there was no indication that Dr. Cahill explained to

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Helpline Highlights



The Wisconsin Guardianship Support Center receives many calls and emails about guardianships, powers of attorney, other advance directives, and more. Each quarter, the GSC shares some of the calls and emails here. All personal and identifying information has been removed to protect the privacy of the individuals involved.

Can a guardian of the person apply for public or private benefits on the ward's behalf?

No, the authority to apply for public or private benefits is solely granted to the guardian of the estate. It cannot be exercised by the guardian of the person (unless the guardian is also the POA-F agent and that document allows for that authority to be exercised). Wis. Stat. § 54.20(3)(e).

When a guardianship is being considered, a full review of the proposed ward's needs must be performed. The size of the proposed ward's estate is not necessarily determinative of whether a guardian of the estate is needed. The review must look to the powers that will need to be exercised and whether the proposed ward is truly able to exercise those powers that could be exercised by a guardian of the estate. This examination should include whether the proposed ward will need to sign up for or renew any public or private benefits, sign a lease for an apartment, create a funeral trust, etc. That review must not stop at the size of the proposed ward's estate or income.

A review of any existing decision-makers, like POA-F agents and representative payees, and whether their authority is sufficient must also be performed.

If the new ward is unable to provide the requisite consent and there is no available legal decision-maker with sufficient authority to provide consent, no one will be able to provide legal consent. Then a petition for guardianship of the estate may need to be filed at a later date resulting in systemic inefficiency and possible harm to the ward or to the ward's estate.

Should a proposed ward's possible future condition be considered in a guardianship or should the guardianship only be focused on the ward's current state?

The proposed ward's current state is the only state the court may contemplate when deciding whether to appoint a guardian. See Wis. Stat. § 54.36(1).

...[A] physician or psychologist, or both, shall examine the proposed ward and furnish a written report stating the physician's or psychologist's professional opinion regarding the presence and likely duration of any medical or other condition causing the proposed ward to have incapacity or to be a spendthrift... Nothing in this section prohibits the use of a report by a physician or psychologist that is based on an examination of the proposed ward by the physician or psychologist before filing the petition for appointment of a guardian, but the court will consider the recency of the report in determining whether the report sufficiently describes the proposed ward's current state and in determining the weight to be given to the report. *Id.*

While it is possible the ward may improve and his or her guardianship may not be needed in the future, the ward may also have the same capabilities or diminished capabilities in the future. The law allows for the expansion, modification, and termination of a guardianship. Depending on the ward's changing abilities, the use of these mechanisms should be considered.

May a guardian consent to involuntary medical treatment?

In this situation, the ward was objecting to receiving relatively basic but necessary medical care needed to maintain his life. The ward was not in a persistent vegetative state – the ward resides in his own home and did not want to leave his home for the purposes of receiving medical care. (He did not object to leaving his home for purposes other than receiving this type of care.)

The guardian may have the authority to consent to involuntary medical treatment if it was granted by the court. Wis. Stat. § 54.25(2)(d)2.ac. If the guardian has that authority and is considering exercising the authority, the guardian must not exercise it at will. The guardian should look at the invasiveness of the medical treatment, the likely benefits

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Don't Forget: Medicare Annual Enrollment Period is Upon Us

by the Legal Services Team at the GWAAR Elder Law & Advocacy Center

From October 15 to December 7, Medicare beneficiaries have the opportunity to enroll in, switch, or disenroll from Medicare Part D prescription drug plans and/or Medicare Advantage Plans (Part C).

Every single year, Part D enrollees should re-examine their Part D plan selection to determine if it is the best option for their needs. Choosing a Part D plan based on name recognition, previous levels of coverage, or premium cost alone is not recommended. Formularies, copays, and premium costs can vary dramatically each year, even for the same exact plan. Additionally, plans may consolidate with another plan, decide not to renew for next year, or change the preferred network of pharmacies. All of these changes can amount to significant price increases to the consumer.

Guardians, powers of attorney agents, and anyone working with Medicare beneficiaries are urged to review the Annual Notice of Change letter sent out to Part D enrollees at the end of September. This is a notice sent by the Part D enrollee's current provider detailing whether the current Part D plan will be available in 2015, and if so, any changes that will occur to the plan pricing or tier structure. If the plan will not be available in 2015, this notice provides information regarding possible auto-enrollment into a new plan. However, it is always better to self-select a Part D based on the individual's medications and coverage needs, rather than be passively auto-enrolled into an alternate plan.

People eligible for both Medicare and Medicaid who are on FamilyCare, IRIS, CIP, COP, or live in a nursing home should not have any copays for their prescription medications under CMS rule. These people must be enrolled in a Part D plan in order to be eligible for zero copays. Certain costs associated with bubble packaging (required in some nursing facilities), or for over-the-counter medications are subject to copays since these are not covered benefits of any Part D plan.

Find the Medicare planfinder at medicare.gov. New 2015 plan information will be released in the upcoming weeks.

Points of Interest

Dementia Care Redesign

The WI DHS held five regional listening sessions throughout the state in July. The purpose was to discuss the status of the Dementia Care Redesign project, to provide an update on certain activities, and to gain feedback from attendees of the listening sessions.

Communication

The Office of Family Care released TA Memo 14-04 entitled "Paying Family Caregivers and Addressing Conflict-of-Interest: A Guideline for MCO Interdisciplinary Team Staff" on June 26, 2014. This memo includes guidelines on considerations made when a guardian is also a paid family caregiver. Find the memo here:

www.dhs.wisconsin.gov/LTCare/Partners/Memos/cy2014.htm

IRIS also released forms related to conflicts of interest and paid caregivers. They are **F-10310: IRIS Program Conflict of Interest Disclosure** and **F-0105i: IRIS Participant Education-Program Integrity-Conflict of Interest**

Find them at: www.dhs.wisconsin.gov/iris/Forms.htm

For assistance with the planfinder or drug plan benefit counseling, call:

Medicare at 800-Medicare (24 hours/day, 7 days/week)

Disability Rights Wisconsin Part D Helpline

For those age 18-59 at (800) 926-4862

Board on Aging and Long-Term Care Part D Helpline

For those age 60+ at (855) 677-2783

Wisconsin SeniorCare

Pharmaceutical assistance program for those age 65+ at (800) 657-2038

Board on Aging and Long-Term Care Medigap Helpline

(800) 242-1060

Local Aging & Disability Resource Center (ADRC)

Find yours at: www.dhs.wisconsin.gov/adrc/

Helpline Highlights



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and side effects of it, and what is in the ward's best interests overall. *Id.* In addition, the guardian should (1) discuss the matter with the ward and (2) obtain the ward's opinion before consenting to the treatment. Certain situations might also benefit from having court review.

[Note: "Medical treatment" does not include the ability to consent to sterilization or to forced psychotropic medication. The administration of psychotropic medication requires a specific court order entered under Wis. Stat. § 55.14. Consent to sterilization is a right retained by or removed from the ward; the guardian cannot provide consent on the ward's behalf. Wis. Stat. § 54.25(2)(c)1.e.]

Do both co-guardians of the estate need to be on a guardianship bank account or can only one guardian hold the account?

Unless otherwise ordered by the court, co-guardians are required to agree on all decisions. If there is no agreement, the disagreed-to decision is void. By default, then, each co-guardian is required to be aware of the decisions made by the other co-guardian. Wis. Stat. 54.46(2)(a). In this situation, one co-guardian wanted to open up a checking account without informing the other co-guardian of the account's existence because of a personal matter between the co-guardians. If this would have occurred, the first co-guardian's (applicable) decisions could have been deemed void because the other co-guardian was not informed and had not subsequently agreed to those decisions.

Several recent callers have contacted the GSC about HCPOAs that were activated due to incapacity soon after their execution and, in fact, executed in contemplation of activating each HCPOA soon after its execution. These

Disclaimer

This newsletter contains general legal information. It does not contain and is not meant to provide legal advice. Each situation is different and this newsletter may not address the legal issues affecting your situation.

If you have a specific legal question or want legal advice, you may want to speak with an attorney.

callers were reporting a general practice performed; no intervening event like a heart attack or an accident had occurred in these situations. Typically, is it okay to have individuals execute HCPOAs when they are being done in contemplation of activating soon afterwards due to incapacity?

Generally, it is extremely poor practice to have individuals execute HCPOAs to be activated upon incapacity only to turn around and activate them a day or two after the execution.

A HCPOA may only be executed by one who is sound of mind. See Wis. Stat. § 155.05(1). A person must not only have the ability to choose his or her agent but also have the ability to understand the powers that can be conferred upon the chosen agent and the significance of those powers, to select the powers conferred, to be aware of the available agents when selecting, and to comprehend the nature of the relationship created in a HCPOA and the rights and limitations of that relationship. Asking only who one wants to make decisions for him or her does not reflect all of the matters that need to be considered when executing a HCPOA.

A HCPOA that is activated upon incapacity and executed in the contemplation that it will be activated soon after is highly suspect. Very likely, an invalid HCPOA has been created in situations like these, and the principal's rights have not been fully considered or respected in its creation.

Drafting HCPOAs under these circumstances also exposes the witnesses, who are certifying the principal is sound of mind at the time of execution, to potential liability. If the witnesses are employees of a larger institution and this is the general practice of that institution, the institution may also be assuming liability.

Frequently this practice is done to avoid guardianships; however, a guardianship may still occur. Not only is there the likely possibility the HCPOA is invalid, there may also be the need for a financial decision-maker.

Had there been a traumatic event like an accident that then called into question the person's capacity to make decisions (between the time of execution and activation), this analysis and conclusion could be much different. Likewise, HCPOAs that are drafted reflective of Wis. Stat. § 155.05(2) but activated another way may be valid.



Case Law, continued from page 5

Kathleen why the medications were prescribed, the benefits of taking the medication, or the possible side effects. Dr. Cahill also did not explain any reasonable alternatives to taking the medication. Dr. Cahill explained that he did not enter a discussion with Kathleen because he thought she would protest. However, no evidence was provided that it would have been impossible to have a discussion with Kathleen. The court found that Dr. Cahill's testimony did not prove by clear and convincing evidence that he explained the proposed medications to Kathleen because his testimony did not strictly adhere to the statutory wording, as required by *Melanie L.*

In the Matter of the Mental Commitment of Vermetrias W.: Kenosha County v. Vermetrias W.

2014 AP 851-FT
(July 16, 2014)

Summary: Kenosha County entered an order extending the mental health commitment of Vermetrias W. Vermetrias appealed, arguing the County provided insufficient evidence to prove that if she were not under a continued commitment, she would go off her medication and become dangerous. The Court of Appeals affirmed her commitment extension stating that the county proved there was a substantial likelihood that Vermetrias would become dangerous, based on her treatment history, if the commitment ended.

Case Detail: Vermetrias W. was diagnosed with bipolar disorder. She has been taking medication and seeing a psychiatrist for over a decade. In June 2013, Vermetrias voluntarily admitted herself for treatment and became the subject of a commitment order. Kenosha County sought to have the commitment order extended and also moved for an involuntary medication order. The county argued that recent hospitalization demonstrated the danger of Vermetrias not receiving treatment. Vermetrias appealed the order extending her commitment arguing that the county did not meet its burden to prove that she is dangerous. To extend an involuntary mental health commitment, a court must find by clear and convincing evidence that:

- The individual is mentally ill, and a proper subject for treatment (Wis. Stat. § 51.20(1)(a)(1)); and
- The individual is dangerous (Wis. Stat. § 51.20(1)(a)(2)). Wis. Stat. § 51.20(1)(a)(2) states that if an individual is a

danger to themselves or others they are a proper subject for commitment. The individual's treatment record showing a substantial likelihood that the individual would be a proper subject for treatment if treatment were withdrawn is evidence that an individual is dangerous. (Wis. Stat. § 51.20(1)(a)(2)(am)). Vermetrias argued that the County did not prove she would become dangerous if her commitment ended because her history demonstrated she would not voluntarily end treatment, and her psychiatrist, Dr. Christenson, testified she would become dangerous only when off medication.

The Court of Appeals affirmed the commitment extension. The court stated that Wis. Stat. § 51.20(1)(a)(2)(am) acknowledges that an individual under a current commitment order is receiving treatment and is unlikely to commit an overt act that would show him or her to be dangerous. The county was not required to prove that Vermetrias is dangerous through the commission of a recent overt act. The statute only required the county to prove there was a substantial likelihood, based on treatment history, that Vermetrias would become dangerous if the commitment ended. The court found that the behavior Vermetrias recently exhibited, and Dr. Christenson's testimony amounted to clear and convincing evidence that Vermetrias posed a danger to herself and others if treatment was withdrawn.

In the Matter of the Mental Commitment and Order for Involuntary Medication and Treatment of Laura B.: Ozaukee County v. Laura B.

2014 AP 1011-FT
(August 13, 2014)

Summary: Laura B. appeals from the circuit court decision to extend her commitment and to order involuntary medication and treatment. Laura argued the County did not establish "that she would become dangerous if treatment were withdrawn." The Court of Appeals affirmed the extension stating that the county met its burden because the County did not have to prove Laura demonstrated dangerous behavior during her commitment.

Case Detail: Laura B. was committed in March 2013, after a police officer removed her from a bridge where she was threatening to jump. Her treatment plan specified she was to follow the recommendations of her psychiatrist. However, Laura

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refused to take the psychotropic medication and stopped seeing a therapist, as her psychiatrist had recommended. The department petitioned to extend Laura's commitment and for involuntary treatment and medication by determining that if Laura were not under a commitment she would not receive treatment, making her dangerous to herself and others. The circuit court for Ozaukee County granted the extensions.

Laura appealed the circuit court order for involuntary medication and treatment and the order extending her commitment. Laura argued that she had the right to refuse the medication, and her refusal cannot be held against her as a reason to grant the involuntary treatment order.

A court may order medication or treatment without a person's consent if the court finds the person is not competent to refuse treatment. Wis. Stat. § 51.61(1)(g)3. To prove a person is not competent to refuse treatment the county must establish:

- 1) Due to mental illness,
- 2) After the advantages, disadvantages, and alternatives to medication have been explained,
- 3) The individual is incapable of expressing an understanding of the advantages and disadvantages of medication and the alternatives, or is substantially incapable of applying an understanding of the advantages, disadvantages and alternatives to make an informed choice as to whether to accept or refuse medication. (Wis. Stat. § 51.60(1)(g)4).

The Court of Appeals held that Laura did have the right to refuse medication, but the involuntary medication order is "supported by Laura's refusal to take medication recommended by her psychiatrist in light of her inability to express or apply an understanding of the advantages and disadvantages of treatment, as applied to her."

To meet the burden of proof to extend a commitment, the court must find by clear and convincing evidence that:

- 1) the individual is mentally ill,
- 2) the individual is a proper subject for treatment (Wis. Stat. § 51.20(1)(a)1), and
- 3) based on the individual's treatment record, there is a substantial likelihood the individual would be a proper subject for commitment if treatment were withdrawn. (Wis. Stat. § 51.20(1)(am)).

University of Wisconsin Research Study

Volunteers Needed To Study the Impact of Health Information Technology on Caregiver Burden

Researchers from UW Madison are conducting a study on the impact of health information technologies on adult caregiver burden. The technology consists of small sensors that can be placed on objects in the home. The study will be conducted for a period of 2 weeks and require the volunteer participation of pairs of older adults (65+) and their caregivers (18–50 yrs.)

The study will involve using a secure website to monitor the sensors. The sensors will be installed in the homes of the older adults for one week. The aim is to determine whether caregiver burden can be reduced with the use of this type of technology in the home.

If interested in participating please contact:
Rashmi Payyanadan at Payyanadan@wisc.edu
or call (608) 770-8829.

Wis. Stat. § 51.20(1)(a)2 states, to show that an individual would be a proper subject for commitment if treatment were withdrawn, the county must demonstrate that the individual poses a danger to himself, or herself, or to others.

Laura did not contest the first two factors, but argued the county did not prove that she would be dangerous if treatment were withdrawn. However, the court of appeals said, the county did not need to show that that Laura demonstrated dangerous behavior during her commitment. Wis. Stat. § 51.20(1)(am) states that a person currently receiving treatment in a commitment is unlikely to commit the kind of dangerous act that would render an individual subject to an initial commitment.

The court of appeals affirmed the circuit court extension of the commitment and involuntary treatment and medication orders. The court found the circuit court relied on the credible evidence of Dr. Rawski's testimony to make the decision — specifically that Laura's delusional thoughts, unwillingness to comply with treatment, and lack of understanding of the advantages, disadvantages, or alternatives to treatment made her a danger to herself and others.

Advocating for the Rights of Your Ward: A Free Training Opportunity for Corporate Guardians

October 14, 2014 Comfort Suites, 725 Paradise Lane,
Johnson Creek, WI 53038

October 15, 2014 Hotel Mead, 451 East Grand Ave.,
Wisconsin Rapids, WI 54494

Experienced advocates will provide an overview of the legal provisions requiring guardians to be advocates for the rights of their wards. Specific topics to be covered include: the guardian's role in guaranteeing least restrictive environment, freedom of association, proper treatment at end of life and sexual expression.

Schedule:

- | | |
|---------------|--|
| 8:00-8:30 am | Sign In |
| 8:30-9:15 am | Overview of DHS 85 and Ch. 54 Advocacy Requirements |
| 9:15-10:15 am | Overview of Ward's Rights in 51.61; DHS 94; and Specific Programs and Settings (Family Care, CBRFs, AFHs) |
| 10:15-10:30am | BREAK-refreshments provided |
| 10:30-12:00pm | Case Studies dealing with the following topics: <ul style="list-style-type: none">• Least restrictive living situation• Freedom to associate• End of life/limiting medical treatment• Sexuality |

Certificates of attendance will be provided.

There is no fee for this training, but preregistration is required.

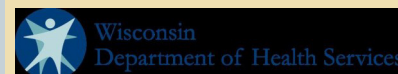
To register:
Call DRW at (608) 267-0214, or
Fax registration form to DRW at (608) 267-0368, or
Email registration form to applel@drwi.org

Sponsors:

Disability Rights Wisconsin,
Department of Health
Services, Greater Wisconsin
Agency on Aging Re-
sources,
Wisconsin Guardianship
Association, Board on Aging

Presenters:

Mitchell Hagopian &
Susan Tess, DRW;
Susan Fisher, GWAAR;
Kim Marheine, BOALTC





Government Accountability Office Researches Unique Challenges of Educating Children in Nursing Homes

by Grace Knutson, Legal Intern at the GWAAR Elder Law & Advocacy Center

Little is known about the vulnerable population of about 5,000 children living in nursing homes in the United States. These children are somewhat separated from their communities and families, which raises a concern that the children are not receiving the educational services required by law. Under the Individuals with Disabilities Education Act (IDEA), the federal government requires States to make available for all children with disabilities a free public education designed to meet the unique needs of each child. States are also required to ensure that children with disabilities receive an education in the least restrictive environment possible. The U.S. Government Accounting Office (GAO) decided to study the delivery of education to children living in nursing homes by examining characteristics of the children, how they are referred to and receive education, challenges in delivering services to these children, and solutions to monitoring their education.

Children who live in a nursing home often have complex medical conditions. Many of the medical conditions also affect the child's ability to learn. Often, either an intellectual disability or a developmental delay places the child at lower than grade level learning ability. There is also difficulty communicating with the child. Many children in nursing homes are nonverbal, or have other disabilities where a teacher cannot recognize how much the child is absorbing.

When a child enters a nursing home, some states have regulations requiring the nursing home to refer the child to the appropriate school district for educational services. The primary method of delivering education to these children was through classrooms at the nursing home, or one-on-one lessons taught at the nursing home. The child's medical condition determines the location of educational activities. Some children are too fragile to be transported to a local school, while others can only handle minimal instructional time.

School officials report difficulty serving the needs of children living in nursing homes. Creating curriculum for these children is difficult. Often the teachers have to modify a school's curriculum to emphasize sensory methods to convey a lesson. Another difficulty is that many teachers are not trained to handle difficult medical tasks, like tracheostomy suctioning, that are necessary during lessons.

Goodbyes

The Guardianship Support Center would like to thank GWAAR's two summer legal externs Kaitlin Kollross and Grace Knutson for all of their hard work and dedication.

Kaitlin Kollross is a third year law student at UW-Madison Law School. She has done externships at the Department of Justice in the Medicaid Fraud & Elder Abuse Unit and the State Public Defender's Office in Eau Claire. In addition to her time at GWAAR, she is also currently working at the Center for Patient Partnerships where she advises clients on Medicare, Medicaid, SSDI, POAs, and ACA questions.

Grace Knutson is also a third year law student at the UW-Madison Law School. She is part of the Women's Law Student Association, Children's Justice Project, Wisconsin International Law Journal, and the first year law student mentorship program. In addition to her externship at GWAAR, Grace also researches children's civil rights and child abuse issues through the Rainbird Foundation in Madison. Grace is fluent in French and studied abroad in France for a semester while earning her undergraduate degree. Prior to attending law school, Grace captioned phone calls for people with hearing impairments.

Both have assisted the GSC throughout the summer including with writing the case law summaries included within this newsletter and with researching legal inquiries made to the GSC. We have appreciated their work, will miss them as they start school this fall, and wish them the best of luck as they continue on with their legal careers!

The GAO made several suggestions for better monitoring this small population of children.

First, the Secretary of Education should create a mechanism to enable information-sharing among teachers of children in nursing homes.

Second, the Secretaries of Education and Health and Human Services should work together to use resources from each department to oversee the education of these children. The small number of children in these situations and their dispersed locations makes them easily forgotten. With more oversight and information-sharing, roughly 5,000 children can receive a better education.



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by many countries. Around 147 state parties have ratified the CPRD (at the time of drafting of this article). The U.S. chose to sign it but did not ratify it.

Article 12 (2) of the CRPD is particularly important, which declares that “States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.” Article 12(3) also provides, “States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.” Thus, all individuals, regardless of their capacity, are to be treated equally; and states are required to provide ways to assure all can be treated equally, specifically including the adoption of supported decision-making models.

As stated above, more than 147 countries have agreed to the terms of the CPRD. Some countries have shown signs of misunderstanding the principles of supported decision-making and how to apply it. Dinerstein at 11-12. Others have had an easier time implementing its principles and with some success. Two successful examples can be found in the Canadian province of British Columbia and Sweden.

In British Columbia, individuals can enter into “representation agreements” allowing for another to help the person make significant decisions, including those on health care or financial matters. Those entering into these agreements might not have the capacity to execute a valid Power of Attorney or will but may still enter into a valid representation agreement. While guardianship is only used in extreme cases, guardianship as well as other advance directives still exist as other possible models of decision-making. Carter at 13.

In Sweden, a position similar to a mentor, called a “god man,” has been created. The mechanism allows for the person to retain his or her right but also provides a *god man* to assist in making decisions. The appointment of the *god man* is subject to court approval. Carter at 15. Kohn, Nina; Blumenthal, Jeremy; and Amy Campbell. “Supported Decision-Making: A Viable Alternative to Guardianship?” 117-4 Penn State Law Review 1111, 1124 (2013). The *god man* should only act with the consent of the individual.

Balch Hurme, S. “World Congress to National Summit: Moving Guardianship Excellence to Reality,” 6 Journal of International Aging Law and Policy, 13 (Fall 2013).

Other models of substitute decision-making still exist in Sweden. A *forvaltare*, like a trustee, may be appointed to assist those who have more significant needs and cannot assist themselves. For more information, go to Riksförbundet for Social och Mental Halsa, “Reflections upon the Draft Prepared by the Committed on the Rights of Persons with Disabilities in the Form of General Comment on the Convention of Rights of Persons with Disabilities Article 12: Equal Recognition before the Law,” United Nations Human Rights at: www.ohchr.org/Documents/HRBodies/CRPD/GC/SNAS/MHArt12.doc (February 19, 2014); or Alzheimer Europe, www.alzheimer-europe.org/Policy-in-Practice2/Country-comparisons/Legal-capacity-and-proxy-decision-making/Sweden, (both last visited July 29, 2014).

United States Cases and Supported Decision-Making

At least two U.S. cases have discussed the concept of supported decision-making – those two being the Jenny Hatch and the *Dameris L.* cases.

Jenny Hatch Case

Jenny Hatch is an adult diagnosed with Down’s Syndrome. In 2013, her mother and stepfather petitioned a Virginian court for guardianship of her. At the conclusion of the guardianship action, the court appointed the guardians she proposed, ordered a guardianship for only one year, and ordered that the guardians provide “supportive decision-making assistance” to help her transition towards complete independence. *In the Circuit Court for the City of Newport News: Julia Ross and Richard W. Ross v. Margaret J. Hatch*, CWF 120000426P-03 (2013).

Dameris L. Case

Dameris L. was a resident of New York. The exact nature of her disability or whether there was a disability was not clearly stated within the opinion other than Dameris was alleged to have functioned at a mental age of a seven year old. *In the Matter of Guardianship of Dameris L.*, No. 2009-0892. (2012)

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Supported Decision-Making, continued from page 13

at 2. Upon a review of the guardianship and the available support Dameris had, the court considered supportive decision-making principles and the CRPD. Ultimately, the court terminated the guardianship. *Id.* at 14-15.

Is Supported Decision-Making a Replacement for Guardianships?

Some argue that supported decision-making can replace guardianships. Considering the current systematic framework, the variance of those individuals currently under guardianships, and the existence of some form of guardianship in states that have adopted supported decision-making (discussed above), the application of some form of supported decision-making may reduce the numbers of those under guardianships, but it appears unlikely to replace guardianship in its entirety.

Those who have access to an adequate support system to assist them with decision-making, those who have the ability to express their desires and to communicate their will, and those who have no significant safety concerns might be appropriate individuals to use a supported decision-making model, and they may greatly benefit from that use. Still, supported decision-making models are unlikely to replace all guardianships.

The concept of supported decision-making assumes that the individual will be able to communicate his or her wishes. Some individuals may be unable to communicate and no will or preference can be inferred.

Those with a disability or illness that has rendered them particularly vulnerable to abuse in the past might need more assistance than what a supported decision-maker might provide. In the alternative, court oversight would be necessary to oversee those support systems.

Some individuals may have no available or appropriate support system. Unless a public support decision-making system was also created, these individuals would have no one to act as a support system and they would not be able to access a supported decision-making model.

Positive Aspects and Drawbacks of Supported Decision-Making

When considering whether to adopt a supported decision-making model, there are several things to consider.

Positive:

- 1) The idea of supported decision-making is fully reflective of the principle of self-determination and allows for the individual to remain in control of his or her life.
- 2) Supported decision-making principles affirm the equality of all individuals, and the application of it can place individuals on equal legal footing with other adults.
- 3) Supported decision-making is also reflective of the concept of “least restrictive.” If supported decision-making is used and used appropriately, a person might not need a guardian.
- 4) Less court or government involvement. Wisconsin guardianships are routinely monitored by and are always subject to the jurisdiction of the court; depending on the model of decision-making adopted, less court monitoring or regulation is possible. (Depending on the situation, this might also be a negative aspect of supported decision-making.)

Drawbacks or Hurdles:

- 1) The adoption of supported decision-making would demand a significant systemic overhaul requiring the creation of appropriate supported decision-making model(s) and the provision of education about its use. This would also include the development of assessment tools tailored to this state to gauge who would be appropriate for an adopted model of supported decision-making and who might require a guardianship.
- 2) A review of the generally available support system would need to be performed and the creation of a public support system considered. In addition, any support system would have to be educated about the principles and particulars of supported decision-making and be maintained.
- 3) Supported decision-making is an evolving concept. Significant study has not been done on some of its most

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pertinent aspects like how decisions are actually made, the accountability of the support system, the effect of using a supporting decision-making model on the person as well as on the support system, and the occurrence of abuse or inappropriate behavior. Kohn, N., Blumenthal, J., and A. Campbell, 1128-1157.

In Wisconsin

Whether the principle of supported decision-making is ever adopted by Wisconsin courts is not clear at this time. To date, there is no known appellate case involving supported decision-making in Wisconsin.

Regardless, under the law courts are required to consider what is the least restrictive for the individual involved. Attorneys and courts, guardians, and other professionals must fully weigh principles of self-determination and least restrictiveness when interacting with a ward. Two prominent features required by law and described below are as follows:

1) Adopt those specific principles of self-determination found within Wis. Stat. § 54.19, 54.20 and 54.25. While guardians are responsible for making decisions in their ward's best interest, they are also required to discover and consider their wards' preferences when making those decisions.

2) Tailor the guardianship to the individual's needs at the time of the guardianship. If modification is needed later, then the appropriate procedure can be utilized and the matter considered at that time. Likewise, significant and particular attention should be given to the removal of each right an individual might lose in a guardianship. A person may not have the ability to make all of the decisions affecting his or her personal well-being or estate, but that person might be able to exercise a specific right.

Conclusion

Supported decision-making can provide a way for individuals to maintain their independence and still provide assistance to those individuals in their daily lives. Nonetheless, supported decision-making is unlikely to replace guardianships soon. Much would have to be done before a support-

Upcoming Events

November 19-20, 2014:

13th Annual FOCUS Conference

Sponsor: WI Department of Health Services, Division of Quality of Assurance

Location: Kalahari Resort & Convention Center, Wisconsin Dells, WI

Contact: UWSP Continuing Education
(800) 898-9472 or (715) 346-3838
uwspce-conf@uwsp.edu

October 14 & 15, 2014:

Corporate Guardian Training (see page 11 of this newsletter)

Sponsors: Disability Rights Wisconsin, Department of Health Services, Greater Wisconsin Agency on Aging Resources, Wisconsin Guardianship Association, Board on Aging and Long-Term Care

Locations: October 14 - Comfort Suites, Johnson Creek; October 15 - Hotel Mead, Wisconsin Rapids

Contact: DRW at (608) 267-0214

If your organization or agency is hosting a state-wide event related to those commonly subjects discussed within The Guardian and you would like to spread the word about that event, you may contact the GSC at guardian@gwaar.org and we may include information about your event in our next quarterly publication.

ed decision-making model could be fully adopted by this state, and more study of supported decision-making is required before it should be adopted. It is an evolving concept with its shortcomings as well its strengths.

Additional Resources

United Nations:

www.un.org/disabilities/index.asp

American Bar Association:

www.americanbar.org/groups/disabilityrights/resources/article12.html

Jenny Hatch Project: <http://jennyhatchproject.info/>