2023 Legislative Task Force on Aging Report

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Introduction

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- Scheller Legal Solutions LLC
- Elder abuse and neglect, Elder Law, Estate Planning, Elder Consultations, Probate, and Elder Mediation
- Legal Advisor and founding member of Elder Voice Advocates
- Founding Board Member of the Minnesota Elder Justice Center
- Legislative Committee Chair for the Elder Law Section of the Minnesota State Bar Association
- Adjunct Faculty at Mitchell Hamline School of Law, teaching Elder Law

Discussion Based on Task Force Initiatives

Minnesota Laws 2023 Chapoter 62, Article 2, Section 120

- To review state resources and current public and private strategies to support an aging population
- To identify and prioritize needed support for an aging population for people to remain in their communities
- To review current plans to improve health and support services workforce demographics
- To determine the governmental entity to plan, lead, and implement recommended policies for aging Minnesotans

Discussion Topics

End-of-Life Planning and care

- Are people having appropriate conversations with medical providers about health care directives, etc.
- What is working (structures already in place for end-of-life planning)
- Where are there gaps
- What needs to happen

Medical aid in dying

Other suggestions for the Task Force on “what needs to happen”

End of Life Planning

Defining - Variety of forms

- Financial arrangements
- Funeral arrangements
- Estate Planning (will, financial power of attorney, and health care directive)
- Health care arrangements

Healthcare Arrangements at End of Life

Person may appoint another to make health decisions (health care directive)

Person may state wishes as to end of life treatment (health care directive)

Person may complete a POLST or DNR/DNI with end of life treatment wishes (physician's order)

Person may seek legal means to end life (MAID in some states; VSED; etc.)

Medical Ethics Board may decide on behalf of person (if dispute and if evidence of wishes)

Definition of Terms

"Principal" = the person granting authority (i.e. the elder)

"Agent" = the person receiving authority (i.e. the son or daughter)

"Surrogate" = an authorized person who stands in the shoes of the principal to make decisions (MN does not have a surrogate statute but proposed)

"Power of Attorney" = the name of the document authorizing agency (in MN generally only financial authority)

"Attorney -in-Fact" = the name of the person appointed as agent (in MN generally only financial authority)

"Health Care Directive" = document authorizing another to make health care decisions pursuant to Minn. Stat. 145C

Introduction to Surrogate Decision Making

Legal Standard – starting point

- Individual presumed to have capacity to make their own decisions unless adjudicated or determined otherwise

2 main scenarios for appointing surrogate decision maker

- Just in Case – Estate Planning mode
- Need –
  - Short Term – Out of country; surgery or short-term illness
  - Long Term - Person can no longer manage and process

Analogy

- Grants of authority like having a password – either you can get in or you are blocked
- This is why appointing a health care agent in advance is important (spouse isn’t agent by default)

Legal Framework – Patient Perspective

Competency to make decisions

- Unless determination by court (guardianship) or attending physician (see Minn. Stat. 145C.01, subd. 1b on decision-making capacity)

Right to refuse treatment

- Minnesota Health Care Bill of Rights, Minn. Stat. 144.651, subd. 12
- No ability to force decisions, unless deemed incompetent

Family concerns

- Children; spouse wishes

Organ donation

Liberty interest in removal of life support (as extension of right to refuse treatment)

Legal Framework – Provider Perspective

From whom does provider take direction (authorized), based on wishes of Principal

No release of information without patient's permission

- HIPAA – Health Insurance Portability and Accountability Act of 1996
- Minnesota Health Records Act - Minn. Stat. 144.291 – 144.34

Duty to stabilize patient in emergency

- EMTALA – Emergency Medical Treatment and Active Labor Act; 42 USC 1395dd

Duties and Oaths as Professionals

- Hippocratic Oath for Physicians
- MN Nurse Practice Act

Medical Futility

- Minn. Stat. 145C.15 – Provider duty to take reasonable steps to provide care itself or to transfer

End of Life Planning - Health-Related Documents & Processes

Provider Related Documents

- DNR/DNI
- POLST

Law Related Documents/Processes

- Health Care Directive – Minn. Stat. 145C.01
  - Old name/statute in MN was Living Will
  - In other states may be called Health Care Power of Attorney
- Supported Decision Making (no court appointment; may be additional support language in HCD)
- Guardianship (involuntary incompetency)
- Civil Commitment (voluntary or involuntary incompetency)

Overview of Health Related End of Life Documents

DNR/DNI

- End of life wishes
- CPR/Intubation
- Maybe MD order
- Maybe EMTALA
- Common in long-term care

POLST

- End of life wishes
- CPR/antibiotics, etc.
- Terminally ill context
- MD order
- No EMTALA
- Common with hospice

Health Care Directive

- Draft at any time
- Appoint agent
- Wishes as known
- HIPAA designation
- Maybe advanced clauses

Provider Related End of Life Documents – DNR/DNI

DNR/DNI

- Commonly utilized in the long-term care environment, among others
- Other terminology
  - Do Not Attempt Resuscitation (DNAR)
  - Allow Natural Death (AND)
- Generally covers only CPR and intubation in the event that heart and/or breathing stop

Provider Related End of Life Documents – POLST/MOLST

POLST/MOLST

- Originally intended to be for those in a terminal condition
- Generally found in the hospital and outpatient setting, but some long-term care settings
- Covers CPR, antibiotics, suctioning, 911, tube feeding, etc.
- History
  - 1991 – Oregon
  - 2004 – National POLST Advisory
  - Furthered significantly by Gundersen Lutheran Hospital in La Crosse, WI

Law Related End of Life Document - Health Care Directive

Governed by Minn. Stat. 145C
- If before 8/1/1998, then Living Will under 145B

Power over medical decisions

Effective when physician determines “lacks decision-making capacity”

Can avoid Guardianship

Does not remove principal’s power to make decisions for self

Does not require court authority or oversight

Clauses in Health Care Directive for End of Life Choices

Health Care Directive may include specific clauses related to end of life choices

- Dementia Clauses
- Mental Health Advance Directives (Advanced Psychiatric Directives) –
  - State by state requirements - https://www.nrc-pad.org/
- COVID – Save Other Souls - https://www.saveothersouls.org/
- Aid in Dying language

Dementia Clauses

Guidance about desired care if worsening dementia (sets bar at desired quality of life)

- Eases burden of family decisions
- Provides resident security of getting the care desired

Example language

- **If I remain conscious but have a progressive illness that will be fatal and the illness is in an advanced stage, and I am consistently and permanently unable to communicate, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve, I would like my wishes regarding specific life-sustaining treatments, as indicated on the attached document entitled My Particular Wishes, to be followed.**
- **If I am unable to feed myself while in this condition:**
  - **I do / do not (circle one) want to be fed.**
  - **I do / do not (circle one) want to be given fluids.**
- Certain language based on mild, moderate, or advanced dementia

Advanced Psychiatric Directive

Legal document

- State person's preferences for future mental health
- Appoints agent to interpret preferences

Example language

- **My Beliefs, Concerns and Preferences about my mental health care.**
- I am telling you what my beliefs, preferences and concerns are about my mental health problems and my care. I am giving you this information because I want my choices to be honored, and I want you to help me have as much control over my life as possible while I work on my recovery and managing my illness.

Consideration as to Psychiatric Advanced Clauses (Ulysses Contracts) in Medicine

- Concept of overriding present request in favor of past request (making a decision when of sound mind that does not honor a current refusal for treatment)
- May be viewed as paternalistic

Save Other Souls – COVID Directive

Preserve medical equipment and supplies for others

Example Language

- If there is an actual or impending shortage of life saving equipment, medication, and/or other medical bed space where I am being treated, regardless of whether I am being treated for COVID-19 or for some other condition, it is my wish and direction that any health care providers and others involved in my care **DIRECT RESOURCES TO OTHERS RATHER THAN TO ME AS SET FORTH BELOW.**

VSED Clause

May include clause related to voluntary stopping eating and drinking (VSED)

Example

- If I develop an advanced stage of [insert condition such as Alzheimer's Disease], it is very important to me that my health care agent(s), medical providers, family members, caregivers, and other loved ones ("care team") know and honor my wishes regarding my care. It is my goal to define for my care team when I would not have quality of life nor want further care. It is also my goal to ensure that my care team understands that I wish to not have any treatment under those circumstances and wish to voluntarily stop eating and drinking (VSED). Regardless of my physical and mental state, I would like pain relief.
- […Additional language related to defining "quality of life"]

Development of Right to Die Concepts

Patient Self Determination Act (PSDA)

Right to Refuse Treatment (Bills of Rights)

Right to Die

PSDA

Patient Self-Determination Act (PSDA) – 1990 federal law requiring providers to inform all adult patients about their rights to refuse treatment; also …

Written documents given upon admission

- health care decision-making rights
- policies with respect to recognizing advance directives

Ask for any advance directive to keep in medical record

Educate staff and community about advance directives

Can't discriminate if patient doesn't have advance directive

Right to Refuse Treatment

Person has broad powers to refuse treatment

- Refuse to eat
- Refuse to drink
- Refuse to prolong life
- Right to terminate life sustaining treatment once begun

Terminology of Medical Aid in Dying

Considered “active” method of dying

Legal in 11 jurisdictions and considered patient directed with physician assistance

Medical Aid in Dying

- Patient makes decision
- Under laws, generally physician prescribes lethal medication, but patient self-administers

Euthanasia – all forms illegal

- Act or omission intended to cause beneficial death

Terminology of Right to Die

Considered "non-active" method of dying

Legal in all states and considered patient directed without physician assistance

Terminal Sedation

- Patient given sedative to induce sleep and ease pain
- Considered legal and medically ethical because goal is to ease symptoms
- Sometimes sedation is called "double effect"

VSED – Voluntarily stopping eating and drinking

VRFF - Voluntary Refusal of Food and Fluid

LSMT - Stop Life-Sustaining Medical Treatment

VSED/VRFF

VSED – voluntarily stopping eating and drinking

- Two uses
  - Voluntary even if capable of eating and drinking
  - Hasten death
- Cause of death generally – cardiac arrhythmia (irregular heartbeat)
- Not Medical Aid in Dying or Physician Assisted Suicide
  - Hand feeding is medical treatment; patient is then refusing medical treatment
  - Passive refusal
  - Act done at intent of patient when they refuse treatment
  - Not killed by lethal injection but rather dies from natural process

Active v. Non-Active Methods

Jurisdictions with laws allowing *Medical Aid in Dying (MAID):* (“active” method)

- California – 2015 by legislation
- Colorado – 2016 by referendum (but 1/3 of medical providers opting out as of 2017)
- Hawaii – 2018 by legislation
- Maine – 2019 by legislation
- Montana – 2009 by case law
- New Jersey – 2019 by legislation
- New Mexico – 2021 by legislation
- Oregon – 1994 by referendum
- Vermont – 2013 by legislation
- Washington – 2008 by referendum
- Washington D.C. – 2016 by legislation

Active vs. Non-Active Methods

Non-MAID states: ("passive" methods available)

- Stop Life-Sustaining Medical Treatment (LSMT)
- Voluntarily Stopping Eating and Drinking (VSED) or Voluntary Refusal of Food and Fluid (VRFF)
- The "Double Effect" (Palliative or Terminal Sedation and Accelerated Opioids)

Passive methods grounded in right to refuse life sustaining treatments

- Minn. Stat. 144.651 – Patient Bill of Rights
  - Right to receive current information about diagnosis and treatment options – in lay terms – subd. 9
  - Right to refuse care – subd. 12
    - If patient competent
    - Informed of the likely results of refusal, with documentation in the record
    - Incapacity but not adjudicated incompetent, fully document

Medical Futility

Some states have medical futility statutes that permit providers to refuse to provide care

MN – Provider has right to refuse care, under regulations

- Create clear policy
- Usually involves Ethics Committee
- Must clarify institution-wide conscientious objection versus individual objection of physician
- Notice and transfer provisions of sections 145B.06 and 145B.07.

- See *In Re: Emergency Guardianship of Albert Barnes*, 27-GC-PR-11-16 (Hennepin County Dist. Ct. 2011).

End of Life Planning - What is Working

Medical providers seeking asking about appointment of agents

Attorney drafting health care directives when drafting wills (estate plan)

- But increase education for all as to advanced clauses

Common forms that are accessible to individuals

- Attorney General
- Five Wishes
- Honoring Choices

In addition to appointing agents, often also asking who is able to receive medical information

Different conversations and forms, as intended, when healthy versus facing terminal diagnosis

Children of elderly seeing need for health care directives themselves when watching parents age

End of Life Planning - Challenges

Form may only be applicable to their own facility, not a general appointment

Triggering language may be insufficient in the forms, such as when lacking medical decision-making capacity

Who makes the determination that a person lacks medical decision-making capacity, a treating provider not familiar with the patient

- With declining capacity, a determination of lacking medical decision-making capacity may be difficult

Many still do not draft health care directives (avoidance; uncertain who to appoint)

Individuals without trusted family or friends don’t know who to appoint

End of Life Planning - Challenges

Providers making determinations about legal capacity v. medical decision-making capacity

Lack of default surrogate decision makers if no appointment of agent

Seeking guardianship or civil commitment too common, particularly to discharge from hospital

Providers tend to focus on wishes; attorneys on agents

Difficulty in getting medical records, particularly in long term care settings (particularly AL)

In long-term care setting, DNR/DNI and POLST documents may not be available in emergency

Inability to obtain notary or two witnesses once in long term care

End of Life Planning - Possible Changes

If appointing a trusted agent, consider appointing the person upon signing the document, to avoid potential confusion around when the person can act

Terminal condition v. non-terminal condition considerations

- POLST concept originally to understand what the principal may want if in terminal condition
- Now being applied more broadly at times

Increase the number of third-party health care agents (i.e. for solo seniors)

Greater education for individuals around health care directives (guardianship may be necessary)

Increase Health Care Decisions Day and other similar efforts to help individuals draft

End of Life Planning – Possible Changes

More conversation between attorneys and providers to understand legal versus medical decision-making capacity

Legislation to provider alternatives to seeking guardianship to facilitate discharge from hospital

Default surrogate decision maker legislation

Increase provider training on release of information training for medical records, rights of residents to receive records

Encourage providers to inform of notary options (i.e. companies with notaries), as appropriate

End of Life Planning – Possible Changes

Provide alternatives for records due to technology barriers (i.e. MyChart) for older population

Improve immediate accessibility of DNR/DNI and POLST documents in long-term care setting such as marker in room (no delays in determining status)

Increase education around advanced clauses in health care directives (i.e. dementia, etc.)

Hospice transparency - treatment that may be covered and right to go off hospice as desired

Education regarding alternatives to MAID

Other Topics for Suggested Changes – Categories Based on Client Experience

Coordination of Services
- Siloed systems
- Lack of coordination of services

Education and Training
- Educating seniors and their families
- Training for providers

Access to Services
- Understanding available services
- Shortage of professionals

Quality of Long-Term Care
- Long-term care worker shortage
- Multiple issues related to quality of care

Remedies/Responses
- Appeals of decisions
- Law enforcement/county attorney

Other Topics for Suggested changes - Coordination of Services

Services, resources, and programs spanning MDH and DHS

- Creates confusion with different structures for license v. waivered services
- Suggestion – create a Department on Aging to meet unique needs of older population

Collaboration and partnership among professionals serving seniors

- Providers, attorneys, financial institutions, guardians, law enforcement, etc.
- Suggestion – MDH/DHS hosting professional work groups and conversations

Bridging gaps between silo care in long-term care

- Specialty services need greater coordination (i.e. wound care; hospice; therapies; psychiatry, etc.)
- Suggestion – Establish model of oversight when concurrent authority among providers

Other Topics for Suggested Changes – Education and Training

Education of medical assistance pre, during, and post MA eligibility

- Collaboration between counties, providers, attorneys, to support education of MA eligibility and services; relay options
- Suggestion: Offer MA education for agents when resident admitted to long-term care

Education and legal services for immigrants

- Challenge to navigate aging services for immigrants and to secure services
- Suggestion: Link opportunities for education and services with processes such as securing driver’s license, citizenship, etc.

Cultural and language barriers

- Barriers between staff and residents
- Suggestion – Offer cultural awareness for residents/families; Offer training for immigrant workers on communication tools

Other Topics for Suggested Changes – Quality of Long-Term Care

Long-term care worker shortage and quality care

- Increase number and pay of trained workers
- Suggestion: Comprehensive review/work group of education; pay structure; workplace satisfaction, etc.

Multiple quality care issues – corporate transparency, accessibility of home care, consistent and timely regulatory action, comprehensive measures of quality for public

- Suggestion – Comprehensive review and measurable goals to improve quality of care for seniors

Few geriatric psychiatry units and geriatric physicians

- Increased need to address medication regime and care to aging, especially those with dementia
- Suggestion – Set a plan for retaining and recruiting geriatric medical professionals; coordinate NP/MD

Hospice transparency

- Within long-term care model, miscommunication or misunderstanding of program
- Suggestion – Amend the Hospice bill of rights to include key rights to information

Other Topics for Suggest Changes – Access to Services

Solo Seniors (need agents, personal representatives, and trustees)
- Increasing number of seniors with no family or friends to appoint as agent
- Suggestion – Increase capacity for professional agents

Senior Transportation
- Mobility for seniors beyond current options, particularly in rural areas
- Suggestion – State subsidized transportation systems; specific funding for transport to health care

Housing
- Independent living options with community support options, including low-income options; combat isolation
- Suggestion – Increase tax incentives for support options (i.e transportation); continue community initiatives

Services for low-income seniors
- Limited options for services, including legal and medical, for low-income seniors
- Suggestion – Create incentive grants to subsidize or provide services; create administrative processes to assist

Other Topics for Suggested Changes

Remedies/Responses

- Medicare appeals (denials of coverage; particularly therapies and three-day hospital stay requirement)
- Law enforcement and county attorney training and assistance in responding to elder abuse and neglect and financial exploitation
- Guardianship concerns (26,000 persons subject to guardianship a majority of whom are under age 65; unique older adult needs)

2023 Case Law

***James Zika v. Elder Care of Minnesota, et al.*, A21-1710 (MN Ct App. 8/22/2022).**

- Minnesota Court of Appeals held that under the plain language of Minn. Stat. 524.5-313(c)(2), a guardian is immune from liability when negligently performing the guardian's duty to provide for the care of the person subject to guardianship.
- Minnesota Supreme Court scheduled oral arguments in 2/2023 on the guardianship issue, later canceling after the death of the guardian.

Thank you and Questions

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