

# Elder Law



## Public Guardianship Legislation Enacted

by Peter Greenfield<sup>1</sup>

A bill creating an office of public guardianship was signed by Governor Gregoire on May 8, 2007. Substitute Senate Bill 5320 had passed the Senate by a vote of 44-0 and the House by a vote of 98-0. The bill originated with the Elder Law Section, and was drafted to implement recommendations made by its public guardianship task force. The successful effort to develop a public guardianship bill and secure its adoption illustrates how lawyers working through the organized bar and with others can promote the public interest by taking on a persistent problem encountered in their practice and contributing to its solution.

The public guardianship task force was appointed by Section chair Jacob Menashe in early 2005 to propose a solution to a problem recognized by Section executive committee members: many people can't get guardianship services they need because they don't have family members or friends to serve as volunteers and don't have sufficient funds to pay for such services and still meet other basic needs. Without needed guardianship services, vulnerable individuals are likely to lose housing, to go without needed medical care, to experience exploitation or to face institutionalization that would be avoidable with appropriate help.

The task force issued a report in August 2005. The report was (and is) posted on the Section's website and the posting was noted on the Section's list serve, soliciting member comment. In September 2005, the executive committee adopted a resolution endorsing the recommendations of the task force, including a recommendation that an office of public guardianship be created. Then it turned to the task of implementation.

The executive committee authorized 2006-07 Section chair Eileen Peterson to retain Joan Mell, of Miller Quinlan & Auter, in Fircrest, to draft implementing legislation and to advise on legislative strategy. Between September 2005 and the end of 2006, drafts were reviewed by the task force and by representatives of interested organizations, including many who started with serious doubts. During that period, many organizations followed the Section's lead

and adopted resolutions calling for the creation of a public guardianship office. There were ultimately some two dozen such organizations, including the Washington State Medical Association, the Washington State Catholic Conference, the Senior Citizens' Lobby, the state chapter of NAELA, the Washington State Long-Term Care Ombudsman Program and the Alzheimer's Association's Western and Central Washington Chapter. In November 2006, the WSBA Board of Governors voted to "sponsor" public guardianship legislation, making it a priority for the Association's experienced legislative director, Gail Stone.

In January of this year, identical public guardianship bills were introduced in both chambers of the Legislature. Senator Rosa Franklin, the prime sponsor of SB 5320, was joined by Senators McCaslin, Kline, Stevens, Prentice, Parlette, Regala, Hargrove, Rasmussen, Murray, Jacobsen, Hewitt, Keiser and Roach. (Names are listed in the order in which they appeared on the bill.) Representative Patricia Lantz, the prime sponsor of HB 1130, was joined by Representatives Jay Rodne, Dawn Morrell, Shay Schual-Berke, Roger Goodman, Phyllis Kenney, Kathy Haigh and Jim Moeller. It was the Senate bill that was finally adopted.

The bill creates an office of public guardianship within the Administrative Office of the Courts, with an administrator to be appointed by the Supreme Court. The office is to contract with certified professional guardians, or with entities employing them, to serve as public guardians.

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## *Public Guardianship Legislation Enacted* from page 1

Public guardians would be available for appointment, under defined circumstances, by courts that have determined, under current law, that appointment of a guardian is needed. The bill makes no changes in the criteria for establishing guardianships. Initially, services will be offered on a pilot basis in two regions of the state, one urban and one rural. (The specific regions remain to be defined.) The cost of the services and the savings associated with them will be the subject of a study and report by the Washington State Institute of Public Policy. For the 2007-09 biennium, the Legislature appropriated \$1.483 million to implement SSB 5320.

Among the responsibilities assigned to the office of public guardianship are the following:

- To adopt criteria to enable the office to target services at individuals with the greatest need
- To adopt standards of practice
- To develop a procedure for responding to complaints
- To monitor performance under its contracts
- To identify guardian training needs
- To consider the need to develop a legislative proposal to make legal assistance with guardianship petitions available
- To report to the Legislature about how services other than guardianship services might be provided under contract with the office, so as to limit the need for guardianship services

The bill also requires that public guardians adhere to caseload limits, that they visit individuals served at least monthly, and that they certify annually that they have reviewed the need for continued guardianship services in each case in which they serve and have notified the court if termination or modification of an order appears warranted.

The bill as proposed by the Section and as passed by the Legislature called for appointment of an advisory committee to provide guidance to the administrator. It was to have members appointed by many different entities concerned with guardianship issues and with the protection of individuals with cognitive disabilities. The Governor vetoed the section creating the advisory committee on the ground that oversight should be the responsibility of the Supreme Court and the Administrative Office of the Courts. It remains to be seen whether an effective mechanism will be created for soliciting the valuable advice the statutory committee might have provided.

The enactment of public guardianship legislation and the initial funding of public guardianship services are important steps. Many Section members, and many others, will be watching with critical eyes to see how the program develops.

- 1 Peter Greenfield is the secretary of the Elder Law Section and chair of its public guardianship task force. He is a staff attorney with Columbia Legal Services.

## Information for Your Clients

Did you know that easy-to-understand pamphlets on a wide variety of legal topics are available from the WSBA? For a very low cost, you can provide your clients with helpful information. Pamphlets cover a wide range of topics:

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Each topic is sold separately. Pamphlets are \$9 for 25, \$15 for 50, \$20 for 75, and \$25 for 100. Pricing for larger quantities is available on request.

To place your order or for more information, please contact the WSBA Service Center at 800-945-WSBA or 206-443-WSBA. Sales tax is applicable to all in-state orders.

## Home Care for the Elderly

by Rachel Miyoshi

Everyone has read about Brooke Astor, the wealthy Park Avenue socialite, alleged by her grandson to be neglected or abused by her son, her guardian and the trustee of her estate. The question that comes to mind is what constitutes neglect or abuse when an elderly client chooses to stay at home and that client may not want all of the help available or necessary for their care. How does an attorney find out what care is needed, available and affordable for that client?

Long-term care on a continuum is a relatively new concept which covers the varying stages of care needed as a person declines. We all know we need help when we age, but our society has become so independent that each person needs to plan for the stages of their care. If a client chooses to stay at home, they are most often in need of some help and may have some family available to help. However, as the person ages in place, those needs will increase and may not be readily recognized.

The first step is to determine the level of care needed. Activities of daily living (ADL) are one of the benchmarks for determining level of care. ADL refers to bathing, eating, continence, toileting, transfers, and dressing. Cognition is another major factor in determining the ability of a person to make the decisions about their own care. People seem to decline either mentally or physically first; the deficits do not usually occur simultaneously. When a person is unable to make their own decisions, a guardian or someone with durable power of attorney must take on that role.

Multiple resources for determining what level and what type of care are available. In Washington, COPES is the state-funded program for determining levels of care at home. For private assessments, there are many ways to make the determination of care needs. The client's doctor, along with their health care team of nurses, social workers, and physical therapists, often can provide enough information to determine the level of care needed on a short-term or long-term basis. The family may also choose to hire an independent consultant, or casemanager, through senior services or specialized agencies. These agencies are listed under senior care on websites or phone directories. Respite care, home health care, hospice, skilled nursing, assisted living, and adult daycare are just some of the major categories of senior or elder care available.

Where to start? There is a wonderful website at [www.seniorservices.org](http://www.seniorservices.org). This website will give your clients information about services in their area. This is only a starting point. The attorney needs to listen to the families and the clients when they are able to articulate the deficits. This is not a simple process, and clients must start as early as possible identifying resources and financial assets available for their care. Clients must understand that there are many contingencies and be ready to change their care plan as their health needs change.

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For further information contact Sharlene Steele, WSBA Access to Justice Liaison, at 206-727-8262 or [sharlene@wsba.org](mailto:sharlene@wsba.org).

## Oregon's Death with Dignity Act 2006 Summary

Nine years after the Oregon Death with Dignity Act became operational, lawyers and others are beginning to assess the impact of the program. Lawyers attending the 2006 annual meeting of the Elder Law Section debated the results of the Oregon law. This article seeks to objectively add to that dialogue by discussing the "Summary of Oregon's Death with Dignity Act – 2006" as published in March 2007 by Oregon's Department of Human Services (DHS).<sup>1</sup> Specifically this article presents general statistical outcomes of the program, significant characteristics of program patients, program impact on hospice referrals, and referred misconduct by physicians.

### Program Background Information and Program Lifetime Statistics

The Oregon Death with Dignity Act (DWDA) was passed by voter initiative in 1997.<sup>2</sup> Following court challenge, the program became available to Oregonians in 1998. Since that time 292 deaths have resulted from participation in the program. In the nine years of reporting, Physician Assisted Suicide (PAS) patients have displayed the following characteristics: median age at death – 74; race identified – 97 percent white; duration of physician-patient relationship prior to death – median 12 weeks; and time lapsed between first ingestion of medication and death – average 25 minutes. The most cited reasons for participation in PAS were loss of autonomy, decreased ability to participate in activities which made life enjoyable, and loss of dignity.

For a patient to request lethal medication, the DWDA requires that a patient be: (1) an adult (18 years of age or older), (2) a resident of Oregon, (3) capable of making and communicating healthcare decisions, and (4) diagnosed with a terminal illness that will lead to death within six months. Patients who meet these requirements may request a prescription.

To receive a prescription, the following steps must be completed: (1) the patient must make two oral requests to his physician, separated by at least 15 days; (2) the patient must provide a written request to his physician which is signed in the presence of two witnesses; (3) the prescribing physician and a consulting physician must confirm the diagnosis and prognosis; (4) the prescribing physician and a consulting physician must determine whether the patient has the mental capacity to make this decision; (5) if either physician believes the patient's judgment to be impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination; (6) the prescribing physician must inform the patient of feasible alternatives PAS, including comfort care, hospice, and pain management; and (7) the prescribing physician must report to DHS.

### General Statistical Outcomes of the Program

In program year 2006, 65 prescriptions were written by 40 different physicians.<sup>3</sup> The maximum number of prescriptions written by any one physician in 2006 was seven. Of the 65 prescriptions, 35 were used resulting in the death of the patient, 19 were unused due to the death of the patient prior to consumption, and 11 prescriptions remained outstanding at the end of the year. Additionally, 11 prescriptions from the 2005 program year were taken and resulted in death in 2006. The total DWDA deaths for the program year 2006 were 46, accounting for roughly 14.7 deaths per 10,000 total Oregon deaths.

### Significant Characteristics of 2006 DWDA Patients

Of patients who used a PAS prescription, 91 percent graduated from high school and 41 percent received a baccalaureate degree or higher. This statistic has remained consistent throughout the life of the program. Of patients not participating in the program but dying of the same underlying illnesses, only 77 percent graduated from high school and of those, only 15 percent received a baccalaureate degree.

Additionally, of the patients participating in the DWDA program, 97 percent (44) had health insurance, one did not and one remained unknown. Private insurance accounted for 64 percent (29) of the patients, while 33 percent (15) had Medicare or Medicaid. Over the life of the program, 62 percent (180) of patients had private insurance and 36 percent (105) had Medicare or Medicaid.

Most patients (93%) choosing to participate in the program in 2006 ingested the medication and died at home rather than in a hospital or other long-term care facility.

### Hospice Referrals

While the report fails to give a control sample for the number of persons enrolled in hospice versus those not enrolled with the same underlying illnesses, the report does state that of the patients enrolled in the program, 76 percent (35) were receiving hospice care. This number is down from previous years, but the program lifetime average remains at 86 percent (248) enrolled.

### Referred Misconduct

In the course of the 2006 program period, 10 referrals were made to the Board of Medical Examiners (BME) for forms improperly completed by physicians. The BME, however, found no violations of the physician's duty to make a "good faith compliance" with the Act. No physicians were sanctioned for "unprofessional conduct." Previous years showed fewer referrals.<sup>4</sup>

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## ***Oregon's Death with Dignity Act 2006 Summary*** *from previous page*

For more information and statistics on the Oregon Death with Dignity Act go to [www.oregon.gov/DHS/ph/pas/ar-index.shtml](http://www.oregon.gov/DHS/ph/pas/ar-index.shtml). There you will find reports from all nine program years as required under state law.

*Matthew Luedke is a candidate for JD in 2008 at Gonzaga University School of Law. He currently ranks in the top 15 percent of his class, is secretary of the Student Bar Association, was elected Tutor of the Year for his work tutoring both Property and Contracts, and intends on focusing his practice in Elder Law and related areas.*

- 1 A complete report of the Oregon Death with Dignity Act report may be obtained from the ODHS website at [www.oregon.gov/DHS/ph/pas/index.shtml](http://www.oregon.gov/DHS/ph/pas/index.shtml).
- 2 Oregon Revised Statutes 127.800 *et. seq.*
- 3 All data is summarized from "Summary of Oregon's Death with Dignity Act" reports published by the Oregon DHS.
- 4 1998 – No data was collected regarding BME referrals.  
 1999 – No data was collected regarding BME referrals.  
 2000 – One physician submitted a consent form with only one witness signature even though other witnesses were in attendance.  
 2001 – One physician submitted an incomplete consent form.  
 2002 – No referrals were made during 2002.  
 2003 – One case was referred to the BME involving a possible non-compliance with the DWDA provisions regarding witnessing of signatures.  
 2004 – One case was referred to the Board of Medical Examiners involving three issues. This case involved failure to submit a physician survey in a timely manner, filing an incomplete Attending Physicians Compliance Form, and witnessing of signatures on a patients request form.  
 2005 – Four cases were referred. One involved witnessing of signatures. Three involved failure to file required documentation in a timely manner.

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## **Annual Fall ELDER LAW CONFERENCE**

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**Tuition: \$199 one-day rate/\$365 for both days**

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