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July 24, 2012

TO: Representative Dan Knodl
Room 218 North, State Capitol

FROM: Grant Cummings, Fiscal Analyst

SUBJECT: Use of Chapter 51 and 55 Procedures to Address Challenging Behaviors of Individuals with Alzheimer's Disease and Dementia

This memorandum provides information regarding the use of Chapter 51 civil commitments and Chapter 55 protective placement procedures to address challenging behaviors exhibited by individuals with dementia or Alzheimer's disease. On May 18, 2012, the State Supreme Court filed an opinion in the case of *Fond du Lac v. Helen E. F.* which concluded that individuals with a sole diagnosis of dementia or Alzheimer's disease should not be subject to emergency detentions under Chapter 51, and instead, are proper subjects for protective placement and services under Chapter 55.

The first section of the memorandum provides a brief summary of Chapter 55 and Chapter 51 procedures and services. The second section describes funding sources for services provided under these chapters, and the responsibilities for state and local governments with respect to these services. The final section examines some of the potential effects of the recent Supreme Court decision.

Brief Summary of Chapter 55 and 51 Procedures and Services

Chapter 55. Chapter 55 defines "protective services" to include any services that, when provided to an individual with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other like incapacity, keep the individual safe from abuse, financial exploitation, neglect, or self-neglect or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself or another person. The statutory definition includes a listing of ten specific services, including: (a) outreach; (b) identification of individuals in need of services; (c) counseling and referral for services; (d) coordination of services for individuals; (e) tracking and follow-up; (f) social services; (g) case management; (h) legal counseling and referral; (i) guardianship referral; and (j) diagnostic evaluation. If certain criteria are met, protective

services can also include the involuntary administration of psychotropic medications.

Protective services may be provided on a voluntary basis in response to the individual's request or at the request of an interested person on the individual's behalf, such as a guardian or agent under power of attorney.

An interested person, county department, service agency, or the Department of Health Services (DHS) may also file a petition in court for an individual to be protectively placed or receive protective services on an involuntary basis. The court may only order a protective placement for an individual if the individual meets all of the following criteria: (a) the individual has a primary need for residential care and custody; (b) for adults, if the individual has been determined to be incompetent by a circuit court; (c) the individual is so incapable of providing for his or her own care or custody as to create a substantial risk of serious harm to himself or herself or others; and (d) the individual has a disability that is permanent or likely to be permanent.

At the time a petition for protective placement is filed, an attorney is appointed to serve as the guardian ad litem for the individual. The guardian ad litem is an advocate for the best interests of the individual and is responsible for informing the individual of their rights, attending all hearings, and requesting additional psychological or medical evaluations. A guardian ad litem should not be confused with a guardian, who is responsible for managing the income, assets, health and safety of an individual who is determined to be incompetent. The guardian ad litem is also responsible for interviewing the person's guardian and, if the person is protectively placed, for meeting at least annually with the person to determine if any changes to the person's protective placement are necessary or requested by the person. A guardian ad litem's fees are paid for by the individual if the individual has resources, or by the individual's county of residence if the person is indigent. Since all individuals found incompetent have a guardian ad litem, and since incompetence is required for court ordered protective services or placements, all persons involuntarily protectively placed are assigned a guardian ad litem.

Once a petition has been filed, a hearing on the petition must be completed within 60 days, with a possible 45-day extension at the request of the petitioner, the county, the individual, or the individual's guardian ad litem. Alternatively, a settlement may be reached between the person and the petitioner's representatives. At the request of the person, the hearing may also take the form of a jury trial, otherwise the hearing is held before a judge. If the court determines that a protective placement is needed, the court also determines the least restrictive setting in which the person will be placed, which may include a nursing home, public medical institution, a state center for the developmentally disabled, the person's home, a residential facility, or another appropriate facility. However, the placement may not include a unit for acutely mentally ill individuals, such as a psychiatric hospital unit. More generally, protective placement in a locked unit requires a specific finding of the court.

Protective placements and services must be provided to an individual in the least restrictive manner consistent with the needs of the individual. In addition, counties must provide for the reasonable program needs of individuals who are provided protective placements or who receive

protective services "within the limits of available state and federal funds and of county funds required to be appropriated to match state funds."

Chapter 55 also provides for the emergency protective placement of an individual if a law enforcement officer, fire fighter, guardian, or a representative of a county department or contracted agency observes or receives a report that it appears probable that the individual is so totally incapable of providing for his or her own care or custody so as to create substantial risk of serious physical harm to themselves or others due to one of the conditions described above. Under s. 55.02(2)(b)(4) of the statutes, every county is required to designate "at least one appropriate medical facility or protective placement facility" as an intake facility for the purpose of emergency protective placements. However, the statutes do not specify the type of facilities counties may use for this purpose.

Within 72 hours of the emergency placement, a hearing must take place to determine probable cause. If the hearing determines the existence of probable cause, the court may order the person to be temporarily protectively placed for up to 30 days, pending the hearing for permanent protective placement. For individuals with developmental disabilities, if the individual is in an intermediate care facility for the mentally retarded (ICF-MR) or nursing home, and the permanent placement hearing determined the need for protective placement, the individual may stay at the facility for up to another 90 days while the county establishes a care plan.

Chapter 51. An individual can be involuntarily committed under Chapter 51, if the individual is all of the following: (a) mentally ill, drug dependent, or developmentally disabled; (b) a proper subject for treatment; and (c) dangerous. In this context, the individual is considered dangerous if he or she meets at least one of five criteria which demonstrate a substantial probability of harming themselves or others, whether through actions, threats, omissions, or an inability to understand the consequences of refusing medication or treatment that may be necessary for his or her health.

The civil commitment process can start in three ways. First, if a law enforcement officer believes that an individual will meet the criteria for commitment described above, the officer can take the person into custody as an emergency detention and bring them to a hospital, mental health institute, center for the developmentally disabled or other approved facility. The individual is considered to be in the facility's custody upon their arrival. Within 72 hours, excluding weekends and holidays, a hearing must be held to determine if there is probable cause to believe that the person meets the involuntary commitment criteria.

The civil commitment process can also begin with a petition filed by three adults in the probate branch of the circuit court for the county in which the individual is present or their county of residence. At least one of the adults must have personal knowledge of the individual's conduct. Once filed, the judge can determine whether the person should be detained as described above or, if no detention is needed, a date should be set for the probable cause hearing and the individual notified.

If a person has been admitted to an approved treatment facility, the facility's treatment

director may hold the individual until the end of the court's next business day. The director must file for an emergency detention, which also begins the commitment process.

After the probable cause hearing, the court orders a psychiatric examination by two physicians, psychiatrists, or psychologists. A third expert may be requested by the individual in question. These experts submit reports to the court regarding the individual's mental condition, possible treatment options, and potential facilities that would meet the individual's needs in the least restrictive setting.

A final hearing is then held to determine if the person meets the criteria for civil commitment. The person has the right to request a jury trial of six jury members if they notify the court of this request at least 48 hours prior to the final hearing. In the hearing, the court will dismiss the petition, transition the case into one regarding protective services or placements, or order the person to be committed. As with Chapter 55 protective placements, while individuals are under involuntary commitment they can be required to take medications and undergo treatment as long as specific criteria are met.

Primary Differences between Chapter 51 and Chapter 55. There are several differences between the Chapter 51 civil commitment process and the Chapter 55 protective placement process that are particularly important with respect to individuals with dementia or Alzheimer's disease. Some of these differences were identified in the state Supreme Court's decision in *Fond du Lac County v. Helen E.F.*

First, the civil commitment process requires that the person be a "proper subject for treatment," while protective placements require that the person's disability be "permanent or likely to be permanent." In *Helen E.F.*, the court found that a person is a proper subject for treatment under Chapter 51 if not only their symptoms, but also their underlying disorder, can be medically treated. If a person's underlying disorder cannot be treated, they are not a proper subject for treatment under Chapter 51, even if their symptoms can be ameliorated. The court went on to determine that Alzheimer's disease was a permanent condition and was not treatable, and therefore protective placement, with its focus on long-term care, would be the more appropriate process.

Second, the presence of guardians ad litem in protective placements is another difference between the two processes. The Supreme Court found that protective placement was a more appropriate process for Helen because it provided her with a guardian ad litem that would be responsible for ensuring that she received "adequate and specialized care." While Chapter 51 civil commitments are intended to result in the individual returning to their homes at the conclusion of their treatment, Alzheimer's disease cannot be treated and some individuals with advanced conditions may not be expected to return to their homes. Chapter 55 requires a guardian ad litem to provide long-term protection for the Alzheimer's patient and to speak to the individual's need for protective placement and medications throughout the protective placement process. Chapter 51 provides no such protection. The Supreme Court determined that the presence of the guardian ad litem in Chapter 55 and its absence from Chapter 51 supported its conclusion that Chapter 55 was the more appropriate process for individuals with a sole diagnosis of Alzheimer's disease.

The Supreme Court's opinion notes that Chapter 55 specifically prohibits an individual from being protectively placed in units for the acutely mentally ill. The Court determined that due to the nature of Helen's condition, and the appropriateness of Chapter 55 to her situation, Chapter 55's prohibition on the use of units for the acutely mentally ill "allows for a more appropriate balancing" between the patient's safety and providing them the least restrictive setting possible than does Chapter 51.

Funding Responsibilities for Services

The services elderly individuals receive under Chapter 51 or Chapter 55 may be funded from several sources, depending on the individual's circumstances. These funding sources include Medicare, medical assistance (MA), private insurance (including retiree health benefits), payments from the individual, and counties. The Chapter 51 and 55 services an individual receives are frequently supported by a combination of these sources.

Medicare. Almost all individuals over the age of 65 are eligible for and enrolled in Medicare Part A, which provides coverage for inpatient hospital services (including inpatient services provided by psychiatric hospitals), care provided by skilled nursing facilities following hospitalization (not custodial care), and hospice care, among other services. Most individuals are not required to pay a premium for this coverage because they paid Medicare taxes while they were working.

Medicare coverage for Part A inpatient psychiatric services is subject to service restrictions and cost-sharing requirements. For example, Medicare coverage for inpatient care provided by psychiatric hospitals is limited to 190 days in a lifetime. With respect to cost-sharing, in 2012, Medicare coverage of all inpatient hospital services, including inpatient services provided by psychiatric hospitals, includes a $1,156 deductible per benefit period. (A benefit period begins the day an individual is admitted to a hospital and ends after the person has been out of the hospital 60 consecutive days.) In addition, in 2012, Medicare inpatient hospital coverage requires coinsurance equal to $289 per day for days 61 through 90 of an inpatient stay and $578 per day for days 91 through 150 of an inpatient stay. The Medicare inpatient hospital benefit does not provide any coverage after an individual has remained in the hospital for 150 days in the same benefit period.

In summary, for individuals age 65 and older, Medicare Part A is the primary payment source for inpatient hospital services, including services provided by psychiatric hospitals. However, Medicare's coverage limitations and cost-sharing requirements result in the payment of some costs from other sources, as described below.

Medical Assistance (MA). Low-income individuals over the age of 65 may be eligible for both Medicare and MA. These individuals are commonly referred to as "dual eligibles." Some dual eligibles are eligible for full MA benefits, including inpatient psychiatric services, and do not pay any cost-sharing that would otherwise be required by Medicare. For these individuals, Medicare is the primary payer, but MA pays all Medicare deductibles and premiums. If an individual uses all of the 190 days of psychiatric inpatient services and the individual continues to

require inpatient psychiatric services, MA pays for all additional days of medically necessary care.

In addition, the MA program pays Part A deductibles and coinsurance for other dual eligibles who are not eligible for full MA benefits, but whose income does not exceed 100% of the federal poverty level.

Private Insurance, Retiree Health Benefits, and Out-Of-Pocket Contributions. Some individuals over the age of 65 have private insurance coverage, such as group health benefits, if they are employed, and retiree health benefits. Depending on the plan and the person's situation, these sources may be the primary payer or may be used to pay costs not covered by Medicare and Medicaid. For example, depending on the size of their employer, some working individuals or individuals with working spouses may have an employer-based health plan that would act as the primary payer. Alternatively, many elderly individuals purchase Medicare supplemental policies, which pay for services not covered by Medicare, as well as Medicare cost-sharing requirements. Other elderly individuals have retiree health benefits available from their former employers, which may also supplement coverage provided by Medicare.

Cost Responsibilities. Individuals who receive services under Chapter 51, including individuals who are subject to emergency detentions under s. 51.15 of the statutes and individuals who are committed under 51.20 of the statutes, often receive these services in psychiatric hospitals and hospitals with psychiatric units. The state operates two psychiatric hospitals (mental health institutes, or MHIs), Mendota Mental Health Institute (MMHI) in Madison and Winnebago Mental Health Institute in Oshkosh, although only MMHI provides inpatient psychiatric services to elderly individuals. Milwaukee County operates the Milwaukee County Behavioral Health Complex in the City of Milwaukee. In addition, there are several other private and county-operated psychiatric hospitals that serve individuals who are committed or are subject to emergency detentions under Chapter 51.

As previously indicated, Medicare covers up to 190 days over the course of an enrollee's lifetime for care in psychiatric hospitals. Once a person's lifetime psychiatric hospital days under Medicare have been used, other sources are used to pay for these services, including MA if the person is or becomes eligible for MA coverage by spending down his or her resources. However, if the individual receives inpatient services at MMHI, the individual's county of residence is required to support the non-federal share (approximately 40%) of the cost of care provided to the individual.

The MA program pays for the protective services MA-eligible individuals receive in Chapter 55 placements. State GPR supports the non-federal share of the MA payment for protective services and placements. These services are generally provided by nursing homes or home- and community-based services, which the Department provides through a number of programs, including the county operated Community Integration Program II (CIP-II) and community options programs (COP) as well as the Family Care, Program for All-inclusive Care for the Elderly (PACE), and Family Care Partnership managed care programs.

There is a significant difference between the daily cost of providing services to individuals who are subject to civil commitments in psychiatric hospitals and the cost of services to individuals

who receive protective placement services in other types of facilities. As previously indicated, individuals who are civilly committed are often placed in psychiatric hospitals or units. The current rate for these services at MMHI is $1,034 per day. Counties are initially billed for the entire daily rate and are reimbursed when DHS receives collections from Medicare, Medicaid, and private insurers. By comparison, most individuals who have been protectively placed are either in nursing homes or community-based facilities. The current average MA reimbursement nursing homes receive is approximately $150 per day, which includes state and federal payments, as well as the patient liability assigned to the facility from the resident's available income, such as social security payments.

Counties' Use of Chapter 51 Procedures for Individuals with Dementia and Alzheimer's Disease

LFB staff spoke with a number of individuals regarding how counties have used Chapter 51 procedures to provide services to individuals with dementia and Alzheimer's disease. Based on these discussions, it appears that in some cases nursing homes would call law enforcement to respond to a person with Alzheimer's disease or dementia who was exhibiting challenging behaviors. If the officer believed the person would meet Chapter 51 or 55 criteria, he would first take the patient to a hospital to ensure the patient's health, perhaps consult with a county mental health worker, and then transfer them to a psychiatric hospital for an evaluation.

Once admitted to the psychiatric hospital, the individual is considered to be in the hospital's custody. For individuals participating in Family Care, the individual's managed care organization (MCO) would disenroll the individual and would no longer be required to assist in finding the individual a new placement. It was suggested that on rare occasions, MCOs have refused to assist an Alzheimer's patient find another placement, but that in most cases MCOs have assisted in finding appropriate facilities for these individuals. It has also been indicated that, on rare occasions, some nursing homes have refused to re-admit a former resident after the resident has received treatment in a psychiatric hospital.

Nursing homes are prohibited from discharging a resident unless the resident has another suitable placement, but they are also prohibited from placing individuals in their care in situations that may result in serious harm or death to a resident ("immediate jeopardy"). Faced with either a citation for improper discharge planning or a citation for immediate jeopardy, it has been suggested that nursing homes choose to risk the citation for improper discharge planning, which has a smaller financial penalty. For example, DHS indicates that facilities pay on average approximately $3,430 for each penalty imposed, on a per instance basis, that results from a citation of the same severity as immediate jeopardy cases. It should be noted that citations imposed on a per instance basis only comprise approximately one third of total citations, with the other two thirds imposed on a per day basis.

DHS data indicate that few nursing homes have actually been cited for improper discharge planning. From 2008 to 2012, only 11 out of thousands of citations issued to nursing homes were for improper discharge planning or refusal to re-admit a patient. None of these citations resulted in

federal monetary penalties. However, one facility paid $4,900 in state monetary penalties for two improper discharge citations. Under 2011 Wisconsin Act 70, state citations will no longer be issued for violations that also receive a federal citation. Nursing homes may be refusing to re-admit residents more frequently than these numbers suggest, but they are not being cited for discharge planning violations.

If a nursing home refuses to re-admit an individual with Alzheimer's disease, it becomes the county's responsibility to find the individual another home. However, counties often have difficulty finding other facilities that will accept these individuals. Aside from the risk of immediate jeopardy, the care provided to persons with Alzheimer's disease is generally more costly for nursing homes than providing care to other nursing home residents. This is especially problematic for nursing homes serving MA patients, since the MA program's payment rates for nursing homes are often insufficient to fully support the costs of care nursing homes provide to their residents, including residents with Alzheimer's disease. In addition, many nursing homes may not have direct care staff trained to care for these types of residents, or are not able to retain such staff. For these reasons, individuals may be required to stay at MMHI or other psychiatric hospitals due to the lack of other appropriate facilities that can address their care needs. While there is currently no cure for Alzheimer's disease, psychiatric hospitals can stabilize the person's behaviors so that they may be able to return to appropriate long-term care settings.

The Director of State Courts maintains information on the total number of protective placements actions are filed annually (1,717 in calendar year 2011); the total number of reviews of protective placements conducted annually (7,673 in 2011), and the annual number of emergency detentions filed under Chapter 51 (16,132). However, the state's reporting system cannot identify how many of these actions involved elderly individuals with Alzheimer's disease or dementia.

DHS has collected this type of information for individuals who receive publicly-funded services. DHS reports that, in calendar year 2011 there were at least 112 Chapter 51 civil commitments of individuals with dementia or Alzheimer's disease statewide and that the average length of time that these patients stay in a psychiatric facility is approximately 23 days.

In addition, DHS provided information on inpatient services the Mendota Mental Health Institute provided to individuals with Alzheimer's disease and dementia for fiscal years 2006-07 through 2010-11. MMHI provides inpatient psychiatric services to individuals who receive services under either Chapter 51 or 55. All patients at MMHI have been involuntarily admitted as the result of a court order. The number of admissions of patients with a primary diagnosis of dementia or Alzheimer's ranged from a high of 45 admissions in fiscal year 2006-07 to a low of 19 admissions in fiscal years 2009-10 and 2010-11. Over the 2006-07 to 2011-12 time period, no more than four patients per year were readmitted to MMHI after a previous stay. The average length of stay was highest in 2008-09 with 119 days, but has decreased each year to a low of 43 days in 2011-12. Dementia and Alzheimer's patients admitted to MMHI under Chapter 55 are only supposed to be at MMHI for up to 30 days. Since 2006-07 the percentage of patients discharged by the 30 day limit has ranged from 44 percent in 2006-07 to 73 percent in 2008-09 to a low of 40 percent in 2011-12. Over the past six years, the number of counties admitting dementia and

Alzheimer's patients to MMHI has decreased each year, from 18 counties in 2006-07 to seven counties in 2010-11, until increasing to 10 counties in 2011-12.

Advocates have expressed concern regarding long stays for individuals with dementia and Alzheimer's disease at MMHI. For each of the years that MMHI provided data, the longest length of stay for an individual was over 200 days. An individual admitted in 2006-07 resided at MMHI for 934 days. Another individual admitted in 2008-09 was at the facility for 809 days and a third admitted in 2009-10 was at the facility for 873 days. Current statute limits a person's emergency protective placement to 30 days. However, in practice, these stays may be for greater periods if a more appropriate placement for the individual cannot be found.

It is important to note that, in practice, individuals with dementia or Alzheimer's arrive at MMHI under either Chapter 51 or Chapter 55. MMHI indicates that of its seven Alzheimer's patients on June 13, 2012, three were Chapter 55 temporary protective placements, two more may be converted to a temporary placement, and only two were admitted under Chapter 51. Advocates may argue that the short-term nature of these facilities means the patient is subjected to more uncertainty, and will need to be relocated more often, than would be necessary if the person was initially placed in a residential facility.

Factors Influencing Counties' Use of Chapters 51 and 55 Procedures

County health services departments usually require law enforcement officers to consult with county mental health workers prior to detaining an individual so the county can decide whether the Chapter 51 or Chapter 55 process should be used. In some instances, a county may have a fiscal incentive to provide protective services to an elderly person with dementia under Chapter 55 instead of providing the individual inpatient psychiatric services under Chapter 51 due to the relatively high cost of care for individuals who receive inpatient hospital services. For example, if an individual was only eligible for MA and the individual received services at MMHI, the county would be required to pay the state's share (approximately 40%) of the daily MA payment rate to MMHI. In contrast, if the same individual could receive protective services in a nursing home or receive community-based care, the state's MA program would fund the entire cost of that care.

On the other hand, if the person were eligible for Medicare but not MA, the county may not have any cost responsibilities relating to the individuals placed at MMHI or any psychiatric hospital under Chapter 51, since Medicare would pay the entire cost of care for the individual (assuming the individual has not exceeded the 190 lifetime benefit limit). As of June 2012, 20 of the 25 individuals at MMHI with a primary diagnosis of dementia or Alzheimer's were covered under Medicare as their primary payer and two more individuals had private insurance as their primary payer and Medicare as their secondary payer. However, counties may incur other costs relating to these individuals.

County Collaboration. As previously indicated, Chapter 55 requires counties to designate at least one facility as an intake facility for emergency protective placements. Counties have met this requirement by designating their county-owned nursing home, establishing an agreement with

a privately owned facility, or establishing an agreement with a nearby county that has their own designated facility.

A number of counties have also created multi-county commissions to share the cost of operating a county nursing home unit specifically for individuals with challenging behaviors from the member counties. There are currently three such commissions in the state. The Marsh Country Health Alliance consists of 11 counties in south central Wisconsin that use the Clearview facility in Dodge County as one of their protective placement facilities. The Mississippi Valley Health Services Commission consists of another 13 members contributing to the use of the Lakeview facility in La Crosse County and the Woodland Enhanced Health Services Commission has 10 members working with the Clark County Health Care Facility. Under these agreements, the commissions lease a portion of the units in their partnering facility and hold the license for those units to serve residents. The attachments provide the county membership of each commission.

Each member of the commission is required to make a one-time contribution of $5,000 for legal and administrative services. The members must also agree to pay a portion of the unit's total costs in excess of MA payments, based on the number of their residents in the facility. State and federal law requires MA providers to accept MA rates as payment-in-full for the services they provide. However, since the commissions are governmental entities, member payments to cover the full cost of operation of the facility are permitted. As non-governmental entities, Family Care MCOs cannot be members of these commissions. These additional payments vary between commissions, but two of the commissions have current rates of approximately $47 and $60 per day per resident.

The Clearview facility in Dodge County currently has 60 beds dedicated to dementia patients from other commission members. The Lakeview facility in La Crosse County has 77 of its 119 nursing home beds and 6 of its 7 developmental disability beds occupied by residents from the county commissions. The remainder of its beds are occupied by Family Care clients who themselves may exhibit challenging behaviors. Lakeview indicates that counties vary in their utilization of the facility. Some counties have admitted only one resident while one county admitted 48 residents.

DHS indicates that not every county has designated a protective placement facility. For these counties, Chapter 55 placements pose an additional cost beyond the guardian ad litem fees, because they would also need to establish a protective placement facility. For example, it would likely cost millions of dollars for a county to own and operate its own nursing home. Even the relatively small payments required by the county commissions would be an increase compared to what the county contributes for individuals with private insurance or Medicare. Counties may also have few if any dementia or Alzheimer's patients whose behaviors rise to the level of emergency detention or protective placement, in which case the initial investment needed for these alternatives may not seem necessary.

There are many factors other than funding sources that may have contributed to counties choosing Chapter 51 over Chapter 55. Space at county homes or other designated protective

placement facilities may be limited, especially at those capable of caring for Alzheimer's patients. County workers and law enforcement may simply have been more familiar with Chapter 51 civil commitments from working with individuals with mental illness.

Possible Impacts of the *Fond du Lac County v. Helen E. F.* Decision

It is too early to know what effects the Supreme Court's decision in *Fond du Lac County v. Helen E. F.* will have. With regards to the use of civil commitments, it is worth noting that the Supreme Court limited its decision to those individuals with a sole diagnosis of Alzheimer's disease. The use of civil commitments for individuals with a dual diagnosis of Alzheimer's disease and another Chapter 51 qualifying illness is left to the discretion of the circuit courts. This is particularly important because many Alzheimer's patients also suffer from depression. It has been suggested that counties may try to use the dual diagnosis exception to continue using the Chapter 51 process for dementia and Alzheimer's patients.

The Department indicates that one impact that has already been seen since the Court of Appeals' April 2011 decision on the *Helen E. F.* case is a reduction in the length of stays at the MMHI's geropsychiatric treatment unit. A decrease in total patient days of care on the geropsychiatric unit is also possible. The geropsychiatric unit has 15 beds, and, as of June 2012 had a year-to-date average daily population of approximately 12.7 patients. While total admissions of patients with a primary diagnosis of Alzheimer's have been higher in fiscal year 2011-12 (27 admissions) than in the previous two fiscal years (19 admissions), the average length of stay for those admissions has decreased (from 56 days in 2010-11 to 43 days in 2011-12). Some of the reduction in average length of stay may also be the result of policy changes implemented by counties in response to the change in 2009 Wisconsin Act 28, which required counties to provide the non-federal share of MA costs for individuals at the MHIs.

It has also been suggested that counties may try to persuade nursing homes to improve their capacity to care for individuals with challenging behaviors. This could reduce the number of patients that need to be discharged from their facilities and may make it easier to place Alzheimer's patients after they have been discharged. However, as mentioned above, nursing homes face a number of pressures that may make it difficult to make such changes. Nursing homes in turn might start refusing to accept patients with even mild dementia and Alzheimer's disease, based on the prospect that those patients might be very costly and difficult to treat in the future. It has been suggested that some nursing homes may have already begun refusing to admit dementia patients for this reason, even before the *Helen E. F.* decision.

Another impact of the *Helen E. F.* decision is that some counties will likely need to improve their options of protective placement facilities. Counties without a designated protective placement facility will likely need to decide whether to establish an agreement with a nursing home in their county or join some form of multi-county agreement.

GC/sas
Attachment

ATTACHMENT 1

County Nursing Home Commission Membership as of July 11, 2012

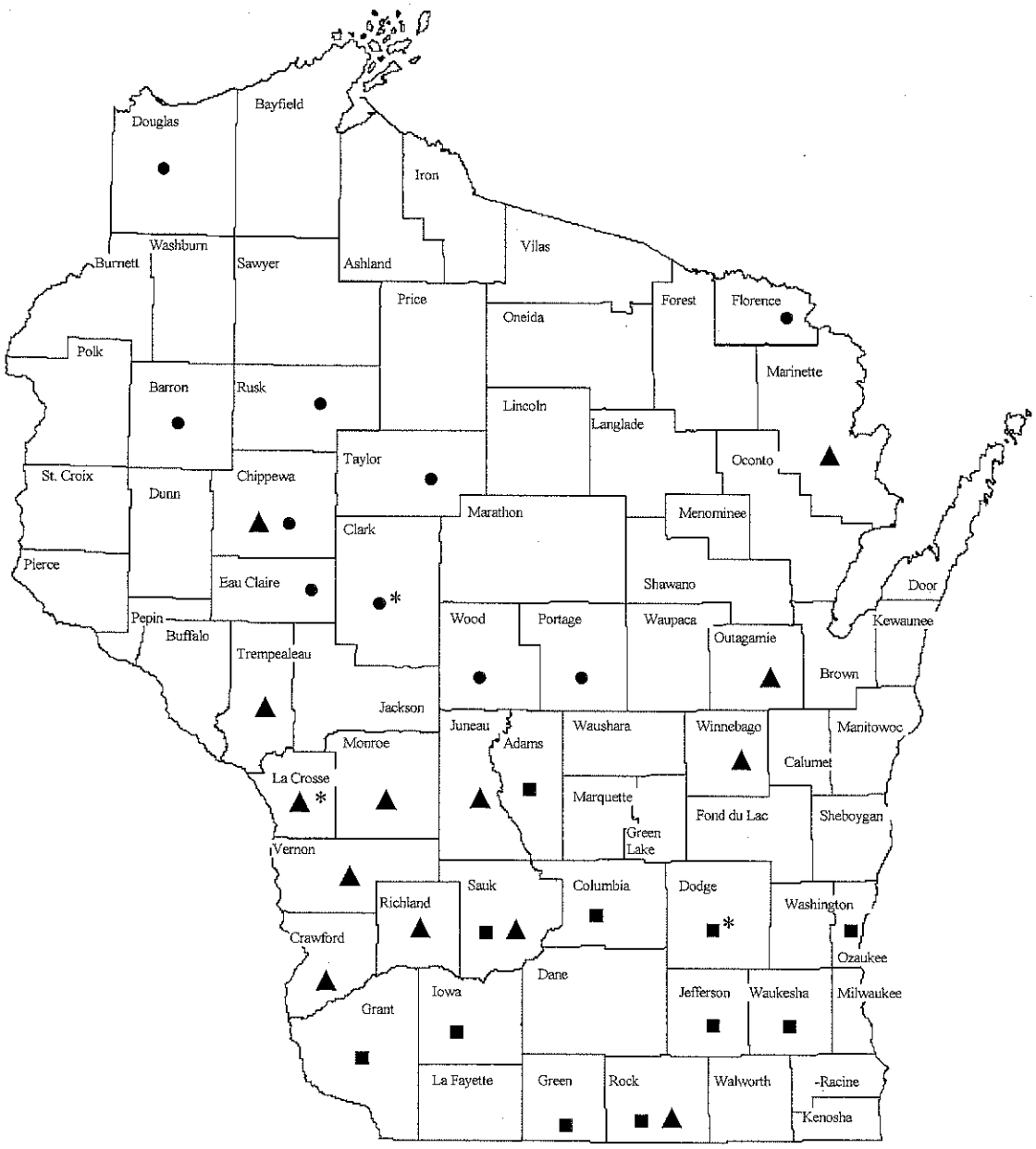
Marsh Country Health Alliance
Adams
Columbia
Dodge
Grant
Green
Iowa
Jefferson
Ozaukee
Rock
Sauk
Waukesha

Mississippi Valley Health Services Commission
Chippewa
Crawford
Juneau
La Crosse
Marinette
Monroe
Outagamie
Richland
Rock
Sauk
Trempealeau
Vernon
Winnebago

Woodland Enhanced Health Services Commission
Barron
Chippewa
Clark
Douglas
Eau Claire
Florence
Portage
Rusk
Taylor
Wood

ATTACHMENT 2

County Nursing Home Commission Membership as of July



■ Marsh Country Health Alliance

▲ Mississippi Valley Health Services Commission

● Woodland Enhanced Health Services Commission

*Locations of County Commission facilities.