State of Wisconsin Legislative Committee Hearing

RE: Ch. 51/55 – Emergency Detention for those with a Diagnosis of Dementia

State of Wisconsin Capitol Building
Room 411 S
Madison, WI
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Testimony From:
HARBOR HAVEN HEALTH & REHABILITATION – Fond du Lac County
Mark Radmer, Nursing Home Administrator
Karen Wagner, Director of Social Services

Good Afternoon, may name is Karen Wagner; I am the Director of Social Services for Harbor Haven Health & Rehabilitation, a 123-bed Skilled Nursing Facility, owned and operated by Fond du Lac County, in the city of Fond du Lac. I have been working in the nursing home setting for over 20 years and throughout my career I have worked with many individual residents that have had significant behavioral health needs, some due to a dementia diagnosis, and in some cases due to a mental illness of another type. It is a fact that working in a nursing home means encountering, at some point or even daily, residents with a Dementia or Alzheimer's diagnosis who will also exhibit behavioral irregularities that these residents would have not otherwise exhibited, had they not been afflicted with this tragic condition.

While these situations certainly present challenges to our caregiving team, facilities like Harbor Haven and many others in the State of WI, view our service to residents suffering from dementia not only as part of our mission, we view this opportunity as a privilege, and do our very best every day to provide the needed care for these individuals. To be clear, our number one concern is the safety, and well-being of all of our residents, and to provide the highest quality of life that is possible for them.

The regulations under which our industry operates were designed to improve the care we provide, yet in some ways these same regulations create limitations in relation to what we are able to do. Residents with Dementia or Alzheimer's may exhibit disruptive behaviors such as: grabbing others, randomly slapping or hitting others, sexually or otherwise inappropriately touching others, throwing objects, and other similar unwanted behaviors. We are often not able to conclude with full certainty why these behaviors exist, and we utilize multiple interventions to improve the situation, and are usually successful in doing so. There may be

times that hallucinations and/or delusions, or, quite simply, the existence in a cognitively altered state, may cause some of these behaviors, with other environmental factors also contributing, yet again we cannot be fully sure of the cause despite all of our efforts and observation. In the nursing home industry, some of the behaviors previously mentioned such as punching or slapping, or sexual inappropriateness are considered "never" events from a regulatory standpoint. Stated differently, if these situations do occur, and the likelihood is that they can or will occur at some point in nearly any facility, despite all of the efforts by facilities like my facility, it is these same facilities that are going to be treated punitively and often harshly through regulatory processes. In our industry, when these situations do occur, the typical results are fines, citations, and other sanctions, not to mention the negative remarks that are left on that facility's record, even though that same facility would have worked tirelessly to prevent these situations from happening in the first place. And even if there would be no actual outcomes involving regulatory consequences, per a given circumstance, the potential for these situations to occur creates additional operational burdens such as intensive educational, investigative, and preventative efforts, and the additional costs of staff time and resources that need to be devoted to these initiatives should not be understated. They are real costs that are being incurred, and they have to be put in place at the expense of, or by diverting resources from, direct resident care. Please know that I share these concerns not to receive sympathy based on the regulatory or reimbursement environment in which we operate; we understand these rules better than anyone. I say this because the regulatory demands of the nursing home industry, along with the limited reimbursement resources should be taken into consideration by this committee, when attempting to answer the question of what can or should be done when we encounter scenarios in the nursing home that involve behaviors with those suffering from dementia, that rise to the level of being dangerous to the same resident, or others. We ask for consideration and acknowledgement of the fact that there are limitations that any nursing home has, particularly when the most severe behaviorally-related occurrences happen.

NEW SPEAKER:

My name is Mark Radmer, I work with Karen, and I am the Administrator at Harbor Haven Health & Rehabilitation in Fond du Lac. Like Karen, I too have worked in the long-term care industry for over twenty years. I actually had my start in this business as a CNA, working on a dementia care unit, so when I prepared for this presentation today, it certainly caused me to reflect back to on my time serving those with dementia. It has been a rewarding time for me, and I will say that over these years, the nursing home industry has improved greatly, with respect to the care we have provided to those suffering from dementia and the methods we have developed over time. Regarding the Helen E.F. decision, and perhaps more importantly, with respect to what can or should be done in situations like this going forward, I would ask the

committee to make their determination without taking any absolute approaches. In other words, there may be circumstances where an emergency detention could help improve the situation for someone with dementia, as well improving things for this person's peers. If we take the position that an emergency detention may never happen for those with dementia, this does not allow for every possible solution toward making things better for them, to be considered.

Our facility uses many different approaches when significant behaviors occur; the nursing home staff will try various approaches such as: 1.) having a medical work up completed to rule out another medical problem, 2.) reviewing current medications, 3.) reviewing the individual's current plans of care from various disciplines, 4.) assessing interpersonal issues that maybe occurring for a resident, 5.) meeting with family members to gain their insight, 6.) reviewing the resident's preferences, their likes/dislikes, and observing their interactions with staff and peers, and 7.) possibly trying antipsychotic medication if warranted by a treating psychiatrist or physician. And these are just a few of the measures that facilities will implement in order to better manage difficult situations. Another intervention we often use in situations like this is to assign 1 or even 2 staff members, solely to the care of the one individual that may require greater attention and care at a particular point in time. And even though this practice is not financially sustainable for any length of time, nor do the current reimbursement systems under which we operate address these kinds of costs in any way, there are many facilities which will dedicate the resources to provide for these measures, in order to do their very best to avoid serious situations that could have very negative consequences. So to be clear, for our facility and for many others, calling the local police with the hopes of having a person with dementia whose behaviors have gone beyond what we are able to control placed in an emergency detention, has never been the first course of action we have taken.

However, if our interventions are not enough despite our best efforts and a resident is still in need of help beyond where we could be effective, the question of "where do we go from here?" still needs to be answered. We as a facility have in the past felt it necessary to call the police to remove a resident TEMPORARILY in order to help protect the resident from injury to him/herself and the other residents. And in the limited number of times where this has happened, it has been temporary, as these residents have returned to our facility. When a resident's behavior is beyond our control and/or unpredictable to the point of being dangerous, nursing homes and the residents who live there need some type of additional assistance to best handle these scenarios. We understand and fully agree that people with dementia do not belong permanently in acute psychiatric facilities, and further agree that even the temporary relocation for someone with dementia in an acute mental health setting could have the potential to be very upsetting and even frightening to a resident with dementia. And furthermore, it is our facility's opinion that nursing facilities should not be allowed to use

emergency detention facilities as a place to rid themselves of folks who present with behavioral challenges. Yet dismissing the possibility that an acute mental health setting could ever help someone with dementia, and consequently not allowing for this type of placement to ever occur, is also denying these individuals access to treatment or services which could be beneficial. And, if this approach is taken, these are services which these same people would have been otherwise entitled to receiving, had they not had a dementia diagnosis in the first place. We feel this situation, where we would deny someone treatment which could help them, solely because they have dementia, is wrong.

Chapter 51 addresses individuals who have mental illness, drug dependence, developmental disabilities, dangerousness, and one who presents as a proper subject for treatment. We need to seek a way for Chapter 51 or another law or regulation to allow for some type of treatment or temporary change of residence, outside of the nursing home setting, for one who is suffering from dementia, and whose condition would be presenting to the point of dangerousness, at a level which would make it unsafe for the skilled nursing facility to continue its attempts to manage the situation. These situations can and do occur, even for those facilities like our own that specialize in caring for those residents with behavioral challenges, and these situations can occur through no fault of the facility. So it would seem to us, important enough that all parties be open to all ideas, even looking at those ideas involving different provider types stepping in, in order the improve the situation for all involved, most importantly for the resident suffering from dementia.

Chapter 51 made it possible to obtain help to keep those residents who are displaying dangerous behaviors safe, to keep other residents safe, to avoid negative psychosocial impact on residents, and to keep staff safe. We would support legislation or policy that would allow for a person suffering from dementia to be <u>temporarily</u> placed in a different and safe alternate environment from their current nursing home living arrangement, for cases where extreme negative behaviors resulting from dementia are present. Offering options like this, again on a temporary basis, would provide protection for this resident, and for an in depth evaluation of their needs, and all involved would be ensured a higher level of safety, until the situation has resolved. We feel that if options similar to what we have discussed are at least available, and if there is a way to better define what would constitute an extreme behavioral incident versus a situation that a nursing facility should first be attempting to resolve themselves, our current situation could be much improved for skilled nursing providers and the residents they serve. I want to thank the Committee again for hearing our comments today, for considering the perspective of nursing home providers, and for recognizing the dedicated service provided by nursing facilities like ours, in the care provided to those who struggle with dementia. Thank you.