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Legislative Committee
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Note: I modified my actual remarks to the committee since the previous 15 speakers had pretty much touched on most of the points I wanted to make. I have taken the original outline I prepared and have modified it to reflect the examples I used.

In regards to the notion that Alzheimer's Disease is not treatable:
symptoms are treatable even if disease process is not "curable"

The court ruling states: "ch 55 provides Helen with the best means of care. This is so because ch 55 was specifically tailored by the legislature to provide for long-term care of individuals with incurable disorders, while chapter 51 was designed to facilitate the treatment of mental illnesses suffered by those capable of rehabilitation."
"Ch 51 is designed to accommodate short-term commitment and treatment of mentally ill individuals, while ch 55 provides for long-term care for individuals with disabilities that are permanent or likely to be permanent."

The patients with dementia that I have been involved with in the past using ch 51 are for the management of acute behavioral disturbances that are a serious risk for harming self or others. The goal is for short term care to effectively manage those symptoms, with the goal of returning to the setting in which the patient came from (home or assisted living or nursing home etc).
Example: a patient with dementia who developed quite an agitated depression and despite our efforts at treatment was quite distressed. She went from the nursing home to a geropsych unit at Stoughton and after a stay of about two weeks came back to the nursing home and was much improved and doing beautifully; content, pleasant, goes out at least weekly with family and for 1.5 yrs has continued to do well.
Another woman was constantly calling out and being very disruptive to other residents, disrupting sleep and tranquility of everyone on the floor. This woman has hemiplegia and aphasia (can answer yes and no well and other short replies sometimes. A multitude of non-pharmacologic measures did not achieve improvement. Antidepressants were used without success. Out patient psychiatry consult led to some different pharmacologic therapy but she was still very disruptive for the other residents. She went to the unit at Platteville and after 2-3 weeks she have adjustments of her medications and returned to the nursing home and has been doing pretty well since that time.
I did note in my presentation that ch 51 was not used in either of those situations, as we were able to have voluntary admissions.

It is also true that sometimes the behaviors of a person have been stressing the limits of current setting (home, assisted living, or nursing home) and the crisis does present as the 'tipping point' which may lead to a change of living situation.

One of my special interests is nursing home care, and I would like to point out some issues particularly problematic to nursing homes.
The nursing home environment is heavily regulated, and it is very clear that nursing homes are subject to citations and fines if any resident is at potential risk of harm from another resident.
There are also regulations that do not allow residents to be isolated.

Therefore, nursing homes have serious problems now related to residents with dementia that are becoming a risk to harm other residents; under the current system, there is little recourse for facilities to be able to have residents sent out for treatment, leaving other residents at risk.
This also has financial implications. If a resident requires one on care there will be a significant financial loss.

I would like to point out that in facilities that I work with closely, all the "right things" have already been done before seeking ch 51 or 55. We strive very hard to do all the appropriate non-pharmacologic techniques.

Another serious issue: currently nursing homes feel that if they admit someone who becomes a serious problem, affecting the well being of all the residents of the facility, they will have no ability to refer the resident out; so admission for anyone with a history of behavioral problems is anticipated to become more difficult.

I would like to point out that crisis situations are all unique; every dementia is unique as symptoms relate to many factors: first of all the disease process is different for every individual. The areas of the brain that are affected will vary in the order and intensity of changes in different areas.
The patient's internal resources (education, baseline personality, previous experiences) are all different.
The external resources (family, friends, living situation, finances etc) are all different.)
Subsequently there is no one size fits all solution.

Example: 69 year old man diagnosed with Alzheimer's a couple years ago. He was living mainly in Arizona with his wife but several months a year in Wisconsin. His wife was divorcing him and he had involuntary admissions in Arizona and his sister had him come Wisconsin and became his guardian. He was confused, often mistaking his sister for wife or fiancé etc. He could usually be redirected, but was quite confused. One day he started choking his brother in law who was able to get away only with great difficulty. Police reported he was unable to be to be ch 51 due to current law; interestingly, he did go to Southwest Care Center with voluntary admission (so man with guardian was admitted to psychiatric unit only if he signed himself in.

Example: 68 year old woman with FrontoTemporal Dementia. Was staying in adult family home and had multiple aggressive episodes. Subsequently went to Southwest Care Center and then admitted to nursing home. Since admission to nursing home and skilled caregivers, has not needed medication and although there are some moments of problems, there have no major incidents and she I treated with no pharmacological agents.
This case illustrates the importance of skilled, compassionate care to prevent escalation of behavioral symptoms. There were presentations to the committee illustrating the importance of training staff and families on the best ways to interact with patients with dementia; the most important way to deal with behavioral problems is to prevent them from happening in the first place and our ultimate goal is to educate and train staff and families in these best techniques.
I could not agree with this philosophy more and is the primary goal for the future.

Example: A nursing home resident has had some inappropriate sexual and physical incidents with staff members but never with his primary CNA. She was taking care of him one day, the same as every other day with no apparent differences, even in retrospect. As she was helping him he suddenly grabbed her by the neck and hit her forcibly. Help arrived immediately and the situation was able to be stabilized.
This illustrates two points: one is the compassion and skill that many CNA's possess (skilled CNA's are my heroes).
The other point is that sometimes, for no discernible reason, aggressive behavior can occur. So despite the best of care, incidents requiring emergent action will happen.

So what do I think we need?
First of all we need evaluation:

1. It is important to evaluate for medical reasons that might cause behavioral problems (pain, infection, poor control of medical diagnoses etc)
2. This would include examination and appropriate laboratory tests.
3. Medication review: consider any medication effects or medicine interactions that may cause problems

We need a therapeutic environment: low stimulus, calming environment with staff skilled in care of patients with dementia.
Staff need to be skilled in non-pharmacological approaches to dealing with the problem behaviors.
For those patients who need further treatment, someone knowledgeable about the appropriate use of medications will be important.

Therefore, I think development of a system to deal with this issue needs to have some flexibility so that a patient can receive the care that is most beneficial. Sometimes that is just moving to a place with a calm environment with people skilled in non-pharmacologic care. Sometimes, that might mean care in a facility that is skilled in the pharmacologic management of symptoms.

My experience is in rural areas: it will be a significant challenge to find places with capability of stepping up to crisis situation with one on one (or more) staffing on a 24/7 365 basis with the above criteria.
I was interested to find out that Dane County also has no identified ch 55 locations, so this is apparently not just a rural issue.

Financial considerations of how to fund these places of care will be very important

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