WISCONSIN LEGISLATIVE COUNCIL
STAFF MEMORANDUM

Memo No. 1

TO: MEMBERS OF THE SPECIAL COMMITTEE ON LEGAL INTERVENTIONS FOR PERSONS WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

FROM: Brian Larson, Staff Attorney and Mary Matthias, Senior Staff Attorney

RE: Summary of Recommendations Made to the Special Committee at the July 31, 2012 Meeting

DATE: September 6, 2012

This Memo summarizes and briefly discusses recommendations made to the Special Committee by speakers who addressed the committee at its July 31, 2012, meeting and by committee members in follow-up correspondence to staff. The recommendations are organized under the following headings:

- Advance Planning Options.
- Provision of Psychiatric Care for Individuals With Dementia.
- Long-Term Care of Individuals With Dementia.

The Memo is intended only as a starting point for discussion. Committee members should feel free to suggest other items that are not included. Please note that some suggestions may be contradictory, and although an attempt has been made to organize and merge similar recommendations, some overlap among suggestions remains. For a detailed description of the current law pertaining to the options discussed in this Memo, please see SB-2012-05, *Legal Interventions for Persons With Alzheimer's Disease and Related Dementias* (July 25, 2012).

More research may be needed to determine the feasibility of some of the recommendations included in this memorandum. In particular, it would be necessary to ensure that any committee proposals pertaining to involuntary commitment and involuntary administration of psychotropic medications comply with court rulings regarding equal protection and due process, and recommendations pertaining to nursing homes comply with federal regulations applicable to nursing homes that participate in the federal Medicare and Medicaid programs.

Throughout this Memo, the term "dementia" is used to refer to people with Alzheimer's Disease and related dementias.

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ADVANCE PLANNING OPTIONS

This portion of the Memo summarizes recommendations related to planning options using a power of attorney for health care (POAHC). Included are recommendations to give health care agents expanded authority to consent to admissions to certain facilities, as well as provisions concerning the effect of statements made by a principal, after a POAHC is in place, on a health care agent's authority to act.

A POAHC is a written document that allows an individual (or "principal") to designate another individual to make health care decisions on his or her behalf in the event that the principal lacks capacity to make his or her own health care decisions. The designated individual is referred to as the health care agent (or "agent").

POAHC Consent to Admission to a Facility

- **Allow an agent to consent to the admission of a principal on an inpatient basis to a treatment facility**. Current law prohibits an agent from consenting to the admission of the principal on an inpatient basis to certain facilities, including any privately or publicly operated facility providing treatment of alcoholic, drug dependent, mentally ill or developmentally disabled persons. [s. 155.20 (2) (a), Stats.] A principal may be admitted on an inpatient basis to any of the facilities specified above only under the applicable requirements of ch. 51 or 55. [s. 155.20 (2) (a) and (b), Stats.] The committee might consider whether to include this as an optional power that the principal must affirmatively select on the document in order to be effective. In addition, it was suggested that this authority be granted in a limited fashion, such as for acute psychiatric needs only. The committee might consider other possible limitations on an agent's authority, such as allowing only short-term admissions, admissions to only certain types of facilities, or admissions only when there is evidence that treatment on an inpatient basis in a psychiatric facility is likely to be successful and that other forms of treatment have been tried and were unsuccessful.

- **Allow an agent to consent to the admission of a principal diagnosed as having a mental illness to a nursing home or community-based residential facility (CBRF)**. Under current law, a principal may consent to the admission of an agent to a nursing home or CBRF as follows: (a) for up to 30 days for respite care; or (b) up to three months for recuperative care directly from a hospital inpatient unit, unless the hospital admission was for psychiatric care. An agent may consent to the admission of the principal to a nursing home or a CBRF, for purposes other than respite or recuperative care only if the POAHC instrument specifically authorizes the agent to do so and the principal is not diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission. [s. 155.20 (2) (c) 2., Stats.] The committee might consider whether to include this authority as an optional power that the principal must affirmatively select on the POAHC document in order to be effective.

POAHC – Directions of the Principal

Current law requires an agent to "act in good faith consistently with the desires of the principal as expressed in the power of attorney for health care instrument *or as otherwise specifically directed by the principal to the health care agent at any time*." [s. 155.20 (5), Stats. (Emphasis added).] That is, even though a principal may have, in a POAHC document, authorized an agent to take certain actions,

the agent may not take those actions if the principal objects to those actions, or provides contradictory directions, at a later time.

The following suggestions were made concerning the impact of directions from the principal that contradict the authority provided by the principal to the agent in the POAHC:

- **Allow a principal to specify in a POAHC that a specific provision in the POAHC will not be affected by later directions from the principal**. For example, if the statutes were amended to allow an agent to be specifically authorized in a POAHC to consent to the principal's admission on an inpatient basis to a private treatment facility, then, under this proposal, the POAHC could also state that the authority to consent to admission will remain valid despite any objections made by the principal at any time.
- **Allow a principal to include in a POAHC a general provision concerning directions and capacity**. It was suggested that a principal be authorized to specify in a POAHC that if he or she, at any point after executing the POAHC, is found to lack the capacity to provide meaningful direction to the agent, then any opinions subsequently expressed by the principal would not invalidate the directions set forth in the POAHC. The committee might consider the standard to be used in determining whether the principal has the capacity to provide meaningful direction.

PROVISION OF PSYCHIATRIC CARE FOR INDIVIDUALS WITH DEMENTIA

This portion of the Memo summarizes suggestions related to the provision of psychiatric care for individuals with dementia. General comments made by speakers addressing the committee that could potentially apply to any of the recommendations below are as follows:

- Provide flexibility for Milwaukee County based on issues unique to Milwaukee County such as its larger population and unique methods of service delivery.
- Provide flexibility for rural counties or other areas where certain facilities and resources may not be available.
- Ensure that proposals address the acute psychiatric care needs of individuals living in private homes.
- Ensure that law enforcement agencies and officers are aware of and understand any statutory changes that impact them.

Basis for Involuntary Commitment for Psychiatric Treatment

- **Specify that an individual with dementia may *not* be involuntarily committed for treatment unless he or she has a separately occurring mental illness that is not related to, a result of, or a symptom of dementia**. It was suggested that this be achieved by: (a) amending the definition of mental illness set forth in s. 51.01 (13) (b), Stats., to specifically exclude degenerative brain disease; and (b) creating the following definition of "dual diagnosis" in ch 51:

  > "Dual diagnosis" means a diagnosis of degenerative brain disease or alcoholism, plus a diagnosis of a separately occurring mental illness that is not related to, a result of, or a symptom of alcoholism or dementia.

- **Allow involuntary commitment based solely on behaviors related to dementia under certain conditions**. It was suggested that short-term involuntary commitment for psychiatric

treatment of behaviors caused by dementia should be permitted if it can be expected that the individual will benefit from the treatment. For example, commitment for treatment could be permitted only if the treatment is likely to result in an improvement of the individual's quality of life or likely to improve difficult behaviors thereby enabling the individual to successfully return to his or her former living arrangement. The committee could consider specifying in the statute the types of behaviors for which commitment for treatment would be permitted.

It was also suggested that commitment of a person with dementia be allowed based on behaviors that fit within the description of behaviors that present with any recognized psychological disorder.

- **Allow involuntary commitment of individuals with dementia who are exhibiting unmanageable physical or sexual aggression and/or refusing necessary services that are essential for the individual's well-being**. It was suggested that the residential facility from which an individual is taken for psychiatric care under these conditions should be required to reassess the individual once the psychiatric facility determines that the individual may return to the residential facility. The residential facility would be required to allow the individual to return if he or she meets the criteria for admission.

- **Eliminate the provision in ch. 51 that states that a person is not a proper subject for commitment if he or she may be provided protective placement or services under ch. 55**. Under ch. 51, a person may be found not to meet the dangerousness standards for involuntary commitment if the individual may be provided protective placement or protective services under ch. 55. [s. 51.20 (1) (a) 2. c., d., and e., Stats.] It was stated that is not rare for a person to need psychiatric treatment in order to be protectively placed in the least restrictive environment consistent with the person's needs, and therefore this provision should be eliminated.

Involuntary Commitment Procedures; Conversion to Ch. 55 Proceeding

- **Develop a special procedure for involuntary commitment of individuals with dementia that is modeled on the procedures in ch. 55, Stats., and that addresses the unique circumstances faced by this population**. It was stated that the procedures in ch. 55 are preferable to those in ch. 51 because they provide for greater involvement by the individual's family and health care agent or guardian, and provide "checks and balances" through the involvement of the guardian ad litem (GAL), particularly through reports the GAL provides to the court.

- **Adopt a provision modeled on the Florida "Baker Act," under which a physician or mental health provider may authorize emergency detention**. The Florida Mental Health Act, Fla. Stat. s. 394, Part I, is commonly referred to as the Baker Act. It is similar in many respects to ch. 51, Stats. However, under the Florida law, if a physician or mental health provider executes a certificate stating that a person appears to meet the criteria for involuntary examination, a law enforcement official *must* take the person into custody and deliver them to a facility for examination. Under Wisconsin law, a law enforcement officer may, but is not required to, take a person into custody for emergency detention based on the report of any other person, including a physician. [s. 51.15 (1) (a) (intro.) and (b), Stats.]

- **In Milwaukee County, allow a treatment director to undertake all responsibilities that are required of a law enforcement officer under s. 51.15, Stats., pertaining to emergency detention**. Under this recommendation, a treatment director would be authorized to make the determination that there is cause to believe a person meets the standards for commitment, take the person into custody, and transport them to a treatment facility. It was also suggested that police responding to a call in which emergency detention was considered should be required to call the Crisis Intervention Service mobile team for assistance, or the mobile team, rather than the police should be authorized to respond to these calls. The mobile team would make the determination as to whether the individual in question is in need of psychiatric services. Several other suggestions pertaining to the role of mobile teams throughout the emergency detention process can be found in the document submitted by Milwaukee County entitled "*Emergency Detention Process-PROPOSED.*"

- **Provide notice of detention, transport, and commitment hearings to family members, health care agents, and guardian, if any**. Under ch. 51, Stats., notice of the detention and transport of an adult individual must be provided to the individual and his or her attorney. The court may designate persons other than the individual and his or her counsel to receive notices of hearings and rights under ch. 51. [s. 51.20 (2) (b), Stats.] It was suggested that for an individual with dementia, notice of detention and transport should be provided to the individual's family members, health care agent, and guardian.

- **Establish a right for family members, health care agents, and guardians to attend and participate in ch. 51 hearings**. Under ch. 51, family members, agents, and guardians do not have the right to participate in hearings. [s. 51.20 (5), Stats.] All hearings under ch. 51 pertaining to involuntary commitment are open, unless the subject individual or the individual's attorney, acting with the individual's consent, moves that it be closed. If the hearing is closed, only persons in interest, including representatives of providers of services and their attorneys and witnesses may be present. [s. 51.20 (12), Stats.] It was stated that family members, health care agents, and guardians of individuals with dementia should have the right to attend and participate in hearings related to detention and involuntary commitment.

- **Increase the length of time for which a court may order protective placement or services following the conversion of a ch. 51 proceeding to a ch. 55 proceeding**. Under current law, if the court determines that there is not probable cause for commitment but there is probable cause to believe that the individual is a fit subject for guardianship and protective placement or services, the court may appoint a temporary guardian and order temporary protective placement or services under ch. 55 for up to 30 days. The court must then proceed as if a petition had been made for guardianship and protective placement or services. [s. 51.20 (7) (d) 1., Stats.] It was stated that in some instances, the 30 day period is not sufficient to enable the preparation of all evidence and material required for a permanent protective placement proceeding. In such cases, after 30 days, the individual must be released even though they may still pose a danger to themself or others.

Transportation of Individuals Detained for Psychiatric Treatment

- **Prohibit the use of handcuffs when transporting a person with dementia**. Wisconsin law does not require law enforcement officers to use handcuffs when transporting a person for emergency detention. The committee may wish to consider whether there may be

circumstances under which the use of handcuffs may be necessary to ensure the safety of the individual being detained, or of the officer.

- **Specify that ambulance services, rather than police vehicles, be used to transport persons with dementia to facilities for psychiatric care**. Current law provides that the law enforcement officer or other person authorized to take a person into custody for emergency detention must "…transport the individual, or cause him or her to be transported, for detention…." [s. 51.15 (2) (intro.), Stats.] It was suggested the police officers could either ride along in the ambulance or follow in the squad car.

- **Authorize mobile crisis intervention teams to transport an individual to a treatment facility**. It was suggested that this option, when safe and appropriate, would prove less traumatic for the individual and free up police resources.

Short-Term Admission to Treatment Facilities for Acute Psychiatric Care

- **Authorize a guardian to consent to involuntary short-term admission to an acute psychiatric inpatient unit under certain circumstances**. Under current law, a guardian may consent to voluntary, but not to involuntary, admission of a ward to a facility for psychiatric treatment. [s. 51.10 (8), Stats.]

  Also under current law, the guardian of an individual who has been adjudicated incompetent may consent to the individual's admission to a nursing home or other facility for which protective placement is otherwise required, for up to 60 days, if the individual needs recuperative care or is unable to provide for his or her own care or safety so as to create a serious risk of substantial harm to himself or herself or others. [s. 55.055 (1) (b), Stats.]

  It was suggested that a guardian be authorized to consent to short-term admissions of a ward to a facility for acute psychiatric treatment if two physicians verify that the individual is in imminent need of treatment to prevent substantial probability of physical harm, impairment, injury, or debilitation evidenced by behaviors exhibited within the last 60 days.

- **Create a procedure within ch. 55 to allow a person who is subject to a protective placement order to be temporarily placed in a treatment facility for acute psychiatric care**. Currently, protective placement may not be made to a unit for the acutely mentally ill. No individual who is subject to an order for protective placement or services may be involuntarily transferred to, detained in, or committed to a treatment facility for care except by following the procedures and meeting the criteria set forth in ch. 51, Stats. [s. 51.12 (2), Stats.]

  It was stated that ch. 55 should be amended to allow an individual to be placed in the location best-suited to address behaviors being exhibited. This could be accomplished by amending the statues to allow for temporary transfer of an individual from his or her protective placement setting to a treatment facility.

  The committee may wish to consider whether initial protective placement in a treatment facility, on a temporary basis, should be permitted. This could, in effect, be similar to the recommendation, set forth above, to develop a procedure for involuntary commitment of individuals with dementia that is modeled on the procedures in ch. 55, Stats.

- **Allow emergency protective services to be provided in any setting in which the appropriate level of service may be obtained**. It was suggested that allowing emergency

protective services to be provided in a treatment facility would provide better delivery of services to the individual and enable county staff to obtain evaluations of the individual needed for the probable cause hearing.

- **Create a special procedure for short-term admission of nursing home residents with dementia to a psychiatric facility for treatment**. It was suggested that this option be made available to residents of nursing homes and other long-term residential facilities, and that the facility be required to develop a customized plan setting forth the conditions and procedures for psychiatric admission for each individual. This plan would be developed prior to the eruption of a crisis necessitating psychiatric treatment. Further recommendations regarding responsibilities of nursing homes to plan for short-term acute psychiatric needs of residents are set forth in the last section of this Memo.

Where Psychiatric Care is Provided

- **Develop methods to provide psychiatric treatment to individuals "in place" or in the lowest acuity setting possible**. It was stated that for individuals with dementia, transferring from one living situation to another can be traumatic and can cause significant disorientation and exacerbation of symptoms. It was suggested that treating in place could be achieved by means such as expanding the use of mobile crisis teams, providing greater support to caregivers, and enhancing the ability of caregivers in a residential setting to provide psychiatric treatment, including medications. It was further stated that a psychiatric facility should be the option of "last resort" for individuals with dementia.

- **Develop alternative facilities for the provision of psychiatric care for individuals with dementia**. It was stated that there is a need for some type of treatment or temporary change of residence, outside of the nursing home setting, for individuals who are suffering from dementia, and who are exhibiting dangerous behaviors, at a level which would make it unsafe for the skilled nursing facility to continue its attempts to manage the situation.

  It was suggested that regional facilities, developed by multi-county consortia, be supported and expanded. It was also suggested that a method be established to enable nursing homes to develop and provide specialized units for providing acute psychiatric treatment and long-term care for individuals with dementia. It was further suggested that if these facilities are available, the law should allow them to be used as protective placement facilities.

- **Require individuals with dementia who are committed to a facility for psychiatric treatment to be housed separately from people with other mental health conditions**. It was stated that it is difficult to get an accurate sense of how an individual treatment plan is progressing if the person is agitated by other patients with other conditions, and this can lead to an increased length of stay.

- **Allow commitment of individuals with dementia to specialized geriatric psychiatric units only**. It was stated that because of the unique characteristics of the elderly, especially as they pertain to psychiatric treatment, elderly individuals with dementia who are involuntarily committed should be treated only in specialized geriatric psychiatric units. The committee may want to consider whether this option is viable in all areas of the state.

Limit Length of Allowable Commitment; Required Attempts to Reintegrate

- **Reduce the length of time that a person with dementia may be involuntarily committed**. Under current law, an initial commitment order may be for a period of up to six months; commitments of the individual may be for a period of up to one year. [s. 51.20 (13) (g) 1., Stats.] It was stated that typically the period of time needed to treat the behaviors for which an individual with dementia is committed is considerably less than six months. It was suggested that if the statutes are amended to clarify that a person with a primary diagnosis of dementia may be involuntarily committed, the period of commitment be limited to more accurately correspond to the needed length of treatment. Limits of 30 or 45 days were suggested.

- **Require that attempts be made to reintegrate an individual with dementia who has been committed to a facility for psychiatric care**. It was suggested that due to the unique issues surrounding dementia, and to ensure that individuals with dementia not be "stuck" indefinitely in psychiatric settings, the law should require that attempts be made to return an individual to his or her former residential setting, or another appropriate setting other than a psychiatric facility, after a certain period of time, or at certain intervals, after the individual's initial commitment. The committee should consider which person or entity would be responsible to make these attempts.

- **Create provisions allowing for long-term care in a psychiatric setting for individuals with dementia**. It was suggested that these provisions would apply only to individuals whose behavior is not controllable in a nursing home, CBRF, or Adult Family Home (AFH) setting and for whom psychotropic medication does not ameliorate unmanageable symptoms of dementia within a short time.

Emergency and Temporary Protective Placement

- **Eliminate the requirement to file a petition for guardianship within three days after making emergency protective placement**. Under current law, when an individual is detained under an emergency protective placement, a petition for protective placement or services must be filed by the person making the emergency protective placement and a preliminary probable cause hearing must be held within 72 hours. If the individual is not under guardianship, a petition for guardianship must accompany the protective placement petition. After the hearing, the court may order temporary protective placement up to 30 days pending the hearing for a permanent protective placement, or the court may order such protective services as may be required. [s. 55.135 (4), Stats.]

- **Require any attorney who files for temporary guardianship or temporary protective placement to subsequently file for permanent protective placement or guardianship, unless excused by the court**. It was suggested that chs. 54 and 55, Stats., both be amended as necessary to add this requirement.

Protective Services Orders for Involuntary Administration of Psychotropic Medications (IAPM)

- **Use caution in loosening any standards for allowing administration of psychotropic medications to individuals with dementia**. It was stated that psychotropic medications are inherently dangerous for individuals with dementia, as indicated by the federally required "black box" warnings regarding the use of many psychotropic medications by individuals

diagnosed with dementia. It was also stated that in some settings, the staff caring for individuals with dementia may lack the knowledge and expertise needed to safely administer these medications, and their overuse may mask underlying medical issues that may therefore go untreated.

- **Eliminate the requirement that a protective placement petition be filed in order to obtain a protective services order for IAPM for a person residing in a facility licensed for 16 or more beds**. Under current law, in order to obtain an IAPM for any individual, the individual must have a guardian. If a guardian is appointed for an individual who resides in a nursing home, a petition for protective placement must be filed in order for the individual to continue to reside in the nursing home, since a guardian may not consent to an individual's admission to a nursing home for more than 60 days without a protective placement order. [s. 55.055 (1) (a) and (b), Stats.]

- **Simplify the evidence needed and process required for obtaining a protective services order for IAPM. Increase the time limits to complete the process of obtaining an order from 30 to 60 days**. It was stated that the standards required for obtaining an order for IAPM should be lower than the standards required for involuntary commitment, in order to authorize the appropriate use of psychotropic medications prior to an individual reaching a crisis stage of behavior management. It was also suggested that as an alternative to increasing the time for completing an order for IAPM from 30 to 60 days, the court be permitted to extend the time limit for good cause.

- **Clarify whether IAPM may be provided as an emergency protective service**. Under current law, s. 55.14 (10), Stats., states: "Nothing in this section [s. 55.14 pertaining to protective service orders for IAPM] prohibits the involuntary administration of psychotropic medication as an emergency protective service under s. 55.13." Section 55.13, which allows emergency protective services to be provided for up to 72 hours, does not specifically allow or prohibit IAPM. It was stated that it is "unlikely" that the Legislature intended to allow IAPM as an emergency protective service without court authorization. It was also suggested that the statute be amended to make it easier to implement in general.

- **Provide that in an annual review of an order for IAPM, the IAPM may be continued if it is shown that absent the IAPM, the individual would meet the criteria for initial IAPM**. It was stated that this change is warranted since a similar provision exists for involuntary commitment under ch. 51, Stats. In a ch. 51 proceeding for involuntary commitment of a person currently receiving treatment, the requirement to show recent acts, attempts, threats, or other behavior justifying commitment may be satisfied by showing that there is a substantial likelihood, based on the subject individual's treatment record, that the individual would be a proper subject for commitment if treatment were withdrawn. [s. 51.20 (1) (am), Stats.]

LONG-TERM CARE OF INDIVIDUALS WITH DEMENTIA

This portion of the Memo contains suggestions primarily related to long-term nursing home care provided to individuals with dementia. Although the suggestions made to the committee were primarily directed at nursing homes, the committee might also consider whether these recommendations may also be applicable to or appropriate for CBRFs, licensed AFHs, or other residential settings.

Currently, when a resident with dementia exhibits so-called challenging behaviors, the law authorizes the nursing home to seek the discharge and transfer of the resident to a psychiatric unit. Often this does not occur through the ordinary discharge and transfer process, but as an emergency detention under ch. 51. As used herein, the term "transfer" includes a transfer as an emergency detention.

Several of the suggestions which seek to reduce the transfer of individuals with dementia to psychiatric settings discussed below refer to "behavior-based strategies" and "medical evaluation." These terms describe approaches to detect and address challenging behaviors early, as follows:

- "Medical evaluation" focuses on evaluation of an individual for potential medical or physical causes of behavior, including previously undiscovered conditions or issues with pain or medication that may be the cause of, or contribute to, challenging behaviors.
- "Behavior-based" strategies involve activities and interventions that incorporate the interaction of the person with dementia, the caregiver, and the environment in which the behaviors occur. These may include formal support for caregivers, training in promising methods of assessment and intervention, a culture shift toward person-centered care, use of the Star Method,[1] and instituting appropriate environmental policies and other appropriate policies and guidelines within facilities.

Discharge or Transfer to a Psychiatric Facility

- **Require a nursing home to attempt to use medical evaluation and behavior-based strategies to address challenging behaviors prior to transfer to a psychiatric unit**. The committee might consider whether to specify specific components of required medical evaluation procedures and behavior-based strategies by statute or require the Department of Health Services (DHS) to do so in administrative rules. The committee might also consider how attempts should be documented and the minimum level of effort that should be required.
- **Create safeguards to prevent unnecessary long-term placements in psychiatric units**. It was suggested that when a long-term care resident with dementia is transferred to a psychiatric unit, the county, or another specified party, be required to attempt to find a less restrictive placement within a certain length of time. The committee might also consider other requirements designed to facilitate the readmission of a resident to a nursing home after short-term psychiatric treatment. These may include requirements related to readmission, or requiring a nursing home to create a plan for readmission of a resident to the nursing home at the conclusion of the inpatient treatment, as well as increased opportunities for advocates and family members to attempt to facilitate readmission.

Administration of Psychotropic Medication

- **Require nursing homes to attempt to use medical evaluation and behavior-based strategies to address challenging behaviors prior to the administration of psychotropic medication to residents**. The committee might consider whether to specify required

[1] The STAR Method, developed by Dr. Tim Howell, Wisconsin Geriatric Psychiatry Initiative, is a tool for addressing complex problems in geriatrics. It involves mapping a patient's clinical data onto a single field with five domains (i.e., a five-pointed star): medications, medical, behavioral, personal, and social.

medical evaluation and behavior-based strategies by statute or require DHS to do so in administrative rules. The committee might also consider how attempts must be documented and the minimum level of effort that should be required. In addition, the committee should consider whether the requirement should apply to both the voluntary and involuntary administration of psychotropic medications, which, in the case of the latter, would require an amendment to the current procedure allowing court to authorize a guardian to consent to involuntary administration of medication under s. 55.14, Stats.

Care Plans

- **Require care plans for residents with dementia to focus specifically on dementia issues, including use of medical evaluation and behavior-based strategies to address challenging behaviors**. Generally, within four weeks after admission of an individual as a nursing home resident, the nursing home must develop a written plan for care of the resident based on the resident's history, and assessments evaluation by and orders of a physician. [s. DHS 132.60 (8), Wis. Adm. Code.] It was suggested that a care plan for a resident with dementia be required to contain specific elements addressing dementia-related issues and also set out a plan for the provision of acute psychiatric care should the need arise. The committee may wish to consider whether to specify the required elements of a care plan by statute or require DHS to do so in administrative rules. In addition, the committee might consider adopting requirements similar to those for developmentally disabled residents. Current law requires nursing homes serving developmentally disabled residents to employ or contract with an "interdisciplinary team" responsible for planning the program and delivering the services relevant to the individual's care needs, and to develop an Individual Program Plan (IPP) to provide a framework for the integration of all the programs, services, and activities received by the developmentally disabled resident. [s. DHS 132.695, Wis. Adm. Code.]

- **Encourage development of adult family homes that specialize in long-term care of individuals with dementia.** It was stated that AFHs, which generally provide care for three to four adults, may be a good option for providing long-term care for individuals with significant care needs related to dementia. The committee may wish to consider how the development of this type of care facility could be facilitated, and whether specific training or other requirements should apply.

Training and Staffing Requirements

- **Ensure that nursing homes provide adequate staffing levels at all times**. It was suggested that a large proportion of instances in which behavioral challenges lead to the emergency detention of a nursing home resident with dementia occur late at night when staffing levels are typically low. Current law requires that there be adequate nursing service personnel assigned to care for the specific needs of each resident, and those personnel must be briefed on the condition and appropriate care of each resident. In addition, nursing home employees may be assigned only to resident care duties consistent with their training. [ss. DHS 132.62 (2) and (3) and 132.44 (1) (b), Wis. Adm. Code.]

- **Require increased or specialized training of nursing home personnel in medical evaluation and behavior-based strategies for caring for residents with dementia.** The committee might consider whether to identify the required medical evaluation and behavior-based strategies by statute or require DHS to identify them in administrative rules. The

committee might also consider whether to require all nursing personnel to receive increased or specialized training, and whether training should also extend to all nursing home staff who come in contact with residents. The committee may wish to review current training requirements for nursing home personnel. The committee might also consider whether to create a new category of nursing personnel specializing in dementia care, as discussed in more detail below.

- **Mandate and fund dementia specific training programs in all facilities that describe themselves as being dementia-specific**. Current law does not impose any special training or other requirements on care facilities that advertise themselves as offering dementia care or otherwise claim to provide specialized services for individuals with dementia. It was suggested that these facilities be required to provide dementia-specific training to their staff, and that state funding be provided to support this training.

- **Increase opportunities for collaboration between facilities and patient representatives, advocacy groups, and hospice and other palliative care programs**. It was stated that increased collaboration may reduce unnecessary psychiatric treatment and administration of psychotropic medication for individuals with dementia. This might include a requirement that facilities connect residents with authorized advocates or family members, when possible, prior to a change in the resident's status relating to psychotropic medications or transfer to a psychiatric unit. The committee might also consider who may serve as a patient representative, and the necessary qualifications to serve as a patient representative. The committee might also consider whether to allow or require facilities to receive training in medical evaluation and behavior-based strategies from individuals or organizations approved by DHS.

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