

2015 Act 272: Dementia Crisis Unit Pilot Proposal

A Report by the Wisconsin Department of Health Services
to the Wisconsin Legislature

Executive Summary

The 2015 Wisconsin Act 272 requires the Department of Health Services (DHS) to submit to the Legislature a proposal for one or more pilot programs for coalitions of two or more counties to create Dementia Crisis Units (DCUs). The proposal is due before November 1, 2016, to the appropriate legislative standing committees with jurisdiction over health, aging, and long-term care or mental health issues.

Act 272 was one of 10 proposals introduced in the 2015-2016 legislative session as part of a package collectively referred to as the “Wisconsin Cares Alzheimer’s and Dementia Legislative Package.” The proposals emerged from the work of the 2015 Speaker’s Task Force on Alzheimer’s and Dementia, which was created by Assembly Speaker Robin Vos in August 2015. One of the charges to the Task Force was to identify ways to improve community-based resources for those with Alzheimer’s disease and dementia.

At times, people with dementia exhibit behaviors that are challenging for their caregivers to know how to interpret and respond to. Such behaviors can be an individual’s way of communicating an unmet need or want, or a response to anxiety or fear. For a small proportion of people with Alzheimer’s disease or related dementias, behavior can become self-injurious, aggressive, or violent towards others and result in a crisis for the person and the caregiver.

The call for DCUs is in recognition of the need to improve crisis response for people with dementia. Yet there is little concrete data about the extent of the need for this type of unit and where in Wisconsin such a need might be greatest. Relocation may cause unnecessary stress and produce negative health outcomes for the person. The goal should always be to respond to a behavioral crisis in a manner that causes the least possible stress and disruption to the individual.

In February 2014, DHS published a Dementia Care System Redesign Plan, which was developed with input from many partners. The Plan is premised on the belief that the difficulty of providing care for people with Alzheimer’s disease and related dementias who exhibit challenging behaviors is best addressed within the larger context of the entire dementia care system. A comprehensive approach to improving dementia-related crisis services should include three critical areas: (1) prevention and early intervention; (2) initial crisis response and stabilization in place; and (3) short-term, facility-based stabilization.

Consistent with this approach, this report presents options for improving dementia-related crisis response and stabilization in each of these critical areas. DHS recommends that the Legislature review the options and pursue a strategy that incorporates components from all three areas. Doing so would significantly advance the state’s capacity to provide quality crisis services for people with dementia and their caregivers.

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Introduction

Dementia Care System Redesign

In recent years, improving the system of care for individuals with dementia and their families has been a priority initiative of the Department of Health Services (DHS). Over five million Americans are living with Alzheimer's disease and related dementias. According to information from the Alzheimer's Association, Alzheimer's disease is the sixth leading cause of death in the United States. It is the only cause of death in the top 10 that cannot be prevented, cured, or slowed. Applying national prevalence rates to Wisconsin's demographics, an estimated 115,000 individuals in Wisconsin have dementia. By 2040, that number is expected to increase to 242,000 people. In 2015, nearly 30,000 of the 115,000 people in Wisconsin with dementia were enrolled in Wisconsin Medicaid.

The large number of people affected, the personal impact on individuals with dementia and their families, and the cost of providing care that can stretch over many years are all reasons for examining and improving the dementia care system in Wisconsin.

In 2013, former DHS Secretary Kitty Rhoades, with support from Governor Walker, called for a redesign of Wisconsin's dementia care system in order to provide appropriate, safe, and cost-effective care throughout the course of the disease. In February 2014, DHS released a [Dementia Care System Redesign Plan](#). The Plan was crafted with the help of many stakeholders, with a vision of creating a more "Dementia-Capable Wisconsin." The Plan is now being implemented by partners across the state.

The Plan includes five key focus areas: community awareness and services; facility-based, long-term care; capacity for dementia-related crisis response and stabilization; dementia care guiding principles and training; and research and data. The focus areas are interdependent; progress in any one area supports the possibility of progress in the other areas. The overarching goal is to support people with Alzheimer's disease and related dementias so each person has the highest quality of life possible consistent with the person's need for care and with the least restrictions placed on his or her personal liberty.

2015 Wisconsin Act 272

In August 2015, Assembly Speaker Robin Vos created a Speaker's Task Force on Alzheimer's and Dementia. Included in the Speaker's stated goals for the Task Force was a charge of identifying ways to improve community-based resources for those with Alzheimer's and dementia and also to determine ways to ensure future quality of care while bending the cost curve of long-term care downward.

The Task Force represented a bipartisan effort to address this critical issue. After conducting public hearings and tours across the state, Task Force members and additional legislators introduced legislation that was collectively referred to as the "Wisconsin Cares Alzheimer's and Dementia Legislative Package." The 2015 Act 272 was one of three bills in the package approved by the entire Legislature and signed into law March 2016.

Act 272 requires DHS to submit to the Legislature a proposal for one or more pilot programs for coalitions of two or more counties to create DCUs. The proposal is due before November 1, 2016, to the appropriate legislative standing committees with jurisdiction over health, aging, and long-term care or mental health

issues. Act 272 defines a “dementia crisis unit” as a unit or part of a unit of a public or private facility that is qualified, competent, and equipped to provide diagnosis, evaluation, and treatment of dementia and medical, psychiatric, and behavioral care to individuals who have dementia and that provides a therapeutic environment that is appropriate for and designed to prevent harm to individuals who have dementia.

DHS is grateful to Wisconsin’s elected officials for the leadership and support they have shown for people living with Alzheimer’s disease and related dementias and their caregivers.

Dementia-Related Behaviors

Many persons with dementia will exhibit behaviors that are challenging for their caregivers at some time in the course of their disease. Such behaviors (referred to in this report as “dementia-related behaviors”) often represent an individual’s way of communicating an unmet need or want, or a response to anxiety or fear. Many dementia-related behaviors can be anticipated, planned for, and avoided with well-trained caregivers, care planning, and support.

Care for people with dementia-related behaviors can be difficult, especially when the person becomes self-injurious, aggressive, or violent towards others. These kinds of behavior occur in a small proportion of people with Alzheimer’s disease or related dementias; however, these behaviors demand attention because of the immediacy and intensity of the need.

A high percentage of people with dementia are cared for at home with few supports other than family caregivers. Regardless of the living arrangement, caregivers are sometimes stressed beyond their capacity to provide care. In such situations, those supporting an individual with dementia are likely to call either law enforcement or the county crisis system to respond, often with a request to relocate the individual.

Dementia-related behaviors exhibited by persons with dementia can occur in the context of interactions between the individual and his or her environment and caregivers. Contributing factors may include untreated pain, an underlying medical condition, medication side effects, noise, light, behavior of other facility residents, a move, or a change in the physical environment. A caregiver’s response can either ameliorate or exacerbate the challenging behavior of the person receiving care.

Responding to dementia-related behaviors by removing the person with dementia from his or her current residence to an alternate setting can further exacerbate confusion and agitation. Relocation may cause unnecessary stress and produce negative health outcomes for the person. The goal should always be to respond to the behaviors in a manner that causes the least possible stress and disruption to the individual.

Current County-Based Crisis Response System

In Wisconsin, counties have the primary responsibility for the well-being, treatment, and care of those who have mental illness, developmental disabilities, and substance abuse issues. Counties have some options regarding the emergency services they provide. However, each county has the responsibility of ensuring that the emergency services it does offer are immediately available when an individual in the county needs them. Wisconsin Stat. ch. 51 requires that services be provided in the least restrictive alternative appropriate to the

needs of the individual in crisis and within the limits of available state, federal, and required county match funding.

Wisconsin Admin. Code ch. DHS 34 establishes standards and procedures for certification of county and multi-county emergency mental health service programs. Counties may comply by operating or contracting for the operation of an emergency mental health program. Such programs can be certified as either a basic emergency services program or an emergency services program eligible for medical assistance program or other third party reimbursement. The level of certification determines the required services provided, but all DHS 34 certified counties must assure that some level of emergency services are available 24 hours a day, 7 days a week. For many years, counties have expanded community services and collaborative efforts in order to stabilize people in-place and divert them from the most costly and restrictive crisis settings. These efforts have been supported by funding initiatives from the state.

DHS has clarified that individuals with “infirmities of aging,” including dementia, are entitled to crisis intervention services if their behaviors require crisis response. However, many county crisis intervention teams do not have dementia-specific training. With no funding earmarked for crisis response for individuals with dementia, there is often a lack of the kind of supports needed to meet the unique needs of people with dementia in crisis. A robust crisis response and stabilization system would have a variety of resources available for people with dementia in crisis. Such resources could include, for example, mobile crisis teams with training in dementia-related crisis response, in-home supports, psychiatric services, short-term residential options, service coordination, referral, and follow-up to address the variety of possible crisis scenarios that could be encountered.

Counties are also responsible for providing adult protective services to vulnerable populations. Wisconsin Stat. ch. 55 establishes a protective services system, with the primary purpose of keeping individuals safe who are at risk of harm due to a condition that is or is likely to be permanent, by providing for long-term care and custody of the individual. Chapter 55 provides protective services and protective placement, including emergency protective placement, for persons with degenerative brain disorders, severe and persistent mental illness, developmental disabilities, and other like incapacities. Services must be the least restrictive. Voluntary protective services are preferred, but services may also be ordered by a court on an involuntary basis.

Both of these county-level systems, mental health, and other services under Chapter 51 and adult protective services under Chapter 55, are used by counties to manage emergency services for people with dementia. In both situations, the individual may be detained in a care setting involuntarily. However, the purpose for which the detention is being made, the standards and procedures that must be adhered to, and the type of facility to which the court orders the individual are different depending on whether proceedings are initiated under Chapter 51 or Chapter 55. Under Chapter 51, emergency detentions are generally made to a psychiatric hospital. Under Chapter 55, placement can be made on an emergency basis to an appropriate medical or protective placement facility but not a psychiatric hospital.

Wisconsin counties are required to designate one or more facilities for Chapter 55 emergency protective placements. Many counties have difficulty finding facilities willing to admit people in crisis. There is no enforcement mechanism and no way for either counties or the state to compel facilities to accept such a designation, or to compel facilities that are designated as emergency protective placement facilities to accept

all individuals in crisis. In many counties, this results in the ongoing use of Chapter 51 emergency detentions for those with dementia.

The use of Chapter 51 rather than Chapter 55 continues in spite of related concerns raised in the Wisconsin Supreme Court's *Helen E.F.* decision, issued in May 2012. The Court held that Helen, who had dementia with no accompanying mental illness and was emergently detained under Chapter 51, would more appropriately have been subject to provisions of the protective service system under Chapter 55.

With the potential engagement of multiple county systems (Chapters 51 and 55) as well as family members, home health care professionals, managed care organizations, hospitals, and long-term care facilities, crisis response for a person with dementia can be exceedingly complex. In some areas of the state, the lack of dementia capable long-term care resources adds to the sense of crisis for those with dementia and their caregivers as urgent solutions are hard to find and are often far away from home. The lack of sufficient numbers of long-term care facilities across the state with the willingness and ability to accept individuals with dementia in a crisis has contributed to the perceived need for creating new options for providing dementia crisis beds for use when stabilization in place is not possible.

Capacity for Dementia-Focused Crisis Response and Stabilization

Context of Crisis Services

The Dementia Care Redesign Plan is premised on the belief that the difficulty of providing care for people with Alzheimer's disease and dementia who exhibit dementia-related behaviors is best addressed within the larger context of the entire dementia care system. Addressing the needs of people with dementia by providing for early detection and intervention, quality care services, and crisis stabilization in home, community, and long-term care settings has the potential to significantly reduce the incidence of serious behavioral concerns that result in emergency protective placements and removal of people from their residences.

Effective crisis intervention for people exhibiting dementia-related behaviors requires a three-pronged approach: the initial crisis response, crisis stabilization, and long-term care for individuals who may require significant levels of support. The goal is to treat the crisis "in place" (i.e., without having to move the person from his or her current residence) whenever possible. If a temporary change in residence is needed for purposes of stabilization, the goal is to then return the person to their previous environment or to the least restrictive setting when a more permanent change is required.

Stabilization services needed in any particular situation depend on the individual's circumstances and available caregiving supports. It may be that medical treatment, medication changes, environmental changes, de-escalation strategies, or short-term extra support is needed. Crisis response often also includes transition planning to ensure that, following resolution of the crisis, there are appropriate supports in place to minimize the likelihood of recurrence.

Varied County Capacity

County capacity for dementia-related crisis response and stabilization varies. Although individuals with dementia in crisis are eligible for crisis response under DHS 34, the development of services in response to

crisis have been focused primarily on adults (and children) with mental illness. The supports developed for that population are intended to stabilize and divert using short-term, intensive, community-based services to avoid hospitalization. Many counties have had great success in these efforts but expanding these concepts to the population with dementia has been a challenge and creating a parallel and separate system for that population would be cost prohibitive.

To gain a better understanding of current county capacity for dementia-focused crisis response and stabilization, DHS staff has talked with counties and county consortia, visited facilities, and conducted surveys of county crisis and adult protective services units. The results indicate that crisis response varies considerably across the state, with approaches differing in terms of agency configuration, relationships among partners, the use of Chapters 51 and 55 for emergency detentions and emergency protective placements, respectively, and the level of dementia expertise and capacity in the crisis response system. In areas of the state where effective solutions have been found, they have been developed locally and involved cooperation among many stakeholders (e.g., county adult protective service and crisis response systems, aging and disability resource centers [ADRCs], care facilities, law enforcement, and managed care organizations [MCOs]). Also important are adequate training, an understanding that behavior is often a way to communicate needs, and a commitment to planning with prevention in mind.

Need for Dementia Crisis Units as a Component of Crisis Response

The lack of specific resources and expertise in dementia-related crisis stabilization makes it more likely that dementia-related crises in which there are serious behavioral concerns will result in emergency protective placements and removal of people from their residences.

Yet, while there is ample anecdotal evidence of the need for specialized facility-based resources for people with Alzheimer's disease or related dementias with significant behavioral issues, DHS lacks concrete data about the extent of the need and where in Wisconsin the need might be greatest.

Specifically, there is no current system that would allow DHS to obtain data about emergency protective placements and emergency detentions that involve persons with dementia. Data is also unavailable as to whether suitable facilities are available when dementia-related emergency relocations are needed. Based on a DHS survey in 2015, only 51 percent of the 69 counties who responded have one or more facilities designated or regularly used for emergency protective placements of people with dementia who exhibit challenging behaviors. Eighty-seven percent indicated they do not have access to a sufficient number of facilities that accept emergency protective placements of people with dementia who exhibit challenging behaviors. Fewer than one-quarter of Wisconsin's counties (23.5%) believe the emergency protective placement process in their county works well for this population either all or most of the time.

In addition to the question of the availability of suitable facilities for dementia-related emergency relocations, a related question concerns the likely level of need for such relocations if adequate resources were available to provide stabilization services in response to a behavioral crisis.

Dementia Crisis Unit Pilot

As defined in Act 272, a DCU could be a valuable component of a dynamic and effective crisis response system. However, there is limited data on the extent of the need for these specialized units and preliminary analysis indicates that costs would likely be significant. In addition, there is the possibility that creating DCUs would have the unintended consequence of leading to an increase in the number of people with dementia in crisis being relocated on an emergency basis as a result of the DCU's availability. Also, if a DCU was created to focus on short-term needs following a crisis, there would still be the issue of finding suitable housing if the person with dementia was unable to return to the previous residence. That would involve another relocation, which would likely add to the stress and confusion for the person needing care. However, if a DCU was created to serve as both a short-term and longer-term residence for individuals with significant dementia-related behavioral issues, it is possible that there would be no space available for the people who need short-term crisis stabilization services.

In June and July 2016, DHS staff consulted with three groups of stakeholders to develop the proposal for a dementia crisis unit pilot as required under Act 272 (for more information on the stakeholder meetings, see Appendix A). The input of stakeholders was critical in identifying certain assumptions and requirements for success of a Dementia Crisis Unit:

Assumptions

1. Quality dementia-related crisis response:
 - a. The development of quality support systems for people with dementia and their families prior to a crisis is the best approach to crisis intervention.
 - b. When a crisis has developed, the first goal should be to de-escalate the crisis and avoid a transfer. Transfers for anyone in a crisis are difficult, and for people with dementia they can be traumatic.
 - c. When a transfer is needed, the least restrictive option available should be used.
2. The nature of a DCU:
 - a. The role of a DCU should be to provide crisis assessment, stabilization, and necessary treatment for individuals for whom the crisis is judged to be significantly related to the person's cognitive issues (suspected or diagnosed dementia) and whose needs cannot be appropriately met with other resources in the region.
 - b. The goal of a DCU should be to stabilize a dementia-related crisis and return the person to his/her previous residence or a least restrictive setting as quickly as is possible. A crisis unit should not serve as a long-term residential care facility; discharge planning should begin the day the person is admitted.
 - c. Due to variability in available resources and working relationships among stakeholders across counties, collaborating counties should be provided with flexibility in determining how best to deliver the services required under Act 272. Therefore, participants in a crisis unit pilot should be identified through an application process managed by DHS, in which applicants would describe in their application how they would meet specified service criteria and goals.

- d. A person with dementia or suspected dementia needing the level of service available in a DCU might be placed as a result of an emergency protective placement under Chapter 55. It is also possible that a placement could result from consent of a guardian of an individual who has been adjudicated incompetent—based on authorization under Wis. Stat. § 55.055 (1) (b)—without court involvement. A person could be placed in a DCU by their agent acting under the authority of an activated power of attorney document if the document authorizes placement in a nursing home.

Requirements for Success

The following requirements would be needed to ensure the success of a DCU in stabilizing a dementia-related crisis and returning the person to his/her previous or a least restrictive setting as quickly as possible:

1. **Size/Environment.** Recommendations include having a unit with:
 - a. A 10-bed maximum capacity.
 - b. Design elements that support quality dementia care (e.g., private rooms, low stimulation, a circular walking path, and supervised access to outdoors).
 - c. A person-centered culture where all staff members receive training on dementia and have a high-level understanding of strategies for diffusing crisis.
2. **Staff Expertise and Availability.** Recommendations include staff qualified to perform the following functions:
 - a. Front-end assessment/intake, including collaborating with community partners involved in the crisis response to determine if transfer to the DCU is warranted and appropriate.
 - b. Development and monitoring of the care plan while at the DCU, including ensuring that needed medical, psychiatric, and behavioral care services required under Act 272 are provided.
 - c. Life enrichment/recreation therapy: For a person with dementia, transfer out of a known environment and routine is highly stressful. Engaging in meaningful assisted behaviors helps restore a sense of well-being. The ability to regularly provide opportunities for residents to engage in meaningful assisted activities would be a critical tool for a DCU in helping stabilize crises and foster more settled behavior. Staff expertise in life enrichment/recreation therapy should incorporate the capability of culturally suitable opportunities.
 - d. Discharge planning: Early planning for the supports needed to transition a person to his or her prior setting (or, if needed, a suitable alternate) in a way that will reduce the risk of a future crisis is essential. To be successful, a DCU would need to have the capacity to provide outreach and training to the care providers in the home or facility-based setting to which the person will be going when leaving the unit.
3. **CNA Ratios.** In addition to the staff expertise described above, a DCU would need higher than average CNA staffing. Recommendations include: four to five CNAs trained in dementia care for eight to 10 people during daytime and evening shifts, with a reduced rate for third shift.
4. **Cross System Collaboration Needed.** It is unlikely that a DCU operating in isolation would be successful. Successful county coalitions require high levels of engagement among partners in supporting individuals

with dementia who are in crisis and finding the least restrictive solutions for stabilization. County collaborations that are interested in participating in a DCU pilot must address local concerns, such as being able to provide culturally sensitive services and meeting emergency transportation needs.

Type of Facility

Based on the anticipated level and complexity of needs of individuals entering a DCU, DHS staff and the majority of stakeholders concur that the treatment setting would have to be, at a minimum, a skilled nursing facility. Under both state and federal regulation, a skilled nursing facility is required to provide physician services, 24-hour nursing care, pharmacy services, dietary services, recreational activities, and specialized rehabilitation services, including occupational, physical, and speech therapy. Similar care is provided to individuals in an acute care hospital setting. To ensure access to the care required under Act 272 and anticipated to be needed by individuals admitted to a DCU, it should be a unit or a freestanding facility on the campus of an existing skilled care facility/nursing home or acute care hospital.

DHS staff has also determined that a DCU should be required to be federally certified to accept Medicaid payments. Currently some counties have established small state-licensed only nursing homes for residents with complex behavioral needs to avoid federal oversight and enforcement liability. The purpose of requiring federal certification would be twofold: (1) to access federal participation for the cost of care through the Medicaid entitlement programs; and (2) to demonstrate that, with adequate resources and the right culture, a certified facility can successfully care for residents with dementia who have complex behavioral needs.

If the Legislature chooses to pursue the idea of creating one or more DCUs on a pilot basis, it is expected that additional legislative action and funding decisions would be needed in order to move forward. It is anticipated that the cost for care would be significant based on the number and skill level of staff needed to complete an assessment and establish a plan of care, provide care and supervision, develop a discharge plan, and find placement for individuals with complex diagnoses and behavioral needs. For information about estimated costs for a DCU pilot, see Appendix B.

Proposal

The DHS proposal for a DCU is to develop a single pilot, which two or more counties would collaborate to create. DHS would create an application, incorporating the assumptions and requirements described above, and coalitions of counties would apply to serve as the pilot. It is recommended that applicants be required to select a federally certified nursing home or a federally certified hospital to serve as a DCU so that it could meet the Act 272 service requirements and be eligible to accept Medicaid payments. Details about financing a DCU would have to be determined. Financing a DCU through a higher Medicaid rate would require approval from the Centers for Medicare & Medicaid Services (CMS).

Range of Options for Strengthening Dementia-Related Crisis Response

In addition to addressing the need for better options for short-term, facility-based stabilization for individuals with dementia, the Legislature could consider a more comprehensive approach to strengthening dementia-related crisis response in Wisconsin. Such an approach would also include strategies to strengthen prevention and early intervention services and crisis response and stabilization supports. A range of options in each of

these three critical focus areas—prevention, crisis response, and short-term, facility-based care—is presented below.

Enhancements to prevention and early intervention services would help minimize the occurrence of dementia-related crises. Those related to improving initial crisis response and stabilization supports would emphasize stabilization in place and would help minimize transfer trauma for people with dementia and their caregivers. These kinds of approaches would be less restrictive, less disruptive, less expensive, and generally more conducive to higher quality of life for people with dementia than strategies that would result in relocation to a short-term stabilization facility.

More detailed proposals could be developed for any of these strategies upon request.

Focus Area: Prevention and Early Intervention

1. Community-Based: Establish and fund a pilot project for county adult protective services and mental health crisis programs and, where available, dementia care specialists or professionals with similar expertise to collaborate in identifying persons with dementia, providing crisis planning, and actively monitoring those at risk for crisis or who have experienced a crisis and are at risk for recurrence.
2. Community-Based: Expand the Dementia Care Specialist Program in ADRCs statewide, while continuing to partner with other grassroots organizations to improve dementia awareness and response. Dementia care specialists are individuals working at the local level who have the knowledge and skills needed to provide education and training on dementia and appropriate response strategies. Dementia care specialists work collaboratively with law enforcement, first responders, crisis workers, adult protective services workers, and other county human services programs. In addition to fostering the development of dementia-friendly communities, dementia care specialists can provide consultation on individual situations, including planning that may reduce the likelihood of a crisis developing.
3. Facility-Based: Establish and fund a dementia companion aide pilot project in assisted living and skilled nursing facilities, modeled after a pilot program in Vermont. Companion aides would be individuals with specialized training in person-centered dementia care and provide a greater opportunity for facility staff to learn about each resident with dementia so that needs and wishes can be more clearly identified. Companion aides would serve as sources of information and support for residents and educators to coworkers.

Focus Area: Initial Crisis Response and Stabilization Supports

4. Establish and fund a dementia crisis innovation grant program to support promising local initiatives. This would be an expansion of an existing grant program encouraging local communities to work together in developing local solutions to dementia crises. More information on the current dementia crisis innovation grants can be found in Appendix C.
5. Establish and fund a pilot project to create county or regional “Dementia Crisis Coordinators” (DCC) modeled after elements of a pilot project in Milwaukee County that created an Elder Abuse Prevention/Chapter 55 Coordinator. The role of a DCC would be to facilitate networking and referral relationships among the various components of the crisis response system. A DCC would be a key source of real-time information on appropriate and available resources in the event of a dementia-related crisis.

It is anticipated that the expertise of the DCC would help reduce the frequency of behavioral crises escalating to the point of needing to involve the legal system in emergency protective placement.

6. Clarify county responsibility and mechanisms for dementia-related crisis response and stabilization and explore options for enhancing availability of such services.
7. Provide ongoing funding for the development and implementation of specific, statewide, dementia-capable crisis response training, including “how to” training for mental health crisis teams, law enforcement, adult protective services, and other crisis responders.

Focus Area: Short-Term, Facility-Based Stabilization

8. Provide the authority and resources needed for DHS to design and implement a method for obtaining data about emergency protective placements and emergency detentions involving persons with dementia. To the extent possible, include information on the availability of appropriate placement options. Such data could be used to help assess the level of need for a DCU as well as the locations in the state that have the greatest need.
9. Establish and fund a pilot project in which two or more counties would collaborate to create a DCU. Under this option:
 - DHS would manage an application process, and interested county coalitions would be encouraged to apply to serve as the DCU. The application would include details on specific requirements (based on the description of the DCU pilot proposal above).
 - A thorough analysis of options for paying for a DCU would have to be prepared. One possibility would be to include funding for Medicaid-eligible residents through a higher Medicaid rate. This approach would require approval from the Centers for Medicare & Medicaid Services (CMS). Initial DHS cost analysis resulted in an estimated Medicaid rate of \$574.33 per patient day. This is comparable to the Medicaid rate paid to skilled nursing facilities for ventilator dependent patients of \$561 per patient day. If the \$574.33 daily rate was implemented and occupancy and payor mix assumptions came to fruition, the annual cost of a 10-bed pilot facility would be \$1.5 million (\$0.6 million GPR, \$0.9 million Fed funds). For more information on this estimate refer to Appendix B.

Recommendation

DHS recommends that the Legislature review the options and pursue a strategy that incorporates components from each of the three critical focus areas of dementia-related crisis response and stabilization presented above, rather than focusing solely on a facility-based solution. By taking a more comprehensive approach, the Legislature has the potential to significantly advance the goal of supporting people with Alzheimer’s disease and related dementias so each person has the highest quality of life possible consistent with the person’s need for care and with the least restrictions placed on his or her personal liberty.

Appendix A: Dementia Crisis Unit Pilot—Stakeholder Meetings

In developing the proposal for pilot Dementia Crisis Units, staff consulted with three groups of stakeholders in June and July 2016. Stakeholders included representatives from the following:

- Group 1: Adult protective services staff; mobile crisis response teams; human services directors, mobile crisis teams, county corporation counsel, and municipal police.
- Group 2: County nursing homes, hospitals (including a geriatric psych inpatient program), Central Wisconsin Center, and MCO staff.
- Group 3: ADRCs, medical professionals with clinical experience caring for people with dementia in crisis, Alzheimer’s associations, area agencies on aging, United Community Center, and Wisconsin’s Silver Alert Program.

Each group of stakeholders was asked to provide input on the following topics:

- The services a Dementia Care Unit would need to be able to provide in-house (based on Act 272 requirements).
- The circumstances under which someone would likely need the level of care provided in a Dementia Care Unit.
- The type of facility that would be needed.
- Transitions into and out of a Dementia Care Unit.
- Requirements for success.

The input of stakeholders was critical in identifying the assumptions and requirements for success that are incorporated into the proposed option for a Dementia Crisis Unit.

Appendix B: Estimated Operating Costs of a Dementia Crisis Unit

Cost analysis resulted in an estimated Medicaid rate of \$574.33 per patient day. This is comparable to the Medicaid rate paid to skilled nursing facilities for ventilator-dependent patients of \$561 per patient day. If the \$574.33 daily rate was implemented and occupancy and payor mix assumptions came to fruition, the annual cost of a 10-bed pilot facility would be \$1.5 million (\$0.6 million GPR, \$0.9 million Fed funds). On a biennial basis, the cost per 10-bed pilot facility would be \$3.0 million (\$1.2 million GPR and \$1.8 million FED funds).

How the Estimate Was Derived

To provide the estimate, it was necessary to develop an estimated per patient day Medicaid nursing home rate for a Dementia Crisis Unit. This estimated daily rate was developed by modifying assumptions in the State's current nursing home rate-setting model to reflect assumptions regarding resident acuity levels and staffing needs associated with operating a Dementia Crisis Unit.

North Central Health Care was chosen as a proxy because it is a facility in a medium-cost area with a dementia program. Starting with the base rate for a high-acuity patient at North Central Health Care, additions to the nursing home rate model were made to account for the extra staffing and benefits of a Dementia Crisis Unit based on the assumptions and requirements described previously. Estimates for these additional salaries and fringe benefits were assembled from nursing home cost reports. It was estimated that each pilot would consist of 10 beds, 80 percent full on average, and that the pilot's payor mix would be 90 percent Medicaid. Occupancy of 80 percent is average for nursing homes in Wisconsin. Payor mix was more difficult to estimate; while a Dementia Crisis Unit stay will not be a Medicare-covered benefit, it may be possible for the facilities to contract with private insurers for coverage. Even if that is not possible, private-pay patients with personal resources would be expected to make up the other 10 percent of the population.

The estimates provided above do not include costs for non-Medicaid residents of a Dementia Crisis Unit, which would be covered through private payment.

Requirements and Options for Implementing the Cost Model

The actual method of setting rates for Dementia Crisis Units would be subject to CMS approval. Public input would be sought, including additional stakeholder input from the participating counties and other skilled nursing facility stakeholders.

If the Legislature were to pursue the idea of creating a Dementia Crisis Unit on a pilot basis, it is expected that additional legislative action, including funding decisions, would be needed in order to move forward.

Financing a Dementia Crisis Unit through a higher Medicaid rate would require approval from the Centers for Medicare & Medicaid Services (CMS).

Appendix C: Dementia Crisis Innovation Grants

DHS has encouraged and supported collaboration among local stakeholders in developing solutions for increasing dementia capability in the existing crisis response system. As part of this effort, DHS provided a competitive funding opportunity for interested counties or consortia to building a more dementia-capable crisis response system. In January 2016, six Dementia Innovation Grants were awarded totaling \$300,000. The 18-month grants reached 12 counties, serving 27 percent of the state population. Through the grants, counties are building collaborations among key stakeholders and gathering much needed data necessary to make informed decisions. These efforts are expected to result in:

- A more coordinated, dementia-capable approach to supporting people with dementia in crisis.
- An understanding of how to assess and plan for those with dementia as a way to avoid or de-escalate crises.
- Shared strategies to anticipate and capably respond to crises in the best interest of the individual with dementia.
- Local/regional care and crisis systems that emphasize stabilization-in-place and use emergency transfers as a last resort for those experiencing crisis.
- Collaboration, communication, and trust among all parties who have a role to play in responding to and caring for persons with dementia who experience crises.
- The availability of valuable data on the numbers and outcomes of dementia-related crisis contacts in participating counties.

The initial results are promising. Participating counties are figuring out how to collect data from all partners to quantify the results of the grants. In addition, grantees are learning from each other and beginning to identify promising practices that will be compiled and shared more broadly across the state.