Milwaukee County Department on Aging

Context

In the Spring of 2010, the treatment of two (2) patients with dementia-related behavioral issues dramatically altered how the legal and long-term care systems manage these patients. In March or 2010, a nursing home discharged an elderly Milwaukee County man to a psychiatric ward due to behavioral issues. Before his death from pneumonia, he got bounced between psychiatric wards and medical facilities. A month later, an involuntary civil commitment occurred for another individual with Alzheimer’s Disease, this time in Fond du Lac County, Wisconsin. Again, the admission to a psychiatric unit occurred due to behavioral issues.

Ultimately, the Wisconsin Supreme Court heard the case1 In December of 2011 and ruled that Alzheimer’s Disease is not a treatable mental disorder, but a permanent disability. As such, the court held that persons with that diagnosis are more appropriately treated under Wisconsin Chapter 55, which governs guardianships and protective placements, than Chapter 52, which governs involuntary civil commitments. Helen, and others like her, may no longer be placed in units for the acutely mentally ill. The Court explicitly did not address proper procedure where there is a dual diagnosis of Alzheimer’s and a Chapter 51 qualifying mental illness.

As a result of these two (2) cases, the Alzheimer’s Association of Southeastern Wisconsin established the Alzheimer’s Challenging Behaviors Task Force to provide additional guidance. Simultaneously, the Wisconsin State Legislature initiated its own review of the then-existing legal process for responding to this population. The goal of both inquiries, in which the Milwaukee County Department of Aging and Department of Health and Human Services played a key role, was to generate solutions to this complex problem.

Milwaukee County’s Department on Aging did not wait for the state-wide initiatives to play out. It recognized that a siloed system that bounces people around is intrinsically flawed, and instead set out to design a comprehensive, coordinated intervention model. The new system would emphasize crisis prevention. And, when crisis did occur, the new system would ensure that whenever possible, the person would be treated in place.

Strategies

Process Improvement. First the Department of Aging looked at the County’s own large and complex system to improve the process of providing services to these constituents. It deemed critical the engagement of the Department of Health and Human Services (DHHS) to include a wide range of life-sustaining and life-saving services provided by divisions (Management Services, Behavioral Health, Disabilities Services, Housing and Emergency Medical Services) under its umbrella.

In addition, it understood as essential the inclusion of long-term care services to frail elders (age 60 and older) managed by Milwaukee County Department of Family Care. It considered involvement of all sectors, from medical and psychiatric hospitals to long term care facilities, in home caretakers, first responders (fire, police and first aide personnel), and court services, since all are involved at various stages of intervention.

Partnerships. Under the leadership of the Department of Aging all County departments and cross sector entities were solicited to join a solution-oriented workgroup. Generally, staff were eager to come together due to consensus that the disjointed response system did not work. Even reluctant prospective partners (such as hospital emergency rooms and psychiatric hospitals) eventually joined the workgroup since this population frequently came to their attention, appropriately or not.

From day one, the group agreed not to finger-point or cast blame. Instead, the task involved finding solution that incorporated all perspectives. The workgroups scope quickly broadened to include persons with developmental disabilities, traumatic brain injury, and other irreversible cognitive disorders. Several solutions quickly emerged. DHHS expanded its mobile crisis unit response hours and strengthened its capacity to work with police departments and first responders to assist with on-site assessment. Memorandums of Understanding (MOUs) were developed between the health care system and the courts. The roles of each of the task force’s member agencies became more clearly defined thus fully engaging each partner group.

Currently, 20 facilities, including the three (3) major hospital systems are part of the partnership. There are also agreements with fire departments, emergency medical services, and police departments in clarifying roles in response and treatment of persons with cognitive behavioral issues. The workgroup meets regularly.

Education. Operationalizing the changes that emerged from the work group required training. The county’s Department of Aging and DHHS contracted with the Alzheimer Association its expert consultants to provide cross sector training in the application of evidence-based interventions, including learning to recognize when a crisis is developing and ways to de-escalate it.

The trainees included in-home caregivers, long term facility nurses, doctors and support staff, fire and police departments, and court personnel. Health care staff learned to look for medical causes of challenging behaviors, such as vitamin deficiency, tooth pain, and other conditions that persons with cognitive limitations may be unable to convey. The training program also focused on how hospital personnel could work with patients throughout the hospital stay when admission is unavoidable and ensure appropriate discharge planning. Law enforcement officers and court personnel were trained on how to approach cognitively impaired elderly people, provided resources, and enabled to take appropriate action. The entire Milwaukee Police Department is currently being trained in an 8 hour session which some officers have already begun as part of the 40 hour CIT training all officers are mandated to complete. Additionally, suburban departments are being trained in two hour sessions as well.

Community Engagement. Data was analyzed to map the locations from which most people come to hospital emergency rooms, so more police officers can be assigned in those areas and deployed with mobile mental health crisis units to divert crisis. Recently DHS was able to upgrade its real time data mapping software so all partner agencies can be better prepared for emergency response. The community representation of in home caregivers in the work group provided additional opportunities for community involvement.

As a result, there is increased public awareness. Local business owners and their employees, such as Barber shops drug, grocery and department stores, have been targeted in awareness campaigns that promote early assistance to elderly people. The public is better educated and recognizing the signs and symptoms of dementia, resulting in better and more efficient diagnosis and treatment.

Results

While the numbers are incomplete, persons with dementia are no longer involuntarily committed, under chapter 51. Crisis’s have been averted and support services are better utilized.

In Milwaukee County, nearly all of those with dementia and recent disruptive behaviors in nursing homes are transferred to live in “ specialized care” units in the community. Additional training has been offered to community partners to work with individuals with dementia with challenging behaviors.

The first comprehensive cross sector training accommodated 20 people. But the demand far exceeded the county's expectations 70 people ended up participating in a tabletop simulation with standing room only. The participants included a county court commissioner who presides over involuntary civil commitments and guardianship hearings. Milwaukee County is extremely proud of its progress but there is still much work to be done the county is actively pursuing funding to expand.

From the “Handcuffed report” members of the community and stakeholders came together to identify and develop a set of common understandings of the complex problems, explore potential solutions and develop the following recommendations to support persons with dementia experiencing challenging behaviors.

Based on the work of the Task Force, basic recommendations for future action were generated and a series of next steps are identified.

**RECOMMENDATIONS**

**A. Find alternatives to using Chapter 51 and the Milwaukee County Mental Health**

**Complex for people with Alzheimer’s disease and related dementias.**

1. Convene a panel with expertise in Alzheimer’s disease, mental health, geriatrics, criminal

justice, health, and long-term care to identify the implications of stopping the application of

Chapter 51 and the use of the Milwaukee Mental Health Complex for patients with

Alzheimer’s and age-related dementias.

2. Explore mechanisms for diverting these resources to the development of the Alzheimer’s

network of services.

3. Continue to provide input to the State Legislative Committee that is reviewing revisions to

Chapter 51.

**B. Establish a network of Alzheimer’s care centers.**

1. Work with providers, hospital systems and nursing homes to establish a network in which

adequate and defined “levels of care” are available for people with dementia in the

community, skilled nursing homes and hospital emergency rooms and inpatient units.

2. Identify “lead agencies” to assure accountability at all levels.

3. Develop cost sharing and blended funding approaches to support the effort and reduce

duplication by concentrating resources and developing a larger number of small sites and a

smaller number of specialized sites.

4. Create a centralized resource and assessment center to serve as the hub of the network,

providing:

a. A multi-disciplinary, mobile “triage team” to help address challenging behaviors on-site at

the time an intervention is needed.

1)Conduct an assessment using antecedent-behavior-consequence (ABC) model.

2)Assess for and make recommendations to manage pain.

3)Coach caregivers and consult with families.

4)Recommend appropriate placement, services, and follow-up.

5)Have authority to initiate change in placement if needed.

b. A combined medical, psychiatric, and social service unit to integrate care for those who need to be stabilized, assessed, and prepared to return to the most appropriate site and receive follow-up care.

c. A training resource for first-responder Emergency Medical Service (EMS) and police on

topics such as identifying and responding to calls involving persons with dementia,

intervention practices, and the existence, location, and services of the centers described above and their designated level of care.

d. Support for facilities and families.

**C. Provide adequate and appropriate training.**

1. Acknowledge and address the need for broad-based understanding of Alzheimer’s disease,

associated challenging behaviors and the factors which can influence their occurrence.

2. Establish a system to provide specialized training for:

a. Family members.

b. Community providers of residential and adult day care.

c. Emergency responders (police, EMS, and emergency room personnel).

d. Nursing home and other facility staff and supervisors on all shifts.

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3. Provide training that:

a. Encourages family members to be advocates.

b. Uses a multi-disciplinary team approach.

c. Includes real time, on-site, case specific coaching.

d. Emphasizes the importance of a “person-centered” approach.

e. Stresses the significance of the interaction between the person, caregiver, and environment.

f. Identifies procedures for seeking appropriate interventions.

g. Identifies resources and support available to families and facilities for follow-up care.

h. Is ongoing.

**D. Create an ongoing system for capturing data.**

1. Establish a pilot program to:

a. Collect data through the Emergency Medical System (EMS).

b. Identify facilities that are calling for emergency interventions.

c. Document the number of people coming into hospital emergency rooms with acute changes in

mental state related to dementia.

d. Document the number of Chapter 51 petitions involving dementia-related challenging behaviors.

2. Document the trajectory and outcomes for individuals with challenging behaviors as well as the

treatment of the family.

3. Use the data to:

a. Target interventions.

b. Demonstrate the economic aspects, including costs and potential savings.

c. Prepare for future response to challenging behaviors.

**E. Support the next steps and follow-up work of the Task Force.**

To begin to implement the recommendations above, the following action steps will be undertaken.

1. Participate in the design of the Alzheimer's State Plan, beginning with the release of this report on

December 14, 2010. See the “Hand in the Plan” website at

http://www.planningcouncil.org/CMS/alt\_login.php.

2. Provide training and information on the topic of challenging behaviors at the Alzheimer’s

Association’s 2011 Statewide Network Conference.

3. increased awareness and training for law enforcement personnel in more municipalities on the topic

of challenging behaviors among people with dementia.

4. Convene a work group to produce recommendations on Chapter 51 and continue to provide input

to the State legislature.

5. Convene a work group to recommend approaches to reducing the use of psychotropic drugs for

people with Alzheimer’s exhibiting challenging behaviors.

6. Convene a work group on training to refine and recommend curricula and approaches.

7. Work with health care systems and the Wisconsin Hospital Association to develop interim and long range

approaches to improve and coordinate emergency and inpatient hospital care.

8. Meet with individual nursing home administrators and state-level nursing home associations to

identify interim and long-range strategies.

9. Reconvene the full Task Force regularly to report on progress and seek additional input.

Following the task force recommendations Milwaukee County continued to work towards change in how people with dementia were treated our hospital systems and community understood the need for significant change and some progress was made towards progress on the above action items. Milwaukee County remained silo’d in the work and support mental health services were separate from aging services. In 2012 the Helen E.F. decision in Fond du Lac County pushed for further changes in how people with dementia were treated. In 2013 DHS Secretary Kitty Rhoades called for redesign of Wisconsin dementia care system of care to provide appropriate safe and cost-effective care for those living with dementia. Also in 2013 2013, County Executive Chris Abele and state-level leaders called for mental health care reforms to address problems with the County-run hospital and involuntary detention services developing a mental health board to guide the system of care for Milwaukee County. Following the system reform DHS awarded Milwaukee County a grant to create a coordinator position for detaining persons with dementia in crisis as part of the first state dementia plan. [Wisconsin State Dementia Plan | Wisconsin Department of Health Services](https://www.dhs.wisconsin.gov/wdsc/index.htm). This plan published two documents reflecting on the accomplishments.

The 2018-2023 and current state plan are listed at the same link.

2014 July position filled in Milwaukee County

Waukesha County model

Faith Russell

Dane County