THE BUDGET ISSUE:


Including:

- Going for the Gold: Participating in the National Quality Award Process is a Win for Everyone
- Entitlement Reform, the Fiscal Cliff and their Effects on Long-Term Care Providers
- The Affordable Care Act Care Act is Here to Stay - Now What?
Happy New Year!

After a long election year in 2012, Wisconsin’s state and federal political leaders will be getting back to the business of governing in 2013. In February, Governor Scott Walker will release his version of the 2013-15 Biennial State Budget. In the subsequent months, the Wisconsin State Legislature’s Joint Finance Committee, as well as the State Assembly and Senate will address several important matters impacting all facets of the long-term care continuum, notably the state’s Medicaid budget and the future of the Family Care program.

In the Winter 2013 Continuum, we offer an edition filled with useful information on issues facing members of the long-term care provider community, including:

- The state and federal legislative landscape for long-term care providers in the coming session;
- The use of antipsychotic medications;
- The implications of the Affordable Care Act for long-term care providers;
- The importance of providers participating in the AHCA/NCAL National Quality Award process;
- The implications of the Wisconsin Supreme Court’s Helen E.F. Decision for providers serving individuals with challenging behaviors.

Traditionally, Wisconsin’s long-term care provider community has been politically alert and active. But as we enter this legislative session, we must do so with intensified resolve and involvement. Members of the provider community that have, in the past, watched from the sidelines must enter the playing field to assure the legislative and regulatory process acknowledges, understands and responds to their needs and concerns.

WHCA/WiCAL is truly proud to represent the individual and collective interests of Wisconsin’s skilled nursing and assisted living facilities. In the year ahead, major issues impacting our state’s entire long-term care continuum will garner greater attention in both Washington and Madison. WHCA/WiCAL and its membership will be prepared to assure their voice and message ring loud and clear throughout the discussions in which these issues are addressed and resolved.

Sincerely,

Thomas P. Moore
Executive Director
WHCA

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- Effective Quality Improvement Resources

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Winter 2013

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PUBLISHED DECEMBER 2012

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10. CAPITOL CONNECTION
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    New Taxes and Fees Under Obamacare
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Surveillance of Atypical Antipsychotic Drug Use is Coming

By Patricia Boyer and Gail Robinson

I
n July 2012, the U.S. Department of Health & Human Services Office of Inspector General (OIG) released results from a study indicating nearly all records reviewed – 99 percent – failed to meet one or more federal requirements for resident assessments and care plans. The sample was a total of 375 Medicare nursing facility records randomly selected from a previous OIG study of 640 nursing facility records from January-June 2007.

A previous OIG study reported about half of the antipsychotic drugs being utilized by skilled nursing residents were not given for medically accepted indications and one-fifth of the drugs were not required “to the extent practicable,” 91 percent of records indicating an RN solely responsible for developing the care plan. Less than 5 percent of records contained evidence of an RN’s coordination of the RAP assessment.

In Wisconsin, there have been safeguards to protect residents from unnecessary antipsychotic drug use. In 2010, the patient rights bill (S. 3604) was introduced in the U.S. Congress. The introduction of a bipartisan bill that would charge HHS to require informed consent before prescribing antipsychotic medications to assisted living residents. The bill (S. 3604) would also establish monthly report cards on each home’s use of the drugs.

The findings cross over many aspects of the antipsychotic drug use management care system in the nursing home practice. The response to the OIG issues included the following:

- CMS issued a national initiative to improve behavioral health and dementia care and to reduce antipsychotic drug use in the nursing home by 15 percent.
- CMS plans to strengthen the State Operations Manual related to documentation of resident and family involvement in assessment and care planning. New surveyor guidance is expected to emphasize medical record compliance, and staff, assessment team involvement in care plans involving such practitioners.
- Expanded the sampling of residents receiving antipsychotic medications in the Quality Improvement Survey process.
- Clarifying guidance/policy revisions related to deficiency determination, and enforcement remedies will be provided in mandatory surveyor training programs.
- Announced new partnerships including consumer awareness, development of consumer educational materials.
- A new quality indicator (QI) will be posted on the CMS Nursing Home Compare website.

The study reported 33 percent of the foundational assessments (e.g. Braden, fall risk assessment, nutritional assessment) were out of compliance: records without documented psychotropic drug RAPs (now CAAs) and 46 percent of records indicated that an RN solely conducting the assessment. There was only one example of documented assessment by the appropriately qualified practitioner: psychiatrist, geriatrician and/or psychologist along with care plans involving such practitioners.

Federal care plan requirements were not met in 99 percent of records reviewed. Care plans were not developed by the interdisciplinary team: 20 percent of records indicating an RN, social worker, or LPN was solely responsible for developing the care plan. Less than 5 percent of records contained antipsychotic medication plans developed by at least a general physician and an RN. As required “to the extent practicable,” 91 percent of the records did not contain evidence that the resident/family/legal representative or physician participated in the plan of care process.

The decision-making process identified confusion between resident assessments and care plans: 98 percent of the 98 records staff had developed the interventions. However, 18 percent of the records that listed care plan interventions for antipsychotic drug use did not contain evidence of the interventions. Monitoring of psychotropic drug interventions in the care plans found blank or incomplete in several cases.

The areas impacted include:

- Education of staff in care of dementia residents and how to address behavioral and psychological symptoms of dementia (BPSD).
- How the facility monitors the use of psychopharmacological medications, specifically antipsychotic medications.
- Administrator will be asked for a list of residents who are receiving or have received antipsychotic medications over the past 30 days.

This increased focus on use of antipsychotics allows the surveyors to work toward meeting the objective CMS has to reduce the percent of drugs utilized.

How does this all apply to the Assisted Living environment?

On September 27, 2012, CMS followed through on these recommendations by publishing S&C: 12-45-NH. Interim Guidance and revisions to State Operations Manual, Appendix P – Traditional Survey Protocol for LTC. These rules were effective December 1, 2012. The changes in the survey process has a lot of focus on use of psychoactive drugs.

Regulations may not be in place as they are in Skilled Nursing Facilities; however, the focus is the same. This is played out in the bill that is before U.S. Congress. The introduction of a bipartisan bill that would charge HHS to require informed consent before prescribing antipsychotic medications to assisted living residents. The bill (S. 3604) would also establish monthly report cards on each home’s use of the drugs.

So, no matter what area in which you work, use of antipsychotic drugs is an issue you need to be aware of and take steps to prevent inappropriate use of antipsychotic drugs in your facility.
Each year, the American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) receive applications from hundreds of facilities from across the country applying for recognition as a skilled nursing facility or assisted living community that provides high-quality care for their residents.

Crafted after the prestigious Baldrige Performance Excellence Program, the AHCA/NCAL National Quality Awards are organized into three categories – Bronze, Silver and Gold. In order to be considered for the next award category, one must complete the previous level. Consequently, the road to receiving a Gold National Quality Award can be a long journey.

In 2012, Golden LivingCenter – Continental Manor in Abbotsford, Wisconsin for receiving the Gold AHCA/NCAL National Quality Award!

By John J. Vander Meer

For more information on how to apply for the National Quality Award go to qa.ahcancal.org

Application Deadlines:

January 31: Bronze Quality Award
February 28: Silver and Gold

Congratulations to Golden LivingCenter – Continental Manor in Abbotsford, Wisconsin for receiving the Gold AHCA/NCAL National Quality Award!

From the dedication of leaders and staff, to the processes built on quality care, to the family environment created through customer and community focus, our goal is to achieve clinical results and exceed expectations.

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Golden LivingCenter – Continental Manor
600 East Elm Street
Abbotsford, WI 54405
715-223-2359

WHCA/WI is the Director of Communications for the Wisconsin Health Care Association and the Wisconsin Center for Assisted Living.
He can be reached at john@whca.com

Golden LivingCenter – Continental Manor
600 East Elm Street
Abbotsford, WI 54405
715-223-2359

WHCA/WI is pleased to announce the re-launch of the member information services on www.whcawical.org, and our new weekly electronic newsletter, CareConnection. For more information on benefits of membership call (608) 257-0125.
I’ve said many times: I truly believe we are in a time of extraordinary opportunities and remarkable challenges. Today, 10,000 Americans turned 65. By 2030, there will be 72 million older persons in this country. We have the opportunity to care for millions of Baby Boomers in our assisted living and skilled nursing centers. Even though many centers are already seeing increased demand for our services, it is only beginning.

In our state capitols and in Washington, D.C., we must become a powerful lobbying voice that cannot be ignored.

At the Table or On the Menu
Entitlement Reform, the Fiscal Cliff and their Effects on Long-Term Care Providers

By Gov. Mark Parkinson

We are admonished to back spending. We are told to save for a rainy day. But when will that day come? In our state capitols and in Washington, D.C., we must become a powerful lobbying voice that cannot be ignored. From fiscal cliff negotiations to one-off pieces of legislation, we must let our lawmakers know about the impact their decisions have on those we care for, those we employ and those we support in our communities.

Long-term and post-acute care faces an ongoing threat of additional budget cuts as the federal government attempts to reduce the deficit and debt. Even after sequestration, bad debt, health care reform, state Medicaid cuts and more, Congress continues to look to our profession to sacrifice.

The first thing we must do is become the cost and quality solution. We are already making great strides in quality. The number of centers recognized by CMS as four- or five-star has increased 30 percent since 2009. Nearly half of all skilled nursing centers nationwide are participating in Advancing Excellence and 22 percent of our members have earned a Bronze, Silver or Gold National Quality Award.

We know that providing quality care is the right thing to do. But we also know that future payment models will require us to continuously improve quality.

The Quality Initiative we launched in February 2012 will help us reach new heights in quality of care. We have set aggressive, measurable goals to safely reduce hospital re-admissions, retain more employees and reduce the off-label use of antipsychotic medications. When we get every member on the path to showing better health outcomes at a lower cost, we will thrive.

Continuous improvement in quality care is critical, but that alone is not enough. We also must be a political powerhouse from coast to coast. In our state capitols and in Washington, D.C., we must become a powerful lobbying voice that cannot be ignored. From fiscal cliff negotiations to one-off pieces of legislation, we must let our lawmakers know about the impact their decisions have on those we care for, those we employ and those we support in our communities.

This summer, AHCA/NCAL created a new mission statement for our organization: improving lives by delivering solutions for quality care. Our mission statement signals a new direction for our profession. We have a renewed focus on quality. We bring solutions to the table. We are a political and lobbying powerhouse.

The patients and residents we care for every year, their families and our employees are counting on us. Our mission is much more than just words on paper. It’s a signal to our audiences – state, federal and everywhere in between – that we are truly committed to surviving and thriving in these extraordinary times.

Thank you for the work you do every day. I look forward to working with you to improve lives in 2013.

To ensure we reach our goals, we need to make. We will have to commit to the hard work that is needed to succeed.
THE BUDGET ISSUE: 

By James McGinn

The November 6, 2012 elections shifted the political power in Wisconsin State Government back to the Republicans as they captured control of the State Senate and maintained the majority in the State Assembly.

In the 33-member State Senate, the Republicans regained the majority and will control the chamber, 18 to 15. The Senate Republicans will be led by Majority Leader Scott Fitzgerald (R-Juneau), while the Democrats will be led by Minority Leader Chris Larson (D-Milwaukee).

In the 99-member State Assembly, Republicans maintained their majority and will control the Chamber 60 to 39. The Assembly Republicans will be led by Speaker Robin Vos (R-Rochester), while the Assembly Democrats will be led by Minority Leader Peter Barca (D-Kenosha). It is important to note that 25 of the 99 members of the Assembly are freshman Legislators and 29 members will be serving in just their second term.

THE BUDGET

As the Legislative session begins, most of the attention will be focused on Governor Scott Walker’s proposed 2013-15 biennial budget bill to be introduced in February. The Governor has indicated that his top 5 priorities for inclusion in his proposed budget bill will be job creation, tax cuts, transforming education and workforce development, reforming government, and investing in transportation infrastructure.

As Governor Walker prepares his budget, fiscal information will be constantly revised and updated as revenues and expenditures change. Legislators and most observers of the budget process will rely on the Legislative Fiscal Bureau’s January 2013 report on revenue estimates and state agency budget requests to accurately reflect and project the state’s fiscal condition.

The Bureau also serves as staff to the Joint Finance Committee – the 16-member committee which reviews and deliberates on legislation affecting state revenues and appropriations. The primary focus of the Committee’s work, and thus, that of the Bureau, in each legislative session is the state’s biennial budget.

While the Governor will also consider the Fiscal Bureau’s analysis, the Department of Administration submitted its own revenue estimates and agency budget request to his office late last year which included the following analysis.

In a November 20, 2012 letter to Governor Walker and the Legislature, the Department of Administration Secretary Mike Huebsch noted that Wisconsin’s “budget is in a much stronger position than two years ago and we are on track to end the 2011-12 biennium with a $348 million gross ending balance.” This is good news as just 2 years ago the 2011-12 Legislature faced with a $3.6 billion structural deficit and was called into session immediately to address the deficit and fix our state’s fiscal problems.

With respect to the next two fiscal years, Secretary Huebsch expects revenue to increase by $518 million in fiscal year 2013-14, and an additional $502 million in fiscal year 2014-15. Again, this is good news, but Secretary Huebsch cautions that “revenue estimates cover more than a two and one-half year period, from now until June 30, 2015, and there is great uncertainty with the federal budget and payments to states.”

All state agencies were instructed by Governor Walker to submit their budget requests to Secretary Huebsch maintaining spending at, or below, state fiscal year 2012-13 levels. Secretary Huebsch reported that state agencies have requested an additional $529 million in state general purpose revenue (GPR-or state tax dollars) in fiscal year 2013-14 and $540 million (GPR) in 2014-15, or $1.7 billion for the biennium.

DHS BUDGET PICTURE

A review of the Department of Health Services budget includes a request for an additional $658 million (GPR) for the Medicaid program alone. The Department’s request includes $248 million for IRIS (Assisted Living) and $410 million to reflect additional dollars for rate increases in existing service areas with no further expansion into new counties.

In state fiscal year 2011, long-term care expenditures reached nearly $2.9 billion and accounted for 43 percent of total Medicaid expenditures.

In state fiscal year 2011, long-term care expenditures reached nearly $2.9 billion and accounted for 43 percent of total Medicaid expenditures.

Per past instructions, the Department did not include in its request any additional dollars for rate increases for Medicaid providers. That decision is made by the Governor and Administration staff.

WHCA/WICAL PRIORITIES

The top priority for WHCA/WICAL in the 2013-15 biennial budget is to include a provision that directs all of the funding derived from the nursing home bed tax to support improvement in nursing home resident care. In the current fiscal year, 2012-13, approximately $45 million have been “skimmed” from the nursing home bed tax and used for other purposes.

Our message is to eliminate the “slim” and return and re dedicate all of the nursing home bed tax revenue to its original purpose, supporting...
and improving the care for the elderly and disabled who reside in Wisconsin’s nursing facilities.

The same biennial budget process has been followed for years. Governor Walker will introduce his proposed budget bill in February, the bill will be referred to the Joint Finance Committee for review and approval by Memorial Day, and both Houses typically debate the measure in June and pass it by July 1. Both Majority Leader Fitzgerald and Speaker Vos have stated that timely passage of a budget bill in February, the bill in June, and passing it by July 1 has been followed for years. Governor Walker will introduce his proposed budget bill in February, the bill will be referred to the Joint Finance Committee for review and approval by Memorial Day, and both Houses typically debate the measure in June and pass it by July 1. Both Majority Leader Fitzgerald and Speaker Vos have stated that timely passage of a budget bill in February, the bill in June, and passing it by July 1 has been followed for years. 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MANY ISSUES FACING LEGISLATURE

Other issues expected to be discussed and debated in the Legislature include revisiting mining legislation that failed to pass the Senate by a single vote last year. Mining companies have expressed a strong interest in revisiting state laws, they believe prevent the opening of an iron-ore mine in Iron and Ashland counties. Another initiative that failed to pass last session and is a priority of legislative leadership is to advance a venture capital bill to encourage economic development and job creation. Also, since the courts have blocked a requirement for photo identification for voting purposes, Legislators have expressed a desire to modify the “photo ID” law to comply with possible legal problems with the law.

WHCA/WiCAL expects the Wisconsin Legislative Task force to have a busy session with a focus on a balanced budget bill, job creation efforts, and a watchful eye on Washington D.C. Walker will again be requesting the membership to assist us to ensure the concerns of all long-term care providers are considered in Madison.

The WHCA/WiCAL Legislative Day will be held on March 26, 2013 at the Inn on the Park, located on the Capitol Square. We encourage all members to attend this important event. Please stay tuned to Care Connection, WHCA/WiCAL’s weekly electronic newsletter, as details on this event will be forthcoming.

Contact Wipfli, a leading accounting and business advisory firm with a strong focus on the health care industry. We can offer you a portfolio of business process improvement services customized for the health care industry that will streamline your business processes, improve employee performance and increase patient satisfaction. Call us today to put the power of our focus to work for your organization!
The Affordable Care Act is Here to Stay
New Taxes and Fees Under Obamacare

By Karen J. W. Breitnauer, J.D.

On November 6, 2012, the American people re-elected Barack Obama as President of the United States for a second term, and with his re-election came the realization that the Affordable Care Act is here to stay.

The initial wave of changes brought about by the legislation included reimbursements, tax credits and mandates intended to bring more robust health care to the nation’s insured. This wave hit in 2014 with the dawn of exchanges, insured. The second wave is set to hit robust health care to the nation’s insured. The second wave is set to hit.

This article will discuss the various changes and benefits, subsidies, premium credits that will be imposed on full-time employees. This article will discuss the various changes and benefits, subsidies, premium credits that will be imposed on full-time employees.

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The Affordable Care Act is here to stay. Understanding the various fees, taxes penalties and other costs associated with it will be crucial as the provisions of this law continue to unwind.

Pay or Play Penalty Example

<table>
<thead>
<tr>
<th>Pay or Play Penalty Example</th>
<th>Penalty = $2,000/FTE – 30 employees</th>
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<tbody>
<tr>
<td>No Health Plan Offered</td>
<td>Penalty = $2,000/FTE – 30 employees</td>
</tr>
<tr>
<td>Employer Continues to Provide Plan</td>
<td>Penalty = Lesser of $2,000/FTE – 30 employees OR $3,000/subsidized employee</td>
</tr>
</tbody>
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The penalty in this situation would be either $2,000 per full-time employee minus the first 30 or $3,000 per subsidized full-time employee, whichever is less. Penalties are not paid on part-time employees.

PCORI FEES FOR HEALTH INSURANCE PLANS

Health insurance plans will be required to pay fees to help fund the Patient-Centered Outcomes Research Institute (PCORI). The PCORI is a private, non-profit corporation that will assist patients, clinicians, purchasers and policymakers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through research.

The fees are effective for plan years ending on or after October 1, 2012. For example, for calendar year policies and plans the fee is applicable for the plan year starting January 1, 2012 and ending December 31, 2012. The fee is $1 per average number of covered lives for plan years ending before October 1, 2013. The fee increases to $2 in 2014 and will be increased thereafter based on a projected per capita rate. The fees will be treated like taxes and will be due on July 1 of every year for the preceding plan year.

The fees are imposed on the health insurance carriers (fully insured plans) or plan sponsors/employers (self-funded plans).

REINSURANCE FEES

The ACA establishes a transitional reinsurance program in each state to assist in stabilizing premiums for coverage in the individual market for individuals with higher cost needs to maintain minimum essential coverage. The cost rises to $695 per uninsured person in 2016.

The Affordable Care Act is here to stay. Understanding the various fees, taxes penalties and other costs associated with it will be crucial as the provisions of this law continue to unwind.

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This decision has created much confusion and discussion about the most appropriate way to address situations when individuals with Alzheimer’s or related dementias present acute situations in which they pose a risk to themselves or others.

Wisconsin’s long-term care provider community provides tremendous care and services to a wide variety of individuals, in various settings, throughout the state. A very small but important subset of individuals served present unique challenges, particularly when, due to underlying conditions or progressive deterioration, causes an individual to create a danger to themselves or others.

Historically, the avenue of last resort may have been a Chapter 51 emergency detention or involuntary commitment when the provider was unable to address the needs of the individual. While this process was sparingly used for individuals with Alzheimer’s or related dementias, it was an option prior to the Helen E.F. case.

BACKGROUND

Fond du Lac County v. Helen E.F. was decided by the Wisconsin Supreme Court in the Spring of 2012, which held that a person with Alzheimer’s disease does not have a Chapter 51 qualifying illness, and is more appropriately treated under the provisions of Chapter 55. This decision has created much confusion and discussion about the most appropriate way to address situations when individuals with Alzheimer’s or related dementias present acute situations in which they pose a risk to themselves or others.

Helen was an 85-year-old woman suffering from Alzheimer’s disease, with symptoms including progressive dementia and memory lapses. She lived in a nursing home in Fond du Lac for six years and began to exhibit agitated and aggressive behavior. She was transported to a hospital emergency room where the behavior persisted and was placed in the hospital’s behavioral health unit under emergency detention pursuant to Section 51.15. Fond du Lac County then initiated a proceeding under Chapter 51 to have Helen involuntarily committed for treatment. A commitment was ordered and the court issued an involuntary commitment order in a locked psychiatric unit, which was appealed.

The Court of Appeals determined that Helen was not the proper subject for commitment or treatment under Chapter 51 because Alzheimer’s disease was not a qualifying mental condition. Notably, the Court of Appeals also stated that since rehabilitation is the purpose of Chapter 51, the treatment of an Alzheimer’s disease patient under this Chapter is inappropriate because individuals with Alzheimer’s disease cannot be “rehabilitated.”

The Court of Appeals decision was heard by the Supreme Court and the Court stated that because Helen was not medically capable of being rehabilitated, she could not be involuntarily committed under Chapter 51.5. Since her disability was likely to be permanent, she was therefore a proper subject for protective placement and services under Chapter 55. The Court also analyzed the purpose of the statutes and found Chapter 55 presented a better balance of Helen’s interest in liberty and the County’s interest in protecting the public and providing Helen with care.

Three specific features of Chapter 55, not found in Chapter 51, include: placement options, the involvement of a Guardian ad Litem, and the need for long-term care versus short-term treatment and rehabilitation. The Court concluded that the features of Chapter 55 are more appropriate for individuals with Alzheimer’s or related dementias, and that Chapter 55 be reserved for individuals with mental illness for purposes of treatment. Of particular note, however, was that the Court did not rule on whether an individual who has a dual diagnosis of both mental illness and dementia could be involuntarily committed under Chapter 51. Instead, the Court left this issue for another day.

FALLOUT

Following the Helen E.F. decision, most counties have modified their procedures in the area of situations involving aggressive or dangerous individuals with Alzheimer’s or related dementias. Providers are increasingly confronted with information from county officials that law enforcement or others are not authorized to initiate an emergency detention for an individual who clearly has dementia. The application of these decisions varies slightly throughout the state with some counties using a more expansive interpretation, particularly when an individual may have both some underlying mental illness and dementia.

LEGISLATIVE COUNCIL COMMITTEE

A joint Legislative Council Committee reviewed the options and possible legislative changes to address some of the issues raised in the Helen E.F. decision. This Committee explored the development of modifications that would address the inadequacies of Chapter 55 for acute emergency placements. Those familiar with Chapter 55 recognize that while the Chapter provides additional protections and procedures for individuals in need of protective placement or services, this also comes at a cost of time which may be crucial for acute situations. If Chapter 55 is a more appropriate avenue for individuals exclusively with Alzheimer’s or related dementias, the additional protections afforded, modifications are necessary in order to shorten the timeframes to allow this to be a viable option when an emergency exists.

Additional stumbling blocks exist with regard to the definition of an "inpatient health care facility" where a protective placement would be made. While Committee members generally agreed that it may be better for individuals with Alzheimer’s and dementia to be placed in a setting exclusive to this client population, the realities of hospitals or other similar providers creating dedicated and separate units to provide such services and treatment may be impractical or cost-prohibitive.

It is hoped that the Committee will advance recommendations for legislation to be considered during the next legislative session. Whether this ultimately results in modifications to Chapters 51 and 55 remain to be seen, but it is imperative that the provider community communicate their issues to their legislators.

While it is only a small subset of individuals that present significant behavioral challenges, providers familiar with such instances will certainly share that they consume a disproportionate amount of time, energy and resources to protect the resident and others. It is hoped that the legislative changes will afford a safe and effective option for individuals with Alzheimer’s and dementia to receive the necessary care and treatment so as to protect them and others around them.

For more information, or to keep abreast of developments in this area visit the Legislative Council webpage located at legis.wisconsin.gov/lc/committees/study/2012/1a, or write me using the contact information listed below.
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