Aging and Disability Resource Center
ADRC of Door County

ADVISORY BOARD - NOTICE OF PUBLIC MEETING

MONDAY, September 19, 2016 - 4:00 P.M.
ADRC of Door County @Senior and Community Center
832 N. 14th Avenue, Sturgeon0 Bay, WI 54235

AGENDA

1. **Call to Order at 4:00 p.m.**
2. **Establish Quorum**
3. **Adopt Agenda**
4. **Approve Minutes from the 07/18/2016 Meeting**
5. **Public Comment**

6. **Old Business**

   - Building Project Update
   - ADRC 2016 Business Plan Update
   - SRC & ADRC Blending Update
   - Memory Screening Update
   - Scope of Services questions

7. **New Business**

   - Wisconsin Dementia Care System Redesign
   - Director's Report

8. **Confirm Next Meeting Date and Time**
   - The next meeting is tentatively scheduled for November 21, 2016 at 4:00 p.m.

9. **Adjourn**

In compliance with the Americans with Disabilities Act, any person needing assistance to participate in this meeting should contact the Office of the County Clerk at (920) 746-2200. Notification 72 hours prior to a meeting will enable the County to make reasonable arrangements to ensure accessibility to that meeting.

Deviation from the printed order may occur. **Posted:**

ADRC Advisory Board - Minutes

Monday, July 18, 2016 at 04:00 p.m.

Senior Resource & Community Center, 832 N. 14th Ave., Sturgeon Bay, WI

THESE MINUTES HAVE NOT BEEN REVIEWED AND APPROVED BY THIS BOARD AND ARE SUBJECT TO REVIEW AND REVISION BY THE BOARD AT THEIR NEXT REGULARLY SCHEDULED MEETING.

Business Meeting

1. Call to Order

- The meeting was called to order at 4:00 p.m. by Helen Bacon. Members present were: Christine Andersen, Helen Bacon, Tom Krueck, Julie Kudick, Tami Leist, and Judy Treptow. Absent were Robert Sullivan, Melissa Wolfe, and Lucille Kirkegaard. Other persons present were Rachelle Gramann. Barb Snow took minutes.

2. Establish a Quorum

- A quorum was established and the meeting continued.

3. Adoption of Agenda

- A motion was made by Christine Andersen, and seconded by Judy Treptow to adopt the agenda. The motion was carried unanimously.

4. Approve Minutes from 5/16/16 Meeting

- Corrections to be made in the minutes were under Public Comment change “country” to “county”; and under New Business change “Social Services is underfunded” to “Social Services has shifted”.
- A motion was made by Tom Krueck to approve the minutes with corrections and was seconded by Judy Treptow. The motion was carried unanimously.

5. Public Comment

- Tom Krueck expressed his concern that Lakeland Care District and Care Wisconsin were in competition on how cheaply they can provide services. When there was a waiver program every person was approved a daily per diem allocation that the county would provide the individual. When Family Care came in people had to be eligible, then pick Lakeland Care District or Care Wisconsin or IRIS. The MCO then gets the per diem which goes into a pool of money which is then used for the greater needs and becomes a bidding competition with the Lakeland and Care squeeze and coming through the provider. It’s bidding contest and it has its good and bad effects on the people. The ADRC needs to be aware this is going to be a constant ongoing problem for increase supply and demand. Rachelle mentioned that there are grievance forms and Tom stated that we need to stay on the cuff of what’s happening. Julie Kudick said we need to work on providers more to stay ahead and development of resources. Helen mentioned that we need to take this forward and that others are saying this as well. Melissa met with a State Representative on where we are falling short in the states concept of Family Care. Helen mentioned the information is in the packet on Governing Board and what’s referenced. Rachelle said the ADRC is aware of things and is in contact with the Regional Specialist. Helen said that Door County is better than some of the other Northern Counties. Rachelle mentioned that the ADRC has to stay away from looking like we are in anyone’s back pocket and stay neutral for resources. Julie Kudick wanted to get more information into our database on resources that are available. Rachelle mentioned that Good People came up and explained their business of helping people stay in their homes.

6. **Old Business**

- **Building Project Update –** Rachelle showed the plans for the new building and discussed the layout. She pointed out the ADRC private waiting room, the bathrooms were bigger and included a family bathroom. The building would have locked access and also have a shared office for the public nurse and a bigger parking lot. We are working on getting to Sister Bay more and looking at advertising as well as becoming a presence with churches and health providers. Tom Krueck mentions that people are saying that Mary Bink's work is fabulous. Rachelle would like more input from the Northern Door area. She states that she went to a Health and Wellness in Northern door and would like input from Lucille Kirkegaard. Tom Krueck wanted to know what the timeline for the new building. Late fall and early winter the plan is to get into the old structure and maybe by November they can start rehabbing the interior of the building. The hope is that it will be done in 2017 sometime.
- **ADRC 2016 Business Plan Update –** Rachelle is still working on the Business Plan which is due November 1st. August 3rd is the Directors meeting. Tom and the Finance Department are helping out with the business plan. We are looking at the numbers so that we can streamline and provide more effective services.
- **Update SRC & ADRC blending.** There is a meeting this Wednesday with Rachelle, Jake, ORCD, and GWAAR to talk about how we are going to move forward at joining the ADRC and Senior Center. The States goal is to join the ADRC and the SRC.
- **Memory Screenings Update.** There were a couple of people who signed up for Memory Screenings. There are more memory screening dates set up for September which we will advertise on WDOR. Alzheimer's will be coming in on a monthly basis. We want to create a more Dementia friendly community. There are talks of more funding for a Dementia Care Specialist. Julie Kudick brought up that they need to have an Alzheimer's Representative presence in Northern Door County.
- **Family Care 2.0 Update.** The State has tabled 2.0. Helen brought up that we should put legislative concerns on the agenda in the future.
- **Directors Meeting Update.**
    - We have the Learning Management System training which also provides information and webinars on this site. This training comes out of DHS in Madison.
    - The ADRC had a Hearing Loop demonstration at the last meeting. The new building will have the Hearing Loop installed in the building. The Door County Auditorium in Fish Creek has the hearing loop.
    - Questions for the Committee are "how do we bring forward the Face of the ADRC and how do we draw more people in? What can we do to get people 16-60, what can we do to bring people in? The ADRC is not just for the needy. Judy Treptow said to bring in Hospital staff and churches. Rachelle said we have been talking about marketing and radio spots in morning. Another question was are we competing with the YMCA with the exercise room. Our exercise room is designed for the population it serves. Radio spots are approved through the board. Tom Krueck mentioned that people don't know what services the ADRC offers. Helen mentioned that people don't pay attention until they really need the service. Judy Treptow said we need to just keep being repetitive, maybe a one liner every month at each church service.

7. **New Business**

- **Garden Volunteers –** Helen mentioned that there is a lady that has worked for a nursery for 9 years that will weed and garden for us. There are 5 or 6 volunteers involved and would like to continue. We also have a memory garden that people can plant on the side of the building.
- **Scope of Services for the Contract Between WI DHS Division of LTC and ADRC**

- **Updates and changes –** Rachelle mentioned a section in the Executive summary handout that "DHS recommends eliminating the requirement that the ADRCs review MCO-related grievances…" that she is in agreement with. Tom want to see us more proactive and not reactive.
- Rachelle noted that the committee read through the Scope and she will put it on the agenda to discuss and ask questions at the next meeting.

- **Governing Boards Authority -** Rachelle mentioned that we are working on time reporting more efficiently. When we are integrated there may be an additional EBS and adjusted DBS hours.
- **HIPAA/Confidentiality**
  - I-Team Restructuring
    - Rachelle mentioned that we are restructuring and making sure Policy and Procedures are where it needs to be in case of an audit. I-Team was huge. It was downsized to rotate in APS and I & A workers. Other participants include EMS, Medical Personnel, Law Enforcement and Sanitarian when needed. EBS and DBS are not on I-Team.
  - Release Form updates
    - The ADRC will have updated release forms. We always need to have a release of information or privacy act signed. We are also updating our policy and procedures book.
    - We will be getting all our documentation in weekly.
- **Change Project**
  - We have 2 change projects.
    - The first one is on Outreach in the community. We will collect the numbers on the first 3 months and compare them to the numbers on the next 3 months. This project is almost complete.
    - The second project Is Restructuring the Caregiver Support Group. Facilitators are being trained and getting more connected to the community. There are 7 Support Group meetings a month. 1-Washington Island, 2-Sturgeon Bay, 2-Sister Bay and 2-Southern Door. Facilitators include, Christine Andersen for Washington Island, Rachelle, Carol, Lisa, Anna and Jake are also facilitators when needed. We also have a CareGiver Support packet that was put together.
- **Trauma Informed Care –** Committee briefly looked at the Trauma Informed Care packet.
- **Director's Report**
  - I & A numbers are down to 228 consumer contacts.
  - The ADRC now has outreach booklets and flyers that we can distribute in the communities.

8. Confirm Next Meeting Date and Time

- The next meeting of the ADRC Advisory Board will be held on Monday, November 20, 2016, at 4:00 p.m. at the Senior Resource & Community Center.

9. Adjourn

- A motion was made by Tom Krueck, to adjourn the meeting. The motion was seconded by Judy Treptow. The motion was carried unanimously. Meeting adjourned at 6:00 p.m.

Recorded by Barb Snow

Aging and Disability Resource Center (ADRC) Business Plan

Current Status and Opportunities for Enhancing ADRC Services and Expanding the Customer Base

Revised 8-12-2016

ADRC Name: ______________________________

Counties Served: ______________________________

Director Name: ____________________ Phone: ______________ E-mail: ____________________

This Business Plan is intended to guide the ADRC's efforts to enhance its services, expand its customer base, and operate efficiently. By pulling together key data on who the ADRC currently serves, how the ADRC presents itself to the public, which services it emphasizes, how its customers perceive the ADRC, and how the ADRC uses its staff and financial resources, this Business Plan format provides a structure for presenting key factors for each ADRC to consider in developing business strategies appropriate to its individual situation.

Customer Base

TABLE 1
Number of ADRC Customers Served

Unduplicated ADRC Customers	Number of Customers	Number of Contacts	Contacts/ Customer
Actual Count, May-July, 2016			
Estimated Annual Number			

Source: ADRC Encounter Data. Does not include elder benefit specialist (EBS) and disability benefit specialist (DBS) customers to avoid duplication in the customer count because of incompatibilities between reporting systems.

TABLE 2
Benefit Specialist Customers*

Benefit Specialist Service	Number of Customers	
	May-July 2016	Estimated Annual Number
Elder Benefit Specialist		
Disability Benefit Specialist		
Total		

Note: Benefit Specialist customers are those for whom cases have been opened. Those receiving brief information only services from the benefit specialist are not included.

TABLE 3
ADRC Market Penetration

ADRC Target Groups*	% of Target Group (TG) Who Are ADRC Customers	
	All ADRCs Statewide (All ADRC Customers / Statewide TG Population)	**This ADRC** (This ADRC's Customers / Geographic Area TG Population)
Elderly (Age 60±)		
Adults with Disabilities (age 18-59)		
Total Target Population		

*Service area population data is from the U.S. Census, American Community Survey, 2010-2014. ADRC customer data is from encounter reporting and includes youth who receive services at age 17 years 6 months. Elder Benefit Specialist and Disability Benefit Specialist customers are not included.

How does the ADRC's market penetration rate compare to the statewide rate for all ADRCs? Are there differences among target groups? What might explain the differences? Are changes to the ADRC's market penetration rate anticipated in the future? If yes, why?

Customer Base (Continued)

TABLE 4
Target Group Distribution - ADRC Customers Compared to Statewide*

ADRC Target Groups	**Target Group as a % of Total Target Population**		**% ADRC Customers in this Target Group** (May-July, 2016)
	Statewide Distribution	**Distribution in ADRC Service Area**	
Elderly (age 60±)			
Adults with Disabilities (age 18-59)			
Total Target Population	100%	100%	100%

*Numbers do not include EBS and DBS customers.

How does the proportion of ADRC customers in each target group compare to the representation of that target group in the ADRCs service area? Do the differences, if any, represent underserved populations or are they reflective of differing needs and why?

TABLE 5
ADRC Customers, Percentages by Disability Type

Disability Type	**% of Customers Age 18-59**		**% of Customers Age 60±**	
	All ADRCs	**This ADRC**	**All ADRCs**	**This ADRC**
Intellectual/Developmental Disability				
Physical Disability				
Mental Health				
Substance Use				
No Disability or Unknown				
Total				

Source: ADRC encounter data for May-July, 2016.

How does the ADRC's service to the different customer groups compare to that of ADRCs statewide? What, if any, are the main differences and what explains them?

Customer Base (Continued)

TABLE 6

Persons with a Disability in the ADRC Service Area, by Type of Disability*

Disability Type	**Population Age 18-64**		**Population age 65+**	
	Number	**% of Age Group Total**	**Number**	**% of Age Group Total**
Independent Living Difficulty				
Self-Care Difficulty				
Ambulatory Difficulty				
Cognitive Difficulty				
Hearing Difficulty				
Vision Disability				
Total with Any Disability				
Total Population		100%		100%

* Source: U.S. Census, American Community Survey, 2010-2014. Population numbers are estimates averaged over a five year period.

What types of customers currently make the most use of the ADRC? Are there disability-related, geographic, economic, cultural or other subgroups within the ADRC's main target populations that could potentially benefit from ADRC services but are currently underrepresented among the ADRC's customers? Groups to consider include but are not limited to: young adults with any level of disability who are not participating in a Long Term Care (LTC) program; adults with chronic conditions such as diabetes, cancer, heart disease, kidney disease, etc.; ethnic minorities; and private pay individuals with LTC needs.

Outreach and Marketing

TABLE 7
How Customers Contacted the ADRC

Who Initiated Contact with the ADRC*	% of Customers	
	For this ADRC	For All ADRCs Statewide
Self		
Guardian, POA or other legal decision-maker		
Caregiver		
Relative, friend, neighbor, or community member who is not a legal decision-maker or caregiver		
Agency service provider (referrals from a human service agency, health care service provider, facility, etc.)		
Other, not initiated by the ADRC		
Total	100%	100%

* Each customer is assigned to the first category in the list which applies and is assigned to only one category.

Describe the ADRC's approach to marketing and outreach. How effective has this approach been in reaching different groups within the ADRC's target populations? In reaching the different types of people who initiate contact with the ADRC?

Service Provision

TABLE 8
ADRC Services, by Service Type, Compared to Statewide Averages
May, June, July 2016

Type of Service Provided	% of Customers		Contacts/Customer	
	State Average	This ADRC	State Average	This ADRC
Information and Assistance				
Options Counseling				
LTC Functional Screen				
Enrollment Counseling				
Disenrollment Counseling				
Disability Benefit Specialist (DBS)				
Elder Benefit Specialist (EBS)				
Assistance with MA application				
Services for youth in transition				
Memory Screens				
Nursing home relocations				
All Other				
Total*		100%		100%

Describe the ADRC's participation in health fairs, prevention programs, and other community activities that reach and educate the public about issues relating to aging and disability and are not reflected in individual customer counts. Include the number of events and participants, if available.

Which services are the main focus of the ADRC's current activities and why?

Does the ADRC provide significantly greater or lesser proportions of some types of services than the average for all ADRCs? How do the number of contacts per customer provided by the ADRC compare to statewide averages? What would explain these differences? What questions or issues does the comparison raise?

Customer Preferences and Expectations

Based on your ADRC's customer satisfaction surveys and other feedback from customers, what do customers like best about the ADRC? What do they want more of, want added, or want improved?

What does the survey data and customer feedback tell you about how well the ADRC is meeting customer expectations in the following areas?

- The ease of locating and contacting the ADRC:
- The number and location of ADRC sites:
- The ADRC's hours of operation:
- How telephone calls to the ADRC are answered:
- The ADRC reception area and other building and office space characteristics:
- The services provided by the ADRC:

Financial Resources

TABLE 9

Sources of Funding in the 2016 ADRC Budget

Funding Source	Amount	% of Total
State ADRC, DCS and nursing home relocation funding		
Federal MA match		
Local financial contribution		
Total		100%
Describe local in-kind contributions, if any, and estimate their dollar value:		

TABLE 10

ADRC Spending Compared to Budget by Year

Over or Under Spending	2013	2014	2015
Underspending of ADRC grant			
• Amount of underspending, if any			
• Underspending as a % of ADRC state grant			
• Underspending as a % of total ADRC budget			
Local financial contribution			

Based on the ADRC's current budget and spending history, what is the ADRC's financial capacity for enhancing the services it provides or increasing the number of people it serves? What opportunities are potentially available for enhancing the resources available to the ADRC? What barriers may limit the potential for service enhancement or expansion? Explain.

Allocation of ADRC Resources

TABLE 11

ADRC Staff Time and Expenditures, by Type of Service

Type of Service Provided*	Number of Known Customers (unduplicated)	Staff Time Devoted to Service Provision			Expenditures by Service Category		
		Staff Time In Hours	% of Staff Time	Average Minutes /Customer	Dollar Amount	% of Total	Cost per Customer
Information and Assistance, and Options Counseling							
LTC Functional Screen							
Enrollment/Disenrollment Counseling							
Youth in transition							
Dementia related services							
Nursing home relocations							
All Other							
Total			100%			100%	
Average per Customer							

* Data on EBS and DBS services is not included in this table in order to avoid duplication of customer counts.

TABLE 12

ADRC Expenditures, by 2015 Budget Category Percentages

Budget Category	Expenditures by Budget Category*			
	ADRC 2015 Budget Percentages		ADRC Expenditure – Allocated by 2015 %	Cost / Customer by Budget Category
	Amount	%	Amount	Cost/Customers*
Personnel				
Other staff-related costs (travel, training, certifications, etc.)				
Rent				
Other building related costs (utilities, furniture, etc.)				
Phone system				
Computer / IT System				
Other direct expense				
AMSO				
Total		100%		

* The total number of known customers from Table 11 is used in computing the cost-to-customer ratios. EBS and DBS data is not included.

Allocation of ADRC Resources (Continued)

What are the ADRC's key service and budget cost centers? Identify areas where efficiencies could potentially be made or resources reallocated to enhance ADRC services, address customer expectations, and expand the ADRC's customer base.

Business Strategy for 2017

Describe the steps the ADRC will take in 2017 to enhance and expand its services and customer base.

- *Reach new customers and increase the number of new ADRC contacts.* Identify which customer population(s) will be targeted and why. Describe how the ADRC will reach out to inform and educate members of these groups about the services of the ADRC and what the anticipated outcome will be.

Business Strategy for 2017 (Continued)

- *Enhance and/or expand current services.* Describe what changes the ADRC will make to increase or improve its services, together with the anticipated result of these enhancements.

- *Realize efficiencies and allocate resources.* Describe areas where efficiencies will be implemented and resources allocated or reallocated in order to facilitate the proposed customer and service expansions.

CARS Reporting Profiles	CARS - FED Payment Profiles	CARS - GPR Profiles (roll for payment)	GPR payment issued on
I&A / Screen Related			
560086	560087	560088	560100
560090	560091	560092	560100
560095		560095	560100
DCS			
560154	560155	560156	560158
560157		560157	560158
NH Relocation			
560060	560061	560062	560065
560063		560063	560065

EBS / DBS (do not use these)			
560070	560071	560072	560100
560074	560074	none	560100
560075		560075	560100
560080	560081	560082	560100
560085		560085	560100

I&A and Screen related profiles 560086, 560090 and 560095
DCS profiles 560154 and 560158
NH Relocation profiles 560060 and 560063
EBS related profiles 560070, 560074 and 560075
DBS related profiles 560080 and 560085

ADPAW RECOMMENDATIONS

FOR

AGING & DISABILITY RESOURCE CENTER

AND AGING INTEGRATION

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Introduction & Overview

Integration of County Aging Units (CAU) and Aging & Disability Resource Centers (ADRC) does not occur with a simple definition. Integration of these two entities is really a philosophy with the focus on what is the best operational arrangement for the customers that they serve. Throughout Wisconsin, CAUs and ADRCs are structured in a variety of ways which has allowed for a lot of experience to be taken into account while developing the recommendations that follow.

> Please note: CAU implies that aging programs are administered through county government. For the purposes of this document, CAU represents both county and non-profit administered programs. Additionally, the task force did not have tribal input and therefore this document in no way represents integration for the tribes.

Aging and Disability Professionals of Wisconsin (ADPAW) received a request from the Bureau of Aging & Disability Resources (BADR) to form a task force to define integration of CAUs and ADRCs. ADPAW recognizes that integration is a demographic imperative. ADPAW formed a task force of **all** interested ADPAW members to fulfill this request from BADR. All persons indicating an interest were invited to be a part of this task force. The ADPAW task force was made up of **all** 20 ADPAW members from varying backgrounds. The task force then split into two subgroups- one group worked on the single county structure and the other group worked on the regional/multi-county structure. Both groups identified key areas for consideration when integrating, which are:

- ***Culture & Customer Experience***
- ***Funding Complexities***
- ***Marketing & Outreach***
- ***Organizational Structure***
- ***Potential Barriers & Opportunities for Improvement***

The ADPAW Integration Task Force met from January 2016 - April 2016 to develop the recommended criteria that needs to be met to be considered integrated. The Task Force developed criteria on two ends of the spectrum of what constitutes minimum integration and what would be considered ideal integration. **Minimum** integration would focus on what is best for the customer. **Ideal** integration would encompass both what is best for the customer and also administratively.

Throughout the process of identifying these criteria, the task force focused on both the mission of the ADRCs as well as the Aging Difference. The ADRC mission statement from the ADRC Contract is "To provide older adults and people with physical or developmental/intellectual

disabilities the resources needed to live with dignity and security, and achieve maximum independence and quality of life." The goal of the Aging & Disability Resource Center is to empower individuals to make informed choices and to streamline access to the right and appropriate services and supports.

The Aging Difference characteristics, per the Aging Manual, states that: 1) The aging network belongs to and is governed by older people, 2) The aging network empowers older people, and 3) The aging network focuses on change. Additionally it states "the aging network is a network of and for older people. It is not primarily a service network. It is a network whose major roles are to empower and enable older people. The network must also work to ensure that existing service systems are responsive and accessible to the elderly."

The Wisconsin Elders Act was created to strengthen Wisconsin's commitment to providing for older adults. According to the Act, aging units will "Provide a visible and accessible point of contact for individuals to obtain accurate and comprehensive information about public and private resources available in the community which can meet the needs of older individuals."

As we examine these, it is obvious that CAUs and ADRCs are more similar than they are different. Additionally, where our differences exist there is an opportunity for a profound synergy to occur. Integration is bringing the best of both together and is in alignment with the Wisconsin's Elder Act.

**Please note that not all criteria can be found in this narrative. For a comprehensive snapshot of all criteria, see Appendix C.*

<u>Culture & Customer Experience</u>

The culture and customer experience of any organization is what leaves a lasting impression with the people utilizing that organization. Local presence as well as local resources are both keys to success. Because both CAUs and ADRCs serve individuals regardless of income and asset levels, it is important to create an environment that is attractive and not intimidating. In addition, customers should be able to obtain information and resources without having to determine if they should be calling the CAU or the ADRC in their county. Both ADRCs and CAUs serve similar target populations so streamlining access to programs and services is imperative.

In order to fulfill the philosophy of integration, one universal agency name should be used which is the Aging and Disability Resource Center of *specified county(s) or region*. In addition to one universal name is also the need for one phone number. In a multi-county structure, integration should include a local phone number since aging programs can vary significantly between counties. Local presence is a very important factor for a positive customer experience. Local presence is about more than just a phone number and is really about the ease

for the consumer in accessing programs and services. In a single county structure, at a **minimum**, there should be one office for the integrated agency. In a multi-county structure, at a **minimum**, there should be at least one office location per county. **Ideally**, in both structures, there would be additional satellite offices, as needed in other parts of the county in which customers tend to identify as 'easy' to access. The culture of the integrated agency needs to embrace the contract and should not be associated with a means tested agency.

Funding Complexities

There are many complexities that come with funding both ADRCs and CAUs. A variety of funding streams from local, state and federal sources with varying requirements on how the grant funding is used can make for a complex budget. Budget integration should maximize resources, increase opportunities while not reducing services. In a single county structure, integrated CAU and ADRC budgets is a **minimum** standard. In the multi-county structure, integrated CAU and ADRC budgets per county is the **minimum** standard with the **ideal** being a fully combined, regional Aging & ADRC budget.

We recognize that local government is a significant stakeholder as they contribute funding, at varying levels, to CAUs and ADRCs. Therefore integration solutions regarding budget should occur at the local level with technical support from BADR and AAA.

Marketing & Outreach

In order for customers to know that CAU and ADRC programs exist in their county, marketing and outreach is essential. To minimize confusion, marketing as a single entity is very important. Our message will reflect a shared mission and philosophy which is to assist older persons and adults with disabilities in accessing needed services and programs in their local community. The marketing message should be built on a foundation of inclusivity, meaning anyone of any income level can access the services of CAU and ADRC programs. In an integrated model the agency, whether single or multi-county, would have one comprehensive marketing plan that promotes the agency as whole. However, the marketing plan for a regional ADRC may include slight variations between counties based on what programs and services are provided by the locally integrated CAU/ADRC office.

Organizational Structure

Organizational structure and department location is another consideration of integration. A common question is "will the ADRC integrate into CAU or will CAU integrate into the ADRC?" which is certainly a local decision. **Ideally**, the resulting integrated agency would remain independent or be its own department within county government. In a single county structure, there should be one Director who oversees CAU and ADRC programs and budgets. In the multi-

county model, at a **minimum**, there needs to be one person who oversees the CAU & ADRC budgets in each county. In an **ideal** model, there would be one Director for the region who is responsible for a regional Aging and ADRC budget.

Potential Barriers & Opportunities for Improvement

We identified several potential barriers as well as efficiencies that would help when becoming integrated. Several of these efficiencies require the assistance of BADR. Streamlining of reporting, meetings and trainings would help significantly increase efficiency and integration in local ADRCs. For example, a single comprehensive Aging Plan Self-Assessment and ADRC Annual Documentation would bring efficiency and cohesion to both program areas. Combining meetings such as the ADRConnect with the ACE meetings is another example to create efficiency and cohesion.

See Appendices A, B & C for a snapshot of identified barriers and opportunities for improvement, support needed from BADR and minimum/ideal criteria at a glance.

ADPAW Integration Task Force

Leslie Fijalkiewicz, Task Force Co-Chair
Director of the ADRC of Barron, Rusk and Washburn Counties

Jennifer Owen, Task Force Co-Chair
Director of the ADRC of Eau Claire County

Dianne Jacobson, ADPAW President
Director of Oneida County Department on Aging

Audra Martine
Director of the ADRC of Western Wisconsin

Barb Peterson
Director of the ADRC of the North

Cathy Ley
Director of the ADRC of the Lakeshore

Charlene Norberg
Director of the ADRC of Eagle Country, Juneau County

Cheryl Batterman
Director of the Dane County AAA

Cindy Piotrowski
Director of the ADRC of Portage County

Debbie Martineau
Director of Ashland County Aging Unit Inc.

Devon Christianson
Director of the ADRC of Brown County

Esther Mukand
Director of Aging for Fond du Lac County

Jennifer Cummings
Director of Aging & Wellness for the ADRC of Central Wisconsin

Jennifer Fischer
Director of the ADRC of Dane County

Joyce Lubben
Director for the Rock County Council on Aging

Linda Olson
Director of the ADRC of Washington County

Michelle Pike
Director of the ADRC of Ozaukee County

Nathanael Brown
Director of the Taylor County Commission on Aging

Pat Peterson
Director of Unit on Aging for Vernon County

Todd Gunderson
Director of Aging in Jackson County & Supervisor for the ADRC of Western Wisconsin

Appendix A-Potential Barriers & Opportunities for Improvement

It is universally accepted that cost/expense is a potential barrier for each criteria of integration listed below. **In some cases, it is a significant barrier**. However, in an effort to reduce redundancy, it will not be listed under each heading, with the understanding that it be a consideration.

This appendix does not represent potential barriers and opportunities for improvement for Tribal Aging Units and Tribal ADRCs.

Integration requires a commitment on the part of all parties, especially local county government. The complexity of the barriers is varied and therefore the level of difficulty and the methods for overcoming the barriers will vary from county to county. This is not an exhaustive list of barriers, nor does it identify methods for overcoming those barriers. Each county, even within a regional ADRC, will work to solve these in manner that is most appropriate for their situation with the flexibility and technical assistance of BADR & AAA.

Barriers to single location, name and phone number

- Higher call and walk-in volume
- Existing locations for CAU & ADRC have insufficient space to accommodate more staff
- Possible negative stigma of being located with primarily means tested services (i.e. DHS, Social Services, etc.)
- Relocation may result in loss of accessible IT support
- Requires extensive cross training for all staff on populations, programs and services
- Perception of loss vs. enhancement both internally (staff) and externally (community)
- Management of change

One website & unified brand in marketing materials

- Services defined by county lines create challenges in unified materials
- Maintaining the conflict free perception (i.e. ADRC logo on Meals on Wheels materials)

Organizational Management Changes

- Change in chain of command and perception that someone is “forced out”
- Learning curve to understand how funding can be blended to maximize services
- Changes to staff work hours, benefits, wage scale, holidays, etc., and possible result of reduced staff morale
- Willing county to take on the employer risk for a region
- Process for appointments to governing board
- Creation and/or dissolution of advisory boards and councils to maintain statutory requirements or reduce redundancy
- Perception that local control is lost in a large regional model

Other challenges

- Too much or not enough involvement from state and AAA with technical support or timeline for implementation
- Overall State/Regional support
- Both CAU and ADRC staff will need to become more familiar with macro and local advocacy issues
- Maintaining local programming such as adaptive equipment loan programs, senior farmer's market vouchers, transportation, dementia services, support groups, etc., while trying to provide consistency across a regional ADRC
- Meeting **ideal** standards when regional ADRC has non-contiguous county(ies)

Appendix B-Support Needed from BADR

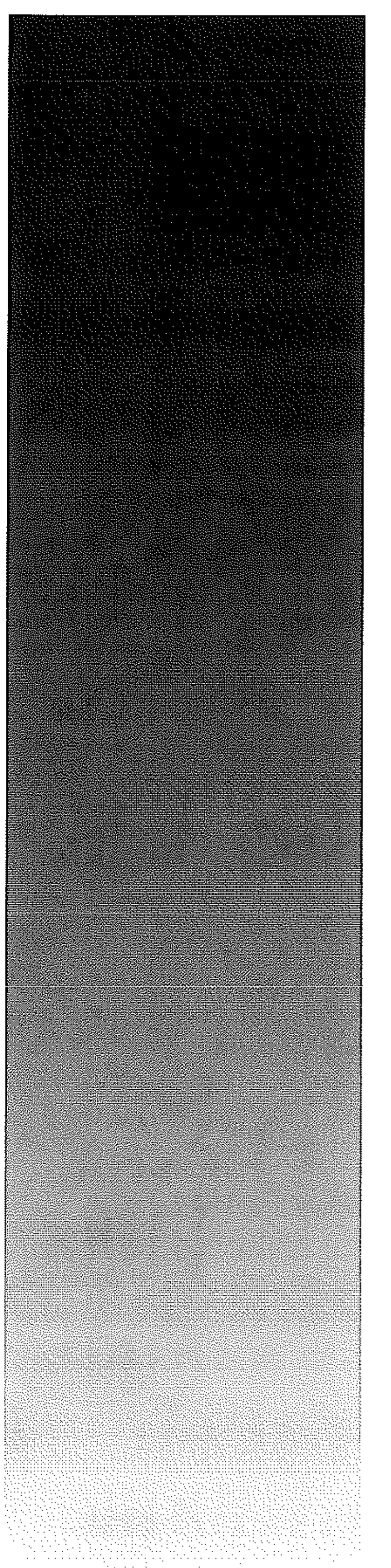
Just as Aging Units/ADRCs will be required to demonstrate and report on progress, there will be a request that BADR continue to provide updates to ADPAW on progress with their own integration activities. Throughout this process, a resounding theme has surfaced...local decision-makers have to be allowed the flexibility to solve the issues surrounding integration in a manner that is best for the county as well as regional ADRC. It was also very clear that BADR needs to be involved to achieve a maximum level of efficiency. The following list is not exhaustive and just as we expect integration of Aging Units & ADRC's will not happen overnight, it is understood that many of these changes will be gradual. We are asking BADR to assist with:

- A 'one-stop shop' structure modeled at the state level of the Office on Aging and Office for Resource Center Development for local ADRCs to access for program assistance, etc.
- Funding support for one-time integration implementation (i.e. office relocations, technology, etc.)
- Technical assistance and support with 'boots on the ground' where State staff can come more readily to the local agencies to assist.
- Clear timeline for implementation that includes deadlines
- One integrated Aging/ADRC plan
- One integrated Aging/ADRC contract
- A single database and client tracking system that works with <u>all</u> Aging and ADRC programs and is ADA compliant
- Governance structure in regional models may require statutory changes to have one single Commission on Aging/ADRC Governing Board for the region
- A combined, annual Aging/ADRC statewide conference
- Combined ADRConnect/ACE/AAA meetings
- Regular in-person meetings and training
- Provide organizational model examples
- Consistency in BADR and AAA communications to the ADRCs
- Strengthen the integration of ADRCs and CAUs through statute
- Standardized materials reflective of the integrated agency and continuation of unbiased service

Appendix C- Integration-At-A-Glance

	Minimum Criteria For Integration (Best for the Customer)	**Ideal Criteria For Integration (Best for the Customer AND Administratively**
Single County Model	• One name (ADRC) and main location, one reception and waiting area that is distinctly separate from means tested agencies (i.e. DHS, Social Services, etc.) • One publicized phone number answered as ADRC by live person, without series of prompts • One website and one unified brand in marketing materials • One Director overseeing a single budget for CAU & ADRC • One Aging Unit / ADRC Plan* • Single Governance • Single database or ability to go between for purposes of continuity of service	All of the minimum criteria, plus: • One Aging Unit / ADRC Contract* • One employer
Regional/ Multiple County Model	• One name (ADRC) and location in each county, one reception and waiting area that is distinctly separate from means tested agencies (i.e. DHS, Social Services, etc.) • One local publicized phone number answered as ADRC by live person, without series of prompts. • One website and one unified brand in marketing materials • One supervisor at each branch office who oversees both local aging and ADRC budgets • Single database or ability to go between for purposes of continuity of service	All of the minimum criteria, plus: • One database & client tracking system throughout the region and across all programs • One administrative agency, IT system and employer (not necessarily the same entity for all) • One Director overseeing a single budget for the regional CAU & ADRC • One Aging Unit / ADRC Plan* • One Aging Unit / ADRC Contract* • Single Governance*

*Criteria that will require involvement of BADR & AAA/GWAAR



Wisconsin Dementia Care System Redesign:

Reflecting on the Accomplishments

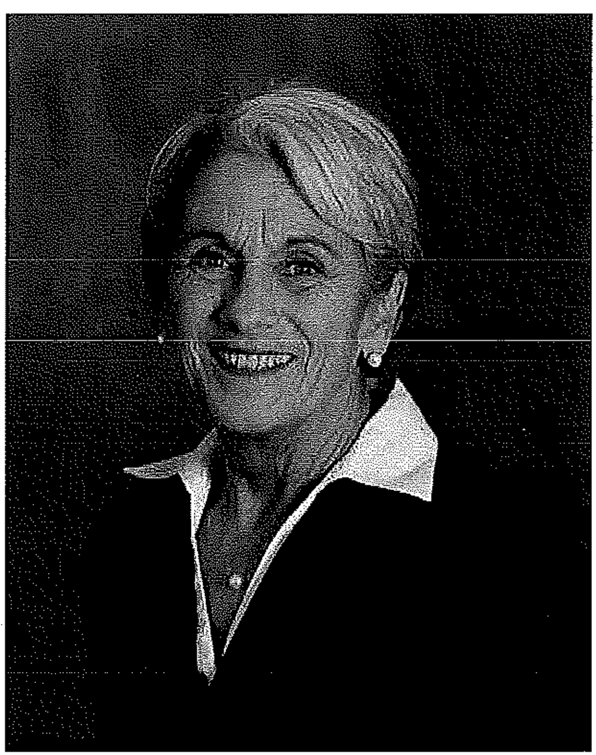
Wisconsin Department of Health Services
P-01555 (08/2016)

Dedication to Secretary Kitty Rhoades

Kitty was a true leader and was committed to the Department of Health Services (DHS) and the citizens of Wisconsin. One of her passions was changing the way state residents with Alzheimer's disease and other dementias are cared for in Wisconsin. Her legacy includes the redesign of Wisconsin's dementia care system as well as bringing the Music & Memory™ Program to Wisconsin.

Kitty recognized that the most effective way to make change is by working together and that our collective path to successfully meeting our mission lies in always acting true to our shared conviction. She incorporated this philosophy into the DHS mission and guiding principles and could be frequently heard saying, "We're all in this together."

We remain committed to moving forward with Kitty's vision of redesigning the way we care for people with Alzheimer's disease and other dementias in Wisconsin.



April 7, 1951 – June 18, 2016

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INTRODUCTION

An estimated 110,000 individuals in Wisconsin have Alzheimer's disease or a related dementia in 2016.[1] By 2040, that number is expected to grow to 242,000.[2] The large numbers 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 compelling reasons for re-examining and improving the dementia care system in Wisconsin.

In 2013, Department of Health Services (DHS) Secretary Kitty Rhoades launched a redesign of the system of dementia care in Wisconsin. It was clear from the start that success would depend on cooperation and coordination among many partners. The redesign effort started with a Dementia Care Stakeholder Summit in October 2013. The summit brought 33 key stakeholders together to identify priorities for moving Wisconsin toward a more "dementia-capable" state. Summit participants identified top strategies that were then used to guide the development of a "Wisconsin Dementia Care System Redesign Plan" (referred to as the Plan), which was published by DHS in February 2014.

The Plan was developed to serve as a living document, one that would evolve to reflect progress made and lessons learned along the way. In the first two years of implementing the Plan, DHS and its many partners have helped foster a statewide conversation about dementia and stressed the importance of creating dementia-friendly communities, workplaces and living environments throughout the state. While there is much work yet to be done, it is evident that Wisconsin is moving closer to achieving the vision of providing the highest possible quality of life for all Wisconsin residents with dementia. This document highlights some of the many successes so far.

OVERVIEW

The original Plan for strengthening Wisconsin's dementia care system was organized into five broad categories. This report presents progress in the following key topic 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.

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[1] Alzheimer's Association. "2016 Alzheimer's Association Facts and Figures," pg 20.
[2] https://www.dhs.wisconsin.gov/publications/p01159.pdf

COMMUNITY AWARENESS AND SERVICES

Alzheimer's disease and other dementias typically progress slowly; people often live with the symptoms of the disease for 10 to 20 years. Individuals with dementia typically spend the majority of this time living at home in the community. As a result, community support is a critical resource in the lives of individuals with dementia and their family caregivers.

The focus of this component of the Plan has been on increasing community awareness and community-based services to help improve the quality of life for people with dementia and their families living in community settings. Outreach under this component has helped foster community conversations about dementia, with the goal of reducing stigma and helping increase community connections and quality of life for people with dementia. The following section describes some of the accomplishments under the Plan and provides examples of ways in which Wisconsin communities are becoming more dementia friendly.

Promoting Dementia-Friendly Communities

Communities that are becoming dementia-friendly are helping to make living with dementia less isolating for individuals with dementia, as well as their family caregivers. Several communities have successfully organized community-wide responses to dementia. Community members have been trained to recognize the signs of dementia, to communicate effectively with people with dementia, and to locate resources for assistance. In order to expand these efforts, state and local public health agencies have become engaged in Wisconsin's dementia initiative.

In April of 2014, DHS received a one-year grant for the Healthy Brain Initiative from the National Association of Chronic Disease Directors with funding from the Centers for Disease Control and Prevention (CDC). The overall purpose of the grant was to implement local and state public health strategies focused on priority actions from **The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013 – 2018**. Wisconsin's project focused on three main areas:

- Creating partnerships with existing Wisconsin dementia-friendly communities.
- Developing a Wisconsin-specific, dementia-friendly communities toolkit.
- Conducting education efforts to promote and engage local health departments in dementia-friendly community initiatives.

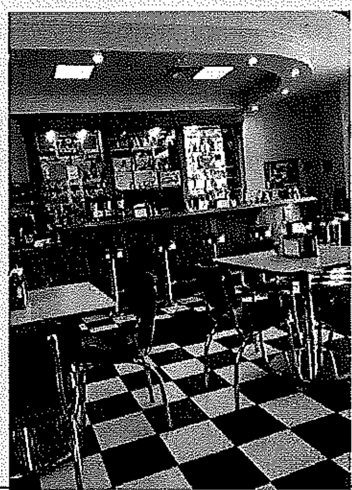
The Alzheimer's Association of Southeastern Wisconsin and the American Association of Retired Persons (AARP) were key partners in this project. AARP collaborated with DHS to host three tele-town hall sessions to provide education on dementia and to promote the concept of dementia-friendly communities. These sessions reached over 42,000 AARP members.

In June of 2015, the toolkit for Building Dementia-Friendly Communities (referred to as the Toolkit in this section) was released. The Toolkit provides information, resources, lessons learned, and steps for building a dementia-friendly community. It is designed to be a user-friendly resource guide for implementing and sustaining dementia-friendly community efforts. The Toolkit also features several Wisconsin communities' dementia-friendly programs. Specific sections include information for use by professionals, businesses, public health, families, and individuals with dementia and include resources and services available from Wisconsin organizations and programs. The Toolkit is unique to Wisconsin, drawing from the direct experiences of local and state partners and agencies that are currently working on projects to improve the quality of life for those with Alzheimer's disease and related dementias and their caregivers.

The release of the Toolkit coincided with DHS providing recognition for one of the first dementia-friendly community efforts in the state. The Fox Valley Memory Project received the Secretary's Award in June 2015, for pioneering work on dementia-friendly communities in Wisconsin. One innovative program that the Fox Valley Memory Project implemented in their region was the Memory Cafe.

Memory Cafes are places where people naturally gather to enjoy social activities, such as coffee shops, restaurants, libraries, nature centers, community centers, places of worship and others. Memory Cafes are not support groups, but are social gatherings convened on a regular basis for people in the early stages of dementia or memory loss and their families and friends. An important part of being a dementia-friendly community is to include people living with dementia and their families and friends in community life. Staying active and engaged is beneficial for people with dementia as well as their caregivers. An important piece of every dementia-friendly community is providing social activities where people can come together without fear of embarrassment from symptoms of dementia.

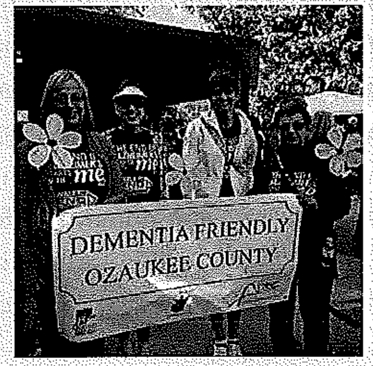
Ferch's Malt Shoppe & Grille Memory Cafe in Greendale



Ferch's provides a safe and comfortable space, free of charge, in a nostalgic setting where people with memory loss and their caregivers can laugh, learn, and remain socially engaged with others traveling on the same journey. The Wurlitzer Jukebox playing the old '45 tunes, tin ceilings, black and white tile floors, wooden booths and a marble bar with red stools all spark memories for participants in Ferch's Memory Cafe.

When reflecting on her experience, owner Betty Ferchoff stated, "You could see it on their faces as they walked through the door. It brought back those warm memories that they experienced growing up..."

In June of 2015, as part of the Healthy Brain Initiative, DHS awarded 15 one-time mini-grants to local health departments. These mini-grants focused on implementing the strategies laid out in the Toolkit and provided resources needed to address dementia within community health improvement plans. The grants explored public health's involvement with issues related to dementia in the community. They also helped to define the roles of public health in prevention and health promotion, community education, and engagement of coalitions and partnerships. Successes included a variety of local initiatives across the state raising awareness of dementia as a public health issue.



Ozaukee County Dementia-Friendly Community Efforts

The groundwork for Ozaukee County to become dementia friendly was laid out at an aging consortium meeting. The community was invited to hear about the dementia-friendly community initiative. Attendees included senior programs and service professionals, government representatives, caregivers, and advocates.

A workgroup was formed to assess where to start and who to involve. In addition to starting two Memory Cafes, the workgroup addressed the underutilization of the Wanderers Registry, a free service to county residents that includes a database for those who may be at risk if they live alone. The application and information was revised and is now called the Safety Registry and includes all information necessary to issue a Silver Alert, which is a public notification system to broadcast information about missing persons, especially seniors. After crafting new language for the Safety Registry, the county had a 400% increase in people enrolling from 2014 to 2015.

Including local businesses is an important component of creating a dementia-friendly community. Having the distinction of being a dementia-friendly business means that management and frontline employees are trained to recognize and assist customers with dementia. Businesses are also encouraged to consider environmental changes (e.g., lighting, signage, layout) that are sensitive to the needs of people with dementia.

Festival Foods Grocery Store in Eau Claire: A Dementia-Friendly Business

At Festival Foods in Eau Claire, employees are trained on how to assist community members who have dementia. Teresa Henrickson, the assistant store director said they are starting to see the impact of the dementia-friendly community training and it is making a difference for customers with dementia. The customers know the store is a safe place to shop and that they will receive the assistance they need.

Henrickson said, "We're able to give an associate to them and say, 'Hey, we're going to help you shop. Let's just go through the store.' We go through each aisle and they leave with a smile on their face."

Expanding the Dementia Care Specialist Program

Aging and Disability Resource Centers (ADRCs) offer the general public a single source for information and assistance on issues affecting older people and people with disabilities, regardless of their income. These resource centers are welcoming and convenient places for people with dementia and their caregivers to get information, advice, and access to a wide variety of services. In 2013, DHS piloted a new program to enhance the capacity of ADRCs to work with individuals and families living with dementia. This program funded Dementia Care Specialist positions in five ADRCs. As part of the Plan, the pilot project was expanded in 2014 to 11 additional ADRCs. Dementia Care Specialist positions were also funded in three Wisconsin tribes to serve the Native American population and in two counties to serve the African American population.

Everyone's experience with dementia is unique, and connecting people with dementia to a community-based dementia specialist can ensure that supports and services are tailored to the needs of each individual. Dementia care specialists are trained to perform memory screens for individuals to determine a need for clinical follow-up with a primary physician or other health care professional. They also provide information and assistance to people with dementia and

their caregivers and connect them with support and options for home help, long-term care, and other needs.

Dementia care specialists have been effective catalysts in promoting dementia-friendly communities. They work with businesses, employers, local organizations, and the community to increase awareness of the unique needs of individuals with dementia and their caregivers. Dementia care specialists provide community education; mobilize community resources; and consult with law enforcement, adult protective services (APS), crisis response teams, medical providers, and others who need information regarding dementia-related issues. Dementia care specialists facilitate and lead efforts to make local communities safe and welcoming for people with dementia. In 2015, dementia care specialists attended 1,669 community outreach events, reaching nearly 31,000 people.[3] Outreach events included health fairs, information booths, public speeches, content-expert presentations, radio shows, and discussion panels.

Dementia care specialists also provide opportunities for individuals and family caregivers to participate in evidence-based programs to improve the experience and outcomes of both caregivers and people with dementia. Two of these opportunities include the Memory Care Connections (MCC) and the Language-Enriched Exercise Plus Socialization (LEEPS) programs. MCC is an evidence-based program (known elsewhere as the New York University Caregiver Intervention program) that provides family caregivers with the tools to care for their loved ones. The MCC program has been shown to help families care for loved ones at home an average of 18 months longer than without the support of the program. The LEEPS program provides opportunities for people in the early stages of Alzheimer's disease or mild dementia to engage in exercise and social opportunities. LEEPS has been shown to help individuals with dementia improve their physical fitness and mood as well as maintain functional ability.

[3] https://www.dhs.wisconsin.gov/publications/p01284.pdf

Location of Dementia Care Specialists in Wisconsin in 2014

Enhancing the Dementia-Related Services of Managed Care Organizations (MCOs)

Publicly funded long-term care programs, such as Family Care, can also support families in providing care at home. Most Family Care members live in home and community settings, with Managed Care Organizations (MCOs) contracting with a wide variety of care providers. Therefore, MCOs have an important role to play in promoting dementia-capable community services. The MCO is able to ensure appropriate, dementia-capable care for MCO members by using its relationship with its provider network to improve the dementia care available to the community at large.

As part of the redesign effort, each Family Care MCO has designated a dementia care lead who is trained to conduct memory screens and support members with dementia. MCOs have developed screening guidelines to ensure Family Care members are being screened consistently for cognitive issues. The dementia care leads act as internal resources to MCO staff in addressing how to best support members with dementia, their families, and professional caregivers. Each MCO has a dementia initiative work plan that identifies specific interventions, outreach activities, and trainings that will be accomplished each year.

Facilitating Early Identification and Screening

Community-based memory screening can help people take action quickly when they have concerns about memory loss or increased confusion. Memory screening is used to identify deficits in one or more areas of cognitive function including: memory, abstract thinking, attention, and reasoning. Screening can identify early signs of dementia, along with other potentially treatable causes of memory impairment. Facilitating early identification of cognitive issues allows for interventions and lifestyle changes at a stage when they have the greatest potential impact on the disease process.

Hot Air Affair: Increasing Awareness in the Hudson Community

The Hudson Hot Air Affair is the premier winter ballooning event and winter festival in the Midwest. Thousands of visitors head to the St. Croix Valley in west central Wisconsin on the first full weekend in February to enjoy family-friendly events. In 2016, one of the 36 balloons carried the banner, "LIVING with Dementia." The "LIVING with Dementia" balloon sponsors, brought together by the dementia care specialist of the St. Croix ADRC, wanted to share the story of living with dementia through a passenger ride experience.

Craig Smith and his daughter Emily were selected to ride in the balloon but unfortunately, due to weather conditions, the balloons couldn't fly. Instead, Craig, a former firefighter, and Emily were able to participate by riding on a fire truck during the parade and engaging the crowd about the importance of early identification of dementia. Craig, Emily, and Nancy Abrahamson, the dementia care specialist, handed out over 500 postcards at Hot Air Affair events with information on dementia and services available through the ADRC.

By the age of 52, Craig Smith had been diagnosed with frontal temporal dementia, a deterioration of the area of the brain that controls decision-making and behavior. The disease forced him to leave his jobs as an iron worker and volunteer firefighter. However, the disease has not stopped him from remaining engaged and living life to the fullest.

As previously stated, existing resources for memory screening now include ADRC and MCO staff. Additionally, DHS has engaged in information exchanges with Aurora Health Systems and the UW Hospital and Clinics about ways to encourage health care professionals to regularly conduct screenings when memory issues are noted and to provide diagnoses when applicable.

If a dementia diagnosis is obtained, the individual and family can be connected to appropriate services and supports, including the ADRCs.

Providing Support for Family Caregivers

Eighty-three percent of care provided to people with dementia living in the community is provided by unpaid caregivers, most often family members.[4] Acknowledgement and support for caregivers is essential to the Dementia System Redesign. Family caregivers often lack sufficient understanding to be able to appropriately respond to the needs of a family member with dementia or to recognize their own need for support. Many spouses and adult children whose parents develop dementia do not think of themselves as caregivers. They are often unaware of the physical and mental stress that being a caregiver has placed on them.

The Wisconsin Alzheimer's Family Caregiver Support Program (AFCSP) was created 30 years ago in response to the stress and needs of families caring for someone with Alzheimer's disease or a related dementia. The purpose of AFCSP is to make an array of community services available to families in hopes of relieving some of the stress on caregivers and helping to keep people in their homes as long as possible. Funds are available in each county for qualified individuals to purchase goods and services needed to care for someone with irreversible dementia. Supporting families who provide care for a family member with dementia can help them feel confident and competent in continuing to provide care as dementia progresses.

In 2015, DHS drafted an AFCSP Policy and Best Practices Manual to help support local programs. The new manual provides guidance to county and tribal coordinators about program requirements as well as best practices for reaching out to and serving families of people with dementia. The new manual is currently being updated to reflect changes to the program as a result of legislation passed in March 2016. The new provisions increase AFCSP respite care funding, change income eligibility requirements for participation, and include tribes as administering agencies at the local level.

Caregiving creates many life changes for caregivers. Serving as a caregiver can impact a person's physical health, create financial strain, and increase general stress levels, which can also lead to depression. These changes have the potential to affect an employee's job performance, but with the proper workplace support, employed caregivers can successfully manage both their

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[4] Alzheimer's Association "2016 Alzheimer's Association Facts and Figures," pg 32.

caregiving and workplace responsibilities. With help from many partners, DHS designed a web-based Dementia-Friendly Employers Toolkit (referred to as the Employers Toolkit in this section) to provide employers with the knowledge and tools needed to successfully support employees caring for a loved one with dementia. The Employers Toolkit explains the benefits that employers gain by being supportive of working caregivers. It includes information on an anonymous survey to help employers gauge the number of working caregivers in a company and offers suggestions for how to meet their employees' needs. The Employers Toolkit also provides a comprehensive list of caregiver support programs and classes available from local Alzheimer's groups, ADRCs, and other local agencies and groups that serve families with dementia. The Employers Toolkit was launched in October 2015 at an event in Lake Geneva that included Governor Walker, Secretary Rhoades, Former Governor Schreiber, and key partners.

Dementia-Friendly Employers Toolkit in Appleton

The Mayor of Appleton, Tim Hanna, has a personal connection with dementia. Both his sister and his mother were diagnosed with dementia and he has been active as his mother's caregiver and power of attorney for many years. At the Regional Public Meeting for Dementia-Capable Wisconsin in Appleton, Mayor Hanna shared, "I love the fact that we are talking about caring for the caregivers in our workplaces...I've struggled with it personally. I've talked to other people in our workplace that are going through the same thing with siblings or parents or other family members. So to have a resource, a toolkit to use as an employer, it's a very valuable thing and now we need to make people aware of it."

Hanna continued, "There is a stigma around behavior that makes people uncomfortable and stigma around being able to admit that you are caring for someone who has dementia. And we really need to push through that because when we push through that, that's when we rally those resources to provide the best care."

Developing Culturally Competent Innovative Programs

Minority communities are at an increased risk for developing dementia and face unique challenges that must be addressed to ensure that all communities have equal access to appropriate dementia care and services tailored to their needs. The Plan includes a goal of

developing innovative programs for engaging underserved populations and provides specialized dementia programming.

In September of 2014, DHS received two three-year grants from the U.S. Department of Health and Human Services Administration for Community Living (ACL) that support this goal including: the Alzheimer's Disease Initiative–Specialized Supportive Services (ADI–SSS) grant and the Alzheimer's Disease Supportive Services Program (ADSSP) grant. The primary focus of the grants is funding activities designed to enable people with dementia to live at home for as long as possible. The grants provide innovative programming and interventions for people with dementia who live alone, the African American communities in Dane and Milwaukee counties, people with intellectual and developmental disabilities (IDD), and caregivers of individuals with challenging behaviors. Interventions include:

- Expanding and enhancing the Share the Care™ program to create networks of family members, friends, neighbors, and volunteers to provide support for people with dementia who live alone.
- Providing outreach, screening, training, consultation, and other support for family caregivers and professional non-medical staff who support people with IDD and dementia.
- Developing awareness and expertise in the medical community concerning diagnosing dementia in individuals with IDD.
- Developing an online behavior management training course for family caregivers.
- Implementing the Music & Memory program (an innovative program that provides personalized music to people with dementia) in tribal community homes.
- Expanding the evidence-based Memory Care Connections program to African American communities.

In 2014, DHS released a competitive grant to fund three tribal dementia care specialists. The Oneida, Menominee, and St. Croix Chippewa were the three tribes who were awarded the funding. The goal of the tribal dementia care specialist project is to develop culturally appropriate dementia care services and family caregiver supports in tribal communities, as well as to aid tribes in becoming dementia capable and dementia friendly. The tribal dementia care specialists also provide support for the Tribal Music & Memory Program and help DHS to better understand dementia in tribal communities.

Engaging Students by Promoting the Department of Public Instruction Dementia Curriculum

A partnership between DHS and the Department of Public Instruction (DPI) resulted in the development of a dementia Brain Health curriculum for middle and high school health classes. The curriculum was piloted in partnership with the Clark Street Community School in Middleton, the Wisconsin Alzheimer's Institute, the DHS Music & Memory program, and the Wisconsin Alzheimer's Disease Research Center. After a successful pilot experience, DPI published the Brain Health Mini-Unit Guidance Document on their website for use by middle and high schools across the state.

Clark Street Community School Brain Health Curriculum Pilot

The Assembly Speaker's Task Force on Alzheimer's and Dementia, a group of state legislators created to make recommendations on policy initiatives related to dementia, visited a Clark Street Community School classroom to discuss the Brain Health curriculum with the students and teachers. Students shared their experiences with the curriculum and how dementia has touched their lives through members of their families. The principal and teachers described the importance of the curriculum and how community engagement opportunities provided valuable experiences for the students. The final report from the Speaker's Task Force included the recommendation to promote the Brain Health curriculum for use in classrooms across the state.

FACILITY-BASED LONG-TERM CARE

Approximately one in four Wisconsin residents with dementia is cared for in a facility-based setting: a nursing home, community-based residential facility, or adult family home. Residential

care apartment complexes are intended for a more independent population but may admit or retain residents with dementia under limited circumstances.

Nursing homes and assisted living facilities are regulated by the Division of Quality Assurance (DQA) at DHS. The responsibilities of DQA include licensing and certifying facilities as well as conducting periodic regulatory reviews. If problems are found during a review, DQA may require the provider to submit and comply with a plan of correction, obtain consultation or pay a fine or a Civil Money Penalty (CMP). Concern about the potential for regulatory violations and enforcement remedies have created a perceived barrier that prevents some facilities from admitting residents with challenging dementia-related behaviors.

The focus of this component of the Plan has been on identifying, sharing, and implementing promising practices to enhance the overall quality of life for facility residents with dementia. In addition, the Plan concentrates on identifying key factors leading to citations and providing guidance on how to prevent or reduce them.

Addressing Citations and Guidance on Reducing Their Incidence

To help address the barriers that may deter some facilities from admitting and providing ongoing care for residents with dementia who exhibit challenging behaviors, DQA developed strategies and best practice guidelines. These guidelines identify what facilities can do to provide good care, meet the needs of residents, and avoid the type of violations that typically result in enforcement action. DHS published the themes and guidance in Nursing Home Strategies to Enhance Quality of Life for Residents with Dementia and Assisted Living Strategies to Enhance Resident Care.

Promoting Promising Practices in Facility-Based Care for Individuals with Dementia

DQA encourages nursing homes and nursing home stakeholders to apply for grants of Civil Money Penalty (CMP) funds to use for projects that will benefit nursing home residents. Grants are available to qualified entities to fund proposals designed to improve the quality of life, care, and treatment of persons living in Wisconsin nursing homes.

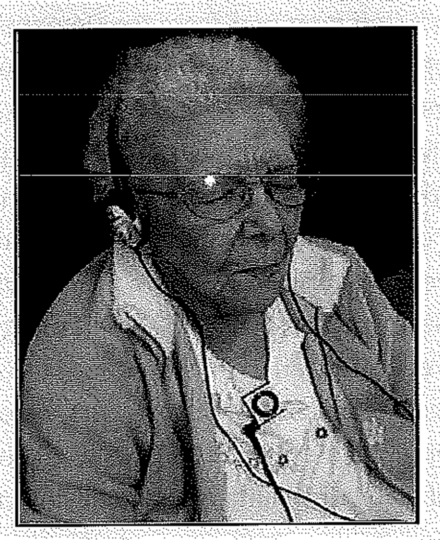
Recommendations for CMP-funded grants are made to the Secretary of DHS by the Quality Assurance and Improvement Committee (QAIC). QAIC is a cross section of long-term care stakeholders appointed to the Committee by the Secretary and includes nursing home staff members, nursing home residents, advocates, trade representatives, physicians, and nurses. DHS staff worked with QAIC, nursing home representatives, and other stakeholders to

encourage and facilitate requests for CMP money to fund training and programs to benefit nursing home residents with Alzheimer's disease or related dementias.

DHS used CMP grant funding to create and expand the Wisconsin Music & Memory program to bring personalized music to individuals diagnosed with Alzheimer's disease and related dementias. Wisconsin's program is based on the Music & Memory™ program founded by Dan Cohen in New York. Facility staff members work with family caregivers to create a personalized music playlist on an iPod for each person with dementia who chooses to participate. Personalized music provides an enjoyable activity for people with dementia, increases cooperation and attention, reduces resistance to care and agitation, enhances engagement and socialization, and provides a valuable tool to reduce reliance on antipsychotic medications.

The program has been expanded to over 300 Wisconsin facilities certified in Music & Memory™ serving over 3,500 people in nursing homes and assisted living communities. The success has spurred other states to promote similar programs. The Wisconsin Music & Memory program website provides more information.

Music & Memory with Margaret



Margaret's days in the nursing home were often spent in her room alone. During her activity interview, she only expressed that she had a passion for music.

Her life changed after she was enrolled in the Music & Memory Program. When Andrea Bocelli began to sing in Italian, Margaret's world stopped as her eyes shut and her head and body moved to the music. She went from spending time alone in her room, to visiting and being social during each meal. Margaret said, "Music makes me feel dreamy, you know, nice. It sends me, it's like I'm gone with the music."

CMP grants were provided for the following additional programs to help improve care and services for nursing home residents with dementia as well as reduce the use of antipsychotic medications:

- Chair Yoga program: Yoga poses are done seated on a chair or the chair is used for support during standing and balancing poses

- Namaste Care: End-of-life care for people with advanced dementia based on loving touch, aroma therapy, and other strategies to improve quality of life
- SNOEZELEN Multi-Sensory Environment room: A relaxing space that helps reduce agitation and anxiety, increase engagement, stimulate reactions, and encourage communication for the person with dementia
- Training for nursing home staff to increase skills and competency in approaches to prevent and manage residents with challenging behaviors
- Developing and implementing a comprehensive train-the-trainer education program regarding sexuality and intimacy in dementia care
- Dementia-related training for facility staff, using the curriculum developed by the UW-Oshkosh Center for Career Development & Employability Training (UWO-CCDET)

Efforts by Wisconsin nursing homes to become more dementia capable are exemplified by Wisconsin being one of the states leading the nation to reduce antipsychotic medications for residents with dementia. In a report on the third quarter of 2015, the National Partnership to Improve Dementia Care in Nursing Homes shows Wisconsin ranked sixth lowest in the nation in the use of antipsychotic medications for nursing home residents.

DHS staff members from the Dementia Care System Redesign team have visited seven nursing homes identified as providing high-quality dementia care to learn about their programs, innovative practices, and suggestions for improving the system. The facilities visited included private for-profit, not-for-profit, and publicly owned homes. Each visit included a tour of the facility and an open-ended discussion with facility staff to gain their perspectives on how best to care for elders with dementia. A number of promising practices were identified, with the overriding principle being a facility culture that is conducive to providing quality dementia care. These practices included: hiring caregivers who are empathic, patient, and flexible; involving direct care staff in decisions about resident care; addressing the underlying cause, rather than focusing on control of behaviors; recognizing and planning for the fact that many residents with dementia may have incidents of challenging behaviors; having regular access to psychiatric and behavioral consultation; and having crisis plans in place.

CAPACITY FOR CRISIS RESPONSE AND STABILIZATION

The Plan noted gaps in the current care delivery infrastructure in crisis response for people with Alzheimer's disease and related dementias. The Dementia Crisis Response Team focused on creating a model for dementia-capable mobile crisis response that includes treating people in place when possible, clarifying roles and responsibilities for crisis response and stabilization,

and addressing the need for appropriate placement options for people with dementia in crisis. Dementia-capable crisis response also requires a care system that is built around having trained staff and using care planning as a crisis prevention strategy to increase the success of stabilization efforts and reduce relocations of individuals during crisis.

Learning from Local Efforts

DHS staff consulted with counties and county consortia and visited long-term care facilities to learn about local efforts and challenges. These interviews helped guide the development of two surveys that were conducted to gain a better understanding of current practices across the state.

In November 2014, DHS received survey responses from 54 county crisis units regarding their capacity for responding to crises that involve people with dementia. A report titled, Wisconsin's Crisis Response System: Capacity for Serving Persons with Dementia, summarizes the status of crisis programs in the responding counties and provides information about training and resource needs for serving people with dementia in crisis. The key takeaway from the survey is that county crisis units are ill prepared because they lack dementia-specific training, tools to screen or assess people in crisis for dementia, clinicians who specialize in aging or care of older adults, and stabilization facilities for people with dementia in crisis.

In February 2015, DHS received survey responses from county adult protective service (APS) units in 72 counties and one tribe regarding how emergency protective placements are used for people with dementia. A report, Chapter 55 Emergency Protective Placements for Persons with Dementia in Crisis, was written based on survey responses. The report describes the results of the survey and how DHS will use the results to identify what is working well and where to focus efforts to improve the dementia capability of Wisconsin's crisis systems. The key takeaway is that almost all counties (90%) reported they do not have access to a sufficient number of facilities willing to accept emergency protective placements of people with dementia exhibiting challenging behaviors.

The results indicate that dementia-related crisis response varies considerably, with approaches differing in terms of agency configuration, relationships among partners, and the level of dementia expertise and capacity in the crisis response system. Effective solutions, when found, have been developed locally, and have typically involved cooperation among a variety of stakeholders including county APS and crisis response systems, care facilities, law enforcement, managed care organizations, and others. Also important are adequate training, an understanding that behavior is often a way to communicate needs, and planning with

prevention in mind. The findings from both surveys have helped inform the need for continuing local collaborative efforts to address problems related to responding to people with dementia in crisis and to emergency protective placements for this population.

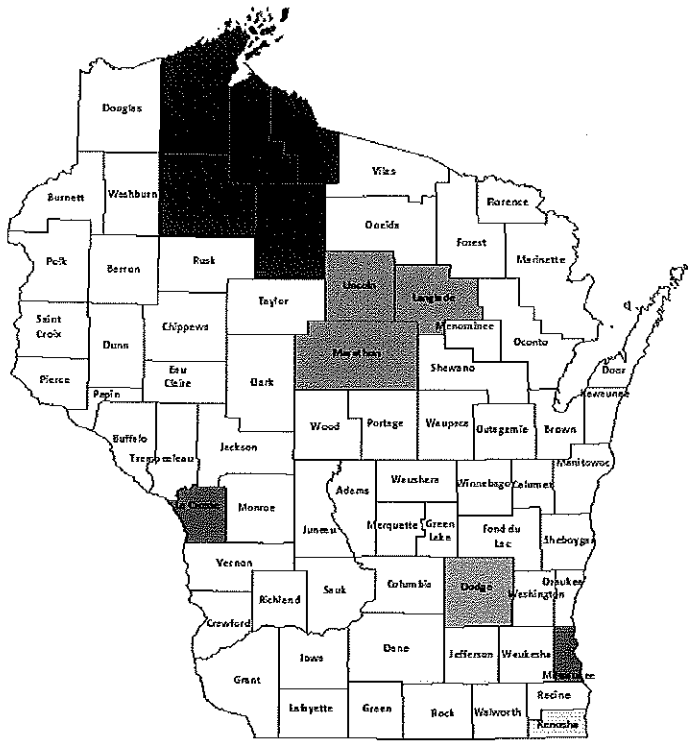
Building Collaborative Dementia-Capable Crisis Response

In October 2015, DHS offered a competitive funding opportunity for interested counties or consortia with a goal of building a more dementia-capable crisis response system. The applicants were encouraged to develop systems that would create the following in their proposals:

- A coordinated, dementia-capable approach to supporting people with dementia in crisis.
- An understanding of how to assess and plan for people with dementia as a way to avoid or de-escalate crises.
- Shared strategies to anticipate and capably respond to a crisis in the best interest of the individual.
- Local and regional care and crisis systems that emphasize stabilization-in-place and use emergency transfers as a last resort for people with dementia in crisis.
- Collaboration, communication, and trust among all parties who have a role to play in responding to and caring for people with dementia in crisis.

Six grantees, representing 12 counties, were awarded funds.

Counties and County Consortia that Received Dementia Crisis Innovation Grants



GUIDING PRINCIPLES AND TRAINING

In order to have a dementia-capable system of care, the Plan recognized that there must be a widely shared understanding of what constitutes appropriate and high-quality care for people with dementia. It is also important for providers to subscribe to that shared vision and to have a competent, well-trained workforce to provide needed care.

The Guiding Principles were developed through a contract with the UWO–CCDET. The project included a review of international and national standards as well as a process to gather ideas from Wisconsin stakeholders. The Guiding Principles supplement existing resources and provide common terminology and values that can be shared across stakeholder groups.

In May 2015, DHS finalized 10 principles for use in guiding the Wisconsin Dementia Care System. The Wisconsin Dementia Care Guiding Principles describe the values and practices necessary to provide high-quality, effective care and support for all people living with dementia. They also include a strong emphasis on prevention or mitigation of crisis situations that may

arise, and on the importance of consumer awareness, person-centered care, and community engagement.

In addition to posting the Wisconsin Dementia Care Guiding Principles booklet and an accompanying poster of the Ten Guiding Principles on the DHS Dementia-Capable Wisconsin website, DHS held regional presentations in the fall of 2015. The purpose of these presentations was to increase awareness of the Guiding Principles and other resources, to facilitate the sharing of stories of the Guiding Principles in action in communities around the state, and to promote grassroots engagement in making communities dementia-friendly.

O'Connell Pharmacy Adopts the Wisconsin Dementia Care Guiding Principles

O'Connell Pharmacy in Sun Prairie includes a retail location and a long-term care pharmacy, both with the mission to keep people at home and independent for as long as possible. O'Connell Pharmacy incorporated the Wisconsin Dementia Care Guiding Principles into their business model to better achieve this mission. By having the majority of their staff trained in dementia-friendly principles, they are able to serve their customers better and promote community awareness.

Their pharmacists are able to screen for cognitive impairment and refer to primary care physicians or specialized memory clinics, if needed. The pharmacy supports maximum independence and choice through their prescription delivery service, monthly medication sync program, "med box" program, and medication therapy management. These programs have shown improvement in medication adherence and health outcomes for patients. O'Connell Pharmacy provides individualized care and services by being flexible in regard to patients' needs and coordinates with local organizations to provide additional services.

DHS also contracted with the UWO–CCDET to create affordable and accessible dementia care training for a wide audience including: family caregivers; community members; nursing home and assisted living facility staff; police, fire and emergency personnel; and county crisis workers. After receiving extensive stakeholder input and working with a group of experts, UWO–CCDET initiated the creation of online dementia trainings on a variety of topics and a registry to record people who have successfully completed the trainings.

Recognizing that many additional training opportunities are needed for professionals and family members who care for with people with dementia, DHS created a catalog of dementia trainings

and posted it to the Dementia-Capable Wisconsin website in the form of a searchable list. For each of the trainings included on the list, there is a brief description of the intended audience, content, cost, availability, and contact information. The intended audiences include professionals in health care, social services or public health; paid caregivers; family caregivers; guardians (corporate, volunteer or family); powers of attorney; law enforcement, adult protective services, and other crisis workers.

Trainings are updated as new information fitting these requirements is submitted to DHS.

RESEARCH AND DATA COLLECTION

The Plan identified the need for data collection to facilitate quality measurement related to dementia care. The initial step was to estimate the Wisconsin population with dementia and identify the subset of that population served by Wisconsin's Medicaid program. A summary of the findings titled, Dementia Care System Redesign Data: Estimated and Projected Wisconsin Dementia Population, was published on the DHS website.

DHS also developed measures to monitor the impact of the dementia initiative. These measures included psychotropic medication use, hospitalizations, long-term care enrollment, and moves in and out of institutional and residential placements. For each measure, baseline data was analyzed and will be compared to data collected on a yearly basis.

CONCLUSION

The accomplishments described in this document highlight only some of the many achievements across the state. Since the Plan was initiated in 2013, these efforts have helped improve the quality of life and care for individuals with dementia. The momentum from the expanding conversation and focus on increasing Wisconsin's dementia-capability continued to grow into the creation of the Speaker's Task Force on Alzheimer's and Dementia.

Looking Ahead: The Wisconsin Cares Legislative Package

The Speaker's Task Force on Alzheimer's and Dementia, created in 2015, highlighted the need for education and resources for individuals with dementia and their family caregivers. This legislative group conducted public hearings throughout Wisconsin, resulting in the introduction of 10 dementia-related bills named the Wisconsin Cares Legislative Package. Out of the 10 Wisconsin Cares bills, three of them were passed by the Legislature in 2016 and signed into law. The Task Force published a Report of the Speaker's Task Force on Alzheimer's and Dementia that summarizes the work of the Task Force and includes recommendations for future legislative action.

DHS would like to thank all of the community partners and stakeholders for their many contributions in promoting the development of a more dementia-capable system of care in Wisconsin. Many exciting changes are happening in our state to reach our goal of every person with Alzheimer's disease and dementia having the highest quality of life possible in Wisconsin. We are all in this together and DHS looks forward to future collaboration in the coming years with partners and stakeholders in this exciting endeavor.