

ADRC Annual Update 2016

ADRC Name: Jefferson Submission Date: _____

Please submit the following documentation:

1. Contact Information

 X Appendix A

2. Governing Board

 X Appendix B

3. Organizational Documentation

 X Personnel Worksheet (Appendix C)

 X ADRC Organization Chart (Please attach; include position titles)

4. Budget Information and Subcontract Information

 X Appendix D

 X Appendix E - N/A

5. ADRC Success Story

 X Appendix F

6. Quality Improvement Project for 2015

 X Please attach a completed Change Project Report or Change Project Summary for your 2015 Performance Improvement Project.

7. Required Policies & Plans

 X Please attach Short-Term Service Coordination Policy

 X Please attach Complaint & Appeal Policy

 X Please attach Quality Assurance Plan

8. Regional ADRC Management Plan (for regional ADRCs)

 Please attach Regional ADRC Management Plan

***Note:** Format is now in Word. When you go to enter information into either Appendix D or E, simply double click into the table. This will open up like a spreadsheet in Excel, yet you are still in your original Word document. When you have entered in everything, please scroll back up to the top of the table and click outside of the table. It will then let you move up and down in the original document. You can still do everything you would normally do in Excel, in this format. *

Please attach all documentation to one email message and send to your Regional Quality Specialist with a cc to DHSRCTeam@wisconsin.gov by **January 4, 2016**. For RQS contact information please go to:

<https://www.dhs.wisconsin.gov/adrc/pros/adrcqualityteam.pdf>

Appendix A - Contact Information 2016

ADRC Contact Information (Please designate one lead staff for the identified program area within the ADRC, this includes one lead for regional ADRC's)

	Name	Office Telephone	Email Address
ADRC Director	Susan Torum	920-674-8136	suet@jeffersoncountywi.gov
Secondary Contact	Sharon Olson	920-674-8139	sharono@jeffersoncountywi.gov
Financial Contact	Joan Daniel	920-674-8147	joand@jeffersoncountywi.gov
Client Tracking Database Lead	Sharon Olson	920-674-8139	sharono@jeffersoncountywi.gov
Resource Database Lead	Sharon Olson	920-674-8139	sharono@jeffersoncountywi.gov
Dementia/Memory Screen Lead	Cathy Kehoe	920-675-4035	cathyk@jeffersoncountywi.gov
Functional Screen Liaison	Karen Tyne	920-674-8731	karent@jeffersoncountywi.gov
DBS Supervisor Contact	Sharon Olson	920-674-8139	sharono@jeffersoncountywi.gov

The contact for each of the areas listed above will receive information from the Department, respond to requests for information and share relevant information within the ADRC.

Outreach Locations

For single county ADRCs, indicate if your ADRC has any satellite/outreach locations other than your main office building.

Location:	N/A
Days Open:	
Hours:	

Resource Center Information		Governing Board Chair*	
Mailing Address:	1541 Annex Road	Name:	Earlene Ronk
Street Address:	1541 Annex Road	Mailing Address:	551 Fairway Circle
City, State, Zip:	Jefferson, WI 53549	City, State, Zip:	Jefferson, WI 53549
General Phone:	920-674-8734	Contact Phone:	920-265-6308
Fax:	920-674-7603	Email:	earlener@gmail.com
Toll Free Phone:	866-740-2372		
Email Address:	adrc@jeffersoncountywi.gov		
Web Address:	www.jeffersoncountywi.gov		
TTY/TDD/Relay:	800-947-3529 TTY 920-674-5011 TTD		
Office Hours:	8:00 a.m.-4:30 p.m. M-F		

*This information is for use by ORCD staff only and will not be shared without permission.

For a regional ADRC, list address and contact information for each branch or satellite.

Name:	
Street Address:	
City, State, Zip:	
General Phone:	
Fax:	
Toll Free Phone:	
TTY/TDD/Relay:	
Office Hours:	
Site Manager:	
Direct Line:	
Email Address:	

Name:	
Street Address:	
City, State, Zip:	
General Phone:	
Fax:	
Toll Free Phone:	
TTY/TDD/Relay:	
Office Hours:	
Site Manager:	
Direct Line:	
Email Address:	

Name:	
Street Address:	
City, State, Zip:	
General Phone:	
Fax:	
Toll Free Phone:	
TTY/TDD/Relay:	
Office Hours:	
Site Manager:	
Direct Line:	
Email Address:	

Name:	
Street Address:	
City, State, Zip:	
General Phone:	
Fax:	
Toll Free Phone:	
TTY/TDD/Relay:	
Office Hours:	
Site Manager:	
Direct Line:	
Email Address:	

Appendix B- Organizational Structure & Governing Board 2016

Please complete the requested information in the space provided.

Name of Board Member	Representative of: (e.g. elders, PD, DD, county board, or other representation)	Term of Appointment (Date from & to)
1. Earlene Ronk, Chair	Elder	07/2012-07/2018
2. Marcia Bare	Elder	07/2015-07/2021
3. Dan Krause	PD	07/2012-07/2017
4. Carol Battenberg	Elder	07/2012-07/2017
5. Connie Stengel	Elder	07/2013-07/2019
6. Ellen Haines	DD	07/2013-07/2019
7. Carolyn Niebler, Sec'y	Elder	07/2013-07/2019
8. Russell Kutz, Vice Chair	County Board	07/2015-07/2021
9. Vacant		

Please remember that County Board members cannot represent a target group.

1. Is the ADRC integrated with the Aging Office? Yes ☒ No ☐

Regional ADRC's please specify by office:

County _____ Yes ☐ No ☐

County _____ Yes ☐ No ☐

County _____ Yes ☐ No ☐

County _____ Yes ☐ No ☐

County _____ Yes ☐ No ☐

2. If the ADRC is regional is the Aging Office also regional? Yes ☐ No ☒

3. Is the ADRC governing board combined with the Committee/Commission on Aging? Yes ☒ No ☐

4. Does the ADRC Governing Board report to another entity? Yes ☒ No ☐

5. If the ADRC Governing Board reports to another entity, to what entity does the board report?

County Board ☐ Human Service Board ☒ Other ☐ _____

6. How often does the board meet? Monthly ☒ Quarterly ☐ Other ☐ _____

7. How frequently does the board report to its larger governing body? Monthly ☒ Quarterly ☐

8. What are the term limits for board members? 2 consecutive, 3 year terms _____

9. If you are a regional ADRC, what is your governance structure?

LTC District ☐ 66.0301 Agreement ☐ Subcontract ☐ MOUs ☐ Other ☐ _____

10. If you are a regional ADRC, do you have a fiscal agent? Yes ☐ No ☐

If yes, please provide the name of the entity / county: _____

Appendix C- Personnel Worksheet 2016

Please include all ADRC staff, whether lead agency or satellite employee. Please report non-government agency subcontracted staff on Appendix E only.

*All Functions should include: I&A, Options Counseling, Enrollment Counseling, LTCFS, DBS, outreach, etc. Include non-ADRC activities if applicable. Please include only one staff member per line. See example.

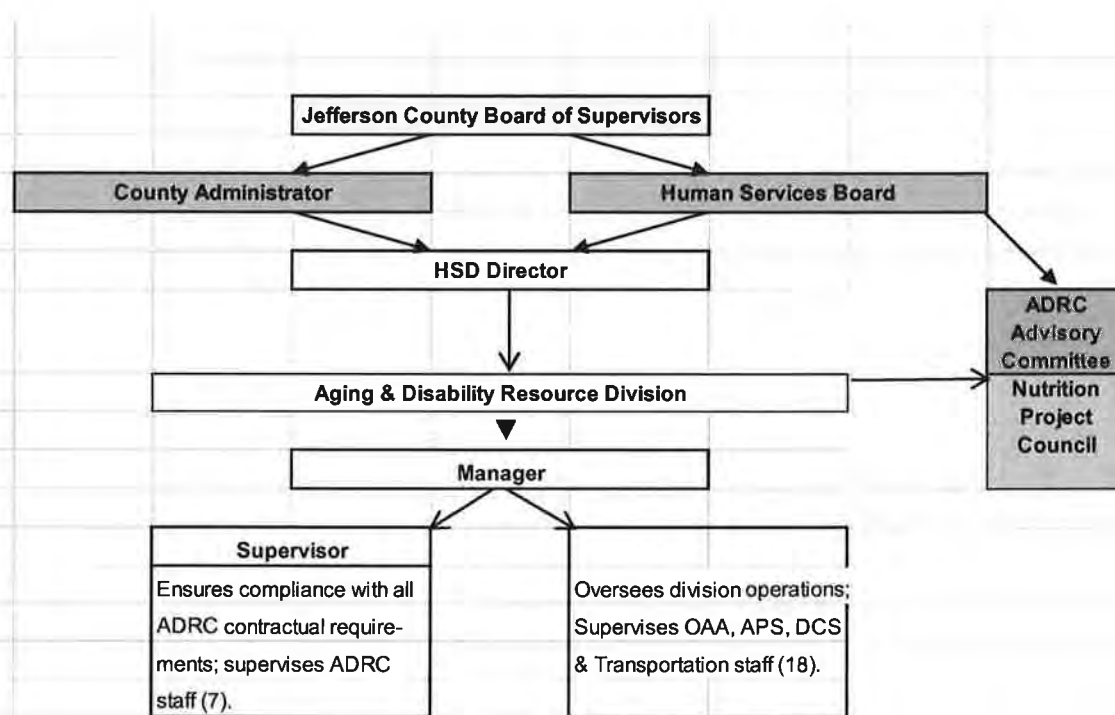
**% FTE funded by ADRC \$ should include contract \$ and federal \$ combined (do not need to separate these funds on this form).

NOTE: IF POSITIONS ARE SPLIT (either duties OR funding), Show the **full** FTE of the position and the **total** annual salary. Then note the % that is ADRC funded and the % funded by other \$, the other source(s) must be listed as well as the method for allocating funds.

Position Title (Please indicate if LTE)	Employee Name (full first and last name)	<input checked="" type="checkbox"/> If AIRS Certified	All Functions* (ADRC and other) performed by this individual (see example below - please include % of time if non-ADRC)	Total FTE for this Person	Annual Salary per Person (not fringe)	% FTE Funded by ADRC \$** (all funds see note)	% FTE Funded by Other Source (list source)	<input checked="" type="checkbox"/> Method for allocation of Split Funded Positions		
Directors/ Supervisors Section								100% Time Reporting	By FTE	By Work Effort
Director	Susan Torum	<input type="checkbox"/>	Plans, directs, implements and monitors the operations of the ADRC which encompasses the OAA Programs, S85.21 Transportation Services & Adult Protective Services	1.00	86,174	31%	Title III = 29% DOT = 22% APS = 9% Elder Abuse = 9%	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Supervisor	Sharon Olson	<input checked="" type="checkbox"/>	Oversees the day-to-day operations of the ADRC, supervises Aging & Disability Specialists & DBS, and oversees 100% time reporting. Maintains training calendar.	1.00	66,809	100%		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other Staff Section								100% Time Reporting	By FTE	By Work Effort
Aging & Disability Resource Specialists	Dominic Wondolkowski Karen Tyne Nancy Toshner Paul Gephart Vacant	<input checked="" type="checkbox"/>	Each Aging & Disability Specialist is expected to perform all of the 16 activities that the ADRC is required to report on. Aging & Disability Specialists salaries and benefits are 100% funded via the ADRC contract. Dominic Karen and Nancy are AIRS certified.	1.00 1.00 1.00 1.00 .48	55,848 59,009 55,848 44,283 20,276	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elder Benefit Specialists	Denise Grossman Alyssa Kulpa	<input type="checkbox"/>	Elder benefit specialists (EBS) help answer questions and solve problems related to Social Security, Medicare, health insurance and other public and private benefits for older adults.	1.00 .48	55,848 20,276	62% 62%	2% Tax Levy 5% SPAP 8% SHIP 23% State EBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability Benefit Specialists	Sandy Free Nicole Lawrence	<input type="checkbox"/>	Disability benefit specialists (DBS) help answer questions and solve problems related to Social Security, Medicare, health insurance, and other public and private benefits for people with	1.00 .48	55,848 20,276	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Paraprofessional	Deb Miller	<input checked="" type="checkbox"/>	disabilities. The purpose of this position is to provide the ADRC with general clerical support and to respond to customer requests for general information about community resources and public benefit programs.	1.00	37,960	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia Care Specialist	Cathy Kehoe		The purpose of this position is to provide support to families and individuals diagnosed with dementia; train and support ADRC staff to ensure that it is dementia capable and provide community outreach and education to create a dementia friendly community.	1.00	45,152	100%		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Totals:				11.5						

Appendix C - Organizational Chart



Appendix D - Annual Budget 2016

Line Item Budget: Include the following information. Regional ADRCs, provide information for the entire entity.

***PLEASE** list what is included in the Administration/AMSO line. Example: Rent, Phone, Corp Counsel, etc.

You do not have to itemize costs by what is included, just identify the expenses included.

Rent must be reflected in the Direct Expense, Indirect Expense Admin/AMSO, or note at the bottom rent not paid.

The ADRC Grant Funding column **MUST** equal the ADRC base contract amount.

Subcontract section should equal amount shown on Appendix E.

MA Match Funding can be added together for multiple contracts (ADRC, NH Reloc, DCS, EBS) & reported in same column.

	ADRC Grant Funding	MA Match Funding	Dementia Care Specialist Grant (if applicable)	Nursing Home Relocation Grant (if applicable)	Other Funding (if applicable) Please list	Grand Total
ADRC Program Personnel:						
Salary	273,247	191,272	45,600	21,700		531,819
Fringe	117,680	77,788	19,152	6,500		221,120
Subtotal	390,927	269,060	64,752	28,200	0	752,939
Direct Expenses:						
Travel	3,314	2,914	2,590	300		9,118
Training	1,700	1,734	3,300	300		7,034
Printing						0
Postage						0
Office Supplies						0
Telephone						0
Computer & Related	1,330	1,120	800	200		3,450
Rent/Lease						0
Equipment						0
Equipment Maintenance						0
Certifications/Professional Dues						0
Translation Services						0
Outreach/Marketing	1,134	938	1,000			3,072
Other Direct Expenses						0
						0
Subtotal	7,478	6,706	7,690	800	0	22,674
Indirect Expenses:						
Administration/AMSO	101,351	64,740	7,558	1,000		174,649
*(Please indicate what is included)						0
Does the ADRC pay rent? No						0
Subtotal	101,351	64,740	7,558	1,000	0	174,649
Subcontracts:						
(include for staff or activities)						0
						0
						0
						0
Subtotal	0	0	0	0	0	0
TOTAL EXPENSES:	499,756	340,506	80,000	30,000	0	950,262

Appendix E - Subcontract 2016

Please complete when appropriate

Contractor Name	Position Title	If AIRS Certified please include an X	All Functions (ADRC and other performed by tis individual)	Staff Name*	Total FTE%	% FTE Funded by ADRC	Annual Salary	Cost
								0

*If the subcontract is for ADRC staff, please complete all columns (see example below). However, if you contract with an agency (such as a marketing firm or the Public Health Department) for a specified service, you only need to complete the Contractor Name, Contracted Work and Cost columns.

Contractor Name				Staff Name*	FTE		Annual Salary	Cost
Employment Resources				Julie	1		38,500.00	
				Chris	1		38,500.00	
				Kathy	1		38,500.00	
				fringe, travel, etc	n/a		35,000.00	
								150,500.00

The total cost of \$150,500 would equal the amount shown on Appendix D Subcontract Section for Employment Resources. Please insert additional lines as needed.

Contractor Name				Staff Name*	FTE		Annual Salary	Cost
XYZ Marketing				Super Marketing Firm	n/a		n/a	25, 000.00

Appendix F- ADRC Success Story from 2015

Use the space provided below.

- 1) Please share a success story about a customer with dementia who was assisted by the ADRC.
(Do not share name or other identifying information.)

Story 1: Worker received a phone call from an individual who was concerned about the cognitive health of a friend. The consumer suffered a stroke 6-7 years ago resulting in memory impairment. A report from the caller state concerns of medication mismanagement, forgetting to eat, poor personal hygiene, and the continuation of operating a motor vehicle with memory impairment. The individual currently lives alone and denies any cognitive impairment. Worker provided a home visit in August of 2015 discussing transportation services, volunteer organizations, pharmacy relocating, assisted living and nursing home options, PF LTC programs and eligibility, the Estate Recovery Program, NFCSP, supports for individuals and family members coping with memory loss, and privately paying for in-home services to remain independent. Worker offered to provide consumer with a memory screen to obtain a cognition baseline. The consumer was hesitant to participate in a memory screen, but ultimately agreed to the testing to satisfy the reporting party. The consumer scored a 9 on the Animal Naming Test, and 1 out of 5 on the Mini-Cog Test suggesting the possibility of the existence of cognitive impairment. The consumer demonstrated difficulty and frustration with their inability to successfully draw a circular clock that read ten after eleven. After the memory testing was complete, worker discussed the benefits of sending the test results to their primary care physician. The consumer provided worker with written permission to send their memory testing results to their primary care physician. The consumer declined assistance from the Aging and Disability Resource Center reiterating he was not in need of any immediate assistance.

In November of 2105, worker received another personal call from the previous caller indicating their friend was now ready to accept services. Worker provided consumer and the reporting party with another home visit to review community resources and options. The consumer disclosed personal assets of approximately \$300,000.00. The consumer discussed his desire to sell his home and move to an assisted living facility. Worker reviewed assisted living options in Jefferson and Dodge County. The consumer discussed interest in an assisted living facility where a family member was currently living. Worker assisted the consumer with contacting the administrator of the selected assisted living facility to gather additional information. Worker facilitated the personal call identifying the availability of private rooms, monthly cost, services provided including assistance with activities of daily living, medications, meals, housing, utilities, cable, and their acceptance of public funds in the event the consumer depletes their assets. Worker coordinated the sending of an admittance application to the reporting party as requested by the consumer. Worker also coordinated a tour of the assisted living facility. The person of concern ultimately made the decision to move to the elected assisted living facility and privately pay for services.

Story 2: ADRC Specialist met with an individual who did not have a diagnosis of Dementia. He just moved to town to live with his sister and a niece that lived nearby. This person was exhibiting signs and symptoms of Dementia. He was getting forgetful and was very suspicious of his family. He was accusing a nephew of stealing a coin collection he had years ago. His sister and her daughter were very frustrated in dealing with him because his personality was changing. He was very paranoid, angry and fixated on the topic of his coin collection. Options counseling was done with this family and they decided to private pay for services in the home when needed. The worker performed a memory screen with the individual which indicated there was a problem with his memory. He gave permission to send this testing to his new primary physician in town. Although the physician did not feel there was an issue with his memory, the family was referred to our Dementia Care Specialist, who instructed the family on some caregiving techniques to use when he was feeling frustrated. His sister and niece took the Powerful Tools For Caregiving Class. The Dementia Specialist reported that the family was coping a lot better

with techniques from the Powerful Tools For Caregiving Class.

- 2) Please share a success story about a customer whose need for publicly funded long term care was delayed or not needed due to the services he/she received from the ADRC?

Story 1: ADRC was contacted in August 2015 by the nephew of an elderly lady. We had a phone conversation about consumer's situation. Nephew was to follow-up with getting a medical appointment scheduled, as consumer has not been to a doctor for 2+ years. Home visit was set up for Options Counseling. Options Counseling was done with nephew and consumer at the home of the consumer. As a result of this meeting, nephew began checking into consumer's financial situation. He found that his aunt had a life insurance policy with cash value. Consumer already had a burial trust in place, so nephew began using the money from the insurance policy for in-home services. After a couple of months, nephew increased the in-home services to include personal care. Home-delivered meals were also set-up for consumer. At this time, consumer does not qualify financially for PFLTC programs, but nephew will continue to monitor services and finances for his aunt. A LTC FS was completed and consumer does qualify functionally. Review of MA application was done with nephew so he has an understanding of what documents will be needed at that time.

Story 2: On 8-31-15, ADRC staff met with a married couple to provide options counseling. ADRC staff had contact with adult children in 2014 when the husband was in a NH for rehab. Since his return from the NH, he has managed with assistance from his wife and adult children. The wife has a history of falls and fell on 4-6-15, fractured her femur bone, and spent two months in a nursing home for rehabilitation. The adult children believe their parents need to move from their private home to senior apartment or assisted living. The home is cluttered and they could benefit from chore assistance. Their two sons reside immediately next-door and help by bringing in their mail, plowing and shoveling the snow, mowing their lawn and will stay at the home when parent's shower as a precautionary measure. Their grandson helps with all housework. They have \$27,000 in cash assets and could apply for MA and LTC enrollment, but elected not to.

Pros and cons of enrollment in a LTC program versus waiting until there is greater need or until they lose informal supports was reviewed. Pros in reference to enrollment would include: having M.A. thus another layer of health insurance coverage. Also, having other supports to give informal supports a break or be used less often. Cons reference LTC enrollment include: being subject to estate recovery. In the end, the couple declined LTC enrollment.

ADRC staff provided referral/printed materials on the National Family Caregiver Support program as an alternate option. Low-income housing options for seniors were also discussed. ADRC staff was able to educate the couple and their adult children about their options and some resources available in lieu of using public assistance.

“Kindness is a language that the deaf
can hear and the blind can see.”

Mark Twain

Aiming For Excellence Project - ADRC of Jefferson County 2015

**On a Friday afternoon, a daughter of a
consumer contacted Staff at the
ADRC to request a sign language
interpreter so she can participate in
the conversation with her mother at
the home visit that was scheduled for
the following week.**

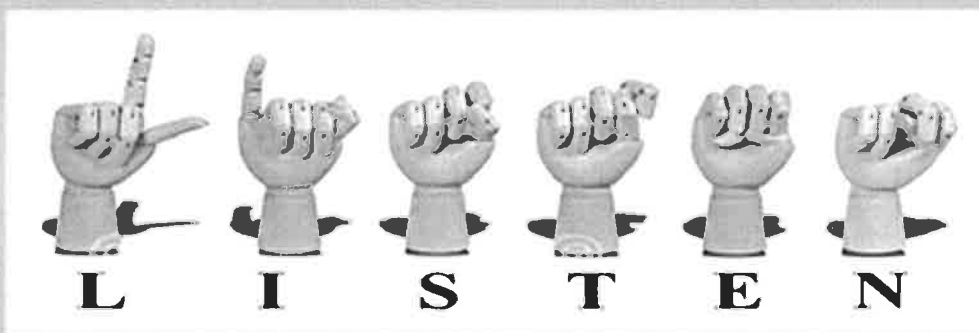
**Several contacts were
made but a sign
language interpreter was
not available for the
scheduled meeting that
Wednesday....**





Our agency had contracted language and sign language interpreters so staff were able to contact and arrange meetings with consumers. The ADRC also established Language Line to be able to meet with consumers who may not speak English.

The concept was to remove the language barrier and enhance our ability to offer an *immediate*, personal and professional conversation to address questions and provide information and assistance to all our consumers.



The Daughter's Request

"I wish to advocate consideration of using a remote interpreting service using a tablet when an onsite interpreting service is not available.

I suggest that ADRC consider this option for Deaf residents living or having relatives living in Jefferson County."

BIG AIM: Reduce customer wait time in securing an interpreter to provide information and unrestricted communication .



Small AIM:
To provide immediate customer service for a consumer and / or their family member who may be deaf or hard of hearing.

The ADRC now has Interpreter Service thru Language Line using the IPAD. Our contract is for all spoken languages as well as American Sign Language. This technology will expedite our customer service. We should no longer need to schedule office visits and home visits in accordance with an interpreters schedule.



The Power of Language Line U

IMPAIRED
scared/055
dark
misunderstood
fear
senses
silent
LOST
gone
confused
different
alone
tears
questions
trapped
mind

HOPE
special
FAITH
LESSON
hands
smile
family
society
INDEPENDENT
interpreter
sign



Short-Term Services Coordination Policy

Performance Goal: People who unable to manage for themselves receive assistance in arranging and coordinating services to assure their needs are being met.

The Aging & Disability Resource Center (ADRC) of Jefferson County will provide short-term services coordination (STSC) provided that funding is available to cover the costs of the service. Jefferson County defines short-term as being 90 days or less.

STSC is intended to provide care coordination services to individuals and their families who require assistance in coordinating community services. STSC services may be approved by the ADRC Supervisor in the following situations:

- Complex services needs have been identified and the individual and/or family members are unable to coordinate these services themselves, and there is no one else to take the lead.
- The person cannot be enrolled in a managed care program.

When a customer has been identified as needing STSC, the Aging and Disability Resource Specialist will provide options counseling to evaluate the individual's needs, resources and their ability to handle the situation. The Resource Specialist will develop a plan involving formal supports and/or recruiting natural supports with the goal to address the immediate concern and stabilize the individual's situation. While a formal care plan is not required, basic information about the services that are needed, the actions to be taken and services to be provided, and the responsibilities of the various parties involved with the person will be documented and shared via the DHS duplicate Next Steps forms F-00888.
<https://www.dhs.wisconsin.gov/forms/f0/f00888.pdf>.

The procedure for monitoring these situations is as follows:

1. When STSC is needed, consult with the ADRC Supervisor to discuss the situation, initial plan and to get approval to provide STSC services.
2. Meet with the individual and jointly develop a service plan which addresses all needs, and includes identifying natural, informal and formal supports and fee-for-service options.
3. Review at the ADRC team meeting to discuss and reevaluate.
4. Schedule a staffing with everyone involved within the first 15-days to discuss the plan as it relates the customer's needs, concerns or issues and termination of STSC services provided by the ADRC.
5. Reassess as needed.
6. Educate others within the support network as to their roles and responsibilities.

The Aging and Disability Resource Center may refer people for private pay case management services, including those that may be offered by the managed care organization(s) in its service area, if staff time or funding is unable to meet needs for short-term service coordination or the person needs ongoing care management services.



Internal Quality Assurance & Quality Improvement Plan

Performance Goal: The Aging & Disability Resource Center provides quality services and incorporates the principle of continuous quality improvement in its operations.

A. Activities to ensure that staff are knowledgeable and skilled

- Aging & Disability Specialists must possess a Bachelor's Degree or equivalent in Social Work or Human Services Field. Two years' experience in the Long Term Support field as a Care Manager, Benefit Specialist or equivalent. All specialists must successfully complete the AIRS Certification within first year of employment and passing score on Long Term Functional Screen within 60 days.

Disability Benefit Specialists receive Training and direct case oversight by State Contracted Program Attorney.

- Staff orientation is provided by the ADRC supervisor using the New (11/2015) ADRC Staff Orientation Plan: <https://www.dhs.wisconsin.gov/publications/p0/p00629a.pdf>. New Staff will attend the Orientation for New I & A Specialist when offered thru DHS.
- An annual Training Needs Survey is reviewed to identify ongoing training needs.
- Staff performance is monitored and evaluated annually. Coaching for Performance Action Plan will be established in 2016 for each ADRC staff person in the areas of Options Counseling, Enrollment Counseling and Disenrollment Counseling.
- Peer support is highly used in the ADRC to help orient and train new staff members. The ADRC team meets bi-monthly, motivational interviewing meetings meet monthly and other types of training is offered as needed and as offered.

B. Activities to ensure quality information and assistance and options counseling

- The ADRC Supervisor's office is in the same location as the staff. There is an open-door policy for case consultation or other issues. The supervisor is AIR'S certified and attends all ORCD trainings and meetings to keep abreast of policies. Coaching, training, reading case notes, making joint home visits and listening in on phone calls are all part of ensuring that staff are providing quality information.
- The SAMS database is updated every 6 months and incorporated into the ADRC website.
- The Aging and Disability Resource Specialists are required to be trained in Motivational Interviewing thru the DHS webcasts and participate in-person training.
- The ADRC supervisor reviews all available information when conducting quality assurance reviews to ensure that timelines are met, follow up is provided and that one-on-one contacts are occurring in a timely manner.

C. Activities to ensure quality enrollment counseling

- ADRC staff who provide enrollment counseling are highly trained in this specialized area and adhere to the Jefferson County Enrollment Plan.
- All enrollments are reviewed by the ADRC supervisor and maintained on an internal spreadsheet. Case files are randomly pulled and staffed with the individual who did the enrollment counseling. Contract compliance with timelines are reviewed as well as the LTCFS and relevant paperwork.
- The ADRC Supervisor, ADRC Director and Economic Support Supervisor have monthly meetings with the Managed Care Organizations and IRIS Manager to discuss concerns and review process improvement for enrollments and change routing referrals.

D. Activities to ensure that the long term care functional screen is applied accurately and consistently

- The lead screener is an RN who receives and provides ongoing staff training as directed by DHS.
- The lead screener and supervisor review LTCFS's on a monthly basis.
- The lead screener consults with DHS on difficult screen decisions.
- The ADRC staff administers the LTCFS consistent with the requirements in the *Wisconsin Long Term Care Functional Screen Instructions*. Adult Long Term Care Functional Screen Instructions | Wisconsin Department of Health Services.
- All staff members participate in the Continuing Skill Testing. The lead screener coordinates the testing and maintains an up-to-date list of screeners. LTCF Screener's are deactivated prior to leaving the ADRC.

E. Activities to ensure that quality Disability Benefit Specialists services are provided

- Maintains weekly/bi-weekly contact with supervising attorney via Disability Rights WI.
- Meets with ADRC Supervisor as needed on cases.
- Attends all required trainings and others as identified.
- Works with Elderly Benefit Specialist Assistant when backlogged to ensure timeliness of disability applications.
- DBS has a private office and there are private conference rooms when needed.

F. Collecting and reviewing data to assess the quality of ADRC operations.

- The ADRC utilizes the Aiming for Excellence model, a process for initiating, implementing and documenting continuous quality improvement within its organization.
- At least one focused performance improvement project is completed annually that examines aspects of services related to improving resource center quality and customer satisfaction.



Your Rights & the Grievance Procedure

As a customer of the Aging & Disability Resource Center (ADRC) of Jefferson County you have the right to be treated with dignity and respect. You have the right to register complaints/grievances and exercise your full due process rights regarding services provided by the ADRC, Managed Care Organization or the self-directed supports waiver program called IRIS, *Include, Respect - I Self Direct*. There will be no reprisal to you for using the process.

Please Note: You may access step 3 of the appeal process, without having gone through Step 1 and 2. Accessing Step 4 is subject to specific criteria as listed in the section titled - Step 4: State Fair Hearing Process. You are responsible for initiating your grievance within 45 days of the event you are grieving

Step 1: Informal Internal Grievance

Many grievances can be resolved at this level, and you are encouraged to contact an ADRC Information & Assistance Specialist and/or the ADRC Supervisor to register your complaint before initiating the formal process. The informal process begins on the date that the ADRC receives it, whether it is in writing on a grievance form, blank sheet of paper or by any other method through which you ordinarily communicate.

Once the grievance is received, the ADRC Supervisor will have 10 business days to resolve it. This may include a face-to-face meeting with you and anyone you wish to bring with you. You will be notified in writing of the outcome of your grievance and of the time limits for accessing other steps of the process. You will have 10 business days from the conclusion of the informal internal grievance process to request a formal internal grievance

If informal internal method does not resolve your issue, the formal internal grievance process is the recommended next step in the process.

Step 2: Formal Internal Grievance

Formal internal grievances should be addressed to the Aging & Disability Resources Division Manager. If the informal internal grievance process is bypassed, the formal internal grievance time limit for filing within 45 days of the event must be followed.

To file an Informal or Formal Internal grievance, call, write, fax or email the complaint to:

ADRC of Jefferson County
1541 Annex Road,
Jefferson, WI 53549

1-920-674-8734 (Voice)
1-866-740-2372 Toll-free

E-Mail: adrc@jeffersoncountys.us

The Aging & Disability Resources Division Manager will work with you to resolve your complaint within 15 business days.

Step 3: Formal External Grievances

The formal external grievance process can be accessed before, during or after the ADRC's internal process.

Complaints Relating to the ADRC:

Aging and Disability Resource Center Complaints

Office for Resource Center Development
Division of Long Term Care
Wisconsin Department of Health Services
P.O. Box 7851
Madison, WI 53707-7851
Phone: 608-266-2536
Fax: 608-267-3203
E-Mail: DHSRCTeam@wisconsin.gov

[Indicate "ADRC Complaint" in the subject line ADRC Quality Assurance Specialist

DHS

Complaints Relating to IRIS. The ADRC shall, upon request, assist IRIS participants in its service area in filing complaints with the Department. Complaints relating to a service provider, the ICA or the Financial Services Agency shall be made to the Independent Consultant Agency by calling 1-888-515-4747 or emailing info@wisconsin-iris.com:

Complaints Relating to Managed Care. The ADRC shall, upon request, assist members of MCOs in its service area in filing complaints with the Department.

Step 4: State Fair Hearing Process

ADRC customers have the right to a state appeal, if filed with 45 days, after receipt of a notice of a decision or failure to act regarding the following types of grievances: Determination of ineligibility for long-term care benefits; Determination of cost sharing for long-term care benefits; Determination that the person is eligible for, but not entitled to, the Family Care benefit as specified in s 46.286 (3) Stats.; Determination in regard to divestment, treatment of trust amounts and protection of income and resources of couple for maintenance of community spouse; and Failure of a Case Management Organization to provide timely services and support.

To access the state appeal process, call, write or fax the request to:

Division of Hearings & Appeals
5005 University Avenue, RM 201
Madison, WI 53703
1-608-266-3096 (Voice)
1-608-264-9885 (Fax)

For all other matters, the Department's review process must be utilized prior to using the State Fair Hearing Process.

Advocacy Organizations

The ADRC maintains a list of advocacy organizations that may be available to help you file an appeal. It will be provided upon request.

Jefferson County Statistics:

63,105 people age 20+ - 19th in WI

County ¹	Total Adults (Ages 20+) ⁴
Milwaukee	702,410
Dane	382,760
Waukesha	294,510
Brown	186,110
Racine	145,830
Outagamie	132,955
Winnebago	128,105
Kenosha	124,180
Rock	119,340
Marathon	100,390
Washington	99,970
La Crosse	88,705
Sheboygan	86,595
Fond du Lac	77,855
Walworth	77,165
Eau Claire	75,555
Dodge	68,180
Ozaukee	64,840
Jefferson	63,105

3.8% (2,398) are on EBD MA - 52nd in WI

54.9% (1,311) of EBD MA in LTC - 2nd in WI

County ¹	% MA EBD in LTC
Ozaukee	58.9%
Jefferson	54.9%

1,078 Acute Care Only - 24th in WI

918 in Family Care - 12th in WI

County ¹	Family Care
Milwaukee	9,891
La Crosse	1,994
Waukesha	1,856
Racine	1,322
Marathon	1,232
Eau Claire	1,126
Winnebago	1,063
Fond du Lac	1,038
Wood	997
Kenosha	977
Outagamie	968
Jefferson	918

113 in Partnership - 5th in WI

County ¹	PACE/ Partnership
Milwaukee	1,626
Dane	1,181
Racine	137
Waukesha	129
Jefferson	113

112 in IRIS - 20th in WI

County ¹	IRIS
Milwaukee	4,518
Waukesha	398
Kenosha	349
Racine	342
Winnebago	311

Eau Claire	255
St. Croix	213
Outagamie	203
Marathon	197
Manitowoc	192
Walworth	180
Barron	176
Ozaukee	153
Washington	144
Sheboygan	129
La Crosse	127
Chippewa	125
Polk	125
Douglas	114
Jefferson	112

150 in SNF - 34th in WI

JEFFERSON COUNTY: ALZHEIMER'S FAMILY AND CAREGIVER SUPPORT PROGRAM (AFCSP)

WAITING LIST POLICY

The Alzheimer's Family and Caregiver Support Program (AFCSP) was created in response to the stress and needs of families caring for someone with Alzheimer's Disease or other irreversible dementia. The purpose of AFCSP is to make an array of community services available to these families in hopes of enhancing lives and keeping people in their homes as long as possible.

The AFCSP program is regulated by Chapter 68 of the WI Administrative Code. Under DHS 68.03 counties are allowed to set a maximum allowed payment, not to exceed \$4,000 per calendar year. Jefferson County has set the maximum payment at \$4,000.

When AFCSP funds are fully committed for the budget year, a waiting list is initiated. AFCSP Waiting List Referrals are submitted to the Division Manager via SAMS case notes that indicate a referral has been made.

Eligible individuals and/or their representatives are advised that there is a waiting list and a letter is sent to them indicating their number on the waiting list upon placement and every 6 months thereafter. Individuals on the waiting list are served on a first-come, first-served basis, unless they are at imminent risk of harm as evidenced by Adult Protective Service interventions.

This AFCSP Policy shall be reviewed and revised annually at the Aging & Disability Resource Center Advisory Committee meeting.

1/2016

Tracking Sheet: 2016-2018 Aging Unit Goals

6-A. Involvement of Older People in Aging-Related Program Development and Planning

Key Outcome Indicator: Throughout the duration of the 2016-2018 Aging Unit Plan, no less than 6 new opportunities will be created for older people to learn about programs, services and advocacy.

Goal 1: In order to increase the opportunity for seniors to engage in discussions about Aging-Related Program Development & Planning, the ADRC Advisory Committee will hold one-fourth of its meetings in different locations by **12/31/16**.

Tuesday, May 3rd at the Jefferson VFW, Topic: Health Action 2016 Conference
Speaker: Deniseg@jeffersoncountywi.gov

Tuesday, June 7th at the Lake Mills Municipal Building, Topic: Senior Dining
Speaker: Jean.Lynch@GWAAR.org

Tuesday, October 4th at the Watertown Senior Center, Topic: Alzheimer's Disease
Community Events: Cathyk@jeffersoncountywi.gov

Tuesday, November 1st at the Fort Atkinson Senior Center, Topic: Transportation
Speaker: Sharono@jeffersoncountywi.gov

Teaching Safe Swallowing Interventions to Reduce Hospital Readmissions

In the middle of the 80 miles between Madison and Milwaukee, Wisconsin sits Jefferson County. This picturesque county of rural farmland, an interstate highway and small towns is home to fewer than 100,000 people. The people of Jefferson County are served by two hospitals, which together reported a readmission rate higher than the state average in 2013.

In June of 2013, local community partners came together for the Southeastern Wisconsin Regional Coalition-Building workshop to review transition of care concerns at the local level. The Jefferson County Care Transitions Coalition was created to serve as a network of community partners with a common goal. The coalition includes two care transition nurses and a speech therapist from the local hospital as well as representatives from local nursing homes, assisted living homes and managed care organizations. As a first step, the group carefully reviewed the practices, processes and systems and engaged community involvement.

"When we started working together in 2013, the overall 30-day readmission rate for residents of Jefferson County were fairly low (12.8 percent) compared to the state of Wisconsin (15.9 percent), per data received from the CSAT database from MetaStar, our state Quality Improvement Organization (QIO) at the time," said Sharon Olson, supervisor of the Jefferson County Aging and Disability Resource Center (ADRC). "As a coalition, we really wanted to look at what was going on in our region. We looked at the data and information compiled from the last 20 readmissions to one local hospital."

After performing a root cause analysis, the group stumbled on an interesting finding. A chart review conducted by the care transition nurses of patients who were readmitted highlighted aspiration pneumonia.

"We found that initially 35 percent of patients were admitted due to pneumonia however, there were hospitals readmissions of 45 percent due to aspiration pneumonia," said Olson. "We determined that just about every other person who was re-admitted from the last 20 readmissions were coming back with an aspiration pneumonia diagnosis."

Armed with this knowledge, the group wanted to know why this would have happened. They decided to use the KATZ Index of Independence in Activities of Daily Living (ADL) to obtain a better understanding of each patient's functional status upon discharge. The group also reviewed attendance at follow-up appointments, social conditions like transportation or medication, and patient mental status. "We found that half of these patients were highly independent, or living at home and the other half were very dependent on others, or living in skilled nursing or an assisted-living environment," said Olson. "Since we knew the population living at home would be difficult to reach, we started exploring the other half of the equation."

A rapid survey was sent to area nursing homes and assisted living facilities from June to August of 2014, capturing feedback from staff at all levels of care including nursing staff, administration, dietary staff and housekeeping. The survey asked if the staff felt they knew their patients' health conditions, if they felt they had the tools to provide high-quality care, and what information or education they would find helpful.

Of the more than 100 surveys sent out, 33 were returned.

"What we found was that many of the staff thought that they were using pretty good communication tools, that 93 percent felt that they knew their resident's health condition but 67 percent felt that they had enough information to adequately provide proper cares upon admission of a new resident or readmission from the hospital," said Olson.

Throughout the survey, when asked to identify improvements for resident transitions from the hospital to assisted living or nursing facility, the most referenced comments were better communication between facility and hospital and tools for learning and help in doing their job better. In addition, 15 of the 33 survey responses indicated a desire for more education about aspiration precaution.

"We took this as our signal to start working to develop a plan on how to help people who are residing in assisted living or a nursing home and give them tools to start reducing the number of patients being readmitted due to aspiration pneumonia," said Olson.

The group developed a "train the trainer" education to empower staff members to take the education back and spread the word at their organization with both care staff and patients.

A pilot program was held in the summer of 2015 and trained 17 leaders in various professional positions. This program included three adult family homes who served 19 residents. The pilot program feedback indicated the charts and materials were well received and presented in an easy-to-learn format. Five

residents served by the organizations in the pilot program had a formal diagnosis of dysphagia. During the training, the participating staff identified two more residents who needed to consult with an interdisciplinary team and physician about choking risks.

After the pilot program, one organization indicated that they would train staff at other locations in their organization, including those that are not located in Jefferson County. They also indicated a strong feeling that training would benefit all community providers. As a result, the coalition offered the Safe Swallowing 2015 Initiative training in September and December of 2015 at a local hospital. All local area assisted living providers, nursing homes, home health agencies and adult day care centers were invited to send staff. Twenty five staff from 13 agencies completed the training. To facilitate sharing these materials with different shifts, the training materials were posted publicly [online](#).

“While the initial staff trained indicate this has been very useful, we’re trying to determine how many people they are training, and if this will make a difference in our readmission rate,” said Olson. “Although we do not have all data reported yet, impressions from our community providers who are utilizing this training experience is phenomenal, in my opinion. I truly believe that this project has been very successful in retrospect to the collaborative relationships that have developed into powerful, meaningful partnerships.”

—*The Jefferson County ADRC is part of the Lake Superior Quality Innovation Network Coordination of Care Initiative.*

For more Lake Superior Quality Innovation Network successes, visit [Success Stories](#).

STATE OF WISCONSIN

SENATE CHAIR
Alberta Darling

317 East, State Capitol
P.O. Box 7882
Madison, WI 53707-7882
Phone: (608) 266-5830



ASSEMBLY CHAIR
John Nygren

309 East, State Capitol
P.O. Box 8953
Madison, WI 53708-8953
Phone: (608) 266-2343

JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative John Nygren

Date: April 1, 2016

Re: DHS Report to JFC

Attached is a report regarding the feasibility of integrating income maintenance consortia and aging and disability resources centers (ADRCs) from the Department of Health Services, pursuant to s. 9118(9q) of 2015 Wisconsin Act 55.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

AD:JN:jm



State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

April 1, 2016

Honorable Alberta Darling
Co-Chair
Joint Committee on Finance
Room 317 East
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

RECEIVED
APR 07 2016

BY: J. Finance

Honorable John Nygren
Co-Chair
Joint Committee on Finance
Room 309 East
State Capitol
P.O. Box 8953
Madison, WI 53708

Dear Senator Darling and Representative Nygren:

Pursuant to section 9118(9q) of 2015 Act 55, the 2015-17 Biennial Budget, I am submitting to you a report regarding the feasibility of integrating income maintenance consortia and aging and disability resource centers (ADRCs).

This report is the first of three reports required by Act 55 concerning ADRCs. The Department will submit a plan regarding ADRC governing boards by July 1, 2016 and report on the long term care functional screen and options counseling functions by January 1, 2017.

Please contact me if you have any questions about the attached report.

Sincerely,

Kitty Rhoades
Secretary

Recommendations Regarding Integration of Income Maintenance Consortia and Aging and Disability Resource Centers



A Report to the Joint Committee on Finance by the
Wisconsin Department of Health Services
Division of Long Term Care
P-01241 (04/2016)

Executive Summary

2015 Wisconsin Act 55 requires the Department of Health Services to study the integration of Income Maintenance (IM) consortia and Aging and Disability Resource Centers (ADRCs), and report to the Joint Committee on Finance no later than April 1, 2016, with recommendations regarding potential efficiencies that may be gained, if any, from the integration of these entities and whether an integration would be appropriate considering the responsibilities of each entity. By requiring this paper, the Wisconsin Legislature has provided the Department with an opportunity to explore and research efficiencies that can strengthen the operations of IM consortia and ADRCs. This is one of three papers that the Department will be submitting to the Legislature by January 1, 2017, that evaluates the process for applying for Wisconsin's Medicaid long-term care programs and the operation and oversight of Wisconsin's ADRCs.

The Department of Health Services has determined that structural integration of the IM consortia and ADRCs is not appropriate; however, the Department recommends operational integration of ADRCs, Tribal Aging and Disability Resource Specialists (Tribal ADRS), IM Consortia, and tribal economic support units. Administrative cost savings from a merger or other structural integration of the IM consortia and ADRCs is likely to be small because of the limited overlap in each entity's respective responsibilities, the need for a continued local presence for both entities' functions, and the fact that both entities continue to experience increases in customer volume; however, similar efficiencies could be obtained by standardizing operational procedures without changing organizational boundaries.

ADRCs provide individualized counseling and assistance to anyone needing help navigating issues relating to aging or disability, regardless of income. ADRCs also serve as the entry point for Wisconsin's Medicaid long-term care programs. ADRCs conduct an extensive, in-person screening process to assess potential applicants' health and functional needs. If the person is functionally eligible, the ADRC may assist in gathering documentation for the IM consortia to use in determining financial and non-financial eligibility while processing the application.

Both ADRCs and IM consortia have a role in helping individuals enroll in Medicaid long-term care programs. In 2014, this work accounted for less than 10 percent of ADRC activity. Community long-term care consumers comprise less than 6 percent of IM consortia caseload. While both entities have responsibilities relating to eligibility determination and assistance with applications for parts of Wisconsin's Medicaid long-term care programs, each entity's client populations and the nature of work is quite different.

The most appropriate approach to focus on is gaining efficiency operationally in the areas where the responsibilities of the two entities intersect, without disrupting each entity's other major areas of responsibility.

The Department recommends that IM consortia and ADRCs should not be structurally integrated and instead recommends that the Department should work with the ADRCs and IM consortia to develop statewide and local or regional strategies to improve efficiency by better coordinating and streamlining the processes that govern access to the state's managed long-term care programs, without merging or

restructuring the IM consortia and ADRCs. This approach focuses on improving efficiencies in areas where IM consortia and ADRC responsibilities intersect, rather than consolidating two organizations that are distinctly different in who they serve, the services they provide, and the organizational characteristics best suited to their assigned responsibilities.

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Introduction

2015 Wisconsin Act 55 requires the Department of Health Services to study the integration of Income Maintenance (IM) consortia and Aging and Disability Resource Centers (ADRCs), and report to the Joint Committee on Finance no later than April 1, 2016, with recommendations regarding potential efficiencies that may be gained, if any, from the integration of these entities and whether an integration would be appropriate considering the responsibilities of each entity. By requiring this paper, the Wisconsin Legislature has provided the Department with an opportunity to explore and research efficiencies that can strengthen the operations of IM consortia and ADRCs. This is one of three papers that the Department will be submitting to the Legislature by January 1, 2017, that evaluates the process for applying for Wisconsin's Medicaid long-term care programs and the operation and oversight of Wisconsin's ADRCs.

The Department of Health Services has determined that structural integration of the IM consortia and ADRCs is not appropriate; however, the Department recommends operational integration of ADRCs, Tribal Aging and Disability Resource Specialists (Tribal ADRS), IM Consortia, and tribal economic support units. Efficiencies gained by structural integration would come from administrative cost savings from a merger and improvements in coordination between ADRCs and IM consortia that result from each entity needing to interact with only one counterpart organization; however, similar efficiencies could be obtained by standardizing operational procedures without changing organizational boundaries.

Wisconsin's Aging and Disability Resource Centers (ADRCs) and income maintenance (IM) consortia provide very important services and support to Wisconsin residents who are looking for information about or applying for Wisconsin's public assistance health and nutrition programs or who need help navigating issues related to aging or a disability. While each entity has distinct and unique functions, there is overlap between ADRCs and IM consortia as it relates to determining eligibility and enrolling in Wisconsin's Medicaid long-term care programs. However, the overlapping areas of work account for less than 10 percent of an ADRC's overall activities and functions and less than 6 percent of the overall IM consortia workload. The amount of overlap is minimal when one considers all of the activities completed by each entity and that a majority of the work completed by each organization is different and distinct.

The Department recommends that IM consortia and ADRCs should not be structurally integrated and instead recommends that the Department should work with the ADRCs and IM consortia to develop statewide and local or regional strategies to improve efficiency by better coordinating and streamlining the processes that govern access to the state's managed long-term care programs, without merging or restructuring the IM consortia and ADRCs. This approach focuses on improving efficiencies in areas where IM consortia and ADRCs responsibilities intersect, rather than consolidating two organizations that are distinctly different in who they serve, the services they provide, and the organizational characteristics best suited to their assigned responsibilities.

This report provides a more in-depth look at the role, function, and work completed by ADRCs and IM consortia, and identifies the areas where each entity's responsibilities overlap and interrelate. This report also identifies possible opportunities for improving efficiency, examines the appropriateness of each opportunity, and presents the Department's recommendation.

To complete this report, Department staff completed a review of statutory, rule, and contractual requirements relating to ADRCs and IM consortia; examined DHS program data; completed external evaluations and analyses of Wisconsin's IM consortia operations and ADRC services; and conducted a series of meetings and conference calls with IM consortia and ADRC stakeholders to collect input and feedback.

Overview of ADRCs and IM Consortia

Wisconsin's ADRCs and IM consortia provide services and support to Wisconsin residents who are looking for information about or applying for Wisconsin's public assistance health and nutrition programs or who need help navigating issues related to aging or a disability.

ADRCs were created to assist older adults and people with disabilities in accessing information and resources needed to live with dignity and security and to achieve maximum independence and quality of life. ADRCs provide information and counseling to help individuals make informed choices and streamline access to appropriate services and supports.

IM consortia administer the eligibility process for Wisconsin's health and nutrition public assistance programs. These programs are intended to provide the means to ensure basic health care and nutrition for low income individuals and families. The IM consortia carry out specific administrative responsibilities that the state has delegated to county and tribal governments, including processing applications, determining eligibility, providing ongoing eligibility case management, conducting fraud investigations, and recovering improper payments.

Who do ADRCs and IM consortia serve?

ADRCs

ADRCs provide assistance to any adult needing help with issues relating to aging or disability, regardless of income. ADRCs specifically work with older adults, adults with physical or developmental disabilities, youth with disabilities making the transition to adulthood, family members, caregivers, physicians, hospital and nursing home staff, and other involved individuals.

IM Consortia

IM consortia process applications and provide ongoing case management for Wisconsin's health and nutrition public assistance programs. IM consortia work with low income individuals, including families, older adults, and people of all ages with physical or developmental disabilities.

What services do ADRCs and IM consortia provide?

ADRCs

ADRCs provide highly individualized and interactive services to assist people with the challenges of aging and disability. ADRC staff help people identify and explore their personal needs and preferences, understand the options available to them, and facilitate the individual's decision-making process. These services are intended to help people maintain self-sufficiency and delay or prevent the need for potentially expensive long-term care.

The ADRC is a central source of information about a broad range of supportive services such as home maintenance, transportation, senior and public housing, meal programs, dementia care, health and wellness, employment for people with disabilities, in-home care, assisted living and nursing home care, mental health care and adult protective services.

In addition to providing information and counseling, ADRCs help people identify and access public benefit programs for which they may be eligible and serve as the single entry point for Medicaid long-term care programs like Family Care; Family Care Partnership; Include, Respect, I Self-Direct (IRIS); and the Community Options Program (COP)/Community Integration Program (CIP) "legacy" waivers. Less than 10 percent of ADRC activities involve helping people with access to Medicaid and the Medicaid long-term care programs.

ADRCs are required by contract to provide services at a location preferred by and at a time convenient for the customer, often in the person's home. In addition to being convenient for the customer, performing the functional eligibility screen in the person's home allows staff to observe how the person functions in their typical environment and to get a better understanding of the individual's real needs and abilities.

ADRC Activities in 2014, by Type <i>No + cases</i>		
Activity	Customer Contacts	
	Number of Contacts	Percentage of Contacts
Information and Assistance	275,400	46.3%
Follow Up	69,200	11.6%
Medicaid and Medicaid Waiver-Related Assistance	58,000	9.8%
• Help With Application	22,600	3.8%
• LTC Functional Screen	15,700	2.6%
• Enrollment Consultation	15,900	2.7%
• Disenrollment Consultation	3,800	0.7%
Options Counseling	40,100	6.7%
Other	151,800	25.5%
Total	594,500	100.0%
Source: 2014 ADRC Activity Reports. Other includes disability benefit specialist activities. Data does not include elder benefit specialist activities.		

IM Consortia

IM consortia are structured in a way that promotes accurate and efficient processing of more than one million cases each year. IM consortia determine eligibility and provide ongoing case eligibility management for Wisconsin's health and nutrition public assistance programs, including Medicaid for Elderly, Blind and Disabled (EBD), BadgerCare Plus, FoodShare, and the Supplemental Security Income (SSI) Caretaker Supplement. Consortia staff uniformly process large volumes of information and apply complex program rules to determine eligibility in each of these program areas.

IM consortia process applications, determine initial eligibility, and process renewals and changes in participant status. IM Consortia also participate in fair hearings and coordinate with the Department on subrogation, benefit recovery, and fraud prevention and investigation. In addition, IM Consortia make referrals to and receive referrals from the federal Health Insurance Marketplace.

Each IM consortium is required to maintain and operate a consortium-wide call center and provide lobby services in each participating county. Lobby services include answering questions from applicants, making state and federal publications on public assistance programs available, accepting forms and other documents to verify eligibility, and providing access to computers for completing and submitting web-based applications. Some IM Consortia maintain a separate unit that specializes in EBD Medicaid and long-term care programs that can provide more direct technical assistance and case management to individuals enrolled in and applying for these programs.

July 2014 IM Consortia Caseload, by Program		
Program	Open Cases in Each Program	
	Number of Open Cases	Percentage
BadgerCare Plus	413,900	41.3%
EBD Medicaid		
• Medicaid Long-Term Care: Institutional	16,200	1.6%
• Medicaid Long-Term Care: Home and Community-Based Care	57,300	5.7%
• Non-Long-Term Care Medicaid	88,000	8.8%
FoodShare*	420,300	42.0%
Caretaker Supplement	6,200	0.6%
Total	1,001,900	100.0%
*Total represents the sum of the number of open cases in each program listed above. It does not include programs that IM consortia or Tribal economic support agencies operate under contract with entities other than DHS. Each case represents a household or individual. The total is substantially larger than the number of cases because the majority of cases involve eligibility determinations for and enrollment in more than one program.		

Where do ADRCs and IM consortia provide services?

ADRCs

Wisconsin has 41 ADRCs, including 28 single-county and 13 multi-county regional ADRCs. Milwaukee County has an Aging Resource Center as well as a Disability Resource Center. All are county or multi-county public entities, except the ADRC of Brown County, which is a nonprofit organization.

Wisconsin Tribes choose to provide ADRC services to their members in one of three ways:

1. Partner with one or more counties to operate an ADRC.
2. Employ a Tribal Aging and Disability Resource Specialist (Tribal ADRS). The Tribal ADRS performs many of the functions of the ADRC for tribal members and serves as a liaison with the local ADRC. When needed, the Tribal ADRS refers tribal members to the ADRC for the Medicaid long-term care functional eligibility determination and other assistance.
3. Create a tribal-only ADRC.

Tribes are in the best position to assist elders by providing competent services and assistance. Cultural competence is especially important for tribal elders, who may not readily seek out assistance from county agencies.

Five of Wisconsin's 11 tribes partner with the ADRC serving their region and six have a Tribal ADRS to provide information and assistance, options counseling, and certain other ADRC functions.

See Appendix A for a list and map of Wisconsin's ADRCs and Tribal ADRSs.

IM Consortia

There are 10 multi-county regional IM Consortia and one IM agency, Milwaukee Enrollment Services, which serves Milwaukee County and is operated by the Department of Health Services. Prior to the implementation of the regional IM consortia in 2012, the income maintenance function was provided by county economic support agencies. Today, each IM consortium is required to provide "lobby services" in every county.

Wisconsin tribes have the option to operate their own economic support units—nine of the 11 tribes already have their own economic support units. The Menominee Indian Tribe of Wisconsin administers all IM services in Menominee County.

See Appendix B for a list and map of Wisconsin's IM consortia and tribal economic support units.

What is the state and federal statutory authority and requirements for providing these services?

ADRCs

Authority, duties, and standards of operation for Wisconsin's ADRCs are found in Wis. Stat. § 46.283. More detailed requirements are contained in administrative rules (DHS 10, Subchapter II) and in the contract between DHS and each ADRC. In addition, the role of the ADRC is defined within the federally approved Home and Community-based Services waivers for Family Care and IRIS. These waivers provide the federal authority for Wisconsin to operate these programs, and any change to the role of the ADRCs would thus require approval from CMS and an amendment to the waivers.

Wisconsin statutes give counties and tribal governments the authority to decide whether to apply to operate a single-county ADRC, multi-county or county-tribal ADRC, or to create a long-term care district to operate the ADRC. An ADRC may be a stand-alone organization or part of a human service department, county aging unit, tribal government, or other county or non-profit organization, as long as it is separate from any managed care organization. If a county elects not to operate an ADRC, DHS may contract with a private, nonprofit organization to provide the ADRC services instead.

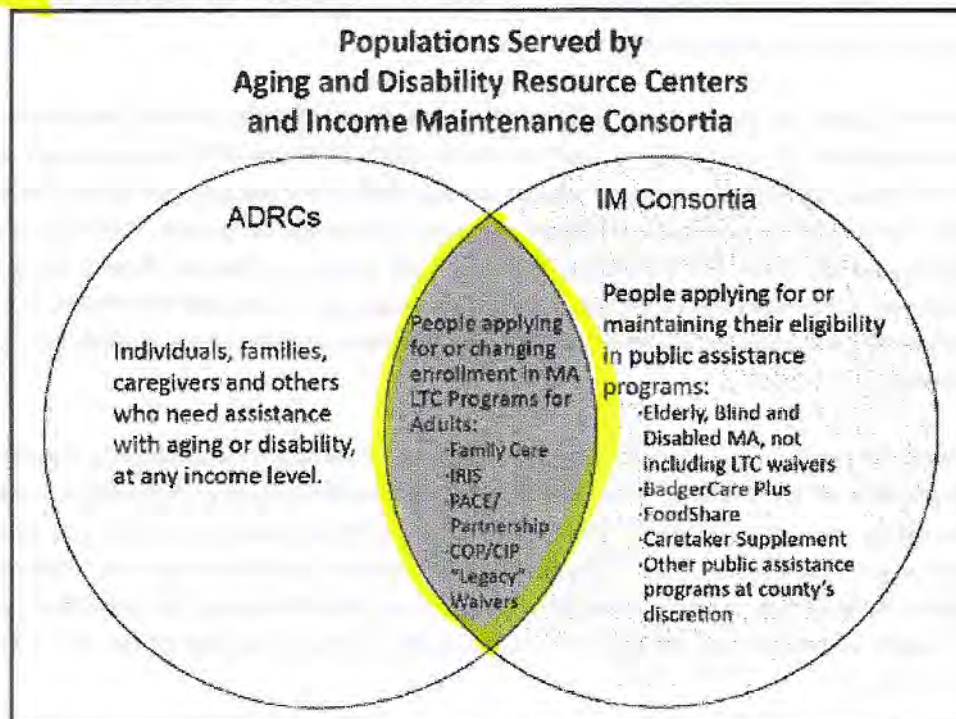
IM Consortia

Wisconsin Stat. § 49.78 requires that counties with populations of less than 750,000 participate in multicounty consortia approved by DHS for administration of IM programs and that the Department administer IM programs in a county with a population of 750,000 or more. Tribal governing bodies may elect to provide income maintenance service for tribal members under a contract with DHS or have the Department administer the Tribe's income maintenance program.

Under state statute, Wisconsin's income maintenance programs include Medicaid, BadgerCare Plus, and FoodShare, which are federal programs jointly funded by the federal government and states, and administered by states. States operate their programs within the context of federal requirements. The federal requirements for Medicaid program eligibility determination are contained in Title 19 of the Social Security Act and 42 CFR 435 of the Code of Federal Regulations. Requirements for the FoodShare Program are contained in Title 7, Chapter 51 of the United States Code—Supplemental Nutrition Assistance Program. State authority and requirements for income maintenance administration are found in Wis. Stat. Ch. 49, in DHS administrative memos, and in the Department's contracts with the IM consortia.

Overlapping Functions and Responsibilities of ADRCs and IM Consortia

Both ADRCs and IM Consortia assist elderly and disabled individuals in accessing the state's community Medicaid long-term care programs. This work represents less than 10 percent of ADRC activities and less than 6 percent of IM consortia caseload.



Note: in the chart above, Medicaid is abbreviated as MA

ADRCs provide assistance at the beginning and the end of the application and enrollment process for Medicaid long-term care programs. ADRCs provide potential applicants with information about the Medicaid program options (fee-for-service, managed long-term care, and IRIS self-directed supports program). If an individual is interested in pursuing enrollment into a Medicaid long-term care program, ADRC staff performs the long-term care functional screen to identify the person's care needs. An algorithm embedded in the functional screen tool determines whether the person meets the functional eligibility requirements to qualify for the program.

Individuals who meet the program's functional eligibility requirements can submit an application directly to the IM consortium or can submit an application with the assistance of the ADRC.

If requested, the ADRC will assist with the application by helping people who are functionally eligible in gathering the income, asset, and other information needed to establish financial and non-financial eligibility. The ADRC will also assist with documentation of the person's medical and related expenses

and make an initial calculation of the amount the individual will be required to contribute to the cost of his or her care. Individuals who meet program's functional eligibility requirements can submit an application directly to the IM Consortium or can submit an application with the assistance of the ADRC.

IM workers process the applications, review and verify the supporting documentation, verify the cost share amount initially calculated by the ADRC, determine the applicant's financial eligibility, and notify the applicant of their eligibility status.

Once the IM Consortium has received confirmation of functional eligibility and that the individual is otherwise eligible for the program, the applicant is referred back to the ADRC for enrollment counseling. During enrollment counseling, the ADRC informs the applicant about the program options, managed care organizations (MCOs), and IRIS consultant agencies (ICAs) available to them. When the person selects a Family Care option and enrollment date, the ADRC processes their enrollment. When they select IRIS, the ADRC refers the individual to the ICA for budget assistance and enrollment. The ADRC or ICA notifies the IM consortium of the enrollment, and the IM consortium sends an eligibility notice to the applicant.

Throughout the Medicaid long-term care program application and enrollment process, the ADRC and IM consortium each work with the applicant and transfer information related to that person's application, documentation, and status. Handoffs within or between the IM consortium and ADRC rely on good communication to be effective. Poor communication can result in duplication of work or in crucial information being missed, increasing the potential for error. Handoffs during the application, eligibility determination, and enrollment process are a natural starting place to look for efficiencies or system improvements.

External Stakeholder Feedback

To inform this report, the Department held in-person and telephone conference meetings with ADRC directors, IM consortium representatives, county human service and social service department directors, Tribal ADRSs, and tribal economic support, and consumer advocates. These stakeholders do not support a merger and instead offered many ideas for potential efficiencies.

Stakeholder input served as an opportunity to identify possible solutions for improving efficiency. Common themes among the identified areas for process improvement are listed below. The actual potential for improving efficiency will differ from one area of the state to another based on the current level of coordination, the variation among and within IM consortia and ADRCs, and in the local environments in which they operate.

- **Technological Improvements.** Reducing the use of paper processes and making the electronic application process more user friendly for older adults and people with disabilities.
- **Promoting More Consistent Policies and Procedures.** Clarifying ADRC and IM Consortia responsibilities and establishing standard procedures regarding who does what at what time to

streamline the elderly, blind or disabled (EBD) and long-term care (LTC) Medicaid eligibility determination process, reduce the potential for discrepancies, and reduce the number of people who are disenrolled only to re-enroll in the same program within 60 days.

- **Developing Standard Forms, Job Aids, Tools, and Informational Materials.** Providing standard forms and tools for IM consortia and ADRC staff to use in informing the public about programs and in collecting and transmitting information for eligibility and cost-share determination.
- **Improving Coordination and Communications.** Establishing channels for communication between the ADRCs and IM consortia about referrals, sharing client information, and resolving discrepancies; and documenting these in formal interagency agreements, if agreements are not already in place.
- **Enhancing Staff Expertise in EBD and LTC Medicaid.** Training IM consortia and ADRC staff on the procedures, technology, and tools/materials to facilitate coordination and streamlining of LTC Medicaid program eligibility and enrollment and having staff experts provide assistance with and process EBD and LTC Medicaid applications.

Possible Options for Integrating IM Consortia and ADRCs

There are two possible options for integrating IM consortia and ADRCs: **operational integration** and **structural integration**. Operational integration involves streamlining and coordinating procedures within and between organizations, while structural integration involves a merger or other changes to the organizations themselves. The potential efficiencies and the appropriateness of integration vary based on the approach to integration that is being considered. The Department recommends option one, operational integration, and does not recommend making the structural changes to either ADRCs or IM consortia that are outlined in option two.

Option One: Operational Integration

The operational integration of IM consortia and ADRCs would involve development of consistent tools and compatible, streamlined procedures for carrying out their mutual responsibilities. This could be achieved through a coordinated statewide initiative directed by the Department of Health Services or through more local initiatives at the IM consortia, tribal economic support, ADRC, and Tribal ADRS level.

Strategy One: Consistent Statewide Strategy for Streamlining Operations

The Department would be responsible for developing and implementing a statewide strategy for improving efficiency in areas where ADRC and IM consortia operations intersect, within the framework of the current organizational structures. Suggestions for improving the EBD and LTC Medicaid application and eligibility determination process include:

- More clearly defining the roles of the ADRCs, Tribal ADRSs, IM consortia, and tribal economic support to facilitate consistent understanding statewide.
- Investing in technology to improve communication between the IT systems used for Medicaid applications by each entity.
 - Provide an alert to ADRCs and Tribal ADRSs of adverse actions or other changes they need to follow up on.

- Utilize technology to help ensure that ADRCs, Tribal ADRSs, IM consortia, and tribal economic support all have access to information about changes in a client's status.
- Developing standardized forms and materials for use by all ADRCs, Tribal ADRSs, IM consortia, and tribal economic support agencies.

A number of efficiencies could potentially be gained from these types of strategies, including: applications processed more quickly, greater accuracy in initial eligibility and cost-share determinations, less need for discrepancy resolution, fewer participants who are disenrolled and then re-enrolled in the same program, more appropriate use of ADRC services, increased customer satisfaction, and savings in staff time that will allow IM consortia, tribal economic support, Tribal ADRSs and ADRCs to better accommodate workload increases as the elderly population grows.

Strategy Two: Diversified Approach to Improving Efficiency

By utilizing this strategy, the Department, IM consortia, tribal economic support, Tribal ADRSs and ADRCs would continue their current efforts to improve coordination and efficiency. All parties are aware of issues that need to be addressed and are open to change. A number of efforts are already underway to improve the efficiency and service of the IM Consortia and ADRCs. The types of efficiencies that could be realized are the same as those identified in connection with the previous statewide strategy.

Additional strategies that aim to improve coordination and collaboration include:

- Having face-to-face meetings between ADRCs, Tribal ADRSs, IM consortia, tribal economic support, and stakeholders to exchange ideas for improving coordination.
- Ensuring that ADRCs, Tribal ADRSs, IM consortia, and tribal economic support are knowledgeable about each entity's responsibilities, processes, and timelines; providing training; and certifying the Tribal ADRSs to perform the Long-Term Care Functional Screen.
- Providing trainings for new and experienced workers, including joint training for ADRCs, Tribal ADRSs, IM consortia, and tribal economic support staff on some topics.
- Using specialized long-term care workers at the IM consortia, economic support assistants at ADRCs, and having a benefit advocate as resource person for tribal staff and tribal members.

This strategy leaves room for local creativity in finding efficiencies. In order to realize the full potential of these efficiencies, activities will need to be consistently implemented at ADRCs, Tribal ADRSs, IM consortia, and tribal economic support agencies.

Appropriateness of Operational Integration

Operational integration provides a variety of opportunities for improving efficiency by instituting standardized procedures and materials for ADRCs and IM Consortia, and without the attendant disruption of structural integration, which would involve a merger or other changes to the organizations themselves. All of the improvements in efficiency that were identified by stakeholders or are the subject of current Department initiatives could be achieved through better coordination and by streamlining of ADRCs, Tribal ADRSs, IM consortia, and tribal economic support procedures. An initiative to coordinate and streamline procedures in the existing entities is the most appropriate approach to integration.

Option Two: Structural Integration

The Department also studied structural integration of ADRCs and IM consortia. Options for structural integration included merging the ADRCs and IM consortia or redrawing the regional boundaries of ADRCs and IM consortia to facilitate coordination.

Strategy One: Merger of IM Consortia and ADRCs

This strategy involves merging the 41 ADRCs and 11 IM consortia into a set of new, regional organizations, each operating under a single director and governance structure and encompassing the full range of responsibilities currently assigned to both entities. County level services would also be merged. Potential efficiencies include administrative cost savings from reducing the total number of organizations, eliminating the need for inter-agency referrals, streamlining procedures, and no longer requiring customers to deal with two different entities when enrolling in Medicaid managed long-term care. The cost savings associated with merging the two organizations are likely to be small as managers would still be needed for the eligibility determination and similar staffing levels would be needed to complete the full breadth of services and functions required. If efficiencies are gained, it does not necessarily mean that Wisconsin would be able to reduce GPR contract funding to the agencies as GPR is not the only funding source for these entities. Counties contribute significant local funds for helping individuals navigate and enroll in Medicaid long-term care programs

Differences in the missions and business models of the ADRCs and IM Consortia also raise issues concerning the appropriateness of a merger. Currently ADRCs assist older adults and people with disabilities in accessing information and resources needed to live with dignity and security and to achieve maximum independence and quality of life. This assistance is not limited to public assistance programs and supports. If ADRCs are part of the IM consortia, the public might not know that ADRCs provide these other services, particularly the information and resources that are provided before a Medicaid long-term care application is completed. As 88 percent of current ADRC customers do not apply for Medicaid, structural integration could limit the Department's goal of preventing and delaying entry into publically funded long-term care.

Strategy Two: Alignment ADRC and IM Consortium Service Area Boundaries

This strategy aligns service area boundaries to facilitate better coordination between ADRCs and IM consortia, without merging or consolidating the functions of the two entities. This approach would require reorganization of the current ADRC and IM consortia entities, resulting in considerable disruption and may have the potential for only limited administrative cost savings. Efficiencies under this strategy would come from improvements in coordination between ADRCs and IM consortia that result from each entity needing to interact with only one counterpart organization. Similar efficiencies could be obtained by standardizing procedures without changing organizational boundaries.

While regional alignment may facilitate coordination in the approximately 10 percent of the ADRC and IM consortia work that intersects, it would not eliminate the need for IM consortia and ADRCs to work with their other partner organizations that also have different regional structures: 5 Department of Children and Families regions, 11 Department of Workforce Development regions, 8 regional Independent Living Centers, 12 Cooperative Educational Service Agencies (CESAs), 7 Family Care MCOs,

APPENDIX A

Aging and Disability Resource Centers in Wisconsin and the Counties and Tribes Served

1. ADRC of Adams, Green Lake, Marquette, and Waushara Counties
2. ADRC of Barron, Rusk, and Washburn Counties
3. ADRC of Brown County
4. ADRC of Buffalo, Clark, and Pepin Counties
5. ADRC of Central Wisconsin (Marathon, Wood, Lincoln, and Langlade Counties)
6. ADRC of Chippewa County
7. ADRC of Columbia County
8. ADRC of Calumet, Outagamie, and Waupaca Counties
9. ADRC of Dane County
10. ADRC of Dodge County
11. ADRC of Door County
12. ADRC of Douglas County
13. ADRC of Dunn County
14. ADRC of Eagle County (Crawford, Juneau, Richland, and Sauk Counties)
15. ADRC of Eau Claire County
16. ADRC of Florence County
17. ADRC of Fond du Lac County
18. ADRC of Jefferson County
19. ADRC of Kenosha County
20. ADRC of the Lakeshore (Manitowoc and Kewaunee Counties)
21. ADRC of Marinette County
22. Aging Resource Center of Milwaukee County
23. Disability Resource Center of Milwaukee County
24. ADRC of the North (Ashland, Bayfield, Iron, Price, and Sawyer Counties)
25. ADRC of Northwest Wisconsin (Polk and Burnett Counties and the St. Croix Chippewa Indians of Wisconsin)
26. ADRC of the North Woods (Forest, Vilas and Oneida Counties and the Sokagon Chippewa Community, Lac du Flambeau Band of Lake Superior Chippewa Indians, and Forest County Potawatomi Community)
27. ADRC of Ozaukee County
28. ADRC of Pierce County
29. ADRC of Portage County
30. ADRC of Racine County
31. ADRC of Rock County
32. ADRC of Sheboygan County
33. ADRC of St. Croix County
34. ADRC of Southwest Wisconsin (Grant, Green, Iowa, and Lafayette Counties)
35. ADRC of Trempealeau County
36. ADRC of Walworth County
37. ADRC of Washington County
38. ADRC of Waukesha County
39. ADRC of Western Wisconsin (La Crosse, Jackson, Monroe, and Vernon Counties)
40. ADRC of Winnebago County
41. ADRC of the Wolf River Region (Menominee, Oconto, and Shawano Counties and the Stockbridge-Munsee Community)

Tribal Aging and Disability Resource Specialists

1. Bad River Band of Lake Superior Chippewa Indians
2. Lac Court Oreilles Band of Lake Superior Chippewa Indians
3. Ho-Chunk Nation
4. Menominee Indian Tribe of Wisconsin
5. Oneida Tribe of Indians of Wisconsin
6. Red Cliff Band of Lake Superior Chippewa Indians

Wisconsin's Aging and Disability Resource Centers



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Revised 3-29-16

APPENDIX B

Wisconsin Income Maintenance Consortia and Tribal Economic Support Services

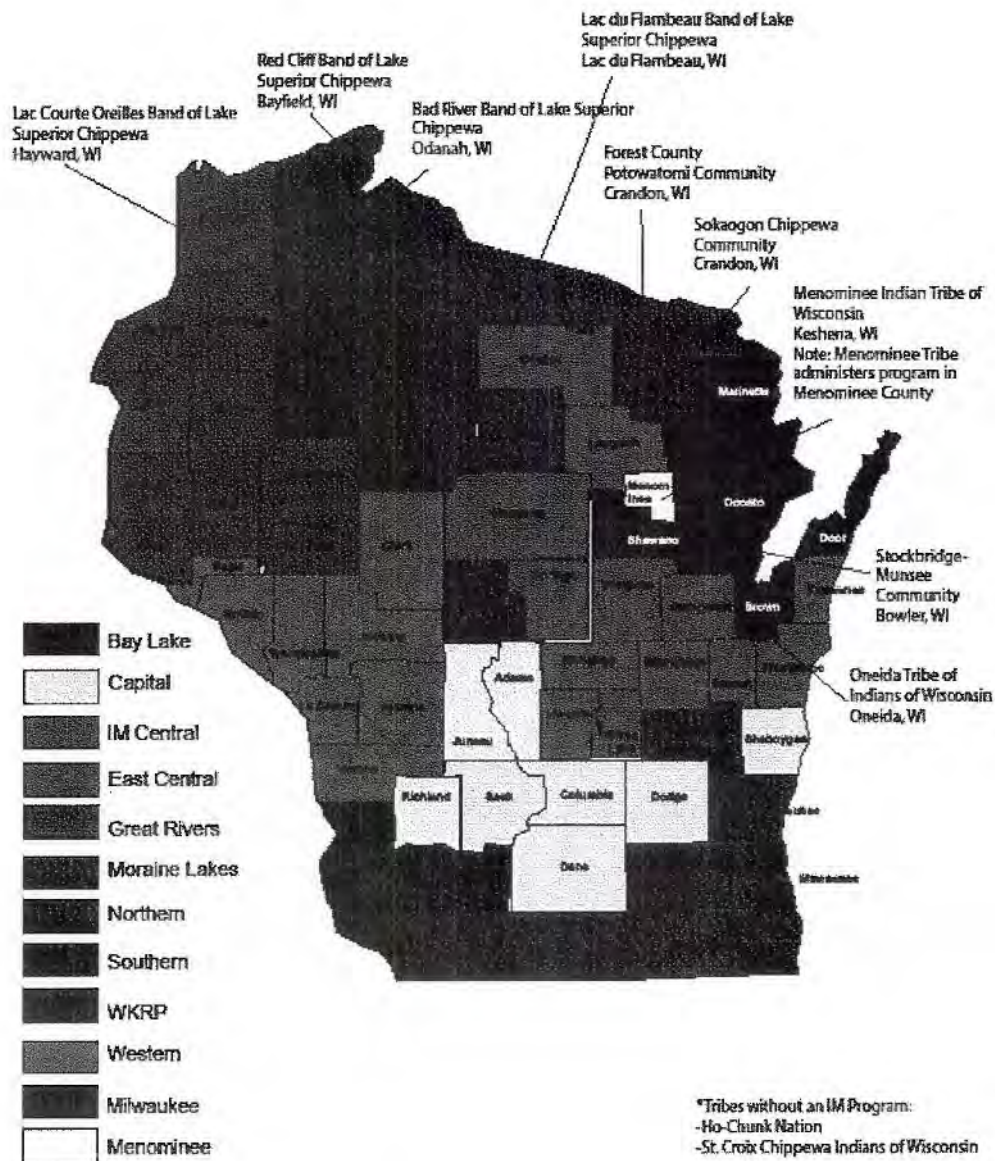
Income Maintenance Consortia and Participating Counties

1. Bay Lake Consortia: Brown (Lead County), Door, Marinette, Oconto, Shawano
2. Capital Consortia: Adams, Columbia, Dane (Lead Agency), Dodge, Juneau, Richland, Sauk, Sheboygan
3. Central Consortia: Langlade, Marathon (Lead Agency), Oneida, Portage
4. East Central Consortia: Calumet, Green Lake, Kewaunee, Manitowoc, Marquette (Lead Agency), Outagamie, Waupaca, Waushara, Winnebago
5. Great Rivers Consortia: Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire (Lead Agency), Pierce, Polk, St. Croix, Washburn
6. DHS Milwaukee Enrollment Services (MILES): Milwaukee County
7. Moraine Lakes Consortia: Fond du Lac (Lead Agency), Ozaukee, Walworth, Washington, Waukesha
8. Northern Income Maintenance Consortium: Ashland, Bayfield, Florence, Forest, Iron, Lincoln, Price, Rusk, Sawyer, Taylor, Vilas, and Wood (lead agency).
9. Southern Consortia: Crawford, Grant, Green, Iowa, Jefferson, Lafayette, Rock (Lead Agency)
10. Western Region for Economic Assistance: Buffalo, Clark, Jackson, La Crosse (Lead Agency), Monroe, Pepin, Trempealeau, Vernon
11. Wisconsin's Kenosha, Racine Partnership (WKRP): Kenosha (Lead Agency), Racine

Tribal Economic Support Services

1. Bad River Department of Social and Family Services
2. Potawatomi Economic Support Department
3. Lac Courte Oreilles Income Maintenance Agency
4. Lac du Flambeau Economic Support
5. Menominee Community Resource Center
6. Oneida Tribe Economic Support Services
7. Red Cliff Social Services
8. Sokaogon Economic Support Agency
9. Stockbridge-Munsee Economic Support Services

Wisconsin Income Maintenance Consortia and Tribal Economic Support





WALA MUSIC & MEMORY PROGRAM

By Jim Murphy, *Executive Director, WALA*

Due to the generous support of many sponsors, WALA was able to launch a Music & Memory program for member providers whose residents suffer from dementia. This program trains care professionals to set up personalized music playlists for residents, delivered on iPods and other digital devices. Hearing favorite musical selections can tap into deep memories not lost to dementia and bring participants back to life, enabling them to feel like themselves again, to converse, socialize, and stay present. The research on results for people with dementia who use M&M is very impressive.

The WALA program trains caregivers to use the program customized. After a caregiver's training through the national Music & Memory program, WALA provides each of the provider's residents with an iPod shuffle, headphones, an AC adapter, an external speaker, a splitter (so more than one person can listen at the same time on headphones, if, for example, a family member or caregiver joins the resident), and a gift card for \$100 worth of music. WALA covers the shipping and handling.

The WALA members in this program include Case del Mare, Diving Living AFH, Villa St. Francis, Azura of Clinton, the Woods of Caledonia, and Sylvan Crossings of Jefferson.

Once staff are certified, they are also connected to the Wisconsin Music & Memory Program community of participants. This is an incredible group set up by Kevin Coughlin to provide the 200-plus nursing homes in Wisconsin using Music & Memory with additional training, support, networking, and best practices, with a free monthly Adobe. Once they have completed the training, each AL community will also be listed as a certified program on the Wisconsin Music & Memory Program website.

MUSIC & MEMORY WITH IPAD PROGRAM

Another program just launched takes the Music & Memory program one more huge step. Sponsored by a Park Family

Foundation grant and coordinated by the Wisconsin Coalition for Collaborative Excellence in Assisted Living (CHSRA), it is the Music & Memory + iPad program!

This program provides all the equipment in the WALA program plus an iPad with appropriate applications that increase its effectiveness and training to use it.

The WALA members in this program include Matterhaus at Gables of Germantown, the Cottages Memory Care in Shawano, and Sylvan Crossings at Fitchburg.

Since the hope is that this program can be the seed to expand via future grants, residents were carefully selected. An evaluation conducted by CHSRA will assess the impact of the program on the residents and the assisted living community. Assisted living communities agree to participate in an evaluation by completing periodic questionnaires regarding the effect the Music & Memory with iPad program has on residents and staff and other requirements by the research agency.

MUSIC & MEMORY AT THE NATIONAL LEVEL

With Wisconsin a national leader in Music & Memory expansion into assisted living, there will be a presentation at the Argentum (ALFA) conference in May in Denver. Kevin Coughlin, Dan Cohen of the national Music & Memory program, and I will present on the Music & Memory program in assisted living. I am very happy that Wisconsin and WALA are part of the movement to expand M&M into assisted living. If you plan to attend the Argentum conference, plan to stop in our session. If you are part of one of the M&M programs in Wisconsin, let me know that you will be there. I will confirm date, time, and location, and will introduce you at the session. You can share with the group your personal experiences and those of the residents in your program. Info on the conference at www.alfa.org.

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Website: www.bdavisdirections.com

Results: 104 surveys

Training Time 3/16/16 2:00pm

Rating

	1	2	3	4
	Disagree	Slightly Disagree	Slightly Agree	Agree
		3	20	81

Question

I know more about dementia than I did before this training

This training will aid me in my personal or professional life

76

I believe I can apply the information I learned to present or future situations

3

4 21 78 (1 blank)

Comments

1 Interesting

2 Thank you Cathy

3 Good information, well presented

4 More information on diet and prevention would be appreciated.

5 Thanks for your time and information

6 Informative

7 Good presentation, informative

8 Dementia and Alzheimer's is real, thank you for making us aware

9 Excellent information! I had no clue what this meant before the training

10 I've been working many years in homecare, liked the hand shake will use it in future

11 Very good brief training

12 Very Helpful

13 Very informative - Cathy does an excellent job

14 I would like to show a copy of this presentation at JCSO briefings. Is it possible to get a copy of this?

15 Good training! I wish I knew that information when my grandfather was still alive. He passed away from Alz Dis

16 Very informative!

17 Cathy did a great job!

18 Very informative, thank you!

19 Good Job

20 I will use the websites to learn more

21 Great Information

Would like more info - 7
Like Dementia Care Specialist to contact me - 2
Any pointers/resources for family member living in a memory care unit



March 1, 2016

Understanding Upcoming Policy Changes that Impact the IRIS Program

The Department of Health Services (DHS) has made us aware that they are getting ready to release two new policies that could have an impact your Individual Supports and Services Plan (ISSP). In addition, there have been changes in wage and hour laws for workers who provide personal/home care work. We want to inform you of these policies and begin to think with you about next steps for you or your family member's plan. We will walk through the information together, and I will leave information for you to review when I leave. This is an introduction to these new policies, and it will not give you all of the details that the final policies will have, but it will give you the information we have right now. We will let you know as soon as the final policies, and other materials that further explain the policies, become available.

Upcoming IRIS Policy: Guardians as Providers


Background:

In 2014, the Centers for Medicare and Medicaid Services (CMS), which is the arm of the Federal government that oversees programs like IRIS, created rules around "Conflict Free Case Management." While we understand there are no "case managers" in IRIS, these rules are in place to ensure that the people making decisions about what services are included in care plans are not the same people who are providing the services. In IRIS, people who sign plans and direct services are considered decision makers, which means that they cannot also be paid providers on the Individual Supports and Services Plans they are signing.

Although the IRIS "Guardians as Providers" policy is not yet published, the federal Conflict Free rules are. Therefore, DHS is asking IRIS Consultants to begin letting people know that this policy is coming, and to help people think about what types of adjustments may need to be made.

Basics:

- The federal rules about avoiding potential conflicts of interest mean that the person who signs the plan (ie. The guardian) and directs services cannot also be a provider on that same plan.
- This rule does not apply to any situations where there is a Power of Attorney for Health Care (Activated or Inactive).
- Some people have co-guardians. Situations in which one guardian signs the plan and the other guardian provides services, would only be allowed if the signing guardian does not benefit in any way from the other guardian providing services. If parents are



co-guardians and share their income with one another, neither parent should be a paid provider on their son or daughter's IRIS plan.

- Currently, the Self-Directed Personal Care (SDPC) Program allows guardians to provide paid services if there is an SDPC Representative appointed. DHS is not asking people to make changes to their SDPC services at this time. We are waiting to learn whether or not a similar Guardians as Provider policy will apply to SDPC as well.
- DHS realizes that the new policy is a big change for people. The coming policy will include a timeframe that people will have to make the changes needed to align with the new policy.
- TMG will be working with other organizations to find resources for people who want to review their guardianship papers or consider different ways to prepare for the upcoming Guardian as Provider policy.

Upcoming IRIS Policy: 40-Hour Health and Safety Assurance

Background:

DHS is working on a new policy that will help ensure that workers are able to provide high quality, safe care to people. This policy will help to prevent worker burnout and tiredness from working a large number of hours.

Basics:

Although the policy is not published, DHS has shared that it will include the following elements:

- The policy will not reduce the hours of care on the person's IRIS plan.
- There will be a 40 hour per week limit for each worker, per employer (person enrolled in IRIS). The hours limit includes all Participant Hired Worker services such as Supportive Home Care, Self-Directed Personal Care, Respite and Daily Living Skills Training.
- Hours worked for other employers, including other people enrolled in IRIS, do not count toward the 40 hour limit.
- There may be some individual exceptions made for workers to work up to 50 hours per week. The policy will include the process people will follow to make that request.
- Workers providing SDPC services will have a firm 40 hour limit.
- Budget Amendments and One Time Expense requests will not be allowed to cover the cost for workers who are granted an exception to work over 40 hours per week.
- People with workers who are currently working over 40 hours will need to find additional workers, hire agencies, or make other arrangements so that their plan aligns with the policy.
- There will be a transition period for people to identify and hire additional workers. We do not yet know when that transition period will begin or how long it will be. DHS is

recommending, however, that people make the necessary adjustments as soon as practically possible.

Federal Fair Labor Standards Act (wage and hour rules)

Background:

Last year, the US Department of Labor (DOL) changed the rules in the Fair Labor Standards Act (FLSA) that related to workers who provide home care services.

Basics:

- The new rules state that most home care workers must be paid at least minimum wage (\$7.25) for all hours worked and must be paid overtime (time-and-half) for all hours worked over 40 per week. In some limited circumstances, workers will be considered “exempt” and the minimum wage and overtime rules will not apply.
 - This means that most workers must be paid overtime if they work over 40 hours/week (which is what most workers are used to).
 - This means that most workers must be paid at least minimum wage for all hours worked.
- DHS, the IRIS Consultant Agencies and the Fiscal Employer Agent are working together to determine how these rules will be added to the IRIS Program.
- There will be more information about FLSA and IRIS available in the coming months. In the meantime, if people enrolled in IRIS have questions about the Fair Labor Standards Act, they can contact the Department of Labor Wage and Hour Hotline at 1-866-487-9243 or visit their website for fact sheets and resources at <http://www.wagehour.dol.gov>.

6.1E.1 Participant-Hired Worker 40-Hour Health and Safety Assurance

Business Rules

1. Participant-hired workers in the IRIS program are limited to working 40 hours per week or less to mitigate safety risks to the participant and the participant-hired worker. These hours may be any combination of Supportive Home Care, IRIS Self-Directed Personal Care (SDPC), Respite, Daily Living Skills Training, or other services paid at an hourly rate and approved by the 1915 (c) Home and Community-Based Waiver.
2. IRIS consultant agencies (ICAs) are responsible for educating participants and/or legal representatives on the 40-hour health and safety assurance to participant-hired worker hours using the Participant Education: Participant-Hired Worker 40-Hour Health and Safety Assurance (F-01702) form. The IRIS Consultant is responsible for delivering the information to the participant in a meaningful and understandable way.
3. IRIS participants are responsible for educating participant-hired workers on the 40-hour health and safety assurance using the Participant-Hired Worker Education: Participant-Hired Worker 40-Hour Health and Safety Assurance (F-01701) form.
4. ICAs and fiscal employer agents (FEAs) are responsible for ensuring all of their staff understand and correctly apply these work instructions.
5. The IRIS Consultant and participant develop an Individual Support and Service Plan (ISSP) in which no participant-hired worker is authorized to work more than 40 hours per week.
6. FEAs will pay only up to the service amount authorized on the ISSP. Example: If the participant-hired worker is authorized 40 hours per week and without prior approval submits a timesheet for 46 hours, the FEA will pay the wages for 40 hours. The claim for the remaining six hours would be denied as services in excess of authorization, per these work instructions.
7. In rare situations, when all other options have been considered, DHS may approve a request for an exception to this policy for service authorizations between 1 and 10 hours above 40 hours. There must be clear documentation of the exceptional need and a description of all options considered. **Budget amendments are not permitted for these additional hours. No exceptions to these work instructions are permitted without DHS written approval. Workers and participants will sign an acknowledgement of this limitation.**
8. If an emergency causes a participant-hired worker to exceed the 40 hour workweek, the IRIS participant must contact their IRIS Consultant (IC) to complete and submit the Participant-Hired Worker 40-Hour Health and Safety Assurance Exception Request (F-01689) form.
9. Participant-hired workers who provide **any** IRIS SDPC hours are not eligible to request a policy exception to provide more than 40 hours per week of any combination of services. IRIS SDPC is defined in the IRIS Service

Definition Manual ([P-00708B](#)). ICAs submit requests for policy exceptions for hours above 40 to DHS by completing the Participant-Hired Worker 40-Hour Health and Safety Assurance Exception Request (F-01689).

10. A notice of action is not issued for a denial of a request for additional scheduled hours over 40 because there was no adverse action (denial, reduction, or termination of services) regarding the number of care hours available to the participant. An additional qualified provider may provide the hours in excess of 40 hours.
11. ICAs may not create service authorizations in excess of 50 hours per week for one worker for any reason.
12. Participants choosing to exercise employer authority should maintain weekly schedules for each worker. The schedule should be communicated to participant-hired workers in advance of performing the work.
13. The FEAs are authorized to pay only up to the amount on the approved service authorization. Participant-hired workers sign the Participant-Hired Worker Education: Participant-Hired Worker 40-Hour Health and Safety Assurance (F-01701) form indicating they accept responsibility for ensuring that the total number of hours listed on the timesheet(s) does not exceed the approved service authorization(s).
14. Participants are responsible for ensuring that they do not sign a timesheet or in any way promise payment for hours worked in excess of the approved service authorization.
15. The participant is required to have a robust emergency backup plan that is in compliance with Section 4.5A.1.
16. DHS defines the “work week” as beginning Sunday at 12:00AM and ending the following Saturday at 11:59PM.
17. Participants choosing to exercise their employer authority are required to be compliant with all United States Department of Labor regulations, including the Fair Labor Standards Act ([FLSA](#)). Information on FLSA is available online at: <http://www.dol.gov/whd/flsa/>.

Education

Step #	Responsible Partner(s)	Detail
Step 1	ICA	Each ICA maintains responsibility for ensuring the field staff is knowledgeable of these requirements and is adequately prepared to assist participants in plan development incorporating the 40-hour health and safety assurance requirement.
Step 2	FEA	Each FEA maintains responsibility for ensuring their staff is knowledgeable of these requirements and is adequately prepared to implement the assurance requirements to participant-hired workers' pay and to provide accurate information to participants and participant-hired workers.
Step 3	ICA	Each ICA maintains responsibility for educating participants regarding the 40-hour health and safety assurance for participant-hired workers using the Participant Education: Participant-Hired Worker 40-Hour Health and Safety Assurance (F-01702) form. This education must occur prior to submitting paperwork to hire the first participant-hired worker and annually thereafter.
Step 4	Participants	As the employer, each participant is responsible for educating his or her participant-hired workers regarding the 40-hour health and safety assurance using Participant-Hired Worker Education: Participant-Hired Worker 40-Hour Health and Safety Assurance (F-01701) form. This education must occur prior to submitting paperwork to hire the participant-hired worker and annually thereafter.

Incorporating the 40-hour Health and Safety Assurance into the Planning Process

Step 5	Participant, IC	The participant and the IRIS Consultant (IC) ensure that the participant has hired enough participant-hired workers and/or agency workers to provide the participant's needed cares without any one participant-hired worker working in excess of 40 hours.
Step 6	IC	The IC verifies that there are a sufficient number of workers available to provide the hours authorized to meet the participant's long-term care outcomes and health and safety needs.

Submitting Timesheets

Step 7	Participant-Hired Worker	The participant-hired worker completes his or her timesheets reflecting the actual number of hours worked ensuring the total is not in excess of 40 hours per week without prior approval.
Step 8	Participant	The participant reviews and approves the participant-hired worker's timesheets ensuring the total hours is not in excess of 40 hours per week.

How FEAs Will Apply the 40-hour Health and Safety Assurance to Timesheets Exceeding the 40-Hour Limit

Step 9	FEA	The FEA reviews the timesheets and pays according to the approved service authorizations. The FEA is not permitted to issue payment for any timesheets submitted with total hours worked that exceed the service authorization.
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Step 10	FEA	The FEA notifies the affected participant(s) and participant-hired workers of the number of hours that were unpaid and the reason for the non-payment. The FEA offers the participant and participant-hired worker assistance in understanding the policy. The FEA also redirects the participant to his or her IRIS Consultant to help the participant make changes to the work schedule if needed.
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Requesting Additional Hours

NOTE: At present, the functionality to identify work requests in the manner described in Steps 11-15 is not yet available. During development, the ICAs and DHS will complete the same process below instead, using email and entering the specified work request types in the subject line of the email. The email address to initiate the policy exception request for additional hours with DHS is DHSIRIS@wisconsin.gov.

Step 11	ICA, Participant	The ICA and the participant develop an ISSP and accompanying service authorizations for an additional 1-10 hours beyond 40 hours across the following services: supportive home care, respite, daily living skills training, or other hourly paid service approved by the 1915 (c) Home and Community-Based Waiver.
Step 12	ICA, Participant	The ICA and the participant complete the Participant-Hired Worker 40-Hour Health and Safety Assurance Exception Request (F-01689) providing justification for the request and documenting the options that were exhausted.
Step 13	ICA	The ICA submits the F-01689, proposed ISSP, and any proposed service authorizations to DHS using the work request type in the Wisconsin Self-Directed Information Technology System (WISITS), "Additional Hours Request: DHS Review."
Step 14	DHS	DHS reviews the request and issues the following decision to the ICA via one of the following WISITS work request types: <ul style="list-style-type: none"> • "Additional Hours Request: Denied" • "Additional Hours Request: Approved" • "Additional Hours Request: Need More Information"
Step 15	ICA	The ICA notifies the participant of the decision in cases wherein DHS approves or denies the request. In cases of approval, the ICA and the participant implement the proposed ISSP.
Step 16	DHS, ICA	In cases where DHS requests additional information, steps 13-14 recur until DHS has sufficient information to approve or deny the request.

Data Collection, Reporting, and Monitoring

Step 17	DHS	DHS ensures the completion of the Participant Education: Participant-Hired Worker Hours Assurance (F-01702) form through the record review process. Remediation of individual negative findings is completed as described in section 10.4A.1, Record Review Process.
Step 18	DHS	DHS reviews the data related to Additional Hours Requests available in WISITS regularly and addresses any performance issues with the appropriate ICA or FEA through the Quality Management Plan process outlined in Section 10.4B.1.
Step 19	FEA	The FEA provides DHS with quarterly data regarding timesheets in excess of the 40-hour health and safety assurance. The FEA provides the following data points: <ul style="list-style-type: none"> • Number of participant-hired workers submitting timesheets in excess of the 40-hour assurance.

		<ul style="list-style-type: none">• Number of hours that were not paid because they exceeded the 40-hour assurance.• Number of dollars that were not paid because the number of hours exceeded the 40-hour assurance.
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BUREAU OF AGING AND DISABILITY RESOURCES
AGING UNIT SELF-ASSESSMENT FOR 2015

County/Tribe: Jefferson County

Name of Aging Unit Director: Sue Torum

Approved by Commission on Aging?

Yes

X

No

Date

Approved:

Part I: Compliance With the Wisconsin Elders' Act

Organization of the Aging Unit

The law permits one of three organizational options. Which of the following permissible options has the county/tribe chosen?

Check One

1. The aging unit is an agency of county/tribal government with the primary purpose of administering programs for older individuals of the county/tribe.

2. The aging unit is a unit, within a county/tribal department with the primary purpose of administering programs for older individuals of the county/tribe.

X

3. The aging unit is a private nonprofit corporation, as defined in s. 181.0103 (17).

Organization of the Commission on Aging

The law permits one of three options. Which of the following permissible options has the county/tribe chosen?

Check One

1. For an aging unit that is described in (1) or (2) above, organized as a committee of the county board of supervisors/tribal council, composed of supervisors and, advised by an advisory committee, appointed by the county board/tribal council. Older individuals shall constitute at least 50% of the membership of the advisory committee and individuals who are elected to any office may not constitute 50% or more of the membership of the advisory committee.

X

2. For an aging unit that is described in (1) or (2) above, composed of individuals of recognized ability and demonstrated interest in services for older individuals. Older individuals shall constitute at least 50% of the membership of this commission and individuals who are elected to any office may not constitute 50% or more of the membership of this commission.

3. For an aging unit that is described in (3) above, the board of directors of the private, nonprofit corporation. Older individuals shall constitute at least 50% of the membership of this commission and individuals who are elected to any office may not constitute 50% or more of the membership of this commission.

Part I: Compliance With the Wisconsin Elders' Act (continued)

Needs to be completed only if there have been changes since completing your 2013-2015 plan.

Full-Time Aging Director

The law requires that the aging unit have a full-time director as

Does the aging unit have a full-time aging director?

described below. Does the county/tribe have a full-time aging director as required by law?	X	Yes
		No
Membership of the Commission on Aging Members of a county or tribal commission on aging shall serve for terms of 3 years, so arranged that as nearly as practicable, the terms of one-third of the members shall expire each year and no member may serve more than 2 consecutive 3-year terms. In the case of county board members, the requirement is 3 consecutive 2-year terms.	Is the aging unit in compliance?	
	X	Yes
		No

Members of the Commission on Aging (please list)			
Name of Individual	Age 60 and Older (x)	Elected Official (x)	Year first term began
Chairperson: Earlene Ronk	X		2012
Carol Battenberg	X		2012
Ellen Haines	X		2013
Daniel Krause			2012
Marcia Bare	X		2015
Russ Kutz	X	X	2015
Carolyn Niebler	X		2013
Connie Stengel	X		2013
Vacant			

IMPORTANT: If the aging unit does not meet with all of the above, it is required to submit a corrective action plan outlining a timeline and goals, in SMART format. The policy manual outlines such plans which must include involvement of older persons, discussion of such a plan at commission on aging/advisory committee meetings and appropriate public hearing notices, meeting notices, agendas, and minutes. Corrective action plan documents must be sent electronically to GWAAR (sarah.cowen@gwaar.org).

Part II: Activities to Help Older People Advocate for Themselves

1. What does the aging unit do to inform older people about the issues that affect their lives?

We send out news releases, Advocacy Alerts, posters and newsletters. We meet with people at various locations to discuss concerns. We send out information to home delivered meal participants and place information in table tents at the Senior Dining Centers. We will go on the radio as well.

2014 - Unchanged

2015 - We distributed ADPAW/GWAAR Advocacy materials related to the governor's budget to Senior Centers, Senior Housing Complexes, and other public places. Information was posted on the ADRC website; including Advocacy Alerts, ADRC Advisory Committee agendas and minutes. Advocacy was often a topic. We included this information in caregiver newsletters and provided updates at various public meetings. Information was sent to home delivered meal participants and was included in table tents at congregate meal sites. The EBS Program provided updates at meal sites.

2. How does the aging unit teach older people to act as advocates?

On November 1, 2013 Jefferson County hosted a Senior Statesmanship Program. We did not have enough interest to hold the program as planned, but we didn't cancel. Five people attended a half day abbreviated program.

2014 - We offer this program when we can, and use our ADRC Committee meetings to discuss ways committee members can engage peers in advocacy efforts on a regular basis.

2015 - Again, through the activities listed in #1 above, we inform and encourage people to call their representatives to tell their story.

3. How does the aging unit advocate on behalf of the older people it serves?

The ADRC Advisory Committee has Advocacy as a standing agenda item. Committee members are asked to help spread the word about any issues that affect older people. The committee also writes letters to legislators. The Aging & Disability Resources Division Manager regularly attends Human Services Board meetings and keeps members informed of issues affecting older people. When there are issues that have the potential to adversely affect services, participants are informed and asked to engage in the process.

2014 - unchanged

2015 - The Aging Unit Director:

- Attended a public hearing on the Governor's Budget at Alverno College in Milwaukee and provided written testimony.
- Attended a legislative listening session held in Jefferson County and provided testimony.
- Engaged in advocacy opportunities via the Core Group/Base Camp a.k.a ADPAW Advocacy Group.
- Invited to and attended the Advocates Group Family Care 2.0/IRIS Public Meeting with

DHS.

- **Attended Human Services Board Meetings and provided updates regularly.**

Part III: Progress on the Aging Unit Plan for Serving Older People – Statewide Priorities				
Section 4 A-F: Statewide Focus Areas	Progress Notes (briefly summarize only those activities completed as of Dec. of each year; explain if a goal was not accomplished)	Check if Done		
		2013	2014	2015
Focus 4-A: Development of a System of Home and Community-Based Services				
Goal 1: To increase the utility of referrals for people who are calling on behalf of a family member with dementia, questionnaires will be sent within two weeks of contact to measure the extent of its usefulness on a Likert Scale. The project will test for three months.	2014 Surveys are complete and the first set was sent out on 2/27. 2015 - Goal to test quarterly abandoned. Surveys will be available on the website and provided when the case is closed.			
Goal 2: To expand staff knowledge of the various avenues of advocacy under publicly funded long term care programs, a project will be undertaken to test staff knowledge. Four staff members will be provided a pre and posttest and those with scores below 90% will retest with results at or above 90%.	Goal Met.		X	
Goal 3: To increase staff awareness in the area of cultural competence, a project will focus on how the ADRC is prepared to respond to non-English speaking customers or those identified as Latino or Hispanic origin. According to most recent Census, 6.2% of Jefferson County residents identify themselves in this category.	Goal Met. We did a NIATx project involving a bilingual client to see what his experience would be entering the ADRC presenting as a non-english speaking individual. He was then invited to lunch to discuss his impressions with the team. They enjoyed this.		X	
Focus 4-B: Older Americans Act Programs				
Goal 1: To increase participation in the Senior Dining Program by 5% the first year of the plan; 7% the second year and 10% the third year.	The goal to increase participation was not met in 2013 or 2014. In 2014 our attendance did increase, but it was only by 3%. We will review our "marketing" strategies and explore new ways of reaching out to potential customers. We had expected the return to Feil's Catering to impact participation at a much greater level. 2015 - This goal was not met overall. Some sites			X

	did exceptionally well in terms of increasing attendance. Others not so well and at this time the home delivered meal program experienced a 2,510 decrease in meals delivered between 2014 & 2015.			
Focus 4-C: Alzheimer's Disease				
Goal 1: Conduct 15 Cognitive Screens by 12/31/2013.	Goal met and ongoing	X		
Goal 2: Develop a county wide identification system for people diagnosed, who also are in some way at risk of interventions by law enforcement, to alert officers to the individual's plan by 12/31/2013.	Goal met see below.	X		
Goal 3: Implement the identification system in two jurisdictions each year of the plan, i.e. Watertown & Lake Mills by 12/31/2013; Jefferson & Fort Atkinson by 12/31/2014 and Palmyra & Waterloo by 2015.	Goal met. In 2013 we hired a dementia care specialist and after speaking with several law enforcement agencies, we learned that the Sheriff's Office maintains a dementia registry that is available to every jurisdiction in the county so we built a registry in that system so all communities are covered. We have a draft brochure in process. It's not an ongoing goal. 2015 - Goal met in 2013.	X		
Focus 4-D: Emergency Preparedness				
Goal 1: To raise awareness about staying safe at Senior Dining Sites, Nutrition Program staff shall provide participants with information about what to do in an emergency at each of its 6 dining centers each year of the plan.	Goal met & ongoing. In April we always review where exits are in the buildings and where to seek shelter if there was a tornado. 2015 - Goal met in April of 2015.	X	X	X
Goal 2: In order to increase awareness of natural events that are prevalent in WI, the ADRC will distribute no less than one news release on a quarterly basis each year of the plan.	Goal met & ongoing: This goes to all dining sites, home delivered meal participants and senior centers, and we have an emergency preparedness section on our website. We have table tents at the dining centers and that is where this information is displayed. We did not do news releases as other	X	X	X

	organizations already to that.			
	2015 - We did the same activities in 2015 as were done in 2014.			
	Goal met and ongoing: The first year the goal was met as stated. We were involved in COOP Plan and that should be back in 2015 from the company hired to produce it. The Dining Site and transportation staff talk about natural disasters much more frequently than others since we are out serving people in all of the elements.			
Goal 3: In order to increase staff awareness regarding their responsibilities before, during or after a disaster, review & revise the agency's Continuity of Operations Plan on an annual basis. Staff training will occur on a quarterly basis to address: flooding, winter storms, tornados, heat, etc.	2015 - The COOP plan was updated again in the fall of 2015. Website materials are reviewed with staff and training occurs at Nutrition Project Council & Site Manager team meetings. The Human Services Department also conducts fire/tornado drills for staff.	X	X	X
Focus 4-E: Evidence-Based Prevention Programming				
	Goal met and ongoing, ADRC Staff offered two CDSMP's in 2013. The first group met in Jan/Feb. The second class was offered and canceled due to lack of interest.			
Goal 1: The ADRC will expand prevention programming by offering 1 evidenced based prevention program in 2 communities by 12/31/2013 and 2 evidenced based prevention programs in 2 different communities by 12/31/2015.	2015 - This goal has been met. Stepping On & Healthy Living w/Diabetes was offered in Fort Atkinson; A Matter of Balance was offered in Lake Mills.	X	X	X
Goal 2: The ADRC will expand its ability to provide prevention programs by training two Aging & Disability Resource Specialists about the <i>Stepping On</i> program by 12/31/2014.	Goal met and exceeded our expectations. In 2014 we established a contract with Lee Clay, Preventative Health Strategies and due to this contract we offered and held the following classes: Powerful Tools for Caregivers; Stepping On; Walk with Ease and Strong Women in addition to Living		X	

<p>Does the aging unit facilitate a local caregiver coalition?</p> <p><input type="checkbox"/> YES or <input checked="" type="checkbox"/> NO</p> <p>If No, please state which local agency facilitates this coalition: The Community Care Alliance of Jefferson County facilitates meetings.</p> <p>If Yes, was information provided in the 3-year plan on the coalition's members?</p> <p><input type="checkbox"/> YES or <input type="checkbox"/> NO</p> <p>If Yes, were goals stated for 2014 to coordinate caregiver services?</p> <p><input type="checkbox"/> YES or <input type="checkbox"/> NO</p>	<p>Please provide a brief update on coalition activities conducted in 2013:</p> <p>We met March 20th – 14 people (agenda forwarded already); June 12th – 6 people; September 11 (3 people including me) so there was nothing significant to report, but we did have 3 meetings. An email was sent to coalition members about how to regroup in 2014.</p> <p>Please provide a brief update on coalition activities conducted in 2014:</p> <p>12/9/14: Reached out to existing Coalition Members asking if they want to continue getting emails about coalition activities.</p> <p>6/20/14: Scheduled a meeting, no-one attended.</p> <p>10/7/14: Sent another email to list serve. Asking who I could count on to help me reinvigorate the Caregiver Coalition. Two responses saying they would like to learn more.</p> <p>After the last GWAAR Ace meeting, I have a better understanding of this requirement (thanks to Jane M.) In 2015, this department will contract with home care agencies who provide direct services under III B and III E to care recipients and their caregivers. I believe this new connection will keep us engaged in discussions about NFCSP and will be the basis on which we build our Caregiver Network. We will have in person meeting and case-by-case consultations which should help educate them about the issues.</p> <p>Please provide a brief update on coalition activities conducted in 2015:</p> <p>In March 2015, the Jefferson County Personal Care Program closed. That meant that the contract that the Aging Unit had with them to coordinate services for caregivers returned back to the Aging Unit. When an agency is chosen by family members, it is generally one of the three that the department contracts with. The Division Manager met with all three and did an in-service on the NFCSP and AFCSP programs. Since that time there is regular, ongoing communication about caregiver needs.</p> <p>In November, the Dementia Care Specialist and Division Manager spoke at</p>
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	<p>the Community Care Alliance (CCA) Meeting and members were provided with information from the 2016-2018 Aging Unit Plan in regarding to the proposed caregiving goals. Members were in favor of being the "designated" entity/public forum for caregiver issues.</p> <p>The relationship between the Aging Unit and CCA will grow throughout the three year plan.</p>
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Part V: Progress on the Aging Unit Plan for Serving Older People – Local Priorities It is expected that each aging unit will have at least one local focus area/goal for each year of the plan. Please provide information here on goals accomplished in the previous year.				
Goal 1: Expand elder abuse prevention training by completing 1 workshop for <i>Your Friends-in-Action Volunteers</i> by 12/31/2013; 1 workshop by 12/31/2014 & 1 workshop by 12/31/2015.	<p>It was not met; I will retry in 2014</p> <p>The workshop was scheduled in February 2015 and cancelled because only one volunteer signed up.</p> <p>2015 - This goal was met. The in-service occurred in June.</p>			X
Goal 2: To dedicate two hours per month to provide information and assistance to elders wishing to discuss concerns about abuse or neglect in a neutral environment where anonymity is guaranteed by 12/31/2013.	<p>This goal will be abandoned. Callers already have the right to remain anonymous and it is difficult to dedicate regular hours due to the unpredictability of Adult Protective Services workload.</p>			
Goal 3: To educate elders about identifying risk factors related abuse/neglect, the I-team will develop a toolkit to use in conjunction with training sessions. The tool kit	<p>H:\Power Point\YEAP Presentation.pptx</p>	X		

Conclusions, Questions and Next Steps

- Continue to improve quality of the home visits
- Identify who needs a home visit and follow up more frequently
- Opportunities for future improvement

Thank you!



Lessons Learned

Strengths

- Satisfaction continues to grow with the experience of the ADRCs
- Domains remain consistent and show a growth in the domains of Knowledge and Guidance
- ADRCs are becoming more knowledgeable and better able to discuss complex issues with customers

Opportunities for future improvement

- Identify who needs a home visit and follow up more accurately
- Continue to improve timing of the home visits

Helping Customers Stay in their Homes

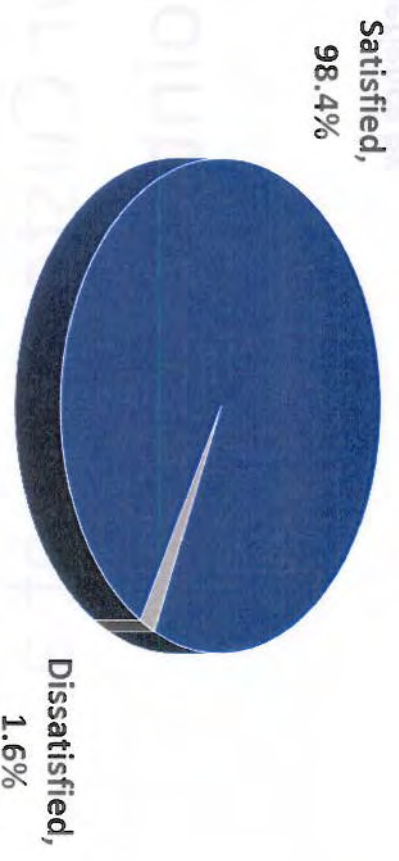
The ADRC helped me to stay at home in a situation where I might otherwise have gone to a nursing home or assisted living.



No or Not Applicable, 70.4%

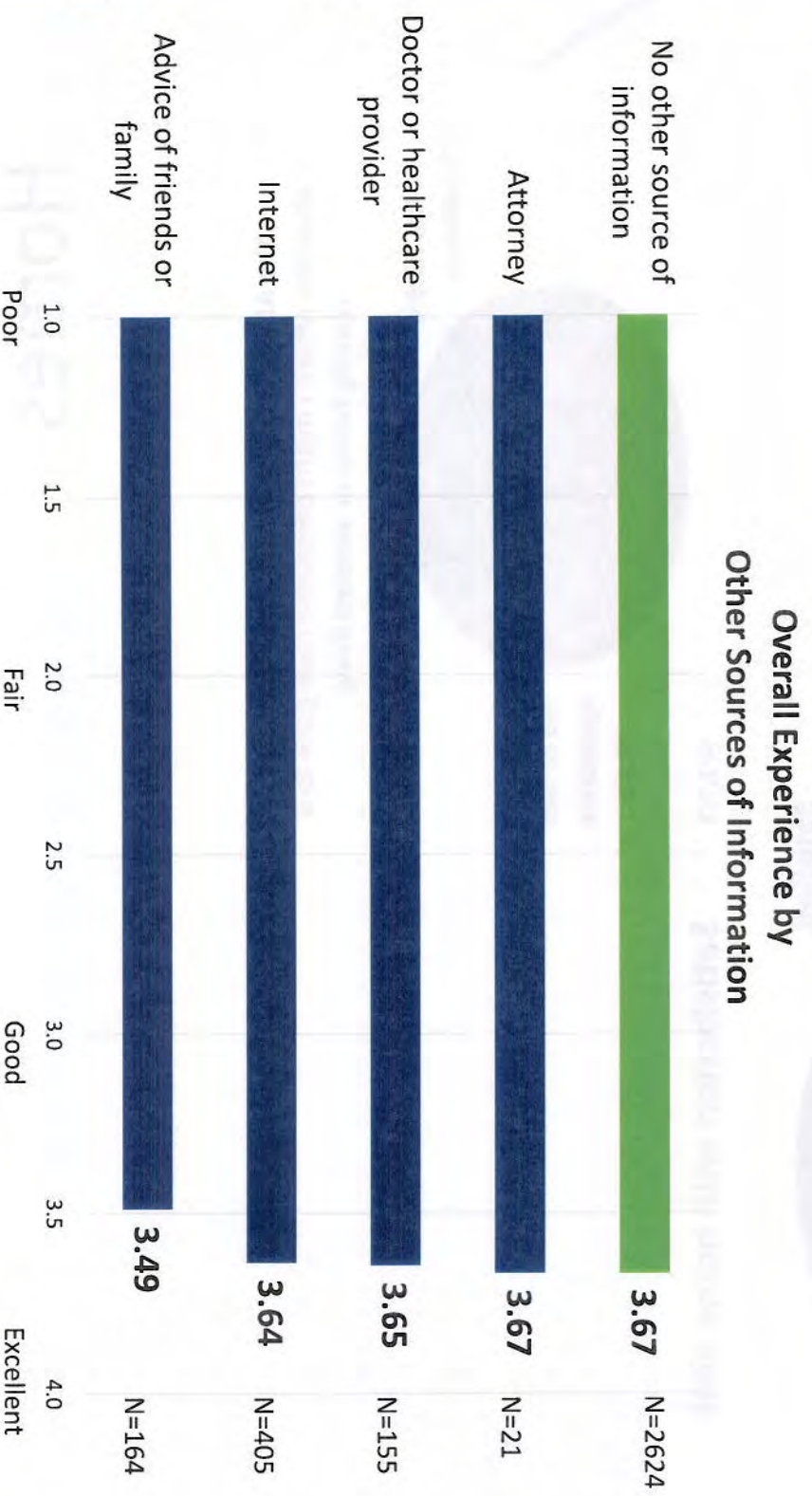
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Satisfaction with home visit

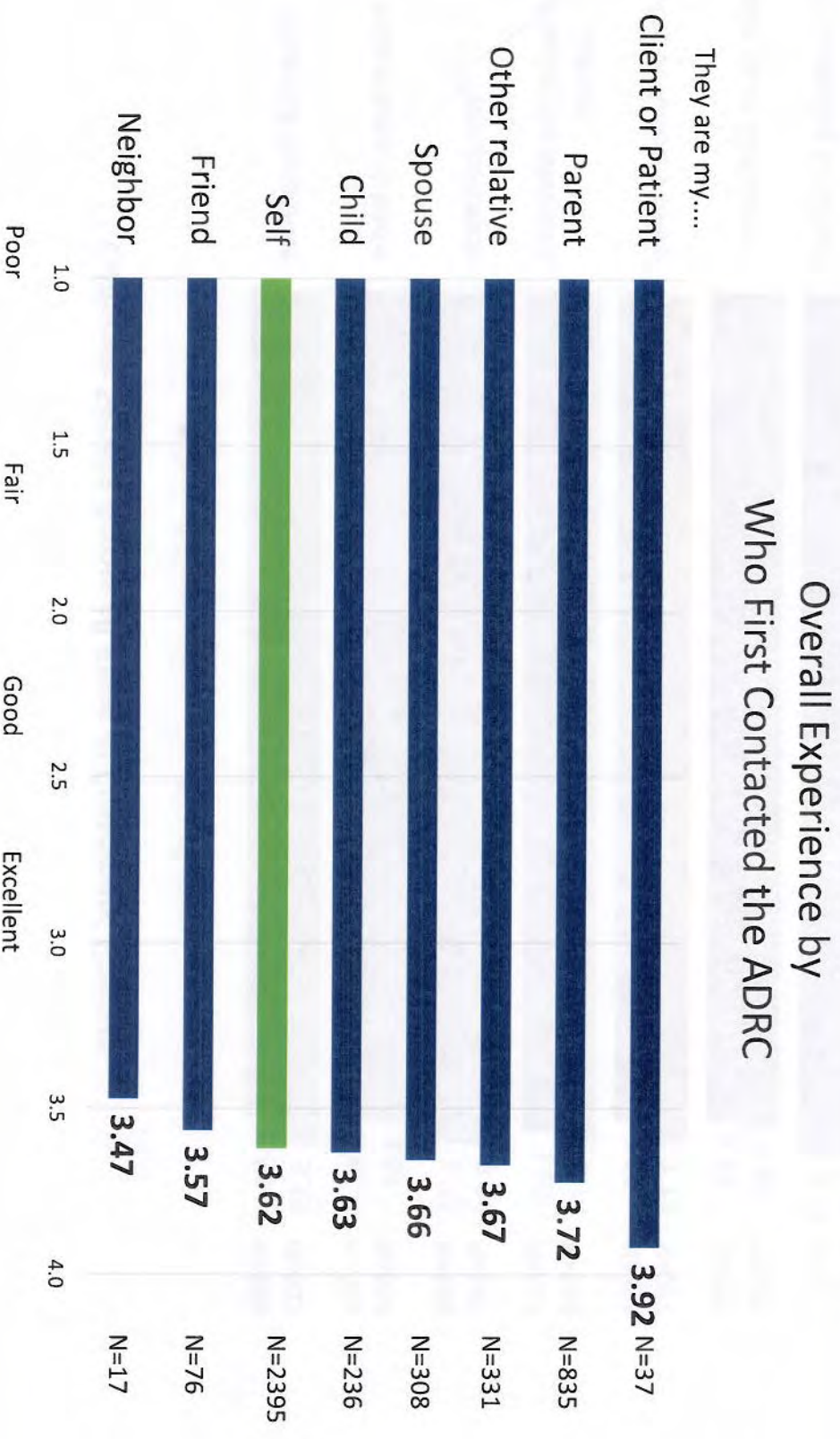


Dissatisfied, 1.6%

Customer Service for Customers at a Variety of Starting Points

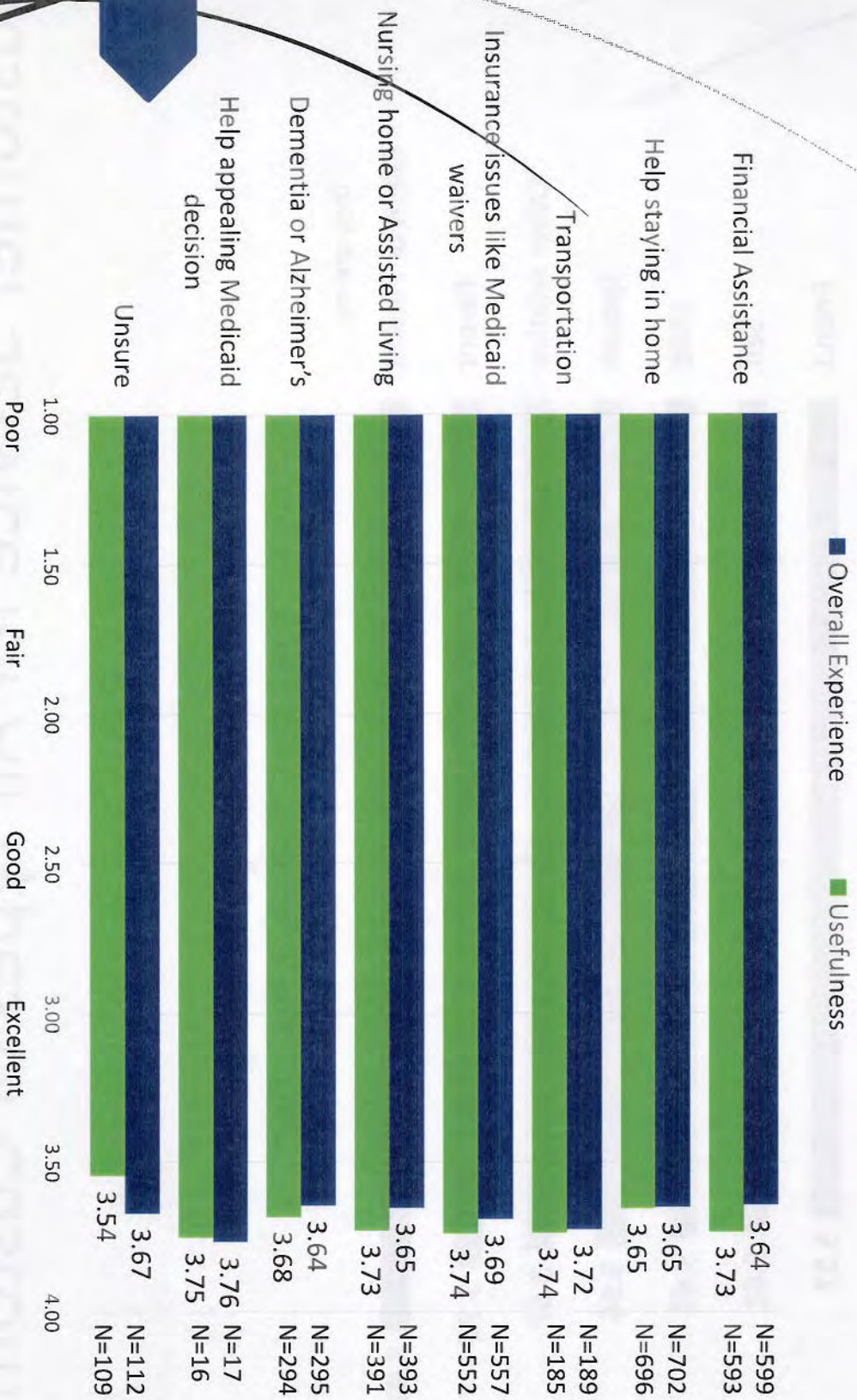


Customer Service for All Types of Customers



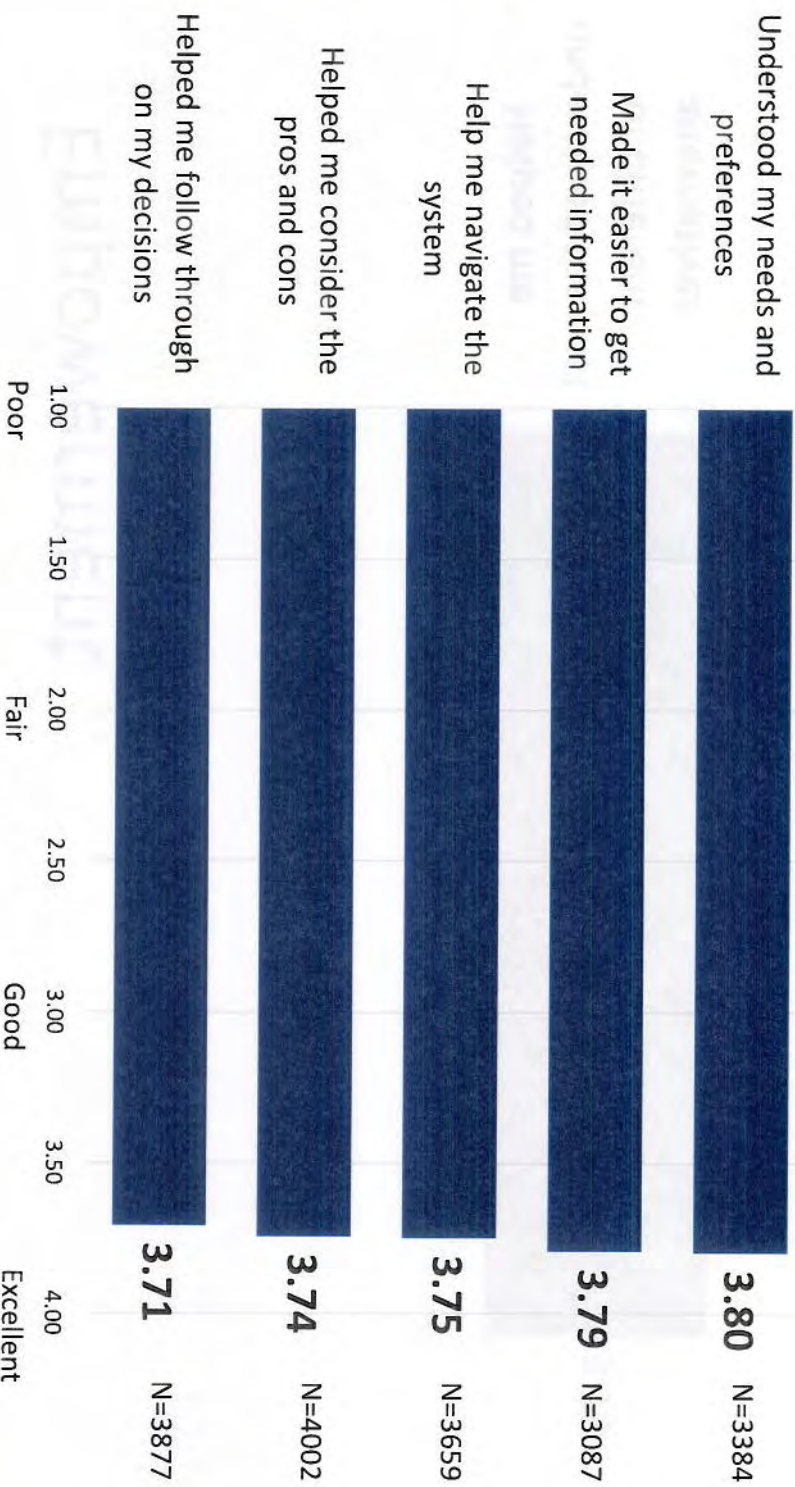
Customers' Main Concerns

Customer Service Across all Areas of Customers' Concern



Empowerment

Customer Empowerment



Empowerment

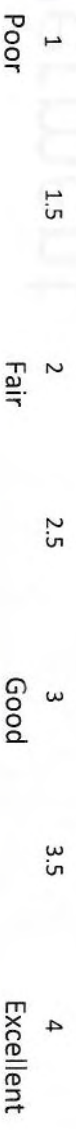
Customer Empowerment

Helped me understand the cost of different alternatives

3.75 N=3265

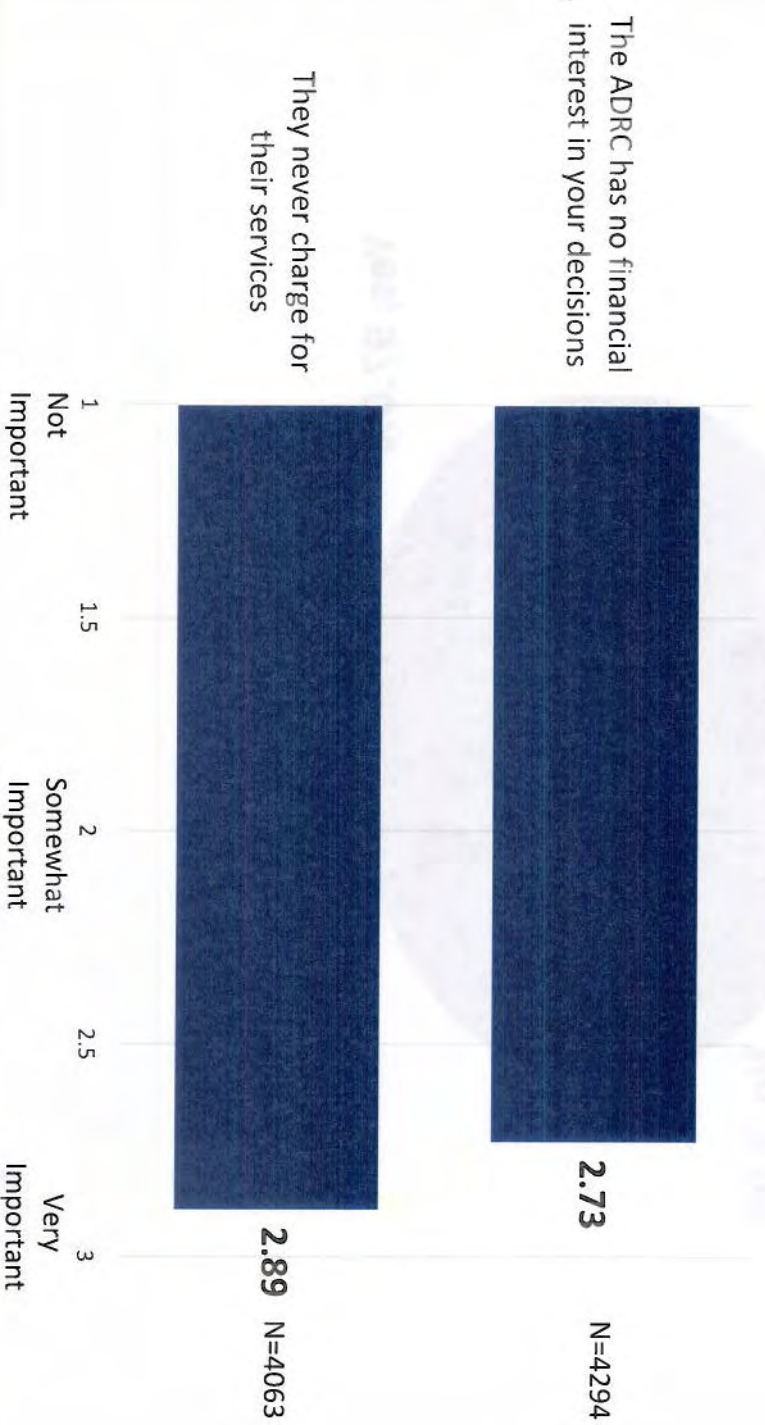
Helped me use resources wisely

3.76 N=3117

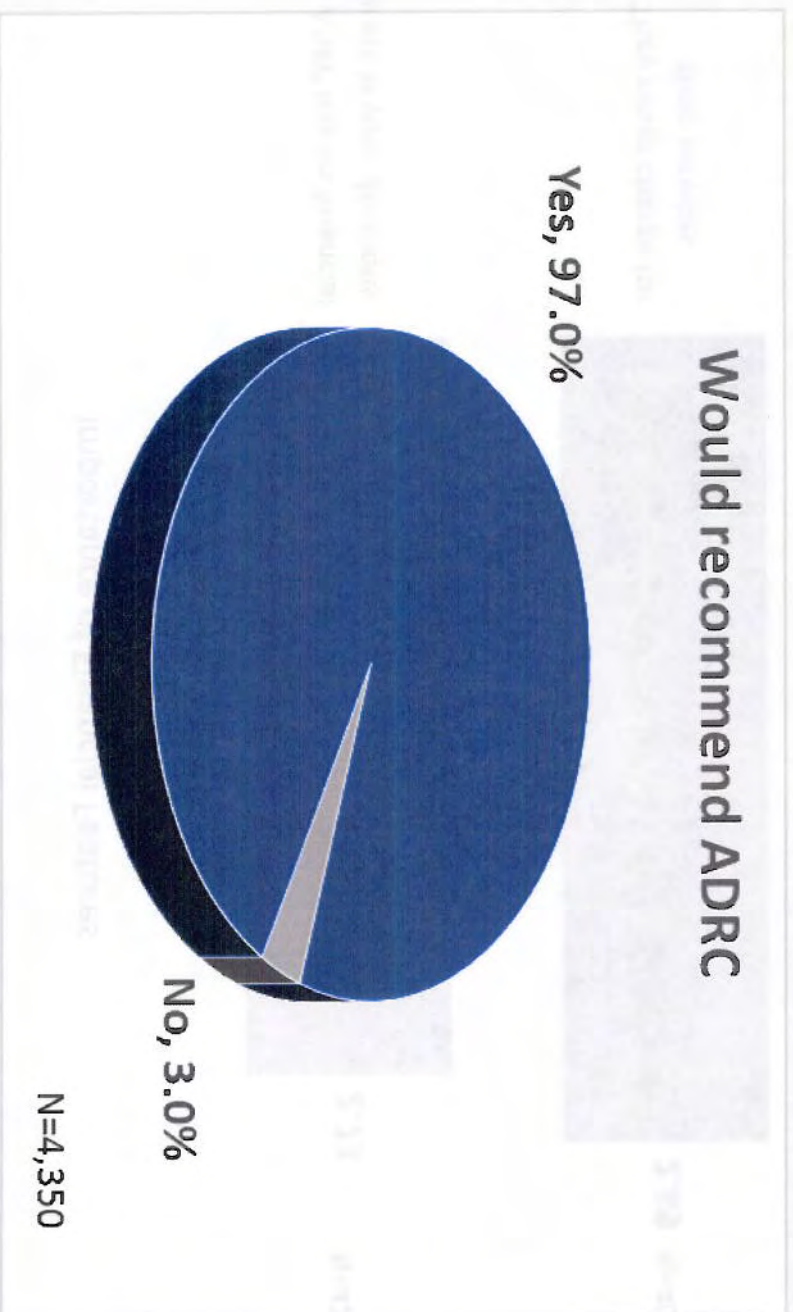


Objectivity

Importance of Financial Features



Recommendations



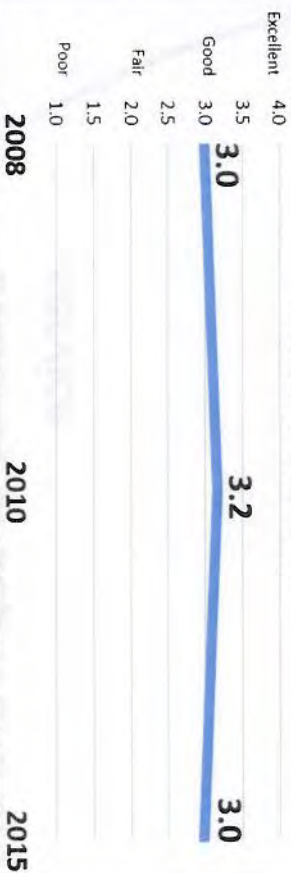


Additional Outcomes

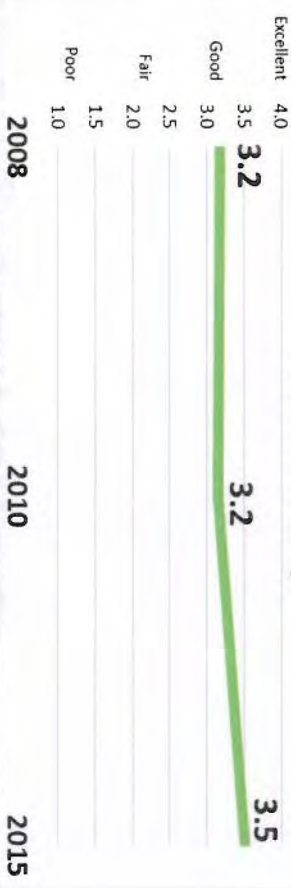
Evidence of depth and breadth of high quality customer service

Domains Over Time

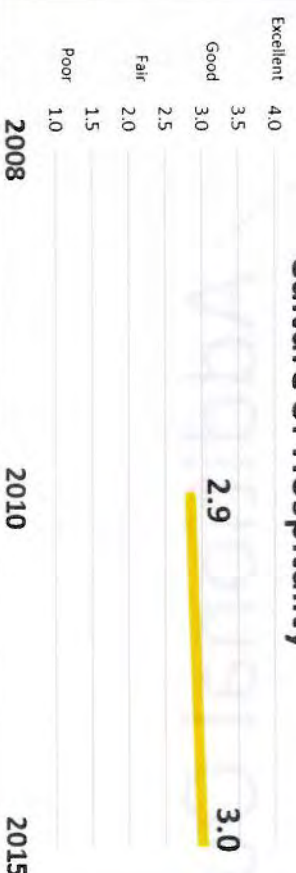
Personalization



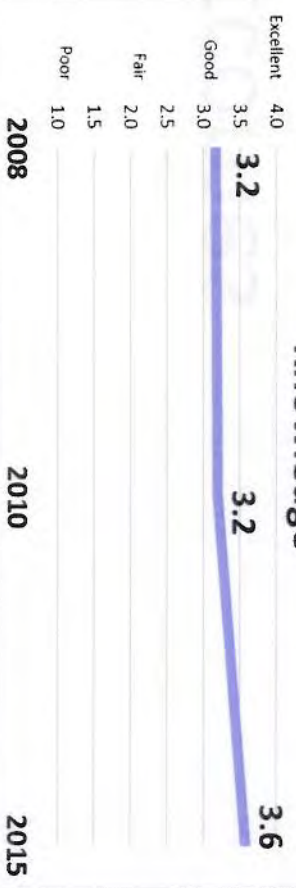
Accessibility



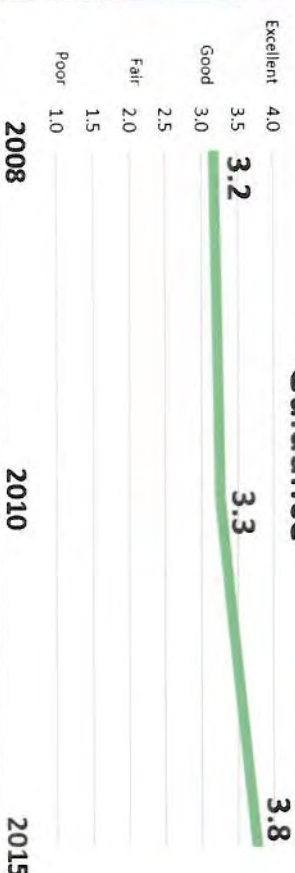
Culture of Hospitality



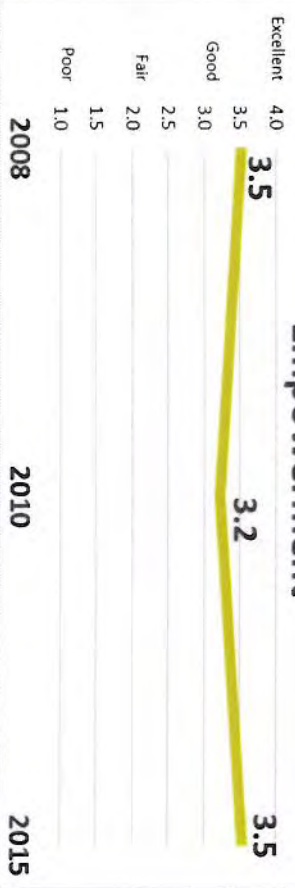
Knowledge



Guidance



Empowerment



Six Domains of Customer Satisfaction

Accessibility	Ease of finding the phone number Returning calls promptly Hours someone is available
Culture of Hospitality	Waiting time in office Comfort of the waiting room environment Privacy of conversation
Knowledge	Was knowledgeable about a range of services. <Did not> overwhelm me with too much information Made it easier to get the information I needed
Personalization	The person I worked with understood my needs and preferences Got a good sense of what I could afford.
Guidance	The person I worked with helped me consider the pros and cons. Explained each step clearly. Helped with the paperwork if needed. Helped me understand the costs. Helped me use resources wisely Helped navigate the system.
Empowerment	Let me know what to expect next. Helped me follow through on decisions. Helped me consider future needs. Helped me understand the cost of different alternatives Helped me use my resource wisely.

Domains

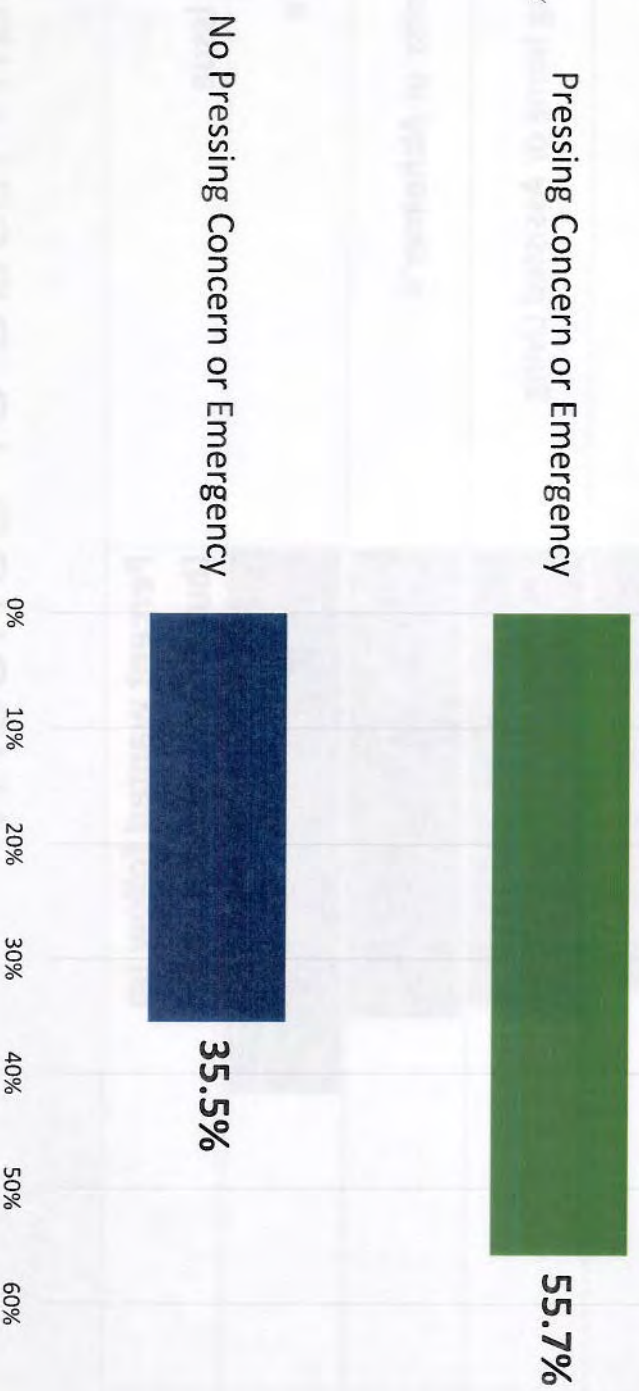
Consistent measures pointing to areas of past growth and potential for new growth



Domains of Customer Satisfaction

Follow up Growth Potential: Type of situation

Would you have liked to have had a follow up?



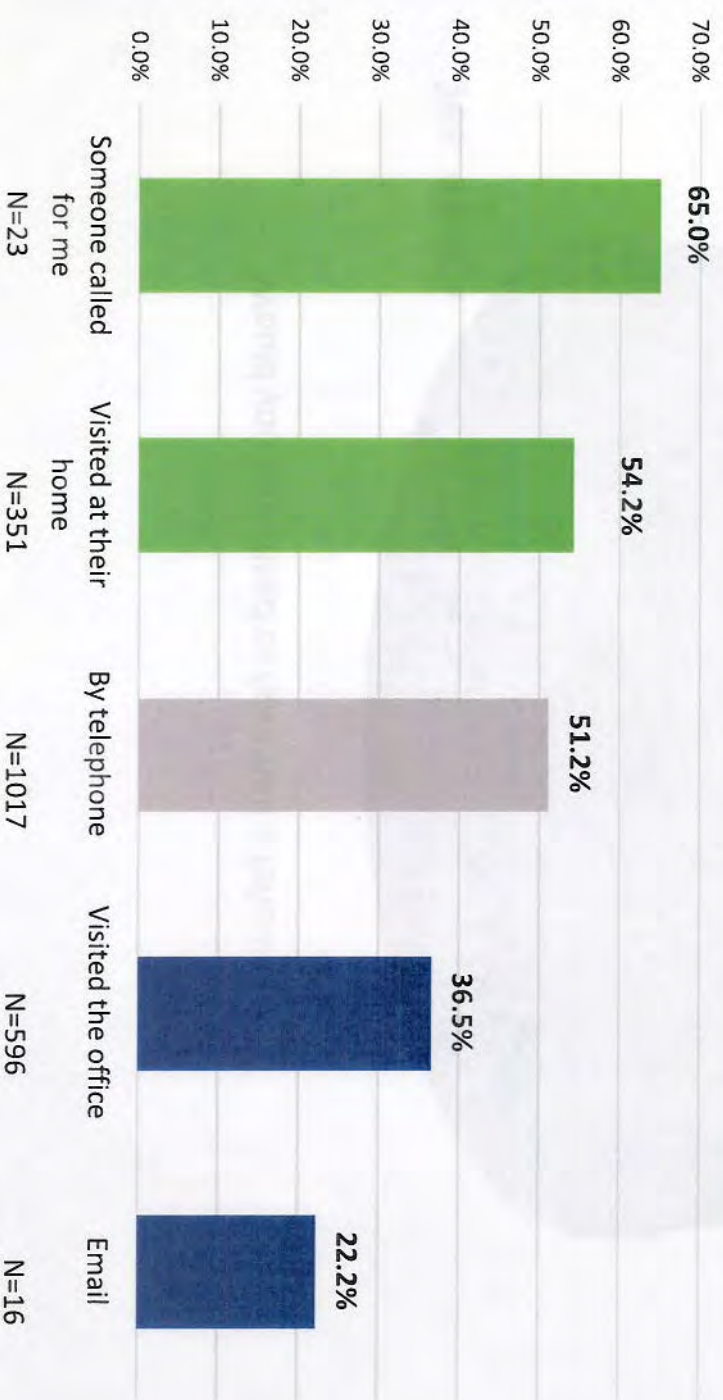
N=1261

Follow up Growth Potential: Main Issue of Concern

Main Issue	Percent wanted follow up (but did not receive one)	Sample Size
Unsure	64.7%	22
Dementia or Alzheimer's	55.8%	43
Nursing home or Assisted Living	54.3%	51
Help staying in home	52.5%	105
Financial Assistance	52.3%	104
Insurance issues like Medicaid waivers	43.8%	74
Transportation	35.9%	28

Follow up Growth Potential: Differences by how a customer first contacts the ADRC

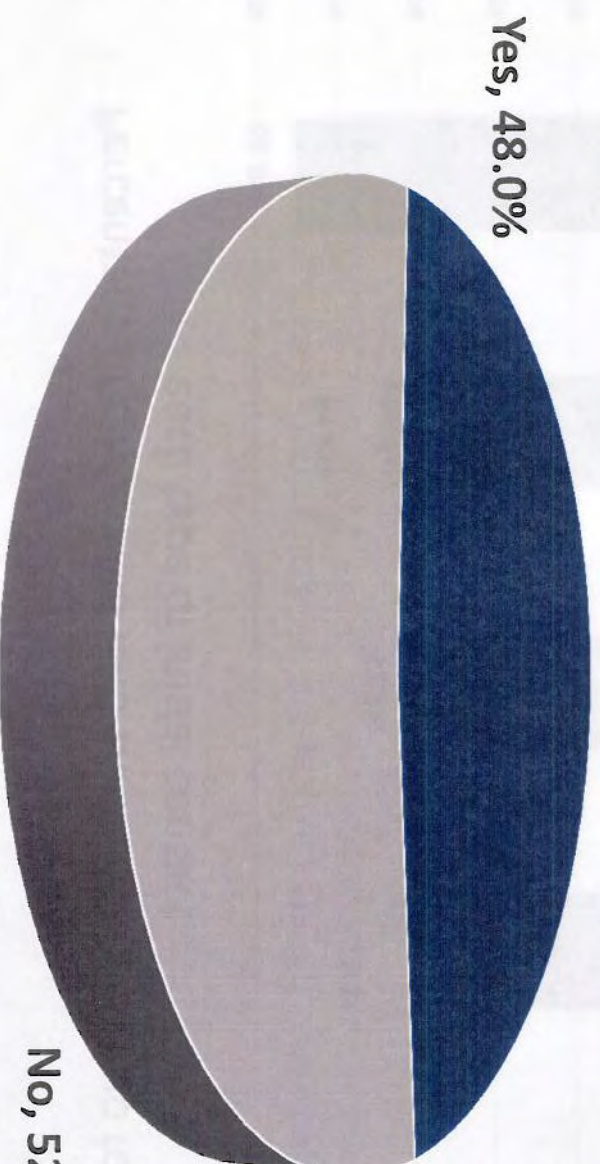
Percentage of customers who wanted a follow up for each type of initial contact



Higher level of agency may indicate less need for follow up.

Identifying the Need for Follow Up

Would you have liked to have had a follow up?



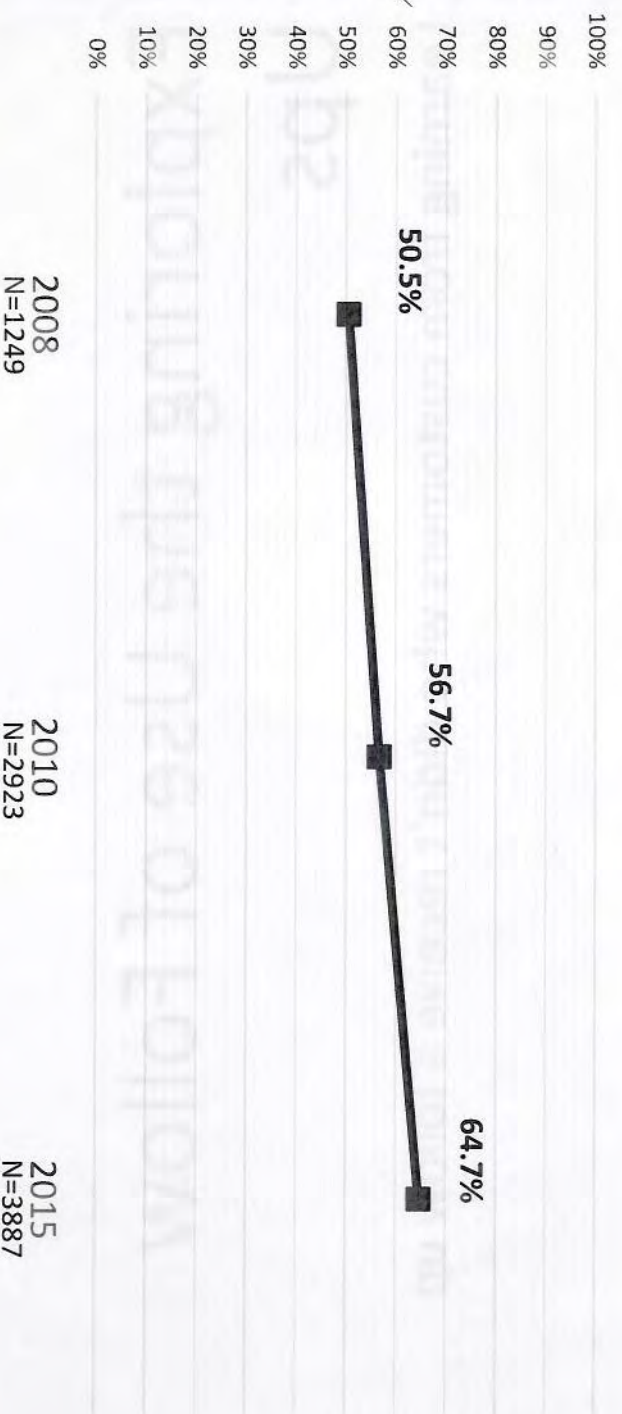
No, 52.0%

Yes, 48.0%

N=3887

Growing Use of Follow Up

Rate of Follow-ups



- Steady increase over time.
- About 5% over each 2-2 ½ year period.

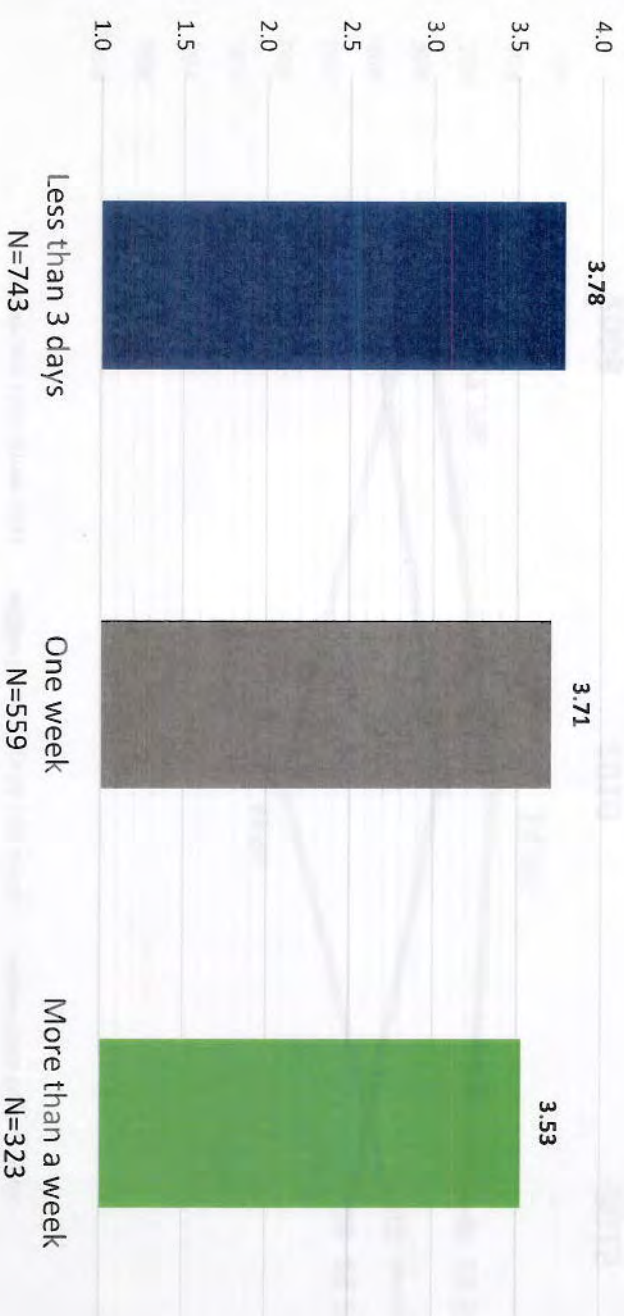
Exploring the Use of Follow Ups

Learning from customers who didn't receive a follow up

Growing use of Follow up

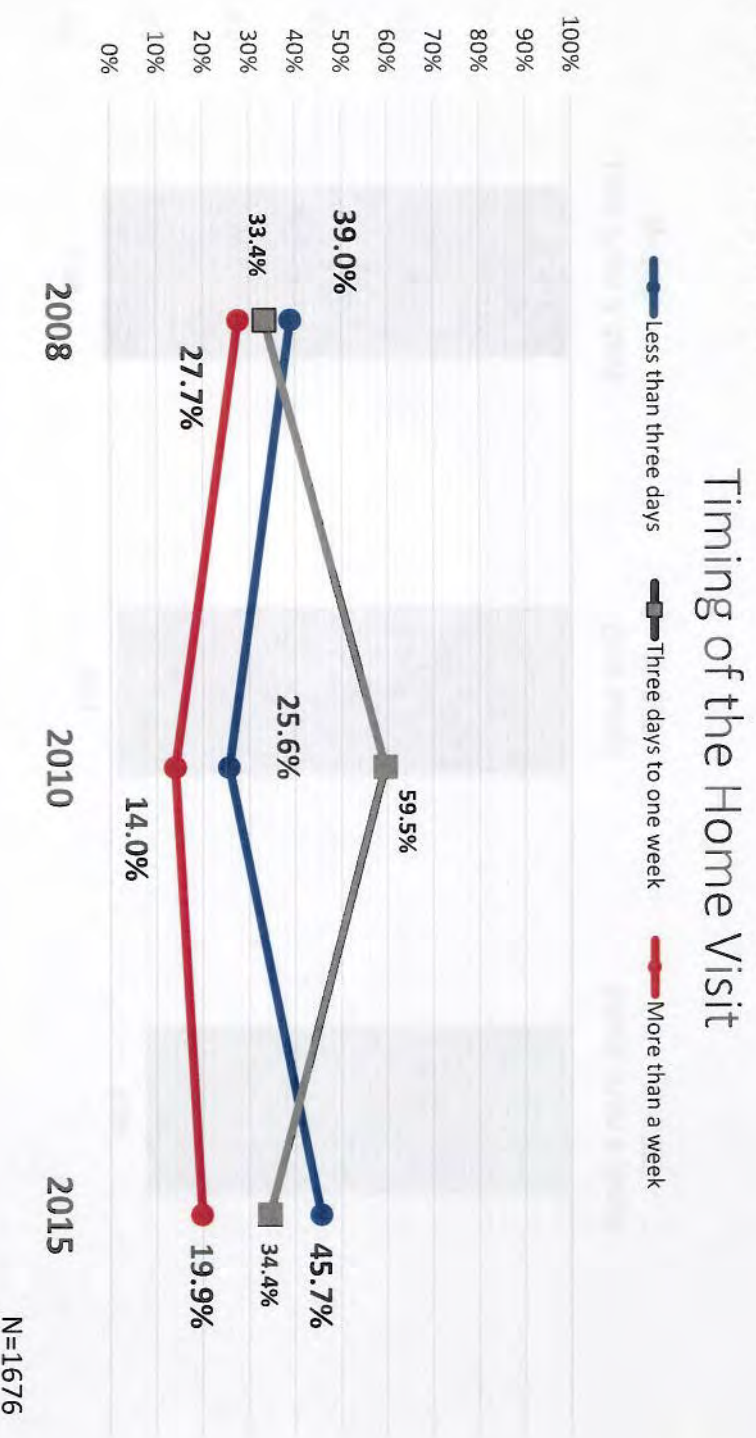
Satisfaction and Home Visits

Average Satisfaction for Each Visit Timing Option



2015 results only
Strong association between length of visit and overall satisfaction

Length of Time Before a Home Visit Over Time



- Significant decrease in over 3-days later visits.
- Significant increase in less than 3-days later visits.
- Transition (2010) in mid-range timing (3 days to a week)

Home visits



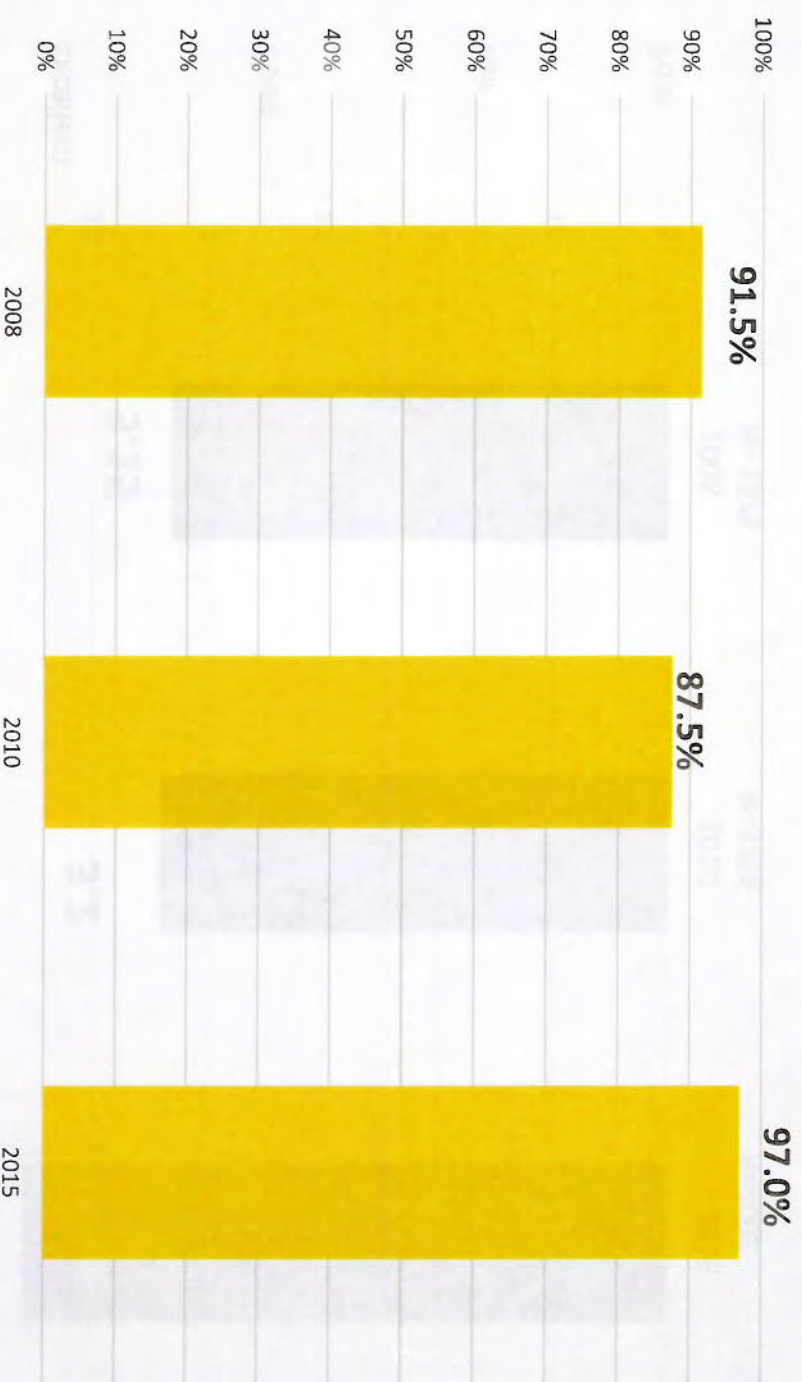
- Significant decrease in percent of customers reporting a home visit.
- Strongly associated with overall satisfaction.
- Yet overall satisfaction increase!



Home Visits

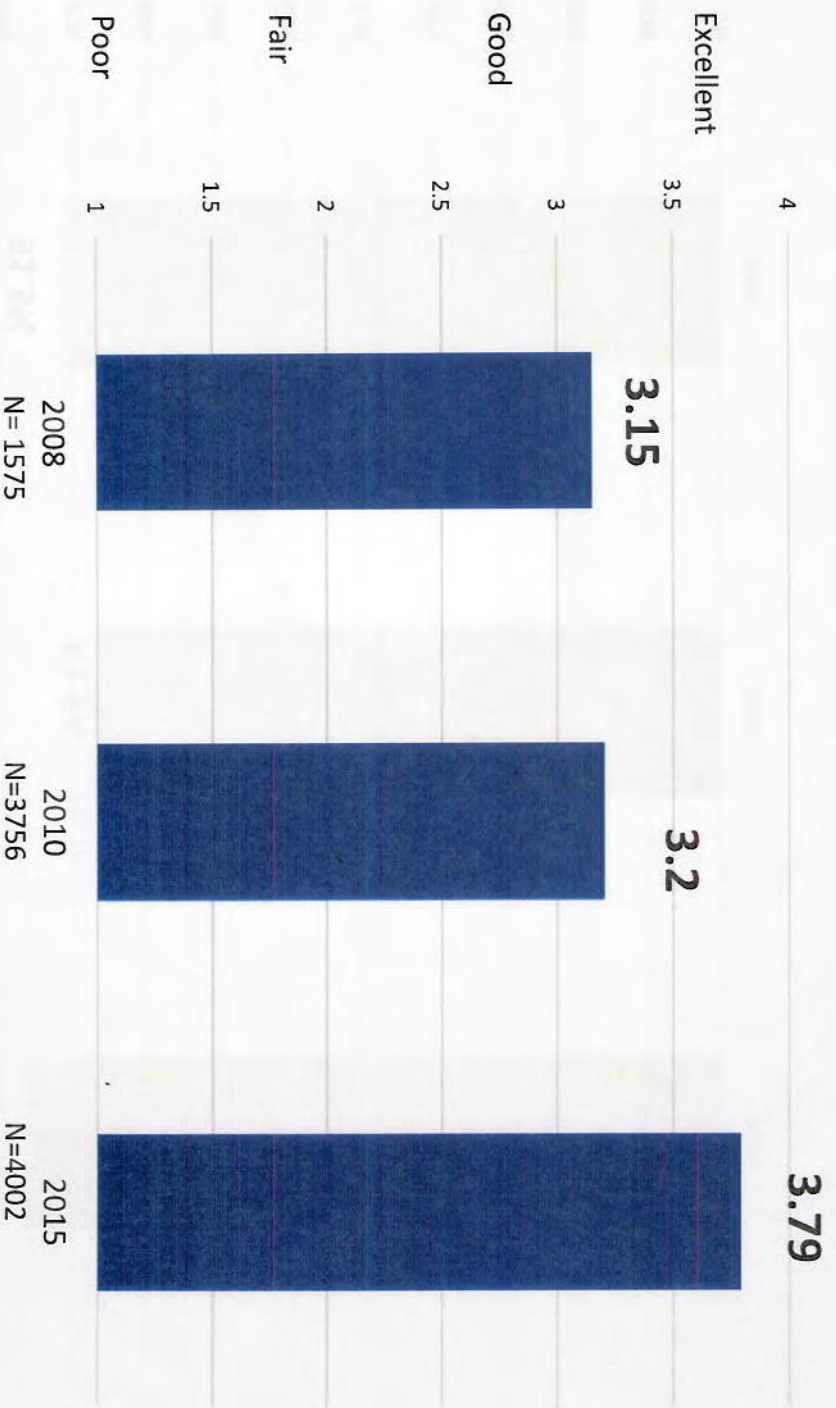
The “when” and the “who”

Would you recommend the ADRC?



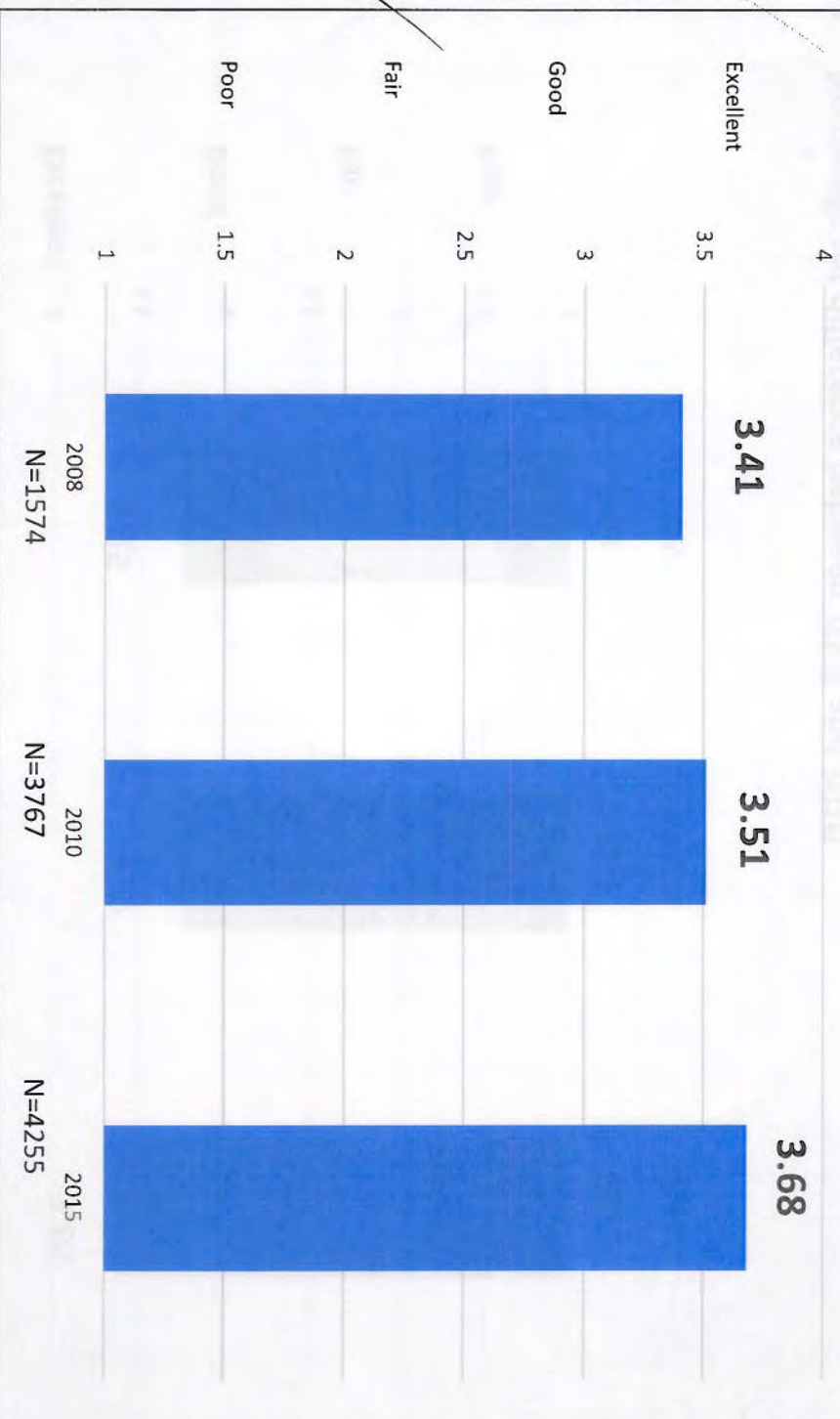
- Steady, significant increase.
- Not much room for improvement.

The ADRC made it easy to access the information I needed



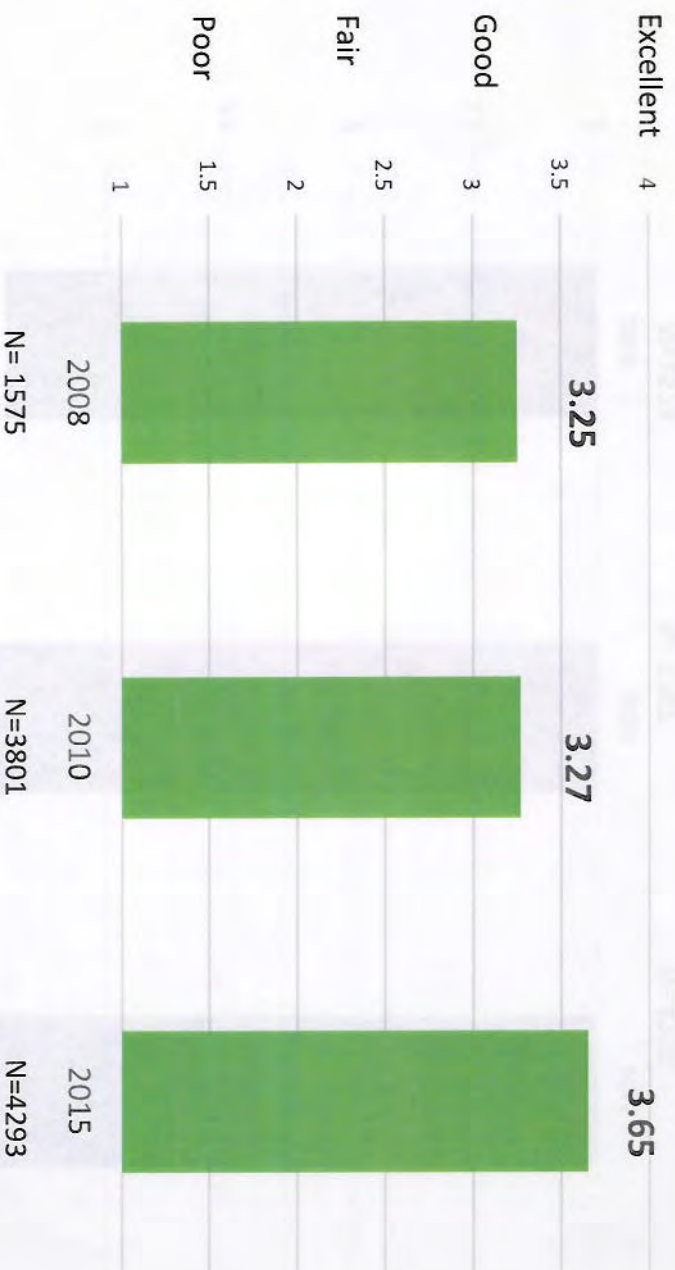
- Steady, significant increase.

How useful was the help you received?



- “Almost” (.1) significant difference between 2008 and 2010, significant increase between 2010 and 2015

Overall, how would you rate your experience with the Resource Center?



- No significant difference between 2008 and 2010
- Significant increase between 2010 and 2015

Quick Summary of the Research

	2008	2010	2015	
Sample Sizes	1653	2308	4453	
ADRCs	18	31	41	

Improving the Customer Experience Over Time

From 18 to 31 to 41 ADRCs

2012

Quick Summary of the Research

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March 2, 2016



Apple of Confusion