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

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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: JFC 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,

K. Rhoades

Kitty Rhoades
Secretary

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		
	Customer Contacts	
Activity	**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		
	Open Cases in Each Program	
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.

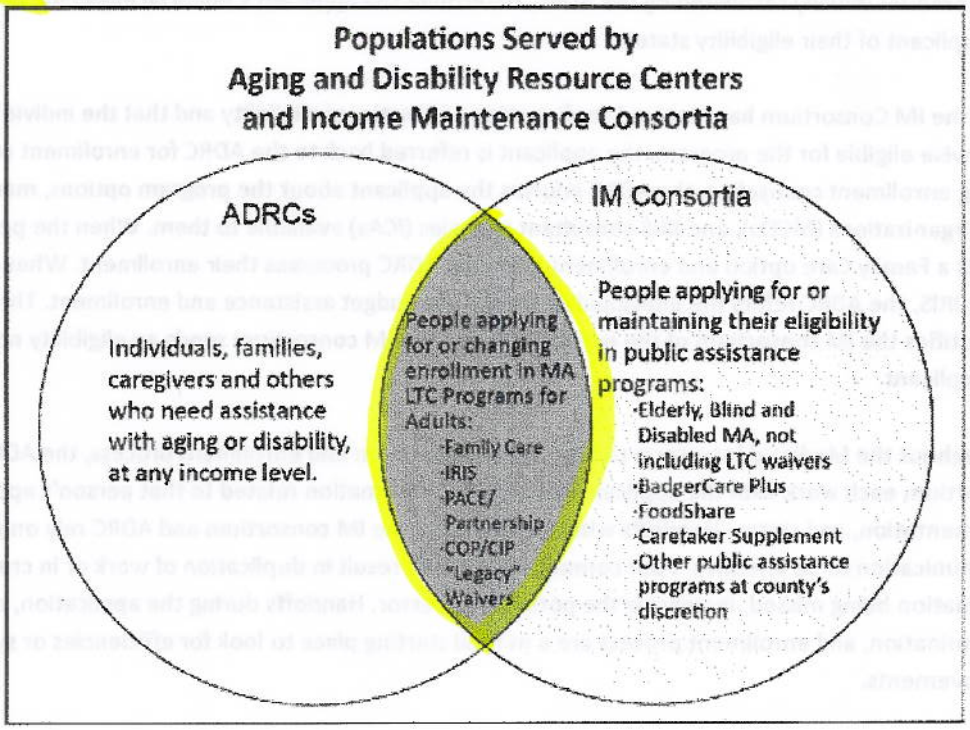
IM Consortia

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

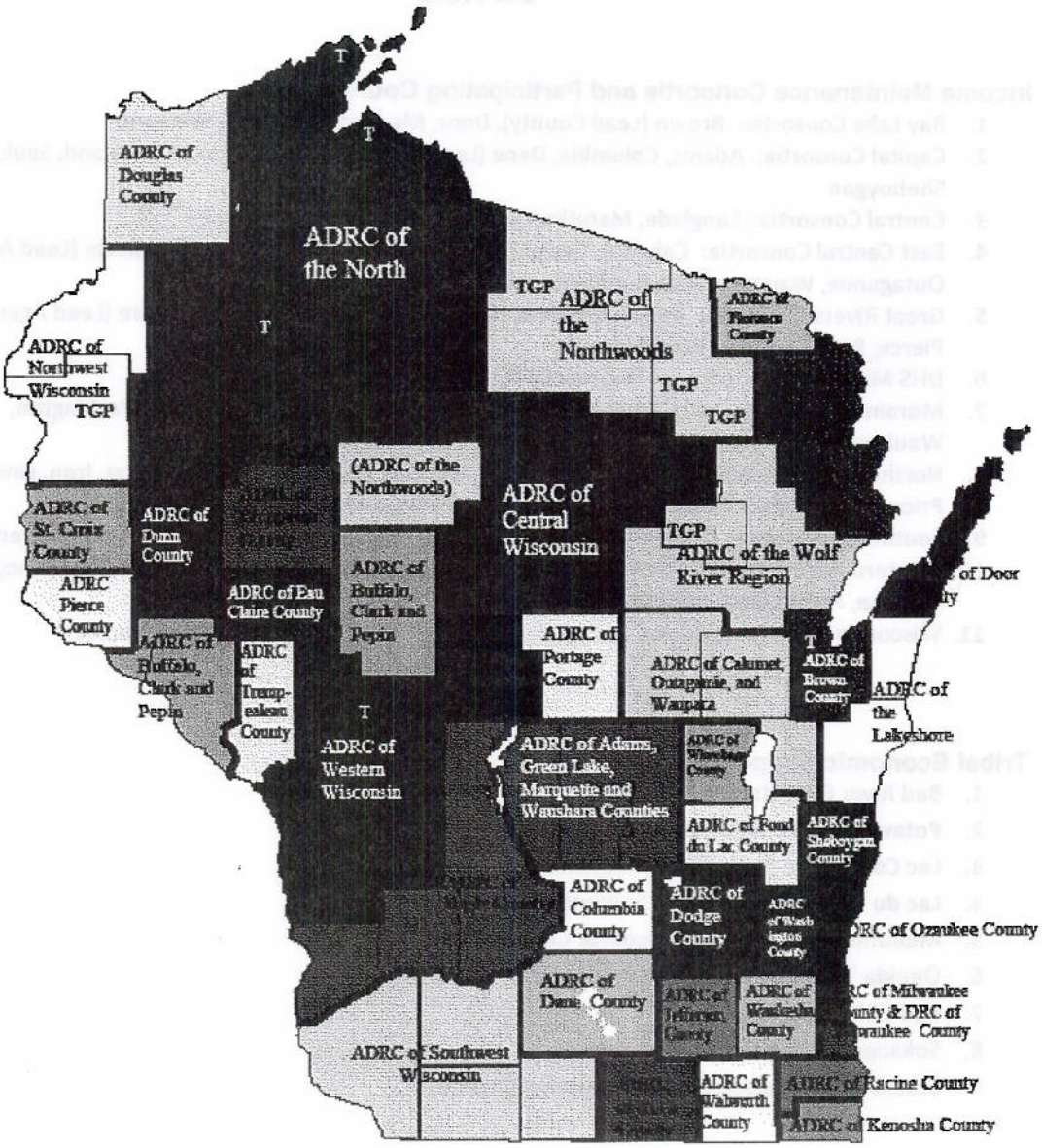
Aging and Disability Resource Centers in Wisconsin and the Counties and Tribes Served

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 Country (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



TGP- Tribal Governing Partner
T- Tribal Aging and Disability Resource Specialist

APPENDIX B

Wisconsin Income Maintenance Consortia and Tribal Economic Support Services

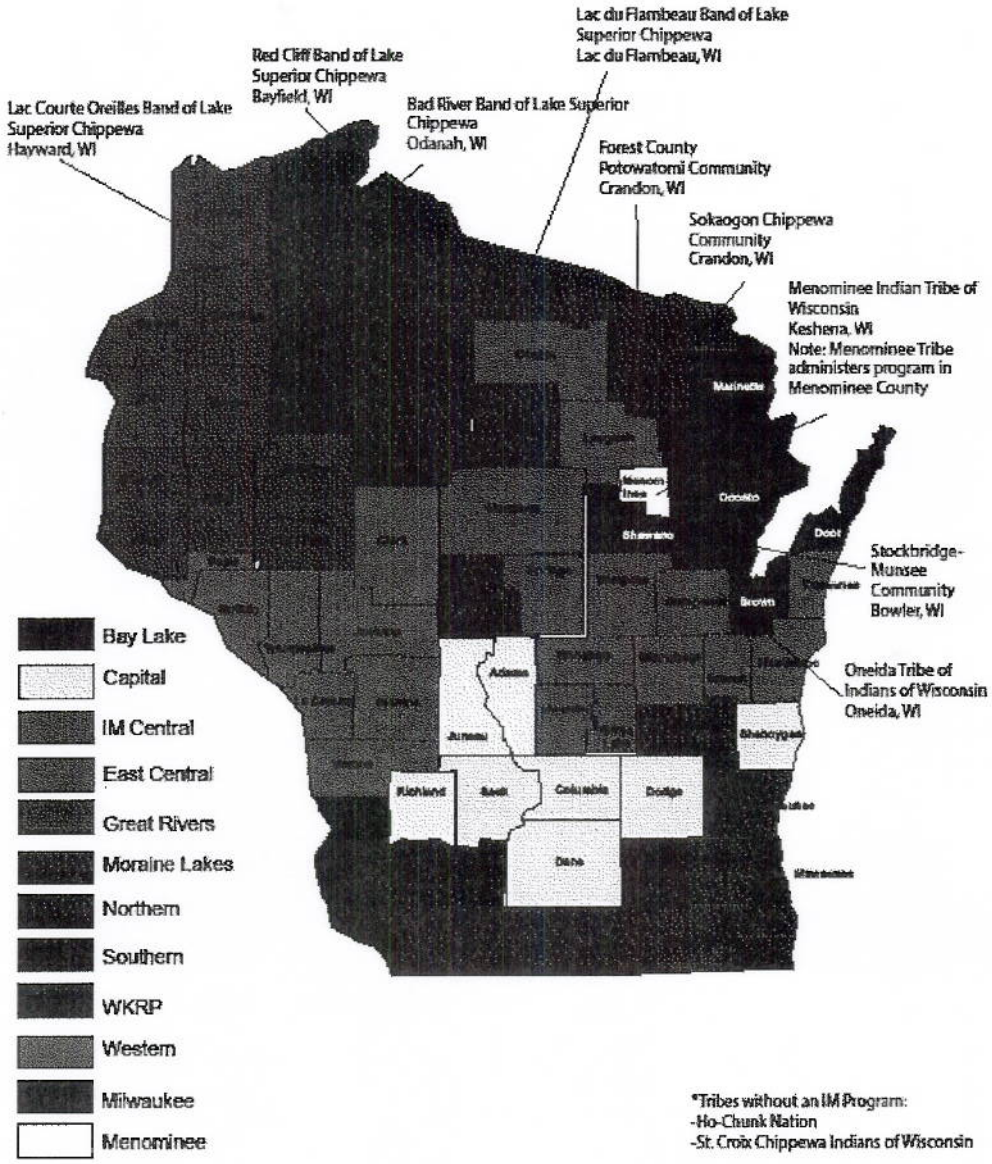
Income Maintenance Consortia and Participating Counties

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!

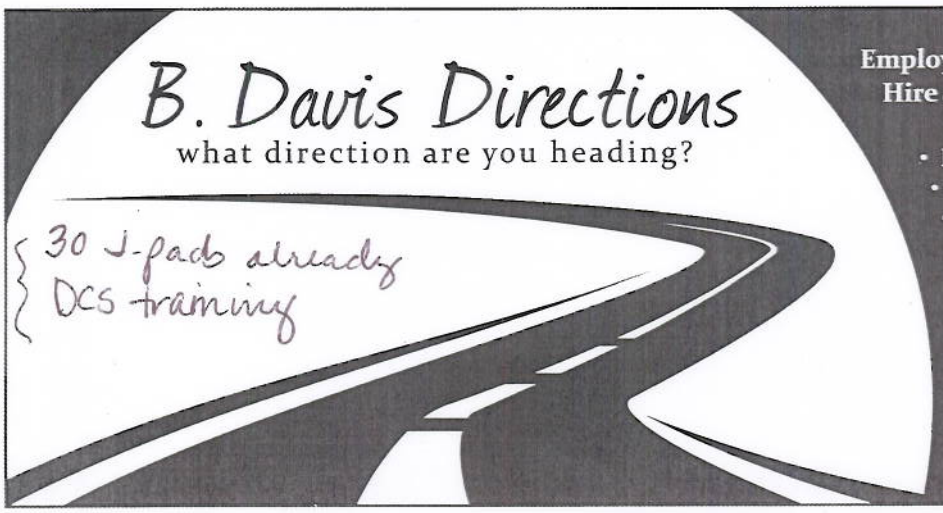
This program provides all the equipment in the WALA program plus an iPad with appropriate applications that increase its effectiveness and training to use it.

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.



Employees matter - to you and the clients you serve.
Hire and retain the people your clients deserve.

- Hiring & orientation planning
- Leadership coaching & staff training
- Curriculum evaluation, revision, & development
- Performance reviews & recognition programs
- Client-driven special projects

B. Davis Directions
Office: (608) 242-2453
Email: bdavis@bdavisdirections.com
Website: www.bdavisdirections.com

Results: 104 surveys

Training Time 3/16/16 2:00pm

Rating		1 Disagree	2 Slightly Disagree	3 Slightly Agree	4 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		3	25	76	
	I believe I can apply the information I learned to present or future situations		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 Azlehimers 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.

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.

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: • "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: • Number of participant-hired workers submitting timesheets in excess of the 40-hour assurance.

		• 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.

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 <u>all</u> 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 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.	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. 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 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.	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. 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 *Stepping On* 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	

Does the aging unit facilitate a local caregiver coalition?

☐ YES or ☒ NO

If **No**, please state which local agency facilitates this coalition: **The Community Care Alliance of Jefferson County facilities meetings.**

If **Yes**, was information provided in the 3-year plan on the coalition's members?

☐ YES or ☐ NO

If Yes, were goals stated for 2014 to coordinate caregiver services?

☐ YES or ☐ NO

Please provide a brief update on coalition activities conducted in 2013:

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.

Please provide a brief update on coalition activities conducted in 2014:

12/9/14: Reached out to existing Coalition Members asking if they want to continue getting emails about coalition activities.
6/20/14: Scheduled a meeting, no-one attended.
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.

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.

Please provide a brief update on coalition activities conducted in 2015:

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.

In November, the Dementia Care Specialist and Division Manager spoke at

	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. **The relationship between the Aging Unit and CCA will grow throughout the three year plan.**

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 *Your Friends-in-Action Volunteers* by 12/31/2013; 1 workshop by 12/31/2014 & 1 workshop by 12/31/2015.	It was not met; I will retry in 2014 The workshop was scheduled in February 2015 and cancelled because only one volunteer signed up. **2015 - This goal was met. The in-service occurred in June.**			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.	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.			
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	H:\Power Point\YEAP Presentation.pptx	X		

Conclusions, Questions and Next Steps

Thank you!

Lessons Learned

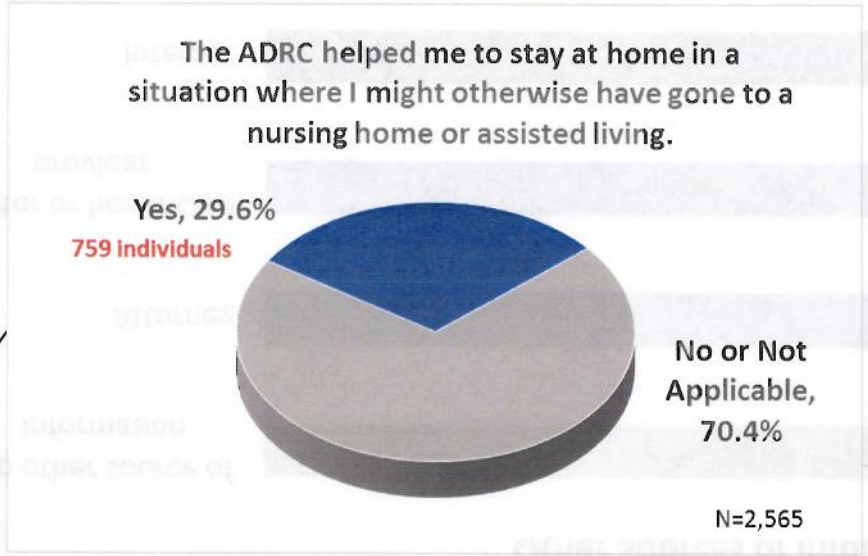
Strengths

- 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

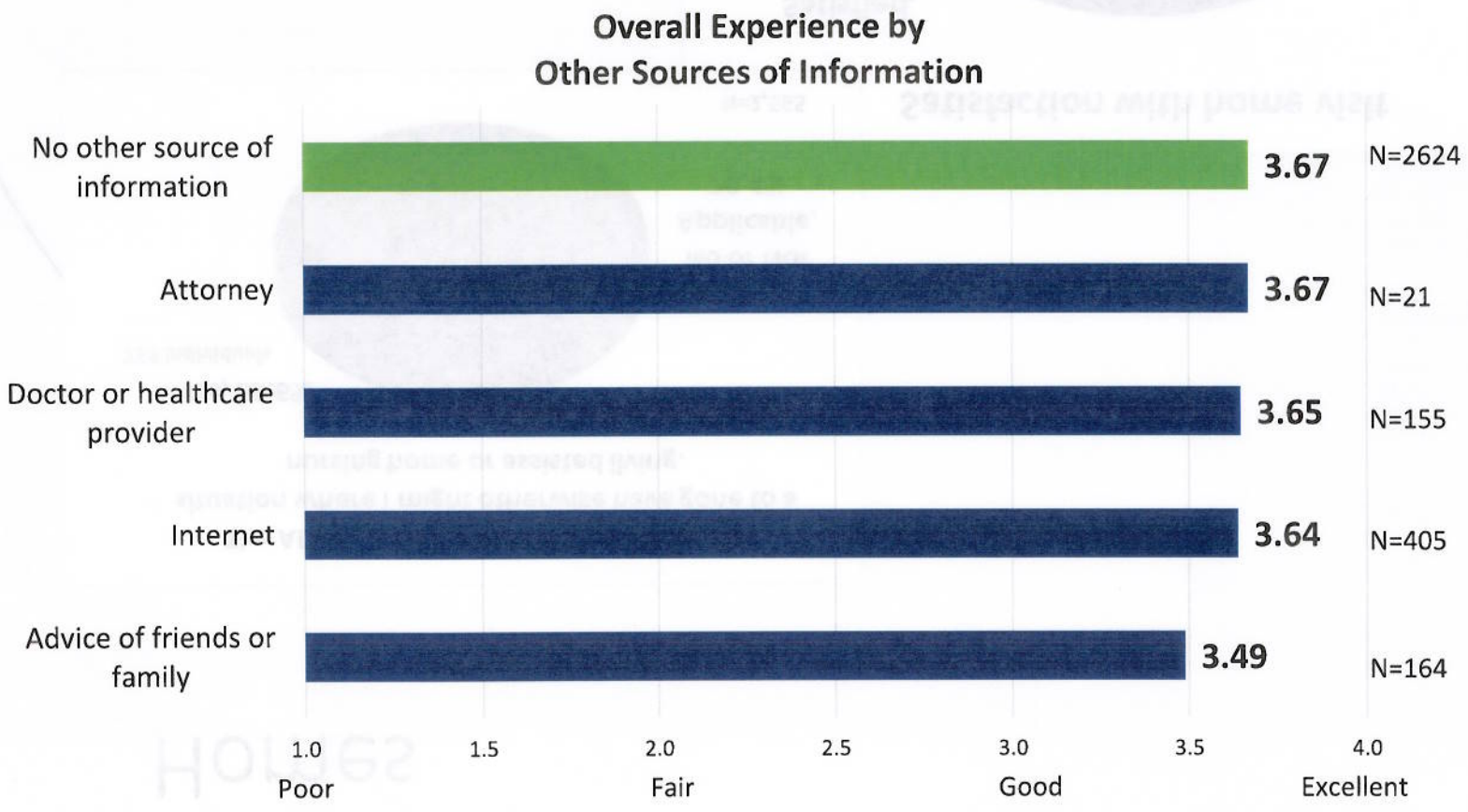
Opportunities for future improvement

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

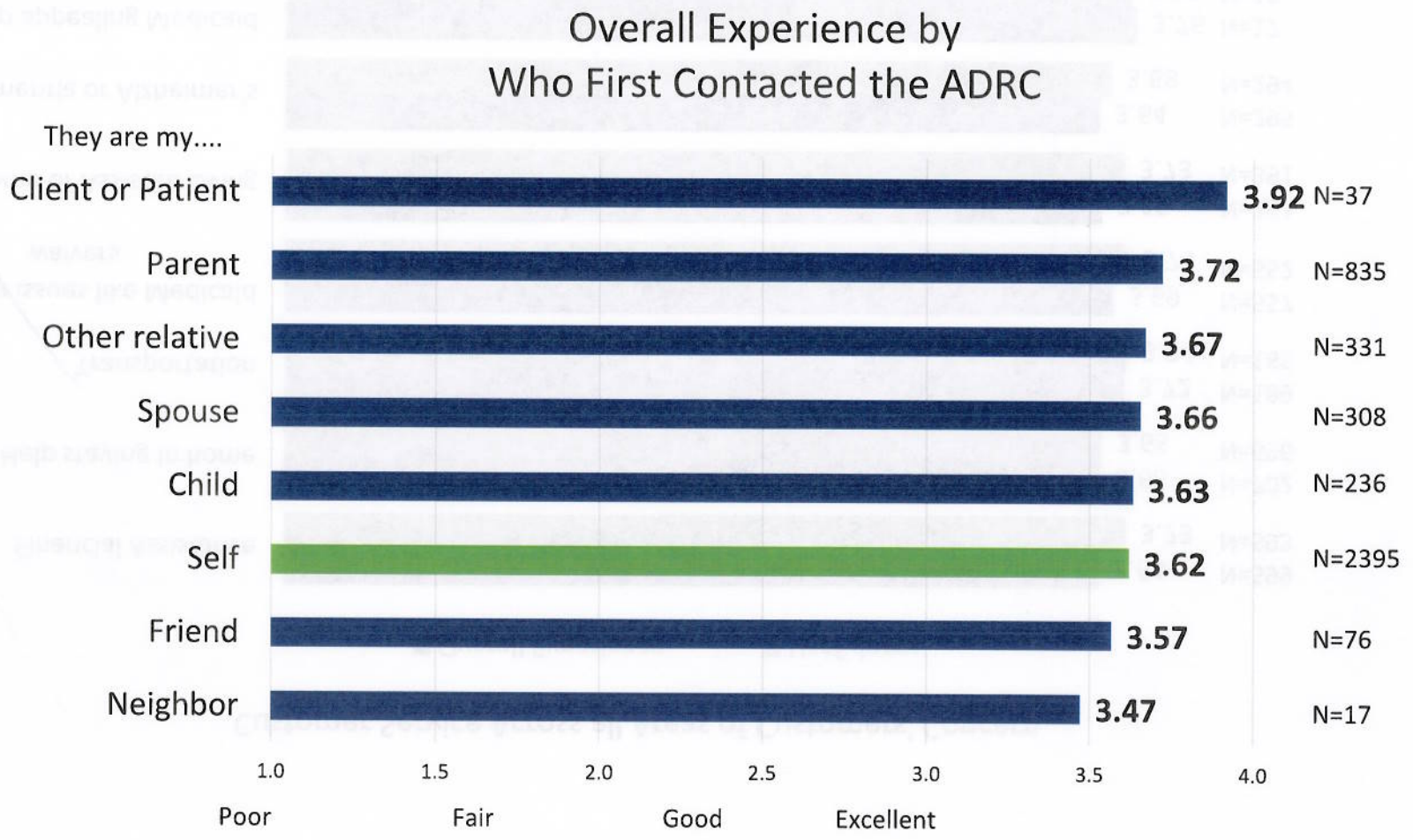
Helping Customers Stay in their Homes



Customer Service for Customers at a Variety of Starting Points

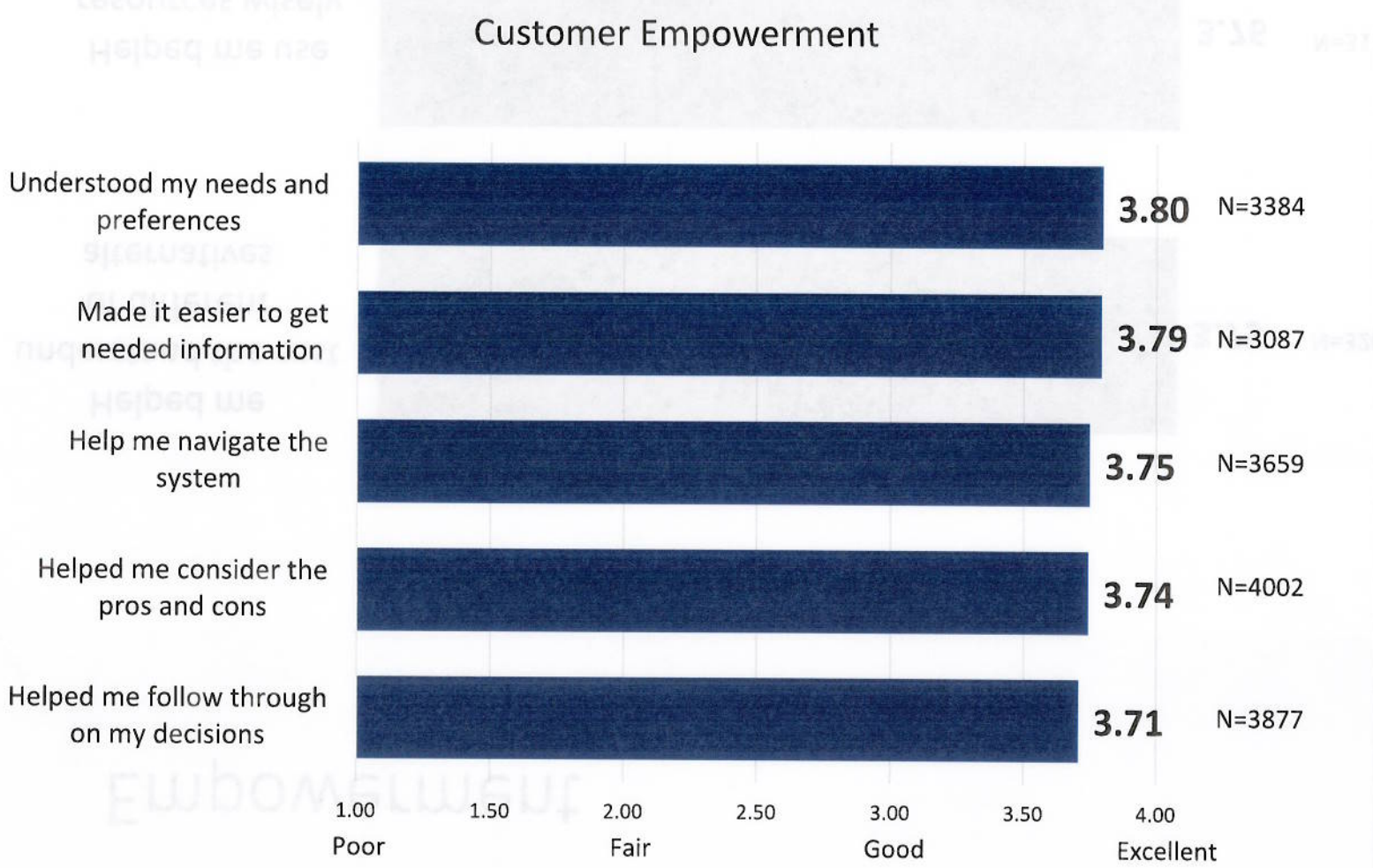


Customer Service for All Types of Customers



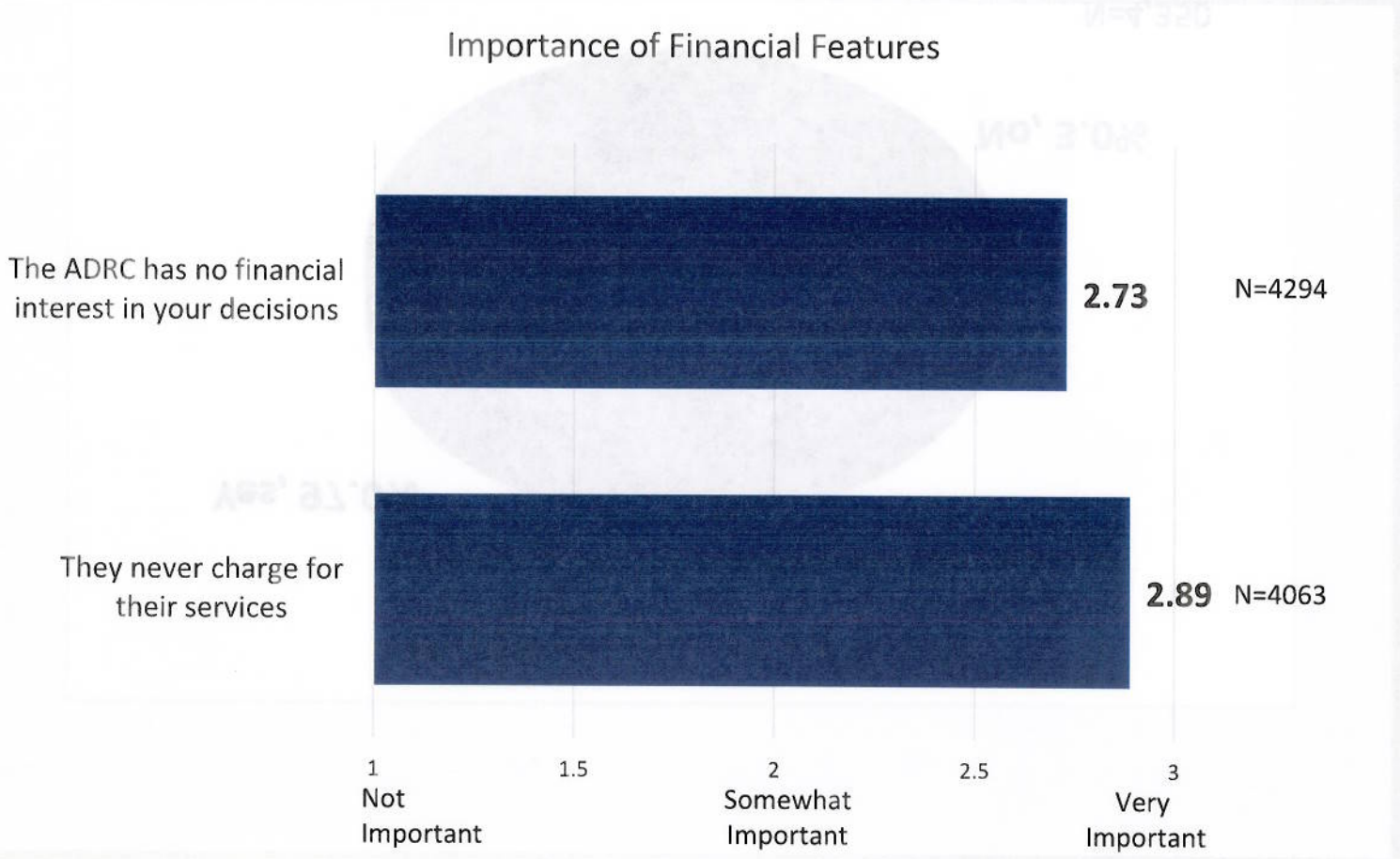
Customers' Main Concerns

Empowerment

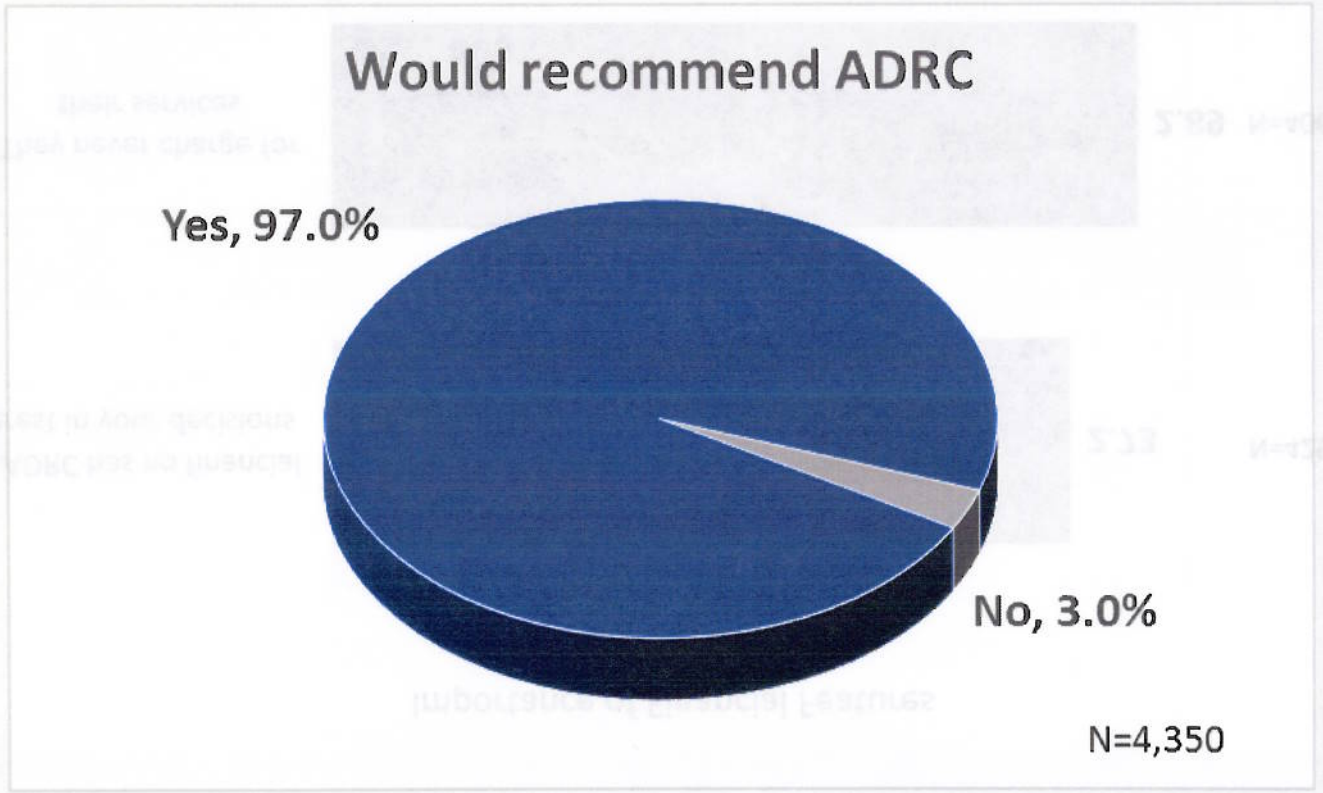


Empowerment

Objectivity



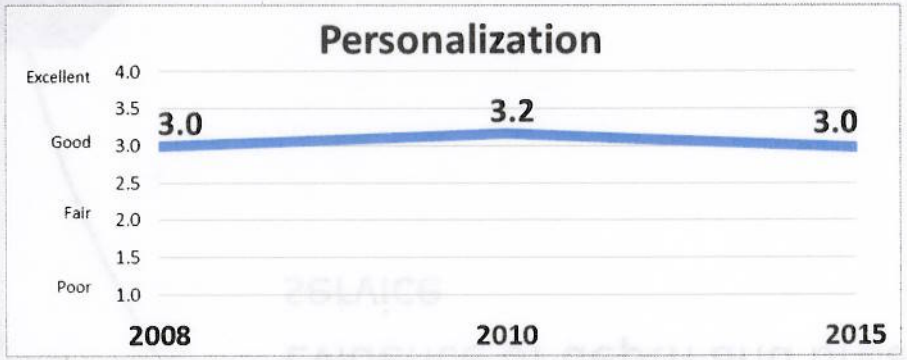
Recommendations

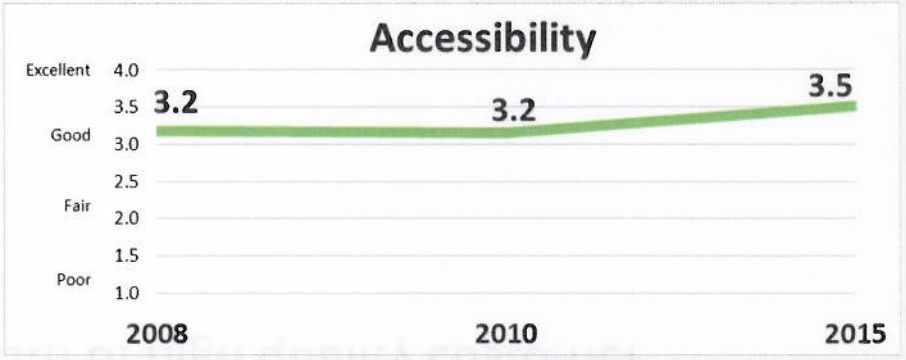


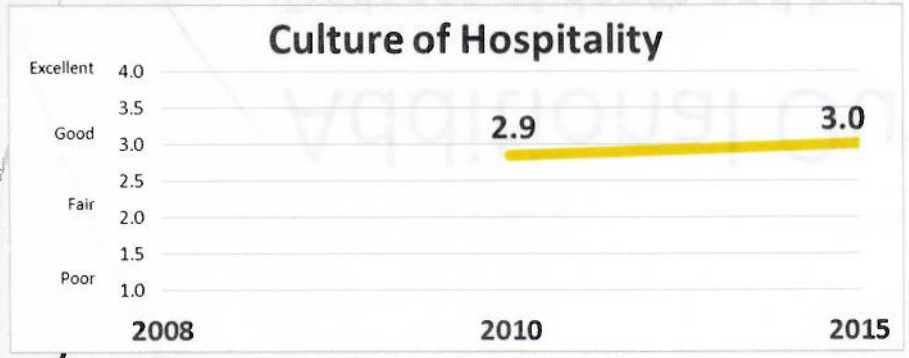
Additional Outcomes

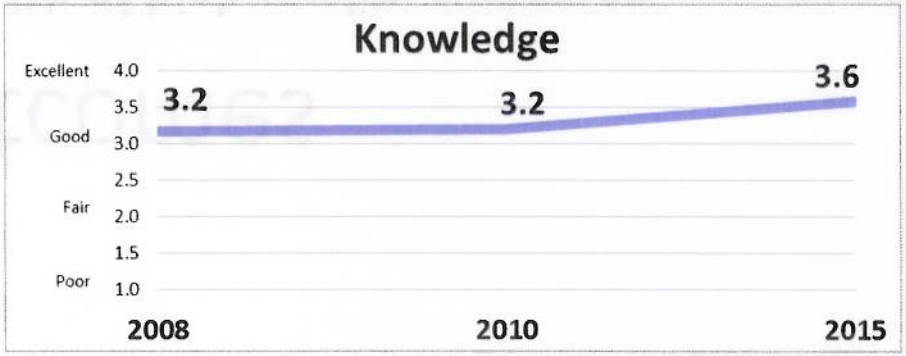
Evidence of depth and breadth of high quality customer service

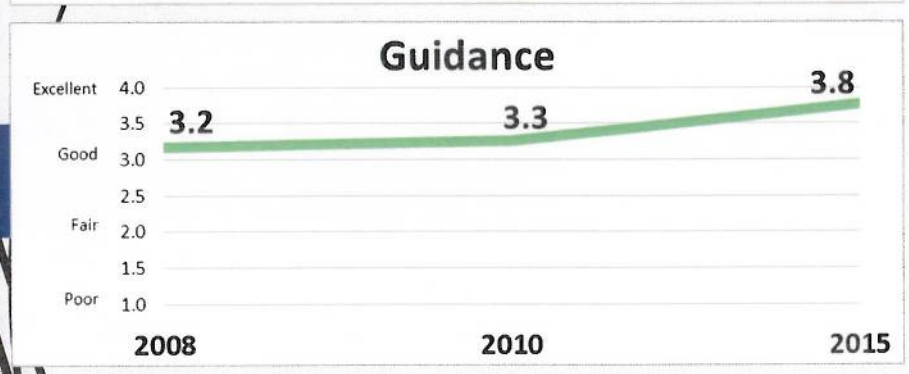
Domains Over Time

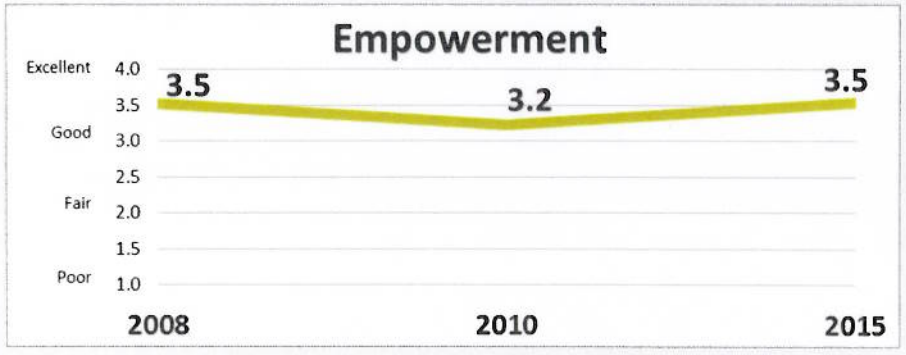












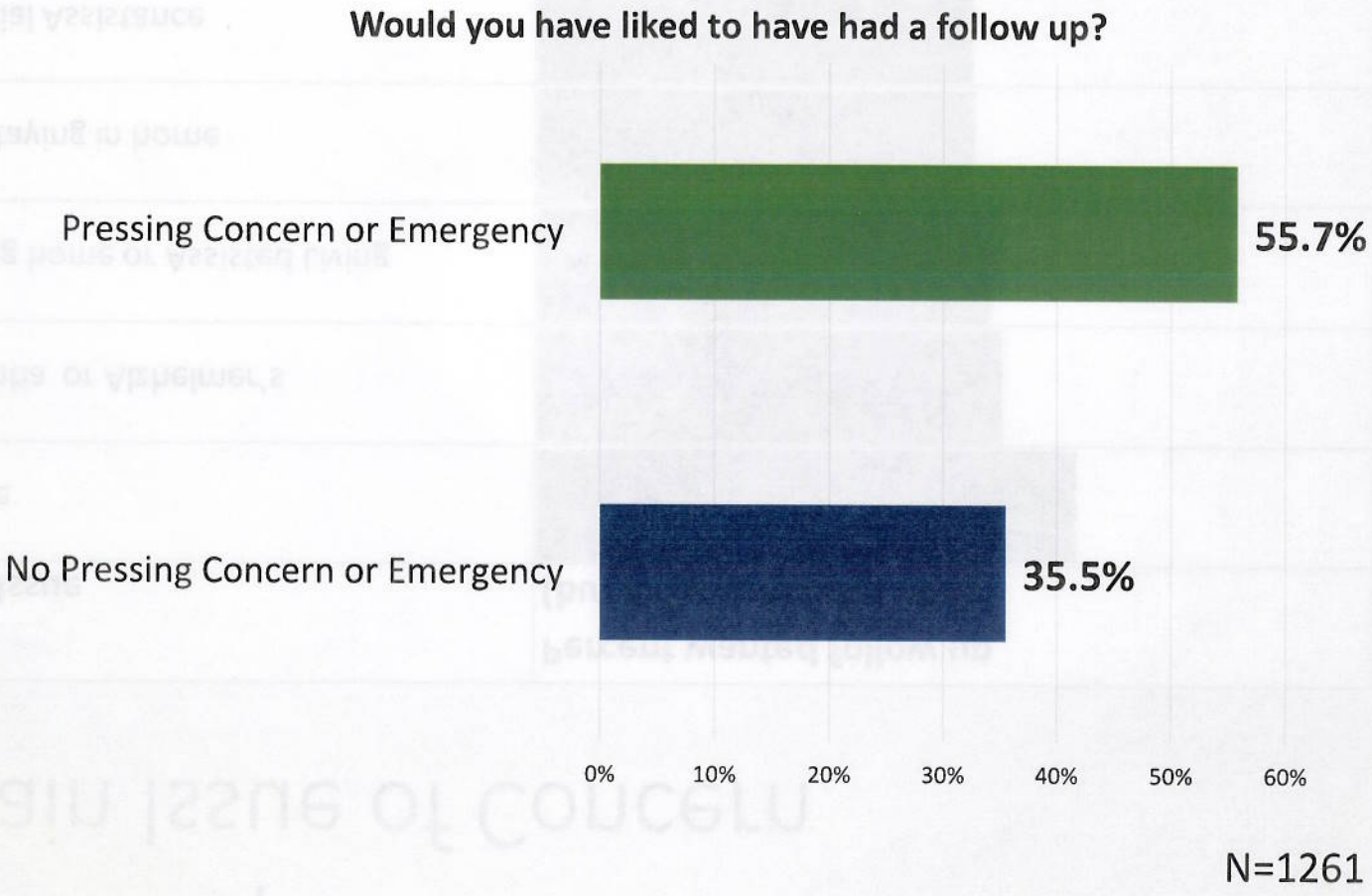
Six Domains of Customer Satisfaction

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

Follow up Growth Potential: Type of situation



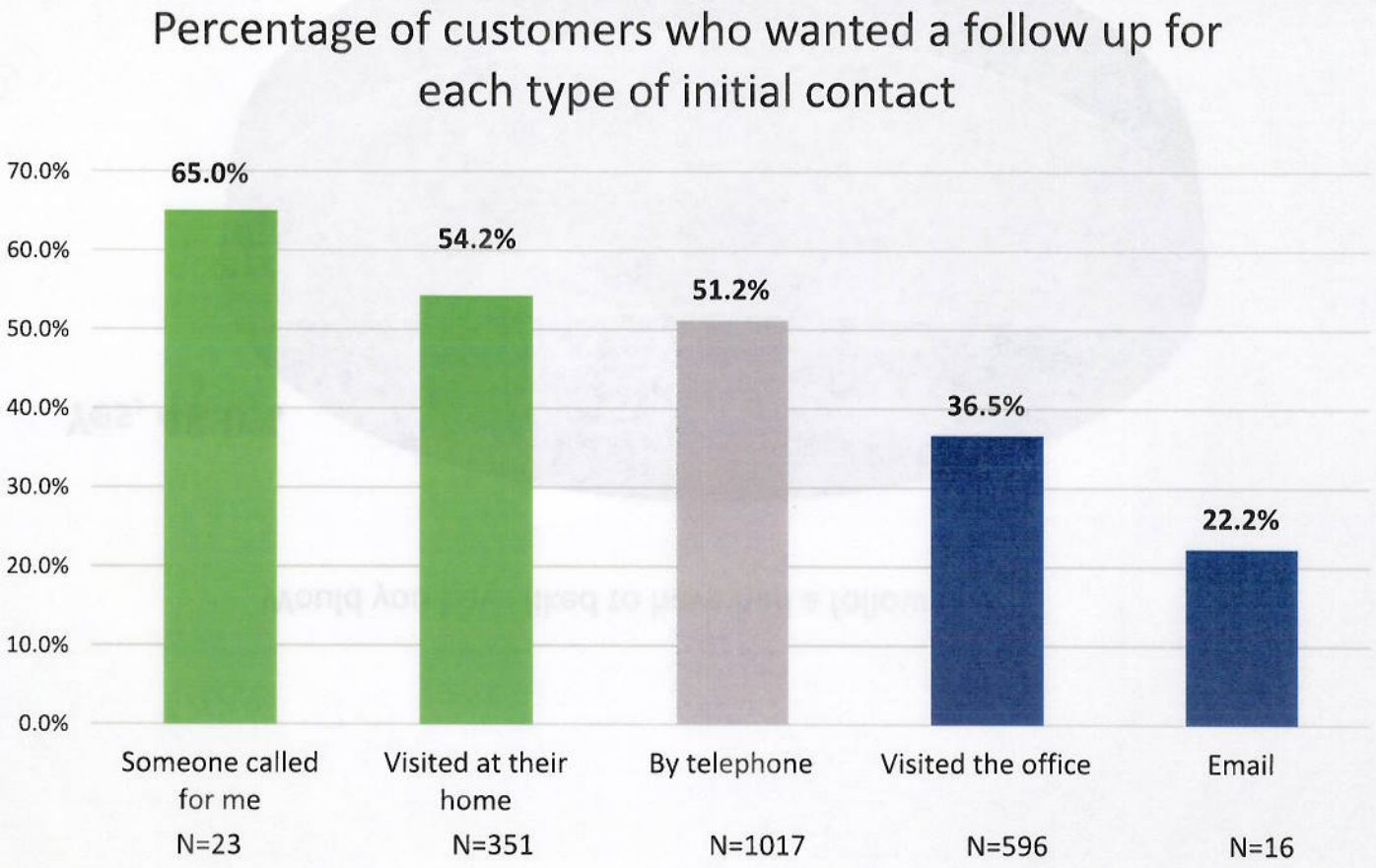
N=1261

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

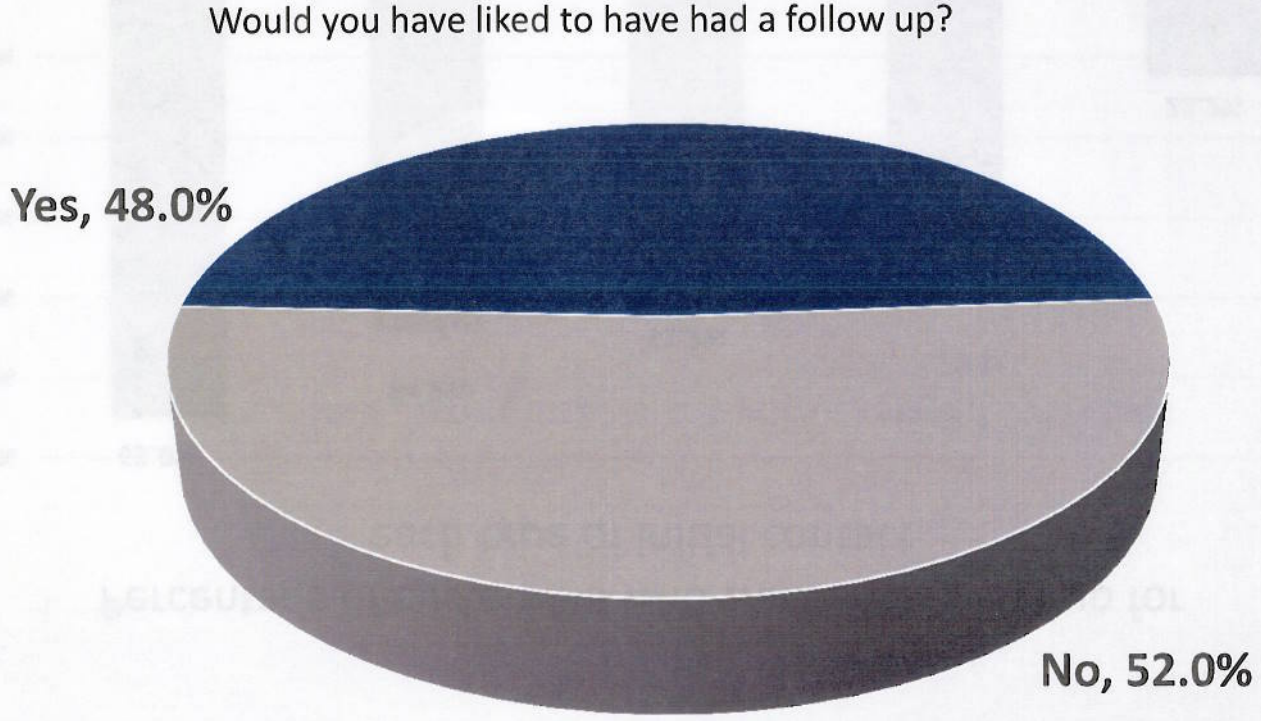
Follow up Growth Potential:

Differences by how a customer first contacts the ADRC



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

Identifying the Need for Follow Up



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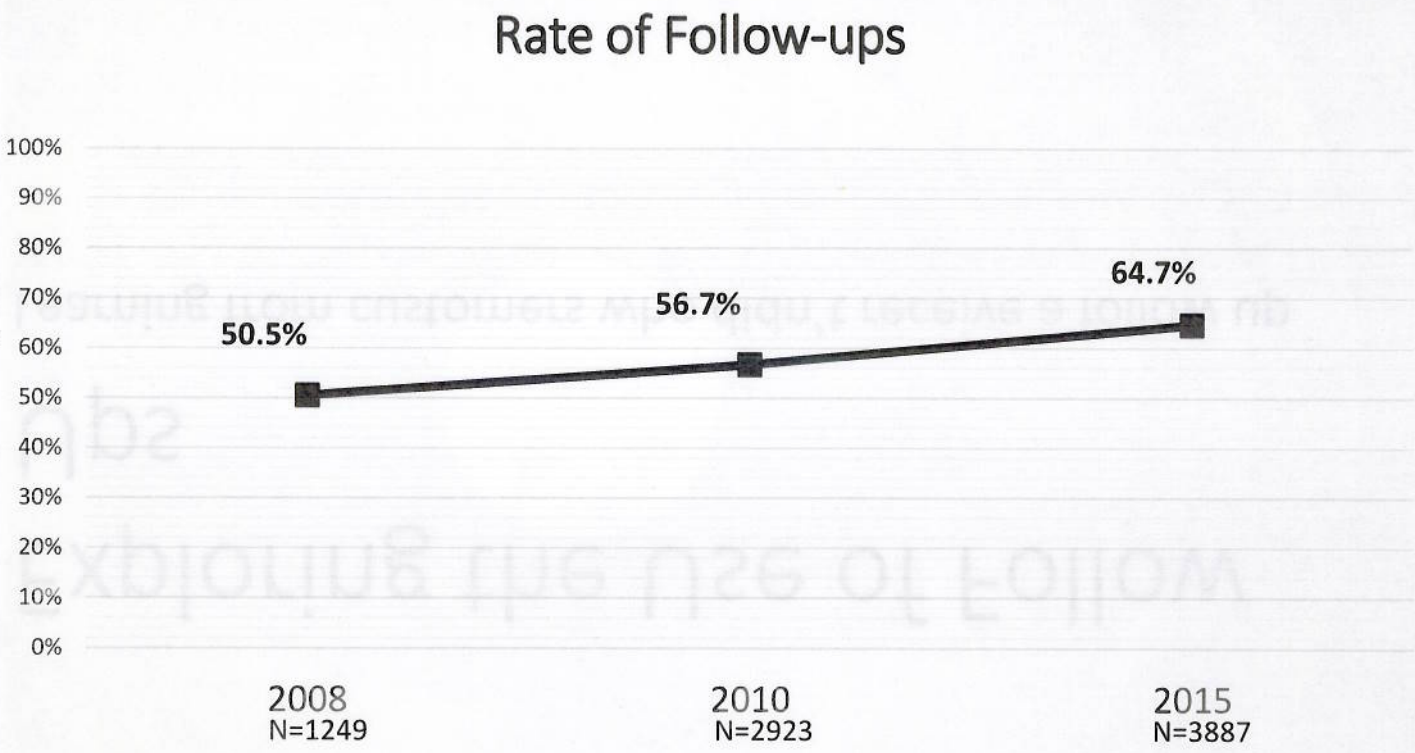
Growing Use of Follow Up

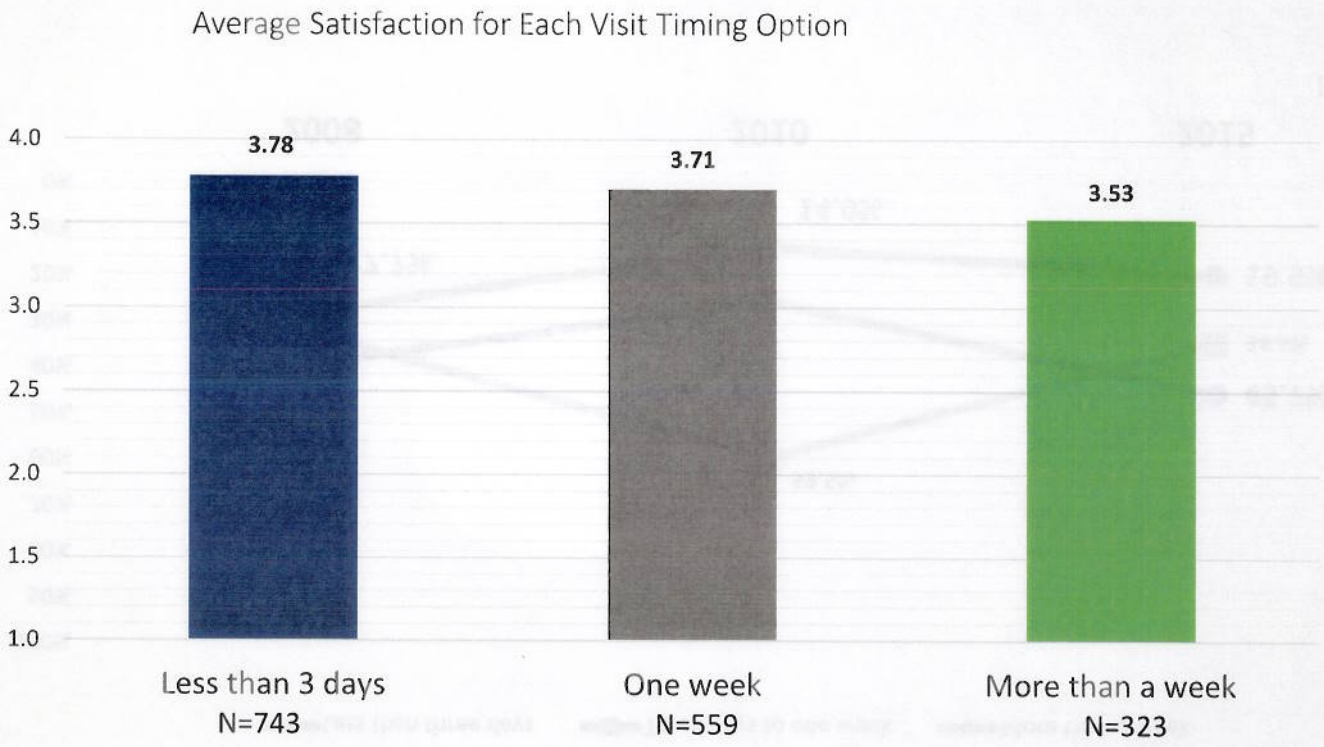


- Steady increase over time.
- About 5% over each 2-2 ½ year period.

Exploring the Use of Follow Ups

Learning from customers who didn't receive a follow up

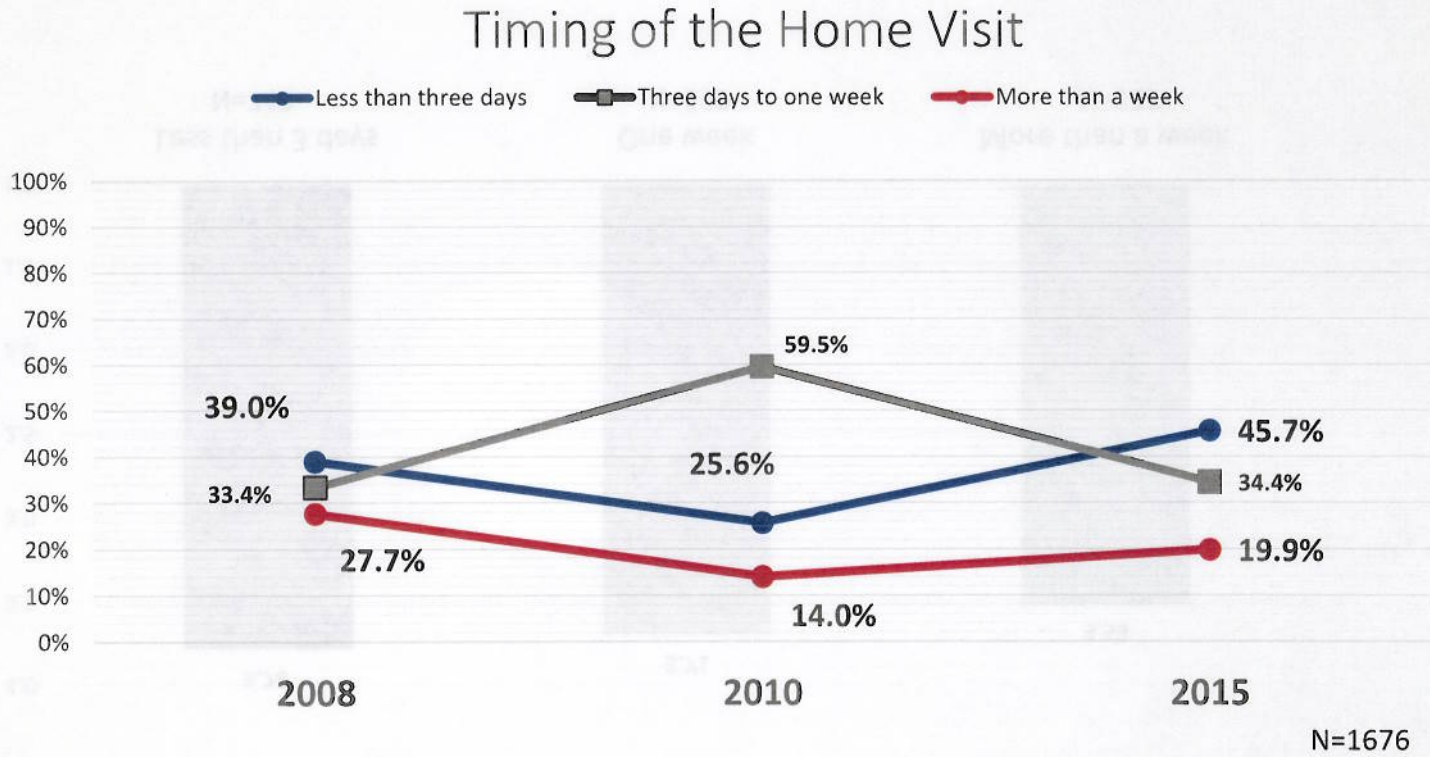
Satisfaction and Home Visits



2015 results only

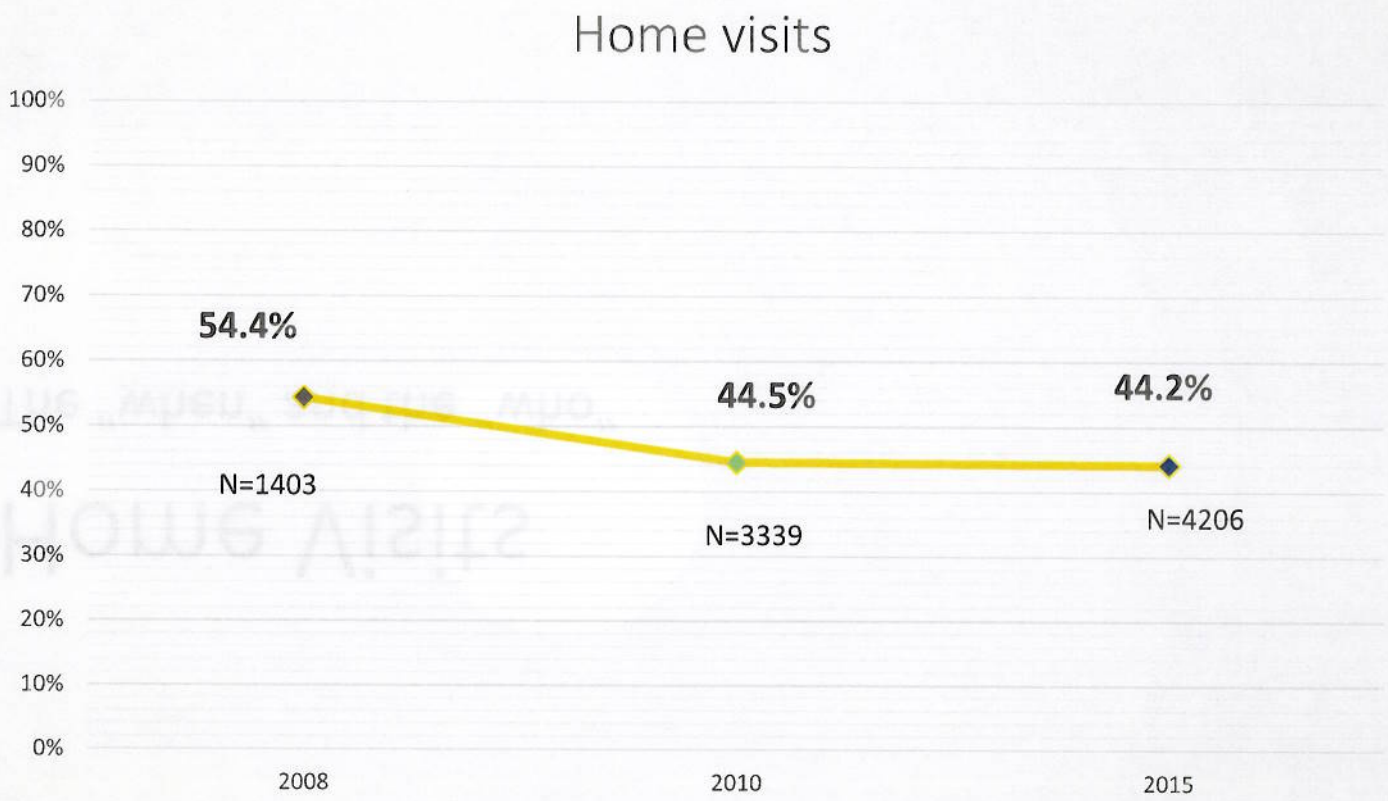
Strong association between length of visit and overall satisfaction

Length of Time Before a Home Visit Over Time



N=1676

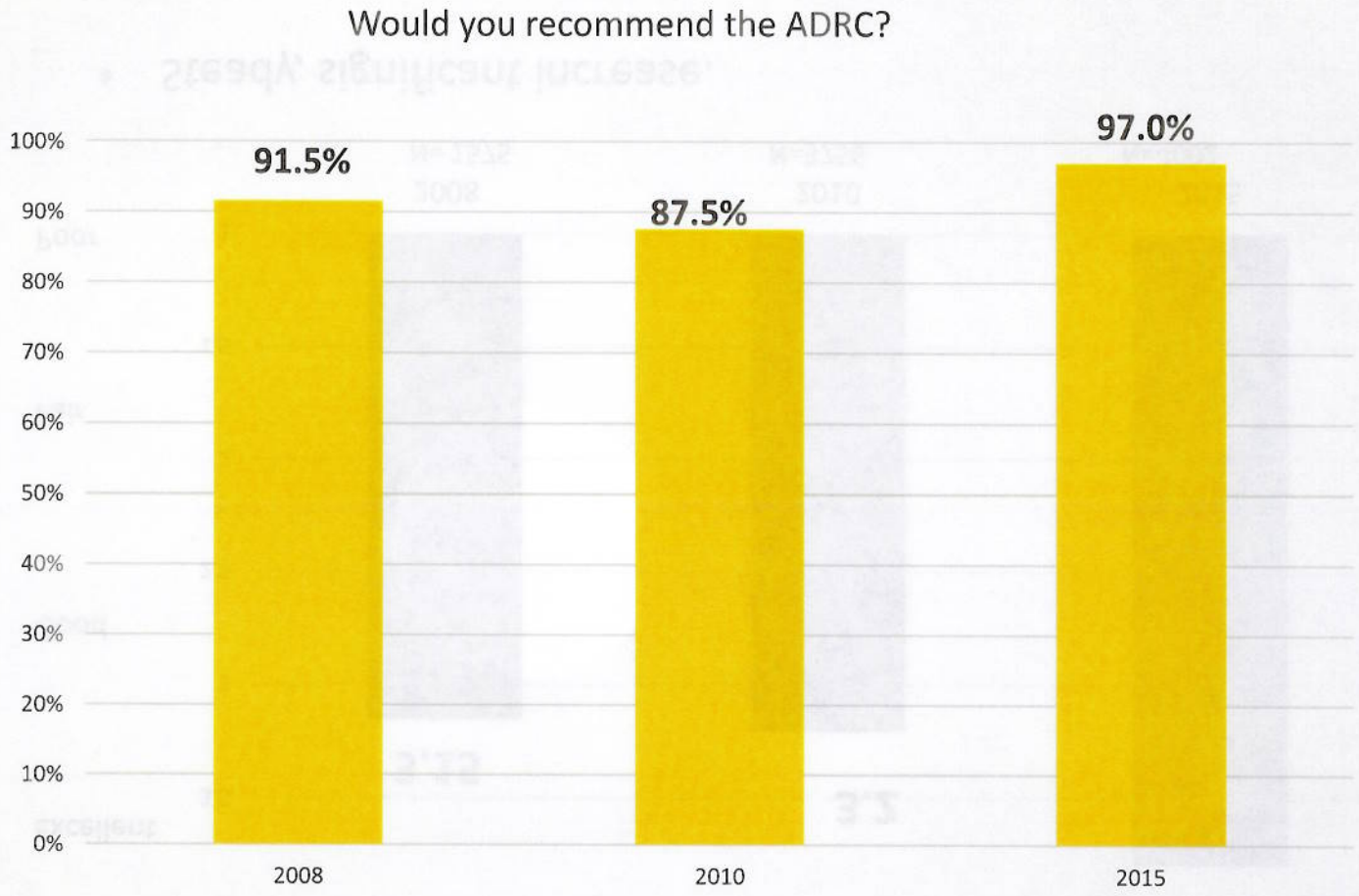
- Significant decrease in over 3-days later visits.
- Significant increase in less than 3-days later visits.
- Transition (2010) in mid-range timing (3 days to a week)



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

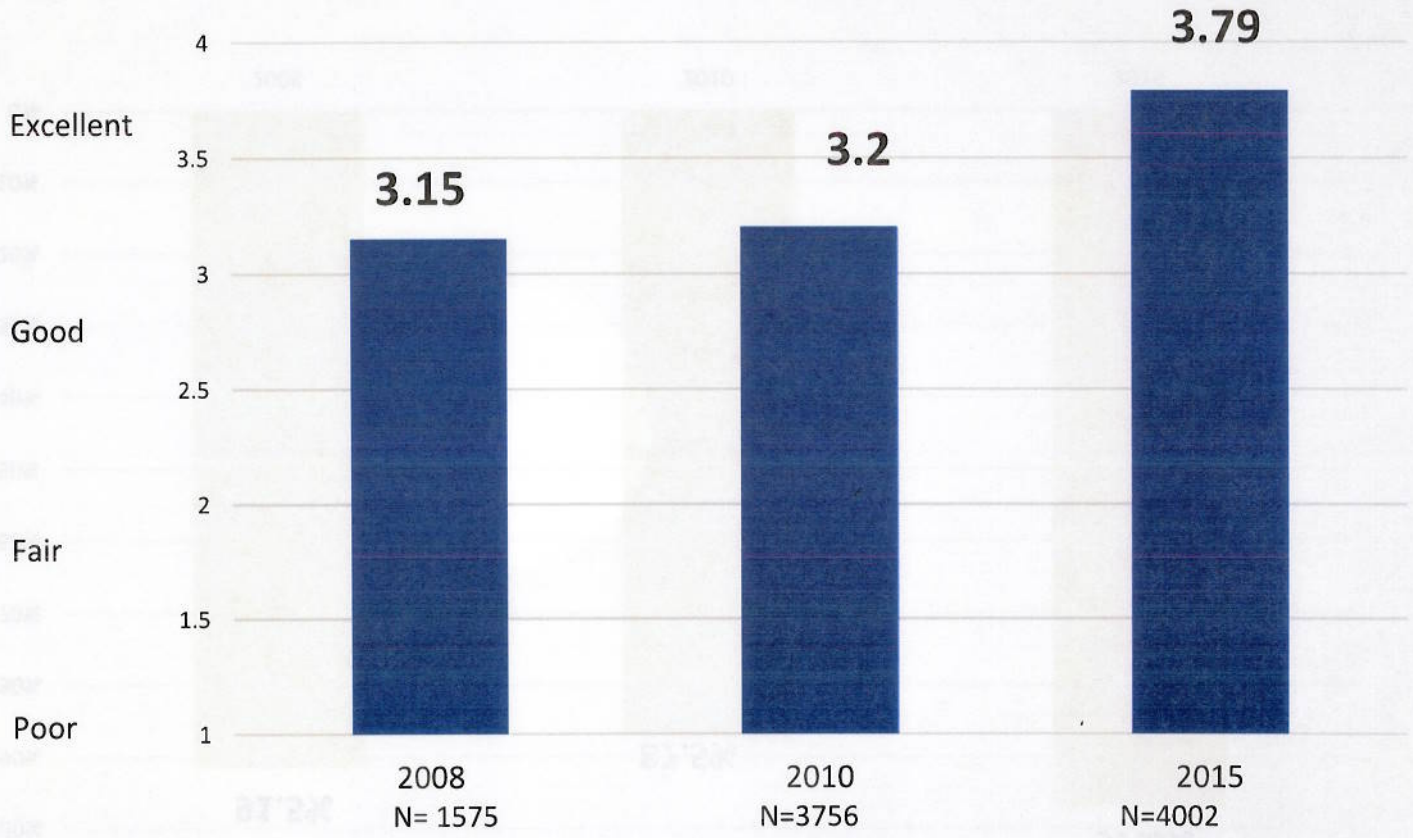
Home Visits

The “when” and the “who”

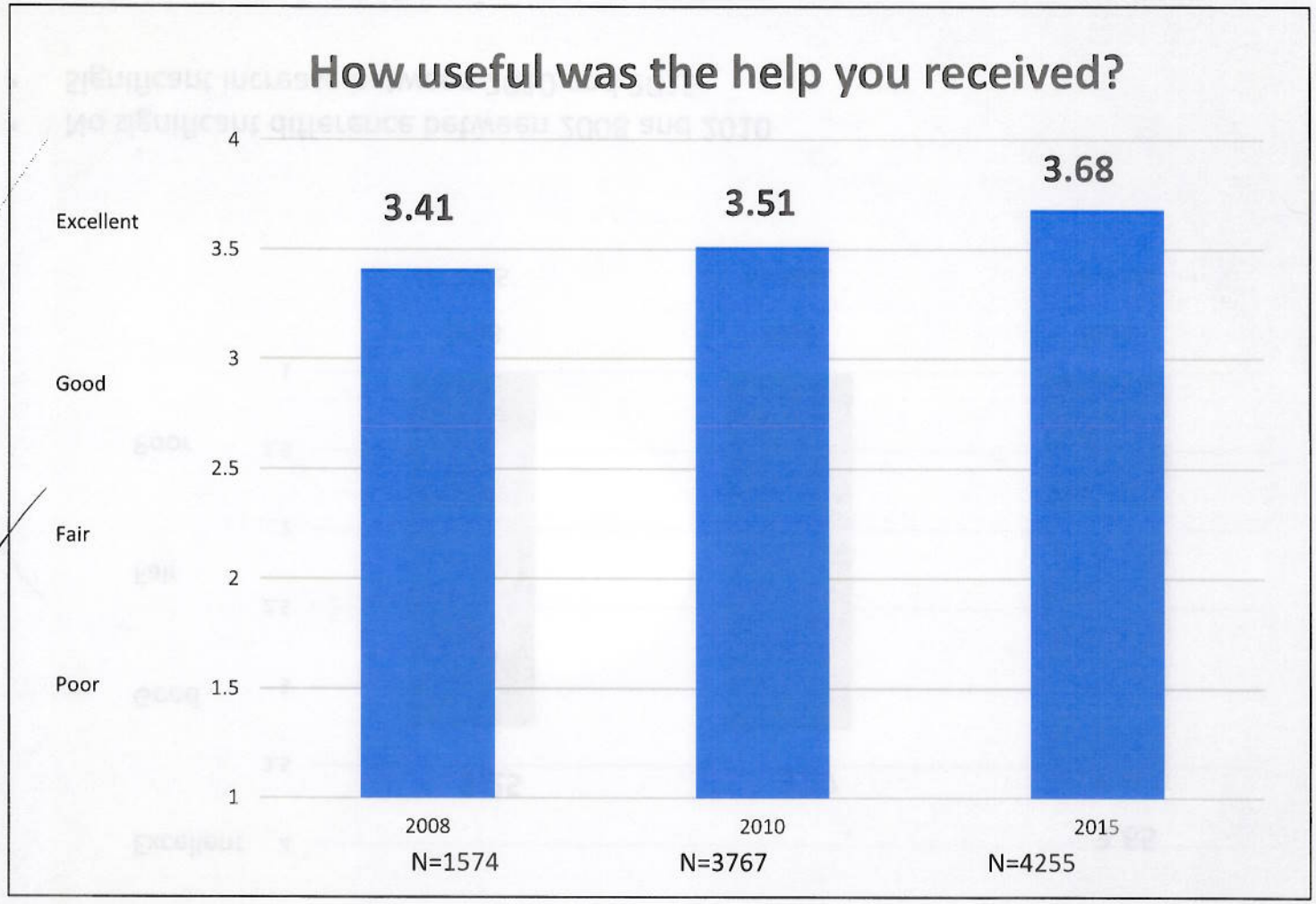


- Steady, significant increase.
- Not much room for improvement.

The ADRC made it easy to access the information I needed



- Steady, significant increase.

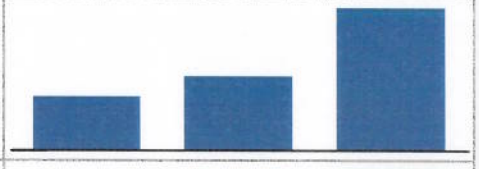


- "Almost" (.1) significant difference between 2008 and 2010, significant increase between 2010 and 2015

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

Table of Contents

Results of the Statewide Satisfaction Survey

March 2, 2016