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DMHSAS Numbered Memo 2016-09

To: Area Administrators/Human Service Area Coordinators
Bureau Directors/Section Chiefs
County Department of Community Programs Directors
County Department of Developmental Disabilities Service Directors
County Department of Human Services Directors
County Department of Social Services Directors
County Mental Health Coordinators
Tribal Chairpersons/Human Services Facilitators

From: Patrick Cork, Administrator

Crisis Training Grant: Recognizing and Providing Services to Individuals with Dementia

Document Summary

2015 Wisconsin Act 274 directs the Department of Health Services (DHS) to award \$250,000 in grants to counties or regions comprising multiple counties to obtain training for their mobile crisis teams on recognizing and providing services to individuals with dementia. The funding is provided on a one-time basis for state fiscal year 2017. This memo describes the application process for these funds and the expectations for their use. **Applications must be received by 4:00 p.m. on Monday, August 22, 2016.**

Background

Funding in the amount of \$250,000 for state fiscal year of 2017 was allocated by the state legislature to provide grants for counties or regions of counties in order to obtain training for their mobile crisis teams on recognizing and providing services to individuals with dementia. These funds become available in the context of the burgeoning number of baby boomers reaching their senior years and recent developments in state priorities and laws including the Wisconsin Dementia Care System Redesign, the State Supreme Court Decision in the *Helen E.F.* case, impending changes in Wis. Stat. ch. 51 requiring a crisis assessment be provided by a mental health professional before proceeding with an emergency detention, and [Wisconsin Attorney General Opinion 04-15](#) of November 12, 2015, concluding that “an officer has no authority to make healthcare decisions for an individual in custody under an emergency detention because the individual generally has the right to make his or her own healthcare decisions.” Emphasis is on training crisis staff in a collaborative learning environment along with relevant partners.

Funding awarded will be a maximum of \$250,000 to be expended between July 1, 2016, and June 30, 2017. The total number of applications funded will depend on the number and quality of applications received to an aggregate maximum of the total appropriation. In no case will funding be able to be extended beyond June 30, 2017.

Scope of the Issue

Burden of Alzheimer's Disease in the United States

In 2013, an estimated five million Americans aged 65 years or older had Alzheimer's disease. Many dementing conditions such as Alzheimer's are progressive and irreversible. The number of persons with Alzheimer's disease may triple to as high as 13.8 million people by 2050. In 2010, the costs were projected to fall between \$159 and \$215 billion. By 2040, these costs are projected to jump to between \$379 and more than \$500 billion annually. Unlike heart disease and cancer death rates, which are currently on the decline, death rates for Alzheimer's disease are increasing—it ranks as the sixth leading cause of death among adults in the United States. Dementia, including Alzheimer's disease, has been shown to be underreported in death certificates and therefore the proportion of older people who die from Alzheimer's may be considerably higher.

Wisconsin's Aging Population

Like national trends, Wisconsin's population continues to increasingly age. According to the Federal Administration on Aging, [Administration for Community Living's Policy Academy State Profile for Wisconsin](#), nearly 20 percent of Wisconsin's population is age 60 or above. By the year 2030, those aged 60 and above will exceed all three younger 20-year age intervals (0-19, 20-39, 40-59). Older adults face many health threats. For example, the 30-day binge drinking rate in Wisconsin (defined as more than three or more drinks for women and four or more for men in one event) is substantially higher than the national average generally and this trend maintains among Wisconsinites age 50-64 and above age 65. Binge drinking is associated with a range of serious problems such as stroke, cardiovascular disease, liver disease, neurological damage, poor diabetes control, falls, and accidents. Cardiovascular disease is associated with at least one form of dementia, multi-infarct dementia.

Context of the Need for Training

Dementia Care System Redesign

In February 2014, DHS released a [Dementia Care System Redesign Plan](#) to address gaps in the current care delivery infrastructure, including community and crisis services for persons with dementia. The plan, which was developed with input from many partners, advocates a model for dementia-capable mobile crisis response focused on treating people in place, when possible; clarifying roles and responsibilities for crisis response and stabilization; and addressing the need for appropriate placement options for persons with dementia in crisis. Embodied within this initiative are [guiding principles](#) that create a foundation for professional practice and guidance for those living with or caring for a person with dementia.

National Focus

In order to help to advance cognitive health as a vital, integral component of public health, the Centers for Disease Control (CDC) and the Alzheimer's Association published [The Healthy Brain Initiative: the Public Road Map for State and National Partnerships, 2013-2018](#). This monograph attempted to “better understand the public health burden of cognitive impairment through surveillance; build a strong evidence base for policy, communication, and programmatic interventions for improving cognitive health; and translate that foundation into effective public health practice in states and communities.”

Role of Crisis Intervention in Serving Individuals With Dementia

The DHS, Division of Mental Health and Substance Abuse Services (DMHSAS), Bureau of Prevention Treatment and Recovery (BPTR), is committed to increasing the ability of certified crisis intervention programs under Wis. Admin. Code ch. DHS 34, Subchapter III, to be able to capably respond to all emergency situations involving DSM-5 conditions, which in this case includes elders, especially those with apparent dementia.

Variability in Crisis Response for Situations Involving Dementia

As a described DSM condition, situations arising out of neurocognitive conditions such as dementia are entitled to receive services from DHS 34 crisis programs, including assessment and response, stabilization, crisis planning, referral, and follow-up (see Appendix A). To date, crisis responses for individuals with dementia have varied across counties and crisis programs. Toward gaining a better understanding of current practice with respect to the crisis response for individuals with dementia, DHS staff have consulted with counties and county consortia, visited facilities, and conducted two surveys. It was found that crisis services vary considerably for persons with apparent dementia. Programs described differing approaches; unique agency configurations; diverse networks of relationships with partners; and varying degrees of expertise and capacity to serve individuals with dementia, their families, and caregivers. Programs that are more effective have developed local resources, typically involving cooperation partnerships among a variety of stakeholders, including county adult protective services (APS), care facilities, hospitals, law enforcement, managed care organizations, and others. Therefore, as an important component to the present initiative, a collaborative learning approach with relevant partners is emphasized.

Crisis Preparedness for and Capability of Response for Situations Involving Suspected Dementia

As emergency mental health services programs are required to respond to crisis situations involving dementia, they are increasingly being called upon to serve persons with dementia, their caregivers, and families. It is critically important, therefore, that mobile crisis teams and their partners be trained, coordinated, and capable. Crisis personnel should have demonstrable competence in: gerontology and dementia, ability to assess elders, have an appreciation for how an elder's behavior can clearly be a form of communication, understand laws and regulations as they relate to elders, while at the same time understanding the importance of stabilization in place whenever possible.

Requirement for a Crisis Assessment by a Mental Health Professional for Emergency Detention

Most counties have what is commonly known as a crisis intervention program under [DHS 34, Subchapter III](#). These programs are typically the agency charged with approving hospitalizations for individuals under an emergency detention by authority of [Wis. Stat. § 51.15](#). As a result of 2015 Wisconsin Act 55, Section 1881, [Wis. Stat. § 51.15\(2\)](#) was amended in relation to emergency detention of persons for reasons of mental illness, drug dependency, or developmental disability as follows:

“The county department may approve the detention only if a physician who has completed a residency in psychiatry, a psychologist licensed under Ch. 455, or a mental health professional, as determined by the department, has performed a crisis assessment on the individual and agrees with the need for detention and the county department reasonably believes the individual will not voluntarily consent to evaluation, diagnosis, and treatment necessary to stabilize the individual and remove the substantial probability of physical harm, impairment, or injury to himself, herself, or others. For purposes of this subsection, a crisis assessment may be conducted in person, by telephone, or by telemedicine or video conferencing technology.”

[These provisions took effect July 1, 2016.](#) Details on meeting this requirement are in Appendix A.

Successes of Stabilization in Place

Crisis intervention programs have effectively helped spare consumers, families, and counties unnecessary psychiatric hospitalization through intervention and stabilization in the community. This has saved individuals unnecessary disruption to their lives, promoted natural supports in the community, reduced traumatization, and saved county governments the expense of transporting and paying for individuals to be hospitalized. This same approach toward stabilization in place—in the community—can be equally applied to individuals living with dementia, their families, and caregivers. Subchapter III programs are eligible for reimbursement through insurers and Wisconsin’s Medicaid program, thus providing offsets to expenses for the county to provide the program.

Creating Replicable Strategies to Stabilize Persons with Dementia

Unfortunately, solid scientific evidence has not yet been obtained for [Non-Pharmacologic Interventions for Agitation and Aggression in Dementia](#). The Agency for Healthcare Quality and Research (AHQR) concluded:

“Although many trials have been conducted to determine effective nonpharmacologic interventions for agitation/aggression in dementia, which is a critical topic, the evidence base is weak because of the variety of comparisons, measurement issues, and other methodological limitations. When evidence was sufficient to draw conclusions about effectiveness for a group of interventions, agitation/aggression outcomes were typically similar to those of control groups. Future research is needed to guide providers and informal caregivers toward effective interventions for agitation/aggression in dementia.”

As noted, methodological limitations have contributed to the difficulty in providing an evidence base to the effectiveness of nonpharmacologic interventions. Through careful study design and advances in training and practice, it is hoped and expected that successful, scientifically validated approaches to reducing agitation and aggression in individuals with dementia will be found. It is hoped that scientifically verifiable strategies can be developed through Wisconsin initiatives.

Treatability Requirement for Emergency Detention Under Chapter 51—*Helen E.F.* Decision On May 18, 2012, the Wisconsin Supreme Court affirmed the decision of the Wisconsin Court of Appeals in [Helen E.F.](#), which stated that Helen, an individual with Alzheimer’s disease, would be more appropriately treated under protective placement provisions in Wis. Stat. ch. 55 than being committed under the provisions of Wis. Stat. ch. 51, as she had a permanent disability that was likely not capable of rehabilitation. Writing for the court, Justice Gableman concluded that:

“After reviewing chs. 51 and 55, we hold that Helen is more appropriately treated under the provisions provided in ch. 55 rather than those in ch. 51. Because Helen's disability is likely to be permanent, she is a proper subject for protective placement and services under ch. 55, which allows for her care in a facility more narrowly tailored to her needs, and which provides her necessary additional process and protections. We conclude that Helen is not a proper subject for treatment because while her Alzheimer's Disease may be managed, she is not medically capable of rehabilitation, as required by the chapter. For these reasons, we agree with the court of appeals that Helen was improperly committed under ch. 51 and we therefore affirm.”

As a result of *Helen E.F.*, many counties are exploring alternative procedures regarding crisis response, protective placement, and involuntary commitment and treatment as they apply to vulnerable adults with dementia.

Developing Crisis Intervention Skill in Serving Elders and Those With Dementia

As the number of elders vulnerable to dementia rapidly grows, crisis programs will increasingly be called upon to be a first responder to intervene with persons who have apparent dementia. Crisis programs, therefore, need greater expertise in working with elderly and in an environment of illnesses more commonly associated with aging. Crisis interventionists must be aware of changes associated with aging as well as the culture of aging. Additionally they must comfortably work with seniors, caregivers, and their families while being capable of compensating for sensory, perceptual, communicative, or cognitive loss often associated with aging. Moreover, crisis personnel must have a working knowledge of relevant laws and rules as they apply to seniors and be able to collaborate with partners in serving elders.

Working With Perceptual and Communication Barriers

Communication with elders who may have dementia can be challenging. Staff must be prepared for dealing with issues of diminished senses (hearing, eyesight, etc.), slowed and diminished thought processes, response latency, diminished verbal fluency, and so on. Additionally, crisis interventionists must contend with the anxiety and fears that individuals may have in the moment and be prepared with strategies to communicate with and support the individual. Sometimes nonverbal communication is the most prominent or the only manner of communication available to person with dementia. Helping stabilize the situation through communication strategies available to the person in the moment and in the context of a given situation can be an invaluable skill.

Being able to recognize and assess situations toward knowing best avenues of intervention is critical. Not only should crisis interventionists know how to identify possible dementia and assess for it, they should also be able to understand precursors or triggers that may lead to a stressful, anxiety provoking, or threatening situation on the part of the individual, family members, or caregivers. Risk must be properly evaluated. Crisis interventionists should also be able to survey for available supports and help design and implement strategies—response plans—to help stabilize the situation, with a preference to the extent possible for stabilization in place. Minimizing “transfer trauma” provoked by relocation is at a premium.

Promoting Person-Centered, Trauma-Informed, Least Restrictive Environment Under the Law

Obviously, the person-centered and trauma-informed approach to working with people is preferred and indeed required in terms of least restrictive measures. Sometimes though, responders must invoke legal structures to keep people safe. Crisis providers must be mindful of the treatability of a person’s condition and therefore know how Wis. Stat. ch. 51 is distinct from Wis. Stat. ch. 55. Staff need to know the circumstances under which each law applies, who are proper subjects for adult protective services and/or placement, who has authority to place an individual in protective placement, what options exist, the related paperwork required, court processes and timeframes, etc. Moreover providers must be aware of the potential for co-morbidity or the simultaneous impact of mental illness and dementia and how that would modify one’s response.

Principles of Treatment

A dated (2004) but nevertheless relevant monograph published by the Alzheimer’s Association reviewed

the [Evidence on Interventions to Improve Quality of Care for Residents with Dementia in Nursing and Assisted Living Facilities](#) identified several treatment principles of which caregivers and interventionists should be mindful:

- “1. Careful assessment of potential causes of agitation, aggression, and depression is essential to determine whether some underlying cause such as adverse medication effects, infections, dehydration, pain, delirium, fecal impaction, or injury is causing the behavior. When assessment provides insight into a cause for behavioral issues, the identified cause should be addressed before moving on to other methods of treating behavioral symptoms.
2. Environmental or behavioral techniques... should be used as a first line treatment of agitation, aggression, and depression, rather than beginning with pharmacological interventions. To determine which intervention might work best with a given resident, practitioners must collect information about the resident’s life before entering the institution and should try a variety of interventions before moving on to pharmacological treatments.
3. If non-pharmacological options fail, then medications should be considered if residents have the potential to harm themselves or others or a resident’s condition has not improved within 30 days. Medications should be administered under the care of a mental health professional. Medications should be used as a last resort and must be used judiciously to avoid severe side effects, such as over sedation and Parkinsonism. Treatments should begin with the lowest efficacious dose and increase slowly. Continued need for treatment should be reassessed every three months.”

De-Escalation, Stabilization, and Crisis Planning with Partners

Finally, for individuals in crisis or at high risk of a recurrent crisis, staff should be able to assess the situation, develop a response, and formulate a crisis plan that sets in place ongoing stabilization strategies and outlines future intervention strategies should the situation deteriorate. Crisis staff also need to know their partners in working with individuals with dementia, including families, caregivers, adult protective services, the aging and disability resource center, etc. Similarly, crisis interventionists should be able to help clarify roles and responsibilities of the involved parties.

Training on Dementia

A variety of training resources exist, a few of which are noted in Appendix B. Included there is UW-Oshkosh (UWO), which has developed a foundational training for crisis staff in a four-hour online format. UWO also offers training to other audiences and a train-the-trainer offering in the fall and spring. Training specific to dementia is foundational to an ability to respond to the burgeoning crisis of persons with dementia in our communities. In addition to training in dementia, programs must have an ability to work with partners toward a capable and collaborative approach to serving elders. Knowledge and skill navigating the matrix of opportunities and challenges experienced by elders requires expertise on the part of crisis staff but also effective collaboration with partners (broadly defined to include families, care providers, hospitals and emergency departments, counties, legal counsel, law enforcement).

Framework for Evaluation Through the Wisconsin STAR Method

Tim Howell, M.D., Geriatrics Research, Education, and Clinical Center within the William S. Middleton Veterans Administration Hospital in Madison, has developed a framework for evaluating the challenges and problems associated with aging. It takes into account an interactive, multidimensional approach to understanding the elder’s situation through five different factors at each point of the star: personal/personality, social, medical, medication, and behavioral factors.

“The [Wisconsin STAR method](#) is a simple concrete way to map and visually process the numerous interacting factors in the complex situations so typically common in geriatrics. How to effectively address multiple co-occurring problems is one of the greatest challenges facing those who develop models of geriatric care, as well as those who provide such care directly. The number of comorbid medical conditions and psychosocial issues, often inextricably intertwined, seem to multiply with age. Some problems are acute, many are chronic, and most change over time. In addition, what each problem means can vary according to the unique perspectives and feelings of those involved at every level of the care system.

The effort required not only to assess but also to address such a sizable number of simultaneously interacting factors taxes both cognitive and emotional resources. Further compounding these challenges is the high degree of variability from one older adult or population to the next, generated by multiple factors ranging from age-related physiological heterogeneity to different sets of psychosocial experiences over the course of lifetimes. Under such circumstances, evidence based guidelines, developed from studies of single problems in homogeneous populations, are of limited utility at best. And not only do providers and planners of care for older adults encounter higher levels of complexity with higher degrees of frequency, but they also face higher levels of ambiguity in terms of diagnosis, prognosis, and plausible interventions stemming from those complexities. (M.L. Malone et al. (eds.), *Geriatrics Models of Care: Bringing ‘Best Practice’ to an Aging America*. Springer International Publishing: Switzerland. 2015)”

One of the areas not highlighted in the Wisconsin STAR method is environment *per se*. Here are some resources on the importance of environment when it comes to elders and those with dementia.

- [Designing Environments for Alzheimer’s Disease](#), Alzheimer’s Association
- [Dementia-Friendly Environments](#), Department of Health & Human Services, State Government of Victoria, Australia
- [Therapeutic Interventions for People With Dementia—Cognitive Symptoms and Maintenance of Functioning](#), National Collaborating Centre for Mental Health, United Kingdom

Application of the Four Major Dimensions of Recovery

The Substance Abuse and Mental Health Services Administration (SAMHSA) has delineated four major dimensions that support a life in recovery for individuals with behavioral health conditions. While the trajectory of illness is different for progressive neurological disorders such as Alzheimer’s disease, the importance of these dimensions cannot be overstated. Each of the four dimensions are important to quality of life for all persons. Having *health* or at least proper management of one’s illness and symptoms is first. Having a sense of *home* is critical to feeling safe, stable, and comfortable. Having *purpose* is essential for the experience of self-efficacy, independence, participation in community, identity, creativity, and self-expression. Along this line, there is an older but relevant book, [Keeping Busy: A Handbook of Activities for Persons With Dementia](#), which has a number of useful ideas. The Alzheimer’s Association also has a monograph of [Activities With Your Loved One](#). Finally *community* connects us to others socially, such that we can have relationships, friends, love, and hope. Fulfillment in these broad dimensions is no less important to the person who is challenged with dementia or related conditions.

Knowledge of the Context of Intervention—Laws and Regulations

The availability of funding for training grants represents an opportunity for increasing the dementia-capability for DHS 34, Subchapter III crisis programs and their community networks. Crisis providers and partners should have a working knowledge of some key aspects of related laws, administrative rules, and programs that provide the parameters of a potential response:

- State social services under [Wis. Stat. ch. 46](#) and provisions under Wis. Stat. § 46.80 (aging) through Wis. Stat. § 46.90 (elder abuse reporting)
- State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act under [Wis. Stat. ch. 51](#)
- State protective services system under [Wis. Stat. ch. 55](#)
- [Safe and Orderly Transfer or Discharge from Nursing Homes](#) under Centers for Medicare and Medicaid Services § 483.12(a)(6) and (7)
- Emergency Medical Treatment and Labor Act (EMTALA) under federal requirement [42 CFR 489.24](#) requires emergency departments to provide a medical screening examination to determine whether an "emergency medical condition" exists. It imposes restrictions on transfers of persons who exhibit an "emergency medical condition" or are in active labor. And EMTALA imposes an affirmative duty to institute treatment if an "emergency medical condition" exists.
- [Family Care](#)
- State support for persons with Alzheimer's disease and their caregivers under Wis. Admin. Code ch. DHS 68.
- Admission and discharge requirements for regulated facilities:
 - State-certified adult family homes ([Wis. Admin. Code ch. DHS 82](#))
 - State community-based residential facilities ([Wis. Admin. Code ch. DHS 83](#))
 - State-licensed adult family homes ([Wis. Admin. Code ch. DHS 88](#))

Eligible Applicants

Legislative intent for the use of these funds was to make a one-time funding resource available to counties or regions comprising multiple counties to obtain training for their mobile crisis teams on recognizing and providing services to individuals with dementia. As such, individual counties can apply separately or a consortium of counties can apply under a single application. Counties that contain tribal lands are strongly encouraged to partner with the tribe(s).

Proposal Application

Please submit a proposal that describes how your county or consortium of counties and partners plan to address the dementia training needs according to the goal and objectives described below for crisis programs included in the application. Ensure that the application includes the required elements and addresses the evaluation criteria below. Proposers must submit their proposal on single-sided, single-spaced 8½x11 inch paper with 1-inch margins and 12-point standard font (prefer Times New Roman). Please limit proposals to 10 pages (not including cover page, budget spreadsheet, appendices, and letters of support or commitment). Budgets are to be submitted on the required [Excel budget spreadsheet](#) as a separate document to the proposal narrative. For both the proposal narrative and the budget, please submit a total of five duplicates (one original and four paper copies) to the contract administrator. Additionally, applicants must submit the entire proposal in electronic form in a non-password protected Portable Document Format (.pdf) and the budget as a Microsoft Excel file using the required template on a reproducible CD(s) or portable flash drive labeled as follows:

Crisis Training Grant: Recognizing and Providing Services to Individuals with Dementia

Name and Address of Proposer

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Required Elements

Goals and Objectives. Funding is available for counties or regions comprising multiple counties, to support training for DHS 34, Subchapter III Emergency Mental Health Services Programs toward recognizing and providing services to individuals with dementia. The overarching goal is to develop a training plan that utilizes a learning collaborative approach that builds a crisis system that provides dementia-capable services. This approach is designed to provide a capable assessment and response as well as involving crisis intervention staff and their partners, as well as crisis planning for individuals suspected of having dementia involving crisis intervention staff, their partners, and to the extent possible the individual's family and caregivers. Through a [learning collaborative](#) structure, projects should achieve the following objectives while establishing structures for ongoing collaboration, learning, and knowledge transfer, which manifests in improved clinical practice in serving persons with dementia. Within the overarching structure of a learning collaborative, many learning resources are available ranging from printed literature, to workshops, lectures, online courses, videos, focused clinical supervision, and feedback, etc.

- **Objective 1. Aging. Provide foundational biopsychosocial understanding of aging to crisis program staff.** Core understandings would include at least some coverage of the elements listed below. Training records including names of those trained, resources, and outcomes must be reported and attached to required quarterly Performance Monitoring Reports due October 15, 2016, and January 15, April 15, and July 15, 2017.
 - Late life—gerontology from the perspective of health and pathology.
 - Health conditions more common to later life, including the dementias.
 - Factors related to culture and cohort, including adult developmental perspectives.
 - Cultural capability for working in an ageist culture.
 - Importance of dignity, choice, and person-centered considerations for the elder in the context of least restrictive environment.
 - Importance of environment and social considerations, adaptations and accommodations, and the concept of transfer trauma.
 - Clarity in respective roles, responsibilities, and stresses of the challenged person, family, caregiver, community, and society.
 - Initiating, interacting with, and responding to elders enabling valid assessment and response.
- **Objective 2. Assessing and Responding to Delirium, Reversible and Progressive Dementia, and Pseudo-Dementia. Demonstrate that crisis staff and partners have a foundational understanding of essential concepts and approaches to working with individuals with these conditions, their families, and caregivers.** Core understandings would involve principles related to the Wisconsin STAR Method embodying a healthy diagnostic skepticism, mindful of the complexities of the multidimensional interplay of various factors in an elder's life; knowledge of the signs, symptoms, and syndromes of delirium, dementia, and conditions masquerading as dementia; importance of a person-centered approach; skilled, state-of-the-art, and collaborative assessment strategies and response planning; competency in identifying and engaging resources and supports in the moment; ability to use effective engagement, communication, and de-escalation strategies. Training records, resources, and outcomes must be reported and attached to required quarterly Performance Monitoring Reports due October 15, 2016, and January 15, April 15, and July 15, 2017.

- **Objective 3. Role Clarification and Partnership. Demonstrate collaboration with partners over respective roles and responsibilities and establishment of memoranda of understanding (MOU) where appropriate.** In addition to the focal roles of crisis and adult protective services, other partners could include but are not limited to: hospitals and emergency departments, skilled care nursing and rehabilitation facilities, senior residential care facilities and residences, senior and subsidized apartments, law enforcement agencies, senior centers, elder support groups, home health agencies, senior meal programs, aging and disability resource centers (ADRCs), etc. Collaborators, partnerships, MOUs, and agreements must be reported and attached to required quarterly Performance Monitoring Reports due October 15, 2016, and January 15, April 15, and July 15, 2017.
- **Objective 4. Parameters or Rules and Laws. Demonstrate a general understanding of interacting legal structures as they pertain to elderly and those with dementia and how to operate within this environment.** These legal structures include Wis. Stat. chs. 48, 51, and 55; Olmstead requirements, Pre-Admission Screening and Resident Review (PASRR); Centers for Medicare and Medicaid Services (CMS) Standards for transfer and discharge from nursing homes; the *Helen E.F.* Supreme Court Decision; the federal Emergency Medical Treatment and Labor Act (EMTALA); and other related laws and regulations. Training records with participant names, resources, and outcomes must be reported and attached to required quarterly Performance Monitoring Reports due October 15, 2016, and January 15, April 15, and July 15, 2017.
- **Objective 5. Learning Collaborative. Establish an enduring learning collaborative structure to enable information exchange and updates, study challenges and opportunities, and to help create training structures or curricula.** Through this structure each grantee would be expected to have an enduring community of partners working in concert to address issues related to serving elders with suspected dementia. Proposers must develop a plan for sustaining and continuing to develop increased knowledge and improved practices beyond the period of the grant. Local support and advocacy partners as available (e.g., Alzheimer's Association) would be a valuable partner. These structures will also encourage the development and sharing of lessons learned to the consortium and beyond to other communities around the state. This can be done through participation in the annual Crisis Intervention Conference (September 29-30, 2016), the quarterly Crisis Intervention Network meetings (August 19, 2016; November 18, 2016; February 17, 2017; May 19, 2017) and in quarterly conference calls between dementia training grantees (September, December, and April). There are various ways to characterize a [learning collaborative](#) approach; partners within a particular collaborative will be dictated by local needs and partner willingness. Partners, participants, and structure of collaborative meetings and networking must be described and reported on required quarterly Performance Monitoring Reports due October 15, 2016, and January 15, April 15, and July 15, 2017.
- **Objective 6. Roles: Transferable Resources. Disseminate collaboratively developed resources among local partners as well as statewide.** As a component of the learning collaborative approach, resources that are developed within projects will be shared with the greater statewide audience. Products that are developed by grantees are expected to be shared. These might be relevant policies and procedures, memoranda of understanding (MOU), manualized training resources, flowcharts, etc. These would be shared within the collaborative as well as with statewide partners, for example at the quarterly Crisis Intervention Network meetings. Any resources that are developed must be attached, described, and reported on required quarterly Performance Monitoring Reports due October 15, 2016, and January 15, April 15, and July 15, 2017.
- **Objective 7. Data Collection. By October 21, 2016, establish approved metrics of deliverables that demonstrate how training is impacting practice.** In addition to the requirement that DHS 34, Subchapter III programs reliably report into the Program Participation System (PPS), grantees will be required to develop approved metrics for not only measuring increased knowledge and skill but

improved outcomes within the scope of the project. The gold standard for improved outcomes is measured in the context of improvements for consumers of crisis services—quality of life for the person of concern with suspected dementia, their families, and caregivers (e.g., satisfaction with services, remaining home, reduced stress and anxiety, better health, increased sense of purpose or community). Secondly, outcomes that impact outward indicators of care quality can be considered (e.g., improved residential stability, reduced restrictive measures, effective environmental modification, more effective medication management, improved diet or exercise). Tertiary indicators are those that show more efficient and effective allocation and utilization of resources (e.g., reduced reliance on emergency services, reduced hospitalizations, and protective placements). By October 21, 2016, grantees are required to submit a data collection plan to the contract administrator for approval. Outcome data must be reported at quarterly intervals on the required quarterly Performance Monitoring Report due October 15, 2016, and January 15, April 15, and July 15, 2017

Required Process Improvement Strategies

Applications for funding must be mindful of process improvement model(s). There are many data-driven models that could be considered, a few of which are: [Plan-Implement-Execute \(PIE\)](#); [Plan-Do-Study-Act](#); [Define-Measure-Analyze-Improve-Control \(DMAIC\)/Define-Measure-Analyze-Design-Verify \(DMADV\)/Design for Six Sigma](#); or [NIATx-type \(Network for the Improvement of Addiction Treatment\) rapid-cycle improvement strategies](#).

Required Program Participation System (PPS) Reporting

As with all DHS 34 Subchapter III programs, there must be a plan to assure accurate, complete, and prompt reporting into [PPS](#). Proposers must describe how this will occur within their proposal for each involved DHS 34 Subchapter III program. These data can be incorporated into the outcome data being gathered.

Proposal Format

Proposals must be organized into clearly delineated sections, as shown below. Each heading and subheading should be separated by tabs or otherwise clearly labeled or marked.

Tab 1. Cover Sheet

- a. Table of Contents
- b. [Vendor Information Form DOA-3477](#)

Tab 2. Goals, Objectives, and Performance Expectations

Tab 3. Environmental Scan, Needs Assessment, Program Design, and Methodology

Tab 4. Work Plan

Tab 5. Organizational Experience and Capacity

Tab 6. Reporting, Performance Measurement, and Quality Improvement

Tab 7. Budget

Tab 8. Appendix – Letters of Support, Letters of Commitment, Memoranda of Understanding (MOU), Contracts, etc.

Evaluation Criteria

Proposals will be evaluated according to the following criteria with a maximum point value of 100.

Environmental Scan and Needs Assessment – 10 points

Proposers should determine the scope of the proposal (county, region, multi-county partnership) and provide an environmental scan and needs assessment outlining strengths, deficits, and barriers for the identified service area regarding the ability of the DHS 34 Subchapter III program(s) to capably provide assessment, response, mobile crisis, crisis planning, and stabilization services to persons with dementia and their families and caregivers. Proposers should examine and describe their situation from the perspective that most effectively reflects the current situation: where the greatest training need is in their system, where the greatest opportunities lie, which challenges are causing the most problems, or greatest potential for impact, etc. The environmental scan should identify collaborators and willing partners. Ideally, partnerships would be substantiated with letters of support or commitments for collaboration. At the most fundamental level it is required that there be a solid collaboration between DHS 34 Subchapter III crisis programs and adult protective services (APS).

Goals, Objectives, and Performance Expectations – 30 points

Proposers must describe goals, objectives, and performance expectations for the grant year to fulfill the requirements described above. Proposals will be evaluated based on scope, feasibility, and reasonableness of the deliverable outcomes and objectives designed to support the overarching goal of developing a learning collaborative approach for training crisis intervention staff and their partners to be capable of providing a skilled assessment, response, and crisis plan for individuals suspected of having dementia. Emphasis is on developing a learning collaborative structure, establishing structures for ongoing collaboration, learning, and knowledge transfer that manifests in enhanced clinical practice in serving persons with dementia. Objectives for the unique project must be framed as SMART deliverables: Specific, Measurable, Attainable, Relevant, and Time-Bound. These will be tracked at quarterly intervals on the [DMHSAS Program Performance Report](#). Consequently reviewers will be looking for projected outcomes in the context of verifiable measures of *how many* (i.e., a number such as 2, 9, 50), of *what in particular* (e.g., agencies, stabilizations in place, partners, trainings, emergency protective placements, people), by *when* (e.g., December 1, 2016), and *how* will these outcomes impact the overall goal and related outcomes of this project.

Program Design and Methodology – 30 points

Proposers must describe and define a viable model for the project that addresses the specifications noted in this memo, with a priority on collaboration toward maximizing the impact of grant funds. This will be accomplished by setting in motion structures that will continue to provide enduring impact for consumers that confers value to partners beyond the grant year. As such, there will be an emphasis on sustainability for bringing our best knowledge to bear on enhancing clinical practice. Universal suicide screening is expected as a standard of practice within crisis programs. The work plan should include a process for gathering data and measuring effectiveness with clear quarterly outcome benchmarks and a final outcome target of June 30, 2017.

Organizational Experience and Capacity – 10 Points

Proposers are required to describe their organizational experience and capacity to accomplish the stated goals and objectives. Proposers shall have capacity to work in concert with area partners and be able to draw upon available education and training resources, maximizing the impact of training, collaboration, and synergy. Promotion of evidence-based or best practices are expected. Organizations should have

familiarity with the [Wisconsin Medicaid](#) and Family Care environment along with knowledge of programs and agencies geared toward serving elderly and persons with dementia (see Appendix B). Proposers should be able to develop, facilitate, or collaborate with other agencies toward accessing or developing training resources that support stabilization in place while reducing unnecessary transfer trauma.

Budget – 20 points

Proposers shall submit a detailed line-item budget on the attached [Excel Budget Spreadsheet](#), along with a narrative justification for all project costs. All budget costs must comply with the [DHS Allowable Cost Policy Manual](#). Proposers shall provide a plan for sustaining the learning collaborative approach beyond the conclusion of the grant year.

Completed applications must be received by 4:00 p.m. on Monday, August 22, 2016, at the address below. Applications may be hand delivered or mailed. Email applications are not acceptable.

Questions regarding this memo should be directed to:

CENTRAL OFFICE CONTACT:

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Memo Websites:

[DMHSAS Information Memos](#)

DMHSAS Information Memos are posted online in PDF format.

[DMHSAS Numbered Memos](#)

DMHSAS Numbered Memos are posted online in PDF format.

[DMHSAS Information and Numbered Memos Email Subscription Service](#)

Receive an email each time a new memo is released. This email will include a link to the online version of the memo.

Appendix A: Scope of Crisis Intervention and Compliance with 2015 Wisconsin Act 55, Section 1881

Dementia is Within the Scope of Crisis Intervention Services.

Emergency Mental Health Services Programs or Crisis Intervention Programs, certified under Wis. Admin. Code ch. DHS 34, Subchapter III, are to provide an assessment and response to situations that constitute a crisis, including situations resulting from an apparent neurocognitive disorder such as dementia.

"Crisis" means a situation caused by an individual's apparent mental disorder, which results in a high level of stress or anxiety for the individual, persons providing care for the individual, or the public, which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual. [DHS 34.02\(5\)](#)

"Mental disorder" means a condition listed in the Diagnostic and Statistical Manual of Mental Disorders IV (4th edition), published by the American psychiatric association, or in the International Classification of Diseases, 9th edition, Clinical Modification, ICD-9-CM, Chapter 5, "Mental Disorders," published by the U.S. department of health and human services. [DHS 34.02\(14\)](#)

During an initial contact with an individual who may be experiencing a mental health crisis, staff of the program shall gather sufficient information, as appropriate and possible given the nature of the contact, to assess the individual's need for emergency mental health services and to prepare and implement a response plan. [DHS 34.23\(3\)](#)

Based on an assessment of the information available after an initial contact, staff of the program shall determine whether the individual is in need of emergency mental health services and shall prepare and implement any necessary response. [DHS 34.23\(4\)\(a\)](#)

Required Crisis Assessment by a Mental Health Professional

The Department of Health Services (DHS), through the Division of Mental Health and Substance Abuse Services (DMHSAS), was tasked with defining three key components relevant to this statutory amendment; specifically, what staff is approved to complete a crisis assessment relative to authorizing an emergency detention and by what modality. Counties, regions, and departments of community programs are required to have written policies and procedures that encompass these three components. The three key components are described and defined below:

- A. Approved Staff to Provide Crisis Assessments.** As defined in the statutory change, a physician who has completed a residency in psychiatry, a psychologist licensed under Wis. Stat. Ch. 455 or a mental health professional, as determined by the department, must provide the crisis assessment for the county department to approve the detention. For the purposes of the directives embodied within 2015 Wisconsin Act 55, Section 1881, DHS defines a "mental health professional" as staff qualified to be listed under a [§ DHS 34.21\(3\)\(b\) 1 through 19](#) roster, who are qualified, trained, and supervised in accordance with the minimum supervision requirements in the [following paragraph](#) regardless of whether or not a county, region, or department of community programs is currently using the services of a [DHS 34 Subchapter III](#) certified program. Procedures must be in place to assure the qualifications of staff include clinical aptitude, background, and skill to assess populations that may require emergency detention due to a range of DSM-5 conditions. Populations include:

children, youth, and families; persons with serious and persistent mental illness; individuals with developmental disability or dementia; individuals with personality disorders or those with substance use disorders. Moreover, it is required that anyone qualified to perform in this capacity have constant access to medical consultation, and that a clinical supervisor be on site or be available by telephone to provide supervision or consultation. All response plans must be approved by a licensed physician, psychiatrist, psychologist, or a mental health professional as described under § DHS 34.21(3)(b) 1, 2, 3, 4, 5, 6, and 7 and must be signed within 14 days of service provision. If the crisis assessment is being provided by a DHS 34 Subchapter III program, the assessment and plan approval must occur in accordance with the rule requirements for a response plan.

- **Minimum Supervision Requirements.** Minimum supervision requirements for staff include documented (and available for review) direct review, assessment, and feedback regarding staff members' delivery of services involved in providing crisis assessments. While supervision requirements vary based on the qualifications and experience of staff under supervision, only staff meeting qualifications of [§ DHS 34.21\(3\)\(b\) 1 through 9](#) are permitted to provide clinical supervision. Provisions within this memo are not to be interpreted as reducing any requirement for a DHS 34 Subchapter III certified program. All certified programs must continue to meet administrative requirements in order to remain certified through the [Division of Quality Assurance](#). Approved mental health professional staff providing crisis assessments must be provided with supervision mirroring that which is required in [§ DHS 34.21\(7\)](#) and according to the agency's written policy. The amount of supervision time and the type of supervision required are defined by the particular qualifications of the supervised staff, mirroring [§ DHS 34.21\(3\)\(b\)](#):
 - Staff eligible to be qualified under the first eight staff roles as described in § DHS 34.21(3)(b) 1 through 8 and with 3,000 hours of supervised clinical experience are required to participate in a minimum of one hour of peer consultation per month.
 - Program staff providing emergency mental health services including crisis assessments who do not have 3,000 hours of supervised clinical experience, or who are not qualified under § DHS 34.21 (3)(b) 1 to 8, shall receive a minimum of one hour of clinical supervision per week or for every 30 clock hours of face-to-face mental health services they provide.
- **Services for Children and Adolescents and Their Families.** Staff providing crisis assessments and response planning to young children or adolescents must have at least one year of experience providing services to this population or receive a minimum of 20 hours of training specific to children, youth, and families. Professional staff shall have the training and experience needed to carry out the roles for which they have been retained, and receive the ongoing support, supervision, and consultation they need in order to provide effective services for clients.

B. Performing a Crisis Assessment. The county department may approve detention only if a physician who has completed a residency in psychiatry, a psychologist licensed under Wis. Stat. ch. 455, or a mental health professional (defined elsewhere in this memo) has performed a crisis assessment on the individual and agrees with the need for detention and the county department reasonably believes the individual will not voluntarily consent to evaluation, diagnosis, and treatment necessary to stabilize the individual and remove the substantial probability of physical harm, impairment, or injury to himself, herself, or others. A crisis assessment will reflect due diligence in collecting sufficient and accurate assessment information through direct interview with the individual, gathering behavioral observations, and obtaining and reviewing collateral and historical information. There are many resources available regarding best practices in the provision of crisis assessments including a monograph describing [Core Elements in Responding to a Mental Health Crisis](#) produced

by the Substance Abuse and Mental Health Services Administration as well as others, a few of which are listed below.¹

At a minimum, the crisis assessment will meet the requirements set in [Wis. Stat. ch. 51](#) and [DHS 34](#). As outlined in Wis. Stat. § 51.15(1), to take an individual who is believed to be mentally ill, drug dependent, or developmentally disabled into custody, it must be determined that taking the person into custody is the least restrictive alternative appropriate to the person's needs. In addition, the individual must be assessed for the following: substantial probability of physical harm to himself or herself, substantial probability of physical harm to other persons, substantial probability of physical impairment or injury to himself or herself or other individuals due to impaired judgment, and behavior manifested by a recent act or omission that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter, or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation, or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness.

Assessment and response as outlined in § DHS 34.23 includes determination of eligibility for services, written policies, information gathered during initial contact, determination of need, development of a response plan, linkage and follow-up, crisis planning, and service notes. During an initial contact with an individual who may be experiencing a mental health crisis, § DHS 34.23(3) indicates that “staff of the program shall gather sufficient information, as appropriate and possible given the nature of the contact, to assess the individual's need for emergency mental health services and to prepare and implement a response plan, including but not limited to any available information regarding:”

- a) the individual's location, if the contact is by telephone;
- b) the circumstances resulting in the contact with the program, any events that may have led up to the contact, the apparent severity of the immediate problem, and the potential for harm to self or others;

¹ Example resources:

Resources in Behavioral Health Crisis Services

<http://www.sprc.org/sites/sprc.org/files/library/SPRC%20Crisis%20Services%20Resource%20Sheet.pdf>

Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline

<https://www.suicidepreventionlifeline.org/media/5370/joiner-et-al-2007.pdf>

The Mental Status Examination <http://www.ncbi.nlm.nih.gov/books/NBK320/>

Suicide Care in Systems Framework

<http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf>

Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals At Risk for Suicide

[http://www.apna.org/files/public/Resources/Suicide%20Competencies%20for%20Psychiatric-Mental%20Health%20Nurses\(1\).pdf](http://www.apna.org/files/public/Resources/Suicide%20Competencies%20for%20Psychiatric-Mental%20Health%20Nurses(1).pdf)

The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults

<http://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760>

Organization Accreditation Standards Manual, 12th Edition, through American Association of Suicidology

<http://www.suicidology.org/Portals/14/docs/Training/CrisisCenters&Workers/12thEd2014revisionsNov22014.pdf> Columbia

Suicide Severity Rating Scale (C-SSRS) <http://www.cssrs.columbia.edu/>

Crisis Stabilization Claims Analysis: Technical Report—Assessing the Impact of Crisis Stabilization on Utilization of Healthcare Services <https://www.wilder.org/Wilder->

[Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/Crisis%20Stabilization%20Claims%20Analysis%20-%20Technical%20Report.pdf](https://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/Crisis%20Stabilization%20Claims%20Analysis%20-%20Technical%20Report.pdf)

- c) the primary concerns of the individual or a person making the initial contact on behalf of the individual;
- d) the individual's current mental status and physical condition, any over-the-counter, prescription or illicit drugs the individual may have taken, prior incidents of drug reaction or suicidal behavior and any history of the individual's abuse of alcohol or other drugs;
- e) if the individual is threatening to harm self or others, the specificity and apparent lethality of the threat and the availability of the means to carry out the threat, including the individual's access to any weapon or other object that may be used for doing harm;
- f) if the individual appears to have been using alcohol or over-the-counter, prescription, or illicit drugs, the nature and amount of the substance ingested;
- g) and the names of any people who are or who might be available to support the individual, such as friends, family members, or current or past mental health service providers.

Based on the assessment information (taking into account needs, strengths, and available resources) a determination of need and an individualized response shall be developed and implemented. In the event that an emergency detention is not pursued, an appropriate dispositional/safety plan will be developed and documented.² Each program must develop policies and procedures regarding assessments in accordance to § DHS 34.23(2). Documentation regarding the assessment shall be maintained in accordance with § 51.15(5) and § DHS 34.28).

Modality: In-Person, Telephone, Telemedicine, or Video Conferencing Technology. To the extent possible, the crisis assessment will be provided by the mental health professional directly with the individual. In-person assessment is the preferred mode but it is recognized that there are times when a face-to-face assessment is not possible, necessitating reliance on a telehealth or telephone assessment. Information is available on the use of telehealth resources in certified mental health and substance abuse treatment programs.³ Assessments where the decision making is based exclusively on a third-party report of others is not acceptable unless there are extenuating circumstances prohibiting behavioral observations and interview of the person. Crisis programs must have written policies identifying criteria for deciding when the situation requires a face-to-face response, the use of mobile crisis services, or telephone assessments based on third-party reporting alone.

² Example safety plan for persons at risk for suicide: <http://www.suicidesafetyplan.com/>

³ *Mental Health and Substance Abuse Telehealth—Criteria for Certification* (DMHSAS Memo 2015-08): <https://www.dhs.wisconsin.gov/dqa/memos/15-011.pdf>

Appendix B: Sample Training Resources and Evidence-Based Practices

Below are hyperlinks that may be of interest and assistance. What follows are only examples as there are many other resources from which to draw. In fact, from the resources below, proposers will be able to identify a wider field of resources, some of which may be more specific to their particular project.

- Administration on Aging (AOA) [Elder Rights Protection](#)
- [Alliance for Aging](#)
- [Alzheimer's and Dementia Alliance of Wisconsin](#)
- [Alzheimer's Association](#)
- [American Association of Retired People \(AARP\) and Chapters](#)
- [CDC Caregiving Resources](#)
- [CDC's Disaster Planning Goal: Protect Vulnerable Older Adults](#)
- [Coalition of Wisconsin Aging Groups and its Elder Law Center](#)
- [Crisis Intervention Team \(CIT\) and Crisis Intervention Partner \(CIP\) Training](#)
- [Crisis Prevention Institute](#)
- [Dementia Behavior Consulting LLC](#)
- [Department of Health Services Dementia Training Catalog](#)
- [National Institute on Health: National Institute of Neurological Disorders and Stroke: Dementia Information Page](#)
- [Pre-Admission Screening and Resident Review \(PASRR\)](#)
- [Regional Area Agencies on Aging](#)
- [UW-Oshkosh, Center for Career Development and Employability Training: Wisconsin Dementia Care Project](#)
- [UW-Green Bay: Behavioral Health Training Partnership](#)
- [UW-Madison: Institute on Aging](#)

With respect to general features of Emergency Mental Health Services Programs, applicants are urged to be attentive to recent developments in the field, including the following resources:

- [2012 National Strategy for Suicide Prevention: Goals and Objectives for Action](#)
- [Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments](#)
- [Crisis Center Accreditation Program of the American Association of Suicidology](#)
- [Crisis Now: Transforming Services is Within Our Reach](#)
- [Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies](#)
- [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#)
- [Hopeline](#)
- [National Suicide Prevention Lifeline Network](#)
- [Prevent Suicide Wisconsin: Zero Suicide in Wisconsin](#)
- [Sentinel Event Alert: Detecting and Treating Suicide Ideation in All Settings](#)
- [Wisconsin Suicide Prevention Strategy](#)

Below is a sampling of evidence-based practices (EBP) relevant to elders from [National Registry of Evidence-Based Programs and Practices \(NREPP\)](#):

- [Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Centers](#)

- [Applied Suicide Intervention Skills \(ASIST\)](#)
- [Cognitive Behavioral Therapy for Late-Life Depression](#)
- [Cognitive Therapy for Suicide Prevention](#)

These are samples of listed EBP programs that have been validated with seniors:

- [Coordinated Anxiety Learning and Management \(CALM\) Tools for Living Program](#)
- [Panic Control Treatment \(PCT\)](#)
- [Prevention of Suicide in Primary Care Elderly: Collaborative Trial \(PROSPECT\)](#)
- [Program of All-Inclusive Care for the Elderly \(PACE\)](#)
- [QPR Gatekeeper Training for Suicide Prevention](#)
- [Senior Reach](#)
- [Short-Term Interpretive Group Therapy for Complicated Grief](#)
- [Transtheoretical Model \(TTM\)-Based Stress Management Program](#)
- [Traumatic Incident Reduction](#)
- [Wellness Initiative for Senior Education \(WISE\)](#)
- [New York University Caregiver Intervention \(NYUCI\)](#)