



Improving Dementia- Related Crisis Response:

Results of Six Innovation Grants



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Executive Summary

This report summarizes strategies employed and lessons learned by counties that received a Dementia Crisis Innovation Grant from the Wisconsin Department of Health Services (DHS) for the period of January 2016 through July 2017. DHS awarded six grants to counties or county coalitions to identify strengths and address shortcomings in their local crisis response systems with respect to serving people with dementia. The grant recipients included: the Aging and Disability Resource Center of the North (ADRC-N), serving Ashland, Bayfield, Iron, Price, and Sawyer counties; the Adult Protective Services Department of North Central Health Care (NCHC), serving Langlade, Lincoln, and Marathon counties; Dodge County; Kenosha County; La Crosse County; and Milwaukee County.

Based on grant outcomes, there are seven broad recommendations for counties planning to improve dementia-related crisis response services:

1. Ensure leadership to oversee the activities of the project.
2. Include a broad-based collaborative coalition of partners.
3. Review the capacity of the existing dementia resources.
4. Evaluate and plan for local training needs.
5. Identify residential facilities willing to accept people needing urgent placement.
6. Create resources for stabilization-in-place supports for people with dementia.
7. Conduct reviews following incidents of dementia-related crisis to inform program improvement efforts.

Introduction

The six Dementia Crisis Innovation Grants awarded by DHS in 2016 were for counties or groups of counties to work with and expand local dementia coalitions with the intent of improving their capacity to respond to people with dementia in crisis. The grantees represented 12 counties and 27 percent of the state's population.

The 18-month grants required a review of local dementia resources, training needs, and crisis protocols and procedures. These reviews aimed to highlight the strengths and gaps in grantees' abilities to respond effectively to a person with dementia in crisis and to help them develop improvement plans.

This guide summarizes strategies employed and lessons learned by grantees as they worked to improve their crisis response capacity for people with dementia. The guide is intended to help counties and their community partners take steps to improve the state of crisis response in the best interest of those with dementia. In addition, the guide identifies gaps still in need of resolution.

Background

Description of the Crisis Response System

Under [Wis. Stat. ch. 51](#) and [Wis. Admin. Code ch. DHS 34](#), counties are responsible for responding to crisis situations in which a person with a mental health condition, substance use disorder, or dementia or other similar condition may harm themselves or others. All counties must have basic emergency service programs in place to provide immediate evaluation and care to someone experiencing a crisis. In addition, county crisis programs may be certified under [Wis. Admin. Code ch. DHS 34, subch. III](#) to provide mobile crisis intervention, which is designed to assess and de-escalate a crisis situation in the place where it occurs, and includes creation of a plan to minimize the need to hospitalize or relocate the person to an unfamiliar setting.

Crisis response systems in Wisconsin vary from county to county, depending on local practices and resources. Some counties have highly skilled personnel and certified mobile crisis intervention teams. In other areas, there is no effective crisis response beyond calling 911 or the sheriff's department. Many county crisis intervention teams do not have sufficient training or resources to be able to identify and manage people with dementia.

Just as someone with a mental illness or substance use disorder may become self-injurious, aggressive, or violent towards others, a small percentage of people with dementia exhibit these behaviors as well. Dementia also may lead to behaviors such as wandering, entering other residents' rooms uninvited, repetitive questioning, sexual inappropriateness, and refusal to bathe or accept care. These behaviors can be challenging to care providers. Other people's actions or responses can either alleviate or exacerbate these symptoms. Responding to challenging behaviors by removing a person with dementia from his or her living environment to an alternate setting can worsen confusion and agitation, cause unnecessary stress, and lead to negative health outcomes for the person. The goal, therefore, is to respond to behavioral symptoms in a manner that causes the least possible disruption to the person.

The appropriate response to challenging behaviors in an individual with dementia alone is likely to be different from the response needed for people who have dementia in addition to mental illness or substance use disorders. There are no generally accepted standards that can be used to quickly identify the presence of a dementia or the specific care needs of a person exhibiting unpredictable or difficult dementia-related behaviors.

In some counties, crisis responders and law enforcement officers have used ch. 51, Wisconsin's civil commitment mechanism, when responding to those with dementia in crisis who need temporary relocation. This has typically resulted in placement to an inpatient psychiatric setting. A 2012 Wisconsin Supreme Court decision in the case of *Helen E.F.*, however, raised questions about whether individuals with dementia, without co-existing mental health diagnoses, are proper subjects for this type of a response. The majority of people with

dementia committed under ch.51 are subsequently found to be proper subjects for guardianship and protective placement or services rather than ongoing mental health services and supports. Yet once a mental health resolution has been applied to someone with dementia only, transition to a long-term care setting is often difficult due to newly prescribed medications or the stigma of having been committed to a psychiatric unit.

Crisis intervention programs would benefit from having appropriate tools and training to better identify, evaluate, and provide crisis response plans for people with dementia who exhibit violent, aggressive, or other serious, challenging behaviors.

In February 2014, DHS released a Dementia Care System Redesign Plan to address gaps in the dementia care delivery infrastructure, including crisis services for people with dementia. The Plan advocated a model for dementia-capable mobile crisis response that 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 people with dementia who are in crisis and who need to be relocated.

County Perceptions of the Crisis Response System and Capability

Two surveys conducted by DHS highlight county perceptions of whether local crisis response systems are prepared to deal effectively with people with dementia who are in crisis. The first, in the fall of 2014, collected information from county crisis response administrators about existing arrangements for county crisis response and the capacity of those systems to respond appropriately to the behavioral symptoms that may accompany dementia. A total of 51 responses representing 54 counties was received.

The results indicated that counties vary widely in their capacity for crisis response involving older adults with dementia, and some county crisis units are ill prepared to respond effectively to people with dementia in crisis. Specifically:

- 50 percent reported that staff do not have access to training specific to dementia.
- 88 percent do not have tools to screen or assess people in crisis for dementia.
- 80 percent do not have access to clinicians who specialize in aging or older adults.
- 68 percent do not have access to facilities to stabilize people with dementia who are in crisis.

In February 2015, DHS surveyed county adult protective service units to learn how emergency protective placements (under [Wis. Stat. ch. 55](#)) are used for people with dementia who exhibit challenging behaviors. All 72 counties and the Oneida Tribe responded to this survey. (The Oneida Tribe was surveyed because it operates its own Adult Protective Services [APS] unit, whereas other Wisconsin tribes have memoranda of understanding with their county's APS units.)

In response to a question about how well the emergency protective placement process is working for people with dementia who exhibit challenging behaviors, half of the respondents

indicated that it works well some of the time, and one-fourth indicated that it rarely works well. Only 33 percent of respondents from counties with a 24/7 mobile crisis team reported that the mobile crisis response team “usually” responds effectively to situations involving people with dementia.

Ninety percent of respondents to the second survey reported that they do not have access to an adequate number of facilities that accept emergency protective placements of people with dementia. One possible result is that people with dementia who are in crisis may be placed in settings ill equipped to provide appropriate support. General hospitals, challenged by wandering or disruptive behaviors, often have difficulty finding a long-term residential facility willing to accept these individuals when they are ready for discharge, resulting in long hospital stays. Some individuals have been sedated as a strategy to mitigate their challenging behaviors until a placement can be found, which further complicates their discharge.

Dementia-Related Crisis Response: Recommendations Based on Grant Outcomes

The six Dementia Crisis Innovation Grants, which are the subject of this report, were provided to enable county coalitions to explore ways to identify the strengths and address the shortcomings in their local crisis response systems. The grant recipients included: ADRC of the North (serving Ashland, Bayfield, Iron, Price, and Sawyer counties); NCHC (serving Langlade, Lincoln, and Marathon counties); Dodge County; Kenosha County; La Crosse County; and Milwaukee County. Over the grant period, all grantees came to appreciate the importance of prevention activities as a way to help reduce the incidence of dementia-related crisis. Some projects included efforts to improve awareness of dementia, support caregivers, and help them to prepare and plan for potential crisis events. Although the success of prevention efforts is often difficult to verify with data, grantees recognized that prevention could be the best hope of improving capacity in the future.

Based on the grant outcomes, the following section highlights recommendations for local, collaborative efforts to improve dementia-related crisis response. More detailed accounts provided by the grantees of their grant activities, achievements, and lessons learned are included as an appendix.

1. Gather a broad-based collaborative coalition of individuals interested in improving the dementia capacity of crisis response and who are willing to invest time in the effort.

Wisconsin counties are statutorily responsible for adult protective services, with specific roles and responsibilities to ensure the protection of resident adults-at-risk, within the limits of available resources. There is a great deal of variability in counties’ approaches to fulfilling those responsibilities.

Adding to the complexity, county agencies do not control all of the activities that may transpire during a crisis, and there is no single funding stream to pay for the services provided to keep a person safe. Counties have limited capacity to control the outcomes of crisis response when it involves other entities, including law enforcement, corporation counsel, the courts, guardians ad litem, family and caregivers, residential facilities, hospitals, and others.

Although involved parties may have differing motivations for their involvement in the crisis system, all are critical in helping to develop and implement improvements. The community grants are intended to help partners recognize their collaborative potential and develop strategies to make positive changes and solutions that require a community effort.

- **Include a variety of stakeholders.**

In many Wisconsin counties, coalitions of individuals and agencies have come together to address issues related to Alzheimer's disease and other dementias. These local coalitions commonly focus on caregiver support, raising awareness, fundraising, and connecting people with resources. In addition, every Wisconsin county is required to have an interdisciplinary team whose primary focus is elder abuse and neglect.

Most of the counties receiving Innovation Grants were able to expand these already-existing local coalitions to include a broader membership focused on crisis response for those with dementia. Dementia innovation coalitions reported involvement of staff from the following partners in their projects:

Project Partners

Adult protective services (APS)	Law enforcement
Aging and disability resource centers (ADRCs)	Legal community
Alzheimer's Association	Managed care organizations (MCOs)
Community-based residential facilities	Mental health crisis system
Emergency medical technicians	Nursing homes
Faith communities	Residential community apartment complexes
Family	Supportive home care agencies
Home health care agencies	911/211
Hospitals	Other care providers

- **Consider various roles.**

Coalitions included a variety of stakeholders and each grantee determined how best to use their coalitions to achieve the goals of the grant. Some conducted community

training events focused on dementia-related issues to inform the community about the grant and solicit their involvement. Some grants helped expand existing coalitions or groups.

Other counties established workgroups of stakeholders to carry out specific tasks, like assessing training needs and developing a work plan to address those needs; exploring options for stabilization-in-place; or expanding the number of facilities willing to accept people in crisis. Regardless of the approach, coalitions were critical to the success of the grants and helped build sustainable efforts to improve capacity in crisis response to people with dementia.

2. Conduct a review of the capacity of current dementia resources.

Several grant counties employed the grant as an opportunity to do an in-depth review of existing dementia resources, update resource directories, and help providers articulate the services they provide as well as their limitations.

The review offered the opportunity to explore the capability and needs of specific stakeholders in the crisis response system, and assess their ability and willingness to expand or improve their dementia capability. For example, grantees found some providers who were very interested in receiving dementia-specific training. Grantees also found that some providers misunderstood the roles, responsibilities, and limitations of the dementia crisis system partners and focused efforts on clarifying those.

3. Evaluate local training needs and develop plans to address.

All of the grant proposals planned on using training as a mechanism to improve response to those in crisis. Lack of dementia-specific training was a key finding from the 2015 crisis response survey. Grantees were required to assess their training needs and implement a strategy designed to address those needs.

Most grantees, in collaboration with their local coalitions, conducted a needs analysis to identify training gaps and solicit feedback from stakeholders. The remaining grantees already had a good sense of local training needs, and developed strategies to implement training efforts with input and assistance from their coalition partners. Relevant trainings are increasingly available from a variety of sources, and the grantees investigated those that were most appropriate for their needs. Grantees partnered with other stakeholders to help provide targeted training to a variety of audiences. Most used a train-the-trainer model for the sake of cost effectiveness, availability, and sustainability moving forward.

- **Target training audiences.**

The grant required participants to track and report training activities in two separate categories: general training provided to a wide community audience, including families and caregivers; and specialized training targeted to crisis responders including APS,

mental health crisis staff, law enforcement, emergency medical technicians (EMTs), and fire department personnel. Over the grant period, some grantees also developed training for home health care service providers.

General training was often provided as part of community events meant to raise awareness of Alzheimer's disease and related dementias. In some places, these efforts dovetailed with the ongoing activities of dementia coalitions and the work of dementia care specialists in ADRCs. Grantees also pursued other opportunities to train caregivers. In some cases, nursing home and residential caregivers were trained at their facilities, which fostered consistency among staff in how to respond to residents with challenging behaviors and defuse situations to minimize the need for outside crisis intervention. Projects also targeted training to other community partners, including, in one example, training Uber drivers who were providing transportation for people with dementia.

Dementia training for crisis responders, law enforcement, and emergency medical services (EMS) more often involved accommodating the unique needs and schedules of those professions. In some cases, dementia training had to be incorporated into annual training activities. For example, some counties added a dementia-focused training module into their crisis intervention training (CIT) for law enforcement. Others found it necessary to plan numerous training opportunities at different times and locations to reach intended audiences. All grant counties reported that these trainings were well received and had a positive impact on response to crisis.

- **Develop role-specific training content.**

All trainings provided general information designed to improve a participant's understanding of Alzheimer's disease and related dementias, and how those conditions can affect an individual's ability to process information, understand the environment, and communicate needs. The trainings emphasized "behavior as communication" and built caregivers' and responders' skills for understanding those unable to express their needs verbally. Training also emphasized the importance of appropriate responses in preventing the escalation of behaviors and decreasing the need for intervention.

Families and caregivers were trained in proactive planning for a potential crisis. Comprehensive contingency planning strategies include identifying others in the individual's support system who can be called upon to assist; identifying care facility preferences in case the person with dementia needs to be relocated; and creating life plans to support individuals to prevent crisis. In addition, family members and caregivers learned how crisis responders could use the plans as a resource to better understand the individual's needs when called upon to respond. Families and caregivers were also taught physical intervention strategies for the safety of the individual in crisis and others in the environment.

Trainings provided information to community audiences about the process of crisis response and stabilization, including the details of crisis referrals, how they should be made, and what response could be expected based on their local system configuration. Trainings introduced the concept of stabilization-in-place as a preferred strategy to avoid relocation of people in crisis situations, and described the potential adverse effects of transferring individuals in crisis, such as transfer trauma, increased disorientation, agitation, and disruption.

Trainings for law enforcement, EMTs, and other crisis responders had many of the same elements as those provided to the general audiences, with additional skill-building trainings on how to approach individuals with dementia, assess the situation, and divert or diffuse crisis. Responders learned about the differences between emergency detention under ch. 51 (mental health commitment) and emergency placement under ch. 55 (protective placement), and how those differences can impact response and outcomes.

4. Explore availability and expand the number of facilities willing to accept people who need urgent placement.

The 2015 survey about emergency protective placements found that 90 percent of respondents did not have an adequate number of facilities willing to admit people in crisis. When this is the case, people with dementia who need to be relocated from their living environment are often transferred to general hospitals or psychiatric facilities, which may be far from the individual's residence. This can create difficulties for individuals and their families and challenge the resources of the county APS agency, which is typically involved throughout the crisis process and with eventual long-term placement in an approved residential setting.

Grantees were expected to conduct a thorough review of available dementia resources, including access to residential care facilities that are willing and able to accept people in crisis. In this effort, several of the grantees worked with their local coalitions, nursing homes, and residential facilities to explore the reluctance and barriers to fulfilling this critical need.

Grantees identified a number of factors, including a lack of clear protocols for crisis responders; the need for medical clearance prior to admission; the risk that people with aggressive behaviors may pose to the safety of residents and staff; associated regulatory pressures; and the need for contingency options should the placement not work out. Another significant barrier is facilities' lack of trust in referral sources and a feeling that behavioral challenges are sometimes downplayed to facilitate admission.

Some of the grantees were able to successfully address and navigate these issues to the satisfaction of facilities; others were not. Those who made progress were able to expand the number of facilities willing to accept people in crisis. To accomplish this, they refined

protocols and incorporated them into the training module. They created decision trees for crisis responders and others to use during crisis. Local hospitals agreed to expedite the screening process to make placement easier, prevent delays, and reduce the burden on law enforcement and the person in crisis. Facilities were assured of their ability to say no to potential placements and found that the training provided to their staff helped to increase the success of placements they did accept.

Over time, the strategies to expand the availability of facilities that were willing to accept emergency placements paid off for some grantees, and admissions increased over the duration of the 18-month grant. The project with the most marked success reported that three individuals were placed during the initial six months of the grant. After their efforts, they were able to successfully place 18 individuals in their final 12 months. Another county had two individuals placed during the first six months and eight individuals in the final 12 months. Of course, other factors may have contributed to these changes, but the grantees felt that the efforts carried out under the grant facilitated these successful outcomes.

Other grantees did not report similar improvements. One county was unable to impact current practice, in which individuals protectively placed are always admitted to local hospitals pending transfer to appropriate long-term care facilities. They continue to make efforts to alter this trend but have yet to find a successful strategy.

5. Create resources to support stabilization-in-place.

County crisis systems consist of two components: crisis response and crisis stabilization. Crisis response is the immediate response to an urgent, potentially dangerous situation; the goal is to address immediate safety concerns and to de-escalate the situation until a longer term plan can be developed and implemented. Crisis response may involve first responders, such as law enforcement, as well as county mental health crisis teams or adult protective service units.

Crisis stabilization consists of short-term, intensive actions and services provided following an immediate crisis; the goal is to avoid moving the person from their current residence whenever possible. Stabilization services include whatever is necessary and available to meet the needs of the person in crisis, such as assistance with housing; medical treatment or medication supervision; linkage and follow-up to long-term treatment providers; and help accessing resources such as economic support and Medicaid programs, environmental changes, or other services as needed. The stabilization services needed in a particular situation depend on the person's circumstances and available caregiving supports.

Over the past several years, Wisconsin's mental health crisis response system has transitioned from a reliance on psychiatric hospitals and institutions to greater utilization of diversion facilities and other stabilization strategies, which is typically the least restrictive and least invasive option. This approach has become the preferred and increasingly more

available response to those in crisis. None-the-less, diversion facilities and other stabilization services remain insufficient compared to the level of need.

For many with dementia who are in crisis, stabilization-in-place is also the preferred choice. However, stabilization supports are generally scarce for people with dementia. For that reason, grant recipients were required to explore the concept of stabilization-in-place as an available response when appropriate. Several reported some progress in reducing relocations through stabilization. One project trained a group of providers to act as supportive independent living staff who would respond to requests for stabilization-in-place supports. Two other grantees eventually were able to contract with home health agencies willing to receive dementia training and consider requests based on staff availability. At least one other grantee was unsuccessful in its attempts to find a stabilization partner.

The challenges of stabilization-in-place are affected by the setting in which the person with dementia is living. Data collected from grantees showed that, of the 96 individuals protectively placed during the grant period, 82 percent lived in their own home or the home of another at the time of the placement. Over 35 percent were living alone. Many of these individuals were unknown to APS prior to the presenting crisis. Though no data were collected on the formal or informal supports available at the time of the placement, sometimes there were none. In other cases, it was the support system itself in crisis, not the person with dementia.

Providing stabilization-in-place supports for people living in care facilities presented different challenges. Dementia training for facility staff at times prevented or defused a crisis but there are complicated issues, such as supervision and client responsibility, involved with bringing in staff from outside agencies; these could not always be overcome.

Grant-funded stabilization-in-place supports, when available, were shown to be beneficial, but the lack of ongoing funding for these types of services is a distinct barrier. Partial funding for crisis stabilization of people with dementia is available through Medicaid for county programs certified under ch. DHS 34, but it requires a 40 percent local county match. The burden of a 40 percent match and the intermittent nature of the need for dementia-related crisis stabilization services make it prohibitive for many counties to add staff or otherwise ensure that the services are readily available.

Some projects were able to make strides in creating stabilization-in-place options that worked well for the individuals in crisis. But until some of the identified barriers are more fully addressed, stabilization-in-place, in lieu of relocation, will continue to be an elusive option in many places.

6. Find ways to review crisis response results and make adjustments in policy and protocol as needed.

In order to assure that training and changes in policy and protocol were effective, some of the grantees incorporated a crisis review process. The after-action review of crisis response

cases encouraged ongoing quality improvement and thoughtful consistency in crisis response, promoting positive outcomes. Some focused on crisis situations where things went wrong, providing an opportunity to debrief and determine whether issues were unique to that incident, or required additional training or adjustments to policy and protocol. Some highlighted successful efforts, allowing for celebration and reinforcement of successful collaboration.

7. Ensure leadership to oversee the initiative.

Four of six grantees planned to have project coordinators to help oversee and facilitate the grant activities. Of those four, three were unable to secure the services of a project manager for the term of the grant, creating delays in project activities and requiring reassignment of those responsibilities to other agency employees. The grantee that was able to successfully engage a project manager, and the two other grantees that had planned for current staff to assume project oversight, seemed to make more immediate progress at the start of their projects, without the delays experienced by others. Although all grantees were ultimately able to move forward and compensate for initial setbacks, the delays some grantees experienced highlight the importance of having someone with project management responsibility designated early on to help organize, plan, and work with the broad coalition of partners at the start of an initiative like this.

Next Steps

This guide presents recommendations for counties intending to improve their capacity for dementia-related crisis response, based on the outcomes of a first set of Dementia Crisis Innovation Grants (now referred to as the “Round One” grants). Due in part to the enthusiastic efforts of the Round One grant recipients, DHS issued a second set of Dementia Crisis Innovation Grants (“Round Two” grants) for the period July 1, 2017 through December 31, 2018. An update to this guide will be issued following completion of the Round Two grants.

Sign up to receive updates on this guide and other DHS dementia news on the DHS [Dementia-Capable Wisconsin](#) website.

Appendix 1

Round One Dementia-Related Crisis Innovation Grants: Grantee Summaries

Aging and Disability Resource Center of the North (Ashland, Bayfield, Iron, Price, and Sawyer Counties)

Description of Grant Activities

The focus of the grant in Ashland, Bayfield, Iron, Price, and Sawyer counties was to provide consistent dementia crisis training across the five counties served by the ADRC of the North to the groups charged with responding to people with dementia in crisis, so that there would be a better understanding of how to work effectively with someone with dementia in crisis. The training was targeted to the I-Team in each county. An I-Team is a group of selected professionals from a variety of disciplines who meet regularly to discuss and provide consultation on specific cases of elder abuse, neglect, or exploitation. An I-Team generally includes law enforcement and first responders as well as ADRC staff, APS, mental health and substance abuse providers, hospitals, and others. The Alzheimer's Association of Greater Wisconsin Chapter provided the validated dementia crisis response training, *Approaching Alzheimer's: Make Your Response the Right Response*. The in-person training, which included three sessions over an 18-month period, focused on strategies and protocols to better assess and triage persons with dementia, and the development of tools and strategies to meet the needs of persons with dementia in crisis.

Achievements

The ADRC of the North implemented the training in each of the five counties, with some customization for each locality. All training participants received manuals, assessment tools, and a decision tree intended to formalize the local response and the process for serving individuals with dementia who are in crisis. The participants expect the dementia care specialist and the ADRC of the North staff to be able to provide additional training as needed or requested, and to be able to consult with crisis service agencies, I-Teams, and dementia networks. The ADRC of the North is still working on developing residential crisis options for people with dementia so they can remain in their communities.

Lessons Learned

The ADRC of the North reports that it would have been helpful to have a designated project manager—they were unsuccessful in hiring someone for this position, so the dementia care specialist and ADRC director assumed those responsibilities. They reported that additional follow-up with training participants is critical to ensure that those individuals are able to implement the knowledge gained through training.

Adult Protective Services Department of North Central Health Care (NCHC)— Langlade, Lincoln, and Marathon Counties

Description of Grant Activities

The focus of NCHC's grant was to increase collaboration between stakeholders in order to positively impact the approach to crisis care, and to increase the community's knowledge of dementia supports by developing best practice approaches and providing guidelines, assessment tools, and standards to crisis responders and providers. NCHC also planned to increase knowledge of dementia in order to improve early identification before a crisis happens. Part of their project was to increase options for crisis services, including placements and agency response to help stabilize a crisis in the least disruptive fashion.

Achievements

Many tools were developed to assist in improving understanding of dementia, including a Person Centered Information form, Protective Placement Location Provider form, a best practice informational tool for better responses to frequent dementia behaviors, communication tips and tricks, a decision tree for actions during a crisis, and helpful informational documents on symptoms and behaviors associated with dementia.

Relationships between stakeholders were created, with more collaboration and communication between agencies. Medical communities are making more referrals to APS, and outreach efforts continue to happen to ensure engagement and awareness of options. There have been connections made with providers willing to assist during a crisis, and swing beds at hospitals have been discussed.

Trainings were developed and continue to happen on an ongoing basis for different audiences, including first responders, APS and crisis staff, providers and the general community.

Lessons Learned

Having a readily available system of support, with ongoing trainings, is necessary in order to overcome the high turnover in staff throughout the crisis care system (e.g., providers, APS, mental health crisis services, home health agencies). It is important not just to establish relationships and communication between stakeholders but to maintain them over time. Stakeholders need to continue to offer training and support to the direct care staff that work side by side with people who have dementia. There is also a need for an increase in providers who would be able to assist during a crisis event.

Dodge County

Description of Grant Activities

Dodge County's goals for the grant included educating existing county crisis staff and other involved stakeholders about dementia; creating and training new dementia crisis response (DC²) teams for rapid response in a dementia-related crisis; increasing community awareness and public education about dementia, targeting families, caregivers, and physicians; and tracking work associated with crisis response for persons with dementia. Various county staff administered different components of the project.

Achievements

Stakeholders worked with Dodge County staff to create two DC² teams that could be available 24 hours a day, seven days a week, to assist with dementia-related crises, with a focus on stabilization-in-place when possible. Memoranda of understanding (MOUs) were also put in place between the county and several placement facilities for situations where residential placement is a necessity.

Training was provided to interested stakeholders countywide, including county crisis staff, first responders, and members of the two DC² teams. The crisis response workflow was updated to include dementia crises and was distributed to all crisis responders. A "Person Centered Information Tool" created by Jefferson County was adapted for use in Dodge County. The tool is filled out with or for the person with dementia by family or facility-based caregivers to provide hospital and emergency staff information needed to assist the person during a difficult time.

With the help of the grant, the county started a Medic Alert + Safe Return program and was also able to have an employee certified in Music and Memory. In addition, collaborations were started with 17 local libraries, through which the libraries make dementia resource binders available to the public. Some libraries now also provide space for holding dementia-related educational presentations for community members.

Lessons Learned

Dodge County felt it would have been helpful to have a project manager for the grant to keep activities on target and serve as a single point of contact for stakeholders. As a rural county, it took longer than expected to build the collaborations and create the DC² teams than had been expected, but the efforts ultimately succeeded in spite of these challenges. County staff reported that those engaged with the grant look forward to building on the relationships forged through the grant opportunity and engaging in additional dementia-related collaborations.

Kenosha County

Description of Grant Activities

The focus of Kenosha County's grant was to improve capacity for dementia crisis response and stabilization, to secure MOUs for in-home and residential crisis stabilization, and to have over 40 emergency responders and health care staff complete a 4.5-hour dementia-capable training.

Achievements

A stakeholder group composed of representatives from law enforcement, nursing homes, assisted living, home health, corporation counsel, APS, crisis, and others was created. This group developed a Client Safety Plan and Files for Life (large pocket files that contain the safety plan, power of attorney for health care and medical information).

MOUs were developed with four in-home providers for emergency respite services.

Numerous trainings were held, with attendance of over 200 people comprised of direct care staff, crisis and APS staff, and emergency responders. Trainings will continue over time and on-site training will be offered.

Lessons Learned

Because of high turnover rates among direct care workers (e.g., CNAs and personal care workers), Kenosha County feels that providing such workers with ongoing and continual training is vital to the community and the aging population within it. The county also noted the importance of offering regular training to people coming into new positions with law enforcement, emergency medical providers, and adult crisis staff. As front-line staff, direct care workers and emergency responders were able to identify better strategies for interacting with people with dementia in crisis as a result of the training they received.

Turnover among nursing home and assisted living administrators and owners was also significant, making it difficult to ensure a consistent commitment to the availability of dementia training for facility staff.

La Crosse County

Description of Grant Activities

La Crosse County's grant included a number of components, including recruiting a project manager to coordinate the grant, analyzing existing community resources, strengthening coalitions and partnerships with professional stakeholders, assessing the current crisis response system, developing both a continuum of crisis response option and a community training plan, implementing the Music and Memory strategies in home settings, and training law enforcement and first responders in the La Crosse region.

Achievements

Twenty-two different training sessions were held for law enforcement and first responders in the La Crosse region, with the result that over 250 people were successfully trained to improve the response to a dementia-related call. Training for mobile crisis staff focused on responding to dementia crisis calls in collaboration with law enforcement and looking at alternatives to hospitalization and Chapter 55 detentions for individuals in crisis.

A successful kickoff event for Music & Memory for the community was held at the La Crosse Public Library. Sixty-three people were in attendance at the ADRC-hosted community event, where former Governor Martin Schreiber presented a book talk on his caregiving journey "My Two Elaines: Learning, Coping, and Surviving as an Alzheimer's Caregiver."

Tools for first responders were developed, with the purpose of providing information specific to the individual if they are unable to communicate this information themselves. A decision tree was designed to help map out options for the responder to take when called to a situation involving someone with dementia.

Lessons Learned

The hope was to develop several options to provide immediate response such as respite adult day care or alternative placement rather than hospitalization when a crisis arose. Meetings occurred with home care agencies and adult day care providers to establish a process to access services, but the services are not as immediately available as hoped. The importance of having community stakeholders involved in the planning phase of training was also discovered at the beginning of the grant period.

Milwaukee County

Description of Grant Activities

The focus of Milwaukee County's grant was to create a process for crisis stabilization for people with dementia. This included establishing partner teams, behavioral supports, prevention efforts, and a crisis response plan with the goal of "in-place stabilization." They also focused on expanding the local coalition with additional community partners, family caregivers, MCOs, and acute care providers.

Achievements

Supported independent living (SIL) teams were developed to work in the homes of older adults with dementia who are in crisis to provide stabilization "in place." Free training was provided to emergency protective placement (EPP) partners, including hospital staff, crisis staff, and residential facilities. Additional expertise and stronger relationships were developed, and the local coalition was expanded with additional community partners, family caregivers, MCOs and acute care providers.

There were a number of other successes as well, including a reduction in the number of EPPs and enhanced expertise of the EPP partners to stabilize-in-place clients with challenging behaviors, thereby reducing unnecessary placements and institutionalizations.

The exposure that resulted from the grant provided a needed boost to help energize the EPP coalition to continue working towards building a crisis system that supports individuals with dementia in place. This includes limiting moves, maximizing resources, and getting the support and care people need, when they need it.

Lessons Learned

There are still a number of hurdles to overcome. Caregivers and other stakeholders want more training, but resources are limited for their staff to attend trainings. Efforts need to continue in order to develop 24/7 mobile response capacity for people with dementia, and to add sustainable resources and training that support community partners and caregivers. It was discovered that the difficulties faced by hospitals when discharging people with dementia who cannot return to their place of residence, which results in longer than necessary hospital stays, need to be acknowledged and addressed. Finally, there is a need for discretionary funds for client stabilization (e.g., transportation, short-term medications, durable medical supplies, moving and clean-up costs, housing expenses), and a need to provide continued ongoing dementia training to first responders.

Appendix 2

Sample Tools and Other Materials Used by Crisis Innovation Grantees

Round One Dementia-Related Crisis Innovation grantees developed and used a variety of tools and resources as part of their work to improve crisis response for individuals with Alzheimer’s disease and other dementias. Some grantees have made their grant-related materials available to the Department of Health Services (DHS). This appendix includes those materials available to DHS staff at the time this report was prepared; the materials here do not represent an exhaustive inventory of all materials developed by Round One grantees. Included here are the following documents:

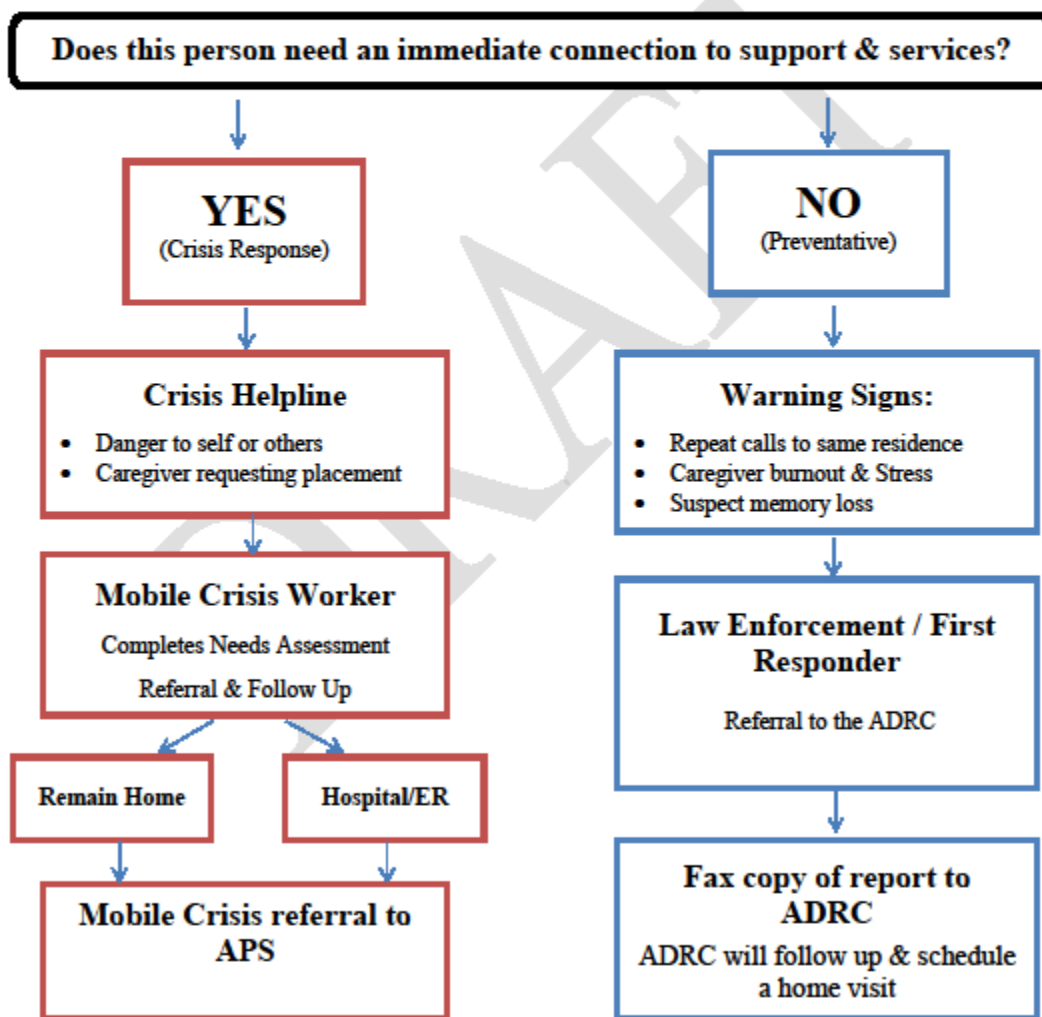
Grantee	Document
ADRC of the North	1. Sample Dementia Capable Crisis Response Decision Tree
Dodge County	2. Dementia-Related Crisis Team Response Flow Chart
Dodge County	3. Dementia Crisis Response Person-Centered Information Tool
Dodge County	4. Instructions for Person-Centered Information Tool
Kenosha County	5. Client Safety Plan
Kenosha County	6. Helpful Dementia Information for First Responders
Kenosha County	7. MOU for Urgent In-Home Respite
La Crosse County	8. Benefits of Personalized Music
La Crosse County	9. Music and Memory
La Crosse County	10. Music and Memory Playlist Questionnaire
La Crosse County	11. Dementia-Capable Crisis Response Decision Tree
La Crosse County	12. Dementia Training—First Responder Evaluation Form
La Crosse County	13. Person-Centered Information for First Responders

1. Sample Dementia-Capable Crisis Response Decision Tree (ADRC-N)



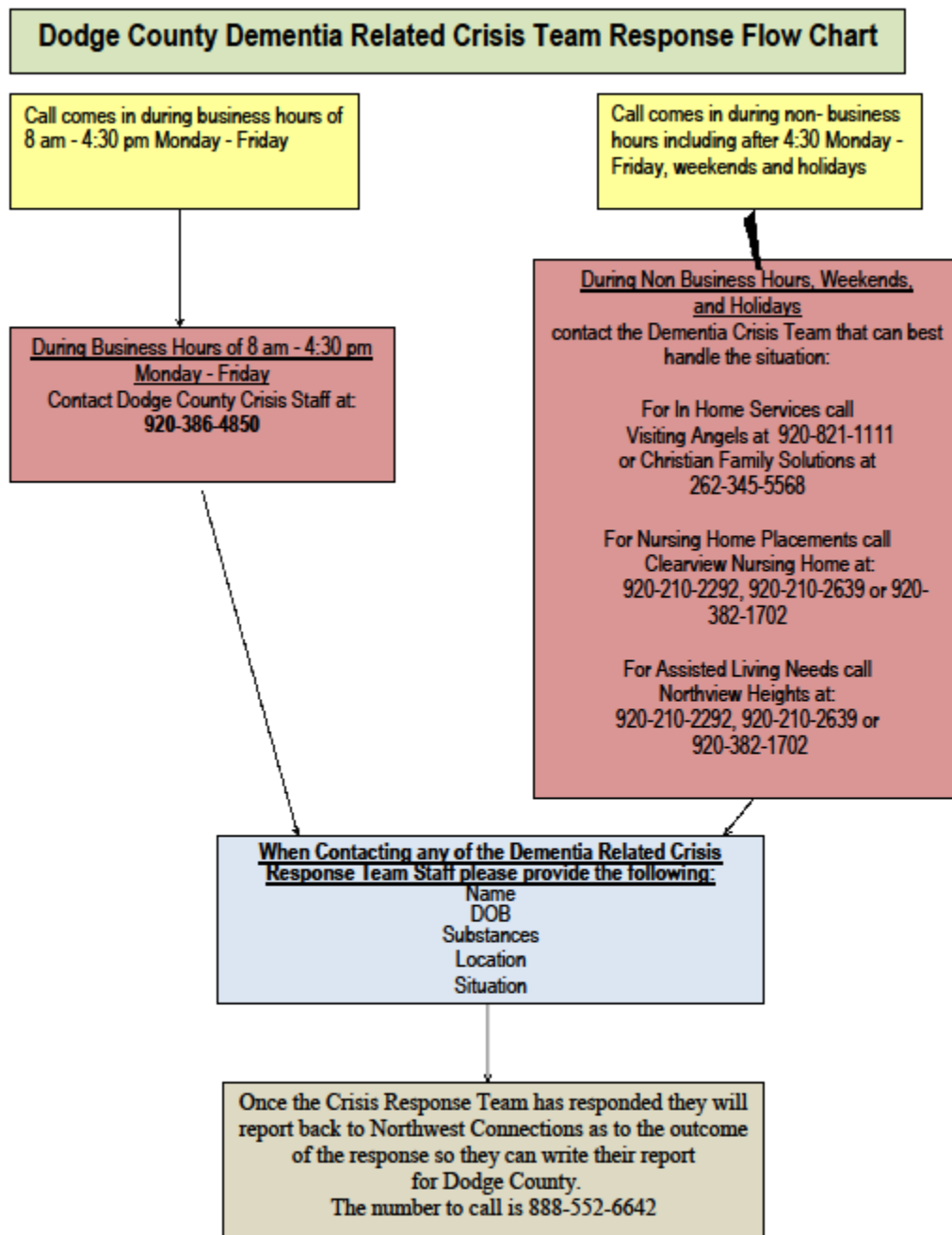
Aging and Disability Resource Center of the North
Serving Ashland, Bayfield, Iron, Price and Sawyer Counties
1-866-663-3707

Sample Dementia Capable Crisis Response Decision Tree



Local branch offices located in Ashland, Hayward, Hurley, Phillips and Washburn

2. Dementia-Related Crisis Team Response Flow Chart (Dodge County)



3. Dementia Crisis Response Person-Centered Information Tool (Dodge County)



Dodge County Dementia Crisis Response Person Centered Informational Tool

Name: _____

I prefer to be called: _____

Please check appropriate box:

☐ I **CAN** be left unsupervised ☐ I **CANNOT** be left unsupervised

Caregiver/Family Member Names and Phone Numbers:

People I trust who motivate me to cooperate are: _____

Some of my personal preferences are: (such as likes hugs versus hates hugs or likes socks and shoes on versus barefoot, etc.) _____

If I am upset / being aggressive or combative you SHOULD / SHOULD NOT approach me (circle one)

Things that upset me:

I express distress by:

The best ways to redirect me are: (such as talk about my past, use photos, sing, offer a snack, take me to my room, etc.)

The best ways to protect me or others from me are: (such as give me more personal space, watch safely from a distance, distract me, move others away from me, have staff / police close to me but at least an arm's length away etc....)

*Give me choices

*Allow me to be right by agreeing with me

*Be aware of how your words and behavior affect me

*Keep your questions to me short and simple, use gestures

*Redirect my attention to something different if I'm upset

Comfort Items to take with me:

Sensory Aids Needed (Glasses, Hearing Aids, etc.):

Medical Conditions:

Allergies:

Pain Areas:

*Remember to attach medication list

*Validate my feelings, to show me you understand
*Repeat my words back to me as a question to clarify

*Give me time to respond, do not rush, and smile
*Use the word "WE" so we can work together

The best way to approach and communicate with me: (such as call me by name, face me directly, make eye contact, use short sentences, etc.)

The best way to help me understand and participate: (such as use gestures, slow down, smile, repeat when necessary in a respectful manner, etc.)

While I am hospitalized I need assistance with: (check all that apply)

- | | | |
|--|--|--|
| <input type="radio"/> Using the nurse Call Button | <input type="radio"/> Choosing my meals | <input type="radio"/> I need a straw |
| <input type="radio"/> Asking for "as needed" medications | <input type="radio"/> Opening containers | <input type="radio"/> I need help in bathroom |
| <input type="radio"/> Using hospital phone | <input type="radio"/> Cutting my food | <input type="radio"/> I need help bathing/washing up |
| <input type="radio"/> Using cell phone | <input type="radio"/> I am at risk for choking | <input type="radio"/> Other _____ |

How to give me medications:

My daytime routine preferences are:

My nighttime routine preferences are:

Comfort measures that I prefer (pillows, blankets, sleep with light on or music playing, positioning, etc.):

Things I enjoy (favorite foods, activities, walking, TV shows (type), music (what types), etc.):

Special Notes:

Name of Person Filling out Form: _____ Date: _____

Address: _____ Phone: (____) _____

(Adapted from the Person Centered Dementia Care Mentors Alliance of Jefferson County, Wisconsin USA)

4. Instructions for Person-Centered Information Tool (Dodge County)



Dodge County Dementia Crisis Response Person Centered Information Tool

Instructions for Completing the Form

Family caregivers or facility caregivers fill out this form with/for the person who has dementia. This tool is designed to give hospital and emergency staff the information needed to assist an individual with dementia during a difficult time. Think about things people need to know regarding what works to help the person, and what to avoid. It is written in the first person as if the person with dementia is telling the helper what he or she wants.

Front Page Instructions:

Name: *Legal name*

I prefer to be called: Nicknames, an abbreviated name, Mr. or Mrs. And last name, a title like "Sarge" if in the military. (Something that would make them feel comfortable)

Please check appropriate box

- ☐ I CAN be left unsupervised
- ☐ I CANNOT be left unsupervised

Consider if the person with dementia was left alone, would he/she be in danger? Examples: Would she wander off, does he need assistance to avoid a fall, would she get into items like soap or medical equipment, could he be confused enough by surroundings that he would become upset, nervous, and maybe yell out?

Caregiver/Family Member Names/Phone Numbers: List the *individual(s)*, whom it is most important to contact for *information*. This could include a *facility caregiver or home assistance caregiver*, in addition to the most knowledgeable *family member(s)*, the person who knows daily/functioning routines of the patient.

People I trust who motivate me to cooperate are: This *individual(s)* would be someone the person trusts. The use of this person's name could help calm anxiety and confusion, which could help assist medical staff with treatment, or in the case of an emergency evacuation. Example: "Tell me more about your daughter Mary" "Mary is on her way to see you" or "Would you like to call your daughter Mary?"

Things that upset me: In this section, try to put yourself in the person's shoes to understand her experience by being with her in the environment. Seeing things from the person's perspective helps us to understand the frustrations and confusion they experience. It also helps us to recognize that we, as helpers, must adjust the way we act, and to interact, to meet the person's needs. *Examples of what doesn't work or what to stay away from doing:* touching without informing first, telling instead of asking, too many questions, being disrespectful, yelling, or being critical. Things around the person can upset them like it being too hot or cold, loud noises, alarms or bright lights. People in uniform, (Police,

Developed as part of a Dementia Friendly Community Initiative by The Person Centered Dementia Care Mentors Alliance of Jefferson County, Wisconsin USA
For updated version go to http://www.jeffersoncountywi.gov/departments/memory_care_support.php or call 920-673-4033. 1/2016

EMT, Fire) could be upsetting when not having anyone familiar nearby. In addition, unmet needs can make a person upset such as pain, needing the bathroom or feeling afraid. Include the different things that you know upset the person.

I express distress by: The person with dementia may have certain body language – or things he says – that indicate that he is getting upset. Examples: pacing, talking fast/loud, crying striking out, saying no, talking about a distressing memory, wringing hands, making repetitive movements or trying to leave, etc. *Whatever signals the person usually gives that indicate he or she is getting upset need to be included.*

The best ways to redirect me are: Consider what works to help keep the person calm. Examples: talking calmly, slowly or quietly, offering reassurance, eye contact, gentle touch, hand under hand, changing the subject, distracting the person's attention. Offering the person an item such as a doll, family pictures, blank, singing a song, music, reminiscing, or talking about a trusted person, can be calming. Environmental changes that can help could be to dim lights, turn off sirens/alarms, and limit the number of people interacting with the person, music, etc. *Include things that you know can calm the person.*

The best ways to protect me or others from me: Consider things such as giving more personal space and watching safely from a distance.

Consider these items below: Think F.A.S.T.

F – Food (snacks like crackers, ice cream)

A – Activities (like TV, picture book reading, talking)

S – Story (favorite topics for conversation)

T – Trip (walks around with staff)

Purple Box on Front Page:

Comfort items to take with me: These are items that the person may need to keep them busy, calm or to provide something familiar. Examples: A doll if she likes to rock it in her arms, a favorite blanket (or other item) to comfort/hold onto, family pictures, puzzle book, whatever is needed. Also, add equipment like walkers, canes and person items of importance to her – like a wallet, purse or keys. *What items calm and provide meaning to the person – will they be upset without the item?*

Sensory Aids Needed: This included glasses, hearing aids and dentures or other devices the person uses.

Medical Conditions: Include important things to be aware of, e.g., diabetic, pacemaker, HIV, chronic bladder infections, thickened liquids needed, stroke paralysis and where, etc. *What are important medical conditions the helpers need to know about right away.*

Allergies: Usually to medication or things like latex or nuts. Include anything that causes severe reactions.

Pain Areas: Indicate places that the person has chronic pain or injuries (arthritis, back pain, joint replacements, heartburn, etc.) This is VERY important because the person may not be able to tell helpers that he has pain, so they will need to monitor for it, especially if behavior gets difficult. *What painful conditions does this person have that need to be identified and treated or comforted?*

Developed as part of a Dementia Friendly Community Initiative by The Person Centered Dementia Care Mentors Alliance of Jefferson County, Wisconsin USA
For updated version go to http://www.jeffersoncountywisc.gov/departments/memory_care_support.php or call 920-673-4033. 1/2016

Back Page Instructions:

The best way to approach me is to: Examples include: *Approach from the front so, they are aware you are coming, walk slowly, allow time for the person with dementia to see that you are approaching. Call him by his preferred name, to get his attention. Crouch down if she is seated, this helps her feel less threatened. Offer your hand, greet, and say your name – this could give you an idea whether or not the person will be receptive. List specific preferences that hospital staff may need to know while the person with dementia is in their care.*

The best way to communicate with me: What things can be done to help the person with dementia express what they mean, and what can be done to help the person understand what is being communicated in return? Examples: make eye contact speak slowly, into the dominant ear, repeating back what they've said. Pointing, and touching gestures along with visuals like words, pictures, and facial expressions all can help the person to communicate better. Certain topics the person with dementia brings up could also mean something else. (Example) whenever she starts talking about feeding the dog that could mean she's hungry and it's time for dinner. Include how this person communicates best.

This helps me understand and participate: How do you assist or help the person with a task? Examples could be prompting by handing him the spoon, modeling a gesture of brushing his teeth, giving her a washcloth to hold while you wash her face so she can help. Asking the person for this help and showing him how to do the activity (like folding towels) can be effective. Giving the person something to keep her occupied can help avoid problems (e.g., holding something to keep the other hand occupied). Bringing up certain topics the person enjoys talking about can encourage the person to talk. What things can be done to help the person participate or do for herself?

While I am hospitalized...

This section is to help staff members who work in the hospital to understand and get to know the person with dementia. Questions are about day to day things that are important to the person. The information here is used to make the person more comfortable, experience less stress, and keep a familiar routine.

How to give me Medications: Indicate if person can self-administer, needs to be given one at a time, supervised, crushed in apple sauce, etc.

My daytime/night time routine preferences: The person with dementia may have specific requests or routines, examples include: sleep late, get up early, bathing morning or night, specific meal time or bathroom requests. What does the person need in order to feel comfortable or "ready" to start the day? Like reading a newspaper, having his teeth in, wearing a bathrobe before the doctor comes in. Include schedule/order person does things during day.

Comfort Measures: Consider items such as pillows, blankets, and music)

Things I enjoy (music/TV shows/food/activities, etc.): It is important to keep the person with dementia busy with things that help him relax, and make him happy. If the person cannot be alone there may be a companion to sit with who does things the person enjoys. Are there favorite snacks, items like a doll to hold, family photo book, types of music, TV shows or her favorite movie? Does the person like hand or shoulder massages, playing cards, puzzles, being read to, or other things? Also, consider topics, items, or

activities that someone can use to distract or refocus the person's attention away from something unpleasant.

Special notes: This section is to be completed with important information that is not listed above. Examples could be, checking the napkins for dentures before throwing anything away, always give pills with milk, sing "you are my sunshine" to change her mood, alarms will get person very upset, must have rosary at bedtime, etc.

How to Use this Form

When you have completed the form consider having the hospital, doctor's office or a relative keep a copy on file, and make sure to put the form in an accessible place where you can have it on hand in an emergency. Give the form to the Emergency Responders and/or staff in the ER.

You can also make copies for caregivers that are new to the person, such as relatives providing care or someone providing in home services; or when the person is attending day services, moving to another location, or staying with someone else for respite. For more forms, see below.

Attachments: attach a list of medications, and other information that would be important to know, that perhaps didn't fit on the form

5. Client Safety Plan (Kenosha County)

Client Safety Plan

Client Name: _____ Date: _____

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Coping strategies – What interventions have worked to take my mind off my problems without contacting another person (relaxation, technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distractions:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
2. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
Urgent Care Services Address _____
Urgent Care Services Phone _____

Step 6: Making the environment safe:

1. _____
2. _____



Dementia Care Specialist Client Safety Plan (262) 605-6602

Created July 2016

6. Helpful Dementia Information for Responders (Kenosha County)

Helpful Dementia Information for Responders



Name: _____ Date Last Updated: _____

Prefers to be called: _____

Family/friends/service providers that can be contacted for support:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Please check: ☐ CAN be left unsupervised ☐ CANNOT be left unsupervised

➤ Things that are upsetting or should be avoided:

➤ Ways that distress is shown:

➤ Things that are calming (including any medications):

➤ Good ways to communicate:

➤ Interests:

➤ Comfort items to take with me:

Sensory/Other Aids: ☐ Hearing Aids ☐ Glasses ☐ Cane ☐ Walker ☐ Other _____

Medical Conditions: _____

Allergies: _____

Pain Areas: _____

Medications: **Attach completed File for Life form with medication list.*

Please remember TALK tactics:

- ✓ Take it slow.
- ✓ Ask simple questions.
- ✓ Limit reality checks.
- ✓ Keep eye contact.



262-605-6646 or 1-800-472-8008

24 Hour Crisis: 262-657-7188 or
1-800-236-7188

7. MOU for Urgent In-Home Respite (Kenosha County)

Memorandum of Understanding
Between Kenosha County Division of Aging & Disability Services
and
_____, a home care agency
for
Temporary, Urgent In-Home Respite for Persons with Dementia or Vulnerable Adults

Kenosha County's Adult Protective Services (APS) and Adult Crisis Services (AC) periodically encounter situations involving the safety of an adult with dementia or other disability, living at home, who can't be left alone when the primary caregiver is suddenly incapacitated and no other family member is readily available.

In such circumstances APS and AC will make every effort to make arrangements for support through a family member or other known and trusted source. When this is not possible APS and AC will call those home care organizations that have agreed to accept referrals for temporary respite, subject to availability of qualified staff.

For such services, if coverage through Medicaid or other funding source is not available, APS and AC agree to pay the provider \$_____ per hour for a minimum of two (2) hours with authorization by APS or AC staff. It is understood that an initial assessment visit by an RN may be required prior to the assignment of a home care worker at a rate of \$_____ per visit.

_____ agrees to provide temporary in-home respite by qualified staff, if available, in the circumstances described above. The agency maintains the right to decline services if circumstances are felt to be unsafe or outside of the agency's scope. The contact name/s and number/s for use by APS and AC to said agency is/are:

Authorized Representative

(Agency)

LaVerne Jaros, Director
Kenosha County Div of Aging & Disability Services

Date

Date

8. Benefits of Personalized Music (La Crosse County)

Benefits of personalized music for persons living with dementia:

Personalized music has been found to be beneficial in a number of situations. The scenarios below are meant to give you some ideas as to when to try personalized music with your loved one living with dementia.

- Try playing music prior to and during the time you are helping your loved one get dressed as it helps to relax muscles and prepares him/her for the activity of getting dressed.
- Playing music prior to and during showers, utilizing an external speaker, has resulted in less resistance to bathing.
- If your loved one becomes agitated, restless, irritable, confused, disoriented and/or calls out in the late afternoon or early evening on a frequent/daily basis (referred to as "sun downing"), note the time of day when it begins.
 - Personalized music has a calming effect and has been found beneficial if tried 30-60 minutes prior to "sun downing".
- Try playing music prior to and during speech, occupational and physical therapy sessions to stimulate participation.
- Personalized music helps with transitions from home to locations such as the Doctor's office, grocery store, restaurants, family gatherings, etc.
- If your loved one requires medical treatments such as dialysis and chemotherapy, personalized music can help to calm and provide a positive distraction during the treatment.

Each person responds and reacts to personalized music in different ways and at different times. There isn't a formula for the length of time or when someone should listen to personalized music. Use the scenarios to help you identify times your loved one may enjoy and benefit from the personalized music.

Local Resources:

- The *Aging and Disability Resource Center of La Crosse County* can be reached at 608-785-5700 and is available to provide information to the general public about services, resources, and programs in areas such as: disability and long-term care related services and living arrangements, home care/respite services, adult day programs, Memory Cafes and support groups for caregivers and persons living with dementia.
- For assistance with the operation of the iPod and/or changes to the music on the playlist, please contact the *La Crosse Public Library* at 608-789-7145.



9. Music and Memory (La Crosse County)



*Music & Memory
helps people find
renewed meaning and
connection in their lives
through the gift of
personalized music.*

The Music & Memory Program has been proven successful in reducing anxiety, calming feelings of agitation and inspiring meaningful memories for persons living with dementia. The Program Coordinator will meet with participants and caregivers to complete a simple music interest questionnaire. Participants will then receive an iPod Shuffle with their personalized music selections and headphones. If you are interested in learning more about this **FREE** Program, please contact the Aging & Disability Resource Center at **(608)-785-5700**.



10. Music and Memory Playlist Questionnaire (La Crosse County)

Music and Memory Playlist Questionnaire

iPod User's Name: _____

Requester Name _____

Requester E-Mail _____

Requester Daytime phone _____

Interview Questions

1. Where did you grow up? _____ Native Language _____
2. What type of music did you listen to when you were young?

3. Did you have a favorite type of music? _____
4. Who were your favorite performers, groups, bands, and orchestras?
_____ What are some of their
favorite songs? _____
5. Do you have any records/tapes that were your favorites?

6. Did you sing at religious services? _____
What are some of your favorite religious music songs/hymns?

Any favorite performers? _____
7. Do you enjoy musicals? If so, which ones are your favorites?

8. Did you ever attend any live performances or music? If so what?

9. Do you have any favorite classical music composers? If you which ones?

Do you have any favorite classical performers? Who?

10. Do you like to dance? If so what type? ____ Ballroom ____ Swing ____ Disco ____ Square
Dance ____ Polka ____ Ballet ____ Line ____ Other _____
11. Any favorite songs from your wedding? High School Prom?

12. Were you in the armed forces? If so, what branch? _____

iPod User's Favorite Music

Blues	Jazz	Pops/Rock
Religious	New Age	Folk
Country/Western	Holiday	
Classical	Opera	Big Band
Easy Listening	Musicals	Soul/R&B

Favorite Eras

20s	30s
40s	50s
60s	70s
80s	90s
Other:	_____

Singers and Performers

Easy Listening Singers

Perry Como
Dean Martin
Michael Buble
Josh Groban
Johnny Mathis
Celine Dion
Bing Crosby
Carol King
The Letterman
Ella Fitzgerald
Dionne Warwick
Anne Murray
John Denver
Nat King Cole
Carpenters
Barry Manilow
Frank Sinatra
Rosemary Clooney
Andy Williams
Neil Diamond

Easy Listening Nonvocal

Percy Faith
101 Strings
Ferrante & Teicher
Montavani
Henry Mancini
Herb Alpert & Tijuana Br.
Mannheim Steamroller
Liberace
Boston Pops

Country Contemporary

Alabama
Clint Black
Garth Brooks
Garth Brooks
Kenny Chesney
Dixie Chicks
Toby Keith
Tim McGraw
Brad Paisley
Lee Ann Rimes
Blake Shelton
Shania Twain
Carrie Underwood
Dwight Yoakam

Broadway

Cabaret
Anything Goes
Camelot
Carousel
Cats
Chicago
Gypsy
Hello Dolly
Les Misérables
Mary Poppins
Music Man
My Fair Lady
Oklahoma
Phantom of the Opera
Sound of Music
South Pacific
Sunset Boulevard
West Side Story

Big Band/Swing

Harry James
Cab Calloway
Andrew Sisters
Count Basie
Les Brown
Tommy Dorsey
Eddy Duchin
Glenn Miller
Artie Shaw
Rosemary Clooney
Woody Herman
Duke Ellington
Benny Goodman
Guy Lombardo

Country Oldies

Johnny Cash
Patsy Cline
Merle Haggard
George Jones
Loretta Lynne
Willie Nelson
Dolly Parton
Charlie Rich
Kenny Rogers
Conway Twitty
Hank Williams
Tammy Wynette

Classical

Bach
Beethoven
Brahms
Chopin
Debussy
Dvorak
Handel
Haydn
Liszt
Mendelssohn
Mozart
Satie
Schubert
Schumann
Shostakovich
Stravinsky
Tchaikovsky
Verdi
Vivaldi

Folk

Joan Baez
Joni Mitchell
Laura Nyro
Scott Mackenzie
Peter, Paul and Mary
Melanie

Blues

John Lee Hooker
BB King
Blues Traveler
Stevie Ray Vaughan
T Bone Walker
Muddy Waters
Ray Charles
Etta James

Soul/Motown

James Brown
Ray Charles
Sam Cooke
Fats Domino
Aretha Franklin
Marvin Gaye
Jackson 5
Temptations
Otis Redding
Diana Ross
Four Tops
Stevie Wonder
Smokey Robinson

Opera

L'Orfeo
The Marriage of Figaro
The Magic Flute
The Barber of Seville
Rigoletto
La Traviata
Pagliacci
La Boheme
Madame Butterfly
Lohengrin
Carmen

New Age

Yanni
Celtic Woman
Philip Glass
Gregorian
Himekami
Mannheim Steamroller
Mythos
Proyecto Oniric
George Winston
Paul Winter

Other**Jazz**

Miles Davis
Louis Armstrong
John Coltrane
Scott Joplin
Fats Waller
Dizzy Gillespie
Dave Brubeck
Wynton Marsalis
Billie Holiday
Ella Fitzgerald
Earl Hines

Religious

Amazing Grace
How Great Thou Art
Hymns
Spirituals
Chant
Christian Rock

Rock/Pop

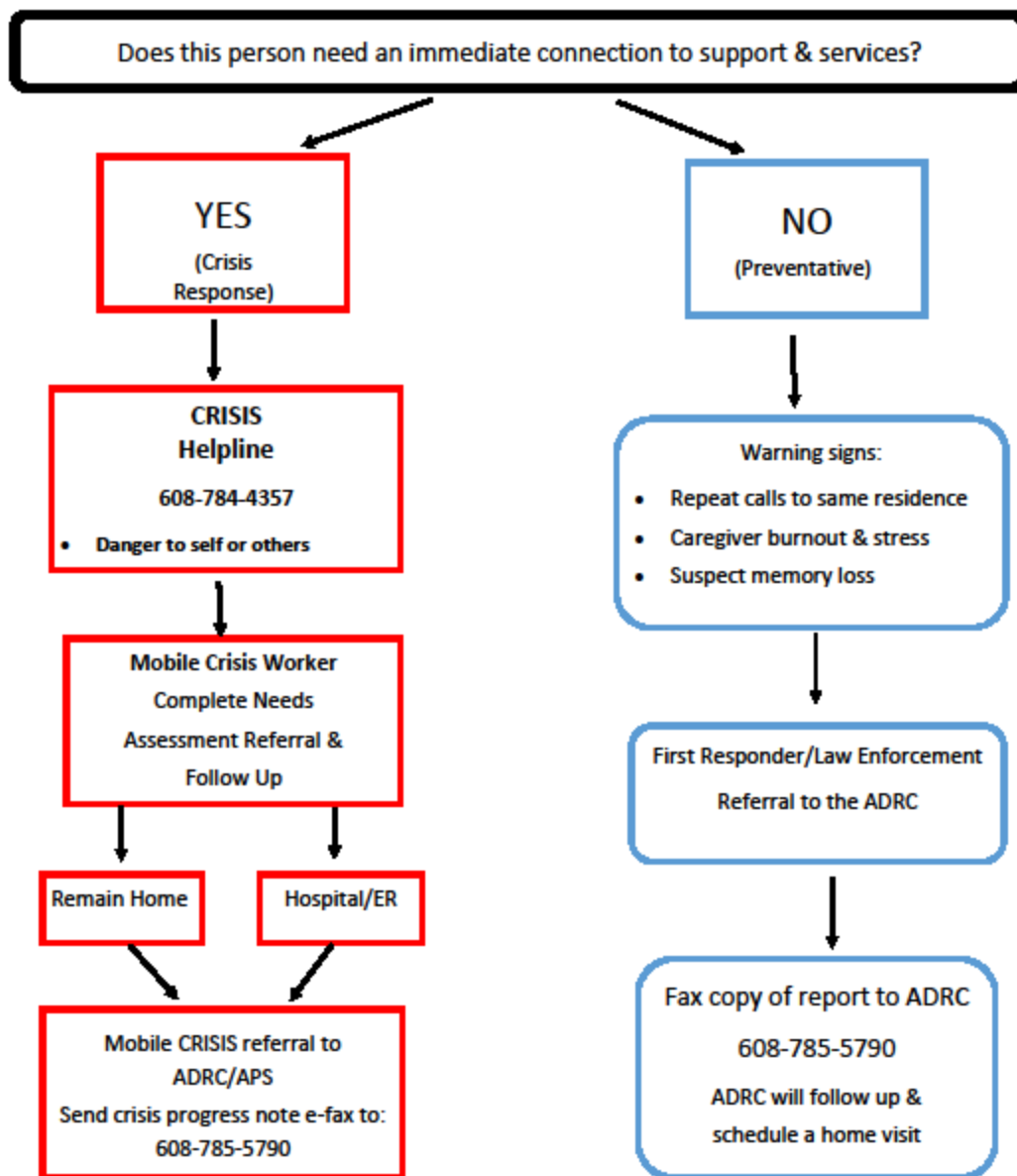
The Beatles
Beach Boys
Bee Gees
Billy Joel
Carpenters
Elton John
Elvis Presley
Four Seasons
Gene Pitney
Rolling Stones
Sonny and Cher
Bob Dylan
Crosby, Stills, Nash & Young
Simon & Garfunkel
The Who

11.Dementia-Capable Crisis Response Decision Tree (La Crosse County)



300 4th Street North | La Crosse, WI 54601
Main: 608-785-5700 Fax: 608-785-5790

Dementia Capable Crisis Response Decision Tree



12.First Responder Dementia Training Evaluation Form (La Crosse County)



First Responder-Evaluation Form

Date: _____

Evaluation Questions	1. Strongly Agree	2. Somewhat Agree	3. Neither Agree or Disagree	4. Somewhat Disagree	5. Disagree
The presentation was clear and understandable.					
The training increased my understanding of dementia.					
The training provided useful information to help me <i>identify</i> the signs that the person in crisis may have dementia.					
The training identified ways to <i>approach</i> a person living with dementia in a crisis situation.					
The training provided helpful information to help me effectively <i>communicate</i> with a person living with dementia in a crisis situation.					
I understand the referral process and when to connect the person living with dementia to Crisis/ADRC for further support and resources.					
Comments/suggestions:					

13. Person-Centered Information for First Responders (La Crosse County)

Helpful Information for First Responders When assisting persons with Dementia

Date Completed: _____

My Name: _____

I prefer to be called _____

Name of person completing this form: _____ ()
Name Phone Number

Alternate Emergency Contact Information (name/address/best contact number/relationship)

1. _____

2. _____

I can be left alone: (please check the appropriate box)

☐ A short while (1-2 hours) ☐ A few minutes ☐ **NOT at all** ☐ Other _____

Is there a more difficult time of day for me? _____

Someone I trust who I rely on to help me make decisions is: _____
Name Phone #

Things that upset me: _____

I show distress by: _____

I am calmed by: _____

The best way to communicate with me to help me understand and participate: _____

Sensory Aides Needed: ___Hearing Aids ___Glasses ___Walker ___Cane ___Other: _____

Comfort items to take with me: _____

Anything else I want you to know to best help me during a crisis (continue on back if necessary): _____

Medical Conditions: _____

Allergies: _____

Pain Areas: _____ Preferred Hospital: _____

*Please attach medication list

Please remember TALK Tactics:

Take it slow

Ask simple questions

Limit reality checks

Keep eye contact

Dementia
Friendly

