DEPARTMENT OF HEALTH SERVICES
F-01922 (03/2018)

DRAFT

STATE OF WISCONSIN

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Wisconsin Long Term Care Advisory Council (LTCAC)			Attending: Audrey Nelson, Beth Swedeen, Christine Witt, Darci Knapp, Dennise Lavrenz, Janet Zander, John Sauer, Kenneth Munson, Lea Kitz, Mary Fredrickson, Maureen Ryan, Sam Wilson, Shanna Jensen, Stacy Ellingen, Cathy Ley
Date: 5/12/2020	Time Started: 9:30 a.m.	Time Ended: 11:30 a.m.	
Location: Virtual Zoom Meeting			Presiding Officer: Heather Breummer

Minutes

Members absent: Cindy Bentley, Denise Pommer
Others present: Brenda Bauer, Kevin Coughlin, Betsy Genz, Jie Gu, Kiva Graves, Kiva Graves, Suzanne Ziehr

Meeting called to order

- Heather Bruemmer went through meeting structure and process for public comment
- Janet Zander moved to approve the March minutes, Dennise Laverez seconded, approved unanimously

Department Updates, presented by Betsy Genz and Brenda Bauer

Department of Medicaid Services (DMS) updates

- Working with IRIS Consultant Agencies (ICAs)/Fiscal Employer Agencies (FEAs)/Managed Care Organizations (MCOs) to test technical aspects of Electronic Visit Verification (EVV) systems
- Home and Community Based Settings (HCBS) non-residential settings
    - Still need to assure compliance by March 17, 2022, so continuing to move on that, not doing onsite visits at the moment. Instead, we are requesting documentation to prepare for future site visits.
- DHS-MCO contract amendment is being worked on
    - Will be sharing in future with council members
    - This will include language on Direct Care Workforce Funding (DCW), Pay for Performance (P4P), Member Care Plan (MCP) signatures, and room and board
    - This will be sent via email for review and comments
- IRIS waiver renewal
    - Current waiver expires December 31, 2020
    - DHS submitted the renewal to Joint Finance Committee in April and received approval from them on Friday
    - Anticipate posting for public comment before end of May
        - Will go out as a GovD message and be posted online for 30 days
        - Will also blast posting out to committees and stakeholders we have contact information for
    - Anticipate submitting to CMS in September for approval
- GSR 12, Dane County, will have an additional MOC
    - CCI will be providing services starting June 1, 2020 for Family Care

Department of Public Health (DPH) updates

- Main goal has been to support our aging and disability network partners so they can meet the critical needs of older adults and people with disabilities residing in their local communities
- Implementation of the new federal COVID-19 funding
    - The Families First Coronavirus Response Act was passed on March 18th and included funding for Older American's Act programming.

        - This funding was distributed to local county aging units/ADRCs. Additional funding was provided to tribes. This funding is to support elder nutrition programs– primarily home delivered meals.
        - In addition to the funding, modifications were also made to the meal program to relax restrictive eligibility requirements- making more people eligible for meals.
        - WI received $4.3 million for local ADRCs/Aging Units.
        - Tribes received an additional allocation.
    - The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was passed on March 27th, with a number of items for BADR programs, both in terms of funding and in additional program flexibilities.
        - The Act provided funding for counties and tribes for Older Americans Act (OAA) programs, including: supportive services, nutrition, caregiver support and the ombudsman program. $14.5 million total for those programs. Tribes will be receiving a separate allocation under Title VII of the OAA.
        - In addition to the OAA funding, the bill also included funding for Aging and Disability Resource Centers (ADRCs) and Independent Living Centers (ILCs).
            - Wisconsin is eligible to receive $750,000 for ADRCs. The funding will be available for one year. The funding will be used to:
                - Improve virtual management of the ADRC
                - Mitigate social isolation through proactive follow-up
                - Develop or enhance innovative services or services structures
            - Independent living centers in WI will receive a total of $1.2 million in CARES Act funding
                - The funds will be used for independent living services that assist people with disabilities to remain safe, connected and independent in their communities, along with covering expenses related to COVID-19 including Technology, staff salaries, wages and leave, and COVID-19 related supplies
- Policy development
    - Since the beginning of March, we have been looking at ways that we can flex our program requirements to adapt to the changing circumstances
    - Much of the programming has had to move on-line/remote
    - Meal programs
        - No more congregate dining has led to an increased need to ramp up home-delivered meals
        - Also doing drive up meals, grab-and-go, working with local restaurants and grocery stores to make deliveries
    - We have been focusing on a number of additional critical needs such as social isolation, transportation, communications accessibility.
    - We have been actively engaged in is working with our stakeholders and communicating with the public
        - Worked with AARP on a tele-town hall for caregivers
        - We have been hosting, in some cases with others, a number of meetings with our partners, including
- The Bureau of Aging and Disability Resources (BADR) has been doing a number of activities that link the broader response work of the Division of Public Health and Department of Health Services

2019 Pay for Performance Results, presented by Jie Gu

- Went through PowerPoint
- Yearly survey since 2018
- Next will be a 2020 survey

- Questions 2, 7, 9, 11 were the Pay for Performance (P4P) questions

COVID-19 Roundtable, moderated by Heather Bruemmer

- Each council member had an opportunity to share what their organizations are doing and seeing related to COVID-19
- Shanna Jensen
    - Approach from a few different levels
        - Individual needs and look at macro level
        - Cannot have a one-size fits all approach
        - Working with statewide and regional resources to see what is available
    - Magellan Cares foundation made donation to food bank in Milwaukee and a Personal Protective Equipment (PPE) donation to residential support foundation in Dane County
    - Frequent contact with those enrolled in TMG IRIS Consultant Agency and beefing up their back-up plans with food, medications, and care and "what happens if" scenarios
- Audrey Nelson
    - Working on instituting brain injury support groups
        - First one will be next Thursday night
        - Helping people link with therapy providers
    - Initially decided to overreact instead of underreact
    - Were able to get PPE funding, which has helped
    - My role on this council is an advocate for brain injury. I am a survivor for brain injury and a residential provider for individual with brain injury. But I am also concerned with how many residential providers will be closing after this. My own homes will be sold to a larger provider by the end of the summer. The stressors are just too much. I have been doing this for 25 years. My reimbursement rates were much higher 285 years ago. This is just impossible to do as a viable business and human service model. My staff are great. I love my residents. This will be very hard for all of us. I just really don't know how to keep doing this. I'm not the only one. Others have waved the white flag or have it in their back pockets ready to go. I don't know what the solution really is, except that I don't feel we are treated as the necessary and valuable part of long term care options that we are. Small providers like me cannot continue like this.
- Beth Swedeen
    - Still hearing a lot of people do not have tech to access virtual supports and are fearful to go back to direct supports
    - Survival Coalition completed a survival survey
        - Small providers have incurred excess costs that haven't been reimbursed
        - Fewer than 25% say they may not be able to continue
        - Concerns about having providers needed
- Cathy Ley
    - Focus on how to serve customers safely and effectively
    - Staff are coming to work every day and providing services over the telephone and virtual appointments, if needed
    - Focused on meals
        - change to meal delivery and have pick-up bag meal program
        - All no contact
        - Seeing people they have never met before
    - Noticing people feeling lonely and self-isolated
        - So starting to contact the meal participants by phone, calling them every week
        - Looked at other customers that used to call in to ADRC, a lot but are not in a Long-Term Care program

        - Went back in files and are calling people they have been concerned about
      - Dropped off care packages to caregivers with activities
      - Sending activities to those that attended memory cafes
    - Volunteer numbers are up.
- Chris
    - Vocational providers are contacting people every day
    - Have had several zoom meetings and created a comprehensive template for providers to use with reopening
    - Setting up virtual coachings
    - Talking with employers and they are planning to bring people back
      - Current plan is that they will start with minimal hours and work up to previous schedule
- Darci Knapp
    - Main concern is PPE
    - Also added cost to personal care agencies
    - Need more communication after things settle down to figure out how to move forward
      - Stipulations sent out in ForwardHealth but how will it look down the road when auditing
- Dennise Lavernz
    - Working to get devises out and ensure connectivity and develop a program to work with MCOs and ICAs on how to reconnect with members
    - Members not understanding why they can't see their friends and go out
    - Doing virtual classes since April 8
    - Had to lay off 100 employees and brainstormed how to work on staffing because of this
    - Less concerned about PPE
- Janet Zander
    - Piggy back on what Cathy shared
    - Heard about people coming to senior and community centers that wanted to stay engaged with one another
    - Had folds with difficulty getting food and groceries delivered
    - Working on helping people to obtain benefits
    - Working through PPE concerns and caregiver supports
    - Working with national partners and disseminating some of the best practices from
- John Sauer
    - Trying to do what we can to keep socialization happening but it's a difficult balance with keeping people safe
    - Long-Term Care and nursing facilities are having a hard obtaining PPE
      - Try to provided what we can with going to vendors and crating special purchases
      - Need more help from federal government
    - Bracing themselves for testing, how it will be implemented, and what will happen when there are asymptomatic workers
      - This will impact how care and services are provided
      - Don't want to invite COVID-19 into facilities
      - Sustainability
        - There will be some facilities failing
        - There will probably be some closures due to declines in revenue.
        - How are workers doing and what supports are in place for those working in facility quarantine areas
      - For residents, Mother's Day was challenging to keep people socially engaged with no group activities, no communal dining, and no outside visitation.

        - Those that wok in nursing homes are the voices of the families. Will send document from agencies.
- Stacy Ellingen
    - Caretakers are usually students from UW-Oshkosh
    - About second week of March, as pandemic rolled out, most went home
    - Stacy has been home with family for over 2 months and unable to work because technology in house is not what she has in her apartment
        - Does lots of Zoom meetings
    - With shortage of aids has been trying to set up interviews
        - Five (5) interviews scheduled last week, but not one showed
        - Have more set up this week
    - Have PPE, plenty of gloves, and relatives are sending her mask for the care people
- Kenneth Munson
    - Both provider and MCO lines have seem loss of life from members
    - See issues with separation and isolation and then adding deaths of friends and family members
        - This adds mental health stress
        - Workers can't have normal interactions they had before due to PPE needs
        - Burned through PPE very quickly
        - Can't rotate staff through multiple locations
            - Some environments are not great that staff are going to and this is making it wose
        - With residential settings need to have workers working all the time in one location since there are no day services currently
        - In addition, some members do not want people in their homes
    - Trying to focus on positive things.

Paused in roundtable to hear public comment

- Maureen Ryan
    - Hard to communicate with some with masks that need to see facial expressions
    - Testing sites are difficult to get to for some
    - Only 30% of those they try to reach out to do not have internet in homes
    - Limited access to cleaning supplies for those with scent sensitivities
    - Concerns with accessing benefits and therapies
    - Maintaining health has been difficult
        - Those with questions on their benefits can be sent to ILCs
        - Working to get more access to internet in different manners
            - Hoping it can be written into Long-Term Care plans.
- Sam
    - Doing best to get info out to populations that are needing access to services, a friendly voice, or how to get care for their loved ones
    - Held town hall meeting with various groups
    - People can request a trained volunteer to check on them on a daily or weekly basis
- Lea Kitz
    - Ombuds not seeing surge regarding COVID-19, but it has complicated the services and cases they do have
    - Concerns with mail-in voting as it doesn't work for everybody
    - Social distancing impact and vulnerability of those with underling conditions
- Mary Frederickson

    - Helping people through this
        - Purchased Zoom subscriptions
            - Psychiatrists and psychologists are using zoom
                - Reduction in missed appointments
                - This may work better for some people ongoing
        - Staff are helping with contract tracing
        - Purchasing whatever families need for personal items, board games/entertainment, electronic or mi-fi devices for connection to the internet.
- Heather Bruemmer
    - Medigap Helpline has been very busy with questions such as:
        - Stimulus checks
        - Insurance coverage
        - Out of state health care
        - Applying after age 65
    - Ombuds staff are all working virtually

Public Comment

- Lindsay Farrrell Govek-Brotoloc
    - Provider teams, it would be important to have that as a future project
    - Have the providers also be surveyed on the MCOs

Adjourn

- Motion to adjourn by Mary Fredrickson, seconded by Christine Witt, The meeting was adjourned unanimously.

Prepared by: Suzanne Ziehr on 5/12/2020.

These minutes are in draft form. They will be presented for approval by the governmental body on: 7/14/2020

LONG PATH *in a* COVID-19 WORLD

Carrie Molke, Bureau of Aging and Disability Resources
July, 2020

AGING AND DISABILITY *for the* LONG PATH

"Let's build a community that allows hard questions and honest conversations so we can stir up transformation in one another."

-Germany Kent

Overview of the Presentation:

1. Discuss how COVID-19 has altered plans
2. Seek input on key implementation questions *(which are highlighted in RED throughout the presentation.)*

Long-path Strategy: Six Phases

How will we scale the initiative

Phase One: Leader Development for "Backbone" Partners

Month, Year

- **Purpose**: To prepare a network of catalysts to serve as community leaders and backbone agencies to facilitate solving complex problems in Wisconsin's communities.
- **Approach**: Regional Trainings (Moved to Zoom; Scaled back to ADRCs for now due to funding and COVID; adding equity leadership training. How do we offer this to others?)

Phase Two: Community Engagement

Month, Year

- **Purpose**: To learn from and engage people from "all walks of life" about current and future needs; to engage communities – anyone with an offer – in making changes necessary to improve local conditions for health and well-being
- **Approach**: Local, community "conversations"/meetings; other engagement strategies

(How do we offer this remotely and safely?)

Phase Three: Local Systems Change Work

Month, Year

- **Purpose**: To work towards community-based solutions; to make changes; to test ideas; to innovate
- **Approach**: Collective impact, reinventing organizations, living and giving systems

(How do we help local leaders facilitate this work safely? Should this move to focus on community restoration more specifically?)

Long-path Strategy: Six Phases

How will we scale the initiative

Phase Four: First Phase of Evaluation

Month, Year

- **Purpose**: To measure whether communities are engaging in local systems change.
- **Approach**: Website, other

Phase Five: Repeat or Redesign Strategy

Month, Year

- **Purpose**: Develop a strategy for continuing and sustaining. (Recognizing that we will be "scratching the surface" of the potential in the first two years)
- **Approach**: Use evaluation data. "Press repeat" or redesign the strategy.

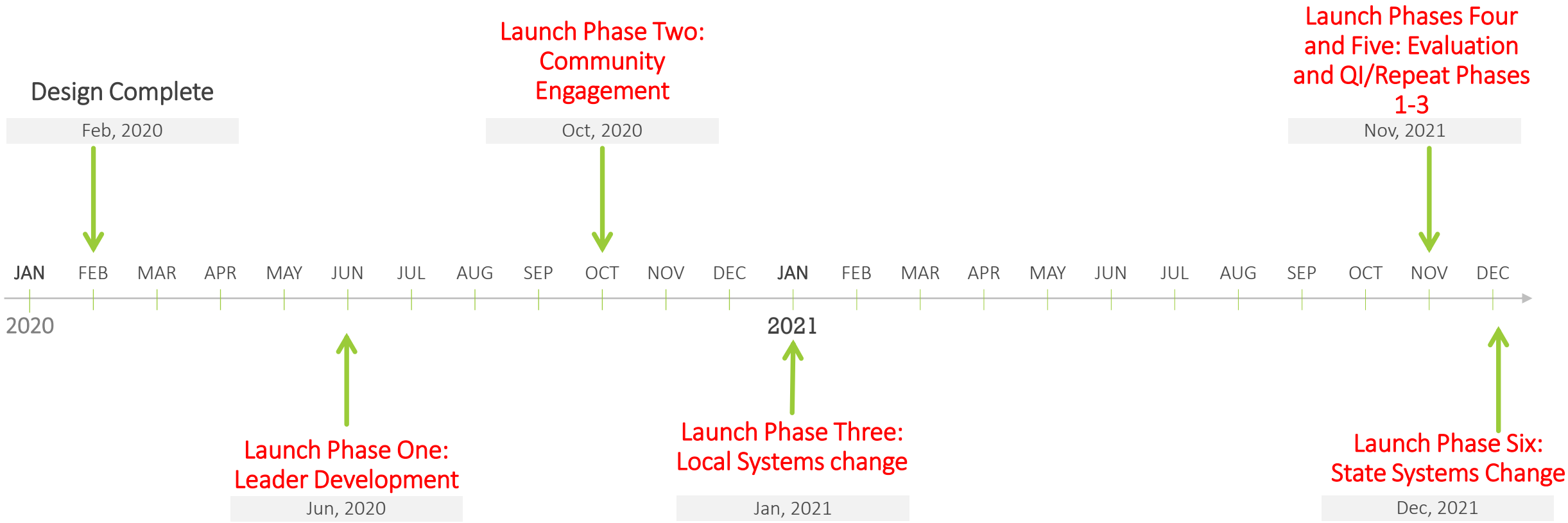
Phase Six: State Systems Change Work

Month, Year

- **Purpose**: Identify any areas where the state can support or use it's levers to further local efforts.
- **Approach**: Website, evaluation, QI

Timeline

The two-year action plan



Phase One: Leader Training for Backbone Partners

Who Will Be Invited?

The State will make an invitation to critical partners

Who should we engage with this modified approach?

What Will Be Taught?

Concepts and tools for strengthening communities' ability to create the conditions for aging well and living with disabilities

Futures Thinking, Collective Impact, Living and Giving Systems, Healthy WI Leadership Curriculum (Health Equity)

What Will Attendees Get?

A Toolkit!

Sample invitations and recruitment materials

Discussion questions and facilitation guides

Systems-change materials and tools

What Will We Ask of Attendees?

Engage community partners

Create invitations for others to lead and engage

Host community conversations; help more spread

Record and share successes

When Will The Trainings Happen?

Kick off in July

Five to eight sessions around the state.

Aging and Disability Network Conference in September

Phase Two: Community Engagement

Utilizing tools from Phase One

Community Conversations

Current and future needs, and solutions identified

Partners: Build collective power

Create/implement a "Spread Strategy"

Link with other planning

Age-friendly and Healthy Communities

Data for local change

Approaches to consider

Link with other planning

Incentives

Local ideas

Statewide recognition

All elevation strategies considered

Phase Three:
Local Systems Change Work

Local Systems Change

Communities across Wisconsin change things, try new things and test their ideas

On-going Support for Leaders

Set up on on-going feedback loop for leaders. Coaching, strategizing, barrier removal

Connecting Statewide

Story-sharing; “community of practice”

Website! Engagement stories “brick by brick”…

Measure the spread

Phase Four: First Phase of Evaluation. How is it working?

Is spread happening?

Are communities working on things?

What is emerging as common topics/efforts?

Not ready to measure whether it's making an impact…that's for a later phase…

Evaluation and QI Phases: Phases Four, Five and Six

Create an opportunity for success

Phase Four: Initial Evaluation

Is it working so far?

Phase Five: QI… Repeat or Redesign Strategy and Keep Building

Make adjustments

Keep it going

Build and Expand

Phase Six: State Systems Change Work

Engage state-level strategies as needed to remove barriers or address systemic issues

(Note: This can happen throughout)

Group Discussion

Building the Long-Path Brick by Brick

QUESTIONS FOR THE GROUP

- **Phase One: Leader Development**
  - Who
  - When
  - How ($; Technology)?

- **Phase Two: Community Engagement**
  - How do we do this safely?
  - What are we now asking them to discuss?
    - Long-path/next generation system;
    - Community restoration for vulnerable populations in light of COVID-19
    - Both/other?

Group Discussion

Building the Long-Path Brick by Brick

QUESTIONS FOR THE GROUP

- **Phase Three: Local Systems Change**
  - How do we help local leaders facilitate this work safely?
  - Should this move to focus on community restoration more specifically?

- **Timelines for All Phases**
  - In light of COVID-19, when can we realistically start the various phases?
    - Phase One: Launch in June, 2020
    - Phase Two: October, 2020
    - Phase Three: January, 2021
    - Phase Four and Five: November, 2021
    - Phase Six: December, 2021

Governor's Task Force on Caregiving

Draft policy proposals

Presentation for DHS Long-Term Care Advisory Committee

July 14, 2020

Status of the Task Force on Caregiving

- Spring 2020: Governor's Task Force on Caregiving drafted policy proposals addressing priorities and charges outlined in Executive Order #11.
- The Task Force is currently collecting public input.
- A public survey is open through today.
- You can find full versions of proposals and the survey here: https://gtfc.wisconsin.gov/content/policy-proposals

TCare – Tailored Caregiver Assessment and Referral

- Pilot TCare for 1 year
- Identifies areas where the caregiver may need additional supports to keep them healthy and allow them to continue to provide care in the community setting, delaying the need for placement in a facility.
- TCare is an evidence-based assessment approved by the Administration on Community Living.
- It is the only family caregiver assessment using an algorithm to triage services and supports to caregivers in the most need.
- Estimated cost: $60,000+

Aging and Disability Resource Center (ADRC): Reinvestment/Caregiver Support

- Support additional investment in ADRCs to provide increased attention to and support for family/informal caregivers.
- Expand caregiver support programing to include caregivers of people between the ages of 18-59 (funding currently only supports caregivers of people age 60 and above.)
- Funding would ensure that all caregivers have access to services and supports and that each county/tribe has a dedicated caregiver support staff person.
- Estimated cost: $3.6 million with an additional $440,000 in support for tribes. These estimates are preliminary and may change upon further refinement of this Task Force recommendation.

Legislative Change: Family Medical Leave Act Amendments

- Expand the coverage in the Wisconsin Family Medical Leave act to include chronic condition and caregiving responsibilities.
- Expand the list of people covered to include grandparents, grandchildren, and siblings.
- Expand the examples of how care can be used to include attending training and education on caregiving duties and responsibilities, discharge planning meetings, and care planning meetings.

Legislative Change: WI Credit for Caring

- Create a nonrefundable individual income tax credit for qualified expenses incurred by a family caregiver to assist a qualified family member.
- Family member must be at least 18 years of age, must require assistance with one or more daily living activities as certified by a physician, and must be the claimant's spouse or related to the claimant.
- Caregiver may claim 50 percent of qualified expenses spent to improve the primary residence in order to assist the family member, equipment to help with daily living activities, and costs associated with obtaining other goods or services to help the claimant care for the family member.
- The maximum amount of credit that may be claimed each year for a family member is $1,000 or $500 if married spouses file separately.
- No credit may be claimed by a claimant whose Wisconsin adjusted gross income in the year to which the claim relates exceeds $75,000 if the claimant is single or is married and files separately or $150,000 if the claimant is married and files jointly.
- Estimated cost: $125 million

Legislative Change: The Care Act

- Requires that a family caregiver is recorded when a loved one is admitted to the hospital
- Caregivers must be notified if a loved one is transferred to another facility or discharged back home
- Facilities would be required to provide an explanation and live instructions on medical tasks for caregivers

Rates Band Proposal

- The Department of Health Services should develop and implement by January 1, 2022 a statewide rate band (fee schedule) to be adopted by the Family Care, IRIS and other Home and Community-Based System (HCBS) long-term care programs.
- The rate bands would be used to establish provider payments.
- Direct DHS to establish rate bands that:
  A. Reflect worker wages based on actual and projected market realities
  B. Are transparent and consistent across all programs and settings
  C Are increased annually based on the Consumer Price Index (CPI)
  D. Are developed with provider input from the beginning

Nursing Home and Personal Care Payment Reform

- Reform the Medicaid nursing home and fee-for-service personal care reimbursement systems to create payment standards that are reflective of the actual cost of care
- Address labor region disparities that exist under the current payment system
- Recognize and reward facilities and providers based on quality measures and a commitment to improving staff wages, benefits and hours
- The nursing home and fee for services personal care payment standards should be adjusted annually by the Consumer Price Index (CPI)

Medical Loss Ratio

- Require a Medical Loss Ratio for Family Care Managed Care Organizations of at least 85% that does not include case management
- MCOs would be required to spend at least 85% of its capitation rates received from the Department of Health Services for direct care and services for Family Care members
- Case management, administration and profits would be funded from the remaining 15%

Direct Care Worker Fund

- Until such time that a Family Care rate bands are implemented (January 1, 2022), the Family Care funding increases for caregivers should primarily occur via the Direct Care Workforce Fund
- Annual increases be provided to the existing Direct Care Workforce Funding program to ensure dollars are allocated directly to the long-term care providers for caregiver wages and benefits
- Direct and support DHS' efforts to secure CMS approval allowing total Direct Care Workforce Funding to be allocated via annual payments
- Does not negate the mandate that the Family Care MCO capitation rate must be actuarially sound, taking into account, at a minimum, member acuity, client mix and the cost of care and services

Medicaid Expansion

- Realize full Medicaid expansion under the Affordable Care Act (ACA) to capture the enhanced Federal Medical Assistance Percentage (FMAP) to cover "newly eligible adults" with income up to 133% of the poverty rate
- In 2020, the enhanced FMAP was 90% while the current FMAP in Wisconsin is approximately 59%
- Newly eligible are adults (non-disabled adults aged 19-64), defined as those who were not covered by the state at the time of the passage of the ACA
- Estimated cost savings: $324.5 million GPR over the biennium

Earnings Disregard

- DSP's earning income through Medicaid Programs could disregard a portion of their earned income when determining eligibility for BadgerCare and Wisconsin Shares Child Care
- Amount of disregard being recommended is still undetermined
- Creates an incentive for members of the direct support workforce to work additional hours without fear of losing their much need benefits/assistance
- Allows DSP's currently not receiving benefits or assistance the possibility to do so

State-Wide Direct Support Professional Training

- Develop a pilot program for statewide best practice standards for training Direct Support Professionals, which would include:
  - a. A person-centered training to meet the needs of clients in both community and facility based settings;
  - b. Alignment with State and Federal regulations for different worker categories;
  - c. A portable certificate with the possible option to include within their registry profile;
  - d. A progressive three-tiered career ladder leading to eligibility for CNA licensure;
  - e. A web-based or E-learning training option; and
  - f. Collaboration with Job Centers

Recognition and Recruitment of Direct Support Professionals

- Expand the successful WisCaregiver Career Marketing Campaign and Tracking System to recognize and recruit direct support professionals for careers in nursing homes, assisted living, in-home care and self-directed supports.
- Repurposed and new tools will be used, including videos for participants and employers, customizable print materials, web design and content and a social and digital media campaign.
- Include a tracking component that provides the state, employers and the public with data about program success: who it is reaching, whether enrollment in training and care workforce jobs has increased, and how long people are remaining in their jobs

Background Check Policies

- Suggests that IRIS adopt the same background check process and criteria that agencies and self-directed clients use within the Family Care program – "Wisconsin Caregiver Program: Offenses Affecting Caregiver Eligibility for Chapter 50 programs and Act 172
- Since IRIS is more restrictive in their hiring process, caregivers might be prohibited from working within IRIS whereas they could be hired in other Long Term Care Programs
- Eliminates existing background check barriers and inconsistencies by achieving equity and uniformity among all Adult Long Term Care Medicaid Programs
- Creates an avenue for approximately 7,000+ untapped workers to become employed by IRIS participants

Medicaid Provider Regulatory Oversight

- Reform the state regulatory process to limit recoupment efforts to situations where care was not actually provided or the claim amount was inappropriate
- The DHS Office of the Inspector General should work with providers to fix documentation or clerical mistakes instead of requiring them to pay back significant sums of money for cares already provided

Home Care Provider Registry

- Establish a free, safe, secure statewide registry to serve as a platform to 'connect' people looking for care/support for children with disabilities, adults with disabilities and older adults as well as others with chronic conditions and/or family caregivers
- Individual consumers/employers and prospective employees would be responsible for performing their own due diligence, conducting background checks and interviews, and establishing clear expectations
- The registry is not intended to replace the employer tasks needed to hire a DSP, nor will it create an employer/employee relationship of any kind
- The registry will not be responsible for the authorship or accuracy of user profiles, nor will it endorse any profile listing
- Participation in, and utilization of, the registry is voluntary

Task Force Next Steps

- Subgroups continue to gather information and take steps to refine the proposals.
- Public input will be summarized, discussed and incorporated.
- Task Force members will update proposals to provide greater detail (i.e. costs, equity considerations, impact)
- On September 10, 2020, the Task Force will take a formal vote on all proposals.
- The Task Force will issue a report including background on the process, public input and final recommendations to the Governor by October.

Questions?

2021 ADRC Contract- Scope of Services – Proposed Revisions

Updated: 6/12/2020

This is a draft document that contains the proposed revisions for the 2021 ADRC contract's scope of services. A few key points about this document:

- This document only contains the sections that have proposed revisions. If you do not see a section on this document, that means there are no changes for that section and it will remain in the 2021 scope of services the same as it currently is in the 2020 scope.
- In lieu of providing a full scope of services document with track changes, this summary provides a side by side comparison of the 2020 contract language and the proposed 2021 revision. The 2020 scope of services page number is provided for those who wish to reference the full document.
- The table of contents allows you to easily skip to sections of interest
- Comments on these revisions and the 2021 scope of services can be sent by Monday, July 13th directly to:

Jennifer Speckien
ADRC Policy Strategist
Jennifer.Speckien@dhs.wisconsin.gov
715-210-1531

Table of Contents

Section II: ADRC Location, Physical Plant, Equipment and Systems

Section II.C – Equipment & Systems

Replace SAMS IR with WellSky to reflect the current name of the client tracking database.

Page	2020 Contract	2021 Contract
7	a. The ADRC's computer system shall: i. Have a high speed internet connection and shall have the capacity to stream both video and voice over the internet. ii. Operate either SAMS IR, or equivalent software, that has the same capacity as SAMS IR for client tracking, resource database and reporting. iii. Provide all ADRC staff will a computer and shall allow all ADRC staff to input data into WellSky or equivalent software.	a. The ADRC's computer system shall: i. Have a high speed internet connection and shall have the capacity to stream both video and voice over the internet, including the ability to access remote meeting capabilities. ii. Operate either WellSky, or equivalent software, that has the same capacity as WellSky for client tracking, resource database and reporting. iii. Provide all ADRC staff will a computer and shall allow all ADRC staff to input data into WellSky or equivalent software. iv. Have the capability to utilize and access systems in the format required by the Department.
8	a. The ADRC shall operate SAMS IR or have a client tracking system capable of: *List i-vi of system requirements b. If an ADRC does not operate SAMS IR, the ADRC shall provide access to its client tracking system for its assigned regional quality specialist for quality assurance.	a. WellSky is the primary client tracking system in use by most Wisconsin ADRCs. Effective January 1, 2021: i. ADRCs that currently operate WellSky are required to continue using WellSky. These ADRCs may not transition to any other client tracking system without first consulting with DHS and obtaining a waiver of the requirement. ii. ADRCs that currently operate a client tracking database other than WellSky may not transition to a new, non-WellSky client tracking database without first consulting with DHS and obtaining a waiver of the requirement. iii. All newly formed ADRCs must use WellSky or consult with DHS to obtain a waiver of this requirement. b. If an ADRC has been approved to operate a system other than WellSky, the ADRC shall provide access to its client tracking system for its assigned regional quality specialist for quality assurance.

Section III: Core Services

Section III.B – Information and Assistance

This section has been revised to align with the options counseling training and standards.

Page	2020 Contract	2021 Contract
13	a. *Evaluate the Call or Request.* Identify the issue(s) leading to the inquiry, establish rapport with the individual, determine the nature of the situation, and evaluate the knowledge and capacities of the individual, in order to determine how to best provide assistance. i. Base the information and assistance provided on the results of this person-centered conversation. ii. Identify and respond quickly to emergency situations and immediate needs. iii. Determine whether the individual could benefit from health promotion, prevention and/or early intervention information, activities, and programs and look for opportunities to help the customer maintain or improve his or her health and function. The ADRC is not required to perform a formal health assessment. iv. Offer a memory screen when appropriate and, if the customer agrees, perform the memory screen, share results with the customer, and provide additional information and referrals as needed. c. *Provide Information and Assistance on a Wide Variety of Topics.* Provide information and assistance on, at a minimum, the topics listed in Subsection 2 below.	a. *Evaluate the Call or Request.* Identify the issue(s) leading to the inquiry, establish rapport with the individual, determine the nature of the situation, and evaluate the knowledge and capacities of the individual, in order to determine how to best provide assistance. Removed.
14	*1. Information and Assistance Topics* The ADRC shall provide information and assistance on a wide variety of topics, and at a minimum must provide person-centered information and assistance on the following topics: • List a-s	Removed.

15	1. *Timeline for Providing Information and Assistance* ADRC staff shall respond to initial inquiries and requests for information and assistance within 24 hours or by the end of the next business day of receiving the request. If necessary, the initial response may be to acknowledge the request and schedule an appointment. Appointments shall be conducted within 10 business days following the customer's request or at another time preferred by the customer.	1. *Timeline for Providing Information and Assistance* ADRC staff shall respond to initial inquiries and requests for information and assistance within 24 hours or by the end of the next business day of receiving the request. If necessary, the initial response may be to acknowledge the request and schedule an appointment. If after providing initial information and assistance there is a need for an appointment, such as a home visit, ADRC staff will conduct that scheduled appointment within 10 business days or at another time preferred by the customer.

Section III.C – Long-Term Care Options Counseling

This section has been revised to align with the new options counseling training and standards.

Page	2020 Contract	2021 Contract
16-17	1. *Options Counseling Services* The ADRC shall provide counseling about the options available to meet long-term care needs and factors to consider in making long-term care decisions. Options counseling is an interactive decision-support process that typically includes a face-to-face interaction, is more than providing a list of service providers or programs for people to choose among, and is time-intensive. The ADRC shall provide options counseling to members of its primary client populations and their families, caregivers, and others who ask for assistance on their behalf. Options counseling shall cover the following: a. An exploration of the individual's personal history, preferred lifestyle and residential setting, and goals for the future; functional capacities and limitations; financial situation; and other information needed to help the individual identify and evaluate options available. When appropriate, offer to perform a memory screen and, if the customer agrees, perform the screen, share results with	1. *Options Counseling Services* The ADRC shall provide counseling about the options available to meet long-term care needs and factors to consider in making long-term care decisions. Options counseling is a person-centered interactive decision-support process that typically includes a face-to-face interaction, is more than providing a list of service providers or programs for people to choose among. The ADRC shall provide options counseling to members of its primary client populations and their families, caregivers, and others who ask for assistance on their behalf. The options counseling process shall cover all of the elements of the options counseling training curriculum and certification. *Add link to the training and/or training guidelines document. The ADRC should conduct an appointment for options counseling within 10 business days of when the customer accepts the offer for this service or at another time preferred by the customer.

	the customer, provide additional information and referrals as needed, and take the results into consideration while providing options counseling. b. The full range of long-term care options available to the individual, including but not limited to: home care, community services, residential care, nursing home care, post-hospital care, and case management services. c. Opportunities and methods for maximizing independence and self-reliance, including the utilization of supports from family, friends, and community, and the self-determination approach. d. The sources and methods of payment for long-term care services, including: i. Information about long-term care services and programs that are available in the area, including, but not limited to, information on providers' quality and costs. ii. The functional and financial eligibility criteria for receiving publicly funded long-term care and for participating in the Medicaid fee-for-service system, in order to assist the individual in assessing the likelihood that they will be eligible. iii. Sources of payment for private pay individuals who do not qualify for publicly funded long-term care. d. Factors that the individual may want to consider when choosing among long-term care programs, services and benefits, including, but not limited to: i. Cost ii. Quality iii. Service restrictions or limitations iv. Outcomes of importance to the individual v. Available resources	

	e. The advantages and disadvantages of the various options in light of the individual's situation, values, resources, and preferences. f. Assistance for the individual in identifying next steps to implement their decision, when appropriate. g. Options and support for the caregiver as well as for the individual with long-term care needs, as appropriate. *1. How Options Counseling Takes Place* a. The ADRC shall provide long-term care options counseling at a time, date and location convenient for the individual, including but not limited to, the individual's place of residence or temporary care setting. b. Options counseling shall involve one or more face-to-face meetings with the individual and any family or others the individual chooses to involve, unless the individual prefers it be done by telephone, mail, email or other means. c. Counseling may be provided to the individual's family and other representatives acting on the individual's behalf.	

Section III.E – Elder Benefits Specialists

Revisions have been made to reflect the funding changes that occurred in 2020.

Page	2020 Contract	2021 Contract
22	Primary funding for the EBS derives from Section 46.81(2) of the Wisconsin Statutes and is allocated to the local aging unit. ADRC grant funds may be used to cover the costs associated with an EBS only after all other EBS program-specific funding from state and local sources has been applied and when all other ADRC services required under this scope of services are being provided.	Primary funding for the EBS derives from Section 46.81(2) of the Wisconsin Statutes and is allocated to the local aging unit. If the local aging unit has approved the ADRC to receive EBS program funding using form XXX, then EBS workers must complete Time and Task reporting and EBS time must be included in the monthly adder workbook submission. ADRC grant funds may be used to cover the costs associated with an EBS only after all other EBS program-specific funding from state and local sources has been applied and when all other ADRC services required under this scope of services are provided.

Section III.G – Access to Publicly funded Long-Term Care Programs and Services

Updated website references for the long-term care functional screen. Included eligibility determination timelines per Wis. Admin. Code. Updates to enrollment counseling and ADRC involvement with the Resource Guide.

Page	2020 Contract	2021 Contract
26	1. Assuring Access to Publicly Funded Long-Term Care Programs and Services The ADRC shall assure that customers who request access to and indicate potential eligibility for publicly fund long-term care are informed about and assisted in accessing these programs, consistent with the requirements in this scope of services and with any additional direction provided by the Department. 2. Provision of the Long-Term Care Functional Screen a. Administration of the Long-Term Care Functional Screen i. The ADRC shall administer the initial long-term care functional screen to determine an individual's functional eligibility for managed long-term care and IRIS. ii. The ADRC shall off the LTCFS when it receives a request or expression of interest in applying for publicly funded long-term care from an individual or from someone acting on their behalf and when the individual applying indicates to ADRC staff that they have a condition requiring long-term care. iii. The ADRC shall perform a LTCFS for residents of its service area who appear to be financially eligible for publicly funded long-term care and wish to relocate from a nursing home iv. The ADRC shall initiate the LTCFS within 10 business days of the time the person requests or accepts the offer of a screen. ADRC staff shall ask if an individual would like to	1. Assuring Access to Publicly Funded Long-Term Care Programs and Services The ADRC shall assure that customers who request access to and indicate potential eligibility for publicly funded long-term care are informed about and assisted in accessing these programs, consistent with the requirements in this scope of services and with any additional direction provided by the Department, including but not limited to Wis. Admin. Code §DHS 10.31(6). 2. Provision of the Long-Term Care Functional Screen (LTCFS) a. Administration of the Long-Term Care Functional Screen i. The ADRC shall administer the initial long-term care functional screen to determine an individual's functional eligibility for managed long-term care and IRIS. ii. The ADRC shall offer the LTCFS when it receives a request or expression of interest in applying for publicly funded long-term care from an individual or from someone acting on their behalf and when the individual applying indicates to ADRC staff that they have a condition requiring long-term care. iii. The ADRC shall perform a LTCFS for residents of its service area who appear to be financially eligible for publicly funded long-term care and wish to relocate from a nursing home. iv. Per Wis. Admin Code §DHS 10.31(6), the ADRC shall determine functional eligibility as soon as practicable, but not later than 30 days from the date the ADRC receives a request or expression of interest per subpar ii above. If there is a delay in determining functional eligibility, the ADRC will notify the individual in writing

	have family or others present when a screen is performed and shall allow family and others present during a screening.	that there is a delay, specify the reason for the delay and inform the individual of their right to appeal the delay by requesting a fair hearing under s. DHS 10.55. v. The ADRC staff shall ask if an individual would like to have family or others present when a screen is performed and shall allow family and others present during a screening.
31	b. Required Enrollment Counseling Components ADRC staff providing enrollment counseling shall: i. Explain the eligibility requirements, cost sharing requirements, and basic features of the publicly funded managed care, fee-for-service Medicaid, and self-directed support programs that are available to the individual. ii. Review, discuss, and provide the individual with objective information comparing covered benefits, provider networks, responsibility for coordination of care, opportunities for self-direction and choice, and other features of Family Care, IRIS and, where available, Family Care Partnership and/or PACE, using Department-developed materials iii. Inform the individual that MCOs are required to make all covered services available to enrollees who need them. iv. Provide additional objective information that is relevant to the individual's choice, using materials developed by the Department. Provide information about MCO provider networks and directories, quality and performance indicators, and other MCO- or ICA-specific details to address the individual's interests, questions and concerns. Provide information about covered medications and drug formularies for Family Care Partnership and/or PACE MCOs in areas where these programs are available. v. After the individual selects a program, review the appropriate Department-provided MCO or ICA options charts with the individual and provide other objective	b. Required Enrollment Counseling Components ADRC staff providing enrollment counseling shall: i. Explain the eligibility requirements, cost sharing requirements, and basic features of the publicly funded managed care, fee-for-service Medicaid, and self-directed support programs that are available to the individual. ii. Ensure access to information and other materials for customers with visual impairments or other communication barriers by providing the information in alternative formats and languages. iii. Review, discuss and provide the individual with objective information comparing covered benefits, provider networks, responsibility for coordination of care, opportunities for self-direction and choice, and other features of Family Care, IRIS and, where available, Family Care Partnership and/or PACE, using Department-developed materials. iv. Provide additional objective information that is relevant to the individual's choice, using materials developed by the Department. Provide information about MCO provider networks and directories, quality and performance indicators, and other MCO or ICA specific details to address the individual's interests, questions and concerns. Provide information about covered medication and drug formularies for Family Care Partnership and/or PACE MCOs in areas where these programs are available. v. After the individuals selects a program, review the appropriate Department provided MCO or ICA scorecard with the individual and provide other objective information comparing the available MCO

	information comparing the available MCO and/or ICA options. Information is to be provided even if there is only one MCO or ICA option available to the prospective enrollee. vi. Information shall be provided in a timeframe that enables the potential enrollee to use the information when choosing among available MCOs or ICAs. vii. Discuss the enrollment process and the timing of enrollment, including any potential waits or delays, and establish the individual's desired enrollment date. viii. Provide information about the enrollee's right to disenrollment, the disenrollment process, disenrollment counseling, the right to appeal, ombudsman and other resources to assist with dispute resolution, and the opportunity to enroll in other programs for which the individual is eligible. ix. Ensure access to information and other materials for customers with visual impairments or other communication barriers by providing the information in alternative formats and languages. x. Refer people who express an interest in IRIS to the ICA of their choice. Provide the ICA with the information it needs to complete the enrollment process, including the LTCFS, cost share, and other data as directed by the Department. xi. Obtain signed enrollment forms for individuals who decide to enroll in managed care, in accordance with the Department's *Long-Term Care Authorization, Enrollment, and Disenrollment Form Signatures Policy* posted on the ADRC SharePoint site and using the standard forms provided by the Department.	and/or ICA options. Information is to be provided even if there is only one MCO or ICA option available to the prospective enrollee. vi. Information shall be provided in within 5 business days of the ADRC's awareness of confirmed functional and financial eligibility so the potential enrollee can use the information to make a selection among available MCOs or ICAs. vii. Discuss the enrollment process and the timing or enrollment, including any potential waits or delays, and establish the individual's desired enrollment date. viii. Refer people who express an interest in IRIS to the ICA of their choice. Provide the ICA with the information it needs to complete the enrollment process, including the LTCFS, cost share and other data as directed by the Department. ix. Obtain signed enrollment forms for individuals who decide to enroll in managed care, in accordance with the Department's Long-Term Care Authorization, Enrollment and Disenrollment Form Signatures Policy posted on the ADRC SharePoint site and using the standard forms provided by the Department. x. Provide information about the enrollee's right to disenrollment, the disenrollment process, disenrollment counseling, the right to appeal, ombudsman and other resources to assist with dispute resolution, and the opportunity to enroll in other programs for which the individual is eligible.

35	Assisting MCO and IRIS Enrollees with Maintaining or Re-establishing Eligibility or Enrollment a. Assisting MCO members and IRIS participants with maintaining eligibility and enrollment is not a primary responsibility of the ADRC. When practical, the ADRC shall refer the individual to the appropriate entity to provide assistance. b. The ADRC shall assist MCO members and IRIS participants for the purpose of continuing or re-establishing Medicaid eligibility and Family Care or IRIS enrollment when their continued enrollment is appropriate and would be jeopardized without the ADRC's intervention.	Assisting MCO and IRIS Enrollees with Maintaining or Re-establishing Eligibility or Enrollment Assisting MCO members and IRIS participants with re-establishing eligibility and enrollment is not a primary responsibility of the ADRC. The ADRC shall refer the individual to the appropriate entity to provide assistance.
New	N/A	Enrollment & Disenrollment Resource Guide The Department of Health Services' Enrollment and Disenrollment Resource Guide describes the roles of the different agencies responsible for providing accurate, efficient and timely eligibility determination and enrollments into Wisconsin's publicly funded long-term care programs. The ADRC shall refer to the DHS' Enrollment and Disenrollment Resource Guide for details regarding each agency's responsibility in the enrollment and disenrollment processes for publicly funded long-term care programs. ADRCs shall participate in the DHS annual review and revision of the Enrollment and Disenrollment Resource Guide and Enrollment and Disenrollment Process Deskaid for Publicly Funded Long-Term Care Programs.

Section III.J – Emergency Preparedness and Response *New*

There has been limited information in the scope of services for ADRCs related to emergency preparedness and response. ADRCs can play a critical role, which has led to the development of this section.

Page	2020 Contract	2021 Contract
38	The ADRC shall identify and plan for its role in natural disasters and other emergencies, including its roles in emergency preparedness planning and response.	Emergency Preparedness and Response a. The ADRC shall identify and plan for its role in natural disasters and other emergencies, including its roles in emergency preparedness planning,

		response and recovery. This includes being knowledgeable about and participating in your local incident command structure, including but not limited to those within public health, and emergency management operations. b. The ADRC shall engage in planning activities to prevent or minimize service disruption in the event of a natural disaster or other emergencies. c. The ADRC shall have available the equipment necessary to operate remotely should a natural disaster or other emergencies require alternative work location(s). d. With DHS approval, temporary modifications may be made to the requirements under this scope of services in the case of a natural disaster or other emergencies, including, but not limited to, service delivery and permissible uses of ADRC grant funds. e. ADRC services should be considered essential. ADRCs should make efforts to identify employees and contractors necessary for the provision of these services during a natural disaster or other emergency.

Section IV: Other Allowable Services

Section IV.3 – Dementia Specific Programs, Activities and Services

This section has been updated to align with the Dementia Care Specialist program and activities.

44	An ADRC may facilitate dementia friendly communities and provide other dementia-specific programming, activities, and related services not covered under other sections of this scope of services, depending on funding availability. ADRC grant funds may not be used to provide respite, home care, or other direct care or support for people with dementia or their caregivers. All ADRC dementia-specific programs, activities, and services shall be informed by the Dementia Care Guiding	*1. Provision of Dementia-Specific Programs, Activities and Services* An ADRC may facilitate dementia-specific programming, activities, and related services not covered under other sections of this scope of services, depending on funding availability. ADRC grant funds may not be used to provide respite, home care, or other direct care or support to people with dementia or their caregivers.

	Principles found at https://www.dhs.wisconsin.gov/publications/p01022.pdf.	*2. Alignment with the Dementia-Care Specialist Program* ADRCs that facilitate dementia-specific programming, activities and related services not covered under other sections of this scope of services should align their efforts with the Dementia Care Specialist Program. ADRCs should contact the Dementia Care Specialist Program Manager and their Regional Quality Specialist to discuss operational requirements in order to ensure consistency and accuracy of dementia-specific service delivery throughout ADRCs. The Dementia Care Specialist Program scope of services can be found at *insert link here.* *3. Dementia Capable ADRC* ADRCs that choose to provide dementia-specific programs, activities, and services need to meet the requirements of a dementia-capable ADRC. A dementia-capable ADRC is defined as an ADRC that trains and empowers all staff members and volunteers to have the knowledge and skills to identify people with possible dementia, work effectively with people with dementia and their family caregivers, and refer people with dementia and family caregivers to appropriate services. A dementia-capable ADRC recognizes and accommodates the needs of people with dementia who experience physical, cognitive, and behavioral symptoms of dementia, in addition to other conditions.

Section V: Organizational and Procedural Standards

Section V.C – Director

This section has been updated to require a full-time director and clarify the expectations for attendance at in-person meetings.

Page	2020 Contract	2021 Contract
47	An ADRC shall have a single director whose position is dedicated to the ADRC, with at least 50% of the director's time spent on ADRC or integrated ADRC-Aging operations and management activities, and who has the responsibilities described below, regardless of whether the	An ADRC shall have a single, full-time director who has the responsibilities described below, regardless of whether the ADRC serves a single county or tribe or a multi-county or tribal region and regardless of what title the position is given. ADRC directors may be responsible for program areas

	ADRC serves a single county or tribe or a multi-county or tribal region and regardless of what title the position is given.	outside of this scope of services, so long as those program areas serve the same target population as the ADRC.
49	ADRC director meetings are used by the Department as a method of communication for important policy and operational changes. The ADRC director is expected to attend director meetings and participate in conference calls as alternative Department communication methods for the information shared at these meetings and calls are not always available.	The Department uses ADRC director meetings to communicate important policy and operational changes. The ADRC director is expected to attend all director meetings and participate in conference calls. Although remote participation at in-person meetings may be provided as an option, the ADRC director is expected to attend a minimum of 50% of statewide meetings in person.

Section V.D – Organization of the ADRC

There is language added to clarify the organizational chart requirements for the programs that ADRC directors may be responsible for overseeing to include the ADRC, Aging and/or Adult Protective Services.

Page	2020 Contract	2021 Contract
50	The ADRC shall maintain organization charts that describe its organizational structure, areas of responsibility, and reporting relationships. The organization charts shall describe the placement of the ADRC within any larger organization of which it is a part and the relationship of the ADRC to its governing board.	The ADRC shall maintain organizational charts that describe its organizational structure, areas of responsibility, and reporting relationships. The organizational charts shall describe the placement of the ADRC within any larger organization of which it is a part and the ADRC's relationship to its governing board. i. Reporting Relationships to the ADRC Director a. All positions reporting to the ADRC director must perform duties that serve the target population of the ADRC. b. ADRC directors who are responsible for directly overseeing staff from program areas other than those that serve the same target population as the ADRC must submit a transition plan for oversight of these other program areas to their Regional Quality Specialist.

Section V.E – Staffing

Language has been added to reflect the requirement for a Disability Benefit Specialist. Removed specific conflict of interest items for shared and part-time positions as this will be incorporated into the revised conflict of interest policy.

Page	2020 Contract	2021 Contract
51	N/A	At a minimum, each ADRC will staff at least one half-time Disability Benefit Specialist (DBS) and apply any staffing recommendations from DHS.
52	*Shared and Part Time Positions* The ADRC shall ensure that shared and/or part-time staff is free from conflicts of interest and have the time and expertise needed to carry out their ADRC responsibilities and provide a high quality, professional level of service as part of the ADRC team a. Clerical and other supportive positions, such as human resources, accounting and IT, may be subcontracted or shared with other organizations where they have similar responsibilities. However, the director is responsible for ensuring that the activities and performance of shared or subcontracted staff supported with ADRC funds are correct and appropriate. b. ADRC management and staff may be shared across the larger organization or with other organizations as long as these organizations do not provide health care or long term care services. c. ADRC staff that performs the LTCFS or counsel customers on options for enrollment may not also be employed by a health care or long term care provider. d. A person who is employed as a DBS or EBS may not also perform the LTCFS, conduct eligibility determinations for SSI-E or other programs, or provide guardianship or adult protective services. e. Staff who provide ADRC services and also work in APS shall not provide enrollment counseling for any APS client with whom they are working.	*Shared and Part Time Positions* The ADRC shall ensure that shared and/or part-time staff is free from conflicts of interest and have the time and expertise needed to carry out their ADRC responsibilities and provide a high quality, professional level of service as part of the ADRC team a. Clerical and other supportive positions, such as human resources, accounting and IT, may be subcontracted or shared with other organizations where they have similar responsibilities. However, the director is responsible for ensuring that the activities and performance of shared or subcontracted staff supported with ADRC funds are correct and appropriate. b. ADRC positions that provide information and assistance, options counseling, and eligibility and enrollment related functions for publicly funded long-term care must be at least half time in the ADRC, with a minimum of .5 FTE assigned to working on these required ADRC functions. This requirement may be waived under exceptional circumstances with prior written approval from the Department. Requests for exceptions shall be made using form F-00054D and submitted to dhsrcteam@wisconsin.gov. Approval is discretionary on the part of the Department and may be conditional or time limited. Approval will be based on a combination of factors, including the individual's training and experience, the proposed job responsibilities, and plan for the future of the position in the ADRC. c. Shared and part-time staff must meet all of the applicable requirements for ADRC staff qualifications and training contained in section V.F of this scope of services. All shared or part-time positions in which a portion of the position is

	f. ADRC positions that provide information and assistance, options counseling, and eligibility and enrollment related functions for publicly funded long-term care must be at least half time in the ADRC, with a minimum of .5 FTE assigned to working on these required ADRC functions. This requirement may be waived under exceptional circumstances with prior written approval from the Department. Requests for exceptions shall be made using form F-00054D and submitted to dhsrcteam@wisconsin.gov. Approval is discretionary on the part of the Department and may be conditional or time limited. Approval will be based on a combination of factors, including the individual's training and experience, the proposed job responsibilities, and plan for the future of the position in the ADRC. g. Shared and part-time staff must meet all of the applicable requirements for ADRC staff qualifications and training contained in section V.F of this scope of services. All shared or part-time positions in which a portion of the position is allocated to the ADRC must be submitted and approved by the assigned regional quality specialist. h. Only that portion of a shared position that is devoted to the functions required under this scope of services may be funded with ADRC funds. For positions where 100% time and task reporting is required to claim Federal Medicaid match, costs must be allocated between fund sources based on time reporting. Funding for other positions may be allocated based on FTE or on another method that has been reviewed and approved by the Office for Resource Center Development Financial Manager.	allocated to the ADRC must be submitted and approved by the assigned regional quality specialist. d. Only that portion of a shared position that is devoted to the functions required under this scope of services may be funded with ADRC funds. For positions where 100% time and task reporting is required to claim Federal Medicaid match, costs must be allocated between fund sources based on time reporting. Funding for other positions may be allocated based on FTE or on another method that has been reviewed and approved by the Office for Resource Center Development Financial Manager.

Section V.F – Staff Qualifications and Training

Subsection 4.a.ii has been removed from this section of the scope of services and has been revised and moved to Section IV.3 Dementia Care Programs, Services, and Activities. The requirements for staff providing information and assistance and/or options counseling have also been updated to align with the new options counseling training and standards.

Page	2020 Contract	2021 Contract

54	All ADRC employees and contractors who work with customers shall be trained on and knowledgeable about the Department's *Dementia Care Guiding Principles* and how to implement these principles in their daily interaction with customers. Information and assistance, options counseling, and other ADRC services shall be provided consistent with these guiding principles.	Removed. Revised and moved to section IV.3.
54-55	ii. Staff providing information and assistance and/or options counseling shall have at least a basic knowledge of Wisconsin's Medicaid long-term care programs, their eligibility requirements, and procedures. iii. Staff providing information and assistance and/or options counseling services shall be knowledgeable about preventable causes of disability and institutionalization, and shall be able to identify risk factors and refer individuals to appropriate prevention and early intervention services and programs. iv. Staff providing information and assistance and/or options counseling shall know the warning signs of abuse, neglect, self-neglect, and financial exploitation, be able to identify customers who may be at risk, and be familiar with the elder-adult-at-risk, adult-at-risk, and/or adult protective services system in the ADRC's service area. v. Staff providing information and assistance and/or options counseling shall be trained on and skilled in the use of the resource and client tracking databases, including how to search for services, retrieve information, and document customer contacts.	Removed. Repetitive to other areas of the scope of services, specifically Section III.
55-56	5. *Training* b. The ADRC shall ensure that all staff completes the Department's mandatory ADRC Orientation Module in the Learning Management System (LMS). Other training shall include, but not be limited to, an orientation to the mission of the ADRC and its policies and procedures, the populations served by the ADRC and their needs, how to recognize and handle emergencies, cultural competency, conflicts of interest, and specific job-related duties and requirements such as EBS/DBS required trainings, screener certification training, and AIRS certification.	*5. Training* b. The ADRC shall ensure that all staff completes the Department's mandatory ADRC Orientation Module in the online Learning Management System (LMS). Other training shall include, but not be limited to, an orientation to the mission of the ADRC and its policies and procedures, the populations served by the ADRC and their needs, how to recognize and handle emergencies, cultural competency, conflicts of interest, and specific job-related duties and requirements such as EBS/DBS required trainings, options counseling certification training, screener certification training, and AIRS certification.

	c. The ADRC shall document when staff has completed the required training and make the documentation available to the Department on request. d. The ADRC shall assure that its professional staff has opportunities to participate in relevant online training and to attend in-person trainings and conferences sponsored or made available by the Department.	c. The ADRC shall assure staff are trained on relevant topics, processes, and procedures for their specific job function including, but not limited to, information and assistance, options counseling, enrollment counseling and disenrollment counseling, and local community resources. d. The ADRC shall assure that its staff is trained on data systems including, but not limited to, the client tracking system. e. The ADRC shall document when staff has completed the required training and make the documentation available to the Department upon request. f. The ADRC shall assure that its professional staff has opportunities to participate in relevant online training and to attend in-person trainings and conferences sponsored or made available by the Department.

Section V.J – Grievances and Appeals Regarding an ADRC or Publicly Funded Long-Term Care

This section has been revised to replace the word 'grievance' with the word 'complaint' throughout.

Section V.M – Reporting and Records

This section has been updated to accurately reflect the MDS Section Q referral system. A section has been added for 100% Time and Task Reporting for Federal Medicaid Administrative Claiming.

Page	2020 Contract	2021 Contract
64	*MDS 3.0 Section Q Nursing Home Referral Reports.* The ADRC shall use the Department's PPS Nursing Home Referral Management Module for reporting MDS 3.0 Section Q referrals.	*MDS 3.0 Section Q Nursing Home Referral Reports.* The ADRC shall use the Department's required system for obtaining Nursing Home referrals and for reporting MDS 3.0 Section Q referrals.
65	N/A	7. 100% *Time and Task Reporting for Federal Medicaid Administrative Claiming*

		a. Staff who perform certain job functions within the ADRC are required to complete 100% time and task reporting for federal Medicaid administrative claiming regardless of how the position is funded. ADRC staff performing any of the following job functions must complete 100% time and task reporting: i. Information and assistance activities ii. Options counseling iii. Enrollment/disenrollment activities iv. Nursing home relocation activities v. Disability benefits counseling vi. Elder benefits counseling vii. Dementia care specialist activities b. If the staff member is performing any of the above functions they must complete 100% time and task reporting regardless of i. Whether or not the funding used to support the position comes from a source other than ADRC grant funds. ii. The amount of time the staff person dedicates to any of the above job functions. c. ADRC staff performing any of the above job functions whose position is split with other job duties must complete time and task reporting for 100% of their time. Examples include, but are not limited to, positions that are split between ADRC and Aging and positions that are split between the ADRC and another department. d. ADRC positions performing job functions other than those listed above are not required to complete 100% time and task reporting. However, an ADRC may elect that they do so. e. Supervisory and support positions are not required to complete 100% time and task reporting so long as they do not routinely provide any of the following: i. Information and assistance activities

		ii. Options counseling iii. Enrollment/disenrollment activities iv. Nursing home relocation activities v. Disability benefits counseling vi. Elder benefits counseling vii. Dementia care specialist activities f. ADRC staff will follow the requirements for completing 100% time and task reporting as described in the technical assistance documented titled "Time and Task Reporting."

Appendices

Appendix A. Definitions

Changed 'grievance' to 'complaint.'

Removed Program Participation System (PPS).

Required Policies

COVID-19 and the Impact on Older Adults and People with Disabilities

CARRIE MOLKE, BUREAU OF AGING AND DISABILITY RESOURCES

Purpose of the Presentation

- To highlight key data re: the impact of COVID-19 on older adults and people with disabilities
- To highlight data re: racial and ethnic disparities and disparities amongst people with disabilities
- To apply a "health equity lens" to COVID-19
- To discuss actions DHS and other critical partners can take in response to the data

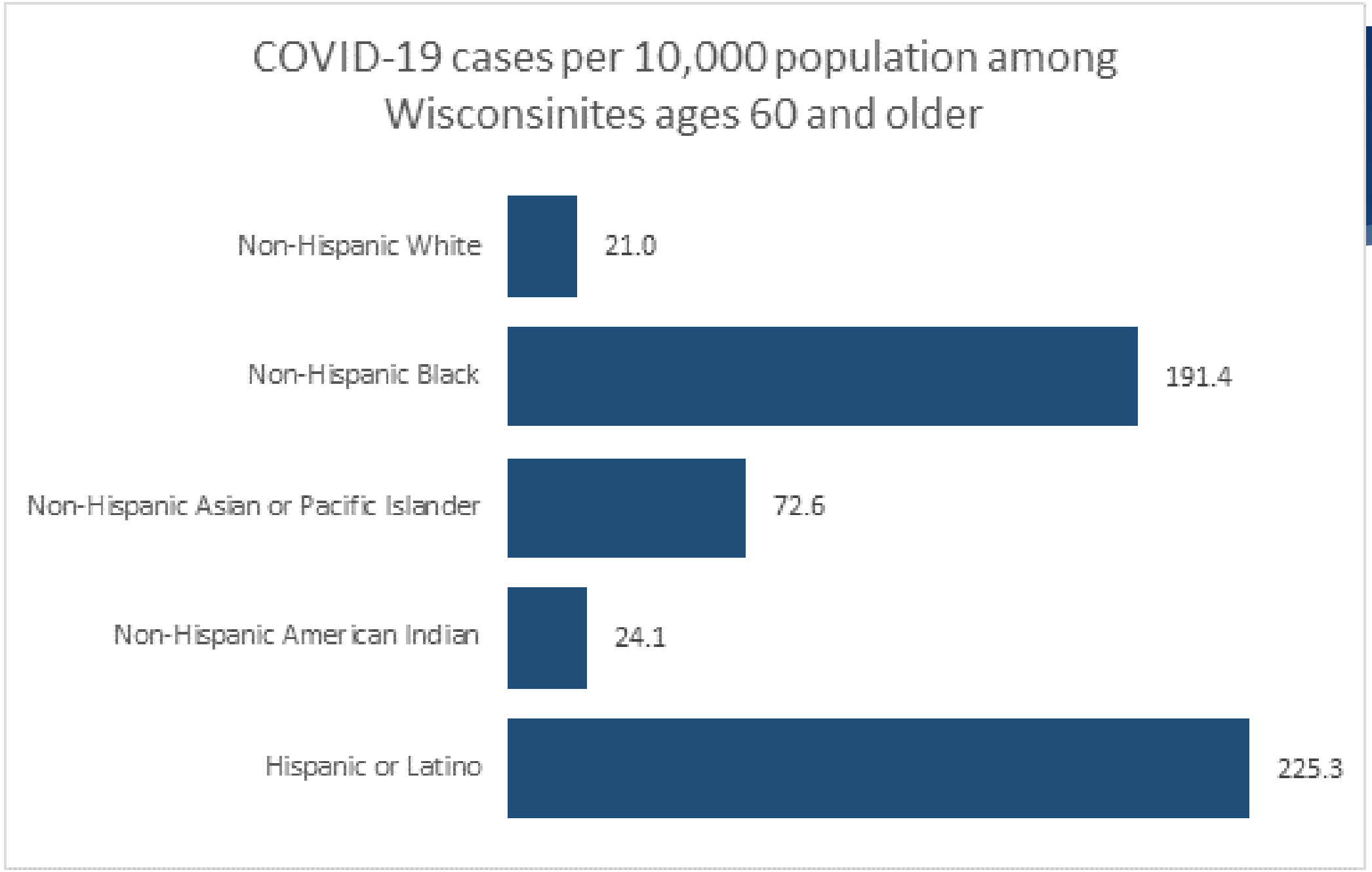
How has COVID-19 Impacted Older People in WI?

- 23% of all COVID-19 cases
- 87% of the deaths
- 4x more likely to be hospitalized
- 18x more likely to die
- ¼ to ½ of people over 60 are hospitalized (depending on age)
- Disparities for people of color

How has COVID-19 Impacted Older People of Color in WI?

Diagnosis

- Older Blacks diagnosed 9x the rate of whites
- Older Hispanics at 10x the rate
- Older Asians at 4x the rate
- American Indians at about the same rate as whites

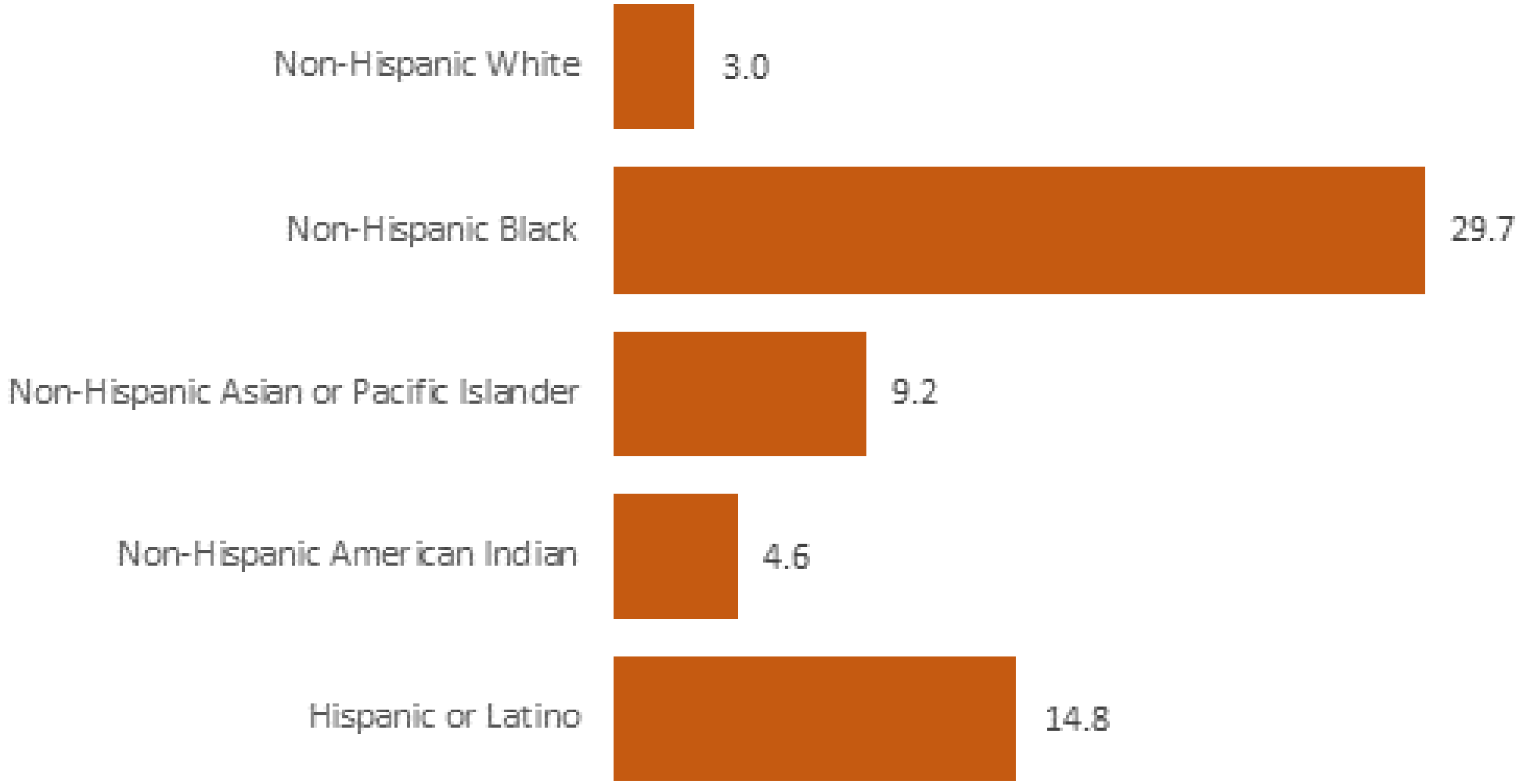

COVID-19 cases per 10,000 population among Wisconsinites ages 60 and older
Non-Hispanic White
21.0
Non-Hispanic Black
191.4
Non-Hispanic Asian or Pacific Islander
72.6
Non-Hispanic American Indian
24.1
Hispanic or Latino
225.3

How has COVID-19 Impacted Older People of Color in WI?

Death

- Older Blacks die at 10x the rate of whites
- Older Hispanics at 5x the rate
- Older Asians at 3x the rate
- American Indians at 1.5x the rate

COVID-19 deaths per 10,000 population among Wisconsinites ages 60 and older



How has COVID-19 Impacted People with Disabilities in WI?

Pre-existing conditions and the disability population

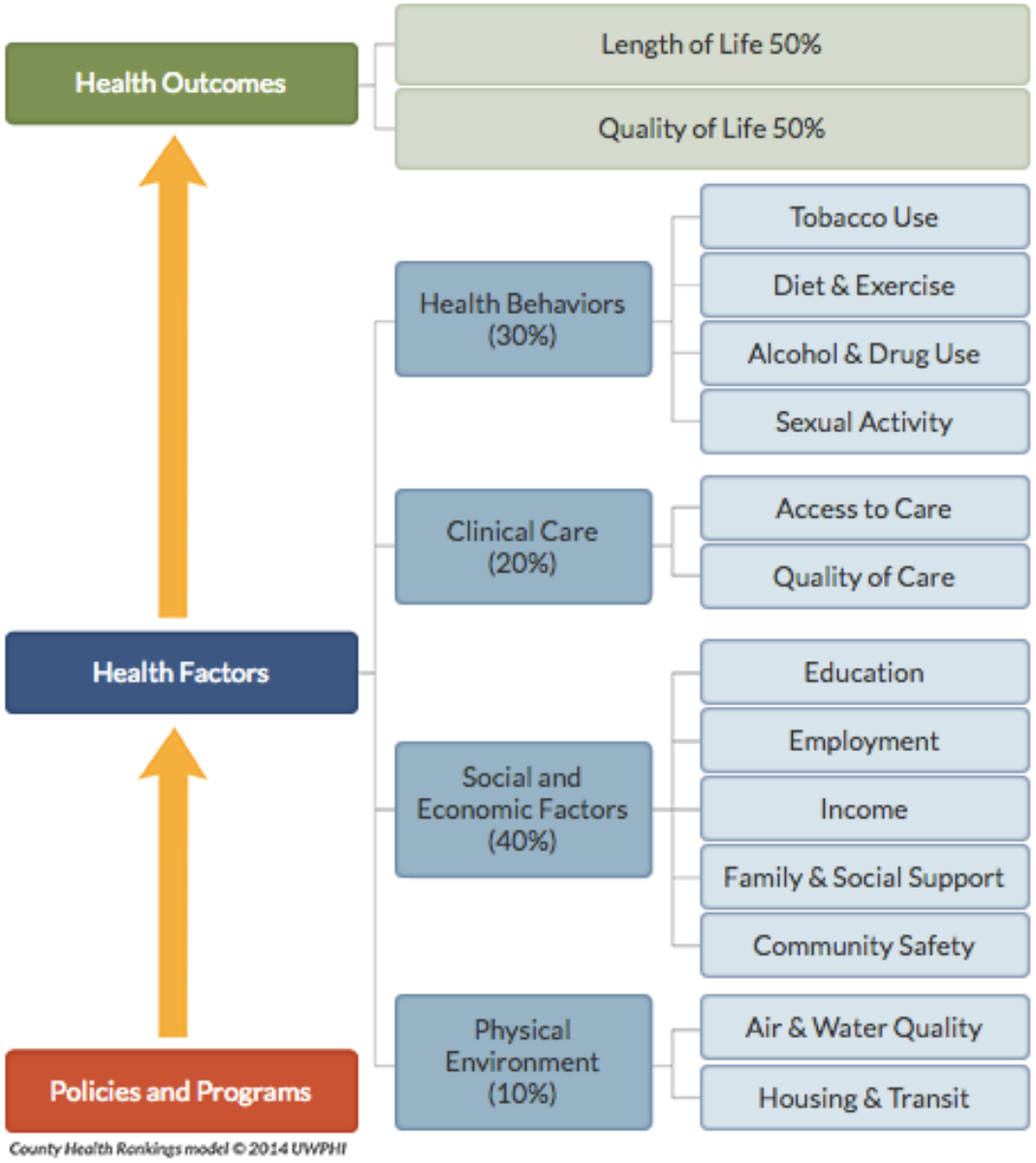
- Health Status
- Diabetes
- Cardiovascular Disease
- Respiratory Issues/Smoking
- Other health conditions: mental health, dental care, violent crime, income, employment, health care access

Disparities among people of color in WI

- Prevalence of Disability
- Average Life Expectancy
- Chronic Disease in Old Age
- Poverty in Old Age
- Alzheimer's Disease and Dementia
- Program Utilization

A Growing Population

- Significantly higher population growth in communities of color and Native American populations (between 2000-2017)
  - Hispanic (any race): 226% growth
  - Asian: 197%
  - Two or more races, not Hispanic: 154%
  - Native Hawaiian/pacific islander: 150%
  - American Indian and Alaska Native: 121%
  - Black/African American: 95%
  - White: 43%
  - *Total 60+ population=* *48%*



Aging and Disability Programs

Prevention and Health Promotion

Nutrition; Access to Food

Employment (and Education)

Income/Financial Stability

Access to Financial Assistance

Caregiver Support

Social Connectedness

Safety/Elder Abuse Prevention

Housing

Community Living Environments

Livable Communities

Transportation

What is Necessary for Health?

- Peace
- Shelter
- Education
- Food
- Income
- Stable eco-system
- Sustainable resources
- Social justice and equity

World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at <http://www.who.int/hpr/archive/docs/ottawa.html>.

Wisconsin named most unequal state in the country

Source: Thinkstock

1. Wisconsin

> **African American population:** 6.2% (24th smallest)

> **Median household income:** $29,223 (black), $59,056 (white)

> **Unemployment rate:** 10.6% (black), 3.8% (white)

> **Homeownership rate:** 26.2% (black), 71.6% (white)

> **Incarceration rate (per 100,000):** 2,542 (black), 221 (white)

What, So What, Now What?

"Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy."

Institute of Medicine (1988), Future of Public Health

Discussion

- First, what is your overall reaction to this data?
- How does this data inform our Health Equity charge?
- How does this data inform our Long-Path charge?
- What actions does this data compel us to take?
  - DHS
  - Stakeholders
  - LTC Advisory Council