GWaar
Greater Wisconsin
Agency on Aging Resources, Inc.

November 1, 2013

Earlene Ronk, Chair, ADRC Advisory Committee
Aging & Disability Resource Center of Jefferson County
1541 Annex Road
Jefferson, WI 53549

Chair Ronk,

I am writing to let you know that Greater Wisconsin Agency on Aging (GWAAR) has approved the Jefferson County 2014 County Aging Plan Amendment and Budget. You should receive your contract by the end of the year.

If you have any questions, please feel free to contact me.

Sincerely,

Carrie Porter

Carrie Porter
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cc: Susan Torum, Manager
Sarah Cowen
Deb Mould

County/Tribal Aging Unit Budget - 2014

Name of County/Tribe: Jefferson

Report for: Budget

Total Budget Amount: $ 354,199

Summary Budget

Expenditure Category	Federal/State Budget	Cash Match Budget	In-Kind Match Budget	Other Federal Budget	Other State Budget	Other Local Budget	Program Income Budget	Prior Year Program Income Budget	Total Budget
1. Administration	29,292	-	-	-	-	-	-	-	**29,292**
2. Personal Care	39,580	8,085	-	-	-	-	-	-	**47,665**
3. Homemaker	-	-	-	-	-	-	-	-	-
4. Chore	-	-	-	-	-	-	-	-	-
5. Home Del Meals	59,381	4,932	-	11,145	15,000	-	80,000	-	**170,458**
6. Adult Day Care	-	-	-	-	-	-	-	-	-
7. Case Management	3,887	-	-	-	-	-	-	-	3,887
8. Congregate Meals	137,073	16,897	-	9,883	-	-	-	-	**163,853**
9. Nutrition Counsel.	-	-	-	-	-	-	-	-	-
10. Assisted Transpo.	-	-	-	-	-	-	-	-	-
11. Transportation	-	-	-	-	-	-	-	-	-
12. Legal/Ben. Assist.	28,215	3,135	-	-	-	-	-	-	**31,350**
13. Nutrition Education	-	-	-	-	-	-	-	-	-
14. Info. & Assistance	3,142	9,155	-	-	-	-	-	-	**12,297**
15. Outreach	-	-	-	-	-	-	-	-	-
16. Public Information	1,000	-	-	-	-	-	-	-	**1,000**
17. Counsel. & Training	500	-	-	-	-	-	-	-	**500**
18. Temporary Respite	22,821	-	-	-	-	-	-	-	**22,821**
19. Med.Mgt/Scr./Edu.	-	-	-	-	-	-	-	-	-
20. Advoc./Lead.Devel.	-	-	-	-	-	-	-	-	-
21. Other	25,025	-	-	-	-	-	-	-	**25,025**
23. Health Promotion	4,283	476	-	-	-	-	-	-	**4,759**
AFCSP Adjustment		-							-
Total	354,199	**42,680**	-	**21,028**	**15,000**	-	**80,000**	-	**512,907**

Remaining Budget Balance	-

Advocate for people with disabilities speaks

By Pam Chickering Wilson, Daily Union staff writer | Posted: Monday, October 28, 2013 10:29 am

JEFFERSON — Evelyne Villines remembers when she was told she couldn't attend school because she was "handicapped."

Now 84 and an international advocate for people with disabilities, Villines showed up for her first day of school with her pencil and notepad, ready to learn. But the young girl, who contracted polio at age 3, was sent home and told to inform her mother, "I don't have time to teach a handicapped child."

When she returned home, she remembered asking, "Mom, am I a handicapped child?"

Villines then was institutionalized with other youngsters who had survived polio, a bleak period of her life that stretched from ages 9-16.

"It was so far away, I rarely saw my parents," Villines recalled.

But most humiliating of all were the times she was selected to go to "conference."

That didn't mean she'd be attending a conference to learn and network; rather, she was to be a subject at a conference, a medical specimen to be paraded around, examined by strangers and made to demonstrate her "crippled" walk.

"Every girl on our ward would secretly — and some not so secretly — cry when our turn came up, because we didn't want to go," Villines recalled.

For when the living specimens arrived at the medical conference, the first thing they'd hear was the order, "Take off your clothes."

"And they meant all of them," Villines told the crowd of grassroots advocates at the Jefferson County Fair Park Activity Center Friday.

The audience, comprised mostly of people with developmental disabilities who are part of Wisconsin's "A team" of self-advocates, gasped, with some of the members speaking up to say, "That's not right!"

The next order Villines heard was "Walk."

"As a very small child, I knew I didn't walk pretty," the polio survivor said. "I limped. I wobbled from side to side. And it hurt."

Then, officials at the conference would start marking her bare skin with black marking pencil, indicating where the bones in her legs weren't right.

"At that point in my life, I didn't care if I ever walked again," she said. "I wanted someone to put their arms around me and hug me."

But Villines did not give up, and she urged the disability advocates in the room not to give up either, but to continue fighting for their rights to fair treatment, respect and the ability to make their own choices.

One of the choices that the "A Team" has been advocating for is the continued existence of supervised workplaces such as the Fort Atkinson-based Opportunities Inc., which work with people of all ability levels, including those who could not obtain a job in the community without considerable coaching, mentoring and on-site training.

The motto of that effort has become "My Work, My Choice," a slogan that was displayed Friday on the backs of T-shirts worn by every self-advocate in the crowd.

The grassroots advocacy event, held in honor of National Disability Employment Awareness Month, took place over two days, with events in Madison on Thursday and Jefferson on Friday.

Before Villines' talk at Jefferson County Fair Park, the national disability advocate had the opportunity to tour the Opportunities facilities in Fort Atkinson.

Opportunities was one of the sponsors of Friday's grassroots advocacy event which filled the entire Activity Center. The audience included people with disabilities, those who work with them through Opportunities and other agencies, and some family members.

The other major sponsor of the event was Rehabilitation for Wisconsin, with partnership sponsors including Maas Bros. Construction, Kandu Industries, St. Coletta of Wisconsin's Consumer Leadership Council, Goodwill Industries and Best Events. Additional event contributors included Buit Mobility Solutions, the Teen Day Broadcast Program, Source America and others.

"You are the reason I am still out on Capitol Hill, backing another senator into a corner," Villines said.

She gave kudos to Opportunities in particular as an exemplary facility, saying that she knows members of Congress have visited the Fort Atkinson-based nonprofit agency, "as I should think they would. This is one of the best facilities I've ever seen," she said.

Villines has been a self-advocate and an advocate for others with disabilities basically her entire life.

She travels worldwide to share her life story and to advocate for ways to better the lives of people with disabilities.

She has held numerous prominent governmental positions, including being appointed by then-President Bill Clinton to a committee that works on behalf of the blind and people with severe disabilities.

When she was growing up, Villines said, she was called "crip," and "gimp," and other terms that she's trying hard to forget.

"And it hurt. It really hurt," she said.

She said she bet a lot of audience members have been the target of unkind names as well, like "dummy" and "retard." A low roar of agreement and outrage from the audience backed up that statement.

"You can change that," Villines said, and Emily, a member of the audience, piped up, "You can make a difference. People are different."

Thankfully, attitudes are chang ing, thanks in part to the Americans with Disabilities Act.

"I was in Washington D.C. when President Bush signed the Americans with Disabilities Act into law," she said. "There is still sadness in my heart that the ADA passed with one person voting against it."

The ADA and other measures which have brought disabilities into the public eye and helped people realize that people with disabilities — of whatever type — have the right to live, to shop, to enter public buildings, and to work, just like others.

Now, a new bill that's set to be introduced in about two months is aimed at adding the United States to the United Nations treaty supporting the rights of people with disabilities internationally.

"This means that we, as Americans, believe that people around the world with disabilities deserve to be treated fairly," Villines said.

The advocate shared another painful memory from her past. Known for her heavenly voice, Villines was asked to sing at many people's funerals — with ailing community members contacting her father before they died to request that she sing at their service.

As a junior in high school, Villines was thrilled to be selected to perform the lead role in the high school operetta, but then terribly wounded when she was informed that she would be singing from behind the person while an "able-bodied" actress portrayed the role visually.

"That was a very different way of saying, 'We don't want to look at people with disabilities.'"

Changes in attitude have brought a change in focus — not on disabilities (what people can't do), but, rather, on abilities (what people can do).

But if they're to make full use of their abilities, people with disabilities must be willing to step forward, to advocate, and to educate others.

The first step is to let people know you're there, and to help them see things from your view.

"We must be willing to talk about our disability," Villines said. "We may walk differently. We may talk differently. We may see or not see. Accept that. Then we have to continue to say … 'We have rights.'"

One of those rights is the right to work in a supported environment.

During her tour of Opportunities, Villines said she saw a lot of people with disabilities doing work that was extremely meaningful and which gave them purpose.

"If you have purpose in life, you know someone needs you," she said.

The speaker said that people who meet a person with a disability and hear about their concerns and viewpoint will better understand all people's need to be accepted as first-class members of the community.

That morning, Villines said, she got up thinking, "What an adventure."

"I couldn't wait to get here, because I had purpose in my life. You are the reason I get on plane after plane, using different wheelchairs. … I am here to tell you, you are a first-class citizen."

Villines said she has only known Barb LeDuc, Opportunities president and CEO, since August, although two Opportunities consumers actually made the trip to Washington D.C. this summer to attend a grassroots conference that Villines was at.

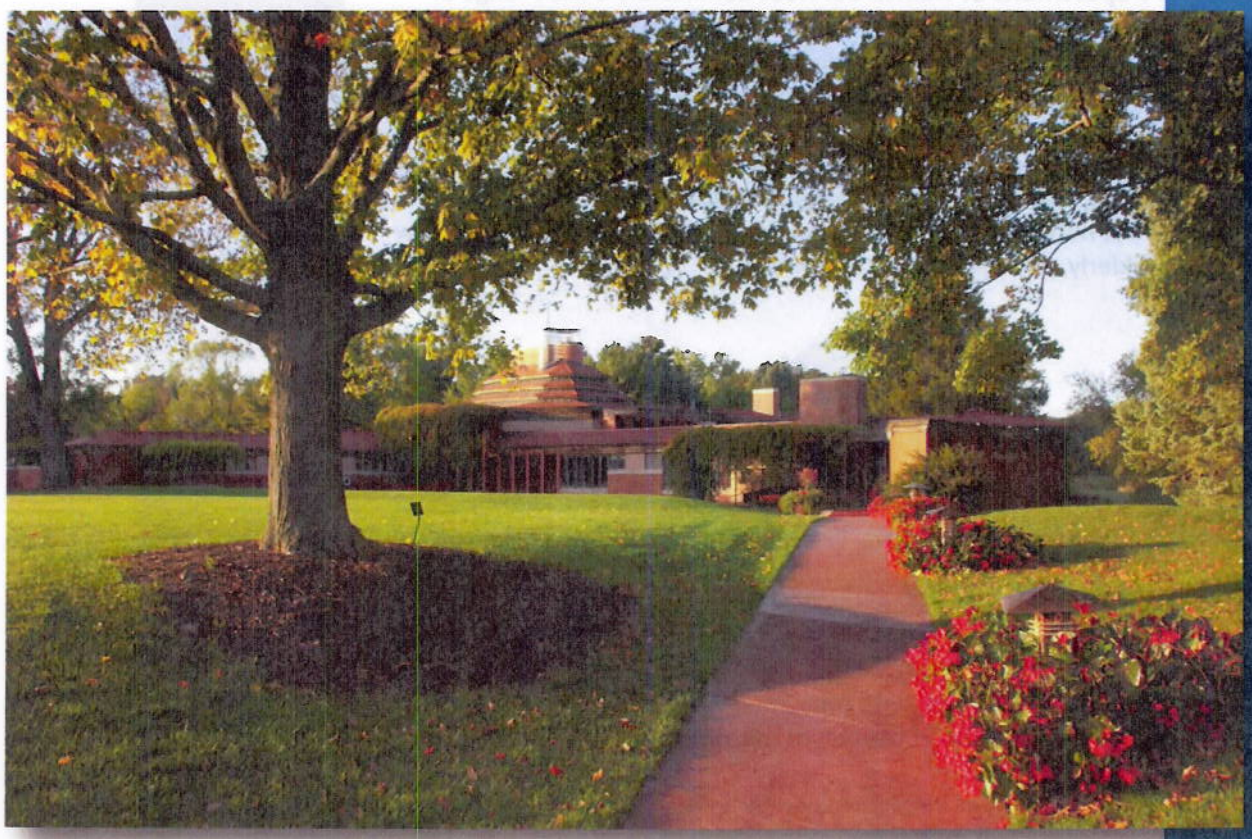
In Washington D.C., the two Opportunities consumers, Jennifer Weigand and Mackenzie Kylmanen, underwent grassroots training and then had the chance to share their stories with senators and members of Congress and their staffs.

"Do you know you can be the most important person in Wisconsin when you go into your senator's office and tell them about your work and what it means to you?" Villines said.

"We need to get to our Congressional delegation," she said. "They need to know you."

Redesigning Wisconsin's Dementia Care System:
A Stakeholder Summit

Wingspread Conference Center
Racine, Wisconsin
October 1-2, 2013



Sponsored by:
The Johnson Foundation at Wingspread
Wisconsin Department of Health Services

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Summit Process and Goals

The Summit was jointly sponsored by The Johnson Foundation at Wingspread and the Wisconsin Department of Health Services to launch an effort to improve Wisconsin's system of care for individuals with Alzheimer's disease and related dementias.

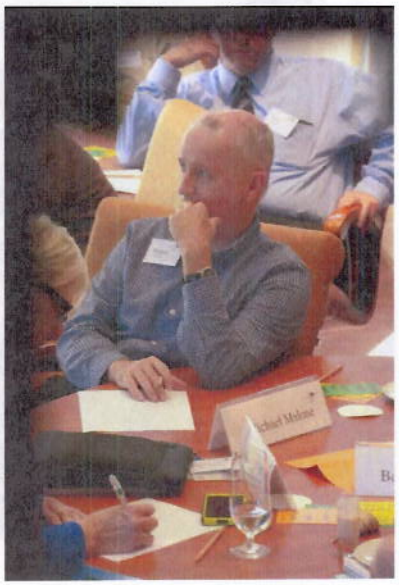
The Summit brought together representatives of key stakeholder groups with a wide variety of perspectives, including clinicians, care facility and service providers, family caregivers, advocates, law enforcement, attorneys and policy makers. Thirty-three stakeholders participated in a one and one-half day structured process, led by a professional facilitator, designed to generate ideas for the Department to build on in developing and implementing its dementia redesign initiative.

Department of Health Services Secretary Kitty Rhoades, speaking via video, told participants to think big, start from scratch, and come up with a design for the state's entire system of dementia care. She asked that participants not get hung up on details or funding, but show the Department what a dementia-capable system should look like and make key recommendations for system change.

During the first day of the Summit, participants were asked to identify characteristics of the current system of care for people with dementia, including both critical areas for change and opportunities for improvement, and then to describe what an "ideal" dementia care system would look like.

The second day of the Summit focused on developing recommendations in five areas that have been identified by the Department of Health Services as elements in the care system that will need to be addressed in its plan for redesigning dementia care. These include community capacity, facility-based long term care, crisis stabilization, emergency protective placement, and care transitions.

Several participants were asked to share information about their experience with promising practices that illustrate successful approaches in each of these five components of the dementia care system. Then, through a process of small group discussion, sharing and winnowing, participants generated a list of concrete strategies for making each of the five system components more "dementia-capable." That process generated a list of 54 different ideas. As a final exercise and culmination of the Summit activity, participants were asked to narrow the list to no more than six priority recommendations.



Results of the Summit are documented in this report. Consistent with the charge given to the group and the nature of the process followed at the Summit, these ideas are presented in bulleted form, without detailed background, explanation, or consideration of how implementation would occur. They represent the collective thinking of experienced stakeholders representing a variety of interests and perspectives on dementia care. The Department of Health Services will work with these ideas to create a system of care that is responsive to the needs of people with dementia throughout the course of the disease, promotes quality of life, provides safe places for people with challenging behaviors, and is sustainable for the State of Wisconsin.

Why Redesign the Dementia Care System Now

The proposal to redesign Wisconsin's dementia care system was prompted, in part, by the Wisconsin Supreme Court's *Helen E.F.* decision, the Special Legislative Committee on Legal Interventions for Persons with Alzheimer's Disease and Related Dementias, and the Department of Health Services' belief that the problem of challenging behaviors exhibited by individuals with Alzheimer's disease and related dementias is best addressed within the larger context of the dementia care system as a whole.

The *Helen E.F.* decision, issued in May 2012, prohibits people with only a dementia condition from being involuntarily committed for treatment under Chapter 51 of the Wisconsin Statutes, which covers emergency detentions of individuals believed to be mentally ill, drug dependent or developmentally disabled. In response to that decision, a Special Legislative Committee was convened and recommended a series of statutory changes to create procedures for psychiatric and behavioral care and treatment for individuals with dementia under the protective placement provisions in Chapter 55. With an awareness of the growing need for dementia care in the community, as well as in institutions, the Department of Health Services proposed the alternative of seeking more broad-based solutions.

The Department requested and received permission to spend two years collecting and analyzing data, researching best practices, and developing a more comprehensive approach to dementia. Such an approach would address the needs of the large and growing numbers of people with dementia living at home and in the community and encompass early detection and intervention, crisis stabilization, and community- and facility-based long term care, as well as addressing the need for emergency protective placements.

In his welcoming remarks, Division of Long Term Care Administrator Brian Shoup noted that the country looks to Wisconsin for leadership and that the outcome of this Summit will not only shape the future of dementia care in Wisconsin, but will be looked at as an example of best practices by other states across the country.

Overview of Dementia in Wisconsin

Approximately one out of every seven individuals age 65 and older (14%) has Alzheimer's disease or a related dementia. After age 85, the proportion of the population with dementia increases to just under half (48%). Based on these prevalence rates[1], it is estimated that 120,000 people in Wisconsin had dementia in 2010. By 2035, as life expectancy lengthens and the Baby Boomer generation continues to "age," this number is projected to increase by another 82,000 people or 68%.[2] This is a number too large to be ignored.

Assessments of Wisconsin residents living in nursing homes demonstrate that about 40% of people residing in nursing homes have dementia.[3] Research indicates that the same is true for residents of assisted living facilities.[4] Wisconsin's population estimate includes 12,000 individuals with dementia living in nursing homes and 18,000 in assisted living facilities. However, these numbers represent only about one-quarter of the all the individuals in Wisconsin with dementia, with the remaining 75% living in private homes.

According to the statewide Behavioral Risk Factor Survey conducted in Wisconsin in 2011,[5] just under 10% of adult respondents of all ages reported having confusion or memory loss that is happening more often or getting worse in the last year, and another 9% indicated that at least one other adult in their household was experiencing similar confusion or memory loss in the last year. Of these, fully 75% reported that they rarely or never got help relating to their memory loss from family or friends, while only 9% always or usually got such help. Over 9,000 people with dementia receive care through the State's Medicaid Home and Community Based Services waivers.[6]

For a variety of reasons, many people with memory loss do not have a diagnosis of Alzheimer's disease or other dementia. Only 28% of those who reported having experienced memory loss in the Behavioral Risk Factor Survey had discussed their memory loss with a health care professional, and of those, only 15% received a diagnosis. That means that 95% of the people who said they have experienced worsening confusion or memory loss have not been diagnosed with dementia.

Between 60 and 90% of people with Alzheimer's disease will exhibit agitated behavior during the course of the disease process.[7] While relatively few of these people will become violent or dangerous, a small but not insignificant proportion will exhibit behaviors that are challenging enough for their caregivers such that an emergency response is warranted. Agitated behavior is the primary reason that people with dementia are placed in psychiatric institutions under Chapter 51. Yet based on *Helen E.F.*, it is not appropriate to use an emergency detention to involuntarily admit individuals with dementia to inpatient psychiatric facilities unless they also have a co-occurring mental illness. This recent development is increasing the need for alternative emergency placement capacity. In addition, it is estimated that, even

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[1] Dementia prevalence rates are those recommended by Denis A. Evans, M.D., et al. "Prevalence of Alzheimer's Disease in a Community Population of Older Persons," Journal of the American Medical Association, 262(18), 1989. Note that these rates may include individuals with or without a confirmed dementia diagnosis

[2] Population Projections, 2005 through 2035, from Wisconsin Department of Administration, Demographic Services Center, Vintage 2008.

[3] Wisconsin Department of Health Services, Division of Quality Assurance (Minimum Data Set - nursing home data)

[4] 2010 National Survey of Residential Care Facilities, U.S. Dept. of Health and Human Services

[5] 2011 Behavioral Risk Factor Survey, Centers for Disease Control and Prevention and WI Office for Health Informatics

[6] Wisconsin Department of Health Services, Division of Long Term Care (Medicaid Waiver data)

[7] Tariot, P.N. and Blazina, L. "The Psychopathology of Dementia," Handbook of Dementing Illness (1994): 461-475.

with strong community and residential care options with well-trained staff, a small number of individuals with dementia will engage in behaviors that are so challenging for caregivers that they will require special care over a longer period.

Without a proactive approach to improve our current system of care, the State of Wisconsin and its facilities, service providers, families and taxpayers will face growing costs and increasingly strained and inadequate resources for meeting the needs of people with Alzheimer's disease and related dementias.

Challenges and Opportunities

The current system of dementia care in Wisconsin involves both challenges and opportunities. Summit participants started their discussion by identifying characteristics of the current system, including areas that need improvement as well as areas that provide opportunities to build on and strengthen elements of the current system.

Gaps and Deficiencies in the Current System

- A fragmented system of care.
- Lack of coordination between the health care and long term care systems.
- People don't know how to navigate the system.
- Families are stressed and don't know where to go for help.
- Stigma leads to people turning away; people suffer in silence.
- Dementia is often considered to be "normal aging."
- Many times, doctors cannot or do not diagnose dementia or refer patients for services. There is a feeling that because there is no cure, nothing can be done.
- Wide variation in access to services. Rural areas have less capacity for diagnosis and treatment.
- Few resources to fund or train caregivers.
- Lack of geriatricians and physicians knowledgeable about dementia.
- Over-medication of people with dementia.
- The system reacts to crises, rather than providing proactive interventions.
- Inconsistency in how emergency protective placements are handled.
- Breakdowns in communication during transitions from one part of the system to another.
- Nursing homes and assisted living facilities are viewed as "the end of the road."
- Nursing homes send challenging patients to other facilities and will not let them return.
- Risk of good facilities, those that are able to care for high needs patients, becoming "dumping grounds."
- Workforce shortages. Low pay, few benefits and lack of training for workers.
- Barriers to offering long term care for people with dementia include reimbursement, regulations and workforce issues.
- Punitive elements and perverse incentives in the system.

Opportunities

- Education and training for the community, family caregivers, and workers.
- Philosophy and methods of person-centered care.
- Early identification and intervention.
- Looking for ways to enhance quality of life for people with dementia.
- Roadmaps for families to follow.
- Flexibility in implementing best practices and standards.
- Incentives for early intervention.
- Making dementia care profitable.
- Care transitions.
- Mobile crisis intervention.
- Avoiding blame and acknowledging that there will be mistakes.

Defining an Ideal System of Dementia Care

Summit participants were asked to envision an ideal system of dementia care by answering the question: Where should the State be going in its effort to develop a dementia capable system of care and how will we know when we get there? The following emerged as key features of a dementia capable system of care:

Single Point of Entry

- Accessible service delivery system – one stop, no wrong doors, person-centered, responsive.
- Single entry points for information and referral, memory screening, diagnostic testing, access to legal, financial and social assistance.
- Capacity for non-English speakers.
- Constant communication flow between single point of entry and community resources – mutual referrals.

Community Involvement

- Public awareness, community awareness, marketing.
- Community "owns the problem," communities are educated and feel responsible for helping.
- Churches, community centers and other community organizations are part of the solution.
- Recognize and define the role of law enforcement, Emergency Medical Systems (EMS) and first responders – people will continue to call them.
- Strategic community outreach in conjunction with nutrition, vaccination, health interventions and other organizations and activities.

Coordinated Care Across Systems

- Support people with dementia and caregivers across entire spectrum of the disease, from preventive care through diagnosis to death.
- Integrated system of care.
- Case management: One person follows individual; "lifetime consultant" stays with person, coordinating care from diagnosis through death.
- Communication, sharing information in both directions between single point of entry, case manager, providers and health systems for the benefit of the person.
- Develop mechanisms for providing feedback.
- Statewide record-keeping, electronic medical records.
- Telemedicine and other uses of technology.
- Regionalize access to services; make access person-centered (where it makes the most sense to the person to go – not necessarily county of residence).
- Outreach and education for primary care doctors and emergency room providers.
- Address comorbidities and coordinate care across diagnostic categories.

Crisis Management

- Clear legal processes in place to address immediate issues.
- Crisis prevention and intervention.
- More attention to crisis prevention in late-stage dementia where communication problems intensify.

Consistent Availability of Services

- Statewide consistency in service availability (standardized expectations), with flexibility allowed for specifics of local implementation.
- Options for different types of supports and services.
- Accessible services – physically, financially, legally.
- Early detection, access to diagnostic clinics.
- Develop approaches to more effectively address early-, mid- and late-stage dementia care.
- Regional centers with multi-disciplinary teams.
- Clarify and strengthen processes and systems to get at the root of the problems.

Person-Centered Care

- Person centered care, responsive to the individual, talk to family members to find out what they need.
- Care and services that are responsive to ethnic, cultural, disability, language and religious needs – inclusiveness is the key (lesbian, gay, bisexual, transgender, disability groups, race, language).
- Ability to provide home visits.
- Support for families and caregivers.
- Person- and caregiver-centered care plans.
- Non-pharmacological protocols for all patients, including those with behavioral symptoms.
- Develop standards for end-of-life care, including obtaining advance directives, "having the conversation" about prognosis and goals for care, opportunities for palliative approaches.

Workforce Development and Support

- Support for all kinds of care providers (professional, paraprofessional, volunteer, family).
- Education and training for all levels of workforce and caregivers; consistent training standards.
- Appropriate pay, health care and other benefits.
- Caregivers have the tools to do the job.
- Professional development and respect for caregiving staff.
- Build workforce in all dimensions: numbers, range of specialties, prestige, self-esteem, compensation.
- Appropriate pay and benefits, commensurate with the work.
- Stigma reduction around the disease and around working with those who have the disease.
- Develop supportive systems for caregivers who are in the workforce.
- Education for employers about how to accommodate and support their caregiving workers.
- Keeping people with early memory loss in the workforce.
- Recruitment of people into the field – starting with those still in high school.
- Creating career paths for caregivers to provide opportunities for advancement.

Education

- Education about the disease (signs and symptoms, brain health, prevention, prognosis; provider/caregiver training about heredity) and its impact on people's lives. Awareness of what is normal and what's not.
- Education about the resources that are available for individuals and families dealing with dementia.
- Provider/caregiver training and decision protocols to prevent situations escalating to crisis.
- Include dementia in medical school curricula.
- Training for law enforcement, EMS and first responders.

Fiscal and Regulatory Reform

- Money should follow the person – people should not be constrained by geographically fixed funding.
- Create financial incentives for physicians and other health care providers to diagnose, treat, follow up and refer for services, payment that allows doctors to spend enough time with patients and families.
- Removal of regulatory disincentives for providers, facilities, families to do the right thing
- Reduce regulatory emphasis on safety at all cost to individual; make it more possible to treat in place, safe harbor for facilities.
- Consider different balance between emphases on individual rights/autonomy and safety.
- Flexibility to be responsive to individual needs.
- Resources to meet needs.
- Public policy strategies that address the public health issues related to dementia.

Decision Support

- Continuous identification of evidence-based practices.
- Measurement of outcomes: data, informatics, assessment tools, quality measures.
- Use of research that measures program efficiency and effectiveness.
- A good business model.
- Alignment of incentives with other components of the system; broad incentives to support system change.

Bright Spots: Promising Practices to Build On

Several participants were invited to share their innovations and best practices, to provide a positive point of departure for subsequent Summit activities. These "bright spots" illustrate practices the presenters have found to be successful approaches to providing quality support and services in different areas of the dementia care system, including community capacity, long term care facilities, crisis intervention, emergency protective placement and care transitions.

A Dementia-Friendly Community

Sue Torum, Director, Aging and Disability Resource Center of Jefferson County

The Aging and Disability Resource Center (ADRC) of Jefferson County has organized a community-wide response to dementia, in partnership with local businesses, service providers, senior housing, the public library, law enforcement, family members, caregivers and others with an interest or concern. The effort is intended to support individuals with dementia in their homes and community through increased awareness and the efforts of local organizations, businesses and individuals.

The ADRC's dementia care specialist organized a local dementia summit to identify issues and launch the effort, and provides outreach to increase community awareness. She also provides training on how to communicate and interact with people with dementia and appropriately respond to the kinds of situations that may arise. The ADRC provides free memory screening. It also helps people affected by dementia to identify potential sources of support, plan how to meet their care needs and address related legal and financial concerns. All ADRC and Adult Protective Services (APS) staff are certified dementia practitioners.

Other community building activities are key features of this effort. Several businesses in Fort Atkinson and Watertown, including the Fort Atkinson library, have had their employees trained and identified themselves as welcoming places that people with dementia can continue to visit as their disease progresses, in order to maintain familiar routines and support quality of life. The Sheriff's Office has created a voluntary registry for people with dementia, so it can contact their families or caregivers if they wander off or get into problematic situations, and is implementing Project Lifesaver to electronically keep track of at-risk individuals. Mobile crisis services are currently not available in the county; however, mental health staff and several physicians who already do home visits are meeting as a group to implement an on-site emergency response.

The goal is to meet people's needs in the community and avoid or delay the need for institutionalization. However, this is not always possible. Facilities are also an important part of the initiative and are being recruited to provide specialty care and accept Chapter 55 emergency protective placements. Two new dementia-specific community based residential facilities (CBRFs) are under construction and will provide 90 more beds. Neither of these CBRFs is a designated emergency placement facility, nor have they expressed interest. However, one nursing home has indicated an interest in becoming designated.

All this has been accomplished in less than a year and Jefferson County is well on its way to achieving its goal of becoming a "dementia-capable" community.

A Coordinated Approach to Dementia in a Long Term Care Facility

Wanda Plachecki, Administrator, Lakeview Health Center, West Salem, WI

Lakeview Health Center in La Crosse County is a regional care center, most of whose residents can no longer be cared for at home or in other facilities. Lakeview takes a comprehensive approach to dementia care, beginning with the transition from the person's prior place of residence. A welcoming committee is assigned to provide staff with information about the person prior to admission and creates a "getting to know you" poster with personal history and other information provided by the individual and his or her family. Staff assignments are made so that the person sees the same faces every day – the same nurses, certified nursing assistants (CNAs), housekeepers and maintenance staff. This helps the resident feel more comfortable and gives staff an opportunity to get to know the person and be able to notice if there is a change or problem developing.

The nurses, social worker and administrator meet every morning to review the preceding 24 hours and have daily "huddles" with direct care workers to talk about how to handle specific situations with individual residents. If a resident needs more urgent care, staff communicate with the mobile crisis team in La Crosse County via phone or e-mail to get ideas about how to handle the situation and head off a crisis. Before asking the mobile crisis team to come on site or calling in the police, the staff team pulls together all the information about the person's plan and the interventions they have tried, to help avoid hospitalization. With this approach in place, Lakeview has not had to hospitalize any resident – with or without dementia – in over a year.

Crisis Stabilization through Serial Trial Intervention

Christine Kovach, RN, PhD, University of Wisconsin-Milwaukee

The Serial Trial Intervention is a method to identify and treat the underlying causes of agitated and disruptive behaviors in people in the advanced stage of dementia who are non-verbal. Underassessment and treatment for pain can be a serious problem for people who are non-verbal and is the root cause of many challenging and disruptive behaviors. Disruptive behavior takes staff time, incites other residents, and is the primary reason for residents being discharged to expensive hospitals and psychiatric institutions which may not be appropriate to meet the person's needs.

Built on the premise that behavior communicates a need, the intervention requires staff to use a decision support tool and step-wise process to solve the problem. The process begins with an assessment to determine if the person has an infection, fracture or other physical cause for the behavior, followed by a decision about whether and how to treat the condition. If the behavior continues, an affective assessment is performed to identify potential sources of stress that can then be addressed by sensory stimulation, calming activities, meaningful interaction, or other changes in the environment. If the behavior continues, then comfort measures and other non-pharmacological interventions are tried. This is followed by analgesics and, if the other efforts are ineffective, then psychiatric consultation and/or psychotropic medication are used. Results obtained from implementing the method in a controlled trial in 12 nursing facilities showed significant reductions in pain, agitation, other (comorbid) medical problems, and stress hormones (cortisol) in the patient's blood. The intervention also resulted in significantly improved assessments of the patient's situation, increased staff persistence in solving the person's unmet need, and a significant increase in use of analgesics to address pain. Dr. Kovach plans to perform a similar controlled trial to test the technique in a community setting.

Emergency Protective Placement

Amy Temby, APS Social Worker, Waupaca County Department of Health and Human Services

Amy Temby told the story of a person with dementia to illustrate the value of emergency protective placement and Adult Protective Services. Rachel[8] lived with an adult son who suffered from mental illness. The home was overrun with animals, including many that had died; the home had an overpowering odor; no running water; and the electricity had been turned off. Neither Rachel nor her son would cooperate with efforts by the APS social worker to intervene. It took law enforcement to get access to the home, where a preliminary assessment indicated that Rachel had profound dementia. Rachel had been isolated from other members of her family, and suffered from clear signs of abuse, neglect and self-neglect. She was carried out of her home under protest, in her rocking chair, and taken to the emergency room, accompanied by Amy. Ultimately, Rachel was placed in a nursing home where, with help from APS and nursing home staff, she was able to re-establish contact with her sisters and brothers and even began to play music again. Her son was charged with abuse and put on a conditional release program with a caseworker, and was able to continue to be involved with his mother in a monitored and more positive way. While APS generally starts with the goal of keeping the person in their home, in this case, Rachel did much better in the nursing home and was able to live out her life there with family connections and a noticeably better quality of life. Emergency protective placement played an essential role in getting Rachel the care and services she needed for the remainder of her life.

Care Transitions with a Dementia Support Team

Rob Gundermann, Alzheimer's and Dementia Alliance of Wisconsin

The Dementia Support Team was established by Dane County Human Services in 2009 to help reintegrate residents with dementia who have been admitted to a psychiatric facility back into the long term care setting. The Team is a collaborative effort on the part of Alzheimer's and Dementia Alliance of Wisconsin, Dr. Kim Petersen, the South Madison Coalition of the Elderly, and Dane County Mental Health. Individuals are enrolled in the program by referral to a case manager at the South Madison Coalition. Alliance staff and Dr. Peterson assess the individual; obtain information from the facility, medical personnel, family members or guardians; conduct cognitive testing when needed; and develop a treatment and intervention plan. The plan includes:

- Diagnosis.
- Medication evaluation and adjustment.
- Evaluation of the facility environment, routines and staff strengths.
- Individualized interventions to minimize challenging behaviors, establish and maintain successful relationships, and create a workable environment for the person.
- An assessment of financial resources and assistance in accessing long term care benefits for those who are eligible.

Team members train staff of the long term care facility where the person is or will be residing about the person's diagnosis, the reasons for behavioral challenges, the person's strengths and life story, and strategies for implementing the intervention plan. Ongoing monitoring is provided by the social work case manager at the Coalition, and the full team is available to provide follow up, additional training and intervention as needed.

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[8] Fictitious name for illustrative purposes only.

The program has been highly effective in working with mental health facilities, having successfully relocated everyone who was referred during the Team's four-year history. The first individual the Team worked with had been housed at Mendota Mental Health Institute for more than nine months at a cost of over $1,000 a day. The Team was able to transition him to a Community-Based Residential Facility within three weeks with no further problems. Team members estimate that 75% of the people they relocate could have been treated in place, if they had received earlier intervention. The Team is now working with residential settings, to help them retain residents with challenging behaviors and avoid the impulse to "just get this person out of here." Preventing an admission by treating the person in non-institutional settings avoids potentially unnecessary trauma and is less costly.

Strategies for Achieving a More Dementia-Capable System of Care

Small group discussions generated the following strategies for achieving a more dementia capable system of care in Wisconsin. These strategies represent ideas generated by Summit participants in each of the five topic areas that have been identified by the Department of Health Services as system elements to be addressed in its plan for redesigning dementia care. These include: community capacity, facility-based long term care, emergency protective placement, care transitions and crisis stabilization.

Community Capacity

1. Increase community awareness of the need for early diagnosis and resource availability by conducting a marketing campaign and expanding the ADRC role.
2. Provide prevention measures and early dementia programming.
3. Involve mobile crisis teams early on, when behaviors are manageable.
4. Take a public health approach to make effective use of resources and build on existing providers in order to scale up coordinated services.
5. Reform reimbursement to incentivize best practices in dementia care.
6. Train police and first responders on dementia and challenging behaviors, with the goal of preventing institutionalization.
7. Create community capacity to respond to crises.
8. Consistent use of screening and diagnostic tools.
9. Have a dementia care specialist/care manager work with the individual throughout the disease course.
10. Support family caregivers by providing structured caregiver support plans.

Facility-Based Long Term Care

11. Revise assisted living and nursing home regulations to incentivize appropriate dementia care.
12. Adjust reimbursement to incentivize dementia care.
13. Provide regional facilities for residents with complex and challenging care needs.
14. Integrate long term care facilities into the community by encouraging them to offer home care services.
15. Establish uniform standards and expectations for facilities and community providers to avoid care transitions.
16. Create a "safe harbor" to allow facilities to care for residents who engage in challenging behaviors in place.
17. Create centers for excellence to expand use of best practices.
18. Use dementia care specialists to coach and mentor staff.
19. Establish an accreditation process, instead of regulation, for dementia care.
20. Incentivize facilities to build a business model that meets standards of dementia care, including payment for staff trainers and consultants to provide excellent care.

Emergency Protective Placement

21. Use evidence-based practice for person centered care.
22. Create a separate statute for emergency protective placement of people with cognitive impairments.
23. Create regional mobile crisis teams, using the Wisconsin Star Method for assessment.
24. Incentivize Chapter 55 designated facilities with expertise in dementia by increasing reimbursement for emergency protective placements.
25. Change the law so that county workers can evaluate people for emergency protective placement.
26. Remove legal obstacles to getting timely emergency protective placements.
27. Have integrated teams that involve mental health, APS, county aging staff and law enforcement, any of whom is authorized to initiate a placement and all of whom are expected to work together.
28. Create regional capacity to assess and treat dementia; additional capacity is needed in rural areas especially.
29. Integrate and coordinate care provided by primary care doctors, emergency rooms and ADRCs to prevent or minimize emergency placements.

Care Transitions

30. Establish community care collaborations statewide to reduce admissions.
31. Ensure transferability of medical records across the spectrum of care.
32. Use telemedicine and other technologies to improve care transitions.
33. Make care management available statewide, regardless of payer source or entry point.
34. Establish an elder court which is familiar with and able to deal with dementia, using the California model as an example.
35. Establish a single statewide call line for accessing resources.
36. Implement a standardized transition process.
37. Make dementia capable teams available to provide crisis response and care in place.
38. Have statewide resource specialists available to triage, consult on what can be done, and follow the person through the transition process.
39. Establish memoranda of understanding between providers and specialists regarding provision of support during care transition.

Crisis Stabilization

40. Use person centered care plans that follow the person before, during and after crises.
41. Build capacity for mobile crisis units.
42. Improve diagnosis and assessment for people with multiple co-morbidities.
43. Use physician extenders.
44. Follow a process to admit, stabilize and then transfer people to an appropriate setting.
45. Use technology such as telemedicine smart phones and Skype to access specialty services, especially in rural areas where access is lacking.
46. Use non-police transfers, with no handcuffs or cages.
47. Expand authority for APS to offer help before starting the emergency placement process, to avoid having to go to court and possibly avoiding the need for placement.

48. Involve emergency rooms in crisis stabilization.
49. Implement a 911 response to crises involving people with dementia, to access information on a registry that could be helpful in de-escalating the situation before a mobile crisis unit is called in.
50. Use a community paramedic model to provide crisis service in the home.
51. Develop regional crisis response systems.
52. Use interveners available in the various facility and community based settings who can assess and potentially diffuse the situation. Interveners could be facility staff or mobile teams.
53. Establish more placement facilities capable of providing care in crisis situations.
54. Realize that there is "no happy ending" for everyone; provide better connections to hospice care.

Priority Recommendations

The following is a short list of priority recommendations developed by Summit participants. These were arrived at by having each of the six small groups pick its top two or three priorities from the previously identified strategies and then post their recommendations for large group review. The facilitator then led a consensus based discussion to arrive at the final short list of strategies. The process included combining numerous strategies since they were closely related. The recommendations below have unanimous support of the planning group as the top priorities for action.

1. Increase community awareness of dementia issues and of the resources available to provide support to individuals with dementia and their family caregivers.

2. Expand the use of dementia care specialists and case managers to coordinate care, help with transitions, and work with individuals and their families throughout the disease process.

3. Revise state regulations to allow for "safe harbors" that let facilities care for residents who engage in challenging behaviors in place with less fear of liability or regulatory penalties.

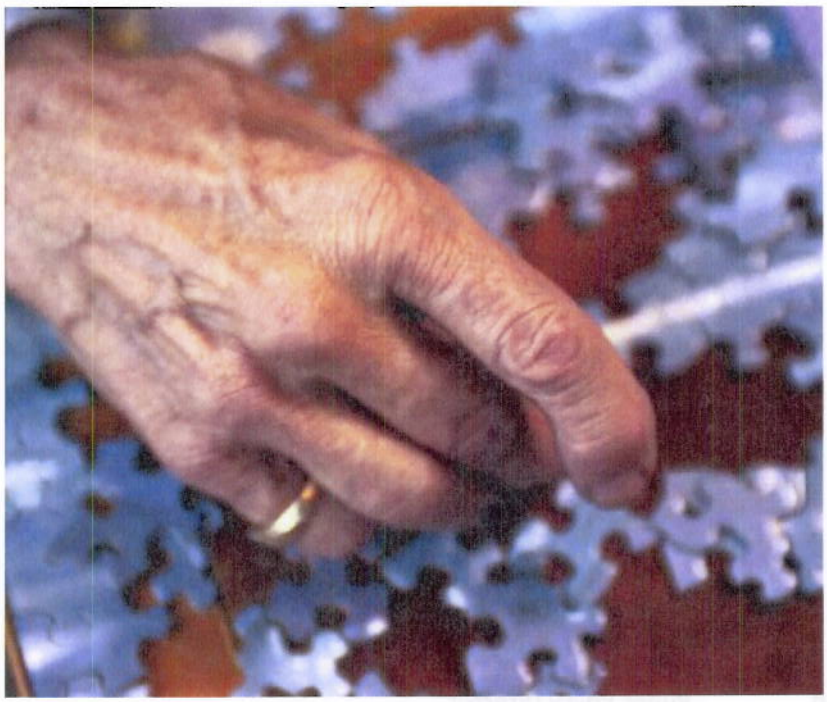
4. Create fiscal and systemic incentives for best practices.

5. Expand mobile crisis teams to assess and diffuse difficult situations and help avoid the need for institutional placement.

6. Create the placement facility capacity to care for people with complex and challenging behavior needs.

Next Steps

The Secretary of the Department of Health Services has committed the Department to shepherding a redesign of the system of dementia care in Wisconsin. The Department and The Johnson Foundation at Wingspread co-hosted the Dementia Care Stakeholder Summit for the express purpose of engaging representatives of key stakeholder groups in a collaborative effort to identify top priorities for this system redesign. Thanks to the dedicated efforts of Summit participants, enhanced by a setting that was conducive to a collective effort, this goal was achieved. The next step is for the Department, informed by the Summit priorities, to develop a *"Plan for a Dementia Capable System of Care"* to address gaps in the current care delivery infrastructure and expand community and crisis services for people with dementia. The focus of the *Plan* will be on steps the Department can take, working with its many partners, to address gaps in the current care delivery infrastructure and expand community and crisis services for people with dementia. The timeline is short; the Department intends to share a draft of the *Plan* by the end of the year. After a period of comment by stakeholders, the *Plan* will be finalized early in 2014 and will be used to guide the work of the Department in the coming years.



List of Summit Participants

Jonette Arms	Assistant Director Milwaukee County Department on Aging Milwaukee, WI
Suzanne Bottum-Jones	Director of Education and Outreach Programs Wisconsin Alzheimer's Institute Madison, WI
Michelle Braun	Neuropsychologist Department of Neurology and Neurosurgery Wheaton Franciscan Healthcare - All Saints Racine, WI
Heather Bruemmer	Executive Director/State Ombudsman Board on Aging and Long Term Care Madison, WI
Lou Bruner	Caregiver Waukesha, WI
Tim Carpenter	State Senator, 3rd Senate District Milwaukee, WI
Al Castro	Program Director United Community Center Milwaukee, WI
Mike Endsley	Representative, 26th Assembly District Sheboygan, WI
Kristen Felten	Alzheimer's Specialist Wisconsin Department of Health Services Madison, WI
Mary Gavinski	Chief Medical Officer Community Care, Inc. Milwaukee, WI 53215
Rob Gundermann	Public Policy Director Alzheimer's and Dementia Alliance of Wisconsin Madison, WI
Linda Harris	Administrator, Division of Mental Health and Substance Abuse Services Wisconsin Department of Health Services Madison, WI

Linda Helmick	Health Division Director Forest County Potawatomi Community Crandon, WI
Tom Hlavacek	Executive Director Alzheimer's Association - Southeastern Wisconsin Milwaukee, WI
Christine Kovach	College of Nursing University of Wisconsin - Milwaukee Milwaukee, WI 53201
Nicholas Lange	Assistant Corporation Counsel Dunn County Menomonie, WI
Barbara Larson-Herber	Executive/Program Director Shawano County Department of Community Programs Shawano, WI
Michael Malone	University of Wisconsin School of Medicine & Public Health Aurora Health Care Milwaukee, WI
Carrie Molke	Director, Bureau on Aging and Disability Resources Wisconsin Department of Health Services Madison, WI
Tom Moore	Executive Director Wisconsin Health Care Association Madison, WI
Wanda Plachecki	Administrator Lakeview Health Center West Salem, WI
Helen Ramon	Program Officer Helen Bader Foundation Milwaukee, WI 53202
Molli Rolli	Medical Director Mendota Mental Health Institute Madison, WI
Faith Russell	Project Manager, Office of Policy Initiatives and Budget Wisconsin Department of Health Services Madison, WI

John Sauer	President/CEO LeadingAge Wisconsin Madison, WI
Brian Shoup	Administrator, Division of Long Term Care Wisconsin Department of Health Services Madison, WI
James Small	Police Chief The City of Altoona Altoona, WI
Mathew Stanford	Vice President Wisconsin Hospital Association Madison, WI 53711
Amy Temby	Adult Protective Services Social Worker Waupaca County Department of Health and Human Services Waupaca, WI 54981
Susan Torum	Aging & Disability Resources Division Manager Aging and Disability Resource Center of Jefferson County Jefferson, WI
Gloria Vaughn	Community Services Supervisor Aging and Disability Resource Center of Barron County Barron, WI
Otis Woods	Division Administrator, Division of Quality Assurance Wisconsin Department of Health Services Madison, WI
Beth Wroblewski	Deputy Administrator, Division of Long Term Care Wisconsin Department of Health Services Madison, WI

Facilitator

Richard Rhyme	President RR Consulting Group Madison, WI

Staff

Cindy Ofstead	Director, Office on Aging Wisconsin Department of Health Services
Wendy Fearnside	Policy Analyst, Office for Resource Center Development Wisconsin Department of Health Services

APPLICATION COVER SHEET AND TABLE OF CONTENTS

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APPLICANT INFORMATION FORM

Application preparer: Susan Torum, Aging & Disability Resources Division Manager

Address: Aging & Disability Resource Center of Jefferson County
1541 Annex Road
Jefferson, WI 53549

Telephone Number	920-674-8136
Fax Number	920-674-8734
E-Mail Address	suet@jeffersoncountywi.gov

Transportation projects administrator: Susan Torum, Aging & Disability Resources Division Manager

Address: Aging & Disability Resource Center of Jefferson County
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Telephone Number	920-674-8136
Fax Number	920-674-7603
E-Mail Address	suet@jeffersoncountywi.gov

Person(s) who will submit required reports: Susan Torum & Mary Jurzcyk, Fiscal Department

Address: Aging & Disability Resource Center of Jefferson County
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Jefferson, WI 53549

Telephone Number	920-674-8143
Fax Number	920-674-7603
E-Mail Address	maryj@jeffersoncountywi.gov

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Jefferson County Human Services Department
Aging & Disability Resource Division
1541 Annex Road
Jefferson, WI 53549

December , 2013

Chief, Public and Specialized Transit Section
Bureau of Transit and Local Roads, Railroads and Harbors
Wisconsin Department of Transportation
P.O. Box 7913
Madison, WI 53707-7913

Dear Transit Section Chief:

Jefferson County hereby makes a 2014 application for $181,805 in state assistance under section 85.21 of Wisconsin Statutes to provide specialized transportation services for the elderly and persons with disabilities in 2014. The County assures that a minimum of $36,361 in local funds has been included in its adopted 2014 budget and will be available as the share required to match the 85.21 grant.

I hereby affirm that the information submitted in this application is true and correct.

Sincerely,

_____
Name

Director
Title

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ACCESSIBILITY STATEMENT

Jefferson County uses s 85.21 funding to provide equivalent transportation services to individuals with disabilities under contracts with two paratransit providers: LaVigne's Bus Company and St. Coletta of WI. Both contractors provide accessible services to non-ambulatory individuals.

Jefferson County operates two programs that directly provide hands on assistance to persons who cannot walk or who walk with assistance. Service is provided via Jefferson County's paid drivers or its volunteers. The vehicles used are owned and operated by Jefferson County or its volunteers.

County provided services are popular with many older people because of the personal services the drivers provide including accompaniment to/from appointments, assistance with carrying packages and 1:1 assistance when needed to ambulate or walk up steps. All drivers are capable of transporting people using wheelchairs provided that the individual can transfer with minimal assistance into the driver's vehicle.

$2,000 of s 85.21 funding will be set aside in order to fund wheelchair accessible transportation to medical related appointments when other funding sources have been exhausted. Funds are used to purchase services from LaVigne's Bus Company, St. Coletta of WI and Brown Cab Company.

COORDINATION

Current transportation resources: Jefferson County has two shared-ride taxi cab companies in the county serving 4 communities. Their fleets include accessible vehicles. In addition, St. Coletta of WI and LaVigne's Bus Company has a large fleet of accessible vehicles. St. Coletta is a Section 53.10 grant recipient.

Transportation needs and gaps for the elderly and disabled populations: According to the 2012 census, 14% of the county's population is age 65+ and approximately 6% are non-elderly, disabled individuals. On 11/12/12, the Community Transportation Association of America (CTAA) facilitated a Mobility Visioning Workshop with providers from Rock and Jefferson County. The needs that were identified as most needed by the elderly and persons with disabilities are as follows (in no particular order): medical (dialysis & wound clinic); visiting families in care facilities; shopping outside of the local community. Some barriers identified include: services are not available with people need them; services are not coordinated; lack of interest in addressing transportation issues and funding.

Coordination plan goals/strategies/activities established to remedy the needs and gaps:

Jefferson County's ***Coordinated Public Transit-Human Services Transportation Plan*** was reviewed on 9/9/2013; the goals, which are based on service gaps, are as follows:

- **Increase rural transportation options and/or service for the transportation disadvantaged by**: improving/expanding service hours, geographic coverage, driver assistance, same-day service; combining efforts to collectively recruit volunteer driver/escort programs to deliver services; reaching out to service organizations to recruit volunteers, i.e. Lions Club to assist in transporting those with low-vision; increasing Taxi Cab services/availability; increasing the availability of accessible vehicles; exploring opportunities for car repair and gas vouchers and by continuing to advocate for and provide support to committee members, in their application of 5310 and 85.21 funding, which would increase transportation access and availability

- **Coordinate and consolidate transportation services** by ongoing support of the CTAA study of Hwy 26 corridor; collaborating with county/city/non-profit agencies to consider joint purchasing options for fuel, vehicle maintenance, driver training and substance abuse testing; sharing the use of operational resources, (vehicles, facilities, support services and dispatch services); assessing available services and determine efficiency.

- **Develop and improve communication of transit options and resources** by creating a centralized listing of county and/or regional transit services; exploring options for coordination software to match users with providers based on eligibility; engaging all transportation providers and stakeholders to be active in Coordination Plan and attend bi-annual meetings; identifying and more actively promoting ride share programs, i.e. state vans, on-line resources, Shared Ride WI and by exploring options for grocery and pharmacy services.

- **Increase transportation resources** by engaging transportation providers and county-wide agencies to provide accurate statistical information on a bi-annual basis and maintaining awareness of current resources and readiness.

- **Increase community awareness and access to information about transportation issues in the county** by engaging political, county and municipal representatives in the Coordination process; developing educational tool(s) to increase community awareness of transportation issues; developing new or enhance electronic access as a vehicle for above mentioned tools and exploring connection to 2-1-1 system.

The collaborating partners in developing the Coordinated Plan were: St. Coletta, the City of Watertown, Your Friends-in-Action Volunteer Network, Brown Cab, UW-Extension Office, and Jefferson County employees from Economic Support, Transportation and the ADRC.

Description of how specialized transportation services in the county are coordinated: County provided transportation services are co-located within the ADRC. The Transportation Coordinator is aware of all transportation resources and schedules ride requests accordingly. Coordination between providers still problematic as there is no central scheduling. A study by the Community Transportation Association of America may address this concern. See page 6 for more information.

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Identify the collaborating partners in coordination, including participation in the s. 85.21 application development and approval:

The Aging & Disability Resource Center (ADRC) Advisory Committee and Human Services Board establish policy and procedures for county provided transportation services. These entities are responsible for reviewing and approving the s 85.21 plan including any project changes as a result of the coordination plan. Transportation is on ongoing topic of discussion at monthly meetings. The county is not part of a regional planning commission, nor does it have a Transportation Coordinating Committee.

Community Transportation Association of America (CTAA) Study

In addition to reviewing and amending the Coordinated Plan, Jefferson County has been involved in the Community Transportation Association of America's (CTAA) study of transportation needs in Jefferson and Rock Counties specifically along the highway 26 corridor. The study is being conducted by SRF Consulting Group and deliverables include:

- Create of a provider inventory
- Quantify transit needs/gaps in the study area
- Develop alternates for transit services
- Refine preferred alternative
- Prepare reports to document the project process and outcomes.

Among the various alternatives, SFR was asked to focus its efforts on two: The first would create a "One-Call" Transportation Resource Center; the second alternative would create taxi service county-wide.

As a result of the study intra-county taxi service will be offered on a limited basis in 2014. Ride requests will go through the Transportation Coordinator for assignment. The development of this service meets several of the goals in the Coordination Plan.

SERVICE PRIORITIES

Jefferson County intends to use trip purpose priorities for all specialized transportation projects funded with s 85.21 aids. Priority shall be given to elderly or disabled consumers needing transportation to medical care and/or nutrition services.

PROJECTS

Project 1: Driver-Escort

1. The general type of service is driver escort.

2. The organization sponsoring and providing this service is the Jefferson County Human Services Department through the ADRC. The Department employs a Transportation

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Coordinator; part-time drivers and utilizes volunteers. Volunteer drivers are recruited and trained by the Transportation Coordinator.

The Human Services Department contracts with LaVigne's Bus Company, St. Coletta and Brown Cab Service for accessible transportation when requested.

3. This project does not use s. 85.21 funds as local match for federal funding.

4. Jefferson County does not own any wheelchair accessible vehicles. The number, type and capacity of vehicles used is as follows:

   - 2011 Dodge Grand Caravan, 7 passenger van (county owned);
   - Two new vehicles (to be purchased in January 2014).
   - Private vehicles (owned, maintained and insured by volunteer drivers); and
   - Contractors maintain their own fleet of vehicles - see inventory.

   Volunteer drivers must certify that they have met the vehicle insurance requirements as established by the county. The liability limits are as follows: $50,000; $100,000 & $10,000.

5. The hours of operation for the service are as follows: 6:00 a.m. to 6:00 p.m. Monday – Friday. Service is available throughout Jefferson County.

6. The level of service offered is door-to-door.

7. The manner in which services may be requested is via a reservation system that requests notice at least four days in advance. Any person using the Driver/ Escort Program will be asked to limit their requests for service to two times per week. The Transportation Coordinator makes every attempt to accommodate late requests.

   Individuals wishing to use county subsidized wheelchair accessible transportation are required to contact the Program Administrator or Transportation Scheduler to make arrangements.

8. The types of passengers eligible for this service include the elderly and adults with disabilities who need transportation to access medical services and meet their nutritional needs. Also prioritized are Human Services Department clients who need transportation to agency appointments. When transportation is provided to a disabled child, a parent, or other responsible adult, is required to accompany them.

9. The passenger revenue policy requires passengers to make a co-payment toward the cost of all trips provided. In 2013 co-payments have been set at: $1.00 for in-county, one-way trips and $5.00 for out-of-county one-way trips. Co-payments shall be collected by the driver at the time of service and are subsequently turned over to the Transportation Scheduler. All co-payments are used to offset costs.

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Individuals requesting wheelchair transportation shall be asked to contribute $1.00 for in-county, one-way trips and $5.00 for out-of-county one-way trips.

Driver's shall collect co-payments for county operated transportation services at the time of service. The county, rather than the service provider, shall collect co-payments for wheelchair van transportation. All contributions are used to offset costs.

Trips provided to passengers enrolled in managed care are authorized and paid for by the managed care organization. The county is reimbursed the full-cost associated with each trip.

Project 2: Senior Dining Program Taxi Subsidy

1. The general type of service provided is a user-side subsidy of the taxi service to the Senior Dining Programs located in Jefferson, Fort Atkinson, Lake Mills and Watertown.

2. The organization sponsoring this service is the Human Services Department. The taxi cab companies providing the service are Brown Cab Company & Watertown Passenger Transit.

3. This project does not use s. 85.21 funds as local match for federal funding.

4. The number, type and capacity of vehicles expected to be used are owned and operated exclusively by the taxi companies, who own a combination of taxi cabs and accessible mini vans.

5. The hours of subsidized service are from 10:00 a.m. to 2:00 p.m. weekdays in Fort Atkinson, Jefferson and Lake Mills. This project will be expanded into Watertown in 2014. The remaining areas of the county do not have taxi service available.

6. The level of service offered is shared ride, curb-side service following no particular route.

7. The manner in which services may be requested is by calling the cab companies directly. This may be done on the day transportation is required or by calling ahead of time. Users run the risk of waiting if calls are made at the last minute, otherwise service is generally timely.

8. The types of passengers eligible for this service and subsidy are elderly persons (60+), and their spouses who are attending a Senior Dining Program.

9. The passenger revenue policy for this project is a required co-payment; passengers pay the difference between the subsidy (.75 cents per ride) and the actual cost of the service which varies dependent upon each community. The difference is paid directly to the cab driver at the time of service.

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Project 3: Intra-County Taxi Service

1. The general type of service provided is a user-side subsidy of taxi cab service to take people to medical appointments on a county-wide basis.

2. The organization sponsoring this service is the Human Services Department; the company providing the service is Brown's Cab Company.

3. This project does not use s. 85.21 funds as local match for federal funding.

4. The number, type and capacity of vehicles expected to be used are owned and operated exclusively by the taxi company, who owns a combination of taxi cabs and accessible mini vans.

5. The hours of operation are from 6:00 a.m. to 7:00 p.m. Monday-Friday.

6. The level of service offered is shared ride, curb-side service following no particular route.

7. The manner in which services may be requested is by calling the Human Services Department's Transportation Coordinator. This may be done on the day transportation is required or by calling ahead of time. Users run the risk of waiting if calls are made at the last minute, otherwise service is generally timely.

8. The types of passengers eligible for this service are elderly persons (60+) and individuals with disabilities.

9. The passenger revenue policy for this project is a required co-payment; passengers pay

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EQUIPMENT ACQUISITIONS; PLAN FOR AIDS HELD IN TRUST

S 85.21 TRUST FUND PLAN

ITEM	OWNER OF EQUIPMENT	PROJECTED COST	PLANNED YEAR OF PURCHASE
Mini Van	Jefferson County	$25,000	2016

County	Jefferson	Prepared By	Susan Torum
Organization	Jefferson County Human Services	Date	11/1/2013
Amount of s.85.21 aid held in trust as of 9/30/13		$25,621.80	
Total projected cost for this plan		$5,000	

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2014 Project Budget #1

County	Jefferson
Project Name	Driver Escort Program

Section	Description		Amount
1. Annual Expenditures/Expenses			
	Personal Services		
	Drivers/Mechanics (salaries, wages, fringe benefits)		$38,235.00
	Administrative Personnel (salaries, wages, fringe benefits)		$80,497.00
	Volunteer Driver Reimbursement		$49,177.00
		Total:	**$167,909.00**
	Contractual Services		
	Transportation Contractor(s)		
1.	Brown Cab - SMV		$600.00
2.	LaVigne's Bus Company - SMV		$700.00
3.	St. Coletta of WI - SMV		$700.00
4.			
5.			
	Repairs and Maintenance		
	Utility Services		
	Other Contractual Services		
		Total:	**$2,000.00**
	Fare Assistance Programs		
	Fare Assistance	Total:	
	Office Operations		
	Office Supplies & Expenses	Total:	$450.00
	Vehicle Operations		
	Fuel and Lubricants		$6,593.00
	Tires, Parts and Supplies		
	Vehicle Leases		
		Total:	**$6,593.00**
	Fixed Charges		
	Insurance		$600.00
	Facility Rental		
	Communications Equipment & Other Rentals		
		Total:	**$600.00**
	Capital Outlay		
	Major Maintenance (greater than $1,000)		
	Capital Equipment (describe below)		
1.	2013 Auto		$20,000.00
2.	2013 Van		$22,000.00
3.	Trust Fund		$5,000.00
		Total:	**$47,000.00**
	Indirect Costs		

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Specify Types of Costs Covered:

1.	Depreciation	$2,891.00
2.	County Indirect	$7,541
3.		
	Total:	**$10,432.00**

Section	Description		Amount
2. Annual Net Expenditures - Summary			
	Total Annual Expenditures & Expenses		**$234,984.00**
	Passenger Revenue		$25,118.00
	Net Expenditures (summary)	Expenses minus Revenue	**$209,866.00**
3. Annual Net Expenditures - Breakout By Funding Source			
	A. s.85.21 Funds from Annual Allocation		$175,620.00
	B. s.85.21 Funds from Trust Fund		$34,246.00
	C. County Funds		
	D. Medicaid		
	E. Other Funds (describe below)		
1.			
2.			
3.			
4.			
5.			
6.			
	Net Expenditures (breakout)	Funding payouts	**$209,866.00**

Summary vs. Breakout Cross-check: This value will equal zero (0) when the totals of Section 2 and 3 are the same.	Checksum	**$0.00**

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Specify Types of Costs Covered:

1.
2.
3.

Total: **$0.00**

Section	Description		Amount
2. Annual Net Expenditures - Summary			
	Total Annual Expenditures & Expenses		**$1,050.00**
	Passenger Revenue		
	Net Expenditures (summary)	Expenses minus Revenue	**$1,050.00**
3. Annual Net Expenditures - Breakout By Funding Source			
	A. s.85.21 Funds from Annual Allocation		$787.00
	B. s.85.21 Funds from Trust Fund		$263.00
	C. County Funds		
	D. Medicaid		
	E. Other Funds (describe below)		
1.			
2.			
3.			
4.			
5.			
6.			
	Net Expenditures (breakout)	Funding payouts	**$1,050.00**

Summary vs. Breakout Cross-check:
This value will equal zero (0) when the totals of Section 2 and 3 are the same.

Checksum **$0.00**

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2014 Project Budget #3

County	Jefferson
Project Name	Intracounty Taxi Program

Section	Description		Amount
1. Annual Expenditures/Expenses			
	Personal Services		
	Drivers/Mechanics (salaries, wages, fringe benefits)		
	Administrative Personnel (salaries, wages, fringe benefits)		
	Volunteer Driver Reimbursement		
		Total:	**$0.00**
	Contractual Services		
	Transportation Contractor(s)		
1.	Brown Cab		$9,000.00
2.			
3.			
4.			
5.			
	Repairs and Maintenance		
	Utility Services		
	Other Contractual Services		
		Total:	**$9,000.00**
	Fare Assistance Programs		
	Fare Assistance	Total:	
	Office Operations		
	Office Supplies & Expenses	Total:	
	Vehicle Operations		
	Fuel and Lubricants		
	Tires, Parts and Supplies		
	Vehicle Leases		
		Total:	**$0.00**
	Fixed Charges		
	Insurance		
	Facility Rental		
	Communications Equipment & Other Rentals		
		Total:	**$0.00**
	Capital Outlay		
	Major Maintenance (greater than $1,000)		
	Capital Equipment (describe below)		
1.			
2.			
3.			
		Total:	**$0.00**
	Indirect Costs		

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Specify Types of Costs Covered:

1.
2.
3.

Total: **$0.00**

Section	Description		Amount
2. Annual Net Expenditures - Summary			
	Total Annual Expenditures & Expenses		**$9,000.00**
	Passenger Revenue		$1,500.00
	Net Expenditures (summary)	Expenses minus Revenue	**$7,500.00**
3. Annual Net Expenditures - Breakout By Funding Source			
	A. s.85.21 Funds from Annual Allocation		$5,625.00
	B. s.85.21 Funds from Trust Fund		$1,875.00
	C. County Funds		
	D. Medicaid		
	E. Other Funds (describe below)		
1.			
2.			
3.			
4.			
5.			
6.			
	Net Expenditures (breakout)	Funding payouts	**$7,500.00**

Summary vs. Breakout Cross-check:
This value will equal zero (0) when the totals of Section 2 and 3 are the same.

Checksum **$0.00**

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2014 County Project Budget Summary

County/Project Name	Jefferson County			Totals
	Driver Escort	Taxi Subsidy	Intra-County Taxi	
Projected Expenses				
Total Projected Expenditures	$234,984.00	$1,050.00	$9,000.00	$245,034.00
Total Projected Passenger Revenue	$25,118.00	$0.00	$1,500.00	$26,618.00
Net Expenditures	$209,866.00	$1,050.00	$7,500.00	$218,416.00

Projected Expenses by By Funding Source				
A. s.85.21 Funds from Annual Allocation	$175,620.00	$787.00	$5,625.00	$182,032.00
B. s.85.21 Funds from Trust Fund move)	$34,246.00	$263.00	$1,875.00	$36,384.00
C. County Funds	$0.00	$0.00	$0.00	$0.00
D. Medicaid	$0.00	$0.00	$0.00	$0.00
E. Other Funds				
Specify Other Funding Source: Managed Care Contracts	0	0	0	
	$18,918.00	$0.00	$0.00	$18,918.00
Specify Other Funding Source: Co-Payments	0	0	0	
	($6,200.00)	$0.00	($1,500.00)	$7,700.00
Specify Other Funding Source	0	0	0	
	$0.00	$0.00	$0.00	$0.00
Specify Other Funding Source	0	0	0	
	$0.00	$0.00	$0.00	$0.00
Specify Other Funding Source	0	0	0	
	$0.00	$0.00	$0.00	$0.00
Specify Other Funding Source	0	0	0	
	$0.00	$0.00	$0.00	$0.00
Total Funding:	$209,866.00	$1,050.00	$7,500.00	$218,416.00

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PUBLIC HEARING NOTICE FORM

Date of notice publication:
Date of public hearing: December 2, 2013
Number of days notice provided for public hearing: 23
(Attach copy of dated published notice here)

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THIRD PARTY CONTRACTING FORM

Proposed Project Name	Anticipated Contractor Name	FEIN	Contract Required (Yes/No)	Bidding Required (Yes/No)	Year Last Bid	Date of Contract	Contract Term (in years)
Driver Escort	Brown Cab		LOA	No	No	01/01/14-12/31/14	1 year
Driver Escort	LaVigne's Bus		LOA	No	No	01/01/14-12/31/14	1 year
Driver Escort	St. Coletta		LOA	No	No	01/01/14-12/31/14	1 year
Senior Dining Program Taxi Subsidy	Brown Cab		LOA	No	No	01/01/14-12/31/14	1 year
Intra-County Taxi Service	Brown Can		LOA	No	No	01/01/14-12/31/14	1 year

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