Wisconsin BPDD

Real Lives, Real Change

Board Meeting Packet

November 18-19, 2020
Virtual meeting

Board Meeting

November 18th-19th, 2020
Virtual Meeting

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November 2020

Dear BPDD Board Members,

"Caregivers are **SUPER HEROES** in comfortable clothes!"

Happy November to all! November is **National Family Caregiver Month**. While we don't need a national holiday to express our appreciation for all of the work, care, and love caregivers provide, let us take some time this month to express our gratitude to all the caregivers in our communities and throughout the State of Wisconsin. We are truly grateful for all that you do to ensure people with disabilities can live safely and productively in their homes and communities!

I want to thank all who attended and participated in our very first-ever virtual Self-Determination Conference. I have no doubt that planning and hosting a virtual conference raised many challenges for organizers, attendees and speakers. However, we can't overlook all the positive aspects that the virtual environment offered to many who are otherwise marginalized due to transportation, accessibility, and many other challenges. The success of our virtual conference this year is triggering a paradigm shift in how our future conferences could look. It is definitely worthwhile exploring a hybrid option providing for both in person and virtual presenters, attendees and participants for our future conferences. This is truly exciting and inspiriting! A special **Acknowledgement**, **Thank You**, and **Congratulations** to our BPDD staff and especially Fil for all the work, efforts and support they provided to ensure we had a successful conference in the midst of a global pandemic. You all ROCK!

Our November meeting agenda has a very demanding schedule. We scheduled two State Plan work sessions: one on Wednesday afternoon from 3:00 – 5:00 p.m. and one on Thursday from 10:30 a.m. to 12:00 noon. Thursday's agenda also includes Governmental Affairs updates from 8:30 – 9:30 a.m.; DRW Annual Plan presentation and discussion from 9:30 – 10:00 a.m. and a brief discussion of the Governor's Task Force on Caregiving Report from 10:00 – 10:15 a.m. Please come prepared to participate and contribute by reviewing the meeting agenda ahead of time and reading all documents included in the board meeting packet.

November is my favorite month of the year! It is the month of Thanksgiving. It's the month set aside to pause and take time to reflect on all the great people and things we have to be thankful for in our lives, communities, state and country. This year my heart, thoughts and prayers are also with many who have been affected by COVID -19 and who will be missing loved ones at their Thanksgiving table. As I close this letter, I want let you know that I am truly thankful to know and to work with each one of you: Board Members and Board Staff. I am truly grateful to be able to work with and to serve people with disabilities and their families in this great State of Wisconsin.

In the spirit of service and thanksgiving,

Elsa Diaz-Bautista

Elsa Diaz-Bautista

Board Chair, Wisconsin Board for People with Developmental Disabilities

BOARD AGENDA NOVEMBER 18-19, 2020

WEDNESDAY, NOVEMBER 18, 2020

Time	Symbol	Topic	Facilitator/Presenter
2:30-3:00 PM		Member Caucus	Staff: Jeremy Gundlach
3:00-5:00 PM		State-Plan	Staff: Molly Cooney

THURSDAY, NOVEMBER 19, 2020

Time	Symbol	Topic	Facilitator/Presenter
7:45-8:30 AM		Welcome and Technical Assistance (meeting starts at 8:30am)	All
8:30-9:30 AM		Governmental Affairs	Staff: Tami Jackson
9:30-10:00 AM		DRW PADD Plan	Mitch Hagopian
10:00-10:15 AM		Governor's Task Force on Caregiving - Report	Elsa Diaz-Bautista/Beth Swedeen
10:15-10:30 AM		Break – FILL OUT, SIGN, AND RETURN TRAVEL VOUCHERS to BPDD STAFF	All
10:30-12:00 PM		State-Plan	Staff: Molly Cooney

= Meal   =Meeting   =Presentation   =Vote   =Walking Activity   =Break
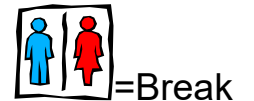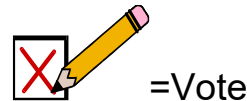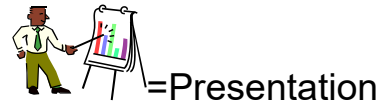
12:00-12:15		Public Comments	
12:15-12:45 PM		**Business Meeting** • Chair Report • Executive Director Report • Executive Committee • Diversity Committee • Nominating & Membership Committee • Partner Agency updates	All • Elsa Diaz-Bautista • Beth Swedeen • Elsa Diaz-Bautista • Andy Thain • Ashley Mathy • DRW, DPI, DHS, DWD, Waisman
		Business Meeting Action Items Motion to accept September 2020 Board Minutes	All

= Meal =Meeting =Presentation =Vote =Walking Activity =Break

Wisconsin BPDD

BOARD MEETING MINUTES - DRAFT

Present:	**Vice Chair:** Greg Meyer, Barbara Beckert, Kevin Coughlin, Pam DeLap, Patrick Friedrich, Desi Kluth, Ashley Mathy, Nathan Ruffolo, Andy Thain, George Zaske, Pam Malin, Stephenie Mlodzik, Daniel Parker, Alicia Reinhard, Hector Portillo, Tricia Thompson, Daniel Parker, Meredith Dressel, Chris Wood, Sydney Badeau, Amy Whitehead, Kelly Weyer, Shannon Mattox, Gail Bovy,
Absent:	Kedibonye Carpenter, Elsa Diaz-Bautista, Houa Yang,
Staff Present:	Fil Clissa, Molly Cooney, Jeremy Gundlach, Kaitlin McNamara, Jenny Neugart, Beth Swedeen, Sally Flaschberger, Natasha Fahey-Flynn, Tami Jackson,

Vice Chair Greg Meyer called the meeting to order at 10:15 AM.

Budget Report:

- Beth gave an update on the closing of our fiscal year 19 funds. Our accountant is finishing closing out the FY19 funds. We are spending our FY20 funds currently. It is looking like the FY21 funds will be late due to congress.

1. Chair Report:

- Vice Chair Greg Meyer thanked board members who have been helping with State-Plan and other board work. He also asked that people attend Tami's presentations either today or tomorrow.

2. Executive Director Report:

- Executive Director Beth Swedeen asked Fil Clissa to talk about the 2020 Virtual Self-Determination Conference. The Conference is at the end of October and is free this year. We have many new board members who have never attended so this is a perfect way to experience the conference during the Pandemic. Fil went through the conference agenda and described how the virtual experience will work. Beth also discussed our ongoing recruitment for the Partners in Policymaking program. She also gave updates on the Disability Vote coalition efforts to support people with disabilities to vote. Barbara Beckert gave an update on the priorities and upcoming events through the Disability Vote Coalition. Barbara asked that Board members and staff act as Voting Ambassadors to help those who have been isolated this year, to register/vote.

3. Executive Committee Report:

- The Exec committee met in August to plan the September board meeting and will be meeting in October to plan to November board meeting.

4. Nominating & Membership Committee Report:

- Did not meet.

5. Diversity Committee Report:

- Chair Andy Thain gave an update on the committee's Monday meeting. The committee discussed the State-Plan community conversations and also the targeted disparity goal for the state-plan.

6. Agency Updates:

DRW: Updates, DVC updates, Karen Avery Forum
DHS: Updates

Waisman: Updates, Org Chart

DVR:
- DVR: Referrals and Applications continue to be down as a result of COVID
- DVR is continuing to provide services remotely. Our staff are available to meet in person if necessary.
- Pre-Employment Transition Services continue to be provided even if schools are learning virtually
- Project Search Update:
  - 22 of 27 sites completed 2019-20 year
  - Interns graduated from all 27 sites (two rotations were sufficient)
  - Later start dates for 2020-21 year
  - Some sites may have alternate locations instruction/vocational skills to ensure social distancing
  - Two sites on hiatus for 2020-21 year (Watertown Memorial Hospital and Janesville Mercy)
- Act 178 (Competitive Integrated Employment Act) report was submitted by June 30.
  - https://dwd.wisconsin.gov/dwd/publications/dvr/pdf/dvr_18664_p.pdf

DPI: Special Education Updates

7. CALL FOR PUBLIC COMMENTS:
- No Public Comments

Motion to adjourn by Greg Meyer at 12:21 PM; seconded by Stephenie Mlodzik. Unanimously passed.

Links to save:

https://drive.google.com/file/d/1Zn7ft9B1Ltur93OET2EomfBTXPKyNWi1/view

https://dwd.wisconsin.gov/dwd/publications/dvr/pdf/dvr_18664_p.pdf

DRAFT 2021

Wisconsin BPDD

January

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Legend:

- BPDD Board Meeting
- BPDD Executive Committee Meeting
- Holiday
- Self-Determination Conference / Disability Advocacy Day / Employment Conference
- Partners in Policymaking
- National Election Day

Updated: 2/26/20 NF

Exec meeteing dates should be scheduled 6 weeks before board mtg dates

Board Meeting Dates & Locations:

January 20 & 21, 2021	Virtual Meeting via Zoom
March 24, 2021	Virtual Meeting via Zoom
May 19 & 20, 2021	Virtual Meeting via Zoom
July 21 & 22, 2021	TBD
September 22 & 23, 2021	TBD
November 17 & 18, 2021	TBD

Executive Committee Meeting Dates

February 9th, 2021	2:00-3:00 PM
April 6th, 2021	2:00-3:00 PM
June 15th, 2021	2:00-3:00 PM
August 10th, 2021	2:00-3:00 PM
October 12th, 2021	2:00-3:00 PM
December 8th, 2021	2:00-3:00 PM

Other BPDD Dates:

March 23rd, 2021	Disability Advocacy Day
May 13th, 2021	Employment First Conference
October 18-20th, 2021	Self-Determination Conference-Virtual

*Dates are not final and still need approval from the Board.

Committee Assignments 2020 - 2021

Diversity committee:

1. **Andy Thain – Chair**
2. **Hector Portillo – Vice Chair**
3. George Zaske
4. Kedibonye Carpenter
5. Barbara Beckert
6. Daniel Parker
7. Meredith Dressel
8. Desirae Kluth
9. Pam Malin
10. Houa Yang
11. Cheryl Funmaker
12. Shannon Mattox

Nominating and Membership Committee:

1. **Ashley Mathy - Chair**
2. Patrick Friedrich
3. Tricia Thompson
4. Nathan Ruffolo
5. Stephanie Mlodzik
6. Kevin Coughlin
7. Pamela DeLap
8. Greg Meyer
9. Chris Wood
10. Kelli Weyer
11. Sydney Badeau

Executive Committee:

1. **Elsa Diaz-Bautista - Chair**
2. **Greg Meyer – Vice Chair**
3. Gail Bovy
4. Tricia Thompson
5. George Zaske

EXECUTIVE COMMITTEE MEETING
MINUTES

Present:	**Chair:** Elsa Diaz-Bautista **Vice Chair:** Greg Meyer; George Zaske, Tricia Thompson, Gail Bovy **Staff Liaison:** Beth Swedeen
Absent:	
Staff Present:	Beth Swedeen, Jeremy Gundlach

Meeting called to order at 2:03 pm.

1. <u>**Set November Board Mtg Agenda**</u>:

2:30 – 3:00 PM	Member Caucus
3:00 – 5:00 PM	State-Plan

8:00 - 8:30 AM	Welcome and Technical Assistance (meeting starts at 8:30)
8:30 – 9:30 AM	Governmental Affairs
9:30 – 10:00 AM	Mitch Hagopian
10:00 – 10:15 AM	Governor's Task Force on Caregiving - Report
10:15 – 10:30 AM	Break
10:30 – 12:00 PM	State Plan
12:00 – 12:45 PM	Business Meeting

2. <u>**Other Agenda Items:**</u>
   - The Caregiver Task Force should be included in the meeting packet so members have it available before the meeting.
   -

Motion to adjourn at 2:17 PM. Unanimously passed.

Diversity Committee Agenda

Members	Chair: Andy Thain, Vice Chair: Hector Portillo; George Zaske, Desi Kluth, Pam Malin, Kedi Carpenter, Cheryl Funmaker, Shannon Mattox, Houa Yang, Elsa Diaz-Bautisa, Barbara Beckert, Meredith Dressel, Daniel Parker, Alicia Reinhard
	Staff Liaison: Molly Cooney

Symbol	Topic	Presenter	Time
	1. Call Meeting to order/Check-in	Andy	12:00
	2. History of the Diversity Committee	Long-time committee members	12:05-12:15
	3. Walk through the Diversity Work Plan; discuss ideas to update the plan	Andy, Hector	12:15-12:45
	4. Identify next steps	Hector	12:45-12:55
	5. Wrap up	Andy	1:00

=Meeting =Presentation =Vote

Wisconsin BPDD

Hello, BPDD Board Members! This is a handout for our board meeting next week. We will be working on the goals and objectives for our state plan. We thought a paper copy of this information might be useful. See you all next week! --BPDD Staff

Handouts for November BPDD Board Meeting

Top Areas Identified through survey, listening sessions and Board discussions

1. **Social Isolation, relationships/friendships**

2. **Inclusion** - Seeing people with disabilities with value; looking at people from different marginalized groups. Uplifting disability as a natural part of the human condition, which leads to genuine connection in the community.

3. **Service Systems -** easy to understand and access; need to change the thinking that people are trying to take advantage of the system

4. Caregiving, including respite

5. Family support; Family navigation

6. Transportation- accessible and affordable rides

7. Employment

8. Independent/Community Living (Housing)

9. Education

10. Technology

11. Mental Health

12. Self-determination and self-advocacy

State Plan Requirements:

- o Self-advocacy goal or objectives

    1. Support a statewide self-advocacy organization

    2. People with disabilities providing leadership training to peers

    3. Support self-advocates to participate in cross-disability coalitions (for example, supporting a Partner graduate to be on a school board)

- o Targeted disparity goal or objective

- o Collaboration with DD Network Partners (we can build this into another objective)

Other repeated themes from our listening sessions and discussions

- o Reaching young families - learning more about topics like dignity of risk, supported decision-making, high expectations

- o The need for more professional development or training for all direct service staff including educators, therapists, respite staff, job coaches, DVR counselors, case managers, etc.

Lessons learned from last state plan

- o Make goals broad enough to encompass emerging issues or trends or opportunities that may come up (i.e. COVID-19; new grants)

- o Include a policy objective to ensure BPDD can be an active advocacy on policy developments which impact people with intellectual and developmental disabilities but may be outside our objective areas

Draft Goals and Possible Topics for Creating Objectives

Goal 1

Aim: Focus on making sure service systems and programs have understandable information and that people can access them to have the life they want in their community

Draft: People with intellectual and developmental disabilities and their families are aware of and able to access and use programs to be more included, self-determined, productive, integrated and independent in community life.

Possible topics for creating objectives (aim for 3-5)

- Caregivers and respite

- Family support; Family navigator

- Easy to understand information/access to info

    - Related to health care, education, mental health, long-term care services

    - Better customer service: clear information, free from unreasonable scrutiny, free from arbitrary barriers

- Education

- Access to technology and internet

- Policy objective

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Goal 2

Aim: Focus on how people are perceived and experience life in their community; improved attitudes and higher expectations; inclusion and connection

Drafts:
People with intellectual and developmental disabilities experience fair treatment, access and opportunity to connect and be seen as valued contributors to their communities.

OR

People with I/DD experience the same expectations and opportunities to be contributing members of their community as those without disabilities.

Possible topics for creating objectives (aim for 3-5)

> Our 3 self-advocacy objectives may fit in Goal 2

- o Social Isolation, relationships/friendships

- o Transportation

- o Employment (or Community-based employment and day services – to include connecting people to their community to continue learning, volunteering, working, recreating)

- o Independent/Community Living

- o Mental health

- o Self-determination

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Target Disparity Draft

Aim: Groups that are underrepresented in the disability service systems will connect to and successfully use a variety of programs for which they are eligible.

Drafts:

By connecting __ (number) of Black, Hmong, Latinx, and Tribal families (LGBTQ?) to family navigators, X% of families will connect to and successfully use at least one program.

Or

By connecting _____(number) Black, Hmong, Latinx and Tribal families (LGBTQ?) to family navigators, X% of families report getting connected to the resources they need.

From public input sessions: Who's missing?

➢ People of color (14) – including Latino families (2); Tribal families (2)

➢ People in rural areas (10)

➢ People who use assistive technology to communicate (6)

➢ Prison population (4)

➢ LGBTQ – lesbian, gay, bisexual, transgender, queer or questioning (3)

➢ People who don't know where to go for information and feel like they can't speak up (3)

➢ Families with low incomes (2)

➢ Those without consistent internet (2)

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Description of topics for possible objectives (from listening session input)

Caregiving

-Need more caregivers: respite workers, childcare workers, residential staff, all direct service professionals

-Due to not enough caregivers, people's wellbeing and independence are limited

-High turnover rate; reduces stability in people's lives; increases trauma

-Need more training and professional development; more support and resources; more respect

-Need better pay, benefits, incentives

-Need to change this from a job to a career, a profession

Family support/Family navigator

-more training/education for families on IEPs, resources, services, public benefits, their rights, how to advocate

-more family networks to a) connect to other families to learn what is possible; b) know who to talk to and what to ask; c) build community; d) pool resources

-support during transitions as well as the time of diagnosis

-more respite and more support to families so that they are not in over their heads

Accessible service systems (education, health care, employment, long-term care, mental health)

-want coordinated services/supports that communicate with each other

-simplified service systems; centralize service systems

-want a support broker or family navigator

-need more service providers and therapists

-more training for therapists, respite workers, social workers, etc.

-want more time with therapists

-better customer service

-more individualized services

-more innovative programming for adults

-want services to facilitate more community connections and relationships

Education

-more inclusive education

-more support and training for school staff

-more bilingual staff

-more access to therapies in school

-teach daily living skills, sex education; meaningful school days

-more college opportunities

Technology

-access to technology to connect to others and with services

-access to internet

-service providers need the technology they need

-more assistive technology available

-more training on how to use technology

-more access to telehealth

Social Isolation; relationships/friendships

-more opportunities to connect with people and community

-marriage without impacting benefits

-more accessible summer and leisure activities

-more opportunities to learn in the community

-more intentional communities for connection and support

Transportation

-Reliable, affordable, on-time, on demand accessible transportation options that can go all places

-more training and support for drivers

-more transportation training for people w/ disabilities

-take advantage of available technology

Employment

-More jobs of a larger variety in all parts of the state

-More hours, benefits, raises

-Employers more open to hiring people and understanding accommodations

-Stronger DVR system; more communication between funders and service providers

-more training for professionals in best practices and how to take a person-centered, individualized approach

Independent/Community Living

-more affordable, accessible housing

-more independent living options w/ range of support available

-more residential settings with less restriction

-more consistency in quality group homes

-shorten waiting list for public housing

-eliminate housing discrimination

Self-determination

-support people to make own decisions, be independent and advocate for self

-change power dynamic between professionals and people w/ disabilities

-more training for people w/ disabilities on their rights

-more training/education about SDM

-more training/education for guardians about best practices

-decrease over-reach by group homes and guardians

-improve Adult Protective System

Rubric for Screening Priority Areas or Goals

Instructions: Score goals (yes, no, maybe) based on how well they meet the criteria listed across the top of this table.

	Align with our vision? All people with developmental disabilities should be fully included in the community	Align with our charge? Leads to systems change, build capacity, increase advocacy	Related to an area of emphasis? Employment Education Child Care Health Housing Transportation Recreation Quality Assurance	Impact will be a) policies created/improved; b) programs created/improved c) money leveraged for sustainability; d) people reach concrete goals (get job, live on own, etc)	Rationale Based on public input and Comprehensive Review and Analysis	Is it a good use of funds? Are other agencies already doing this work or charged with this work? Do we have ability to impact the issues? Is it achievable with our resources?
Priority/Goal 1: _____						
Priority/Goal 2: _____						
Priority/Goal 3: _____						
Priority/Goal 4: _____						
Priority/Goal 5: _____						

Decision-making Tool: Impact/Effort Grid

← **Effort** →

	Easy to do	Difficult to do
Major Improvement	1.	3.
Minor Improvement	2.	4.

↑ **Impact** ↓
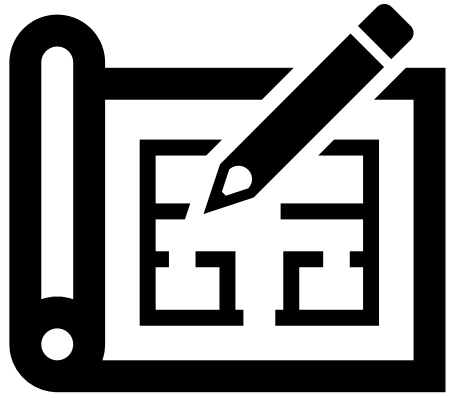
Glossary

- **accessible**: anyone can use it; it's easy to use

- **align:** when things are in agreement; putting things in a certain position so that they line up

- **complementary:** combining things in a way that brings out the good in each

- **conflict of interest:** when a person may benefit from decisions made in their job or other role

- **coordinate**: bringing things together in a way that works well and gets a good outcome

- **Developmental Disabilities Act:** a law that aims to make sure people with intellectual and developmental disabilities and their families participate in the design of and can access services and supports that help them be more independent, self-determined, productive and integrated in their community

- **disparities:** a difference between things that should not be different

- **perceived:** how someone looks at or views someone or something else

Glossary

- **pet project:** a project or activity that is done because it is someone's favorite; not because it is important or necessary

- **prioritize:** deciding in what order to do tasks or ideas based on how important they are

- **professional development:** training that helps someone become better at their job

- **quality**: how good something is compared to something else

- **quantity**: the amount of something

- **rubric**: a tool to judge or grade something

- **targeted**: aim or direct attention at something specific; focused

- **underrepresented:** not getting the attention that something or someone deserves

- **unique:** one of a kind or unlike anything else

Agenda for next two days

❖ Timeline; State plan requirements; and Decision-making tools

❖ Review Top Issues identified

❖ Goals: Discuss drafts and finalize language

❖ Objectives: Select topics for objectives; brainstorm language

❖ Activities: If time, begin brainstorming possible activities

Our aim for this board meeting is to decide on our goals and objectives.

Timeline for 2022-2026 State Plan

Timeline	Activities
September 2019	Begin discussion and plan for gathering input Brainstorm emerging issues Public Input Mapping
November 2019	Review current state plan and ongoing discussion on emerging issues and Conversation Café locations
January – August 2020	Hold Conversation Café's and other forums for public input, discussions and speakers on emerging issues, and comprehensive review and analysis.
September 2020	Review all the input and develop goal areas

Timeline	Activities
November 2020	Develop specific goal language and suggestions for objectives
January 2021	Review objectives and make any needed modifications; develop budget allocations
February 2021	Send out draft for 45-day public input and hold public hearing
March 2021	Review public comments and make any revisions; send out for another 45 days, if needed
April 2021	Write final version of Plan
May 2021	Final approval of plan
August 15, 2021	Submit Plan to federal government

Keep in Mind
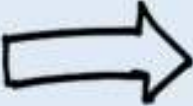
Prioritize a small number of goals—quality is better than quantity!

Be careful not to take on too much

Challenge "pet projects" or projects that we've simply done for a long time

Feel okay talking about conflicts of interest

What is the Role of the Wisconsin Developmental Disabilities Council?

4 Lenses for Creating Our State Plan	Systems Change	Individual and Family Advocacy	Capacity Building	Equity (Targeted Disparity)
Big Question	What are we doing to change the system to work better for people with developmental disabilities (DD) and their families?	How are we advocating for people with DD and their families?	How are we helping individuals and organizations improve how they support people with DD and their families?	How does our work benefit people who reflect the diversity of our state?
Other Questions to Think About	• How do we identify policies, supports, services, and programs that need to be changed? • How do we prioritize what systems changes to focus on? • Who are we collaborating with and how? • What is the role of our DD Network partners?	• How do we identify and prioritize advocacy needs? • How do we advocate? • How do we help others advocate? • How are we meeting the needs of self-advocates and family advocates? • How are we providing information and resources to the DD community?	• What kind of training and technical assistance are we providing to: o People with DD o Families o Service systems o Other organizations • How are we identifying and prioritizing needs for capacity building? • How are we identifying individuals/organizations to support?	• What are the geographic, ethnic, socioeconomic, and service eligibility demographics of the people who benefit from our work? • Which communities are we working with and how do we communicate with them? • Who serves on our Council and staff? • Whom do we give grants to? • Whom do we contract with?

3 Requirements in the State Plan

1. **Self-Advocacy**
   The Developmental Disabilities Act (DD Act) requires that we have a self-advocacy goal every year of the state plan that includes:

   a) Support to a statewide self-advocacy organization,

   b) Facilitating people with developmental disabilities providing leadership training to their peers, and

   c) Activities to promote the participation of people with disabilities in cross-disability and culturally diverse leadership coalitions.

3 Requirements in the State Plan
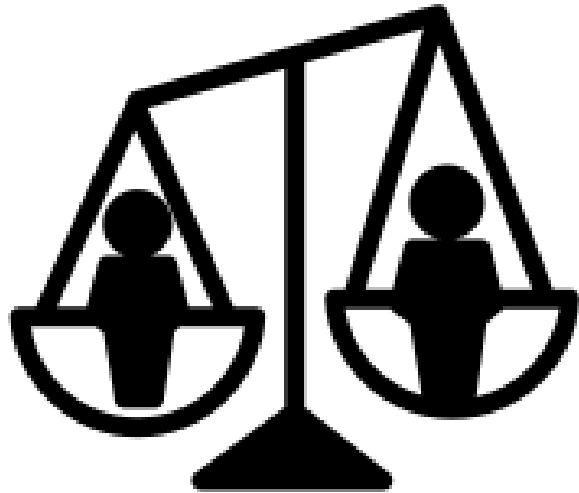
2. **Targeted Disparity**

   Identify and address a disparity that a group of people experience.

   Disparity = a difference in people's outcomes or how they access or use service systems

   a) Identify a subgroup of people with intellectual and developmental disabilities

   b) Identify the disparity we are going to focus on

   c) Craft an objective that will decrease the differences in access, use of services, and outcomes for people in this community over the next 5 years

3 Requirements in the State Plan

3. Collaboration with DD Network Partners
Identify strategic activities that the Developmental Disabilities Network Partners can do together.
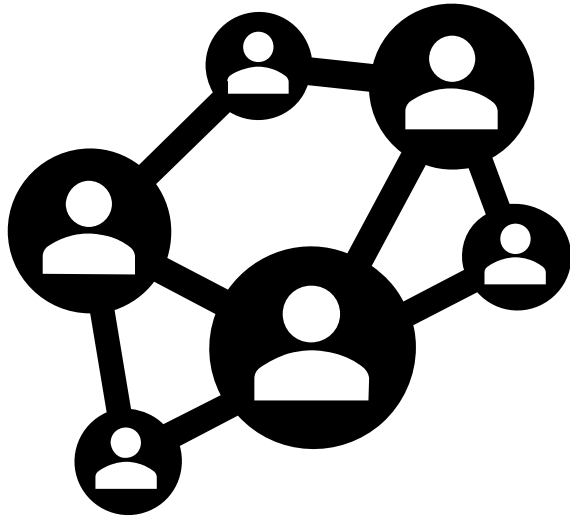
DD Network Partners =
Disability Rights Wisconsin (Wisconsin's Protection and Advocacy organization) and
Waisman Center UCEDD (Wisconsin's University Center for Excellence in Developmental Disabilities)

Each agency has a unique yet complementary role in achieving the purpose of the Developmental Disability Act

We are asked to coordinate and collaborate in our projects and activities, if appropriate

Decision-making tools

Rubric for Screening Priority Areas or Goals

Instructions: Score goals (yes, no, maybe) based on how well they meet the criteria listed across the top of this table.

	Align with our vision?	Align with our charge?	Related to an area of emphasis?	Impact will be	Rationale	Is it a good use of funds?
	All people with developmental disabilities should be fully included in the community	Leads to systems change, build capacity, increase advocacy	Employment Education/Early inter. Community services Child Care Health Housing Transportation Recreation Quality Assurance	a) policies created/improved; b) programs created/improved c) money leveraged for sustainability; d) people reach concrete goals (get job, live on own, etc)	Based on public input and Comprehensive Review and Analysis	Are other agencies already doing this work or charged with this work? Do we have ability to impact the issues? Is it achievable with our resources?
Priority/Goal 1						
Priority/Goal 2						
Priority/Goal 3						
Priority/Goal 4						
Priority/Goal 5						

Impact/Effort-Based Grid

← **Effort** →

	Easy to do	**Difficult to do**
Major Improvement	1.	3.
Minor Improvement	2.	4.

↑ **Impact** ↓

Let's talk about goals

What's a goal?

A statement about what we want to achieve or what we hope to impact in a specific area over the next 5 years.
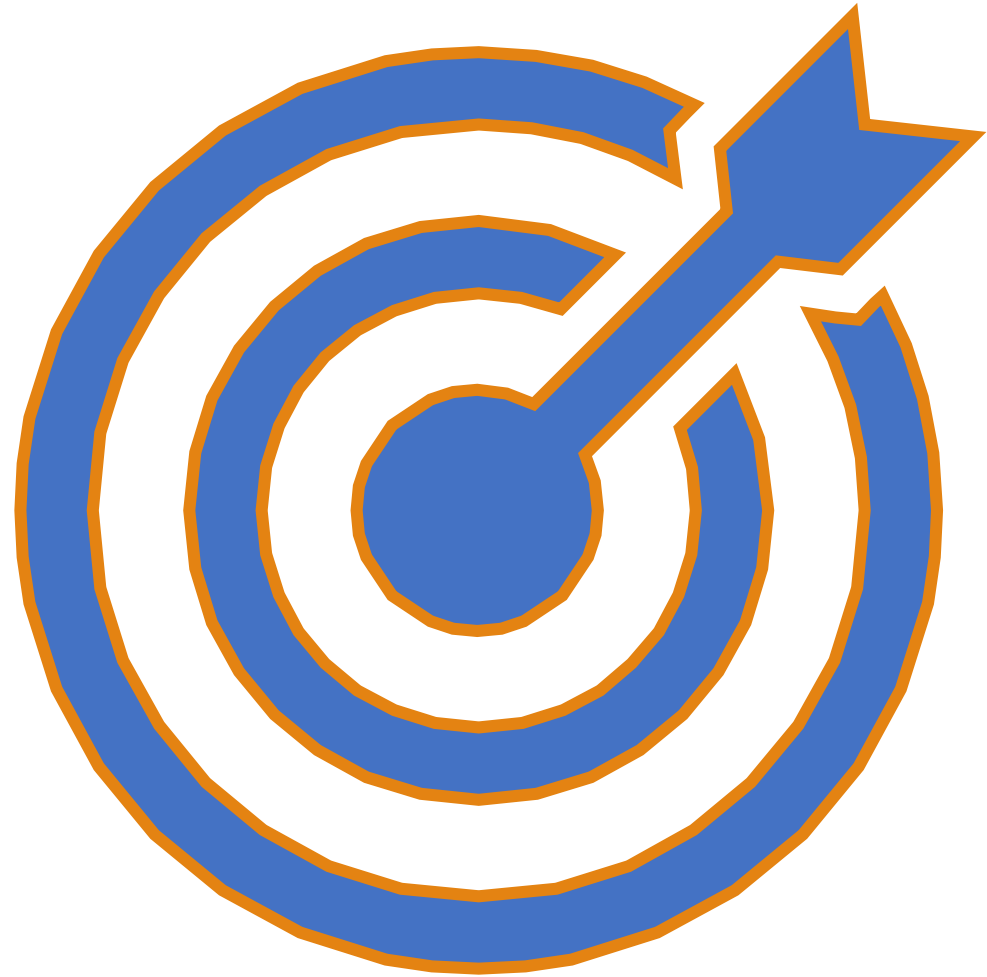
"Good" Goals

Specify an expected program effect

Identify the target population to be affected

Set overall priorities for our work

Checklist to assess goals	Yes	No
GOAL: A broad statement of our purpose that describes the expected impact of our efforts over 5-years in a particular area		
1. Does it specify an expected program effect in addressing an issue for people with disabilities and their families?		
2. Does it say who the goal is focusing on? (for example, people with intellectual and developmental disabilities and their families)		
3. Is it a declarative statement?		
4. Is it free of jargon?		
5. Is it concise?		
6. Is it easily understood?		
7. Is it stated in positive terms?		

Framework for Goals and Objectives

Broad goals with "SMART" objectives

Grab your Handouts!

Draft Goals and Possible Objectives

Goal 1 Draft:
People with intellectual and developmental disabilities (I/DD) and their families are aware of and able to access and use programs to be more included, self-determined, productive, integrated and independent in community life.

Possible objectives
- Caregivers and respite
- Easy to understand information/access to info
  - Related to health care, education, mental health, long-term care services
  - Family navigator/Family support
  - Better customer service: clear information, free from unreasonable scrutiny, free from arbitrary barriers
- Access to technology and internet (policy efforts)
- Policy objective
- Self-advocacy objective
- Targeted disparity objective
- Collaboration with DD Network Partners

Goal 2 Draft:
All people with I/DD experience equity and inclusion in their communities, within public programs, and in the workplace as evidenced by...

Possible objectives
- Social Isolation, relationships/friendships
- Transportation
- Employment (or Community-based employment and day services – to include connecting people to their community to continue learning, volunteering, working, recreating)
- Housing
- Self-determination
- Improved attitudes and higher expectations

Top Areas Identified

1. **Social Isolation, relationships/friendships**

2. **Inclusion** - Seeing people with disabilities with value; looking at people from different marginalized groups. Uplifting disability as a natural part of the human condition, which leads to genuine connection in the community.

3. **Service Systems** - easy to understand and access; need to change the thinking that people are trying to take advantage of the system

4. Caregiving, including respite

5. Family support; Family navigation

6. Transportation- accessible and affordable rides

7. Employment

8. Independent/Community Living (Housing)

9. Education

10. Technology

11. Mental Health

12. Self-determination and self-advocacy

Based on statewide input and our discussions…

AIM OF GOAL 1

Focus on making sure service systems and programs have understandable information and that people can access them to have the life they want in their community

AIM OF GOAL 2

Focus on how people are perceived and experience life in their community; improved attitudes and higher expectations; inclusion and connection

Goal 1: DRAFT

Aim: Focus on making sure service systems and programs have understandable information and that people can access them to have the life they want in their community

People with intellectual and developmental disabilities and their families are aware of and able to access and use programs to be more included, self-determined, productive, integrated and independent in community life.

Goal 1: Feedback, suggestions, notes

People with intellectual and developmental disabilities and their families are aware of and able to access and use programs to be more included, self-determined, productive, integrated and independent in community life.

-
-

Goal 2: DRAFTS

Aim: Focus on how people are perceived and experience life in their community;
improved attitudes and higher expectations;
inclusion and connection

People with intellectual and developmental disabilities experience fair treatment, access and opportunity to connect and be seen as valued contributors to their communities.

Or

People with intellectual and developmental disabilities experience the same expectations and opportunities to be contributing members of their community as those without disabilities.

Goal 2: Feedback, suggestions, notes
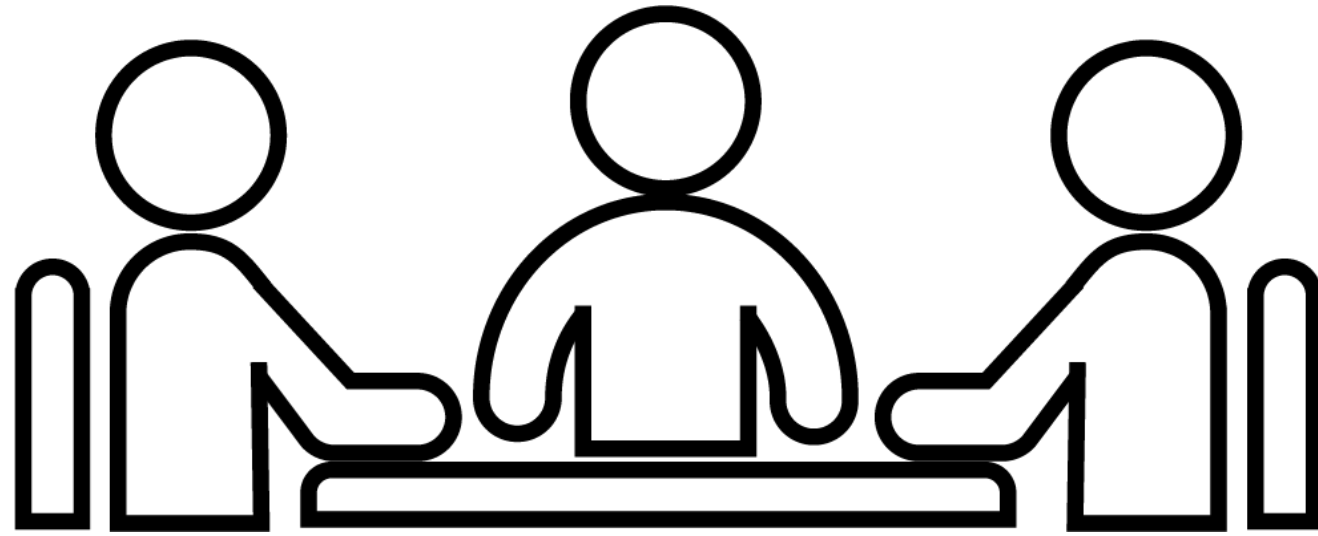
People with intellectual and developmental disabilities experience fair treatment, access and opportunity to connect and be seen as valued contributors to their communities.
Or
People with intellectual and developmental disabilities experience the same expectations and opportunities to be contributing members of their community as those without disabilities.

*
*

Small Group Discussions

We have our goals. Now let's identify our objectives.

What is an objective?

A specific, measurable statement about the outcome of the initiative that will help us to reach our goal.

The objectives will...

❖ Describe the results we want to achieve and how we will achieve them

❖ Set targets for progress

❖ Set targets for accountability

Our objectives are steppingstones to reach our goals.

We need to pick 3-5 objectives per goal.

SMART Objectives

SPECIFIC

MEASURABLE

ACHIEVABLE

REALISTIC

TIME BASED

Objectives Checklist

Is the objective SMART?	Yes	No
Specific: Who (target population and persons doing the activity?)		
Specific: What (action/activity)		
Measurable: How much change is expected		
Achievable: Can be realistically accomplished given current resources and constraints		
Realistic: Addresses the scope of the program and proposes reasonable programmatic steps		
Time-phased: Provides a timeline indicating when the objective will be met		

To keep in mind…requirements

- Self-advocacy objectives

  - Support a statewide self-advocacy organization

  - People with disabilities providing leadership training to peers

  - Support self-advocates to participate in cross-disability coalitions (for example, supporting a Partner graduate to be on a school board)

- Targeted disparity objective

- Collaboration with DD Network Partners (we can build this into another objective)

To keep in mind…other themes and lessons learned

Other repeated themes from our listening sessions and discussions

o   Reaching young families - learning more about topics like dignity of risk, supported decision-making, high expectations

o   The need for more professional development or training for all direct service staff including educators, therapists, respite staff, job coaches, DVR counselors, case managers, etc.

Lessons learned from last state plan

o   Make goals broad enough to encompass emerging issues or trends or opportunities that may come up (i.e. COVID-19; new grants)

o   Include a policy objective to ensure BPDD can be an active advocacy on policy developments which impact people with intellectual and developmental disabilities but may be outside our objective areas

Goal 1:

Possible topics for creating objectives

- Caregivers and respite
- Family support; Family navigator
- Easy to understand information/access to info
    - Related to health care, education, employment, long-term care services, mental health
    - Better customer service: clear information, free from unreasonable scrutiny, free from arbitrary barriers
- Education
- Access to technology and internet
- Policy objective

Goal 2:

Possible topics for creating objectives

- Social Isolation; relationships/friendships
- Transportation
- Employment (or Community-based employment and day services – to include connecting people to their community to continue learning, volunteering, working, recreating)
- Independent/Community living
- Mental health
- Self-determination

The Self-Advocacy Objectives could fit with Goal 2

Small Group Discussions about Objectives for Goals 1 and 2

Day 2

REVIEW YESTERDAY'S DISCUSSIONS

OBJECTIVES FOR GOALS 1 & 2

SMALL GROUP DISCUSSIONS

Goal 1 Objectives: Feedback, suggestions, notes

-
-

Goal 2 Objectives: Feedback, suggestions, notes

-
-

Targeted Disparity Objective
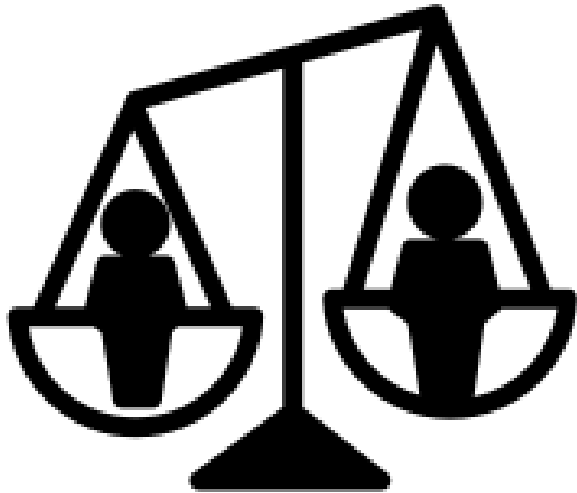
Identify and address a disparity that a group of people experience.

Disparity = a difference in people's outcomes or how they access or use service systems

a) Identify a subgroup of people with intellectual and developmental disabilities

b) Identify the disparity we are going to focus on

c) Craft an objective that will decrease the differences in access, use of services, and outcomes for people in this community over the next 5 years

How do we pick a subgroup?
Federal Guidance and State Information

Federal Guidance states…

Populations unserved or underserved:

- ➢ People from racial and ethnic minority backgrounds
- ➢ Lesbian Gay, Bi-Sexual, Transgender, Queer and Questioning (LGBTQQ)
- ➢ Disadvantaged people (those living in poverty)
- ➢ People who speak a primary language other than English
- ➢ People from underserved geographic areas (rural or urban)
- ➢ Specific groups of individuals within the population of people with developmental disabilities, such as people who require assistive technology in order to participate in and contribute to community life

How do we pick a subgroup? Federal Guidance and **State Information**

Statewide Listening Sessions

➢ People of color (14) – including Latino families (2); Tribal families (2)

➢ People in rural areas (10)

➢ People who use assistive technology to communicate (6)

➢ Prison population (4)

➢ LGBTQ – lesbian, gay, bisexual, transgender, queer or questioning (3)

➢ People who don't know where to go for information and feel like they can't speak up (3)

➢ Families with low incomes (2)

➢ Those without consistent internet (2)

Targeted Disparity Drafts

Aim: Groups that are underrepresented in the disability service systems will connect to and successfully use a variety of programs for which they are eligible.

Ideas:
--Use of family navigators
--Focus on young families or specific age group

By connecting _____(number) of Black, Hmong, Latinx and Tribal families (include LGBTQ?) to family navigators, X% of families will connect to and successfully use at least one program.

Or

By connecting _____(number) Black, Hmong, Latinx and Tribal families (LGBTQ?) to family navigators, X% of families report getting connected to the resources they need.

Small Group Discussions

Targeted Disparity Objective: Feedback, suggestions, notes

-
-
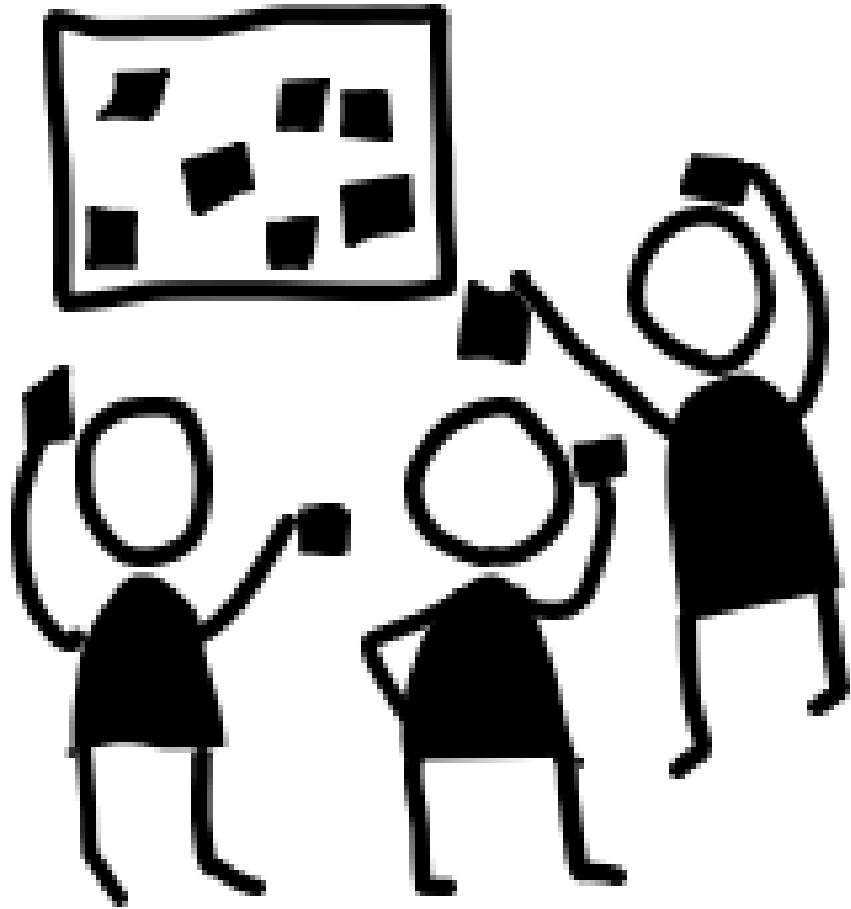
Brainstorm

ACTIVITIES

PROJECTS

Possible projects or activities for Objectives

-
-

Debrief,
Wrap-up,
Next Steps

Wisconsin Caregivers in Crisis:

Investing in our Future

Governor's Task Force on Caregiving

September 2020

Letter to Wisconsin Governor Tony Evers

September 30, 2020

The Honorable Governor Tony Evers
State of Wisconsin
115 East, State Capitol
Madison, WI 53708

Dear Governor Evers:

The members of the Governor's Task Force on Caregiving are pleased to present the following report detailing the process and recommendations developed by the Task Force to address the charges in Executive Order #11. The co-chairs speak on behalf of all members when we say that we have been proud to serve as representatives focusing on this important issue.

Caregiving is truly in crisis throughout Wisconsin. As we have convened over the past year, we have heard from families, recipients of care, direct care workers and providers who are struggling. Stories that illustrate when people have gone without care or without a break are heart wrenching. Individuals who believe passionately in the importance of this work are not paid enough to support their own families, yet throughout the COVID-19 pandemic, they have been on the front lines as essential workers, keeping our loved ones healthy and safe.

We believe the policy recommendations in this report can improve conditions for caregiving on all fronts. When we convened prior to the pandemic, we had a vision for big picture solutions that would require the state's immediate attention and significant investment. We did not abandon this approach in light of changing circumstances. In fact, we believe these policy changes are now even more critical.

There are an estimated 580,000 family caregivers and more than 90,000 direct care workers in our state. These Wisconsinites deserve our urgent support. These recommendations make good sense, are informed by experts or the experiences of other states and some can be implemented over time. Many have direct or future cost savings and all will certainly improve the quality of life in our state.

We thank you for the opportunity to serve on this Task Force, and we hope you and your Administration will work toward implementation and join collaboratively with the Legislature to adopt the changes described in this report.

Sincerely,

Lisa Pugh

Co-Chair

Todd Costello

Co-Chair

Executive Summary

Wisconsin is facing a critical shortage of direct care workers that leaves families and individuals struggling to meet care needs and has dire and costly impacts for nursing homes, assisted-living facilities and home and personal care agencies. At the same time, the role of a family caregiver has expanded to include more tasks that used to be provided by care or medical professionals, increasing stress on family caregivers. The percentage of the population age 65 and older is increasing, and people with chronic conditions and disabilities are living longer, contributing to an even higher demand for paid and family caregivers in Wisconsin's future.

Recognizing the need to address the caregiver shortages both now and in the future, Governor Evers signed **Executive Order #11** in February 2019, creating the Governor's Task Force on Caregiving. The charges laid out for the Task Force included analyzing strategies to attract and retain a strong direct care workforce and to assist families providing caregiving supports and services. In partnership with the Department of Workforce Development, the Department of Health Services was tasked with supporting the work of the Task Force.

The 28 member Task Force met regularly starting in September 2019. From the start, members established a goal of developing policy proposals to present to the Governor in Fall 2020. A request for public input on draft versions of the proposals resulted in more than 1,500 responses, providing valuable comments for consideration as the proposals were finalized. On September 10, 2020, Task Force members voted to recommend the following 16 policy proposals to the Governor and other state leaders:

Family Caregiving

1. Caregiver Assessment: Tailored Caregiver Assessment and Referral Proposal
2. Aging and Disability Resource Center (ADRC): Reinvestment/Caregiver Support
3. Family Medical Leave Act Amendments
4. The Wisconsin Credit for Caring Act
5. The Care Act

Direct Care Workforce Proposals: Rates

6. Rates Band Proposal
7. Nursing Home and Personal Care Payment Reform
8. Medical Loss Ratio for Family Care Managed Care Organizations
9. Direct Care Worker Fund

Direct Care Workforce Proposals: Benefits

10. Medicaid Expansion
11. Earnings Disregard for Direct Care Workers

Direct Care Workforce Proposals: Untapped Workers

12. State-Wide Direct Support Professional Training
13. Recognition and Recruitment of Direct Support Professionals
14. Background Check Policies
15. Medicaid Provider Regulatory Oversight

Home Care Provider Registry

16. Home Care Provider Registry Pilot

This report lays out the process and rationale used by Task Force members to develop these 16 proposals, presents the 16 proposals in full, and concludes with a discussion of next steps needed for implementation.

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Background

Wisconsin and the nation as a whole have recognized that caregiving is in an era of crisis. At the same time that thousands of paid direct care worker positions remain open or are in a state of perpetual turnover, those who choose to stay in the profession make so little income that they often qualify for public benefits. A role that typically provides the most intimate daily cares to our aging loved ones and people with disabilities can also take a toll on the physical and mental health of workers and family caregivers in the home. The many charges of the Governor's Task Force on Caregiving tackle these growing concerns.

Individuals who provide care or support to people with disabilities and older adults in Wisconsin go by many different titles, roles and terms. The Governor's Executive Order #11 broadly refers to these individuals as "caregivers." Task Force members considered part of their charge as drawing attention, respect and recognition to the role of caregiving in both its paid professional and unpaid forms. For purposes of organizing their efforts, as well as this report, Task Force members decided to distinguish between workers who are choosing direct care as a career or job and people who are providing care and assistance in a voluntary or unpaid way. The term "direct care worker[1]" is used to describe someone who is primarily paid for their caregiving work, including a variety of formal paid roles (e.g. personal care worker, home health aide, certified nursing assistant). The terms "caregiver" or "family caregiver" are generally used to describe an unpaid individual who is providing care in a voluntary or unpaid way a majority of the time. Where specifically noted, the term caregiver is occasionally used more broadly to include both paid and unpaid caregivers.

Governor Evers Executive Order #11 begins by noting that caregivers, including paid and unpaid, provide critical services that promote the wellbeing and enhance the quality of life for thousands of Wisconsinites. The demand for these services has increased in recent years, while the availability of people to provide them is declining. There is both a current and growing shortage of caregivers compared to the level of need.

A significant reason for the shortages is the changing population. It is projected that between 2015 and 2040, the population ages 65 and older will grow by 640,000 people -- an increase of 72%. That rate is six times higher than the overall Wisconsin population growth projection of 12% for the same period. Those 65 and older comprised 15% of total population in 2015. By 2040, they are expected to make up 24%.[2]

In Wisconsin currently 64% of people with intellectual and developmental disabilities live with family and 25% of these family caregivers (typically parents) are over 60 years old.[3] The pressures on younger family members and the paid workforce can be expected to increase when higher percentages of elderly parents must discontinue their care. An increasing number of siblings of adults with intellectual and developmental disabilities are already taking on care responsibilities for their brothers and sisters as their parents age.

In a survey of constituents in 2016 by the Survival Coalition, which represents people with all types of disabilities throughout the state, 95% of responding constituents reported difficulties in finding home care workers. Moreover, 85% of the respondents reported not having enough workers to fully cover open shifts.[4]

At the Task Force's initial meeting in September 2019 Task Force members were briefed about challenges specific to the direct care workforce. In a presentation by Stephen Campbell, data and policy analyst with PHI (Paraprofessional Healthcare Institute, Inc.), and Barbara Kleist, with the Research and Training Center on Community Living at the University of Minnesota[5], it was noted that home care, residential care, and nursing home providers struggle to attract and retain direct care workers, and cited the following as contributing factors:

Low wages and part time hours for direct care workers result in economic hardship	Lack of a career pathway	Competition from other industry sectors for workers

When direct care worker positions remain unfilled in home, residential, and facility-based settings, the burden on existing workers increases, contributing to burnout and higher rates of turnover.

On the family caregiving side, Kristin Litzelman, from the Department of Human Development and Family Studies at the University of Wisconsin-Madison, reported on preliminary results of a 2019 Family Caregiver Survey[6] conducted for the Wisconsin Family and Caregiver Support Alliance. The majority of the 612 survey respondents reported caregiving difficulties, including:

73% Not meeting their own personal care needs

63% Not balancing caregiving and work

60% Not balancing the needs of children and other family members

53% Not understanding government programs such as Medicaid, Medicare, SSI, etc.
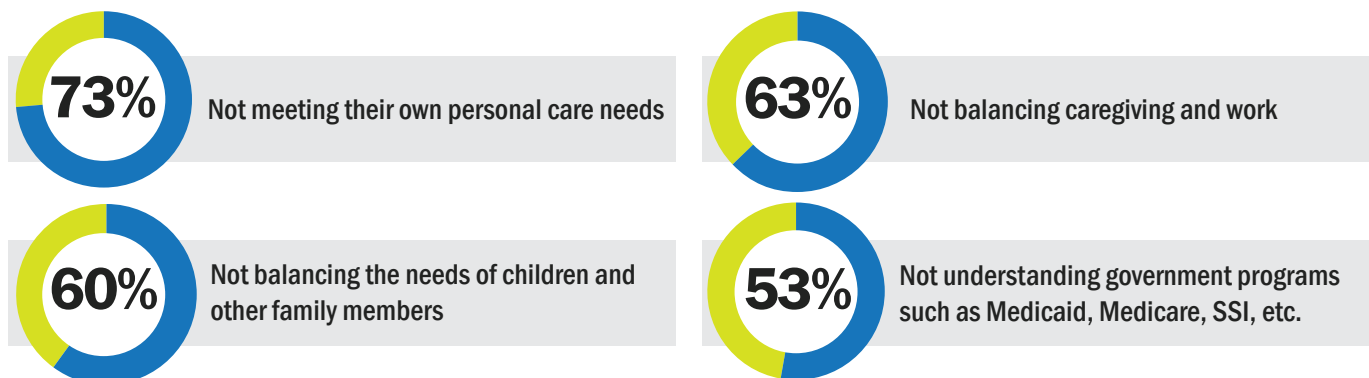
Survey respondents also noted personal impacts such as fatigue (72%), decreased social life (64%), negative impacts on relationships with friends and/or family (53%), and worsening emotional and/or physical health (90%).

With the shortage of direct care workers, as consumers struggle to access appropriate care, the burden on family caregivers is increasing. A 2019 special report by the founders of the Home Alone Alliance "Home Alone Revisited: Family Caregivers Providing Complex Care," analyzes responses of 2,089 family caregivers to an on-line survey. Key findings included that today's family caregivers are managing multiple health conditions that are often accompanied by pain, and that caregivers who are socially isolated or who have no choice about caregiving are more at risk for experiencing difficulties in providing complex care.[7]

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[1] Note that the training recommendation aims to allow a direct care worker to further professionalize their role leading to recognition as a "direct support professional," which is a term that is also recognized nationally.

[2] Wisconsin Department of Administration, Demographic Services Center, Population Projections, Vintage 2013 https://doa.wi.gov/Pages/LocalGovtsGrants/Population_Projections.aspx

[3] Tanis, E.S., Lulinski, A. & Wu, J., Braddock, D. & Hemp, R. (2020). The State of the States in Intellectual and Developmental Disabilities, Department of Psychiatry, University of Colorado. www.stateofthestates.org

[4] Wisconsin's Direct Care Workforce Crisis; Survival Coalition Consumer Survey, November 2016; http://www.survivalcoalitionwi.org/wp-content/uploads/2016/11/SurvivalSurveyFactSheet.pdf

[5] Stephen Campbell and Barbara Kleist: "The Direct Care Workforce in WI: Key Trends and Promising Practices" https://gtfc.wisconsin.gov/gtfcfiles/meetings/direct-care-workforce.pdf

[6] Wisconsin Family and Caregiver Support Alliance: http://wisconsincaregiver.org/system-navigation-and-access-workgroup

[7] "Home Alone Revisited: Family Caregivers Providing Complex Care," https://www.aarp.org/ppi/info-2018/home-alone-family-caregivers-providing-complex-chronic-care.html

Task Force Charges & Methods

Executive Order #11 charged the Task Force with the following strategies to strengthen the direct care workforce and support families providing caregiving supports and services:

Analyze strategies to attract and retain a strong direct care workforce.	Establish one or more registries of home care providers and develop a plan to provide referral or matching services for individuals in need of home care.
Support families providing care for their loved ones through respite services and other supports.	Develop a plan to implement recruitment and retention programs to expand the pool of providers.
Assess compensation and fringe benefits for caregivers, including ways to make healthcare affordable for the caregiving workforce through employer-sponsored plans, Medicaid buy-in plans, or other health insurance coverage options.	Explore and develop solutions, in collaboration with other relevant departments and agencies, to support and strengthen the direct care workforce, increase access, and improve the quality of caregiving in Wisconsin.

The Governor received many applications to serve and ultimately appointed 29[8] Wisconsin residents with diverse background and caregiving experiences to serve on the Task Force. A complete list of the members appointed by the Governor can be found at the end of this report. The Executive Order did not include a specific timeline, but at its inaugural meeting in September, 2020, members agreed to set a goal of having recommendations ready to submit to the Governor's Office for consideration by October 2020. This would be considered "Phase I." Members further agreed that, after submission of the recommendations to the Governor, there would be discussion of whether to move into a Phase II to work on implementation of the Phase I recommendations and discussion of additional, longer term solutions to the caregiving challenges facing Wisconsin.

Task Force members met regularly in public meetings from September 2019 through September 2020. The initial plan was to meet in locations across the state. However, as in-person meetings became difficult due to the COVID-19 pandemic, all meetings since March 2020 were held using remote meeting technology. A complete schedule of the meetings and meeting minutes can be found on the **Task Force on Caregiving website**.

Expert briefings and additional resource materials provided to the Task Force highlighted data showing that one in four direct care workers is a person of color[9], and that multi-cultural groups are over-represented among the ranks of family caregivers.[10] It is clear that the challenges facing both professional and unpaid caregivers may be exacerbated by existing social inequities and health disparities. From early in their planning processes, Task Force members committed to highlight issues of equity as the recommendations were developed.

As the preliminary policy ideas were identified, two primary workgroups were created, one to focus on the Direct Care Workforce and the other on Family Caregiving. A third workgroup focused on developing ideas for a home care provider registry.

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[8] One of the initial appointees was unable to serve due to family caregiving responsibilities.
[9] https://gtfc.wisconsin.gov/gtfcfiles/meetings/direct-care-workforce.pdf
[10] https://www.aarp.org/ppi/info-2018/home-alone-family-caregivers-providing-complex-chronic-care.html

Impact of the Pandemic

The emergence of a pandemic during Task Force deliberations only heightened the need to implement improvements, including additional supports for family caregivers and better worker protections. These sentiments were expressed in comments received by Task Force members from recipients of care, family caregivers, nursing homes and other facilities, personal and home care agencies, employers and others, as well as through discussion among the members themselves.

On two occasions, the Task Force reached out to the Governor to urge better support for the direct care workforce who were seen by members as serving on the front lines of the pandemic. On March 20, 2020, the Task Force co-chairs sent the Governor a letter relaying concerns of all members:

> An overarching concern expressed in our most recent meeting is that the direct care workforce, including those providing critical daily cares in facility-based settings, in the community and within people's homes are essential workers in this crisis. Keeping people with disabilities and older adults healthy and cared for in their current home setting, wherever it may be, is essential to diverting folks into the overloaded hospital and acute care system. These workers must be supported with proper safety equipment, expedited training, and other supports in order to continue this critical work. Providers must continue to have the cashflow and regulatory flexibility to hire and support qualified workers to meet local needs promptly. Families must have a way to report when they are in crisis or in need of help, including supports to mitigate the negative impacts of isolation.

On May 14, 2020, the Task Force held a special meeting to vote on a proposal that a recommendation be sent to the Governor to include direct care workers in all COVID-19 response planning and policies enhancing protections for health care workers. The proposal was approved and sent to the Governor the following day. (Proposal located in the May 14, 2020 minutes on the **Task Force website**.)

The populations most in need of caregiving services, older adults and people with disabilities, will continue to require extra attention until an effective vaccine is developed and distributed. And the impact of the pandemic on the direct care workforce is likely to be long-lasting. Providers are facing additional costs and additional responsibility for safety measures (e.g. providing personal protective equipment and regular testing for workers and adhering to new rules), increasing the burden on an already challenged workforce. Direct care workers, particularly those working in community and home settings, were not included in initial emergency measures to protect essential health care workers, including priority access to personal protective equipment and child care. The pandemic also amplifies the direct care workforce shortage and limited service options available in some areas of the state, particularly in rural communities. It has become even clearer that this is an essential workforce worthy of state investment.

Racial Disparities and Health Equity

The racial disparities in health conditions and unequal access to care that already existed in Wisconsin were exacerbated by COVID-19. These disparities are reflected in published data about the number of infections and deaths in minority populations.

The Task Force concluded that Wisconsin's direct care workforce shortage and the increasing burden it places on family caregivers cannot be solved without addressing disparities across our current programs and systems. Equity is needed in the delivery of caregiver support services, in expanding the number of care providers who are trained in cultural awareness, and in the form of higher wages and benefits for direct care workers.

It is well documented that minority populations and women experience disparities in access to health care, expectations to take on caregiving responsibilities, and opportunities for economic advancement. Paid care professionals and unpaid family caregivers, who are mostly women, were already experiencing all three of these inequities before the COVID-19 pandemic added a fourth. COVID-19 has resulted in higher rates of sickness and death for older people of color and in minority communities as a whole.

Caregiving is prevalent in all women's lives, but even more so in the lives of non-white women. The AARP's Caregiving in the U.S. 2020 Report, shows that three in five caregivers are women (61%). AARP also reports that African American caregivers are providing more hours of care each week (31.2 hours on average), as are Hispanic caregivers (26.0 hours of care weekly). These totals are higher than hours reported by either White (21.2 hours) or Asian American (24.1) caregivers.

Hours of Caregiving Each Week

	Hours
African Americans	31.2
Asian Americans	24.1
Hispanic	26.0
White	21.2

Caregiver Statistics

Pie chart:
- 84.5% White
- African American 6.8%
- Hispanic 3.8%
- American Indian 1.7%
- Reporting as other races 2.3%
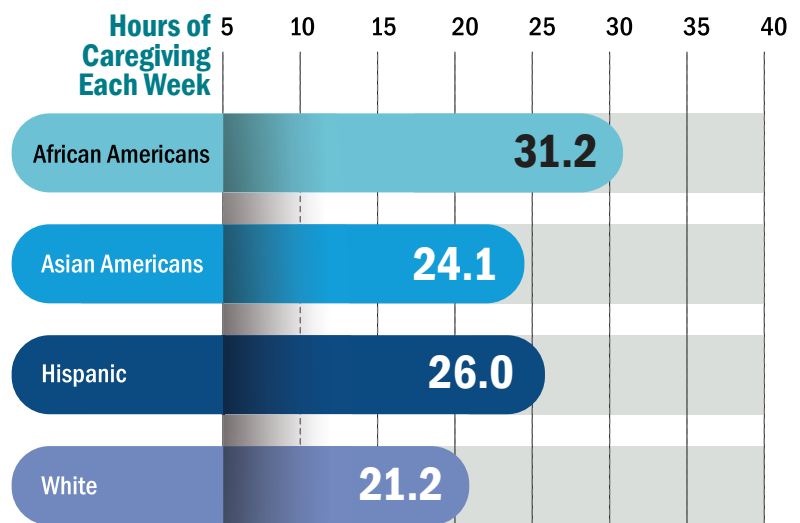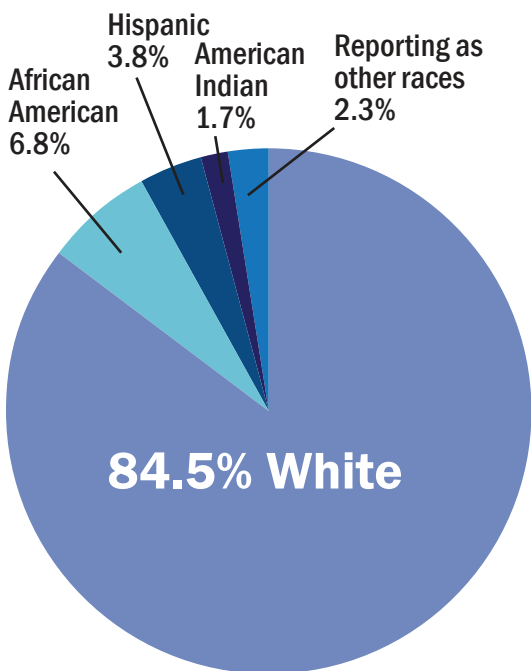
Statistics from the 2016-2018 Wisconsin Family Health Survey show that 85.4% of caregivers are Caucasian, 6.8% African American, 3.8% Hispanic, and 1.7% American Indian, with the remaining 2.3% self-reporting as other races. We know from anecdotal evidence and interviews that African-American caregivers often feel that their opinions are not valued when interacting with healthcare professionals. Interactions often make them feel they must prove themselves worthy of being taken seriously or considered reliable, trustworthy and capable caregivers.

Also, worth noting is the growing number of Wisconsin grandparents of all races who have become primary caregivers for their grandchildren. The increase has been driven by multiple factors, including Wisconsin's decade-long opiate crisis, which has resulted in more parents being incarcerated, hospitalized, ordered into treatment, or in some cases dying. In 2017, 26,895 Wisconsin grandparents provided primary care to a minor child; of them, 66.3% were White; 17.9% were Black; 9% were Hispanic or Latino; 4 % were American Indian, and 1.6% were Asian.

A final and growing gap is lack of direct care providers, health care facilities, and caregiver support services in Wisconsin's rural communities. The diminishing provider network in rural areas is evidenced by the fact that 24 of Wisconsin's 72 counties have five or fewer personal care provider agencies. As agencies continue to close due to low Medicaid reimbursement rates and unfunded mandates, consumers in rural locations are left with fewer and fewer options for receiving care that allows them to live at home.

Summaries of Task Force Proposals

The Task Force makes the following 16 recommendations to the Governor and other state leaders. A full description of each recommendation is included in the **Appendix**. The Task Force advances these recommendations recognizing that some measures could be implemented in the 2021-2023 biennium while others, because of cost and/or complexity, may need to be implemented over time.

Family Caregiving

1. **Caregiver Assessment: Tailored Caregiver Assessment and Referral (TCARE) for family caregivers.**

FACT:
TCARE is currently being used by tribal nations (most recently on the Seneca Nation in New York) and has been translated into Spanish, Vietnamese, Chinese, Mandarin, Cantonese, French and Korean.

Conduct a one-year pilot of an evidence-based care management protocol designed to support family members who are providing care to adults of any age with chronic or acute health conditions. The protocol includes both a Pre-Screening Tool and a full Assessment that asks questions of the family or informal caregiver in order to assess their health and well-being, stress levels, challenges, skills needed to perform care, informal support system and strengths that enable them to provide care. Regional consortiums would apply to participate; participation by any caregiver would be voluntary.

Estimated costs:
- One-time implementation fee of $10,000
- Licenses for a minimum of 25 trained staff to carry out assessments: $50,000 ($2,000/license) per year

2. **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. Currently, some ADRCs' programs for caregivers are for older people and people with dementia but do not include caregivers of adults younger than 60 or people with disabilities. This funding would make services and supports in all ADRCs available to all caregivers, including caregivers of adults age 19-59 Specific components of the recommendation include:

- Expand caregiver support services to ensure that all ADRCs include and address the needs of caregivers of adults age 19-59 with disabilities by providing the same resources and services that are provided by the National Family Caregiver Support Program
- Require all ADRCs to designate a specific "Caregiver Coordinator" to manage caregiver program funds; attention to cultural competence is a focus
- Require ADRCs to create a marketing plan to increase knowledge of Caregiver and other programs at the ADRC and measure impact, particularly within underserved communities

Estimated cost: The Caregiver support enhancement is estimated to cost $4 million/year and includes support for tribes.

> **"** This is so very important. The ADRC was my FIRST contact when I assumed caregiving for two family members. **"**

3. Family Medical Leave Act Amendments

Expand the Wisconsin Family and Medical Leave Act to:

- Specifically include chronic conditions 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

Estimated cost: No estimated cost to the state.

> " Flexible FMLA for caregivers can make the difference between maintaining employment or losing it because of the care needs of loved ones. "

4. The Wisconsin Credit for Caring Act: Based on 2019-20 WI State Legislative Session Senate Bill 126/Assembly Bill B126

Create a nonrefundable individual income tax credit for qualified expenses incurred by a family caregiver to assist a qualified family member. Include the following provisions on the proposed legislation referenced above:

- To qualifiy, a family member must be at least 18 years of age, and 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.
- Subject to a number of limitations, a claimant may claim 50% of the costs of qualified expenses the claimant paid for in the year to which the claim relates. Qualified expenses include amounts spent to improve the claimant's primary residence to assist the family member, equipment to help the family member with daily living activities, and 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 particular family member is $1,000 or $500 if married spouses file separately. If more than one claimant may file a claim related to that family member, the amount of credit each may claim is based on the percentage of the family member's

qualified expenses for which each claimant paid during the year. 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: Approximately $125 million (lost revenue) annually

5. The Care Act: Based on 2019-20 WI State Legislative Session Senate Bill 516/Assembly Bill B584

The legislation requires that a discharged hospital patient's caregiver will have been given in-person instructions and have knowledge of any care that will be needed after discharge. The CARE act helps family caregivers be informed of what will be needed in care performance when their loved one is dismissed from the hospital and will ensure they are notified if a loved one is transferred to another facility or discharged back home.

Estimated cost: No estimated cost to the state.

Direct Care Workforce Proposals: Rates

6. Rate Bands Proposal

Require DHS to develop and implement by December 31, 2023 a statewide minimum rate band based on a comprehensive and transparent rate evaluation that results in transparent, equitable and sustainable rates for home and community-based long-term care supports. Require the new rate bands system to include the following:

- Starts with evaluating and establishing equitable and sustainable direct care worker wages
- Is transparent and consistent across programs and settings
- Has built-in increases based on Consumer Price Index (CPI) annually
- Is developed with a workgroup comprised of providers and an independent outside entity with expertise in rate analysis across the spectrum of service categories from the beginning
- Includes a tiered system to recognize acuity levels/complexity of care that reflects the needs of the participant in a consistent, quantifiable and transparent process
- Holds harmless existing provider rates
- Develops a process for identifying cost outliers, and
- Is in compliance with CMS rate band guidance

In the interim years of 2021 and 2022, provider agencies with direct care workers whose wage categories are less than $15/hour (personal care, supportive home care, residential and day-program supports, pre-vocational and vocational support workers) receive an 8% increase per year to reflect recognition of wage stagnation experienced by all WI low-wage earners during the past 20 years, and the essential nature of work performed by direct care workers. All providers should be able to demonstrate how this rate increase directly benefits direct care worker wages.

Estimated cost: Not available.

> **" Direct service has been the most under-valued and under-paid position in the long-term care system for decades... Our organization has not had a rate increase for 10 years. This is not sustainable. "**

FACT:
Caregivers of recipients who live in a rural area more often report helping with medical/nursing tasks (62 percent vs. 56 percent of those caring for someone living in a non-rural area).

7. Nursing Home and Personal Care Payment Reform

Nursing Facility Payment Reform: Recommend linking nursing home reimbursement rates to the actual cost of care (i.e., rates should be set at payment standards based on the statewide median (50th percentile) plus percentage, for the cost of Direct Care and Support Services. When allocating dollars to the Direct Care-Nursing Cost Center (primarily CNA, RN and LPN expenses), the funds must be spent directly on the workforce. Facilities would only receive the full rate allowed under this payment standard if they incur caregiver costs equal to or greater than the standard.

In addition, separate payment standards for the Direct Care- Other (primarily personal comfort and medical supplies, over-the-counter drugs; and activity/recreation, social worker, volunteer coordinator religious and therapy aide personnel) and Support Services (primarily housekeeping, dietary, laundry, maintenance and administrative services) cost centers under the current payment system.

FACT:

93% of nursing home direct direct care workers are women; almost one in four is a person of color.

49% of Direct Care Workers overall earn less than 200% of poverty, and **23%** of DCWs working in home health earn below 100% FPL.[11]

Each payment standard would be annually adjusted by the appropriate cost index, similar to the Consumer Price Index (CPI).

The nursing home payment recommendations noted in this section are generally based on the State of Minnesota's nursing home payment reforms adopted in 2016-17.

Personal Care Rate Recommendation: Recommend that the State Budget explicitly allocate dollars to personal care agencies to fund an estimated hourly wage for personal care direct care workers similar to the approach used in the 2019-2021 Biennial Budget.

Building off the current State Budget assistance for personal care workers, the proposal is to establish payment standards such that rates paid to personal care agencies for direct care workers reflect necessary market adjustments and CPI increases. The personal care agency payment standard would be applied to personal care provided on a fee-for-service and managed care basis, as well as for personal care services provided to IRIS participants, including self-directed IRIS personal care services.

The personal care payment standards should be annually adjusted by CPI.

[11] PHI. "Workforce Data Center." PHI, 11 Oct. 2019, phinational.org/policy-research/workforce-data-center/.

Estimated cost:

- The fiscal effect of the nursing home and personal care agency proposals is dependent on the payment standards selected (for example, payments tied to the cost centers' median plus a certain percentage). As a phased-in payment standard is considered, it is worth noting that increasing nursing home funding by $20/resident day ($10/resident day for the Direct Care- Nursing payment standard a $5/resident day increase both for the Direct Care- Other and Support Services payment standard) would require an annual increase of approximately $66 million all funds [$26.4 million of which would be general purpose revenue (GPR)]. The cost of the nursing home labor region proposal is estimated to annually cost no more than $4.0 million GPR.

- The 2019-2021 State Budget provided a 12% increase to the Medicaid Personal Care Reimbursement Rate: The rate increased by 9% on July 1, 2019 to about $18.23 per hour and it is estimated the rate will increase by 3% in July 2020 to about $18.77 per hour. The cost of this initiative was $15.3 million GPR in 2019-20 and $21.6 million GPR in 2020-21. These amounts offer some insights as to the cost of increasing the personal care rates similarly in the future.

8. Medical Loss Ratio for Family Care Managed Care Organizations

> **By requiring an amount be spent on care, it's more likely caregivers will be paid better.**

Require a Medical Loss Ratio (MLR) of at least 85% for direct care and services, limiting the Managed Care Organizations (MCOs') administration and case management expenses to 15% of the capitation rate received from DHS.

Estimated cost: No estimated cost to the state other than staff time to implement.

9. Direct Care Worker Fund

Recommend that annual increases be provided to the existing Direct Care Workforce Funding program to ensure dollars are allocated directly to long-term care provider agencies for direct care worker wages and benefits. Further, direct and support DHS' efforts to secure CMS approval allowing total Direct Care Workforce Funding to be allocated via annual payments. The measure is intended to provide immediate assistance to support the direct care workforce until such time that a Family Care rate band is implemented.

Estimated cost: The Direct Care Workforce funding appropriation for 2020-21 is $67,985,100 all funds ($27.5 million GPR). Under the proposal, this amount would be increased to meet market demands for direct care worker wages. For example, it is roughly estimated increasing the Direct Care Workforce Funding by 5% in each year of the 2021-23 biennium would cost approximately $28.1 million GPR in 2021-22 and $57.7 million GPR in 2022-23.

> **We are in a caregiver crisis which will only get worse over time unless we pay caregivers what they deserve and need to support themselves and their families and treat them as respected professionals.**

Direct Care Workforce Proposals: Benefits

10. Medicaid Expansion

Expand Medicaid eligibility as per The Patient Protection and Affordable Care Act (PPACA), which allows states to cover non-disabled, non-pregnant adults under age 65 up to 138% of the federal poverty level (FPL) through their Medicaid state plans at an enhanced federal medical assistance percentage (FMAP). This change would increase the available shift hours for direct care workers as they maintain health benefits.

Estimated cost: According to an estimate in the DHS Agency Budget Request for the 2021-2023 Biennium, in spite of increased administrative costs, Medicaid Expansion would result in a net savings to the state of $588.3 million GPR in the 2021-2023 biennium.

> " As a small provider, we have always struggled to obtain health insurance that we and our employees can afford... Some of our employees elect to work part-time (and earn less money) because it's the only way they can get healthcare for themselves and their kids! No one should have to make this choice. "

11. Earnings Disregard for Direct Care Workers

Establish earnings disregard for direct care workers when determining eligibility for specific public assistance programs. Specifically:

- Allow direct care workers the ability to disregard $10,000 of direct care worker earnings when applying for BadgerCare benefits through a potential waiver or pilot program
- Allow direct care workers the ability to disregard $10,000 of direct care worker earnings when applying for Wisconsin Shares childcare subsidy program
- Allow direct care workers the ability to disregard $10,000 of direct care worker earnings when applying for funding through the FoodShare program (Wisconsin's name for the Federal SNAP program)

For purposes of this recommendation, direct care worker earnings consist of wages earned while supporting recipients in Wisconsin Medicaid programs.

Estimated cost: Not available.

> **"** I want to work but can't because I'll lose my benefits. Can't afford to lose my benefits but I want to contribute to society. **"**

Direct Care Workforce Proposals: Untapped Workers

12. State-Wide Direct Support Professional Training

The direct care workforce in Wisconsin consists of a variety of caregiving professions and care settings, each with different training requirements and competency standards. Currently there is limited consistency and portability of training for direct care workers. For purposes of this recommendation, the term Direct Support Professional (DSP) is used to emphasize the intention under this recommendation to provide a career path with credentialing opportunities.

This training recommendation recognizes that multiple training options exist within the industry (facility and community-based). Therefore, this training proposal encourages flexibility to accommodate proven effective training options that are consistent with the identified standards of practice. The recommendation is to pilot a program, which would provide:

- A person-centered direct support professional training to achieve consistent standards of practice
- A collaboration between DHS and DWD, along with the Wisconsin Technical College System and providers
- Identified standards of practice to allow providers the flexibility to apply these standards to their existing training while also meeting the needs of clients in both community- and facility-based settings
- Trainings that are consistent with regulatory requirements
- Develop a tiered career ladder leading to potential CNA certification

Estimated cost: Not available.

> **FACT:**
> Research tells us that more than half of home care workers have completed no formal education beyond high school, and thirty-seven percent of home care workers report speaking English "not well" or "not at all". It is imperative that any training be sensitive to the limited English language needs and educational attainment levels that many caregivers face.[12]

13. Recognition and Recruitment of Direct Care Workers

Create a statewide marketing strategy to recognize and recruit direct care workers, timing its roll out to recognize the impact of the COVID-19 pandemic on state revenue and the primacy of worker compensation reforms to an adequate workforce.

- Phase One would develop and disseminate customizable marketing tools to community and facility-based provider agencies, trainers, health care employers and other stakeholders for their use in social media, on websites and other outlets to attract prospective employees

- Phase Two would be launched after other reforms take effect that would make careers in direct care more attractive (i.e. better wages, benefits). The WisCaregiver Careers program would be leveraged to create a statewide initiative to recognize and attract direct care workers for care positions in nursing homes, assisted living, in-homecare, personal care and self-directed supports. DHS

> **"** A caregiver is under paid and over worked. The rate of pay for this role of caregiver is too often below the poverty level. Why are caregivers who are expected to care for the world's aging population, the disabled, and children regarded so poorly? **"**

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[12] PHI. 2017. https://phinational.org/resource/u-s-home-care-workers-key-facts/, Bronx, NY: PHI.

would administer the program, manage a revised WisCaregiver Career website and oversee amended contracts and interagency agreements for marketing and tracking. Phase two would include mini-grants to providers and an evaluation component.

Estimated cost:
- Phase One Estimate: $25,000-$75,000 depending on breadth of assets/tools redesigned for template use

- Phase Two Estimate: $200,000 over two years; plus $100,000 over two years for tracking and evaluation and $100,000 for mini-grants ($25,000 x 4)

14. Background Check Policies

There are many untapped workers in Wisconsin who possess the skills/experience or could be trained to provide quality caregiving. This recommendation is intended to expand the direct care worker pool of applicants by eliminating barriers to hiring related to background checks and creating consistent hiring criteria across all adult Long-Term Care programs.

> **This is a large untapped labor pool, and most of these individuals were charged with "petty" or victimless crimes... The provider I work for has long supported the idea of giving people a second chance or a fresh start, and it has worked well for us. I believe it's worth exploring on a larger level.**

Policy Components:
- Uncover the existing barriers and inconsistencies that prohibit the hiring of individuals with similar background check findings in the IRIS self-directed long-term care program
- Recommend that IRIS adopt the background check process and criteria that agencies and self-directed clients use within the Family Care managed long-term care system
- With safety being of utmost importance, develop a risk agreement based on informed consent disclosed by the background check. This would be similar to **Act 172** requirements used within the Family Care system. This agreement would provide an avenue for disclosure of certain (non-barred) convictions between the parties and reduce risk while allowing the participant the choice of hiring a qualified direct care worker
- Develop increased quality-monitoring initiatives and standards to support the health and well-being of consumers who choose to hire individuals with a risk agreement. These standards would be followed by Managed Care Organizations and IRIS Consultant Agencies. Recurring analysis would be required to ensure this change creates the desired effects and does not increase risk to the individuals needing care
- Targeted recruitment strategies to address this untapped workforce
- Allow the use of the Rehabilitation Review process for all adult long-term care programs

Estimated Cost: Administrative expenses of:
- Recruitment and onboarding of this workforce
- Development of system-wide risk agreement criteria/process
- Data collection and any related quality initiatives to ensure the health and safety of consumers employing individuals with a risk agreement
- Increased administrative costs with additional Rehabilitation Review processes

15. Medicaid Provider Regulatory Oversight

Adopt the following policies to strengthen collaboration and ensure consistent policies to help increase quality, improve access to care for consumers, support workers with limited English proficiency, and allow direct care workers to focus on providing hands-on care:

- Establish a collaborative workgroup of DHS staff, direct care workers and providers to implement the Wisconsin Supreme Court's Papa vs. DHS ruling and develop practices that support high-quality providers through enhanced education efforts and corrective action processes. The workgroup should:
  - Be guided by the Papa vs. DHS ruling as they work to evaluate and address any pending recoupment efforts
  - Ensure that regulatory interpretations are consistent between regulatory entities Division of Quality Assurance (DQA) and Office of the Inspector General (OIG)
  - Develop a corrective action process to fix documentation or clerical errors instead of implementing penalties for paperwork mistakes that do not impact consumer care
  - Develop a process to give providers at least 30 days from the date they receive DHS's preliminary audit results to provide additional documentation not provided to DHS during the audit
  - Look at creating administrative flexibilities
  - Limit recovery window to one year with an emphasis placed on proactively working with providers and direct care workers to address potential errors early on with the opportunity to correct mistakes. The workgroup should develop the following look-back windows.
    1. *External Audit:* the look-back period should not be more than 90 days for external audits related to client hospitalization.
    2. *Internal Audit:* (OIG onsite at the agency to perform the audit): the look-back period should not be more than 12 months from dates of payment.
- Establish a collaborative workgroup with DHS Staff, direct care workers, consumers and providers to develop consistent processes across Medicaid programs and payers. The workgroups should evaluate and find solutions for creating:
  - Consistent service authorization processes
  - Consistent discharge/change of service processes and timeframes
  - Prior authorization consistency
  - Electronic signature capture

Estimated cost: No estimated state cost

> **FACT:**
> Wisconsin direct care providers have increasingly relied on workers who come from minority or immigrant communities to fill their positions.

> " I work very hard for my clients and take pride in giving them the best care that I can. We live in fear of the state audits that can take back many months of pay for very minor infractions, such as clerical mistakes. "

Home Care Provider Registry

16. Home Care Provider Registry Pilot

Conduct a one-year pilot using the Lightest Touch software platform, which supports In-Home and Community-Based Long-Term Care Supports, including ICAs, MCOs, ADRCs, private pay clients, provider agencies, independent care workers, and vendors of the care service industry. Lightest Touch is a HIPAA compliant database with a platform that allows everyone in the industry to join and then find each other.

The one-year statewide pilot would:
- Provide all users full functionality and advanced features for free for the first 3 months; advanced features available for cost after 3 months; basic functions of the platform remains free and accessible to all (always free for care recipients and direct care workers)
- Facilitate the sharing of data contained within DHS/DWD to populate Lightest Touch's registry at no cost to the state
- Perform quarterly user evaluations to determine the utilization, effectiveness, and other key metrics to assess the platform and usefulness; A workgroup of volunteer stakeholders to support the evaluation process
- Direct the state to issue member communications to promote the Lightest Touch platform which houses the Care Worker Registry

Estimated cost:
- No state funding required for implementation or the ongoing management of the care worker registry
- The state would provide the software company access to data, including available direct care worker information; care workers would be invited to participate and to update their data
- Ongoing funding for the platform would come from agencies that post job openings

> **FACT:**
> The Wisconsin Personal Services Association (WPSA), an organization representing 73 personal care providers, surveyed its members in 2015 and 2016 and found that 93 percent of personal care providers reported difficulties in filling job openings, and 70 percent were unable to staff all authorized hours.[13]

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[13] WPSA, 2017a. http://wpsa.us/sites/default/files/WPSA%20 Talking%20Point.pdf.

Public Input to Task Force Work

The Task Force collected comments on the draft proposals from members of the public through the following means:

- A "Public Comment" opportunity that was noticed on the agenda for every open meeting held by the Task Force
- **A day-long public input session** on June 29
- A "Leave a Comment" function on the Task Force on Caregiving website
- Comments emailed directly to co-chairs and staff, and A public input survey that was available from June 29 through July 14

More than 1,500 individuals completed the **public input survey** commenting on draft proposals. Respondents had the option to rate as many proposals as the wanted to, and to offer comments about how the proposals could be improved. Rating options included: (i) strong support; (ii) somewhat strong support; (iii) neutral; (iv) somewhat opposed; and (v) strongly opposed. Each proposal was somewhat or strongly supported by at least 75% of respondents, with the highest level of support at 92%. Taken together, these proposals were strongly or somewhat supported by 85% of respondents, and only 6% of respondents were in opposition (9% were neutral). The **summary report** of the public input survey includes the ratings for each proposal.

Acknowledgments

Task Force members would like to thank the following for their contributions to this effort:

- Governor Tony Evers for recognizing the critical caregiver shortage and its impact on Wisconsin's care recipients and their families
- The family caregivers and direct care workers throughout Wisconsin for what they do each day to support the independence, the dignity and the wellbeing of care recipients and their loved ones
- The professionals who shared their expertise by presenting on data, resources, best practices and personal experiences in the early stages of the Task Force's work:

  - *Dennis Winters*, Chief Economist, DWD
  - *Steven Campbell*, PHI
  - *Barbara Kleist*, University of MN Institute on Community Integration, Research and Training Center on Community Living
  - *Kristin Litzelman*, Department of Human Development and Family Studies, Division of Extension, University of Wisconsin-Madison
  - *Elaine Ryan*, Home Alone Alliance: The Front Line of Care -- Providing Supports for Family Caregivers, AARP

- Leaders and staff of the Departments of Health Services and Workforce Development for their guidance, coordination, technical support, and subject matter expertise
- Members of the public for sharing their concerns and recommendations
- The Board for People with Developmental Disabilities, for coordinating and underwriting the design work for this report

The Task Force co-chairs would like to also express gratitude to the Task Force members as a whole. It would not have been possible to develop these recommendations in the space of one year, and during a pandemic, without their dedication, expertise, and generosity of time.

Conclusion

If implemented, the recommendations in this report would represent significant steps toward reducing the strains on the caregiving system in Wisconsin. The Family Caregiving and Home Care Provider Registry proposals would help shore up support systems for family caregivers. In doing so, they would allow people in need of care to remain in their own homes and other community-based settings for longer periods of time, which is typically both the preferred and more economical approach. The Direct Care Workforce proposals focus on the critical workforce issues identified in Executive Order #11, and include recommendations to address low wages and insufficient benefits, and finding new ways to recruit direct care workers to the field.

Task Force members understand that even if all of the proposals were fully implemented, more work remains. Until broader issues of equity in access to health care and healthy living environments are addressed, the caregiving system will continue to face challenges.

Task Force members considered development of these recommendations to be "Phase I" of their work. They strongly recommend continued, broad stakeholder engagement in the implementation of these recommendations. Task Force members are ready to move into a Phase II effort, and work with the Governor, the Wisconsin Legislature, and state agencies to guide implementation of the sixteen recommendations and develop additional strategies to strengthen family caregiving and the direct care workforce in our state.

Appendix

Full Text of Task Force Policy Recommendations
Caregiver Assessment: Tailored Caregiver Assessment and Referral

Brief Description

One-year Pilot of the Caregiver Screening/Assessment tool, TCARE Tailored Caregiver Assessment and Referral (TCARE) is an evidence-based care management protocol designed to support family members who are providing care to adults of any age with chronic or acute health conditions. (TCARE may also be called a family caregiver survey.) It includes both a pre-screening tool and a full assessment that asks questions of the family or informal caregiver in order to assess their health and well-being, stress levels, challenges, skills needed to perform care, their informal support system, and strengths that enable them to provide care.[14]

·   The pre-screening tool is available to any community agency that interacts with family caregivers and is used to identify high-risk caregivers who are then referred for a full TCARE assessment.

·   The assessment is completed by staff who are trained and licensed by TCARE. The assessment produces a list of recommended services tailored to meet the specific needs and preferences of the caregiver. The assessment is repeated at three-month intervals in order to adjust the care plan as appropriate.

·   The caregiver is then referred to appropriate caregiver supports such as, for example, the National Family Caregiver Support Program (NFCSP), Wisconsin Alzheimer's Family Caregiver Support Program (AFCSP}, and Aging and Disability Resource Center (ADRC) programs.

·   This two-step process helps prioritize distribution of limited caregiver support resources so that they are available to caregivers with the greatest need.

Implementation

The Department of Health Services (DHS) would administer the pilot program. Agencies that would be encouraged to apply include ADRCs, MCOs, Aging Units, IRIS agencies, tribal agencies, and health care providers.

·   DHS will seek applications to participate in the TCARE pilot program from a consortium of provider agencies. The pilot will include three to six consortiums from both urban and rural areas. DHS should support and encourage the development of consortiums in areas with the greatest need.

·   Each consortium must include both a Medicaid and a non-Medicaid agency in order to allow for data collection and assessment of TCARE success in both populations. Agencies such as ADRCs, MCOs, IRIS consultant agencies, tribal and county aging units, independent living centers, and health care organizations are seen as potential partners.

·   Participation by caregivers is voluntary.

·   When the TCARE assessment is used, it will replace other caregiver needs assessments currently being used to avoid duplication.

·   This proposal covers the cost of training and licensing 25 people to be TCARE assessors, which is the minimum required by TCARE.

·   Evaluation data will be collected and analyzed prior to and at the end of the pilot period to determine success of the program.

·   Measures of success will include an increase in the number and diversity of caregivers referred to supportive services, particularly in underserved areas; delay of nursing home placement and related Medicaid cost reductions; decrease in the number of emergency calls and reduced requests by caregivers for crisis services; documented reduction in caregiver reports of stress/depression; increase in use of less costly caregiver support services.

Analysis and Anticipated Benefits

Caregivers who are supported with resources specific to their needs will be able to provide care for a longer period of time, delaying placement of their loved one in a LTC facility[15]. One research study has shown an 18-24 month delay of placement in a long-term care facility that resulted in a 20% reduction in Medicaid Services. The same study also showed an 84% reduction in stress/depression among caregivers within six months.

·   The Family Caregiving Alliance National Center on Caregiving reports that the assessment process itself is beneficial to caregivers in that they feel their needs are heard, taken seriously, and attended to.

·   TCARE is anticipated to decrease the number of emergency calls from families in crisis[16].

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[14] Tailored Caregiver Assessment and Referral (TCARE) https://acl.gov/sites/default/files/programs/2017-03/Tailored_Caregiver_Assessment_and_Referral__ISR_08_20-2014.pdf
[15] Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings From a Randomized Controlled Study https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202705/
[16] The State of the Art: Caregiver Assessment in Practice Settings, Lynn Friss Feinberg, MSW - September 2002 https://www.caregiver.org/sites/caregiver.org/files/pdfs/op_2002_state_of_the_art.pdf

- Results from two randomized, longitudinal studies conducted with 20 organizations in four states have shown that the TCARE® lowers intentions of individuals to leave the caregiving role, among other benefits[17].

Potential Funding Options/Cost Savings/Benefits
- Some states have used federal CARES Act funding to invest in caregiver assessments. The ADRC reinvestment fund proposal included in this package of recommendations includes caregiver support and assessment enhancements, and if adopted, would be a source of funds to support the TCARE Pilot. Current staff supporting caregivers should be redirected to this role in pilot counties.
- A pilot study involving 2,300 people in Washington State serving 2,300 people showed the implementation of the TCARE assessment contributed to a 20% reduction in Medicaid Services, which equates to $10 million savings.[18]
- A 2010 study in Georgia indicated that use of the TCARE® tool by care managers or a family specialist could simultaneously promote the well-being of the family caregivers and efficient use of scarce resources.[19]

Cost Estimate
- One-time implementation fee: $10,000
- Licenses for a minimum of 25 trained staff to carryout assessments: $50,000 ($2,000/license) per year.
- Additional DHS staff time to manage the project and support coordination with TCARE and pilot-agency staff. DHS should be encouraged to look across all Task Force recommendations impacting caregivers and the direct care workforce for additional ways to utilize staff time in implementing recommendations in order to maximize utilization of any new position. Limited Term Employee (LTE) or contractors could be used to save funds.
- Staff at the local level could be diverted from using current family caregiver assessments or include the TCARE family caregiver assessment as part of their typical care management practices.
- It is possible that proper implementation of the pilot project would include some base infrastructure funding for pilot agencies to complete data collection and participate in project evaluation.

Public Input
This proposal had strong public support: 83% of those responding to the Task Force Public Input Survey indicated support, with almost 80% of family caregivers showing support.
- Respondents felt that caregivers should have the option to participate in the pilot, and that the pre-screen should not duplicate other screenings. Both issues have been addressed in this proposal.
- Respondents commented on the importance of having resources available to caregivers after they are screened. The implementation fee includes resource mapping, which will be an important method of identifying available resources as well as detecting gaps in caregiver supports. The resource mapping itself will be beneficial to caregivers and providers across the state.

Aging and Disability Resource Center (ADRC) Reinvestment

Brief Description
Support additional investment in ADRCs to provide increased attention to and support for family/informal caregivers. Currently, some ADRC programs for caregivers are for older people and people with dementia but do not include caregivers of adults younger than 60 or people with disabilities. This funding would make services and supports in all ADRCs available to caregivers of adults age 19-59. Specific components of the proposal include:
- Expand caregiver support services to ensure that all ADRCs include and address the needs of caregivers of adults age 19-59 with disabilities by providing the same resources and services that are provided by the National Family Caregiver Support Program (NFCSP):
  - *Respite care* (in-home or facility-based)
  - *Supplemental services* - adaptive equipment, assistive technology, home modifications, transportation, and other resources or supplies necessary to care for the person in their home
  - *Support groups, counseling and training* to help caregivers in solving problems related to their caregiver role

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[17] Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings From a Randomized Controlled Study https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202705/
[18] Has the use of Tailored Caregiver Assessment and Referral® System Impacted the Well-being of Caregivers in Washington? https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/Washington%20Report_May%202014_Montgomery.pdf
[19] Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms: Preliminary Findings From a Randomized Controlled Study https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3202705/

- *Information to caregivers about available services* (marketing and outreach)
- *Assistance to caregivers in gaining access to services* (limited case management)

Implementation
The Department of Health Services Office on Resource Center Development would be responsible for implementation.

Analysis and Anticipated Benefits
- Every ADRC will designate a specific "Caregiver Coordinator" to manage caregiver program funds. The Caregiver Coordinator should ideally manage NFCSP and Alzheimer's Family Caregiver Support Program funding. If a different agency holds those funds, every effort must be made to coordinate with that agency.
- The Caregiver Coordinator must maintain close communication with the Dementia Care Specialist.
- ADRCs will be contractually required to create a marketing plan to increase knowledge of Caregiver and other programs at the ADRC and measure the programs' impact, particularly within underserved communities.
- The ADRC would determine how to use the additional funds to meet the requirements above, utilizing other sources of funding (local funds, partner agencies, etc.) whenever possible.
- More caregivers will be served by ensuring that all ADRCs offer services to caregivers of all adults, not just those age 60+.
- One designated staff person will manage the caregiving program, ensuring that more complete support is offered.
- Emphasis on coordination of all caregiver support programs and resources will increase efficiency and reduce duplication of services.

Potential Funding Options/Cost Savings/Benefits
- According to a Statewide Customer Satisfaction Survey of Wisconsin ADRCs published in 2016, help staying in the home is the main issue of concern for one in four ADRC customers (24.6%). Data collected in 2016 concluded that Wisconsin ADRCs help prevent or delay entry into Medicaid long-term care programs. In a 2015 customer satisfaction report almost one in three respondents (29.6%) said that the ADRC helped them stay in their home when they might otherwise have gone to a nursing home or assisted living facility, which costs considerably more. Often caregivers provide critical support to a person with a disability or older adult that ensures care in the home can continue.
- Expanded ADRC marketing efforts are essential to reach and support caregivers: The ADRC Customer Satisfaction report from 2015 shows a majority of customers first heard of the ADRC through word of mouth and were facing a pressing concern or emergency. Expanded marketing efforts will save money by encouraging customers to request help sooner.
- When ADRCs partner with outside agencies to provide required services, not only are there cost savings, but these partnerships also expand outreach to more caregivers. For example, a health care organization might facilitate a caregiver training class or support group and the local Independent Living Center could offer adaptive equipment.
- Providing support such as respite, adaptive equipment, support groups and training prevents or delays long term care placement. Connecting caregivers with services before a crisis also reduces the need for more expensive emergency supports[20].
- Because caregivers and those they care for are a high-risk population impacted by the pandemic, CARES Act and other federal COVID-19 funding to support caregiver outreach and improvement should be tapped.

Cost Estimate
- Caregiver support enhancement is estimated to cost $4M, including support for tribes. These funds shall ensure all services listed above are provided including a designated Caregiver Coordinator staff person and marketing plan. Efforts should be made to distribute these funds equitably throughout the state.

Public Input
- 70.8% of respondents to the Task Force Public Input Survey strongly support the proposal. In response to comments in the public input survey, the following items have been added to this proposal:
  - A marketing plan to increase awareness of the ADRC and its programs
  - Cultural competency training for ADRC staff
  - Emphasis on distributing funds equitably throughout the state

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[20] Has the use of Tailored Caregiver Assessment and Referral® System Impacted the Well-being of Caregivers in Washington? https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/Washington%20Report_May%202014_Montgomery.pdf

Family Medical Leave Act Amendments

Brief Description
- Expand the coverage in the Wisconsin Family Medical Leave Act to include chronic conditions and caregiving responsibilities. Currently the law covers serious health conditions under the care of the physician which typically addresses only acute conditions.
- 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.

Under current law, an employer that employs at least 50 individuals on a permanent basis in this state is required to allow an employee who has been employed by the employer for more than 52 consecutive weeks and who has worked for the employer for at least 1,000 hours during the preceding 52 weeks to take the following: (a) six weeks of family leave in a 12 month period for the birth or adoptive placement of a child; (b) two weeks of family leave in a 12 month period to care for the employee's child, spouse, domestic partner, or parent with a serious health condition; and (c) two weeks of medical leave in a 12 month period when the employee has a serious health condition that makes the employee unable to perform the employee's employment duties.

Implementation
- DWD would be responsible for implementation.

Analysis and Anticipated Benefit
This expanded FMLA policy would benefit working family caregivers by ensuring they can attend the necessary meetings and interactions with health care providers that are essential for them to continue to provide care to a loved one. Population trends indicate there are additional groups of people who now require leave flexibilities from their employment while they serve as a main caregiver. While some employers do allow for caregiving leave for chronic conditions, many do not. This Act would clarify coverage and ensure that more employers allow it.
- According to a 2020 AARP report, 61 percent of caregivers were employed at some point in the last year[21].
- Six in 10 employed caregivers work full time (60 percent) and another 15 percent work between 30 and 39 hours. One in four caregivers work fewer than 30 hours a week. On average, employed caregivers work 35.7 hours a week
- According to 2017 data, 28,000 (2%) children in Wisconsin are living with a relative with no parent present[22].
- 74,457 (5.7%) of children under 18 are living in homes where householders were headed by grandparents or other relatives[23].
- 26,895 of Wisconsin grandparents are householders responsible for their grandchildren who live with them; 63.9% of these grandparents are in the workforce and 18.1% are in poverty.
- An increasing number of siblings of adults with intellectual and developmental disabilities are taking on care responsibilities for their brothers and sisters as their parents' age. In Wisconsin currently, 64% of people with intellectual and developmental disabilities in Wisconsin live with family and 25% of these family caregivers (typically parents) are over 60 years old.
- In the United States, over five million people have assumed – or expect to assume – responsibility for a dependent sibling, and that number is growing as baby boomers age[24].

Potential Funding Options/Cost Savings/Benefits
- No additional governmental funding is needed.
- Expanded FMLA policies can sustain a qualified workforce by allowing caregivers the relief they need to keep employment.

Cost estimate
- No additional cost to the state

Public Input
- The Task Force Public Input Survey showed the FMLA expansion proposal received high support: 82% strongly support with another 10 % somewhat supporting it. There were two areas of concern expressed in both the comments at the Task Force public hearing and in the survey. One was that the benefit is too meager and should provide more time and pay. The other was that this proposal would be too burdensome for small businesses. The proposal was not changed for either of these concerns because (1) most small businesses are not covered by the current WI FMLA and (2) the Task Force workgroup

[21] 2020 Report: Caregiving in the U.S. https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf
[22] State Fact sheets for Grandfamilies: Wisconsin https://www.grandfamilies.org/Portals/0/State%20Fact%20Sheets/Grandfamilies-Fact-Sheet-Wisconsin.pdf
[23] Tanis, E.S., Lulinski, A. & Wu, J., Braddock, D. & Hemp, R. (2020). The State of the States in Intellectual and Developmental Disabilities, Department of Psychiatry, University of Colorado. https://stateofthestates.org/
[24] About Siblings https://wisconsibs.org/who-we-serve/adult-siblings/

viewed this expansion as a parity issue making caregiving for chronic conditions equal to the benefit for caring for someone with an acute health issue. In addition, Wisconsin population changes indicate a growth in kinship care, including an increasing number of grandparents caring for grandchildren. This updated FMLA policy addresses these trends.

Wisconsin Credit for Caring (The Caregiver Tax Credit)
2019-2020 legislative session bill SB 126/ AB 126
https://docs.legis.wisconsin.gov/2019/proposals/sb126

Brief Description
- The AARP publication Valuing the Invaluable shows that the average caregiver spends $7,000 of their own money annually providing care for family members. For those taking care of family long distance, the money spent is approximately $14,000[25].
- This proposal supports legislation to create a nonrefundable individual income tax credit for qualified expenses incurred by a family caregiver to assist a qualified family member. To qualify, a 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. This proposal was previously introduced as legislation in the 2019-2020 legislative session as SB 126/AB 126.
- Subject to a number of limitations, a claimant may claim 50% of the costs of qualified expenses the claimant paid for in the year to which the claim relates. These expenses include amounts spent to improve the claimant's primary residence to assist the family member, equipment to help the family member with daily living activities, and 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 particular family member is $1,000 or $500 if married spouses file separately. If more than one claimant may file a claim related to that family member, the amount of credit each may claim is based on the percentage of the family member's qualified expenses for which each claimant paid during the year. 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 $150,000 if the claimant is married and files jointly.
- Generally in this proposal, qualified expenses may not include general food, clothing, transportation, or household repair costs, or amounts that are paid or reimbursed by an insurance company or the government.
- Because the credit is nonrefundable, it may be claimed only up to the amount of the claimant's tax liability.

Implementation
The Department of Revenue (DOR) would be responsible for implementation.

Analysis and Anticipated Benefits
- This bill would give some financial relief to family caregivers who are incurring expenses keeping their loved ones in the community and out of institutions. Family caregivers often spend their own personal savings and forego their own employment income to provide care.
- This proposal was first introduced as a bill in the 2019-2020 legislative session. The bill's sponsors expressed the hope that in the long run it would reduce the number of people reliant on Medicaid and keep people out of government funded programs for as long as possible. Medicaid payments, particularly institutional care, is very expensive and avoiding or even delaying institutional care would save the program significant money. While there are many variations on how the Medicaid rate for nursing homes is set, the average monthly rate per person is $5,212.
- Supporting family caregivers to meet caregiving costs can ensure family caregivers remain healthy and have the funds they need to retire. Survey data show that nationally one in 6 family caregivers have reduced the money they set aside for retirement, one in 7 have spent less on their own health care, more than one in 10 have gone into their retirement savings and another one in 10 have taken out a loan[26].

Potential Funding Options/Cost Savings/Benefits
This proposal is a revenue loss, not a savings. However long term return on investment would eventually significantly reduce Medicaid costs. The current Medicaid nursing home annual payment is an estimated $62,539, which is much greater per care recipient than the $1,000 tax credit paid to the caregiver.

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[25] Valuing the Invaluable https://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html
[26] Family Caregiving and Out-of-Pocket Costs: 2016 Report https://www.khi.org/assets/uploads/news/14680/family-caregiving-cost-survey-res-ltc.pdf

Cost Estimate

The Department of Revenue (DOR) has estimated the tax credit would cost $125 million.

Public Input

· In the Task Force Public Input Survey, this proposal received 66% strong support and 24% somewhat support. Concerns have been expressed that in this time of anticipated budget shortfalls, the $125M tax credit would be a significant state revenue loss. However, the charge of the Task Force is to address the issues of caregiving and while this proposal may not be immediately feasible in the next budget, the long term benefits to both the caregiver and the return on investment for the state are too great to not advance this proposal.

· In an AARP 2019 survey, about 9 in 10 Wisconsin registered voters age 40 and older support the provision of a state income tax credit to family caregivers who incur expenses for the care and support of a family member living in Wisconsin[27].

· When this proposal was advanced as legislation in the 2019/2020 session, the following organizations registered their support (no organizations registered opposition):
  · AARP
  · Alzheimer's Association
  · American Heart Association
  · Coalition of Wisconsin Aging Groups
  · Greater Wisconsin Agency on Aging Resources
  · Home Care Association of America
  · The Arc Wisconsin
  · Wisconsin Association of Local Health Departments and Boards
  · Wisconsin Coalition of Independent Living Centers, Inc.
  · Wisconsin Nurses Association
  · Wisconsin Public Health Association

The CARE Act (2019-20 Legislative session SB 516/AB584)[28]

Brief Description

This proposal is modeled after legislation introduced in the 2019-20 legislative session as SB 516/AB 584 and would:

· Ensure that a family caregiver is recorded when a loved one is admitted to the hospital.

· Ensure that the caregiver is notified if a loved one is transferred to another facility or discharged back home.

· Ensure that a facility provides an explanation and live instructions on medical tasks caregivers are expected to perform.

Implementation

The Department of Health Services (DHS) would be responsible for implementation.

Analysis and Anticipated Benefits

· In a 2019 AARP Wisconsin survey of Wisconsin voters age 40+, 76% of responding caregivers said their loved one had been to admitted to the hospital while under their care; 34% of these current or former caregivers said they had not received education or instructions on the follow-up medical tasks and care for their loved one during the hospital discharge process, even though these were tasks they would need to perform at home.

· Because this legislation would require hospitals upon discharge to provide the training and education in medical/nursing duties that the caregiver is expected to perform after discharge, there would be better follow-up care provided by the caregiver.

· This bill should reduce hospital readmissions. Caregivers caring for a recently hospitalized son, for example, who requires more complex care may be at higher risk for long-term care placement outside the home and therefore, could benefit from supports that have been shown to help delay placement.

· The more hours of care provided, the more often a caregiver helps with medical/nursing tasks: 84% of caregivers who provide 21 or more hours of care weekly are helping with medical/nursing tasks (compared to 45% of those providing 20 or fewer hours of care). A similar pattern emerges for the level of care index, where caregivers in higher-intensity situations more often do medical/nursing tasks[29]. Supporting high-hour caregivers in their roles is essential to sustain their ability to provide care.

· This proposal will reduce caregiver stress. Caregivers report that one source of stress is not feeling adequately trained/ prepared to carry out nursing/medical tasks, indicating the need for more support with instruction[30].

[27] Family Caregiving in WI: Overwhelming Support for a Caregiver Tax Credit https://www.aarp.org/content/dam/aarp/research/surveys_statistics/ltc/2019/wisconsin-caregiving-survey-caregiver-tax-credit.doi.10.26419-2Fres.00259.092.pdf
[28] 2019 Senate Bill 516 https://docs.legis.wisconsin.gov/2019/proposals/sb516
[29] Home Alone Revisited: Family Caregivers Providing Complex Care https://www.aarp.org/content/dam/aarp/ppi/2019/04/home-alone-revisited-family-caregivers-providing-complex-care.pdf
[30] Report: Caregivers tackling complex medical tasks with little training https://healthjournalism.org/blog/2019/07/report-caregivers-tackling-complex-medical-tasks-with-little-training/

- How hospitals communicate with caregivers is becoming more important as the population ages, people with disabilities live longer and the number of unpaid family caregivers increases. An estimated 44 million Americans have cared for a relative in the past year[31].

Potential Funding Options/Cost Savings/Benefits
There would be no cost to the state taxpayers. No state funding is needed.

Cost estimate
There would be no cost to state taxpayers. As for increased cost for hospitals, it is difficult to gauge and is outside the purview of the Task Force. In hospitals where this type of caregiver identification and education is currently being provided there should be no additional cost. For those where it is not, the costs to the hospitals are most likely offset by the reduction in readmissions.

Public Input
During the last legislative session, the Wisconsin Hospital Association (WHA) opposed the CARE Act legislation. Task Force members invited WHA to formally present their concerns on May 6. A panel from WHA highlighted the best practice work of one major Milwaukee Hospital system to incorporate caregivers in the hospital experience of the care recipient. WHA also provided data from a CMS survey of patient satisfaction which showed that Wisconsin hospitals ranked high, this year ranking number 1, in providing discharge instructions to patients. Unfortunately, this data did not address the questions and concerns of a designated caregiver. The WHA satisfaction survey data tracked the provision of written instructions to the care recipient but did not address caregiver concerns about their ability to perform complex medical and other care tasks post-discharge nor the desire expressed by caregivers for hands on task demonstrations.

While WHA also contended that implementation of new discharge planning requirements would be expensive, Task Force members suggest that incorporating this additional and necessary conversation with a designated caregiver is essential to prevent costly re-admissions and to delay placements in other institution settings.

In both the public hearing and the public input survey the CARE Act proposal received wide support with 470 providing their feedback. In the survey 77% registered strong support with 13% somewhat support. Of the nearly 200 caregivers or family members who responded to this question in the public input survey, more than 90% supported this proposal.

Rate Bands

Brief Description
DHS should develop and implement by December 2023 a statewide minimum rate band based on a comprehensive and transparent rate evaluation that results in transparent, equitable and sustainable rates for home and community-based long-term care supports.

A new rate bands system should:
- start by evaluating and establishing equitable and sustainable direct support professional wages
- be transparent and consistent across programs and settings
- have built-in annual increases based on the Consumer Price Index (CPI)
- be developed with a workgroup comprised of providers and an independent outside entity with expertise in rate analysis across the spectrum of service categories from the beginning
- include a tiered system to recognize acuity levels/complexity of care that reflects the needs of the participant in a consistent, quantifiable and transparent process
- hold harmless existing provider rates
- develop a process for identifying cost outliers
- be in compliance with CMS rate band guidance[32].

Implementation
- DHS and an independent third-party rate evaluation contractor/service would be responsible for implementation.
- DHS must direct actuaries to reflect the realities of a new provider rate system. DHS must also direct the IRIS consulting agencies to reflect the realities of a new provider rate system in their usual and customary parameters. Statewide public comments must be gathered and considered before a final rate band is established. Minimum rate bands must incorporate certificate/tier training completion of direct care workers (DCWs), resulting in higher wages for DSPs with advanced training.
- In the interim years of 2021 and 2022, direct care provider agencies with direct support professionals whose wage

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[31] Caregiving for Family and Friends: A Public Health Issue https://www.cdc.gov/aging/agingdata/docs/caregiver-brief-508.pdf
[32] "CLTS Waiver Program Service Rates Initiative." Wisconsin Department of Health Services, 1 July 2020, www.dhs.wisconsin.gov/hcbs/ratestructure.htm

categories are less than $15/hour (personal care, supportive home care, residential and day-program supports, pre-vocational and vocational support workers) receive an 8% increase per year to reflect recognition of wage stagnation experienced by all Wisconsin low-wage earners during the past 20 years, and the essential nature of work performed by direct support professionals.

· All providers should be able to demonstrate how this rate increase directly benefits direct support professional wages[33].

Analysis and Anticipated Benefits

· Establishing a consistent, transparent statewide rate band that starts with direct support professional wages, incentivizes additional training/service years, and recognizes the inadequacies of existing wages increases the likelihood that the direct support professional is adequately compensated; that the provider network is adequately compensated; that the rates reflect current costs; that less time is invested in rate negotiations; that consistency across the state and across providers is established; and that increasing costs (CPI) are built in so that rates do not become stagnant. It avoids the current "look back" model that becomes a self-fulfilling prophecy of inadequate rates based on the past. This benefits the direct support professional with an adequate wage, the provider network by ensuring robust business models, ensures transparency to the care recipient and to taxpayers with a publicly-accessible set of rates; and increases the likelihood that people needing care have an adequate network of appropriately compensated providers.

· In 2017 the Government Accountability Office issued a **report** on the need for improved oversight in rates paid for long-term services and supports: Their report identified the need for rates to take workforce dynamics into account, noting that the payment rates set by MCOs to community-based providers, such as home care workers, could have an impact on access to services. CMS issued an informational bulletin in August 2016 that encouraged states to be mindful of the relationship between access to care and wages for the Medicaid home care workforce. In its **2016 Bulletin** "Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce" – the Center for Medicare and Medicaid Services (CMS) said: "Wages paid to individual workers are often slow to be adjusted in response to inflation and economic growth, and can lag behind wage increases in other health and service sectors. Analyses of how the home care industry relates to the larger marketplace within a state are encouraged when states establish rate-setting methodologies to providers, and when providers determine the wage structure for their employees."

Potential Funding Options/Cost Savings/Benefits

Benefits exist through the likelihood of ensuring an adequate provider network, increasing the health and safety of people needing care, and avoiding costly health care crises that occur when there is a direct care worker shortage.

Cost Estimate

DHS will need funds to increase contractual services for a. actuarial re-adjustment; to perform a comprehensive, independent and market-driven rate analysis of the existing system; and c. to determine what increased investment in rates is necessary to achieve an accurate reflection of true costs that reflect current competitive market wages.

The 8% increase in the years of the rate analysis will require an estimated increase of $45 million in the first year, $92 million GPR in the second year.

Public Input

Overall, public support was strong: 85% approved and 7% were neutral. 6.2% opposed. The final proposal takes into consideration multiple public input comments that: 1. Any rate band changes directly impact the worker (thus starting with a rate evaluation to establish equitable and adequate wages); 2. Consider tiers of acuity to account for higher levels of need in the participant, and thus higher wages/skills from DSPs; and 3. Quicker implementation than originally proposed (end of 2021). Thus, the Task Force proposes immediate 8% increases during the rate analysis to address the magnitude of the wage crisis; 4. Ensure there are no "winners and losers" by implementing hold harmless on wages and infuse additional revenue into the system.

Medicaid Nursing Home and Personal Care Reform
Brief Description

The Wisconsin Medicaid nursing home and fee for service personal care reimbursement systems should be reformed to create payment standards that are reflective of the actual cost of care. Currently, the Medicaid program establishes payment rates for nursing homes and personal care workers according to the funding levels made available by the Governor and Legislators through the State Budget process. As proposed, budgeting for these services in the future would be more directly tied to: (1) paying for a specified percentage of the actual cost of care (for nursing homes) and (2) an estimated hourly wage to be paid to personal care workers.

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[33]Walther, Anna. "Declining Returns to Low-Wage Work in Wisconsin." INSTITUTE FOR RESEARCH ON POVERTY, University of Wisconsin–Madison, Sept. 2019, https://www.irp.wisc.edu/resource/declining-returns-to-low-wage-work-in-wisconsin/.

The Current Medicaid nursing home payment formula significantly under-reimburses nursing facilities for the actual cost of care, and these inadequate payment levels suppress hours, wages and benefits paid to direct support professionals (caregivers and related personnel). Personal care agencies also are limited in their ability to increase direct support professional wages and benefits due to low Medicaid rates. If we are to expect nursing facilities and personal care agencies to increase wages, benefits, and hours, then the unacceptably low Medicaid rates for nursing homes and personal care workers must be addressed (increased). This remains true despite the nursing facility and personal care funding increases authorized in the 2019-2021 Biennial Budget.

Implementation

The Department of Health Services would be responsible for implementing both the nursing home payment standard and personal care payment standard proposals. The actual payment standards would be developed with stakeholder involvement from the very start, following a fully transparent and open process.

Analysis and Anticipated Benefits

· Wisconsin's nursing facilities are in financial crisis, a fact that is well documented. The reality is: (1) According to a January 2019 Legislative Fiscal Bureau report, "75% of facilities experienced direct care nursing costs in excess of the rates provided for that cost center, after factoring in direct care-related provider incentives. However, when Medicaid costs across all cost centers are considered, 97.1% of nursing homes reported total costs that were greater than the total fee-for-service reimbursement rate, largely due to significant deficits in the support services cost center."[34]; (2) National reports indicate Wisconsin has the second worst nursing home payment system in the country (relative to covering the actual cost of care)[35]; (3) A national accounting firm's study reported Wisconsin nursing homes had an overall net operating margin of -3.5%, considering all funding sources[36]; (4) Since 2016, Wisconsin has faced 41 nursing facility closures and thousands of additional beds have been delicensed as facilities have implemented strategies to cope with ever-increasing Medicaid losses[37]; (5) Wisconsin's nursing facilities report a caregiver vacancy rate of 23% and facilities have been forced to deny admissions due to lack of staff[38]; and (6) Wisconsin hospitals are experiencing difficulties in placing Medicaid-eligible patients[39].

· Personal care rates, which support community-based personal care workers, have been underfunded for decades. Consistent rate increases are needed to support an adequate provider network and a quality workforce— both of which are in jeopardy because of chronic underfunding (This remains true despite the personal care increases provided in the 2019-20121 State Budget). The current personal care rate is estimated to be $18.77 per hour and this amount must fund all of the agencies' costs associated with providing care, including: (a) wages, health insurance and related benefits for personal care workers; (b) the agencies' other direct care costs, such as nursing staff, supervisors, and travel costs; and (c) indirect costs, such as office operations and insurance costs[40]. Thus, rate increases provided to personal care agencies must cover several operating expenses in addition to direct care workers' wages and benefits. As a result, the personal care worker average hourly wage is estimated to be about $12.00 per hour. Some have estimated the personal care rate results in an operating loss of at least $2.00 hour, meaning the current system is unsustainable.

· The well documented long-term care workforce shortage is so severe that it is jeopardizing the health, safety and welfare of older adults and people with disabilities. The Legislative Fiscal Bureau's May 2019 budget paper reported: "WPSA found that 84% of the personal care agencies surveyed as part of its 2018 member survey downsized in the past year and that one out of two agencies are considering no longer providing MA personal care services. 83% of the members surveyed found it difficult to fill job openings and one out of three agencies were experiencing turnover rates above 50%. 6. In 2016, Survival Coalition surveyed over 500 long-term care recipients and their families and found that 85% of long-term care recipients do not have enough direct care workers to work all of their shifts."[41] In the past six years, over 80 personal care agencies have closed or stopped providing Medicaid personal care[42].

[34] Legislative Fiscal Bureau Informational Paper #41: Medical Assistance and Related Programs https://docs.legis.wisconsin.gov/misc/lfb/informational_papers/january_2019/0041_medical_assistance_and_related_programs_informational_paper_41.pdf, January 2019
[35] Medicaid Papers and Briefs https://www.ahcancal.org/facility_operations/medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf)
[36] 34th SNF Cost Comparison and Industry Trends Report — National Themes, Local Insights https://www.claconnect.com/resources/white-papers/2019/34th-snf-cost-comparison-and-industry-trends-report
[37] Wisconsin Nursing Facility Closures: 2016-2020 August https://leadingagewi.org/media/90586/nh-closures-2016-2020-updated-8-17-20.pdf
[38] 2020 Workforce Crisis Report https://leadingagewi.org/media/83324/2020-workforce-reportfl.pdf
[39] Interviews with WHA officials and meetings of the LTC Subcommittee of the State Disaster Medical Advisory Committee https://publicmeetings.wi.gov/view/bd456ac6-02fe-4eec-9b34-2ac974a4baf5
[40] WPSA Legislative Updates: February 2020 https://www.wpsa.us/legislative-criticalupdates
[41] LFB 2019-21 Budget Summary: Personal Care Reimbursement Rate https://docs.legis.wisconsin.gov/misc/lfb/budget/2019_21_biennial_budget/102_budget_papers/370_health_services_personal_care_reimbursement_rate.pdf
[42] WPSA Personal Care in Crisis https://static1.squarespace.com/static/5af1fcbb25bf0239ef4c73f7/t/5cf01061d34fe70001fc5120/1559236705439/MAPofCountiesImpactedbyClosuresandDownsizings.pdf

- This proposal includes the following recommendations to address nursing facility and personal care caregiver challenges:
  - Nursing Facility Payment Reform: The recommendation is to link nursing home reimbursement rates to the actual cost of care (i.e., rates should be set at payment standards based on the statewide median (50th percentile) plus a percentage, for the cost of Direct Care and Support Services. When allocating dollars to the Direct Care- Nursing Cost Center (primarily CNA, RN and LPN expenses) it is important to note that these funds must be spent directly on the workforce. That is, facilities will be paid at the *lessor* of the payment standard or the provider's actual cost. In short, facilities would only receive the full rate allowed under this payment standard if they incur caregiver costs equal to or greater than the standard.
  - Establish separate payment standards for the Direct Care- Other (primarily personal comfort and medical supplies, over-the-counter drugs; and activity/recreation, social worker, volunteer coordinator religious and therapy aide personnel) and Support Services (primarily housekeeping, dietary, laundry, maintenance and administrative services) cost centers under the current payment system. As noted above, increases in these cost centers are necessary because without overall rate increases (in addition to Direct Care- Nursing) many nursing facilities will not be able to fund critical operational expenses, threatening the sustainability of the facility. Furthermore, some low-cost facilities may choose to use increases provided outside of Direct Care-Nursing to more quickly fund direct care expenses because there may be a 12-18 month time lag between when a facility increases Direct Care- Nursing costs and when these costs will be reimbursed by the Medicaid program. Each payment standard should be annually adjusted by the appropriate cost index, similar to the Consumer Price Index (CPI). Lastly, the nursing facility recommendation would increase and fund Direct-Care Nursing payments to those facilities in the lowest labor regions within the current nursing home reimbursement system. Presently, about one-half of all Medicaid resident days fall within these lower labor regions and facilities located in these labor regions receive lower Medicaid rates, limiting their efforts to increase Direct Care-Nursing related hours, wages and benefits. (Note: The nursing home payment recommendations noted in this section are generally based on the State of Minnesota's nursing home payment reforms adopted in 2016-17)
  - Personal Care Rate Recommendation: This recommendation is relatively straightforward in nature due to the way agencies are reimbursed under the Medicaid program. As proposed, the State Budget would explicitly allocate dollars to personal care agencies to fund an estimated hourly wage for personal care direct care workers similar to the approach used in the 2019-2021 Biennial Budget. Building off the current State Budget assistance for personal care workers, the proposal is to establish payment standards such that rates paid to personal care agencies for direct support professionals reflect necessary market adjustments and CPI increases. The personal care agency payment standard would be applied to personal care provided on a fee-for-service and managed care basis, as well as for personal care services provided to IRIS participants, including self-directed IRIS personal care services.
  - Consistent with the Task Force's Family Care recommendations, the nursing home and fee for services personal care payment standards should be annually adjusted by CPI. The goal of reimbursement adjustments is to prioritize increases in worker wages to reflect market dynamics.

Potential Funding Options/Cost Savings/Benefits

If Wisconsin hopes to improve wages and benefits to caregivers serving nursing home residents, the overall nursing home payment system must be reformed. One cannot happen without the other. This investment is necessary to preserve CNA jobs and improve wages, benefits, and hours.

Personal Care Agencies, and those they serve, would be greatly assisted if the State of Wisconsin committed to a payment standard reflective of market trends and the need to offer competitive wages and benefits for direct care workers.

Cost Estimate

The fiscal effect of the nursing home and personal care agency proposals is dependent on the payment standards selected (for example, payments tied to the cost centers' median plus a certain percentage). As a phased-in payment standard is considered, it is worth noting that increasing nursing home funding by $20 per resident, per day ($10 per resident per day for the Direct Care-Nursing payment standard a $5 per resident per day increase both for the Direct Care- Other and Support Services payment standard) would require an annual increase of approximately $66M in all funds ($26.4 million of which would be GPR). The cost of the nursing home labor region proposal is estimated to annually cost no more than $4.0 million GPR.

The 2019-2021 State Budget provided a 12% increase to the Medicaid Personal Care Reimbursement Rate: The rate increased by 9% on July 1, 2019 to about $18.23 per hour and it is estimated the rate will increase by 3% in July 2020 to about $18.77 per hour. The cost of this initiative was $15.3 million GPR in 2019-20 and $21.6 million GPR in 2020-21. These amounts offer some insight as to the cost of increasing the personal care rates similarly in the future.

Public Support

Nearly 90% of the comments the Task Force received supported the recommendation to pursue nursing home and personal care payment reform (only 3% opposed). Clearly, these recommendations are valued by those who support building a stronger and more sustainable direct care workforce.

Medical Loss Ratio

Brief Description
Require a Medical Loss Ratio (MLR) of at least 85% for direct care and services, limiting the Managed Care Organizations' (MCOs') administration and case management expenses to 15% of the capitation rate received from DHS.

Original Proposal: Include in the Family Care contract (FC, FCP, Pace) a requirement for an 85%/15% medical loss ratio. Provide that case management expenses cannot be included in the direct care and services cost component of the calculation.

Note: Very recently, MCOs and the Department of Health Services (DHS) raised concerns that imposition of the proposed 85%/15% MLR may not fall into compliance with the federal managed care regulations. Because the Centers for Medicare and Medicaid Services (CMS) has not ruled on this matter, the Task Force recommends advancing the proposed 85%/15% rule and, should CMS subsequently determine that the proposal is not allowable under the federal rules, then DHS should pursue additional MCO accounting and oversight controls to ensure proper maximization of dollars are available to fund the direct care and services portion required of Family Care participants. In addition, the proposed MLR would ensure the MCOs' administrative and related costs are in line with an efficiently and economically operated insurance company, consistent with the goals of the Family Care program.

Implementation
The Department of Health Services Division of Medicaid Services would be responsible for implementation.

Analysis and Anticipated Benefits
· A medical loss ratio in managed long-term services and supports (MLTSS – programs like Family Care and Family Care Partnership) is the percentage of capitation rate dollars a managed care organization spends to provide medical services and health care quality improvement activities for its members. "Health plans that spend a higher proportion of the premium on medical services are viewed as providing better value for the payer and consumer than plans that spend a higher proportion of the premium on administrative expenses and profit margins." (Dominiak and Libersky 2012).
· The Center for Medicare and Medicaid Services (CMS) published a final rule on May 6, 2016, that requires Medicaid MCOs (like those in BadgerCare) to calculate, report, and use an MLR to develop capitation rates. The final rule requires that the capitation rates for MCOs be set for a minimum MLR of at least 85 percent. States can also apply MLR standards in managed care within long-term services and supports, but there is no requirement to do so.
· In its 2016 report on MLTSS, the National Council on Disability, which visited Wisconsin during the investigation for its report, states that "Advocates should provide details on the kinds of activities that should be included as a community integration activity for purposes of the MLR numerator."
· The Family Care contract[43] includes no MLR percentage requirement – only a reporting requirement. Also, all care management expenses are included in the service cost component and are not delineated from direct services to participants.
· "The MLR calculation for the FC, FCP and PACE programs includes care management service expenses in the service cost component of the calculation."
· The federal Health and Human Services (HHS) Office of Inspector General (OIG) conducted an analysis of Wisconsin MLR in 2017[44]. Two Family Care MCOs were included, and their MLR was above 90%, however, including care management costs in the calculation may not provide a clear picture of expenditure on direct services.
· In 2020, in part to address the direct care workforce crisis, DHS directed the actuaries who develop capitation rates for Family Care to include in the 2020 MCO capitation rates, "a rate adjustment to increase average provider reimbursement rates by 1% for waiver services provided in mature GSRs (i.e., all GSRs other that GSR 12) above the unit cost trend included in the rate development. With this rate adjustment is the expectation that certain Family Care MCOs will implement corresponding provider rate increases effective CY 2002." [45]
· Despite this specific rate adjustment, not all Managed Care Organizations passed along rate increases to providers, nor was there required reporting to identify whether this had occurred.
· DHS posts MCO quarterly financial summaries[46]. The MCOs' financial statements for the full calendar year 2019 are provided in the table below, identifying the proportion of capitation rate spent by each MCO on care management (ranging from 9.4% to 14.0%) and member service expense (ranging from 78.0% to 89.8%).

[43] DHS Generic MCO Contract https://www.dhs.wisconsin.gov/familycare/mcos/2018-generic-final.pdf
[44] DHS-OIG Review of WI Medicaid Managed Care Program Potential Savings with Minimum Medical Loss Ratio https://oig.hhs.gov/oas/reports/region5/51500040.pdf
[45] Milliman Report to State of WI DHS: 2020 Capitation Rate Development – Family Care Program https://www.dhs.wisconsin.gov/non-dhs/dms/fc-2020capitationrates.pdf
[46] DHS Website: Family Care and Partnership/PACE Financial Summaries https://www.dhs.wisconsin.gov/familycare/mcos/financialsummaries.htm

Member Service Expense, Net	78.0%	81.2%	84.3%	82.7%	89.8%	82.7%
Care Management Service Expense	14.0%	11.7%	12.2%	9.4%	10.6%	11.7%
Total Member Service Expense	**92.0%**	**92.9%**	**96.5%**	**92.1%**	**100.4%**	**94.4%**
Administrative Expense	4.3%	3.6%	3.2%	2.3%	3.9%	3.5%
Total Operating Expense	96.3%	96.5%	99.7%	94.4%	104.3%	97.9%
Income (Loss) from Operations, CY	**3.7%**	**3.5%**	**0.3%**	**5.6%**	**-4.3%**	**2.1%**
Net Income/(Loss)	3.9%	3.9%	2.30%	5.7%	-2.2%	2.9%

- It is important to note that three of Wisconsin's five MCOs currently would meet or be very close to meeting the 85% / 15% proposed MLR under consideration by the Task Force
- Should CMS not approve the 85%/15% Medical Loss Ratio as proposed by the Task Force, DHS should audit the MCOs' administrative and case management expenses to determine if additional dollars should go towards the direct care and services portion of the capitation rate. This audit should also include a review of the Family Care participants' satisfaction level with the respective MCOs' case management services, including information about the type and level of case management support provided to meet member goals.

Potential funding options/cost savings/benefits

Requiring an MLR in the Family Care contract and removing case management expenses from the calculation should offer greater transparency into the rates paid to providers who offer direct services. More attention to efficiency in case management expenditures could save funds over time. Any directed increase in the capitated rate for a specific service component, including direct care, should be reflected in the member services portion of expenditures.

Cost estimate

The MLR requirement should not increase costs.

Public Input

The MLR proposal was widely supported (80%) by public comments submitted to the Task Force.

Direct Care Worker Fund

Brief Description

- Propose that 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. Further, direct and support DHS' efforts to secure CMS approval allowing total Direct Care Workforce Funding to be allocated via annual payments.
- The measure would provide immediate assistance to directly support the caregiver workforce until such time that a Family Care rate band is implemented
- This recommendation 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.

Implementation

DHS would be responsible for implementation.

Analysis and Anticipated Benefits

For the past two years, the Legislature approved and the Governor signed into law the $67,985,100 (all funds 2020-21) Direct Care Workforce Funding program. This program, which was subsequently approved by CMS, provides critically necessary funding for providers to help offset employment expenses for direct caregivers. The payments have been provided in quarterly installments, passed through to providers by their respective MCO.

Allocation Category	Q2 Percent	Q3 Percent	Q4 Percent
Wage Increases	33%	39%	40%
Retention/Longevity Bonuses	28%	26%	27%
Performance Bonuses	28%	23%	20%
Employee Paid Time Off	9%	9%	9%
Staff Referral Bonuses	1%	2%	2%
Signon Bonuses	2%	2%	2%
Total	100%	100%	100%

Because the payments have not been provided quarterly as planned (2019/2020 payments came near the end of the fiscal year), and with no assurance these dollars would be available on a continual basis in subsequent years, many providers have elected to use the money for one-time bonuses to employees rather than as wage increases, thus not solving the wage issue for caregivers. Recipients of direct care workforce payments reported how payments were allocated by category via a survey tool. Survey information has been collected for CY 2018 quarters 2 through 4. This data includes all provider submissions and may not accurately reflect the actual dollars allocated due to the self-reported nature of the data.

- Annual increases to the Direct Care Workforce Funding program would ensure dollars are allocated directly to providers and are not retained by the MCOs.
- By switching the payments to an annual schedule, the initiative would be used to support immediate wage increases as a gap measure to caregivers until such time the rate band funding mechanism is established.

Potential Funding Options/Cost Savings/Benefits

Because annual increases to base Direct Care Workforce Funding would be set by the Legislature and the Governor with operational and program assistance from DHS, overall funding levels would be clearly identified using the average wage paid to DCWs in the state and the difference required to bring them up to an effective living wage. The money would be earmarked, giving the provider community confidence that these dollars will be available to fund ongoing employment expenses because MCOs would be required to pass on these dollars directly to providers.

Cost Estimate

The Direct Care Workforce Fund appropriation for 2020-21 is $67,985,100 all funds ($27.5 million GPR). Under this proposal, this amount would be increased to meet market demands for caregiver wages. For example, it is estimated that increasing the Direct Care Workforce Fund by 5% in each year of the 2021-23 biennium would cost approximately $28.1 million GPR in 2021-22 and $57.7 million GPR in 2022-23. (Note: DHS would be able to provide more precise estimates on the cost of providing 5% annual increases in 2021-23) Once the rate band system is established, the Direct Care Workforce Fund could either be continued or folded into the new system.

Public Input

The public input received expressed support for continued investments in the Direct Care Worker Fund, however, the wage pass-through program in its current state, while appreciated, is viewed as cumbersome. Research indicates that many pass-through designs may have a questionable impact, but in the Task Force Public Input Survey 67.1% showed strong support with a further 18.8% saying they somewhat support. There were 544 individuals registering an opinion on this proposal with only 2% who were strongly or somewhat opposed.

Individual comments showed support for changing to an annual payment. The Wisconsin Long-Term Care Workforce Alliance provided comments saying the payments have been extremely helpful for providers in allowing them to give additional pay increases, bonuses, and other incentives that they may have not been able to give due to lack of reimbursement. We also heard from IRIS providers/consultant agencies that the department must prioritize parity across long-term care programs, including IRIS workers who do not currently receive payments or funding to attract and retain qualified caregivers. Commenters requested that DHS develop a simple, user-friendly mechanism to access the Direct Care Worker Fund that is consistent with employer authority under IRIS.

Wisconsin Medicaid Expansion per the ACA

Brief Description

The goal is to expand Medicaid in Wisconsin to 138% or more to strengthen and stabilize health care access for low wage caregivers. Unpaid family caregivers who have taken on caregiving responsibilities by leaving the workforce or reducing their hours, thereby losing employer provided insurance, would also benefit from Medicaid expansion. In non-expansion states, only 42% have the option to receive Medicaid coverage, as compared to 75% in expansion states[47].

- Wisconsin is in a caregiver crisis
- Expanding Medicaid eligibility offers comprehensive health insurance coverage to low-wage caregivers
- Expansion of Medicaid allows caregivers to work more hours without losing other public benefits
- Low-wage workers, which includes caregivers, are disproportionately impacted by the COVID-19 pandemic and recession
- Workers who lose employer-based health insurance are predicted to remain uninsured in non-expansion states
- Increased federal payments as a result of a full Medicaid expansion would bring an additional $1 billion in revenue to Wisconsin
- The Wisconsin Office of Commissioner of Insurance finds that Medicaid expansion lowers insurance premiums in the individual market by 7 to 11% compared to non-expansion states[48]

Implementation

The following entities will each play a part in implementation:
- Legislature
- DHS
- CMS

[47] The Working Poor Families Project www.workingpoorfamilies.org Press Release, May 7, 2019 - Insurance
[48] Commissioner Says Medicaid Expansion Lowers Insurance Premiums on Individual Market https://oci.wi.gov/Pages/PressReleases/20190507Expansion.aspx

Analysis and Anticipated Benefits

Expanding Medicaid eligibility offers comprehensive health insurance coverage to low-wage caregivers. Data from PHI[49] on direct care workers in Wisconsin include:

· 37% are on public assistance. Expanding Medicaid would allow an additional 60% of caregivers to obtain health insurance
· 49% of caregivers are in or near poverty
· Their median annual income is $18,600
· Their median wage is $12.28 (includes CNAs and home care workers)
· The number of paid caregivers employed in 2019 was 101,180
· Projected job openings from 2016 to 2026 is 173,900
· Expanding Medicaid eligibility directly affects the paid caregiving workforce by allowing employees who currently limit their work hours so as not lose publicly-funded health insurance coverage to work more hours. If Medicaid expansion were adopted:
    · Wisconsin would realize increased revenue from increased FMAP through Medicaid expansion.
    · Wisconsin's caregiver workforce shortage could be improved by allowing people who are already working to work more, earn more money and retain their health insurance. These additional hours would reduce staff shortages and provide more care to people in need.
    · Caregiver retention is improved because caregivers have health insurance. The cost to agencies and providers is decreased because of lower turn-over and thus reduced training expenditures.
    · The more people with health insurance, the less uncompensated costs there are.
    · Medicaid expansion will lower private health insurance premiums.

Full Medicaid Expansion under the ACA, which covers "newly eligible adults" with incomes up to 138% or more of the FPL, would increase state revenues. In 2020 the FMAP in states with Medicaid Expansion was 90% while the FMAP in Wisconsin is 59%. Increasing FPL eligibility to 138% allows the 30% of the caregiving workforce who are currently enrolled in BadgerCare to work an additional shift per week while maintaining their health insurance, which translates to 457 more hours a year.

According to a Wisconsin Board for People with Developmental Disabilities Task Force on Caregiving report shared with the Governor's Task Force on Caregiving members, expanding Medicaid would allow an estimated additional 8,000 direct care workers to be eligible for BadgerCare. It would also expand coverage to adults and non-disabled adults who were not previously eligible.

Forty-nine percent of caregivers are low-wage workers, and they are more affected by COVID-19. On April 14, 2020 the CDC reported more than 9,000 health care workers had contracted COVID-19. The pandemic complicates this as some low-wage workers did not have employer-sponsored coverage while they were working. As higher percentages of people lose their employer insurance, they become uninsured in states that have not expanded Medicaid eligibility[50].

Unemployment in Wisconsin is currently between 8-14%, ranking the state 20th in unemployment nationally. One of the effects of COVID-19-related unemployment is that individuals who have lost their employer sponsored plans may turn to Medicaid for health coverage. Thirty-one percent of people report that if they or their spouse lost their jobs they would turn to Medicaid. Fifty-five percent of Americans say that Medicaid is important to them. Twenty-three percent anticipate that they or a family member will require Medicaid in the coming year[51].

Should unemployment reach 20% in expansion states, it is estimated that 9 million additional people would enroll in Medicaid. In comparison to non-expansion states with 20% unemployment, only 3 million who lost their employer coverage would be able to enroll in Medicaid[52].

Those losing their employer health insurance due to unemployment as a result of Covid-19 will turn to Medicaid for themselves and their families. Wisconsin does not avail itself of the full 90% FMAP. In many cases, researchers have found that Medicaid expansion generates savings to the state in comparison to the cost to the state. Expansion also increases economic activity; thus, more taxes are collected. Work-related injuries are common in the caregiving field. Nursing assistants were among the group with the highest days off in 2015 due to on the job injury, according to the Bureau of Labor Statistics. The average injury days off were six days[53].

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[49] PHI: State of Care – Wisconsin's Home Care Landscape https://phinational.org/resource/state-of-care-wisconsins-home-care-landscape/
[50] https://www.nytimes.com/2020/04/14/health/coronavirus-health-care-workers.html; https://www.rwjf.org/en/library/research/2020/07/changes-in-health-insurance-coverage-due-to-the-covid-19-recession--preliminary-estimates-using-microsimulation.html
[51] https://www.kff.org/report-section/kff-health-tracking-poll-may-2020-health-and-economic-impacts/
[52] https://healthpayerintelligence.com/news/ok-becomes-first-state-to-adopt-medicaid-expansion-during-covid-19
[53] https://www.bls.gov/news.release/archives/osh2_11102016.pdf

Worker retention is improved through the extension of health care coverage benefits.
· Caregivers are typically caring for the highest cost Medicaid populations. Home and Community Based caregivers working in Medicaid-funded long-term care programs-Family Care, IRIS, Pace and Partnership are keeping aging adults and people with disabilities living in their homes and out of more expensive Medicaid-funded institutional settings. Improving worker retention also provides administrative savings to personal care agencies which may be passed on as increased wages to caregivers.
· Currently, 70% of personal care agencies are unable to staff all hours of care needed on a daily basis, and 93% of agencies find it difficult to fill job openings. The annual turnover rate is more than 50% and can be as high as 67%[54].

Medicaid expansion in Wisconsin will decrease premiums for those with private insurance[55].

Cost Estimate
Estimated cost: According to an estimate in the DHS Agency Budget Request for the 2021-2023 Biennium[56], in spite of increased administrative costs, Medicaid Expansion would result in a net savings to the state of $588.3 million GPR in the 2021-2023 biennium.

Public Input
In public comments to the Governor's Taskforce on caregiving, 80.2% of respondents strongly supported Medicaid expansion and 9.8% somewhat supported Medicaid expansion as a recommended a strategy to attract and retain a strong direct care workforce.

Earnings Disregard for Direct Care Workers (DCWs)

Brief Description
An earnings disregard allows DCWs the ability to work, gain income and self-sufficiency and disregard a portion of this income without the fear losing their much-needed public assistance.

Policy recommendations include:
· Allow DCWs to disregard $10,000 of DCW earnings when applying for BadgerCare benefits through a potential waiver or pilot program
· Allow DCWs to disregard $10,000 of DCW earnings when applying for Wisconsin Shares childcare subsidy program
· Allow DCWs to disregard $10,000 of DCW earnings when applying for funding through the FoodShare program (Wisconsin's name for the Federal SNAP program)
· DCW earnings consist of wages earned while supporting recipients in Wisconsin Medicaid programs

Implementation
· The following entities would have a role in implementation:
· DHS
· Legislature
· Medicaid
· Wisconsin Shares Program
· SNAP program

Analysis and Anticipated Benefits
Direct Care Workers are essential workers and vital to the health and well-being of older adults and people with disabilities. Wisconsin is facing a caregiver workforce crisis as DCWs face many challenges such as low wages and lack of benefits. While DCWs are caring for others, many times DCWs do not receive benefits or adequate wages to cover their own basic needs so public assistance is vital. A Wisconsin Study on the Direct Care Workforce by PHI[57] showed the following due to sub-standard wages within the DCW field:
· Median annual earning - $18,600
· 49% in or near poverty
· 37% on public assistance
Studies show lack of benefits are a main reason why workers leave their place of employment. This causes caregivers to leave the field. The Wisconsin Personal Services Association (WPSA), an organization representing 73 personal care providers, surveyed its members in 2015 and 2016 and found that 93%t of personal care providers reported difficulties in filling job openings, and 70% were unable to staff all authorized hours. The annual turnover rate is more than 50% and can be as high as 67%. In addition, people with disabilities do not have access to care due to the workforce shortage. People needing care and provider agencies are faced with significant recruitment challenges.

[54] http://www.survivalcoalitionwi.org/wpc content/uploads/2019/02/FAQ_WorkforceMedicaidWaiver_022019.pdf
[55] https://www.healthaffairs.org/do/10.1377/hblog20190605.87178/full/#:~:text=Medicaid%20Expansion%20In%20Wisconsin%20Would%20Lower%20Premium
[56] https://doa.wi.gov/budget/SBO/2021-23%20435%20DHS%20Budget%20Request.pdf
[57] http://phinational.org/wp-content/uploads/2019/10/Wisconsin-DCW-2019-PHI.pdf

According to a 2019 PHI study, the $10,000 earnings disregard equates to 54% of a caregiver's salary based on direct care workforce median annual earnings of $18,600.

Key Benefits:
· Allows the approximately 40% of DCWs currently on BadgerCare the ability to work more hours without losing insurance
· Allows the approximately 40% of DCWs who receive Wisconsin Shares childcare assistance the ability to work more hours without losing this assistance
· Allows the approximately 40% of DCWs who receive FoodShare the ability to work more hours without losing their assistance
· Allows DCWs currently not receiving assistance the ability to gain assistance

Additional Benefits:
· Additional workforce hours gained to meet the caregiving needs as more hours could be worked without fear of hitting the benefit cliff or losing their much-needed assistance. The risk of hitting the benefit cliff is reduced. A benefit cliff occurs when total income drops (even though wages increase) due to a drop in benefits, leaving the family with less resources
· DCWs are essential workers who endure health risks daily in their job tasks, particularly during pandemics like COVID-19; therefore, it is vital that they have access to health insurance and other public assistance to cover their own basic needs
· DCW retention is improved because they will have access to public assistance to meet their day-to-day needs without leaving the caregiving workforce
· The cost to agencies and providers is decreased due to lower turnover. This is important because the rates paid to agencies and providers have remained stagnant and do not reflect the cost of providing care
· Makes direct care work more economically sustainable by enhancing the quality of life for workers and their families
· Recognizes the value and contributions of these essential workers who help Wisconsinites in need of cares to live with the independence and dignity they deserved
· Provides an incentive and opportunity to work more hours without losing benefits, creating a bridge to economic self-sufficiency
· If families can find a bridge to economic self-sufficiency they will likely stay employed, increasing the pool of workers

Studies show the following:
· Childcare is of significant importance to low income families and one of the largest items in a household budget[58]
· A significant support for low income families come from the SNAP benefits[59]
· Benefits are key to attracting and retaining workers and health insurance is the most important benefit to workers[60]
· Hitting the benefit cliff creates a disincentive to work and creates an anchor, rather than a ladder out of poverty. It also serves as a disincentive to work[61]
· Policies that enable workers to continue receiving public benefits while their income increases are seen by some policymakers as a way to simultaneously increase employee retention and family stability. For businesses, such policies help keep employee turnover in check and mitigate the negative effects of worker shortages. For workers, income disregards help them stay in the workforce and provide for their families. Earned income disregards allow certain types and amounts of income to be excluded for purposes[62]
· Development of earnings disregards in Minnesota:[63]

Potential Funding Options/Cost Savings/Benefits
DHS will need additional funds for public assistance programs. However, a decrease may occur as DCWs work toward self-sufficiency as the result of receiving higher wages. A complete and comprehensive analysis is necessary to predict future costs of implementing this recommendation.
· Increased retention produces continuity of care for recipients
· Decreased administrative costs to provider agencies. This is important because the reimbursement rates paid to provider agencies have been stagnant, are sub-standard and do not reflect the cost of client care. Savings in administrative costs could be shifted to DCW pay
· Increased retention and number of DCWs keeps people in their homes versus that of a higher cost alternative

[58] Reducing the Cliff Effect to Support Working Families https://ascend.aspeninstitute.org/reducing-the-cliff-effect-to-support-working-families/
[59] Reducing the Cliff Effect to Support Working Families https://ascend.aspeninstitute.org/reducing-the-cliff-effect-to-support-working-families/
[60] https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/alter-benefits-attract-retain.aspx
[61] Moving on Up: Helping Families Climb the Economic Ladder by Addressing Benefit Cliffs http://www.ncsl.org/documents/cyf/Benefits_Cliffs_Brief_32099.pdf; Whole Family Approach to Jobs: 6-State Policy Brief Addressing Benefit Cliffs https://webcache.googleusercontent.com/search?q=cache:zFW68I8IztAJ:https://www.acf.hhs.gov/sites/default/files/oro/wholefamilypolicybrief.docx+&cd=1&hl=en&ct=clnk&gl=us
[62] Moving on Up: Helping Families Climb the Economic Ladder by Addressing Benefit Cliffs http://www.ncsl.org/documents/cyf/Benefits_Cliffs_Brief_32099.pdf
[63] MN Dept. of Health Services: Earned Income Disregards https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=CM_001818

Potential Barriers: After the development of this proposal, we were informed by DMS that "adding a disregard for BadgerCare Plus eligibility is erroneous. The Affordable Care Act eliminated all flexibility for states to adopt additional deductions or disregards in determining financial eligibility under the Modified Adjusted Gross Income methodology. There still remains some flexibility under 1902 (r) (2) of the Act for SSI-related, but that was removed for the AFDC-related populations."

Based on this feedback, we are still seeking the earnings disregard for WisconsinShares and FoodShare, and the exploration of waiver options or a pilot program for the earnings disregard related to BadgerCare since Health Insurance is vital to DCWs and the benefit most needed for these essential workers.

Cost Estimate: Not available.

Public Input
·   Public input received by the Governor's Task Force on this proposal suggests strong support, including:
     ·   Strong support   69.9%
     ·   Somewhat support   15.4%
     ·   Neutral   6.8%
     ·   Somewhat oppose   3.9%
     ·   Strongly oppose   3.9%
·   Many of the objections to the proposal referred to raising the wages or reimbursement rates so benefits could be purchased or provided
·   Much concern that health insurance access and affordability is crucial for DCWs
·   Many comments asked that SNAP benefits be included, which this proposal now addresses

Statewide Direct Support Professional Training

Brief Description
The Direct Care Workforce in Wisconsin consists of a variety of caregiving professions and care settings, each with different training requirements and competency standards. Currently there is limited consistency and portability of training for Direct Care Workers. For purposes of this recommendation, the term Direct Support Professional (DSP) is used to emphasize the intention under this recommendation to provide a career path with credentialing opportunities for direct care workers. This training proposal recognizes that multiple training options exists within the industry (facility and community based). Therefore, this training proposal encourages flexibility to accommodate proven effective training options that are consistent with the identified standards of practice.

The recommendation is to pilot a program, which would provide:
·   A person-centered direct support professional training to achieve consistent standards of practice.
·   A collaboration between DHS and DWD, along with the Wisconsin Technical College System and providers.
·   Identified standards of practice to allow providers the flexibility to apply these standards to their existing training while also meeting the needs of clients in both community- and facility-based settings.
·   Trainings that are consistent with regulatory requirements.
·   Develop a career ladder leading to potential CNA certification.
     ·   Tier 1 to be inclusive of the requirements designated within DHS 105.17 regulations[64], the Direct Care Competencies developed by the Wisconsin Personal Services Association (WPSA)[65], additional soft skills, and cultural sensitivity principles.
     ·   DSPs who complete Tier 1 may earn credit towards CNA certification or a badge similar to the existing Technical College continuing education badge system[66].
     ·   Tier 2 would provide additional training and an avenue for credentialing Direct Support Professionals with the option to identify this within their registry profile. It also would provide for advancement opportunities for DSP's. These opportunities could be available across all care settings. Examples of advanced roles include client education and coordination of community resources, DSP peer mentoring, job coach, etc.
     ·   Tier 3 would be achieved through successful completion of the minimum 75-hr. training requirements leading to eligibility of CNA certification[67]. (Contingent on successful passing of state exam)
     ·   The creation of a web-based or e-learning training option. (Explore opportunities to incorporate the Wisconsin Technical College system and WisCaregiver Career program technology to support web-based access and testing capability)[68].

[64] Wisconsin State Legislature. 2020.https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17
[65] Wisconsin Personal Services Association, DCC 1. 2020. https://www.wpsa.us/dcc-i
[66] Madison Area Technical College. 2020 https://madisoncollege.edu/digital-badges, Madison, WI
[67] Wisconsin State Legislature. 2020 https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/129/II/07
[68] Wisconsin Department of Health Services. 2020 https://www.dhs.wisconsin.gov/caregiver-career/index.htm

- Outreach to Job Centers to ensure they are aware of the Direct Support Professional career ladder.

Implementation
The following entities would play a role in implementation:
- DHS:
  - To determine how licensing and authority of training sites will be determined.
  - To certify the components of the training and standards of practice.
  - To extend the technology of the WisCaregiver Career Program to assist in developing online training and testing options.
  - To collaborate with training sites to identify options for tracking and housing DSP certification data.
  - To offer guidance related to certification data sharing with the registry.
  - Wisconsin Technical College System
  - Community-based personal care/supportive homecare providers
  - Facility-based providers
  - IRIS participants
  - Family Care participants
  - CLTS participants
  - Other Long Term Care participants
  - Non-HCBS/LTC funded recipients of care

Analysis and Anticipated Benefits
Family caregivers, individuals with disabilities, older adults and others who rely on support to be able to live independent, fulfilling and self-directed lives within their homes and communities will have access to a more highly trained workforce regardless of where they live in Wisconsin. Direct Support Professionals will have the opportunity to be credentialed and have access to a statewide, recommended training that reflects the best standards of practice. Training will reduce turnover of Direct Support Professionals, as they will feel more prepared and have access to tools to successfully complete tasks. Offering a career ladder option allows flexibility for Direct Support Professionals who wish to advance their career.

Potential Funding Options/Cost-Savings/Benefits:
- Any work to update payment rates for providers must include recognizing providers that are aligning training for their workforce that aligns with this new tiered standard and supporting workers who achieve the credential
- Direct Care Workforce funding should support the funding of the approved college credit for those who achieve this level of training, adding a significant new benefit that can be promoted to potential workers
- Require DWD to allocate $1 million from the Department Workforce Training Grant GPR appropriation ("Fast Forward grant") in the 2021-2023 fiscal biennium budget for grants to develop the training tiers and to train new DSPs.
- Early implementation could benefit from the available "Fast Forward" grant:
  - (5i) Fast Forward grants for personal care workers. Of the amounts appropriated under s. 20.445 (1) (b) in the 2019-21 fiscal biennium, the Department of Workforce Development shall allocate money for a grant program that promotes the attraction and retention of personal care workers who provide home-based care and community-based care and which focuses on providing quality care.
  - 106.27 (1) (g) Grants for programs that promote the attraction and retention of personal care workers[69].
  - PHI – Explore grant opportunities available.
  - Center for Healthcare Strategies, Inc. - Explore grant opportunities related to their, "Training and Supporting Community Health Workers and Promoters and their lessons from work with California and other States".
  - Maximize use of any continued WisCaregiver Career program funding or infrastructure[70].

Savings / Benefits Include:
- Hiring entities may benefit from cost savings associated with decreased turnover and recruitment expenses.
- Empowering DSP through training to handle new responsibilities such as assisting with "observation" and reporting, educating clients on health promotion and supporting the Care Team with coordination across disciplines would improve quality of care and potentially reduce cost[71].
- Providers or organizations may also experience cost savings by mitigating risk and cost associated with liability, workers compensation claims, and retention of client base through client satisfaction.
- A higher quality workforce could reduce hospitalization, emergency room utilization, and costs associated with poor care to individuals. Families and individuals will benefit from the assurance that a worker has a standardized base level of knowledge and skill that includes essential components that are not currently consistently required or prioritized.

[69] WI State Legislature. 2020. http://docs.legis.wisconsin.gov/2019/related/acts/9/9150
[70] Wisconsin Department of Health Services. 2020 https://www.dhs.wisconsin.gov/caregiver-career/index.htm, Madison, WI
[71] PHI. 2017. https://phinational.org/issue/training-advanced-roles/. Bronx, NY: PHI.

- The ability to include DSP training credentials and recognize these standards of practice within a registry will help individuals, families and agencies in the hiring process. An avenue for credentialing Direct Support Professionals with the option to identify this within their registry profile.
- Partnerships with existing training options that align with state regulatory requirements (DHS 105.17) such as DCC developed by WPSA. Collaborating with the Technical Colleges and other accredited state educational facilities for transferable credit will reduce the cost of continued education for DSP's[72].

Center for Healthcare Strategies, Inc.'s initiative for training and supporting healthcare workers may be a helpful resource as well as a possible funding source

"Community health workers and promoters-members of the community who connect patients to needed health-related and social services in a culturally competent manner- are increasingly recognized as valuable contributors to the health care system. Recognizing the value of health workers, many states are developing policies to support their deployment, yet no uniform training or certification standards exist for this valuable workforce"[73].

Cost Estimate
- The cost to increase wages for Direct Support Professional who complete each tier.
- Consistent with Rate Band Proposals that would support incentive payments to providers who hire a certain percentage (For example: 5% Tier-One DSPs, 8% Tier-Two DPSs, and 10% Tier-Three DSPs.) of DSPs with certificates
- DHS staff time.
- To provide technology for e-learning, testing, and tracking of data.
- Administrative costs related to:
    - DSP competency testing,
    - DSP and trainer continuing education,
    - Training evaluation,
    - Review and approve provider-training programs to ensure that they meet the regulatory standards and tiered requirements.

Public Input
Eighty-six percent of the public comments indicated support and recognition of the value of a consistent statewide training. From those comments, as well as comments submitted by DQA and DHS, adjustments to this proposal include:
- More detail in the 3 training tiers
- Consideration of existing training, such as:
    - A statewide Geriatric Nursing Assistant program, integrating credit-based learning through technical colleges. Base training for all licensed CNAs should include increased training in dementia, end of life, and hospice. This aligns with the Dementia State Plan, 2019-2023[74].
    - Add courses such as dementia specialist, person centered assessment and planning, crisis interventions/managing challenging behaviors to the CBRF training program[75].
    - Use WPSA's DCC Best Practice training program as a tier to laddering to CNA. DCC is a proven successful model since 2005. Working with WPSA professionals as a team to incorporate this training model, SAVING DOLLARS, rather than reinventing a training program would benefit all.
- Realizing that portability exists for Certified Nursing Assistance, this proposal encourages equity among all care settings. Therefore, training focus is on the needs of caregivers associated with CBRF, AFH, RCAC, and community based Personal Care Agencies settings.
- Continuing education opportunities to support skills demonstration/evaluation.

Additional Material for Direct Support Professional Standardized Training:
- These training topics are to be applicable to meet certification requirements across all categories of care settings – including long-term care residential facilities (i.e. nursing homes) and home and community based settings (i.e. homes, apartments, and other supported living environments).
- Furthermore, the compensation ascribed to each tier shall increase with each additional tier as training and skill develops.

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[72] Wisconsin State Legislature. 2020.https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17
[73] Center for Healthcare Strategies, Inc. 2020 https://www.chcs.org/resource/training-and-supporting-community-health-workers-and-promotores-lessons-for-states/ Madison, WI
[74] Wisconsin Department of Health Services. 2020 https://wcltc.wisconsin.gov/wcfiles/state-dementia-plan.pdf Madison, WI
[75] Wisconsin Department of Health Services. 2020 https://www.dhs.wisconsin.gov/regulations/cbrf/training.htm. Madison, WI

Additional Detail on Tiers

Tier 1 Topics

- · 'Standards of Practice'
- · Bathing
- · Toileting
- · Grooming
- · Dressing
- · Skincare
- · Feeding and assistance with feeding (oral only)
- · Non-mechanical supported transfers
- · Hoyer and other mechanical supported transfers
- · Ability to recognize obvious home safety hazards and remediate them
- · Basic fire safety (e.g. operate handheld fire extinguisher, knowledge of fire escape plan, etc.)
- · Respond to medical emergencies (e.g. calling 911, emergency contacts, etc.)
- · Infection control
- · Universal precautions
- · Hand washing techniques
- · Proper use and disposal of personal protective equipment (PPE)
- · Housekeeping (e.g. vacuuming, sweeping, dusting, washing dishes, etc.)
- · Meal preparation (e.g. safe handling of raw food, use of oven, microwave, stove, etc.)
- · Grocery shopping
- · Laundry (e.g. operation of washer/dryer, use of liquid/powder detergents, folding clothes)

'Soft Skills'

- · Active listening (e.g. eye contact, body language, nonverbal cues, etc.)
- · Problem solving
- · Critical thinking
- · Responsible
- · Team-oriented(their role in a multidisciplinary team)

Training on the following:

- · Cell phone/social media etiquette
- · The family unit and family member "roles" (parent, child, sibling, etc.)
- · Death, dying and end of life
- · Cultural competency
- · Client Rights under WI State Statute
- · Caregiver/DSP ethics
- · Confidentiality, Privacy and HIPPA
- · Reporting abuse and neglect (e.g. Mandated Reporter)
- · Caregiver misconduct consequences
- · Client Grievance Process via DHS' Department of Quality Assurance
- · Person-first language
- · Independent Living Philosophy
- · Awareness of all Long Term Care target groups: (physical disability, developmental disability, older adults, children)
- · Disability rights history
- · Trauma Informed Care
- · Addressing challenging behaviors and conflict
- · Record keeping (as designated by the State EVV training requirements) Timesheet documentation protocols / provider protocol

Tier 2 Topics

- · Empowering DSP through training to handle new responsibilities such as assisting with "observation" and reporting, educating clients on health promotion and supporting the Care Team with coordination across disciplines would improve quality of care and potentially reduce cost.
- · Record keeping (2 locations – EVV Documentation, timesheet, etc.)
- · Reporting critical incidents and events
- · Verbal de-escalation
- · Mentoring skills
  - · Peer to peer / workforce
  - · Client mentoring

- Job coaching techniques (Direct Support Professional– DSP)
- Knowledge of Long Term Care and other community resources
- Care Coordination
- Procedures for handling complaints
- Alzheimer's/dementia/memory loss
- Traumatic Brain Injury
- Working with children and adolescents with disabilities
- Strategies for DSP and caregiver wellness

Tier 3 Topics
- Successful completion of minimum of 75-hr. training requirements leading to CNA certification.
- Develop a statewide Geriatric Nursing Assistant program as the top tier, integrating credit-based learning through technical college. - Base training for all licensed CNAs should include increased training in dementia, end of life, and hospice. This aligns with the Dementia State Plan, 2019-2023.

Recognition and Recruitment Campaign for Direct Care Workers

Brief Description
This proposal provides a statewide marketing strategy to recognize and recruit direct support professionals, timing its roll out to recognize the impact of the COVID pandemic on state revenue and the primacy of worker compensation reforms to an adequate workforce.

- Phase one would develop and disseminate marketing tools to community and facility-based provider agencies, trainers, health care employers and other stakeholders for their use in social media, on websites and other outlets to attract prospective employees.
  - Tools will be designed that can be easily customized and replicated by various employer agencies to use in their recruitment efforts. DHS, providers, ADRCs, associations and others will help to create awareness about and disseminate these free templates.
  - Materials will be developed in consultation with community leaders of underserved groups to assure cultural appropriateness.
  - Assets already developed for the DHS WisCaregiver Careers Program and other sources may be adapted to create customizable templates for print material, social media and other tools, highlighting diversity of professionals and consumers in age, gender, ethnicity and disability across care settings. Currently these materials are geared toward Certified Nursing Assistant (CNA) positions in institutional care settings. Specific attention will be given to expanding materials relevant to community-based care.
  - Permission may be sought from organizations in other states to use/purchase and distribute the excellent videos they have developed featuring diverse consumer and professional populations in various support settings.

- Phase two would be launched after other reforms take effect that would make careers in direct care more attractive (i.e. better wages, benefits). The WisCaregiver Careers program would be leveraged to create a statewide initiative to recognize and attract direct support professionals for care positions in nursing homes, assisted living, in-homecare, personal care and self-directed supports. DHS would administer the program, manage a revised WisCaregiver Career website and oversee amended contracts and interagency agreements for marketing and tracking.
  - Using the tools developed in phase one and protecting against racial bias in media algorithms this will include: website, a social media marketing launch.
  - This phase must include an evaluation component. This may include extending the collaboration between DHS and UW Oshkosh to provide a tracking system for two years that will provide data about the success of program components, who it is reaching, whether enrollment in training and jobs has increased and how long people are remaining in their jobs. This will include: Survey data from participating students, training programs and employers; Secure login that will give participants access to certain information such as marketing assets, toolkits, etc.; program evaluation
  - Alternatively, the Department should evaluate whether extending its current National Core Indicator survey contract to include the Staff Stability Survey[76] would provide comprehensive and essential ongoing information about the effectiveness of marketing and recruitment investments and other investments in the workforce. The Stability Survey is helping states track reliable data on turnover, wages, benefits, and recruitment/retention strategies. Evaluation efforts/surveys would need to be inclusive of workers supporting all populations in Wisconsin's long-term care system.

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[76] National Core Indicators: Staff Stability Survey https://www.nationalcoreindicators.org/staff-stability-survey/

- Potential Phase II work for the Task Force could also include administration and evaluation of mini-grants to providers or provider coalitions to develop high intensity local/regional campaigns that may include the above marketing materials in addition to local assets and strategies.

Analysis and Anticipated Benefits

Compensation, training and other Task Force proposals are key to stemming Wisconsin's critical shortage of paid caregivers to care for citizens with disabilities and older adults. However, the urgency to fill our care gap also requires concurrent messaging and outreach to untapped workers so that they can learn about the need, value and variety of settings in which they could make a difference in peoples' lives. That messaging will also tell current workers that they are valued by their communities.

- The previous WisCaregiver campaign, focusing on nursing assistant careers, attracted over 9,000 people to register for the program.
- Community Living Connections[77], a statewide non-profit provider agency, generated 20 new applicants a month through a targeted social media campaign in 2019. Agencies are finding social media recruitment efforts to be both successful and cost-effective.
- Using digital media campaigns Minnewaska Community Health and Mother of Mercy in Albany MN significantly increased hires with increased retention and reduced turnover.
- Small employer providers with limited marketing budgets will benefit from the investment in free template materials that are customizable to their market and needs.

Costs Estimate

- Phase One Estimate: $25,000-$75,000 depending on breadth of assets/tools redesigned
- for template use.
- Phase Two Estimate: $200,000 over two years; plus $100,000 over two years for tracking and evaluation; and $100,000 for mini-grants

Public Input

Seventy-two percent of the 346 individuals who responded to the Task Force Public Input Survey strongly supported this proposal; and 15% somewhat supported it. There were over 125 comments. Many were reminders that recruitment, and subsequent retention of direct support professionals, will only be successful if we improve their wages and compensation.

A number of comments cautioned about the need to assure cultural diversity and protect against racial bias in media algorithms relative to the marketing campaign. Several commenters were concerned about cost and whether dollars would be better spent on wages. This input was reflected in the final proposal and its' separation into two phases. There were many other excellent suggestions that can be utilized in planning and implementation, should this proposal be approved.

Background Check Policies

Brief Description

There are many untapped workers in Wisconsin that possess the skills/experience or could be trained to provide quality caregiving. This proposal looks to expand the Direct Care Workers (DCW) pool of applicants by eliminating barriers to hiring related to background checks and creating consistent hiring criteria across all adult Long-Term Care programs.

Policy Components:

- Uncover the existing barriers and inconsistencies that prohibit the hiring of individuals with similar background check findings in IRIS.
- Recommends that IRIS adopt the background check process and criteria that agencies and self-directed clients use within the Family Care System
- With safety being of utmost importance, a risk agreement would be developed based on informed consent disclosed by the background check. This would be similar to Act 172 used within the Family Care system. This agreement would provide an avenue for disclosure of certain (non-barred) convictions between the parties and reduce risk while allowing the participant the choice of hiring a qualified caregiver[78].
- Increased quality-monitoring initiatives and standards would be developed to support the health and wellbeing of consumers who choose to hire individuals with a risk agreement. These standards would be followed by Managed Care Organizations and IRIS Consultant Agencies. Recurring analysis would be required to ensure this change creates the desired effects and does not increase risk to the individuals needing cares.
- Targeted recruitment strategies to address this untapped workforce.
- Allow the use of the Rehabilitation review process for all Adult Long-term care programs

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[77] Community Living Connections https://clconnections.org/careers-at-clc.php
[78] 2007 Wisconsin Act 172 https://docs.legis.wisconsin.gov/2007/related/acts/172

Implementation
The following entities would play a role in implementation:
· DHS
· DWD
· State Rehabilitation Program
· IRIS Consulting Agencies and Fiscal Employer Agents
· Self-Directed IRIS Participants
· Provider Agencies
· Wisconsin Dept. of Justice/Criminal Justice System

Analysis and Anticipated Benefits
· This proposal could increase the applicant pool of Direct Care Workers (DCW) by 5,000-7,000 based on the following:
    · Fiscal agent supporting IRIS estimates that 10% of IRIS worker applicants have background check issues that make them ineligible for hire.
    · As of December 1, 2019, the IRIS enrollment map shows 20,044 participants/consumers.
    · A fiscal agent reached out to DHS and gave an estimate of 2.5 workers for each IRIS participant.
        · Calculation of 20,044* 2.5 = 50,110. 50,110 *10% = 5,011
    · In addition, a fiscal agent supporting IRIS estimates that 5-10% do not even apply for positions due to background check criteria.
        · Calculation of 20,044*5% = 1,002
· Current experience suggests that the request to hire individuals are often family members or friends who are currently providing unpaid support for these same services. However, these same caregivers might be barred as paid DCWs based on past convictions which may have occurred several years ago or do not relate to client care. This leaves the participant to find a caregiver not as skilled or knowledgeable. This proposal creates an equitable avenue to allow friends or family members to continue to provide needed supports and earn wages.
· Eliminates barriers to obtain workers
    · The workgroup created a crosswalk across all adult programs. Findings showed there were 40+ additional convictions in the IRIS program that make applicants ineligible for hire. (Note that in some cases the applicant can appeal this based on the conviction.) However, these same applicants could be hired by self-directed individuals within the Family Care system.
    · DHS is seeking to change the background check statutes across all Long-Term care programs. At this time, the criteria/process has not been determined. The statute request may or may not align with this proposal.

Potential Funding Options/Cost-Savings/Benefits
· Supports the choice of individuals who wish to hire applicants with prior convictions where the convictions are several years old and/or do not directly relate to client care.
· Creates equity and consistency among all adult Long Term-Care programs and recipients.
· In some instances an IRIS participant could hire the same Direct Care Workers at a lower cost with this proposal because if that person cannot be hired through IRIS due to the extensive barred list, then could possibly be hired through an agency at a higher cost.
· WI State Medicaid Program could achieve cost savings through the efficiency of IRIS participants hiring DCW's directly, reducing the amount of IRIS consumer budget amendments.
· Allow for employment for rehabilitated individuals with a criminal history that could minimize their use of other public funded services and increase the tax base.

Cost Estimate
· Potential low administrative costs associated with:
    · Recruitment and onboarding of this workforce
    · Develop system wide risk agreement criteria / process
    · Data collection and any related quality initiatives to ensure the health and safety of consumers employing individuals with a risk agreement.
    · Increased administrative costs with additional Rehabilitation review processes

Public Input
· Public input collected from the Governor's task force actions on this proposal suggest strong support as follows:
    · Strong support   58.1%
    · Somewhat support   17.1%
    · Neutral   9.4%
    · Somewhat oppose   7.7%
    · Strongly oppose   7.7%

- Public concerns and opposition were expressed around safety concerns; therefore, this proposal was enhanced with a recommendation to include the development of a risk agreement and quality monitoring initiatives.
- The need for consistency across programs and the need to enhance recruitment efforts by offering choice, equity, and inclusion.

Medicaid Provider Regulatory Guidelines

Brief Description:
Direct care providers support efforts to fight waste, fraud and abuse in the state's Medicaid program. However, inconsistent rules and policy interpretations used by both the State Division of Quality Assurance (DQA) and the Office of Inspector General (OIG) -- have made it difficult for providers to navigate the regulatory landscape, led to Direct Care Workers (DCW) leaving the profession and limited access to care for consumers.

Burdensome and inconsistent regulatory policies can negatively impact small business providers and DCWs. Direct care providers and professionals are increasingly choosing to leave the Medicaid program. This directly harms individuals in need of caregiving services by either limiting their choices about who provides their care or, in some areas of the state, leaving them with no choices at all. Immigrant DCWs with limited English proficiency or administrative skills, can feel ill-equipped for the rigorous documentation required by their jobs, and thus turn away from the profession. Unfortunately, if DCWs cannot meet the strict paperwork standards needed for regulatory approval, they are at risk of losing their job. This leads to quality direct support professionals leaving the workforce. A Wisconsin State Journal article[79] highlighted the stories of several private duty nurses who left the profession as a result of these issues.

The Wisconsin Supreme Court ruled unanimously on July 9, 2020, that the Department of Health Services Office of Inspector General's (DHS OIG) audit and recoupment "perfection policy" goes beyond statutory authority. The Court directed DHS OIG to limit recoupment activities to situations where DHS OIG cannot verify one of the following: 1) that services were actually provided; 2) that the reimbursement claim is appropriate for the service provided; 3) that the reimbursement claim is accurate for the service provided. The Wisconsin Supreme Court ruling is limited to OIG's ability to recoup payments. This presents an opportunity for stakeholders and DHS staff to work collaboratively on enacting additional reforms aimed at enhancing provider education and quality efforts and to streamline policies between regulatory entities.

Analysis and Anticipated Benefits
Strengthening collaboration and adopting consistent policies will increase quality, improve access to care for consumers and allow direct support professionals to focus on providing hands-on care. Recommended steps to achieve this include:
- Establish a collaborative workgroup of DHS staff, direct support professionals and providers to implement the Wisconsin Supreme Court's Papa vs. DHS ruling and develop practices that support providers through enhanced education efforts and corrective action processes. The workgroup should:
- Be guided by the Papa vs. DHS ruling as they work to evaluate and address any pending recoupment efforts.
  - Ensure that Regulatory Interpretations are consistent between regulatory entities DQA and OIG. According to a 2020 survey of WPSA members, 42% of respondents said that OIG ordered them to pay back money for a regulatory issue that was in direct conflict with advice from DQA. The interpretation of policies need to be consistent between DQA and OIG to ensure that DHS staff are consistently interpreting regulations and to ensure that Medicaid providers and DCWs understand the regulations.
  - Develop a corrective action process to fix documentation or clerical errors instead of implementing penalties for paperwork mistakes that do not impact consumer care. (i.e. bad penmanship, missed signatures, etc.) Seventy-six percent of WPSA agencies surveyed said that OIG did not provide them with any guidance on how to fix the "errors" for which they were being required to return their pay.
  - Develop a process to give providers at least 30 days from the date they receive DHS's preliminary audit results to provide additional documentation not provided during the audit.
  - Look at creating administrative flexibilities. Currently, DHS OIG can, and has, penalized agencies for scheduling RN supervisory visits outside of the normal plan of care hours. Agencies should be given flexibility to work with the client, the DCWs and the RN supervisor to schedule a time for this administrative visit to occur when it works with everyone's schedule.
  - Limit the recovery window to one year. An emphasis should be placed on proactively working with providers and DCWs to address potential errors early on with the opportunity to correct mistakes. Given the high client and DCW turnover rate, an extended look-back period creates budgetary uncertainty for agencies and DCWs. Providers have already paid their DCWs for services rendered. It is not financially sustainable for providers to be required to pay back money years later. There have been audits where hundreds of thousands of dollars were recouped in situations where the client was either deceased or discharged months, or even several years, before the audit took place. The workgroup should develop the following look-back windows:

[79] 2007 Wisconsin Act 172 https://docs.legis.wisconsin.gov/2007/related/acts/172

- · *External Audit*: The look-back period should not be more than 90 days for external audits related to client hospitalization.
  - · *Internal Audit*: (OIG onsite at the agency to perform the audit): The look-back period should not be more than 12 months from dates of payment.
- · Establish a collaborative workgroup with DHS staff, DCWs, consumers and providers to develop consistent processes across Medicaid programs and payers. Take steps to improve communication and care coordination in our long-term care system. Direct care providers and DCWs contract with many different programs and payers (Family Care, IRIS, BadgerCare, MCOs, HMOs etc.), most of which have their own unique policies and procedures in place. Duplicative administrative functions take scarce resources and funding away from DCW wages and retention investment. In addition, some processes such as prior authorization delay consumers receiving care and create a lag in providers and DCW receiving pay. The workgroups should evaluate and find solutions for creating:
  - · Consistent service authorization processes. (i.e., prior authorization period should be at least 1 year across all programs)
  - · Consistent discharge/change of service processes and timeframes when a client is either discharged or has a change in authorized hours. This would help prevent disruption in services.
  - · Prior Authorization Consistency to ensure continuity of care. Clients enrolled in Medicaid often have their insurance plan changed--sometimes without their knowledge or the provider's knowledge. Consistent prior authorization processes across Medicaid will prevent unnecessary disruptions to client care.
  - · Electronic Signature Capture. Providers should have the flexibility to use electronic signatures for documentation of services rendered for personal care services. This will lead to faster service delivery.

Implementation
The Department of Health Services Division of Quality Assurance and Office of the Inspector General would be responsible for implementation.

Analysis and Anticipated Benefits
- · Puts DCWs' focus back on providing care. The emphasis placed on documentation and paperwork increasingly pulls DCWs' focus away from providing hands-on care. As we work to make regulations and policies consistent across programs, DCW can get back to doing what they do best---caring for their clients. Addressing over-regulation and moving away from the documentation "perfection policy" will also keep qualified immigrant DCWs in the workforce and allow them to advance and alleviate burnout experienced by direct support professionals. Rigorous documentation requirements in charting place extra stress and administrative burdens on DCWs.
- · Supports quality providers and keeps them in the Medicaid System. Providers struggle to meet increasing, unfunded administrative mandates in the face of low reimbursement rates. Providers are increasingly choosing to leave the Medicaid program due to excessive administrative requirements, which impacts consumer access to care. Streamlining regulations across programs will alleviate administrative strain on providers. In return, providers will have more time to provide care to consumers and spend more time educating and supporting DCWs.
- · Increases access to care for consumers. Wisconsin is experiencing a severe shortage of DCWs, which is limiting consumer access to care. Regulatory practices that are burdensome for small employer providers have forced some agencies out of business or caused DCWs to leave the profession, increasing the shortage in some areas of the state. As Wisconsin takes steps to retain quality Medicaid providers, consumers will benefit from having more options to choose. In addition, adjusting current Medicaid prior authorization guidelines will increase continuity of care for consumers.

Potential Funding Options/Cost Savings/Benefits
No cost for these regulatory changes.

Cost Estimate
No cost for these regulatory changes.

Public Input
A total of 219 individuals provided feedback about this proposal through the Task Force Public Input Survey. Of them, 71.2% indicated strong support and 14.2% indicated somewhat support. Those who expressed caution were concerned about fraud and waste. The proposal was updated to emphasize the intent to maintain a strong fraud, waste and abuse oversight process while addressing concerns that negatively and unnecessarily impact DCWs and small business employers. Many commenters supported the idea of helping to better educate both provider agencies and DCWs to avoid infractions.

In a Task Force subgroup meeting on August 13th, OIG staff expressed willingness to work collaboratively with providers on audits and claims. DQA provided written feedback to the Task Force on August 11 stating that DQA and OIG are working on a more unified application/enrollment process for personal care providers. In addition, they clarified that the focus of DQA's regular

review of providers (done in accordance with state statute) is to evaluate whether clients are receiving quality care and treatment as outlined in their plan of care.

Home Care Provider Registry

Brief Description

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 in need of Home and Community Based Services (HCBS) with Direct Care Workers interested in providing HCBS. Individual consumers/employers and prospective employees will be responsible for performing their own due diligence, conducting background checks and interviews, and establishing clear expectations to best ensure the needs of the care recipient will be met. The registry is not intended to replace the employer tasks needed to hire a DCW, nor will it create an employer/employee relationship of any kind. The registry will not be responsible for the authorship or accuracy of DCW profiles, nor will it endorse any profile listings. Participation in, and utilization of the registry is voluntary and will be useful for those who use either public or private funds to pay a DCW to provide care in their home or community.

Specific Components/Policy Strategy:

The following strategy is based on an RFI process of which the Lightest Touch[80] was a respondent. The Registry Workgroup viewed a demo of the Lightest Touch, in addition to several others. The following strategy is based on the learnings and understanding of the workgroup that best meet the goals of the policy above. Lightest Touch will work with DHS/DWD to:

· Pilot the Lightest Touch software platform statewide for 1 year and provide all users full functionality and advanced features for free for the first 3 months. After the first 3 months, users can continue to use the software for free and/or pay for the advanced, optional features. No care workers will be dropped from the registry, regardless if they choose to pay for advanced features or not. (Some users may incur fees for optional features such as agencies wanting to post job openings. The platform is always free for individual care recipients seeking workers and individual workers looking for care hours)
· Facilitate the sharing of data contained within DHS/DWD to populate Lightest Touch's registry at no cost to the state.
· Perform quarterly user evaluations to determine the utilization, effectiveness, and other key metrics to assess the platform and usefulness. It is recommended a workgroup of volunteer stakeholders be formed to support the evaluation process.
· Provide the state with the necessary information to issue member bulletins or memos statewide to promote the Lightest Touch platform which houses the Care Worker Registry.

Implementation

· DHS would work with Lightest Touch to determine which data sources, (e.g. CLTS Provider Management System, EVV, CNA Registry, CBRF, IRIS workers, etc.,) where individuals have the option to be included in the data transfer or sweep into Lightest Touch.
· DHS forms a workgroup to explore and identify how to repurpose the use of WisCaregiver Careers website, information & marketing materials to promote the registry and other related resources
· DWD and Lightest Touch explore ways to collaborate to enhance DSP recruitment

Analysis and Anticipated Benefits

· The Lightest Touch software platform supports In-Home and Community-Based Long-Term Care Supports. ICA's, MCO's, ADRC's, Private Pay Clients, Provider Agencies, Independent Care Workers, and Vendors of the Care Service industry are supported on the platform. Lightest Touch is a HIPAA compliant database with a platform that allows everyone in the industry to join and then find each other. The Lightest Touch is a robust platform that provides:
  · A database of organizations that support this industry, each with their own contact pages, with the ability to market their services & products to clients.
  · A registry of people providing respite, attendant care, daily living skills, home services, community integration, housekeeping, transportation, job coaching, companionship, personal cares, and so much more.
  · Search tools for all users to find what they are looking for with filters to refine matches.
  · Ability for funded clients, private pay clients, the client's natural supports, and the client's funding sources to search for the right caregiver, service, and/or products the client needs
  · Vetting systems and verifications of attributes such as background checks & certifications
  · Training and career paths for providers of respite and Caregiving
  · Client outcome goals and caregiver career goals to help the software suggest opportunities to reach them
  · Resources such as transportation, durable medical equipment, home monitoring devices, etc.
  · Provider agencies with access to better training for their employees and more opportunities for their employees to find additional hours near them.
  · Independent caregivers/providers and provider agency employees to search for the right client
  · Funding source care teams with more (and better) options for their clients

[80] Lightest Touch https://www.lightesttouch.com/

- User friendly interface accessible from personal computers, tablets, and smart phones
- Reports and monitoring tools for provider agencies and funding sources.

*****It is worth noting that many HCBS agencies throughout Wisconsin have seen a demo of Lightest Touch and there is strong interest in this platform.*****

For users of the registry:
Lightest Touch is designed to support the clients, care workers, and the support systems needed, such as funding sources, natural supports, provider agencies, and other agencies that support the industry. Care workers can use the Lightest Touch system regardless if they work for an agency or if they work independently. Likewise, clients can benefit from Lightest Touch platform regardless if they are private pay or funded by an MCO, HMO, IRIS, Insurance, etc. Each user account for a caregiver that is uploaded (with permission) to the registry database will hold metadata related to that user's role such as background checks, certifications, training, and services needed to refine and improve search results. Again, it is the responsibility of an individual employer to verify the accuracy of this information to the degree needed.

Potential Funding Options/Cost Savings/Benefits:
- No funding is required by the state for any aspect of implementation or the ongoing management of the care worker registry – other than initial technology agreements between platforms to transfer data.
- The state will only need to endorse/promote the software, add a link to their websites and marketing tools, and provide the software company access to the registry data, which includes a minimum of the care workers name and email address.
- Lightest Touch will then invite the care workers to join the registry and update their own data and settings.
- Funding for the platform will come from agencies that wish to post job openings within a dedicated 'care' platform or MCO's/ICA's who desire to add clients (with client's approval) to the database. (Clients can add themselves for free and do not have to be added via an MCO or ICA or any other agency).

Cost Estimate
There will be no significant cost to the State other than staff time to assist with technology connections from state platforms to Lightest Touch.

Public Input
In the Task Force Public Input Survey this proposal generated 314 responses total – showing more than 80% overall in strong or somewhat support. More than a third of survey respondents on this issue were family members or caregivers – with 84% in support; people with disabilities in need of care also showed support at 82%. Many who submitted comments were concerned about privacy, use of data, the "freshness" and accuracy of data, and the ability to opt-in. These issues were discussed and are reflected in the final proposal. All public input related to a statewide HCBS and employment matching registry supported the net for such a platform.

Members of the Governor's Task Force on Caregiving

Members of the Task Force are appointed by the Governor and include:

- Members of the Legislature, representing each caucus.
- At least one individual who receives caregiving services.
- At least one individual who provides caregiving services.
- At least one individual representing a provider who employs direct care workers.
- At least one individual from an organization providing respite services.
- Such other individuals as the Governor shall appoint.

Name	Affiliation
Ted Behncke	St. Coletta of Wisconsin
Senator Kathy Bernier	Wisconsin State Legislature
Stephanie Birmingham	Options for Independent Living, Inc.
Carol Bogda	Oneida Nation
Jane Bushnell	Knapp's Development, Inc.
Sharon Cornell*	Family Caregiver
Todd Costello	Community Living Alliance
William Crowley	Disability Rights Wisconsin
Elsa Diaz Bautista	Alianza Latina Aplicando Soluciones
Helen Marks Dicks	AARP Wisconsin
Jason Endres	Self-Advocate
Adien Igoni	Flora Homecare LLC
Laverne Jaros	Kenosha County
Representative Deb Kolste	Wisconsin State Legislature
Michael Lauer	Services Employees International Union
Jane Mahoney	Greater Wisconsin Agency on Aging Resources (GWAAR)
Irma Perez	Broadscope Disability Services
Michael Pochowski	WI Assisted Living Association
Lisa Pugh	The Arc Wisconsin
Anne Rabin	Family Caregiver
Susan Rosa	Caregiver Challenge
Delores Sallis	Parent University
John Sauer	LeadingAge Wisconsin
Senator Patty Schachtner	Wisconsin State Legislature
Lisa Schneider	Respite Care Association of WI
Margie Steinhoff	TMG/Magellan Health
Beth Swedeen	WI Board for People with Developmental Disabilities
Mo Thao-Lee	Universal Home Health Care Inc.
Representative Chuck Wichgers	Wisconsin State Legislature

*Appointed by the Governor but unable to serve due to family caregiving responsibilities