**GWAAR ACE MEETING – May 8, 2024**

**Textable Take aways and Host notes**

**NUTRITION**

* It's hard to have time to set up and maintain a pop up
* Make your goals relevant to your population, based on your surveys, not just “cute” or “original”
* Provide transportation to & from site with low-income housing
* Warm atmosphere increases participation
* Visit other counties utilizing voucher programs
* Veggie beds for healthier meals
* Making a diabetic meal available
* Encouragement
* Pop ups can be bag lunch
* Pop up sites focusing on different cultures
* What would efficiency look like as a goal?
* Survey foods on menu to find favorite or least favorite foods
* Use community engagement to figure out my goals
* Focus on partnerships
* There are goals that may take more than 3 years – can we get an example of a longer-term goal
* Pop up sites, community engagements, open additional meal site to complete service for nutrition to elders in service areas
* Nutrition education and voucher program
* Need better nutrition emergency meals, “shelf stable” meals
* Include article in newsletter of how to reach Tribal Elders or how to serve elders
* Try using interns

Nutrition Chats at ACE Meeting (Round 1 and 3)

Ideas for Aging Plan Goals:

* Revitalizing Congregate Dining
	+ Pop-Ups
	+ Restaurant Models
	+ Menu Construction
* Revamping Nutrition Education
* Intergenerational Programming
	+ Community Invitation for evening event
	+ Community Garden
* Increasing Availability
	+ Opening another Dining Location
	+ Pop-Ups in locations unserved
* Addressing Food Insecurity
* Building Equity
	+ Pop-Up Sites focusing on difference cultures

At one Nutrition Goal Table (Round 3) Oneida Nation Director, Eli and I were there so we

were asked: How do we reach underserved Tribal Elders in our communities?

* It was suggested to add “Tribal Nation: \_\_\_\_\_\_\_\_\_\_” to the Nutrition Intake/Assessment form so that if the elder was requesting services, you could coordinate with their Tribal Aging Department better.
* Eli said if he is called by an elder requesting service off reservation, he will refer them to the county that they are living in (but conversation was included about maybe instead of just giving the elder the number, the Tribal Aging Director reaching out first).
* There was a suggestion that an article be produced that Counties can put into their Newsletters about service coordination. As well as an article in the Tribal Aging Newsletters that would help Elders off reservation know how to better navigate services from counties or other tribes.

New Director Chats at ACE Meeting (Round 2)

One of my tables was just NEW Tribal Aging Directors (3)

We discussed:

* Where are they at with their community engagement? (2 out of 3 have started, had results)
* What are they doing for their community engagement?
* What results did they receive? (1 out of 3 went over their highest ranking)
* How are they going to use those results to build their goals? (there were goal ideas being shared by all)
* Any worries or concerns about writing their goals?

**CAREGIVING**

* Low cost, no cost resources
* Development of “Safety For All Seniors” kits – includes items/information for falls prevention.
	+ Can be used as a support for caregivers for themselves and/or for the care recipient.
	+ Effort is a collaboration with the local health department.
	+ Opportunity to use key metrics collected by other partners with this goal.
	+ Consider partnering with local clinics, hospitals, pharmacies, fire department/EMS, YMCAs, Health Promotions Coordinator, and more to collect data and to achieve goals.
* Establish continuing education for all AU staff on low-cost / no-cost resources, specific to family/friend caregivers. Focus on providing resources and support to all who encourage AU, even those caregivers not eligible for NF/AFCSP. (Equity)
	+ Please see Appendix A for resources to be explored, taught, bookmarked, and shared.
* Collect, print, and share private caregiver lists as part of the Resource Directory. (person-centered approach, allowing greater choice)
	+ Typically, lower-cost alternatives to agency referrals.
	+ A strategy could be to encourage private providers to sign up for the Respite Care Association of Wisconsin (RCAWs) respite care registry.
	+ A strategy could be to encourage private providers to Wisconsin Certified Direct Care Professional (CDCP) training.
	+ A strategy could be to hold a resource fair inviting local providers and family/friend caregivers.
* A goal of spotlighting businesses that have taken dementia-friendly and/or caregiver-friendly training. (Equity)
	+ Can share about their training in newsletters and/or social media.
	+ Follow-up surveys could capture positive experiences or quotes which also can be shared in newsletters and/or social media, hopefully boosting business in a dementia-friendly and/or caregiver-friendly supportive environment.
* A goal of increasing the number of caregivers and care recipients who have completed Power of Attorney (POA) documents. (personal Advocacy)
	+ Helps to reduce caregiver burden and care recipient to retain rights (vs. guardianship and/or emergency protective placement if POA is not completed.)
	+ Opportunity to partner with local Adult Protective Services (APS), doctor’s offices, and healthcare systems to achieve a greater number of POA completions.
	+ Examples: Vernon County continuously offers POA workshops! No need to reinvent the wheel, a strategy could be to refer caregivers to these workshops and track on # of referrals as well as # of completed POAs. Chippewa Falls – APS will do POA anytime! They feel so strongly about POA completion. Once again, a metric could be to track on # of referrals to APS as well as # of completed POAs. LaCrosse County has had wonderful success in partnership with Gunderson Health Care. Could contact this county for advice.
* A goal of increasing the number of AU that have completed SAGE Care Certification. (Equity and Advocacy)
	+ Offer training for professionals to ensure a welcoming environment to all caregivers (equity).
	+ Advocate for training of all staff. A metric would be # of people who were trained prior to the goal and the increase in # of staff trained as strategies were implemented.
	+ Use existing tools to gather key metrics! Add a question to the Initial Evaluation and Post Evaluation rating of feelings of being “welcomed” and/or “safe” to disclose sensitive information.
	+ Display SAGE training certification and highlight this accomplishment in newsletters and/or on social media.
* A goal could be to host in-district meetings with local representatives, which could co-occur with an already planned event such as a caregiver conference. (Advocacy)
	+ The goal would be to give a voice to family/friend caregivers.
	+ Advocate for more support, more money, etc. Make a lasting impact so the topic is top of mind and ongoing. Build relationships for future endeavors.
	+ [When available, insert a link from Aging Advocacy Day In-District Events training.]
* Tribal AFCSP Focus.
	+ A goal to spend % of funds. (Historically 0 dollars have been spent.)
	+ A strategy could be to build communication/relationship with the Tribal clinic – educating clinic staff on AFCSP and other caregiver resources. (Use Appendix A) With Release of Information (ROI) obtain diagnosis information to enroll more family/friend caregivers.
	+ Outreach strategy could be to use Great Lakes Native American Elder Association (GLNAEA) events to share about AFCSP and caregiver programs/resources. (Use Appendix A)
	+ Reminders: Tribes are not required to spend a minimum of 40% but are encouraged to do so. This flexibility allows for a large amount of AFCSP funds to be used early on to promote the program, educate the community, and identify caregivers to enroll. Later, AFCSP’s goal and funding would shift to direct services like offering respite care to those enrolled.

**HEALTH PROMOTION**

* Access – hybrid programs
* Join local coalitions to gain buy in
* Partner with other vendors, hospitals (not for profits) and spread the referral base
* Partnerships! Partnerships! Partnerships!

**SUPPORTIVE SERVICES**

* Complexity does not always equal success. Think simply about needs identified in your county
* Intergenerational programming for older adults and high schools, colleges
* Idea to get more people to ride our bus: play games like bingo on the bus while they ride
* Supportive services to develop volunteer services
* Intergenerational opportunities
* Making a list of people that can volunteer for supportive services. Make this list public for the community
* Support services goal to sustain and advocate
* Getting more riders to participate in a new grant program to get older adults to medical appointments
	+ Staff ride along the first time, transportation to nutrition site will make them want to use it for other reasons
* Outreach to promote transportation services
* For social isolation, provide rides to special locations once a month
	+ Out of town, certain stores
* Professional caregivers being paid to do in home chore services
* Transportation to pop-up meal sites

**ADVOCACY**

1. Build capacity by developing participant leadership
2. Get to know your legislators
3. Advocacy training
4. Volunteer challenges
5. Creating pilot program for transportation
6. Add advocacy as standing item on ADRC and aging office boards/commission meeting agenda
7. Do the math for buy in … “If we don’t have volunteers and we pay $10/meal route, it will cost XX dollars.”
8. Make space in governing board meetings to hear what members are concerned about in their community round table discussions with our local legislators
9. Train yourself and your board
10. Consider non-legislative local advocacy such as County Board and other departments
11. Bring people in to speak at meal sites (not while meals are being served)
12. Shared needs – empowerment – ownership
13. Empower others, especially board/advisory members, to take on a larger advocacy role and to take ownership of advocacy that directly impacts them (ex. low vision).
14. Invite board members and local legislators to program sites, like dining rooms or transportation hubs for meetings
15. Have an advocacy section during board meetings – empower others, unmet needs, what they are seeing, advocacy alerts

**NEW DIRECTORS**

* Changes can result in small steps for this cycle
* Sustainable – do things we are already doing better or more efficiently
* Plan is flexible – you can pivot or change if needed. A “living document”
* Housing was discussed in all three rounds and is a major concern, but there is no dedicated focus area for this. Look at developing an advocacy goal around housing education and advocacy. A goal can be developed around housing even if there isn’t a focus area dedicated to it.
* Longterm vision – remember to think about long-term goals as well as short-term goals. long-term goals are instrumental when you are trying to make system changes.
* Document can be changed at any time – living document
* Sustainability
* Asking for help
* Online resources (aging unit website) <https://gwaar.org/plansamendmentsassessments>
* Fundraising activities can’t be paid for out of OAA funds. If you are interested in fundraising, please reach out to GWAAR and BADR staff to see if allowed.
* Aging plan is a living document
* Consider incorporating ADRC programming in Aging Plan for a “complete” plan
* Goals can be changed and modified over time
* Goals will be reviewed yearly
* It is ok for a goal to be a pilot project or exploring effort
* Goals can be long term and extend well beyond 3 years
* Focus on sustaining programs or making programs for efficient
* What can ADRC do to help with your goals
* Community engagement
* Housing issues keep coming up
* Adding goals
* Community engagement
* Broader than just focus areas - needs are needs
* Partnerships
* Participant leadership development
* When issues arise that are out of scope – can build a goal around research, pilot programs, partnerships, and funding/sustainability exploration
* Look at past aging plans
* Look at community engagement – glaring issues
* Transportation, housing, sustainability of goals
* Community engagement – need at least 2 methods, 1 report for each

**METRICS**

* Learning about cultural needs rather than just research on numbers of populations and basing service on the numbers rather than cultural need
* Provide data reports, etc. from state DB system – currently difficult to obtain outcome data
* Manage/reduce harm when implementing prioritization or other service reductions due to lack of funds
* We need support to actually analyze the data we collect
* Sources: UW Extension, UW local campuses
* Challenge with tracking how to equitably serve those who need and want service assistance, info when the resources don’t currently exist
* We need tools to help ask good survey questions
* Make sure goals are program based not person base – needs of program v. what a person wants to do
* Help turning information into useful visual presentation and narrative
* Canned templates we could customize
* We could use customizable ROI calculators for different program services

**Appendix A**

**To Enhance AU staff training - Bookmark and Share**:

* Alzheimer’s Association 24/7 Helpline – 1-800-272-3900 or [live chat](https://www.alz.org/help-support/caregiving).
* Alzheimer’s Family Caregiver Support Program or [AFCSP](https://gwaar.org/api/cms/viewFile/id/2005362).
* [Caregiver Teleconnection Program:](https://www.wellmedcharitablefoundation.org/caregiver-support/caregiver-teleconnection/) Offers one-hour conference calls two to three times each week as well as archived programs for any caregiver.
* [Independent Living Supports Pilot](https://www.dhs.wisconsin.gov/arpa/hcbs-ilsp.htm), if applicable in your county.
* [Kinship Navigator](https://dcf.wisconsin.gov/kinship/navigator) – Resources for relative caregivers.
* [Legal and Financial Resources](https://wisconsincaregiver.org/legal-and-financial-resources) page of the [WisconsinCaregiver.Org](https://wisconsincaregiver.org/) site offers local, state, and national resources such as information about Wisconsin [Advance Directives](https://www.dhs.wisconsin.gov/forms/advdirectives/index.htm), the National Council on Aging’s (NCOA) [Benefits Check-Up](https://benefitscheckup.org/), and diagnosis-specific grants such as [American Parkinson Disease Association](https://www.apdaparkinson.org/wp-content/uploads/2018/07/WI-APDA-Patient-Aide-application-2021.pdf) and more!
* Local caregiver support groups & [Virtual Caregiver Support Groups](https://wisconsincaregiver.org/virtual-events-for-caregivers) - free telephonic, virtual, and online events
	+ National Family Caregiver Support Program or [NFCSP](https://gwaar.org/api/cms/viewFile/id/2007225).
* [Powerful Tools for Caregivers:](https://www.powerfultoolsforcaregivers.org/) classes to help caregivers take better care of themselves while caring for a friend or relative. These are scheduled by individual programs at different times throughout the year.
* [The Respite Care Provider Training (RCPT):](https://respitecarewi.org/free-training-courses/) is a series of free courses for anyone interested in providing respite care as a career, a part-time job, or even a volunteer activity to individuals with varying disabilities and ages. Learners can work at their own pace to complete the ten required online courses, stopping and starting as needed.
* [The Respite Care Registry](https://respitecarewi.org/registry/): This FREE registry connects those needing respite care with respite care providers. Direct care professionals or providers can sign up to be found as a respite care provider and find meaningful caregiver jobs, and primary caregivers can search this database for in-home or agency-based respite care providers that most closely meet their needs.
* [United Way:](https://www.unitedwaywi.org/page/caregiversupport) 211 Wisconsin, in partnership with AARP, is offering direct and consistent contact to caregivers throughout the state. This project is intended to reach informal/unpaid family caregivers who are 18 years or older, who are providing care to those 18+. If you, or someone you know, could benefit from this type of connection, call 211.
* [VA Caregiver Support Program - Caregivers Support Line (CSL):](https://www.caregiver.va.gov/help_landing.asp) Is a toll-free number for caregivers, family members, friends, Veterans, and community partners to contact for information related to caregiving and available supports and services.
* [Wisconsin Dementia Care Project Learning Center](https://wss.ccdet.uwosh.edu/stc/dhsdementia/psciis.dll?linkid=458964&mainmenu=DHSDEMENTIA&top_frame=1): Are you interested in learning more about dementia including Alzheimer's Disease? Are you a family or professional caregiver or do you play another role in the life of someone who is living with dementia? This program offers a series of online and classroom-style dementia courses, originally developed for and approved by the Wisconsin Department of Health Services. The curriculum is appropriate for a variety of learners from beginning to advanced levels.
* [Wisconsin Certified Direct Care Professional (CDCP)](https://www.dhs.wisconsin.gov/caregiver-career/index.htm): Free training, bonuses, and access to job opportunities! Get a jump start on a new health care career. A free online program to become a Certified Direct Care Professional (CDCP) offers training to make life better for older adults and people with a disability. Becoming a CDCP will prepare you to enter the caregiving workforce, the first step on a career path with unlimited opportunity.