Wisconsin Counties Association

2025 ANNUAL CONFERENCE GAME DAY

8:00 – 9:00 AM

Long-Term Support Systems: Caring Across the Lifespan

2025 WCA Annual Conference

Caring Across the Lifespan: Long-Term Support Systems in Wisconsin

September 22, 2025

MILWAUKEE COUNTY

CHILDREN, YOUTH & FAMILY SERVICES

CHILDREN DISABILITIES PROGRAM

DEPARTMENT OF HEALTH & HUMAN SERVICES

MISSION

Empowering safe, healthy and meaningful lives.

VISION

Together, creating healthy communities.

ABOUT CHILDREN, YOUTH & FAMILY SERVICES

Children and young adults are a part of the children's system of care that aims to enhance community wellbeing. It is a countywide integrated network of resources which require shared responsibility and accountability to assure that Milwaukee County families have access to the services, programs and supports they need. Children, young adults and their families will have support to thrive, actively participate in their community and experience life in an inclusive way which is meaningful to them. While partnering with families, the local system of care integrates the work of disabilities services, family and treatment courts, youth justice, health, mental health, child welfare, education, and other community organizations through team decision-making and addressing inequities.

DISABILITIES

YOUTH JUSTICE

BIRTH TO 3 PROGRAM

The Wisconsin Birth to 3 Program is an early intervention special education program that supports the growth and development of children under the age of 3 who have delays or disabilities. The Birth to 3 Program is required by the federal government under Part C of the Individuals with Disabilities Education Act (IDEA).

EARLY YEARS ARE IMPORTANT!

The earlier a child’s developmental delays are discovered, the more opportunities there are for the child to increase their skills and abilities-narrowing the gap between the child and their peer's typical development.

MILWAUKEE COUNTY BIRTH TO 3 PROGRAM

MILWAUKEE COUNTY

- CURATIVE CARE NETWORK
- PENFIELD CHILDREN'S CENTER
- ST. FRANCIS CHILDRENS CENTER

BIRTH TO 3 REFERRAL

How is a referral made?

IDENTIFICATION

Identify a child with signs of developmental delays or disability.

FORM

Use the **Referral to Wisconsin Birth to 3 Program** form and obtain a signature of the parent/guardian.

Note: *Family consent or signature is not required but highly recommended.*

INFORMATION

Verify accuracy of information:

- Child's Full Name
- Parent/Guardian Full Name
- Child's Home Address
- Primary Phone Number
- Primary Language
- Reason for Referral

SUBMISSION

Submit referral to one of the following methods:

- **Fax** at 414-289-8564
- **Email** Birth_to_threedsd@milwaukeecountywi.gov
- **Call** 414-289-6799

FOLLOW UP

A **Notification to Referral Source** form notifying referral source of the referral result will be submitted.

BIRTH TO 3 REFERRAL PROCESS

RECEIVED

Referral is submitted to Milwaukee County Birth to 3 Program.

PROCESSED

Referral is reviewed and processed. Referral is assigned to contract agency daily.

**Referral Sources may be contacted for additional information.*

INITIAL CONTACT

Agency receives referral. Service Coordinator establishes contact within 48 hours. If family does not respond, a letter is sent requesting a call back within 10 business days or referral will close.

SCREENING OR INTAKE

Initial contact is established and first visit is scheduled. Developmental Screening and/or Intake is completed. Consents, child & family information is obtained to determine best evaluator.

EVALUATION

Evaluation is scheduled and completed to determine eligibility for the Birth to 3 Program.

BIRTH TO 3 ELIGIBILITY

Includes children age birth to 3 years of age who:

- 25% DELAY IN 1 OR MORE AREAS OF DEVELOPMENT
- DIAGNOSED CONDITION
- ATYPICAL DEVELOPMENT

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

An IFSP outlines the early intervention services a child and their family will receive. It's centered around the family's goals, concerns, and priorities and it helps guide services to support the child's development.

IDENTIFY CHILD'S STRENGTHS AND DEVELOPMENT NEEDS

Through evaluations, assessments, and observations we take time to really understand the child holistically, not just what they need help with but also what they enjoy, what they are good at, and how they interact with the world.

UNDERSTAND FAMILY'S CONCERNS AND ROUTINES

Understanding what matters to the family, their challenges, and how their day-to-day life looks helps us create a plan that naturally fits into their everyday life and supports their child's development and family's goals.

SET SPECIFIC, MEASURABLE OUTCOMES

With support from the team, the family develops clear outcomes based on what the child/family need and want to achieve. These outcomes include what they are working towards, how progress will be measured, and developing practical skills.

PLAN FOR SERVICES AND SUPPORTS

Services and supports are planned in the child and family's natural environment like the home, a grandparent's house, the park or childcare so learning can happen during real-life routines.

SERVICES & SUPPORTS

Service Coordination

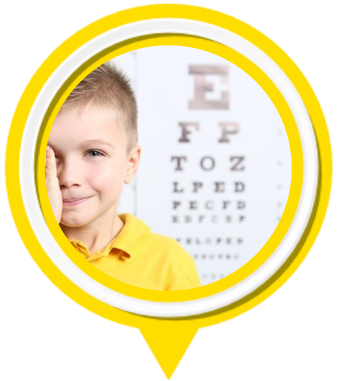
Special Instruction

Speech Therapy

Physical Therapy

Occupational Therapy

Social Work Services



Vision & Audiology Services

PRIMARY COACH APPROACH TO TEAMING IN NATURAL ENVIRONMENT

NATURAL LEARNING ENVIRONMENT PRACTICES

These practices support parents and other caregivers' recognition and use of child interests as a way of capitalizing on the many learning opportunities within a child and family's everyday lives. NLE extend beyond settings and locations and include everyday routines, experiences, and activities.

COACHING PRACTICES

An evidence-based adult learning strategy that is used to build the capacity of a parent or colleague to improve existing abilities, develop new skills, and gain a deeper understanding of their practices for use in current and future situations.

PRIMARY SERVICE PROVIDER TEAMING PRACTICES

An approach to service delivery in which one member of an established, multi-disciplinary team is selected through a collaborative process to serve as the child and family's primary service provider (PSP). The PSP offers support to parents and caregivers by promoting child learning and development, while receiving coaching and support from other team members.

TRANSITIONING OUT OF THE BIRTH TO 3 PROGRAM

Transition if the planned process of preparing a child and family for life after early intervention as the child approaches age three. The goal is to ensure a smooth and supported transition so the child can continue to grow, learn and thrive beyond early intervention.

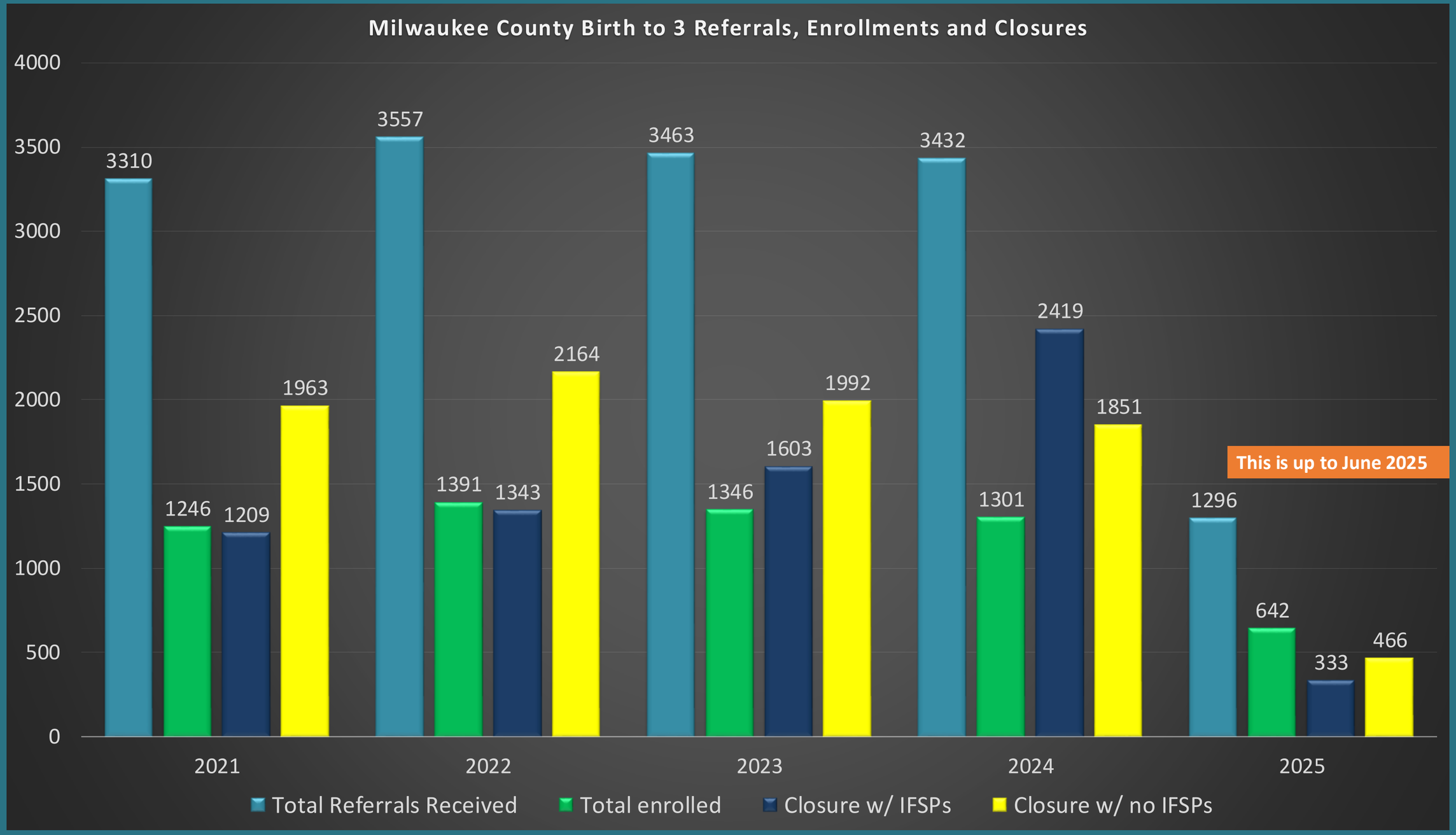
Starting Early

Team Collaboration

Transition Plan

Options After 3

Family-Centered


Milwaukee County Birth to 3 Referrals, Enrollments and Closures
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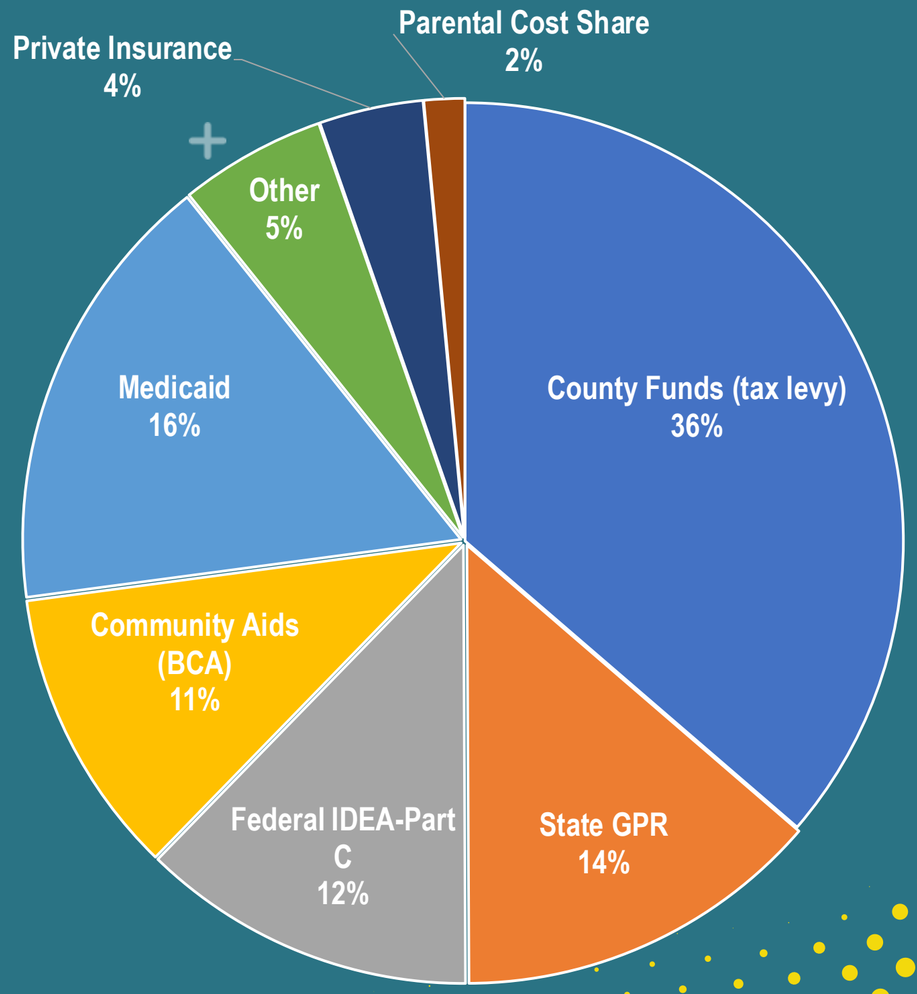
333
466
This is up to June 2025
2021
2022
2023
2024
2025
Total Referrals Received
Total enrolled
Closure w/ IFSPs
Closure w/ no IFSPs

BIRTH TO 3 FINANCIAL INVESTMENT FROM COUNTIES

- Birth to 3 Statewide Budget = $49M
- Budget relies heavily on county contributions – nearly half the budget = Levy + BCA.
- With Medicaid and private insurance reimbursement declining and the state's GPR remaining flat, counties support greater financial burden.



Birth to 3 Sustainability Effort

Informal group of counties and providers came together to problem solve

Focused on key issues impacting program: enrollment, funding challenges, and raising awareness

Sustainability Report developed along with focused media campaign

Counties and DHS working in collaboration to implement report's recommendations

MILWAUKEE COUNTY

Children, Youth & Family Services

THANK YOU

Together, we can empower safe, healthy, meaningful lives and building a community of support for children with disabilities and their families in Milwaukee County.

+414-289-6799

WWW.MILWAUKEE.GOV/EN/DHHS/DISABILITIES-SERVICES/CHILDREN-SERVICES

Milwaukee County Children, Youth & Family Services | Milwaukee WI | Facebook

1230 W CHERRY STREET MILWAUKEE WI 53205

Caring Across the Lifespan: Long-Term Support Systems in Wisconsin

Children's Long Term Support Waiver Program

Kelly Firlus, CSW
Children, Youth, and Family Services Manager
Juneau County Department of Human Services

CHILDREN'S LONG-TERM SUPPORT WAIVER PROGRAM (CLTS)

- The Children's Long-Term Support (CLTS) Waiver Program is a Medicaid Home and Community-Based Waiver program that provides supports and services for children with disabilities.
- The program helps children with disabilities and their families through supports and services that help children grow and live their best lives.
- The goal is to promote person-centered planning, strengthen the capacity of families, and support individuals in achieving personal outcomes, community integration and inclusion. Every child and family is empowered to live their best life
- The program uses a Medicaid waiver to fund the services

CLTS Referral Process

Referral

- Referrals can be made by parents or professionals
- Parents should be aware of the referral and in agreement

Assessment

- Programs have 10 calendar days from the date of referral to make contact and schedule meeting
- At the meeting the program is discussed and completes a functional screen

Eligibility

- The agency has 45 days to determine eligibility
- When functional and financial eligibility have been completed the program has 45 days to enroll

CLTS PROGRAM ASSESSMENT

Utilizes the Children's Functional Screen

Must meet an institutional level of care

Eligibility

- Components of eligibility
  - Be under 22 years old
  - Meet an institutional level of care as determined by the Children's functional screen
  - Reside in an eligible living situation
    - Home of parent or caregiver, foster home (all levels including Level 5)
  - Have a full-benefit category of Medicaid
    - Katie Beckett, Foster Care MA, Adoption assistance MA, SSI Medicaid, HCBW (waiver) MA
    - ** parents may have a parental payment based on income

Support and Service Coordinators

- Each client is assigned a Support and Service Coordinator (SSC)
- Support and Service Coordinators work with the family to develop an Individualized Service Plan (ISP) and Outcomes
- Primary responsibility is promoting client's health, safety, and welfare in their home and community
- Roles and Responsibilities
  - Develop ISP, conduct 6 month reviews and annual recertification, update as services are added and removed
  - Make referrals to additional services and resources
  - Advocate for and support parents in advocating for the child
  - Maintain monthly contacts with parent or collateral contact, direct contact with parents every 3 months, in-person contact every 6 months with child, annually at least one contact must take place in the home of the child

Supports and Services

- Medicaid Home and Community-Based Services (HCBS) Waiver Manual lays out all aspects of program
- Allowable Services
  - Providers much enroll in the online CLTS Provider Registry and sign a Medicaid Provider Agreement and Acknowledgment of Terms of Participation
  - DHS verifies and approves providers to be on the registry
  - Counties are also required to be on the registry
  - Participants have the choice of providers for services with exception of SSC
  - Payments to parent/primary caregiver are not allowed except for transportation service
  - Authorizations for services must be submitted to ForwardHealth Portal and claims are processed by Gainwell Technologies, LLC as of mid 2025.
  - All allowable services are fully-funded by DHS and paid through Gainwell (third-party administrator)

Enrollment Dashboard

- https://www.dhs.wisconsin.gov/clts/enrollment-dashboard.htm

- Shows:
  - How many children are in the CLTS program
  - How many children are eligible for the CLTS program, but not yet enrolled
  - How long it takes to enroll a child in the CLTS program
  - Can view information for state as a whole or

Children's Community Options Program

- Children's Community Options Program (CCOP) is a funding source which pays for many supports and services that are not allowable through Medicaid, other insurance, or the CLTS Program
- The amount of funding received by counties varies from county to county
- Allowable services mirror CLTS with the addition of recreation and specialized clothing
- Eligibility
  - Under 22 years of age
  - Residing in eligible setting-parent/guardian home, Foster care, certified adult family home
  - Functionally eligible as determined by the Children's functional screen
  - Medicaid eligibility is NOT a requirement

Transition to Adult Services

- Referrals are made to the Aging and Disability Resource Center at age 17 years 6 months
- Referrals are made to Adult Protective Services for guardianship at age 17 years 9 months (this may vary from county to county)
- Participants qualifying for adult service programs must be enrolled into those programs at or shortly after age 18
- Participants cannot delay or forgo enrollment in adult services and remain in the CLTS program
- Participants who are not found eligible for Adult services may remain on CLTS until age 22

The Role of ADRCs in the Provision of Long Term Care Services

Cindy Piotrowski, Director
ADRC of Portage County

What is an Aging & Disability Resource Center (ADRC)?

- Establishment of ADRCs
  – first step in Wisconsin's LTC redesign process

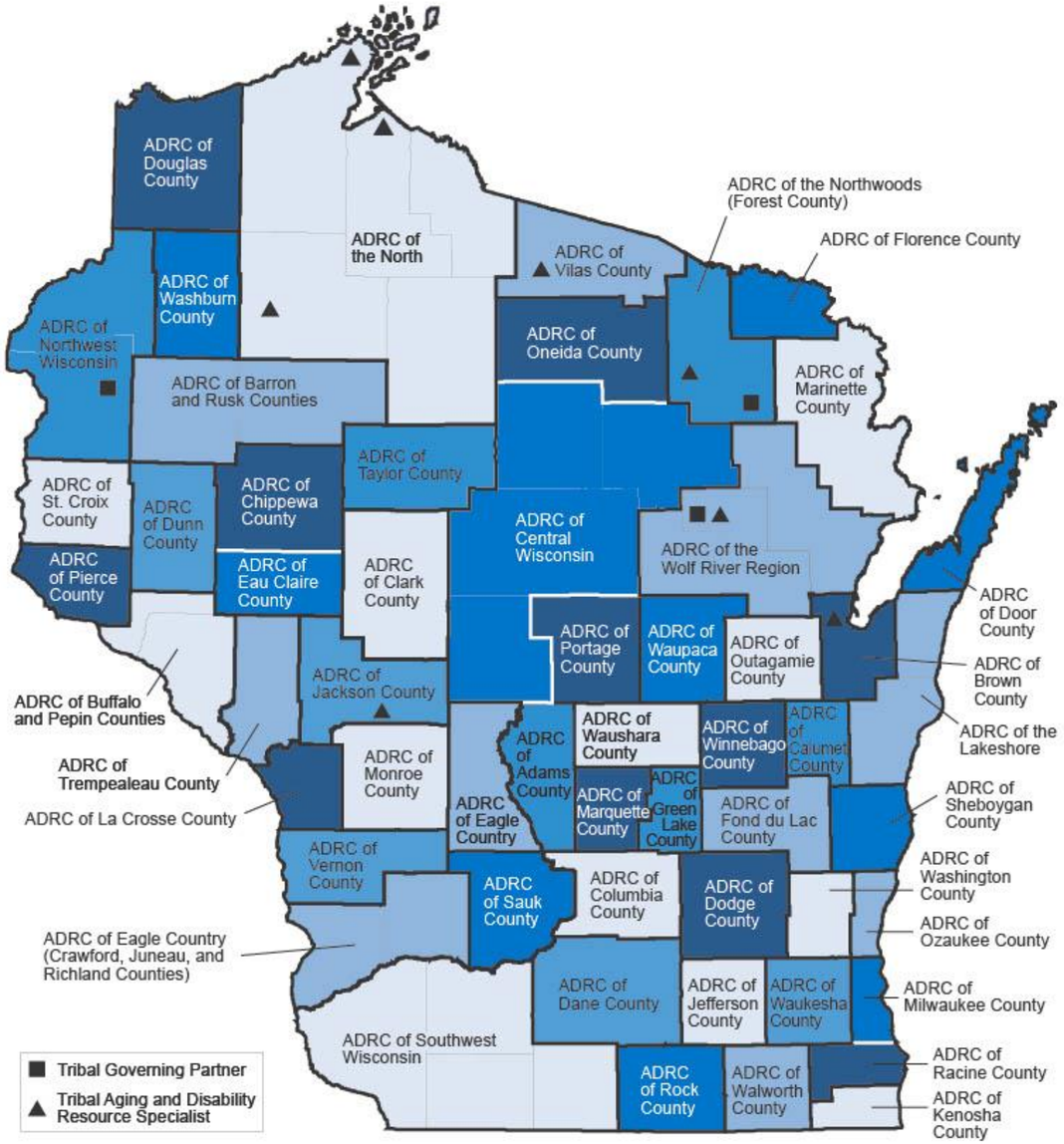
- 1998 – Eight counties and one tribe selected to develop and pilot ADRC programs for 18 months

ADRCs in 2025

- – September 2025:
  54 ADRCs operating in Wis.
  10 regional and 44 single county

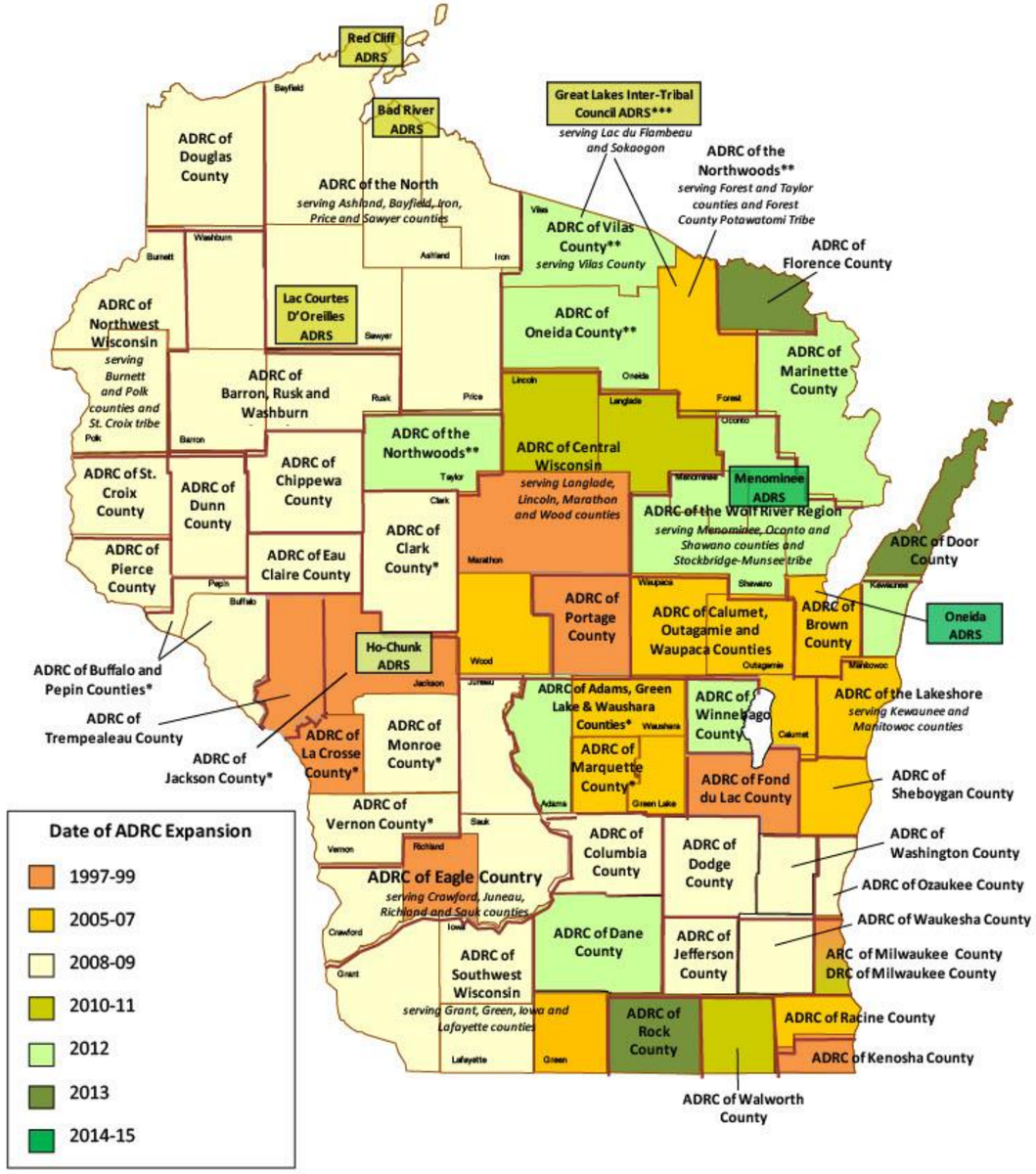
TOTAL = 72 counties served by an ADRC

Wisconsin's Aging and Disability Resource Centers



Wisconsin Department of Health Services
Division of Public Health
P-02356 (01/2025)

Wisconsin Aging and Disability Resource Centers (ADRC) and Tribal Aging and Disability Resource Specialists (ADRS)



*These ADRCs were reconfigured in 2016-2018.
** These ADRCs were reconfigured in 2018-2019.
***These ADRS was reconfigured in 2019.

(revised 10/2020)

ADRC Structure

- An ADRC can be a county or tribal entity, a multi-county consortium, a private non-profit organization, or a combination of the above.
- An ADRC can be a stand alone organization or can be combined with an aging unit or a human services department.

*The bottom line is, “If you’ve seen one ADRC, you’ve seen one ADRC!”

What is Long Term Care?

- **Long-term care** (LTC) is a variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time.
- LTC includes custodial and non-skilled tasks like dressing, bathing, and using the bathroom. Increasingly, long-term care involves providing a level of medical care that requires the expertise of skilled practitioners to address the often multiple chronic conditions persons needing care may have.

Long Term Care (Cont.)

- Long-term care can be provided at home, in the community, in assisted living facilities or in nursing homes. Though it is more common for LTC to be needed by older adults, individuals of any age may need this care.

What is Family Care?

- Combined the state's long term care programs for frail elders & adults with physical and/or develop-mental disabilities (COP/CIP, etc.) into one Medicaid managed care program.
- Has a self-directed supports option

What is Iris?

- IRIS – Include, Respect, I Self-Direct

  – is Wisconsin's Self-Directed Supports Program for older people and adults with disabilities.

- In IRIS, a budget is determined and then the consumer determines the combination of supports and services needed, including who will provide the services and when and how they will be provided.

What is the Role of an ADRC in the Provision of LTC?

- Welcoming and convenient place(s) for the general public to get information about preventive services and long term care options.
- Also serve as the single entry point for publicly funded long term care services.

ADRC Provides:

Free…

- Unbiased information about local services and resources available to meet an individual's needs or wants.
- Information about the costs and eligibility information associated with specific services.
- Information about a wide variety of public benefit programs.

ADRC PROVIDES (Cont.):

- Individualized assessments of abilities and risk screens
- For those unable to pay for services, LTC Screen assessments to determine functional eligibility for publicly funded LTC services and referral to Economic Support Unit for determination of financial eligibility

ADRC PROVIDES (Cont.):

- Options counseling to assist consumers in evaluating and weighing their LTC service options. This is a process that provides information on options to meet an individual's LTC needs that is **person-centered** and relevant, both in terms of the person's needs, but also **consistent with the individual's values and goals**:
  - Identifying the Need(s)
  - Welcome
  - Discovery
  - Decision Support
  - Action Planning
  - Follow-Up

ADRC PROVIDES (Cont.):

- Transition services for young adults with disabilities transitioning from children's services to the adult LTC system.
- Prevention and early intervention services: including evidence-based classes and programs.
- Assistance in accessing services, if necessary (Short Term service coordination
- Enrollment and disenrollment counseling for publically funded long term care programs.

Who provides these services?

- Resource Center/ADRC Specialists or Information & Assistance Specialists
- Elderly and Disability Benefit Specialists
- Dementia Care Specialists
- Other professionals – Registered Nurses, Community Health Educators, Nutritionists, etc.

Who does an ADRC Serve?

- Older adults and adults with disabilities or their families and caregivers interested in…

  1.) prevention/early intervention programs to help maintain optimal health and independence and preventing or delaying the need for long term care services.

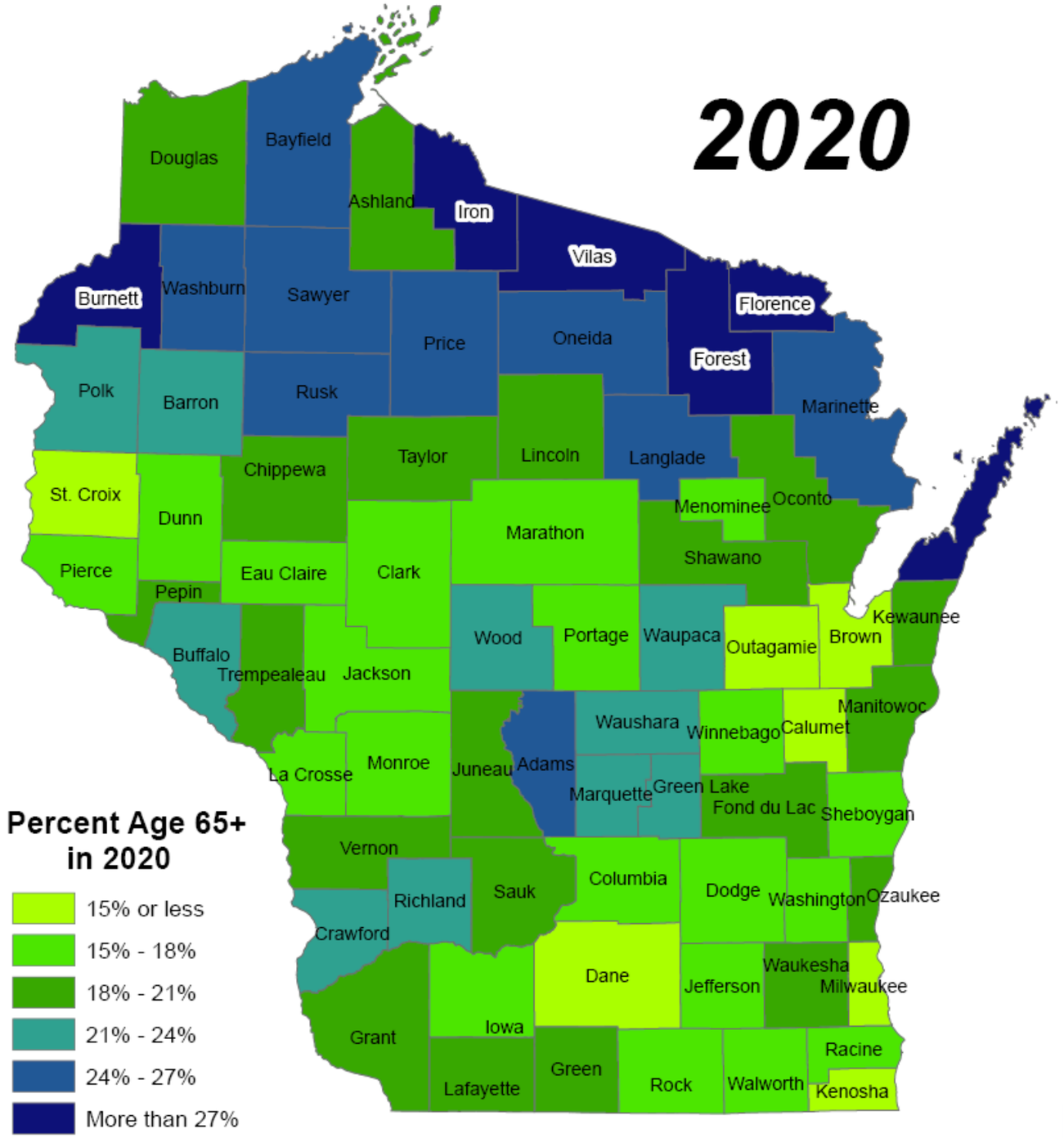
  2.) planning for future long term care needs.

  3.) LTC services due to: advanced age, developmental disabilities, physical disabilities, dementia, and terminal conditions.

  4.) programs and services for caregivers.

Accessing an ADRC:

- Walk-in office visits
- Scheduled visits – office, home, hospital, temporary residence, other location
- Telephone – local and toll-free number. May have after hours on – call staff available
- Website – information, links, email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Percent Age 65+ in 2020
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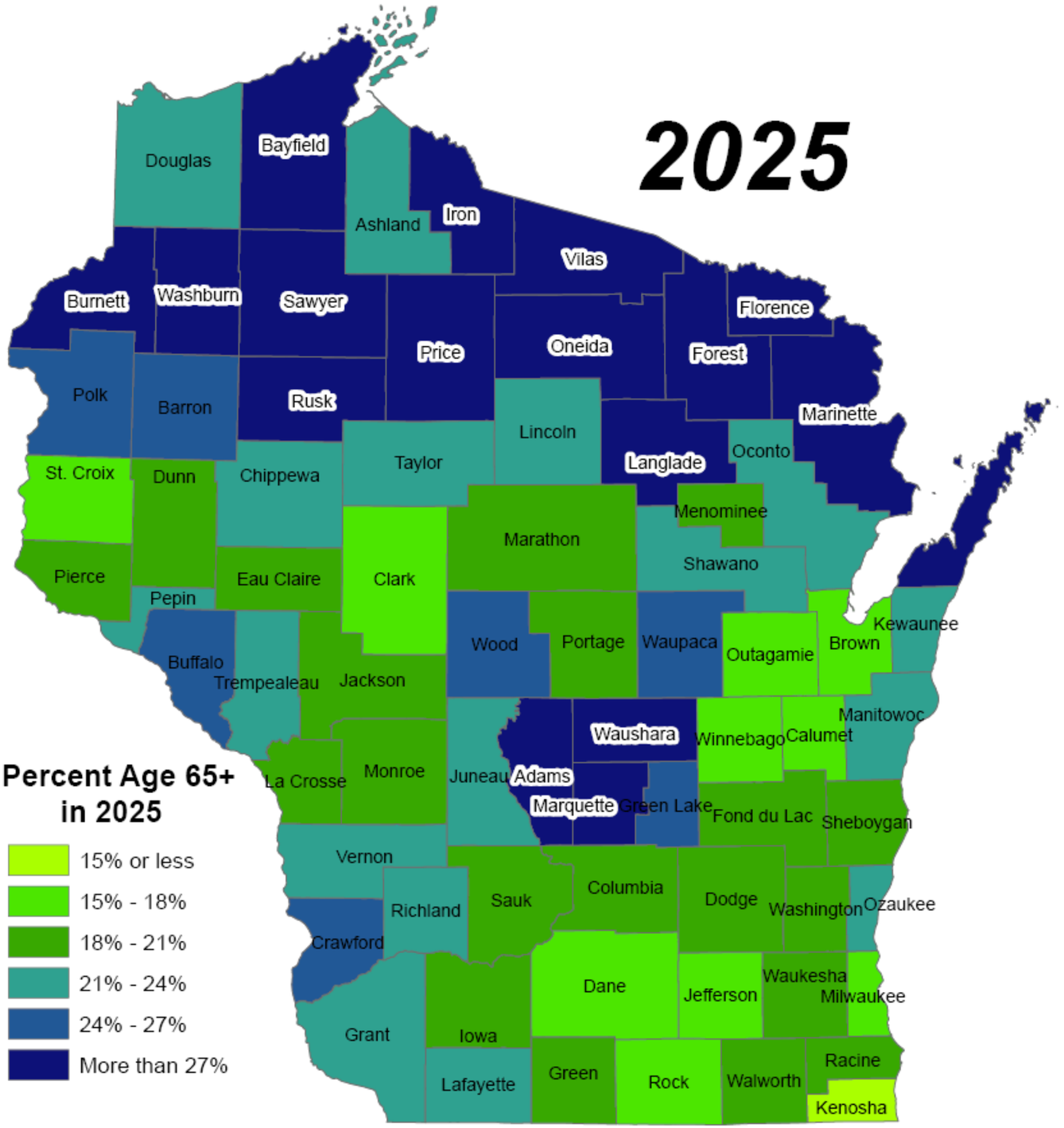
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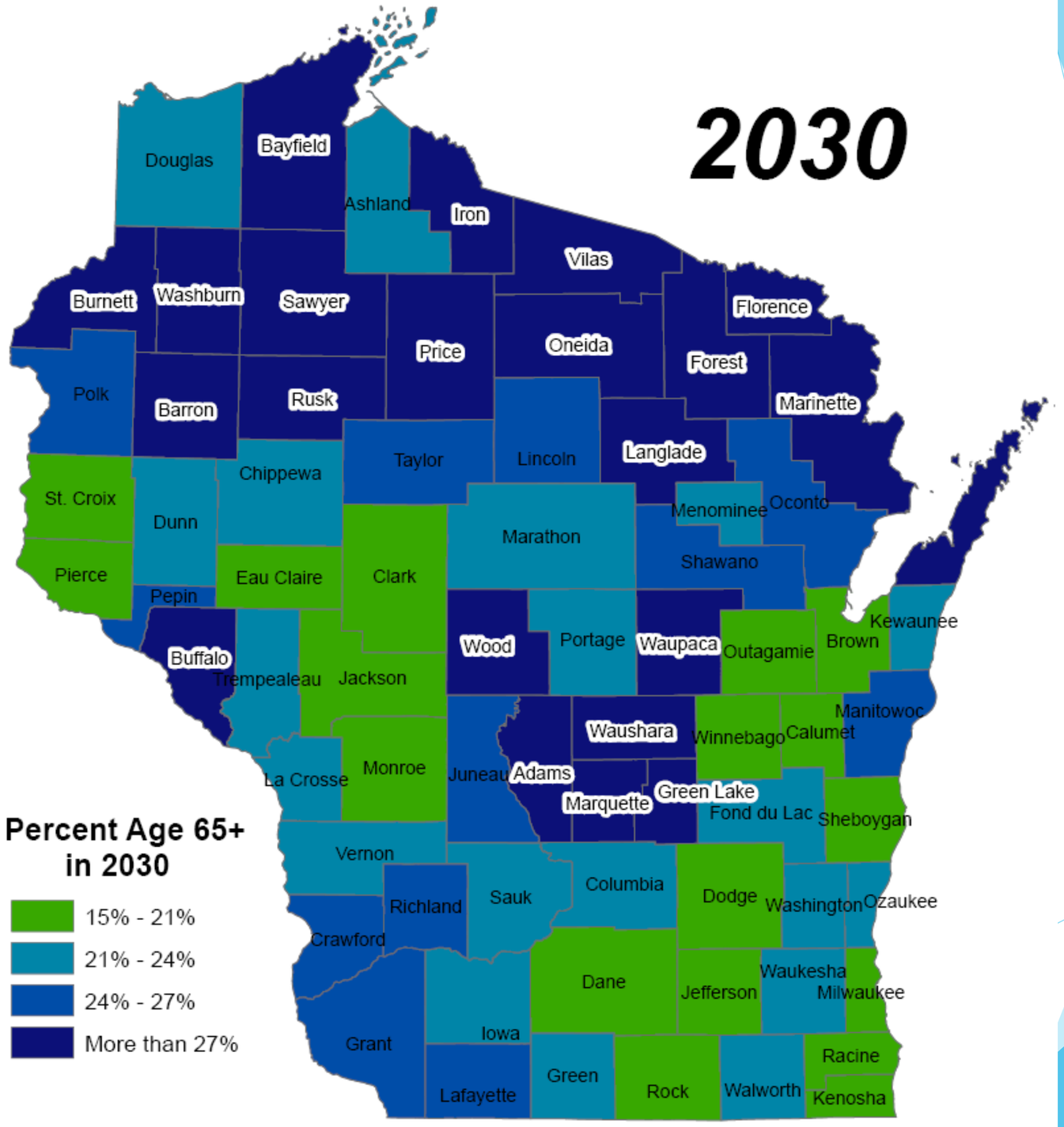
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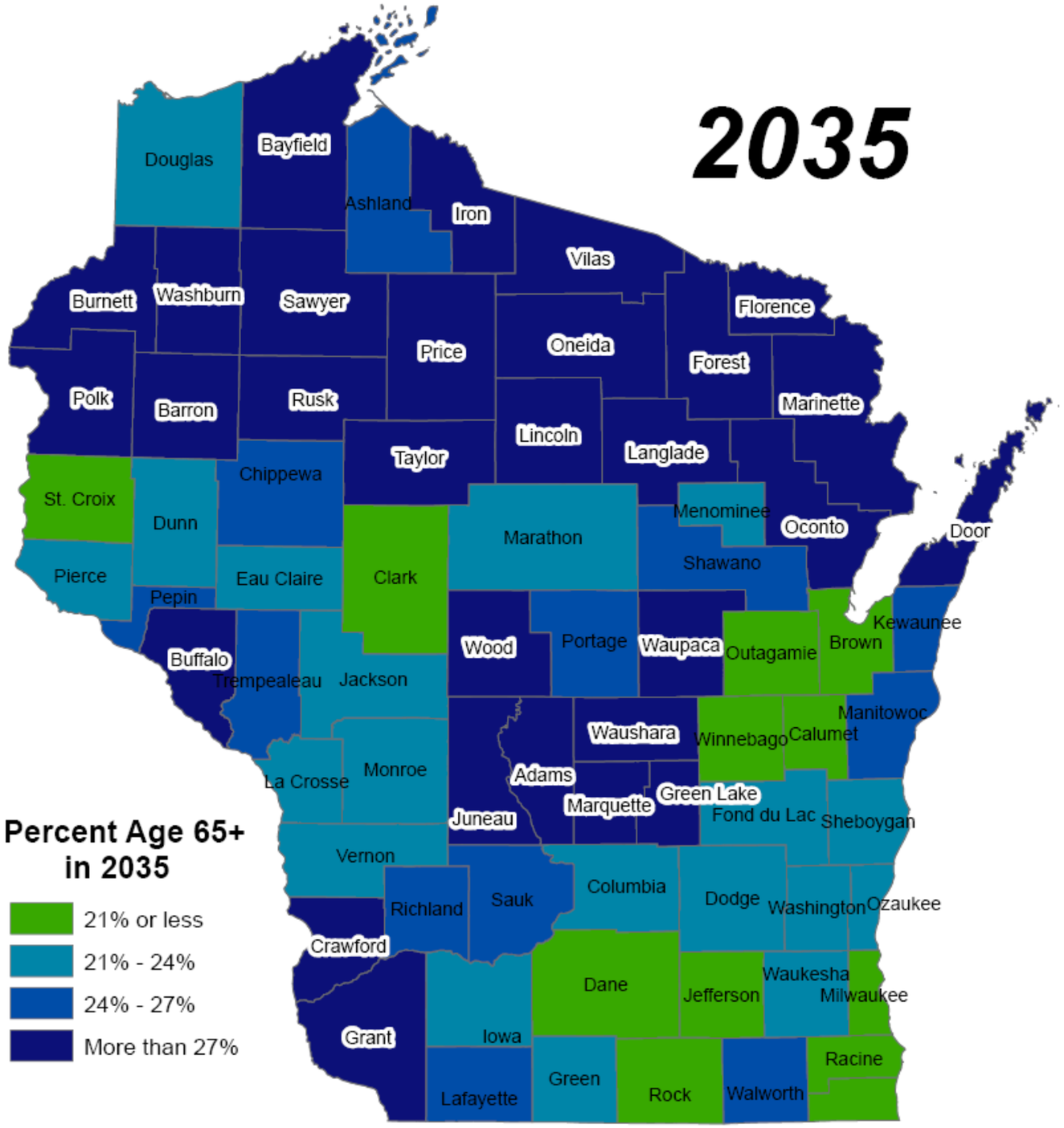
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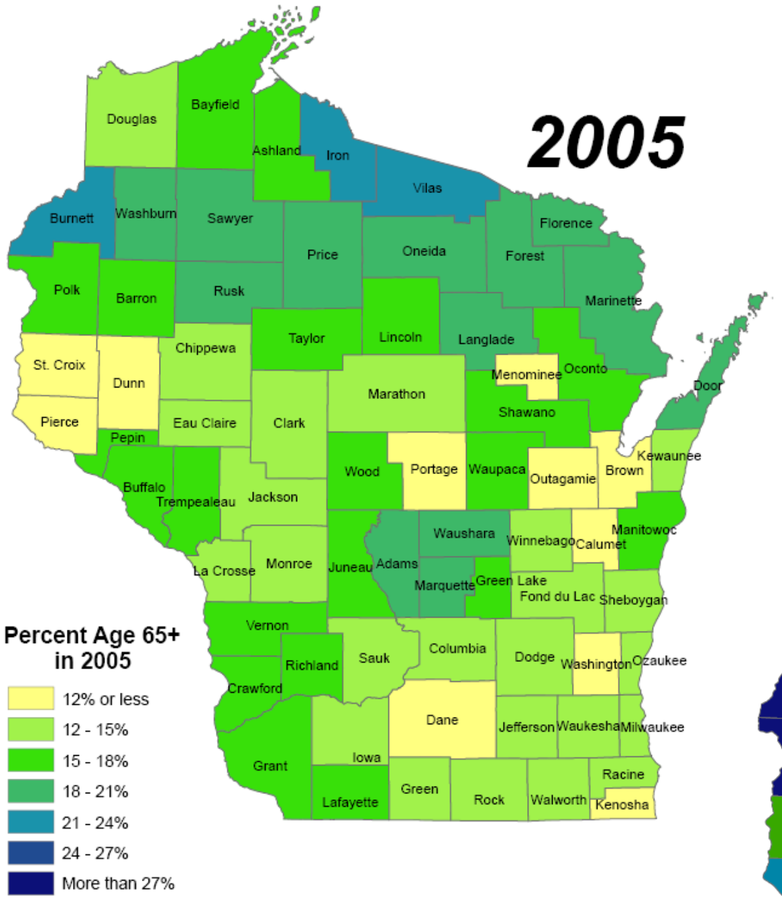
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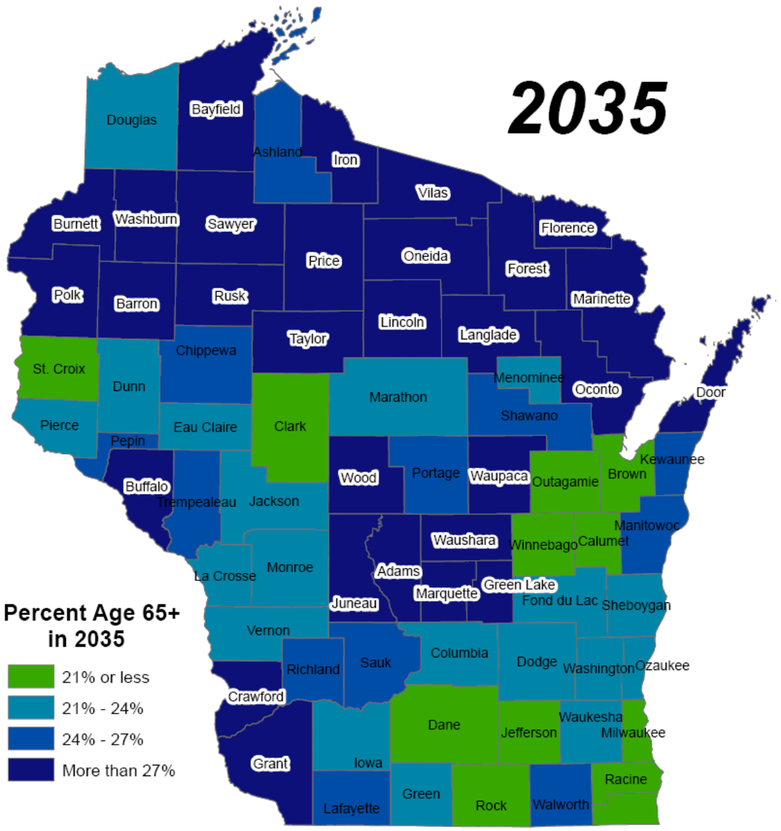
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Pierce
Eau Claire
Clark
Shawano
Pepin
Kewaunee
Wood
Portage
Waupaca
Outagamie
Brown
Buffalo
Trempealeau
Jackson
Manitowoc
Waushara
Winnebago
Calumet
La Crosse
Monroe
Adams
Green Lake
Marquette
Fond du Lac
Sheboygan
Juneau
Vernon
Columbia
Dodge
Richland
Sauk
Washington
Ozaukee
Crawford
Dane
Jefferson
Waukesha
Milwaukee
Grant
Iowa
Racine
Lafayette
Green
Rock
Walworth
Percent Age 65+ in 2035
21% or less
21% - 24%
24% - 27%
More than 27%

Questions???

Thank You!