History of Wisconsin's ADRCs
ADRC Operations Manual

I. Introduction: The Aging Difference

The Older Americans Act of 1965 includes among its defining objective "to assist our older people to secure equal opportunity to the full and free enjoyment of … independence and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community-based services and programs provided for their benefit, and protection again abuse, neglect, and exploitation."

At the core of this objective is the notion that people for whom programs and services are designed ought to decide what those programs and services are and should have a real sense of ownership and agency regarding them. This notion stems from the essential principle of democratic social order: each individual has a stake and a say in the decisions that affect their life. The Older Americans Act grew out of the widespread social engagement and grassroots advocacy that wrought a cluster of social laws and programs during a period of legislation collectively known as the "Great Society." These included the Senior Citizens Housing Act of 1965, the Civil Rights Act of 1964, environmental laws such as the Clean Water Act of 1965, the Older Americans Act of 1965, and legislation to enact Medicare and Medicaid.

The Older Americans Act (OAA) emerged from recommendations of the first White House Conference on Aging in 1961, in which nearly 3,000 representatives from 53 states and territories gathered in Washington, D.C., to create recommendations for nationwide system change. States sent delegates and referenda chosen through local advisory councils, commissions, subcommittees, and aging organizations "representing as broadly as possible the population" and charged with envisioning the challenges posed by population-aging and proposing action to solve or prevent anticipated problems (Due, Verna E., "Report on the White House Conference on Aging," 1961). The conference's participatory, delegate-oriented approach established a solidly democratic foundation for person-centered planning as the aging network was born.

The OAA-authorized aging network has long expressed the idea that aging programs and services differ from those offered through more traditional social welfare systems. First, the process of aging affects everyone who survives youth. It knows no economic, cultural, social, or political bounds, and a lifetime of solid work ethic and personal responsibility can't stave off its fundamental challenges. Second, the network's foundation in participation and advocacy by engaged older adults

established a strong role for involvement, empowerment, and ownership in building and operating aging programs. Unlike the paternalistic "poor house," "soup kitchen," or "welfare" models of social support that view those served as incapable of surviving without charitable or governmental help, older adults ideally organize and operate their own service network and, as a result, feel it belongs to them.

To extend this notion of participation and ownership as widely as possible, all individuals aged 60 and older are eligible for OAA services, and some OAA programs serve people aged 55 and older. A few related advocacy and service organizations, like AARP (founded in 1958 as the American Association of Retired Persons), encourage membership even earlier. The motivating impetus for including younger members is to engage a wide swath of the population as active contributors and volunteers in the system, buttressing the sense of broadly shared ownership and minimizing the inter-group competitiveness and stigmatization that come with narrowly defined eligibility criteria.

Establishing and institutionalizing local aging programs

By all accounts, OAA program development and delivery in the early years clearly reflected the impact of "the aging difference," with widespread volunteer participation in the operation of senior centers, congregate nutrition and home-delivered meal programs, transportation services, exercise and activity programs, and companion or friendly visitor services.

Over time, federal, state, and local support for these types of programs grew, allowing them to hire administrative and service staff and become established institutions of local communities. Many local governments brought aging services into social service or human services departments, giving them access to administrative, fiscal, and human resources support. The need for a professional aging network staff grew and eventually evolved into a set of educational and credential requirements. Insurance issues and liability concerns edged volunteers out of many core program roles. Confidentiality concerns and the need to protect the personal information of program participants further limited the options for volunteer work in aging units, but staff positions flourished, and aging network organizations grew.

By the time of the 2015 White House Conference on Aging (WHCOA) and OAA Reauthorization, the aging network had been firmly institutionalized as a successful, mission-driven bureaucracy noted for the commitment and professionalism of its administrative and service staff, a large share of whom were credentialed social workers with advanced degrees. The dream of an established and visible aging network with reach into every corner of America had been achieved.

But the 2015 WHCOA also revealed a more troubling aspect of aging network evolution. Whereas earlier WHCOAs built policy recommendations on a foundation of local, grassroots input presented by state delegates reflecting the population of

older adults, in 2015 the WHCOA was organized and orchestrated by the Administration for Community Living, with a single national coordinator creating five regional meetings of officially invited guests representing an array of professional aging organizations. A televised national event featured scripted panel presentations on key topics. The results were widely considered underwhelming and had little to no impact on public or political discourse.

Institutionalization versus public ownership

What's troubling about this episode is the gulf it reflects between the OAA's intended "aging difference" and the reality of the modern aging network. Public participation and advocacy have reached a low ebb. Public input into local, regional, and state aging plans, while required by law, has become a formality with marginal impact on most programs. A sense of public ownership has been displaced by a curious mix of disinterest and entitlement. For example, a recent discussion with one state's aging advisory council revealed that only two of twelve members had ever attended a congregate meal site, and those who hadn't could not imagine why they ever would. At the same time, the prospect of dismantling foundering meal sites (serving two to five customers weekly) regularly stimulates local conflict between activists supporting older adults' "right to a free meal" versus those protecting "taxpayer interests."

Next stage: aging and disability resource centers

As a next step in the maturing of the aging network, Wisconsin and many other states have established aging and disability resource centers (ADRCs) offering a one-stop approach to an array of services that complements, and can also encompass, traditional OAA programs. In Wisconsin, ADRCs operate as county or regional organizations that are often, but not always, integrated with county aging units. In recent years Wisconsin has moved to expand this integration geographically and deepen the organizational bonds between ADRCs and aging units—ideally resulting in a single entity with seamlessly unified aging and ADRC administration and program delivery.

In some localities these efforts have generated tension around the idea that the core principles of the aging difference are threatened by integration. Simply stated, aging unit leaders worry that their absorption into the ADRC model undermines local commitment to aging advocacy, public input, and active participation. Aging units grew directly out of the principles and culture of the Aging Difference. In Wisconsin, they are designated by county governments and have a high degree of organizational flexibility and variability. Early leaders, including some who remain active today, often began as volunteers and advanced into staff positions and eventually management and administration.

The activities and organization of ADRCs, in contrast, are more clearly delineated by the state's funding contract, held and controlled by the Department of Health Services (DHS). The contract also includes stricter statewide standards for the preparation and professional qualifications of staff than does the aging unit model. The ADRC model is "top-down," while the aging unit model evolved locally in response to broad programmatic guidelines. The resulting differences can make it hard for local entities to embrace one another. Local funding, culture, and politics can further complicate the process.

II. Development of ADRCs in Wisconsin

In the mid-1990s, Wisconsin began efforts to redesign the long-term care system. At that time, the long-term care system was fragmented and options for home and community-based long-term care were limited. There was a vision to develop a "one-stop shop" concept for individuals to obtain information and resources related to long-term care, making ADRCs a principal component of Wisconsin's long-term care redesign since its inception. The first ADRCs opened in 1998, and statewide coverage was achieved in 2013.

Individuals in need of publicly funded long-term care were only able to access Medicaid in the following ways:

- If the county they resided in had an opening for a home and community-based program participant in the Community Options or Community Integration Programs
- By entering an institutional setting, such as a nursing home

Counties had long waiting lists for home and community-based services, which forced individuals to obtain the care that they needed by entering institutions such as nursing homes. For many, continuing to reside in their own home with support was cost-effective for Medicaid and gave individuals the quality of life that they deserved. Eliminating waiting lists and creating entitlement to home and community-based care was another principal component of Wisconsin's long-term care redesign. Today these programs are known as Family Care, Family Care Partnership, PACE, and IRIS. As of 2021, access to these programs is an entitlement for those that meet the eligibility criteria, regardless of their county of residence.

The Administration for Community Living, known as ACL, is the federal agency responsible for the No Wrong Door Systems initiative nationally, with ADRCs being a vital component. ACL sees the No Wrong Door system as a way to provide information and assistance not only to individuals needing either public or private resources, but also to professionals seeks assistance on behalf of their clients and to individuals planning for their future long-term care needs. No

Wrong Door systems also serve as the entry point to publicly administered long-term supports, including those funded under Medicaid, the Older Americans Act, Veterans Health Administration, and state revenue programs. From ACL's perspective, ADRCs address the frustration many consumers and their families experience when they need to obtain information and access to supports and services. ADRCs are designed to raise visibility about the full range of public and private options available, while providing objective information and a counseling. Wisconsin has been a national leader in the development and implementation of ADRCs.

Wisconsin Stat. § 46.283 and Wis. Admin. Code ch. DHS 10 contain the requirements and regulations related to ADRCs.

III. Timeline and Milestones

A. ADRC concept design (pre-1998)

1995 Planning for the redesign of Wisconsin's long-term care system begins.

1996 Wisconsin aging resource center concept paper is distributed.

1997 Preliminary proposal for redesigning Wisconsin's long-term care system, including the development of ADRCs, is released by the Department of Health and Family Services which is known today as the Department of Health Services.

Authorization and funding for resource center pilots is included in the 1997–1999 biennial budget.

A request for proposals for ADRC pilots is released. Over 30 counties and one Tribe respond.

The Oneida Tribe is selected as one of nine ADRC pilots.

B. ADRC implementation and expansion (1998–2013)

1998 Governor Thompson proposes the Family Care initiative in his State of the State address.

ADRC pilots begin operation in nine counties: Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, and Trempealeau.

1999 Authorization for the Family Care benefit is included in the 1999–2001 biennial budget.

2000 Family Care managed care organizations (MCO) begin operating in five pilot counties.

2005 ADRC services begin in Barron, Brown, and Green counties.

2006 Governor Doyle signs legislation authorizing statewide expansion of Family Care, including ADRCs, on May 10, 2006.

ADRCs begin operation in 11 additional counties: Calumet, Forest, Green Lake, Manitowoc, Marquette, Outagamie, Racine, Sheboygan, Waupaca, Waushara, and Wood.

2008 ADRCs begin operation in 15 additional counties: Chippewa, Columbia, Dodge, Dunn, Eau Claire, Jefferson, Juneau, Monroe, Ozaukee, Pierce, Sauk, St. Croix, Washington, Waukesha, and Vernon.

The IRIS self-directed supports waiver begins operation in July.

Tribes are invited to apply for Tribal aging and disability resource specialists (ADRS). Funding for the Tribal ADRS is made available when the area in which the Tribe is located begins providing ADRC services.

2009 ADRCs begin operation in 18 additional counties: Ashland, Buffalo, Burnett, Clark, Crawford, Douglas, Grant, Iowa, Iron, Lafayette, Pepin, Polk, Price, Rusk, Sawyer, Walworth, and Washburn. The St. Croix Tribe partners with the regional ADRC serving Polk and Burnett counties. The Milwaukee Disability Resource Center opens.

Continued expansion of ADRCs is included in the 2009–2011 biennial budget.

A position paper, Options for Aging and Disability Resource Center Services to Tribal Members, is issued in February.

Applications for Tribal ADRS are issued in February 2009. Funding for Tribal ADRS becomes available to a Tribe when Family Care begins enrollments in the area where the Tribe is located.

The ADRC of Northwest Wisconsin opens in April, with the St. Croix Chippewa Tribe as a full partner in the ADRC. The ADRC serves Polk and Burnett counties as well as the St. Croix Chippewa Indians of Wisconsin.

2010 ADRC services begin in Langlade, Lincoln, and Winnebago counties. Tribal ADRS positions are funded for the Red Cliff and Lac Courte Oreilles Tribes.

2011 Statewide expansion of ADRCs is included in the 2011–2013 biennial budget.

The Bad River and Lac Courte Oreilles Tribes hire Tribal ADRS positions.

2012 ADRC services begin in 10 counties: Adams, Dane, Kewaunee, Marinette, Menomonie, Oconto, Oneida, Shawano, Taylor, and Vilas. Four Tribes join regional ADRCs: the Sokaogon Chippewa Community, the Lac du Flambeau Band, and the Forest County Potawatomi Community join the ADRC of the Northwoods and the Stockbridge-Munsee Band of Mohican Indians join the ADRC of the Wolf River Region.

The Ho-Chunk Nation hires a Tribal ADRS.

2013 ADRCs open in Door, Florence, and Rock counties.

Statewide implementation is complete. Wisconsin has 41 ADRCs serving 72 counties.

C. Statewide ADRCs and new initiatives (2013–present)

2013 The Dementia Care Stakeholder Summit takes place and the Stakeholder Summit Report (P-00563) is published.

The Dementia Care Specialist (DCS) program pilot is awarded to six ADRCs: Jefferson County, Kenosha County, the Lakeshore, the North, Portage County, and Racine County.

The Oneida Tribe's application for a Tribal ADRS is approved.

2014 The DCS program expands to include 11 additional ADRCs: Barron, Rusk, and Washburn counties; Brown County; Dane County; Dodge County; Eau Claire County; Milwaukee County; Ozaukee County; Rock County; Southwestern Wisconsin; St. Croix County; and Waukesha County.

The Wisconsin Dementia Care System Redesign Plan (P-00586) is published.

2015 Tribal DCS application are approved for the Menominee, Oneida, and St. Croix Chippewa Tribes.

Of Wisconsin's 11 Tribes, five Tribes have Tribal ADRS (Red Cliff, Bad River, Lac Court Oreilles, Ho-Chunk, and Oneida) and four Tribes have partnered with counties to form regional ADRCs (St. Croix Chippewa, Lac du Flambeau, Forest County Potawatomi, and Stockbridge-Munsee).

2017 The ADRC of Western Wisconsin dissolves. As a result, the following counties establish separate ADRCs: La Crosse, Monroe, Vernon, and Jackson.

The ADRC of Buffalo, Clark, and Pepin counties dissolves. As a result, two new ADRCs are established: the ADRC of Clark County and the ADRC of Buffalo and Pepin counties.

The 2017–2019 biennial budget includes funding to continue the current DCS positions and fund an additional five.

Wisconsin has 45 ADRCs serving all 72 counties and 11 Tribes.

2018 The ADRC of Adams, Green Lake, Marquette, and Waushara counties dissolves. As a result, two new ADRCs are established: the ADRC of Marquette County and the ADRC of Adams, Green Lake, and Waushara counties.

An additional five DCS positions are awarded to the following ADRCs: Winnebago County, Pierce County, Marinette County, La Crosse County, and Eagle Country.

Wisconsin has 46 ADRCs serving all 72 counties and 11 Tribes.

2019 The ADRC of the Northwoods, serving Vernon, Oneida, Forest, and Taylor counties, as well as the Forest County Potawatomi Tribe, dissolves. As a result, three new ADRCs are established: the ADRC of Oneida County, the ADRC of Vernon County, and the ADRC of the Northwoods serving Forest and Taylor counties as well as the Forest County Potawatomi Tribe.

Great Lakes Inter-Tribal Council's (GLITC) application for a Tribal ADRS to serve the Lac du Flambeau Band of Lake Superior Chippewa Tribe and the Sokaogon Tribe is approved.

The DCS program expands to include an additional nine positions, serving a total of 14 ADRCs and two Tribes: Douglas County; Northwest Wisconsin; Marinette County; the Wolf River Region; Jackson County; Monroe County; Buffalo and Pepin counties; Trempealeau County; Chippewa County; Dunn County;

Central Wisconsin; Calumet, Outagamie, and Waupaca Counties; Racine County; Walworth County; the Lac du Flambeau Tribe; and the Sokaogon Tribe.

Wisconsin has 48 ADRCs serving all 72 counties and 11 Tribes.

2021 The 2021–2023 biennial budget expands the DCS program statewide.

Waiting lists for publicly funded long-term care programs are eliminated as Wisconsin reaches program entitlement statewide.

2022 Expansion of the DCS program is statewide, covering all 72 counties.

Planning for expansion of the DCS program to all 11 Tribes begins.

The ADRC of Milwaukee County is established, combining the Aging Resource Center and Disability Resource Center into a single organization.

Wisconsin has 47 ADRCs serving all 72 counties and 11 Tribes.

2023 Expansion of the DCS program to all 11 Tribes is complete.

The ADRC of Barron, Rusk, and Washburn counties becomes two separate ADRCs: the ADRC of Washburn County and the ADRC of Barron and Rusk counties.

Sauk County leaves the ADRC of Eagle Country, becoming the ADRC of Sauk County.

Wisconsin has 49 ADRCs serving all 72 counites and 11 Tribes.