JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

Wraparound Initiative
Alzheimer's Disease Demonstration Grants to States

Request for Proposals (RFP) Information Meeting
Held March 6, 2006

1. **Meeting Agenda**

2. **Questions and Answers**

3. **Handouts from Meeting**

4. **Training Provided by MDCH:**

   a) Wraparound Facilitator Training will be held May 22, 23, 24, 2006, with a follow-up to tailor this training to the new target population.
   b) One-Day Wraparound Orientation will be held for the two developed Community Teams (CTs) and potential providers. Dates TBD with awarded agencies. A half day on Roles and Responsibilities of the CT will follow.
   c) Training and on-site consultation on Cognitive Impairment and Interventions will be provided to CTs and potential providers.

Wraparound Initiative
Alzheimer's Disease Demonstration Grants to States

Request for Proposals (RFP) Information Meeting
Monday, March 6, 2006
1:30 – 4:30 pm
Lake Ontario Room, Michigan Library & Historical Center
Lansing, Michigan

1:30 pm	Welcome Brief history of Administration on Aging (AoA) grant, Role of Mental Health & Substance Abuse (MH&SA) of Michigan Department of Community Health (MDCH) and Michigan Dementia Coalition (MDC) *Marci Cameron, MA, Dementia Care Program Consultant and Coordinator of Michigan's ADDGS Grant, MDCH*
1:45 pm	Impact of Alzheimer's Disease *Marci Cameron*
1:55 pm	Introduction to Advances in Knowledge About Behavioral Symptoms of Distress and Interventions That Can Be Learned by Professional and Non-Professional Caregivers *Shelly Weaverdyck, PhD, Director of Eastern Michigan University Alzheimer's Education and Research Program and Consultant/Specialist in Cognitive Intervention*
2:30 pm	Wraparound Model for Children & Families *Connie Conklin, MSW, LMSW, Wraparound/System Reform Coordinator & Trainer, MDCH*
3:00 pm	Break
3:10 pm	Request For Proposals: Stated Problem, Target Population, Grant Purpose, Grant Goals & Objectives, Review Criteria, Dates *Marci Cameron*
3:45 pm	Preparing Your Budget Proposal *Alyson Rush, MSW, Mental Health Rehabilitation Specialist, MDCH*
4:15 pm	General Questions
4:30 pm	Adjournment

All questions posed during presentations and responses will be posted on the MDCH website.

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Questions and Answers from the Alzheimer's Disease Demonstration Grant to States (ADDGS) Bidder's Information Meeting
March 6, 2006

A good resource for Wraparound, suggested by Connie Conklin, Wraparound Coordinator, Division of Mental Health Services for Children and Families: book, Share the Care.

1. Q. Is the Single Point of Entry (SPE) Request for Proposal related to the ADDGS Request for Proposal?
   A. No, it is not. Wraparound for individuals with dementia is a separate pilot initiative through the ADDGS. The SPE uses a "person-centered planning process as the model for all activities, regional SPE demonstration agencies will identify available long-term supports and services and assist consumers in accessing the services and programs of their choice through a single regional entity. A long-term care single point of entry is defined as '...a system that enables consumers to access long-term and supportive services through one agency or organization.' Facilitating consumer choice is a key role of an SPE."

2. Q. Can a lead agency apply to provide service in both urban and rural areas?
   A. Yes

3. Q. What if the geographical area for the CT is primarily suburban and neither urban ethnic nor rural?
   A. The Administration on Aging has determined that ethnic urban and rural areas are priority areas of focus, but not a requirement of funding. Michigan has 83 counties, of which 72 are designated rural.

4. Q. Can the proposal's plan cut across more than one Community Collaborative?
   A. Yes

5. Q. How does the concept of Self-Determination relate to the Wraparound process for individuals with dementia?
   A. Services and supports are determined with involvement of the persons with probable Alzheimer's Disease or related disorder and their family members, and are based on individual circumstances.

6. Q. Can Medicaid coverage be counted as match?
   A. No. Medicaid, which consists of federal funds and state funds to match federal Medicaid, cannot be used to match other federal funds.

7. Q. How should budget forms be completed if subcontractors are not yet identified?
A. Under the Contractual line, specify the anticipated amount of funds allocated and note that the contractor is yet to be identified. Supply the information as soon as identification occurs.
When completing DCH form 0386, line 5, include each subcontractor (name and address for those identified) amount, and carry the total over to DCH form 0385, line 5. A DCH 0386 and 0385 must be completed for each subcontractor for Year 1. For Year 2 and 3, estimated totals for subcontractors are adequate.

8. Q. What is the source of funding for the Wraparound Initiative?
A. The funds originate from the Administration on Aging and are awarded to the State of Michigan Department of Community Health (MDCH), through the Alzheimer's Disease Demonstration Grants to States. Funds for the two pilot Wraparound initiatives are awarded to the two pilot agencies through the MDCH.

9. Q. How will eligible persons with dementia be identified?
A. To be eligible for this program, individuals with dementia experiencing acute behavioral symptoms of distress must already live in a community setting, which may include Adult Foster Care homes. Participants from an inpatient setting, such as a hospital or nursing home, must be in the process of discharge planning to be considered for Adult Wraparound services. It is up to the Community Team to identify and enroll participants, and to determine the process of referral.

10. Q. Are there age or income restrictions for persons with dementia using the Wraparound process?
A. No, the Administration on Aging allows for any adult at any income level with probable Alzheimer's or related disorder exhibiting acute behavioral symptoms of distress to participate. Co-pays may be assessed based on ability to pay.

11. Q. What model of Wraparound facilitation is encouraged?
A. A facilitator must be identified, either through the grantee agency or through a contractual agreement between the grantee agency and the subcontractor. The facilitator creates the structure for the Wraparound process, including the formation of a Community Team, drawing on existing community strengths. Further description of the Wraparound Model is provided in the RFP *Attachment D: Communique No. 9.*

12. Q. How will grantees evaluate the project progress?
A. A required evaluation and survey tool will be included in the contractual agreement between MDCH and the grantee agency. Additional information may be gathered by the agency if desired.

13. Q. Can participating persons receive any service beyond Wraparound or "usual" services?
A. Yes. Wraparound is a process rather than a service. The individual's needs, assistance available, and unmet needs must be identified. It is anticipated that some needs cannot be met within the traditional service array. ADDGS funds are flexible and may be used for a broad array of services. Other community funding sources should be used when possible. In Wraparound planning, any existing benefits should be identified and maximized prior to the use of flexible funding budgeted for the Wraparound process. Programs and services currently in place may remain so if deemed beneficial to the process.

14. Q. What is the anticipated length of time a person with dementia will use Wraparound?
A. There is no time limitation. As dementia is a degenerative illness, needs will probably change and increase through the illness process. Wraparound's "no ejection" value dictates that intervention planning continues as needs change and even increase. The process will probably end for individuals with dementia when institutionalization is necessary or death occurs.

15. Q. Is the facilitator also the team leader?
A. Not necessarily. The facilitator is responsible for developing a Wraparound Community Team and for ensuring that Wraparound Model aspects are followed. Others on the Community Team and Family Teams may assume leadership roles. The facilitator is a neutral, non-supervisory service provider who works with the persons with dementia and the family to identify and help form the plan to meet individual family needs.

16. Q. Are there credentialing requirements for the facilitator?
A. No

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17. Q. Can agency representatives who are a part of the Community Team or a collaborating agency designate their time as in-kind local match?
A. Yes. The grant awardees should obtain appropriate documentation for reporting purposes.

18. Q. Is it necessary to form a new Community Team (CT) if there is one in existence that addresses aging issues?
A. It is not necessary to form a new Community Team if there are separate CTs for older adults and children.

19. Q. How big are Wraparound Teams?
A. Teams vary in size, based upon needs of the people served.

20. Q. How are Family Teams formed?

A. The Facilitator works with the individual with dementia and family members to identify persons they relate to who should be included in intervention planning. They could be family members, neighbors, friends, or professionals they already relate to, such as a nurse. In addition, members may be professionals who can contribute to identified needs. There may be situations where it would be appropriate to include an adult protective services worker or law enforcement representative on a Family Team. Family Team membership can change as issues change. For instance, representatives of community agencies providing volunteer services may participate at an early stage, and clergy and end-of-life legal planners may participate at a later point.

2/23/06

REQUEST FOR PROPOSALS

The Michigan Department of Community Health has issued a Request for Proposals (RFP) for the Michigan Alzheimer's Disease Demonstration Grants to States (ADDGS) Wraparound Initiative. The MDCH will award two grants to pilot the development of Wraparound Model Initiatives. The Proposal Application Deadline is April 14, 2006. The project period is May 15, 2006 through September 30, 2008. The RFP is available on the Internet at http://www.michigan.gov/mdch (Click on Mental **Health & Substance Abuse [left side], then Mental Health [left side], then Reports & Proposals [left side]).** Eligible applicants are community mental health services programs, aging network organizations, public health or other community-based service organizations as lead agency for the project.

The Administration on Aging (AoA) awarded funding for ADDGS in July 2005 to further the development of innovative approaches to provide care for people with Alzheimer's disease and support for their family caregivers. The AoA is strengthening the ADDGS Program by continuing to incorporate a greater focus on community-based care, including state programs to streamline consumer access to services and family caregiver support programs. The two pilot lead agencies will each identify a facilitator, develop a wraparound community team, and implement an integrated system array of wraparound protocols, services, and supports for individuals with dementia who exhibit acute behavioral symptoms of distress and their families. A Wraparound Model that is currently successfully used for children and families will be modified to provide a strategy to help this new target group to remain in the community and prevent premature institutionalization.

The Wraparound Initiative (one of three Michigan ADDGS initiatives) will grant each lead agency up to $75,000 per year for a project of approximately 29 months. Non-federal matching funds provided through the lead agency are required. The Michigan ADDGS grant is administered by MDCH's Mental Health & Substance Abuse Administration. **Contact Marci Cameron at cameronm@michigan.gov for questions.**

Wraparound Initiative Information Meeting
Alzheimer's Disease Demonstration Grants to States
March 6, 2006

Welcome

Brief history of AoA grant, Role of MH&SA and MDC

The Alzheimer's Disease Demonstration Grants to States was initiated with federal funding in 1991. Its purpose is to further the development of innovative approaches to provide care for people with Alzheimer's disease and support for their family caregivers. The ADDGS program has proven successful in targeting service and system development to traditionally underserved populations, including ethnic minorities, low-income and rural families coping with Alzheimer's disease. Michigan is one of only a handful of states that have participated in the grant program since its inception.

The Administration on Aging (AoA) awarded funding for ADDGS to Michigan in July 2005. The AoA is strengthening the Program by continuing to incorporate a greater focus on using the ADDGS Program as a vehicle for advancing changes to a state's overall system of home and community-based care, including state programs to streamline consumer access to services and family caregiver support programs.

The Michigan ADDGS grant is administered by the Mental Health & Substance Abuse (MH&SA) Administration of the Department of Community Health. Partners include the Michigan Office of Services to the Aging, Michigan Public Health Institute, Michigan Dementia Coalition and Primary Care Physicians Network, Michigan Quality Community Care Council, Michigan Direct Care Workers Initiative, Alzheimer's Association chapters and local service providers, as well as academic resources of Eastern Michigan University, Lansing Community College, and Michigan State University. The Michigan Dementia Coalition serves as the state level advisory body for the overall project. The Coalition represents a collaboration of consumers, community groups, universities, and state agencies convened to improve the quality of life of persons with dementia and their families.

The Mental Health & Substance Abuse staff, with myself as project coordinator and Alyson Rush, will manage contracts with the two funded lead agencies, provide training and technical support to local teams that implement wraparound services and supports, conduct periodic site visits for the purpose of support and consultation, will analyze and report on data collected by local implementation teams to evaluate the quality of wraparound services and supports, and will coordinate dissemination of findings and lessons learned.

The MDCH Division of Mental Health Services to Children and Families Wraparound consultants – Mary Ludtke and Connie Conklin – have provided tremendous support to

us in developing this project and will provide technical assistance and training during the project.

Subcommittees of a Wraparound Project Team will provide assistance in proposal review, data collection development and review, progress review, and technical assistance to pilot teams. Project Team members represent administrations of Public Health, Mental Health, Department of Human Services, Medical Services Administration, and the Office of Services to the Aging (OSA).

Wraparound Pilot Projects:

The ADDGS Wraparound Initiative is one of three Michigan ADDGS initiatives. It will fund implementation of a Wraparound Model in two communities in the second half of our Year 1 through Year 3 (May 15, 2006 through September 30, 2008). The two pilot lead agencies will each identify a facilitator, develop a wraparound community team, and implement an integrated system array of wraparound protocols, services, and supports for individuals with dementia who exhibit acute behavioral symptoms of distress and their families. A Wraparound Model that is currently successfully used for children and families will be modified to provide a strategy to help adults with dementia remain in the community. Wraparound is a term that describes an approach to building constructive relationships and networks of support with individuals and families whose needs fall outside the scope of traditional service systems and require integrated coordination among organizations and the individual's natural supports to reduce the use of institutional settings.

Contact Information:
Marci Cameron: cameronm@michigan.gov
Alyson Rush: rusha@michigan.gov

WHY THE INTEREST IN CAREGIVERS of PERSONS WITH DEMENTIA?

Kim Walsh, MS, Program Director
Alzheimer's Association-Michigan Great Lakes Chapter

Prevalence

- Currently 4.5 million Americans have Alzheimer's disease
- More than 7.7 million have a dementia-related illness
- Estimate between 11.3 and 16 million persons with dementia by 2050
- "Silver Tsunami" begins 2006
- Every five years there is a 5% higher prevalence

Impact on Society

- U.S. society spends at least $100 billion/year on dementia-related illnesses
- More than 7 out of 10 persons with dementia live at home (average $12,500 per year in direct costs)
- Between 50-70 percent of all nursing home residents have some form or level of dementia (average $42,000 per year)
- The average lifetime cost of care for an individual with AD is $170,000

Impact on Michigan

- 210,000 Michigan citizens have Alzheimer's disease or related dementia
- For each person with dementia, at least 2.3 family members are drastically impacted as care partners

What Is Dementia?

- Gradual loss of brain cells
- Gradual decline of multiple cognitive abilities
- Warning signs include:
  - memory loss, misplacing items
  - language problems
  - disorientation
  - poor judgment
  - difficulty performing familiar tasks
  - changes in personality, mood, behavior
  - loss of initiative
- Dementia is only a description of symptoms (loss of cognitive abilities)
- Does not give any explanation of etiology
- More than 24 broad categories of causes that can cause constellation of symptoms
- Alzheimer's disease makes up 55% of all cases of dementia

Who are the caregivers?

- Spouses – largest group, many with health concerns of their own
- Daughters and Daughters-in-law – often referred to as the "Sandwich Generation" because they are providing care for elderly parents and young children
- Sons – often focus on the financial, legal, and business aspects of caregiving
- Brothers and Sisters – many are older with their own health problems
- Others – friends, neighbors, members of the faith community

Understanding Effects on Caregivers

- Caregiver needs differ at different stages of dementia
- Caregivers need to be assessed for depression, burnout, and their own health needs
- Caregivers need information on the disease, what to expect, and how to get help

The Caregiver's Needs at Different Stages

- Early Stages
  - Education on changes in brain and behavior
  - Support
  - Guidance on planning for the future
  - Knowledge of community resources
- Middle Stages
  - Information on personal care, communication and behaviors
  - Support from others who are coping with the effects of AD
- Late Stages
  - Acceptance of grief
  - Guidance on end-of-life decision making
  - Information on physical health needs
  - Guidance on continued communication
  - Encouragement that they make a difference

Feelings of the Caregivers

- anger
- embarrassment
- helpless and discouraged
- guilt
- sadness and depression
- laughter, love and joy
- grief
- isolation and feeling alone
- worry
- being hopeful and being realistic
- fatigue and illness

Literature on Interventions

- Multiple approaches have more impact, support group and education
- Programs tailored to the particular caregiver situation or to specific patient behaviors rather than a general framework have been more successful (individualized strategies of care)
- Caregivers can acquire skills and knowledge that permit them to carry out sophisticated tasks

Benefits of Caregiver Support and Education

- Helps to alleviate symptoms of depression in caregivers
- Reduced stress and burden
- Delayed nursing home placement
- Improved quality of care

SUMMARY

- Prevalence of dementia is increasing
- Caregivers are drastically impacted when a loved one has dementia
- Support and education services have positive results for persons with dementia and their care partners
- We need to have support and education services in place for families to help them provide care for persons with dementia.

Wraparound IS NOT

A Program

It is a Process!

Best Practice Values

- Child Well-Being
- Family-Centered
- Safety
- Unconditional Commitment
- Strength-Based
- Community Collaboration
- Cost Effective and Cost Responsible
- Individualized
- Culturally Relevant
- Community Based
- Parent Professional Partnership
- Outcome-based
- Social Networks and Informal Supports

Parent's Perspective

•A group of people who come together to help our family

•They listen and comprehend what is happening with our family and help us figure out ways to be successful as a family

•As a family we learn new ways to cope, handle situations and appr eciate each other for who we are.

Connie's Perspective

•Wraparound is a PLANNING process with emphasis on PLANNING

•It is not case management, therapy or group therapy

•The intent of Wraparound is to provide strategic opportunities to children, youth and families that optimize their strengths and respect their culture

•It is important to balance Process and Outcomes

Wraparound in Michigan

- Tends to serve children at risk of out of home placement
- Children and Families involved in multiple systems
- Projects tend to be funded by multiple sources
- The Community Team in each county tends to provide the gatekeeping function for Wraparound
- At a state level, the evaluation and training of wraparound is the same for DCH and FIA

Our Guiding Belief:

"If Human Beings are perceived as potentials rather than problems, as possessing strengths instead of weakness, as unlimited rather than dull and unresponsive, then they thrive and grow to their capabilities"

Robert Conklin

The Steps of the Process
What are the results/outcomes of each step?

- Engagement
- Strengths and Culture
- Child and Family Team
- Mission Statement/Bumper Sticker
- Needs Discovery
- Prioritization
- Action Planning
- Outcome Development
- Crisis and Safety Support Plans

Engaging Families

Engaging with people is a process not an event or one appointment

Strength and Culture Discovery

"A positive attitude may no t solve all your problems, but it will annoy enough people to make it worth the effort"
Herm Albright

Key Assumptions in Strength Discovery

- All people have strengths
- Each person's strengths are unique
- Change is supported by building on strengths
- People know their own strengths and needs
- All environments have strengths to be built upon
- Cultures, traditions, rituals should be viewed as a strength to be build upon and respected

Another way to think about Strengths/Culture

- **Attitudes/Values**: We take care of our own, we are independent, spir itual
- **Skills/Abilities**: I.e. woodworking, writing, talking to people, grows beautiful roses
- **Preferences**: Likes to spend time alone, prefers not to watch T.V., junk food
- **Attributes or Features**: pretty blue eyes, high energy, talker
- **Interests**: Politics, Religion, history, sports, computers

"Joy comes from using our potential"
Will Schultz

Child and Family Team Development

The Impact of "Gathering"

Why Teams?

- A team has more knowledge than any single individual
- A team can help people think in a variety of ways
- A team can improve communication
- A team can assure better use of resources
- A team can increase productivity and efficiency
- A team can help those people involved in the family's life become interdependent with one another

"Teamwork divides the task and doubles the Success"

Vision/Mission: Bumper Stickers

Family Mission Statements

Some examples of bumper stickers are:

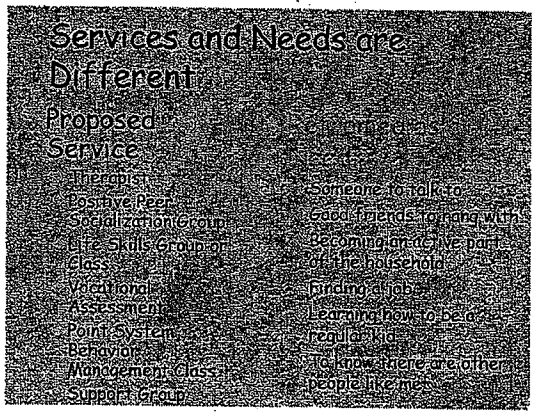
- Learn, Love and Live together peacefully
- One for all, all for one, Thou Shall not give up on thy family
- Get the monkey off my back, give peace a chance
- To have a life my children and family can be proud of
- To acknowledge/learn from our past but move towards our future

Life Domain Areas

- ↗Social/Fun
- ↗Emotional/Feelings
- ↗Family
- ↗A Place to Live
- ↗School/Work
- ↗Cultural
- ↗Spiritual
- ↗Safety
- ↗Legal
- ↗Medical/Health
- ↗Finances
- ↗Relationships/

Third Big Idea

Getting a service does NOT necessarily mean needs are met



Action Planning

Creating an Action Plan

- A blueprint for change
- Use strengths inventory to help brainstorm creative options for addressing key needs
- Express options in the context of a person's culture and preferences
- Try to imagine at least two informal options for every formal one suggested
- Be prepared for needs to change

Getting to Outcomes

The difference between measuring how hard we work and whether it makes a difference

Effective Outcome Statements

- Are based in the life of the family
- Describe how we will know life is better
- Need to be positively stated
- Are simple enough anyone can understand
- Reflect the concerns of the team
- Are measurable

"One's destination is never a place, but rather a new way of looking at things" Henry Miller

Crisis and Safety Planning

Support Plan

Supervision/Child Care Plan
Week of _____ Date:

Time	Sun	Mon	Tue	Wed	Thu	Fri	Sat

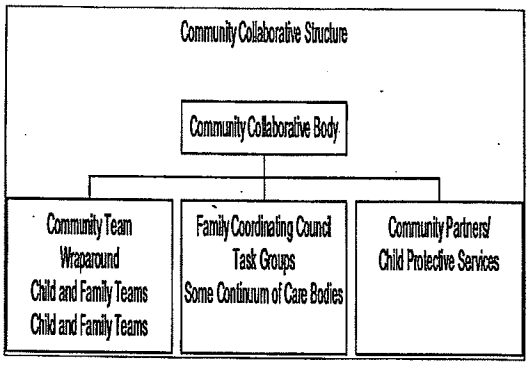
Wraparound Support Plan

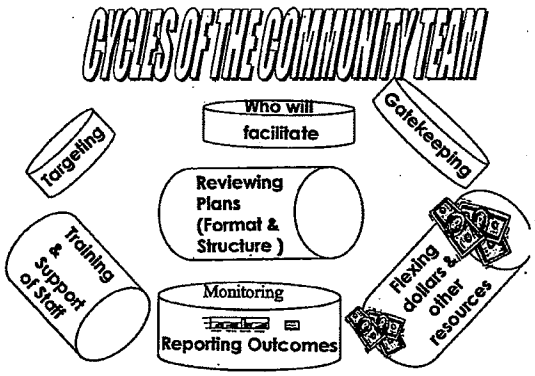
Strengths/Interest/Learning style of Individual/Family:

Anticipated Situation or Behavior	What we will do:	Who will do it?	By When
	To Prevent from happening: 1. 2. 3. 4. 5		
	How will we react: 1. 2. 3. 4.		

Signature of the Team/Family:

(adapted from community partnerships)





"To accomplish great things, we must not only act, but also dream; not only plan, but also believe"

Anatole France

Wraparound Initiative Information Meeting
Alzheimer's Disease Demonstration Grants to States
March 6, 2006

Request for Proposals

Problem and Target Population:

Michigan has received national recognition for its contributions to improving community and provider understanding about good dementia care. However, a gap has been identified for serving those individuals with acute behavioral symptoms of distress. These individuals may be described by others as resistant to care, challenging, agitated, disruptive or aggressive. Behaviors are upsetting to others and may result in injury, discharge from community services, excessive use of physical and drug restraints, and institutionalization. Severe behavioral or psychiatric symptoms affect a reported 20-40% of people with Alzheimer's disease. These symptoms pose a significant burden to families and are strongly related to institutional care.

Often individuals with dementia who exhibit acute behavioral symptoms of distress "fall through the cracks" of community services, and those who care for these individuals may be frustrated by systems barriers. Family issues are often multiple and cross service systems. Symptoms may create increased risk of injury to themselves or others. The health and functioning of family caregivers may be compromised.

A multi-system approach is required to develop and coordinate an integrated array of responsive, appropriate services and supports that can help sustain these individuals in the community and help them lead a high quality life.

Goals and Objectives:

The lead community agency will develop a new Community Team, in collaboration with the local Community Collaborative, that will respond to the target population. Collaborative partnerships and a wraparound model structure will be developed. Individuals with dementia and families will be referred to the Community Team for participation in the project. Family Teams will be developed to "wraparound" each family, focusing on their desired outcomes.

The Levels of Initiative Goals are outlined in the RFP. Major points:

1. A higher quality of life and health functioning for persons with dementia and their family caregivers will be attained.
2. There will be increased knowledge by professional and non-professional caregivers on interventions to reduce acute behavioral symptoms of distress

3. Community organizations will have greater awareness of all services, supports, and funding available for this target population, and will have the structure to work together for increased efficiency and effectiveness.
4. A new, modified model of wraparound will be developed for adults with dementia and their families.
5. A strategy for sustainability for this Model will be identified.

Eligible Applicants as lead agency for the project:

Community Mental Health Services Programs, aging network organizations, public health or other community-based service providers. Public or private organizations. As this is a pilot project, we are open to community-based organizations that are involved in collaborative efforts for this target population.

Major Points Regarding Review Criteria:

1. Consumer involvement in planning and project work is essential.
2. Explain how partnering organizations will be actively involved in the project.
3. Demonstrate awareness of existing services available in the community, as well as gaps and challenges.
4. Include partners across systems, including a partner with knowledge of funding supports and benefits available to the target population.

Application Checklist:

1. Proposal Face Sheet (Attachment A)
2. Narrative
3. Project Work Plan for FY '06 through FY '08 (Attachment C)
4. Four (4) pairs of Budget Forms (Attachment B)

Concluding Points to emphasize:

1. This is a team approach, with collaboration among organizations AND natural supports of the individual and family members, with the individual with dementia and family caregivers as the center.

2. Consideration of sustainability and funding sources is included from the beginning of the project. Use of natural and community supports and services should be creatively sought.

3. Identification of the Supports Facilitator/Coordinator is key to the success of the project, requiring someone who is committed to the Wraparound approach and its values, and who is capable of developing and facilitating collaborative efforts.

4. Wraparound goes way beyond case management. This is an extended level of involvement with and support for individuals with dementia and their family caregivers. It is a new approach to reach those who generally are underserved in the community.

Upcoming Dates:

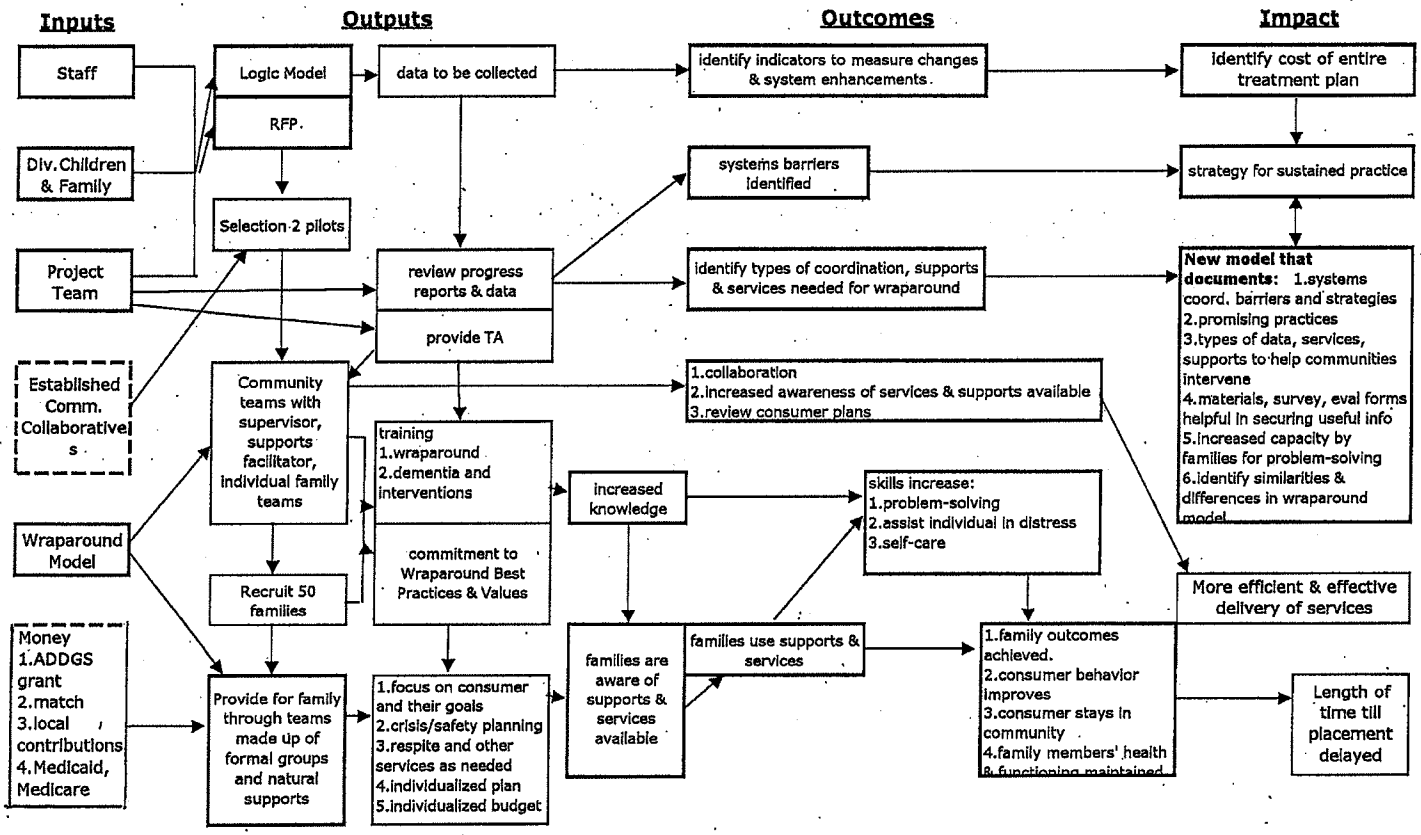
Deadline for submission of proposals is **April 14**. You may submit electronically, by mail, or hand-delivered. Please do not wait until April 14 as glitches occur.

First week of May decision on award. All those submitting proposals will be notified.

The project period begins **May 15**. An agreement will be developed between MDCH and the awarded lead agency.

Training will be provided in **May and June** on wraparound and cognitive impairment and interventions.

Logic Model: Wraparound Initiative



ATTACHMENT B

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

I. INTRODUCTION

The budget should reflect all expenditures and funds associated with the program, including local, state and federal funding sources. When developing a budget it is important to note that total expenditures for a program should equal total funds.

The Program Budget Summary (DCH-0385) is utilized to provide a standard format for the presentation of the financial requirements (both expenditure and funding) for each applicable program. Detail information supporting the Program Budget Summary is contained in the Program Budget-Cost Detail Schedule (DCH-0386). General instruction for the completion of these forms follows in Sections II-III.

II. PROGRAM BUDGET SUMMARY (DCH-0385) FORM PREPARATION

Use the **Program Budget Summary (DCH-0385)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.1)** for reference. **The DCH-0386 form should be completed prior to completing the DCH-0385 form.** (Please note: the excel workbook version of the DCH 0385-0386 automatically updates the Program Summary amounts as the user completes the DCH-0386).

A. Program - Enter the title of the program.

B. Date Prepared - Enter the date prepared.

C. Page ___ of ___ - Enter the page number of this and the total number of pages comprising the complete budget package.

D. Contractor - Enter the name of the Contractor.

E. Budget Period - Enter the inclusive dates of the budget period.

F. Address - Enter the complete address of the Contractor.

G. Original or Amended - Check whether this is an original budget or an amended budget. The budget attached to the agreement at the time it is signed is considered the original budget although it may have been revised in the negotiation process. If the budget pertains to an amendment, enter the amendment number to which the budget is attached.

H. Federal Identification Number - Enter the Federal Identification Number as stated on page one of Part I of the agreement.

I. Expenditure Category Column – All expenditure amounts for the DCH-0385 form should be obtained from the total amounts computed on the Program Budget - Cost Detail Schedule (DCH-0386).

Expenditures:

1. Salaries and Wages
2. Fringe Benefits
3. Travel

4. Supplies and Materials
5. Contractual (Subcontracts)
6. Equipment
7. Other Expenses
8. Total Direct
9. Indirect Cost
10. Total Expenditures

Source of Funds:

11. Fees and Collections - Enter the total fees and collections estimated. The total fees and collections represent funds that the program earns through its operation and retains for operation purposes. This includes fees for services, payments by third parties (insurance, patient collections, Medicaid, etc.) and any other collections.

12. State Agreement - Enter the amount of MDCH funding allocated for support of this program. (This amount should equal the amount reported in box 16 of the DCH 0016.) State percentages are not required.

13. Local - Enter the amount of local contractor funds utilized for support of this program. Local percentages are not required. In-kind and donated services from other agencies/sources should not be included on this line.

14. Federal - Enter the amount of any Federal grants received directly by the Contractor in support of this program and identify the type of grant received in the space provided.

15. Other - Enter and identify the amount of any other funding received. Other funding could consist of foundation grants, United Way grants, private donations, fund-raising, charitable contributions, etc. In-kind and donated services should not be included unless specifically requested by MDCH.

16. Total Funding - The total funding amount is entered on line 16. This amount is determined by adding lines 12 through 15. The total funding amount must be equal to line 10 - Total Expenditures.

J. Total Budget Column - The Program Budget Summary is designed for use in presenting a budget for a specific program agreement funded in part by or through the Department or some other non-local funding source. Total Budget column represents the program budget amount. **The "J" Total Budget column must be completed while the remaining columns are not required unless additional detail is required by the Department.**

III. PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386) FORM PREPARATION

Use the **Program Budget-Cost Detail Schedule (DCH-0386)** supplied by the Michigan Department of Community Health. An example of this form is attached **(see Attachment B.2)** for reference.

A. Page ___ of ___ - Enter the page number of this page and the total number of pages comprising the complete budget package.

B. Program - Enter the title of the program.

C. Budget Period - Enter the inclusive dates of the budget period.

D. Date Prepared - Enter the date prepared.

E. Contractor - Enter the name of the contractor.

F. Original or Amended - Check whether this is an original budget or an amended budget. If an amended budget, enter the amendment number to which the budget is attached.

G. Salaries and Wages - Position Description - List all position titles or job descriptions required to staff the program. This category includes compensation paid to all permanent and part-time employees on the payroll of the contractor and assigned directly to the program. This category does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, professional fees or personnel hired on a private contracting basis should be included in Other Expenses. Contracts with sub-recipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Subcontract) Expenses.

H. Positions Required - Enter the number of positions required for the program corresponding to the specific position title or description. This entry may be expressed as a decimal when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of a time study or time reports to support time charged to the program.

I. Total Salary - Compute and enter the total salary cost by multiplying the number of positions required by the annual salary.

J. Comments - Enter any explanatory information that is necessary for the position description. Include an explanation of the computation of Total Salary in those instances when the computation is not straightforward (i.e., if the employee is limited term and/or does not receive fringe benefits).

K. Salaries and Wages Total - Enter a total in the Position Required column and the Total Salaries and Wages column. The total salary and wages amount is transferred to the Program Budget Summary - Salaries and Wages expenditure category. If more than one page is required, a subtotal should be entered on the last line of each page. On the last page, enter the total Salaries and Wages amounts.

L. Fringe Benefits - Specify applicable ("X") for staff working in this program. Enter composite fringe benefit rate and total amount of fringe benefit. (The composite rate is calculated by dividing the fringe benefit amount by the salaries and wage amount.) This category includes the employer's contributions for insurance, retirement, FICA, and other similar benefits for all permanent and part-time employees assigned to the program.

M. Travel - Enter cost of employee travel (mileage, lodging, registration fees). **Use only for travel costs of permanent and part-time employees assigned to the program**. This includes cost for mileage, per diem, lodging, registration fees and approved seminars or conferences and other approved travel costs incurred by the employees (as listed under the Salaries and Wages category) for conducting the program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Travel line (line 3) exceeds 10% of the Total Expenditures (line 10).** Travel of consultants is reported under Other Expenses - Consultant Services.

N. Supplies & Materials - Enter cost of supplies & materials. This category is used for all consumable and short-term items and equipment items costing less than five thousand dollars ($5,000). This includes office supplies, computers, printers, printing, janitorial, postage, educational supplies, medical supplies, contraceptives and vaccines, tape and gauze, education films, etc., according to the requirements of each applicable program. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Supplies and Materials line (line 4) exceeds 10% of the Total Expenditures (line 10).**

O. Subcontracts – **Specify the subcontractor(s) working on this program in the space provided under line 5.** Specific details must include: 1) subcontractor(s) name and address, 2) amount by subcontractor and 3) the total amount for all subcontractor(s). Multiple small subcontracts can be grouped (e.g., various worksite subcontracts). Use this category for written contracts or agreements with sub-recipient organizations such as affiliates, cooperating institutions or delegate contractors when compliance with federal grant requirements is delegated (passed-through) to the sub-recipient contractor. Vendor payments such as stipends and allowances for trainees, fee-for-service or fixed-unit rate patient care, consulting fees, etc., are to be identified in the Other Expense category.

P. Equipment - Enter a description of the equipment being purchased (including number of units and the unit value), the total by type of equipment and total of all equipment. This category includes stationary and movable equipment to be used in carrying out the objectives of the program. The cost of a single unit or piece of equipment includes the necessary accessories, installation costs and any taxes. Equipment is defined to be an article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. **Equipment items costing less than five thousand dollars ($5,000) each are to be included in the Supplies and Materials category. All equipment items summarized on this line must include: item description, quantity and budgeted amount and should be individually identified in the space provided under line 6. Upon completing equipment purchase, equipment must be tagged and listed on the Equipment Inventory Schedule (see Attachment B.3) and submitted to the agreement's contract manager.**

Q. Other Expenses - This category includes other allowable cost incurred for the benefit of the program. The most significant items should be specifically listed on the Cost Detail Schedule. Other minor items may be identified by general type of cost and summarized as a single line on the Cost Detail Schedule to arrive at a total Other Expenses category. Some of the more significant groups or subcategories of costs are described as follows and should be individually identified in the space provided on and under line 7. **Specific detail should be stated in the space provided on the Cost Detail Schedule (DCH-0386) if the Other Expenses line (line 7) exceeds 10% of the Total Expenditures (line 10).**

1. Communication Costs - Costs of telephone, telegraph, data lines, Internet access, etc., when related directly to the operation of the program.

2. Space Costs - Costs of building space, rental of equipment, instruments, etc., necessary for the operation of the program. If space is publicly owned, the cost may not exceed the rental of comparable space in privately owned facilities in the same general locality. Department funds may not be used to purchase a building or land.

3. Consultant Services - These are costs for consultation services, professional fees and personnel hired on a private contracting basis related to the planning and operations of the program, or for some special aspect of the project. Travel and other costs of these consultants are also to be included in this category.

4. Other - All other items purchased exclusively for the operation of the program and not previously included.

INSTRUCTIONS FOR PREPARATION OF BUDGET FORMS (DCH-0385, DCH-0386)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM BUDGET-COST DETAIL SCHEDULE (DCH-0386)FORM PREPARATION (continued)

R. Total Direct Expenditures – Enter the sum of items 1 – 7 on line 8.

S. Indirect Cost Calculations - **Enter the allowable indirect costs for the budget.** Indirect costs can only be applied if an approved indirect cost rate has been established or an actual rate has been approved by a State of Michigan department (i.e., Michigan Department of Education) or the applicable federal cognizant agency and is accepted by the Department. Attach a current copy of the letter stating the applicable indirect cost rate. **Detail on how the indirect amount was calculated must be shown on the Cost Detail Schedule (DCH-0386).**

T. Total Expenditures – Enter the sum of item 8 and 9 on line 10.

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM (A) Budget and Contracts		DATE PREPARED (B) 7/01/xx	Page (C) 1 / Of 2
CONTRACTOR NAME (D) Michigan Agency		BUDGET PERIOD From: (E) 10/01/xx To: 9/30/xx	
MAILING ADDRESS (Number and Street) (F)		AGREEMENT: (G) ☐ Original ☒ Amendment ▶	Amendment Number 1
CITY	STATE / ZIP Code	Federal ID Number (H)	

(I) EXPENDITURE CATEGORY				(J) TOTAL BUDGET
1. Salaries and Wages	43,000			43,000
2. Fringe Benefits	11,180			11,180
3. Travel	5,000			5,000
4. Supplies and Materials	37,000			37,000
5. Contractual (Subcontracts)	3,500			3,500
6. Equipment	5,000			5,000
7. Other Expenses:				
	8,000			8,000
8. **Total Direct Expenditures** (Sum of Lines 1-7)	112,680			112,680
9. Indirect Costs: Rate #1 %				
Indirect Costs: Rate #2 %				
10. **TOTAL EXPENDITURES**	112,680			112,680

SOURCE OF FUNDS:

11. Fees and Collections	10,000			10,000
12. State Agreement	90,000			90,000
13. Local	12,680			12,680
14. Federal				
15. Other(s):				
16. **TOTAL FUNDING**	112,680			112,680

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385 (E) (Rev 4-04) (W) Previous Edition Obsolete. Also Replaces FIN-11

ATTACHMENT B.2

PROGRAM BUDGET – COST DETAIL

(A) Page 2 Of 2

Use WHOLE DOLLARS ONLY MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

(B) PROGRAM	(C) BUDGET PERIOD FROM	TO	(D) DATE PREPARED
Budget and Contracts	10/01/xx	9/30/xx	7/01/xx

(E) CONTRACTOR	(F) ORIGINAL BUDGET	AMENDED BUDGET	AMENDMENT NUMBER
Michigan Agency			1

(G) 1. SALARIES & WAGES – POSITION DESCRIPTION	(H) POSITIONS REQUIRED	(I) TOTAL SALARY	(J) COMMENTS
Nurse	1	25,000	
Project Director	.5	18,000	
(K) Total Salaries and Wages	1.5	43,000	

(L) 2. FRINGE BENEFITS: (Specify)

☒ FICA ☐ LIFE INS. ☐ DENTAL INS ☒ COMPOSITE RATE
☒ UNEMPLOY INS. ☐ VISION INS. ☒ WORK COMP AMOUNT 26 %
☐ RETIREMENT ☐ HEARING INS.
☐ HOSPITAL INS. ☐ OTHER

TOTAL FRINGE BENEFITS $ 11,180

(M) 3. TRAVEL (Specify if any item exceeds 10% of Total Expenditures)

Registered Nurse to attend 5 day seminar

TOTAL TRAVEL $ 5,000

(N) 4. SUPPLIES & MATERIALS (Specify if any item exceeds 10% of Total Expenditures)

Office Supplies 2,000
Medical supplies 35,000

TOTAL SUPPLIES & MATERIALS $ 37,000

(O) 5. CONTRACTUAL (Subcontracts)

Name	Address	Amount
ACME Evaluation Services	555 Walnut, Lansing, MI 48933	$ 2,000
Presentations Are Us	333 Kalamazoo, Lansing, MI 48933	$ 1,500

TOTAL CONTRACTUAL $ 3,500

(P) 6. EQUIPMENT (Specify)

Microscope $5,000

TOTAL EQUIPMENT $ 5,000

(Q) 7. OTHER EXPENSES (Specify if any item exceeds 10% of Total Expenditures)

Communication Costs	$2,400
Space Costs	$3,600
Consultant: John Doe, Evaluator, 100 Main, E. Lansing	$2,000

TOTAL OTHER $ 8,000

(R) 8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7)	$112,680
(S) 9. INDIRECT COST CALCULATIONS	
Rate #1: Base $ X Rate % Total	$
Rate #2: Base $ X Rate % Total	$
(T) 10. TOTAL EXPENDITURES (Sum of lines 8-9)	$112,680

DCH-0386 FY2005 (E) (W) 4/04 COMPLETION IS A CONDITION OF FUNDING AUTHORITY: P.A. 368 OF 1978

ATTACHMENT B.3

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CONTRACT MANAGEMENT SECTION

EQUIPMENT INVENTORY SCHEDULE

Please list equipment items that were purchased during the grant agreement period as specified in the grant agreement budget, Attachment B.2. Provide as much information about each piece as possible, including quantity, item name, item specifications: *make, model,* etc. Equipment is defined to be a article of non-expendable tangible personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. Please forward to this agreement's contract manager.

Contractor Name: _____ Contract #: _____ Date: _____

Quantity	Item Name	Item Specification	Tag Number	Budgeted Amount
1	**LW Scientific M5 Labscope**	• Binocular • Trinocular with C-mount or eye tube • 35mm and digital camera adapters available • Diopter adjustment • Inclined 30 degrees (45 degrees available), rotates 360 degrees • 10X/20 high point eyepieces • Interpupillary distance range 50-75mm	N0938438EW098	$ 5,000.00
				$
				$
				$
				$
				$
				$
			Total	$ 5000.00

Contractor's Signature: _____ Date: _____

UNDERSTANDING WHY DIFFICULT BEHAVIORS OCCUR: PROBLEM-SOLVING STRATEGIES

There are a number of behavior problems that sometimes accompany Alzheimer's disease and related illnesses. These behaviors may include resistance, wandering, agitation, incontinence, etc. The presence or absence of these behaviors can vary greatly from one person to another throughout the progression of the disease.

There are many reasons why a difficult behavior may be occurring. Sometimes the behavior may be related to changes taking place in the brain. In other instances, there may be events or factors in the environment triggering the behavior. In some situations a task, such as taking a bath, may be too complex. Or the person may not be feeling physically well.

It can be helpful for caregivers to try to understand why the person with dementia is behaving in a particular way. If caregivers can determine what may be causing or triggering the behavior, it may then be possible to figure out ways to prevent the difficult behavior from occurring again. Listed below are four categories of possible causes of difficult behaviors. It is important for caregivers to systematically look at all of these potential causes, as one or more of them may be contributing to the behavior.

CAUSES RELATED TO THE PERSON'S PHYSICAL AND EMOTIONAL HEALTH

People with dementing illnesses suffer progressive brain damage which can affect their behavior. This is an important factor to consider when planning interventions for behavior problems.

People with dementia can also have other medical problems that greatly affect behavior. Listed below are some of the more common physical problems that caregivers should be alert to.

1. **Effects of medications.** People with dementia are very vulnerable to overmedication, to reactions from combinations of drugs, and to their side effects. Drugs can cause confusion as well as sudden changes in a person's level of functioning. Falling, drowsiness, a sudden increase in agitation, strange mouth or hand movements may be side effects of medication and should be reported to the doctor immediately. Tranquilizers and sedatives are sometimes given to facilitate sleep or calm behavior, but these medications can also affect bladder functioning and can cause incontinence problems.

2. **Impaired vision or hearing.** Both these problems can affect a person's ability to understand what is being said. It is important to see a doctor to correct, if possible, any hearing or vision problems. If caregivers are aware of these deficits, they can often help the person compensate for them.

3. **Acute illness** such as urinary tract infection, pneumonia, gastrointestinal infection or fever may lead to increased confusion. It is not always easy to recognize acute illness in people with dementia, since they may not be able to verbalize symptoms. Any sudden changes in behavior should be reported to the doctor.

4. **Chronic illness** such as angina, congestive heart failure or diabetes can affect a person's mood and/or level of functioning. Also, chronic pain associated with arthritis, ulcers or headaches can cause irritability.

5. **Dehydration.** Many dementia victims do not get enough fluid, because they no longer recognize the sensation of thirst or they forget to drink. Symptoms of dehydration may include dizziness, confusion, refusal to drink, skin that appears dry, flushing and fever, and rapid pulse.

6. **Constipation.** This can be very uncomfortable and eventually can lead to bowel impaction. In some people with dementia, fecal impaction can contribute to delusional behavior.

7. **Depression.** Many of the symptoms of depression, such as impaired concentration, memory loss, apathy and sleep disturbances resemble those of dementia. It is often very difficult to tell which are caused by depression or by the dementing illness itself or a combination of both of these problems. It is important for your doctor to be aware of your family member's symptoms and do a thorough evaluation for depression.

8. **Fatigue.** Disrupted sleep patterns can cause angry or agitated behavior.

9. **Physical discomfort** because the person's immediate needs aren't being met. For example, the person may be hungry, the person may need to use the bathroom, the temperature of the room may be too warm or too cold.

CAUSES RELATED TO THE ENVIRONMENT

1. **Environment too large.** Sometimes the physical space in which the person with dementia is living is just too confusing. Try closing off part of the house. In nursing homes, consider a small separate dining area for people who may need some assistance with eating. Encourage small groups (4-6 people) for social and activity programs rather than trying to include twenty or more impaired people at one time. Some long term care facilities are designing special dementia care units.

2. **Too much clutter.** Sometimes there is too much in the environment for the person to absorb. Try removing furniture that is no longer being used or other objects that may be in the way. If a person tends to wander, clear a pathway through the house. Whenever possible, simplify the environment so that the confused person is not too overwhelmed.

3. **Excessive stimulation.** When there is too much going on in the environment, such as music during conversation or there are too many people around, some people with dementia may respond with anger or frustration. They may have reached a saturation point and may no longer have the ability to cope with stress. It is important for caregivers to think about what was going on right before the outburst. Too much noise? Was the size of the group too big?

4. **No orientation information or cues.** As people become more cognitively impaired they encounter increasing problems with negotiating the environment. People with dementia become very dependent on the environment to support them. They may get lost trying to find their way to the bathroom because all the doors in the hallway look the same. Some people may be able to read and understand signs, while others may have lost that ability. It may be necessary to provide the information in different ways. For example, some people will be able to follow a sign indicating the direction to the bathroom; some will recognize a brightly colored awning hung over the bathroom door, and still others will need a line on the floor from the dining room to the bathroom.

5. **Poor sensory environment.** As people grow older, their ability to hear, see, feel, taste and smell changes. Usually one or more of these senses are impaired in people with dementing illnesses. Lighting, visual contrasts between floors and walls, the use of colors can affect a person's behavior and level of functioning. Inadequate levels of light may affect a person's ability to concentrate when he/she is trying to eat. Patterned tile floors can look like steps, causing the person to trip or become uncertain. Glare from direct sunlight or a highly polished floor can affect a person's ability to see.

6. **Unstructured environment.** People with dementing illnesses need a certain amount of routine and daily structure on which they can depend. This consistency is important in helping to minimize the amount of stress the person with memory loss may be experiencing. For example, don't change the furniture arrangements in the house. At the same time, there needs

to be flexibility in the daily routine to accommodate the changing moods of the person. For example, a rigid bath schedule can cause problems for both the impaired person and the caregiver.

7. **Unfamiliar environment.** An environment which is new or unfamiliar is more likely to be confusing to the person with dementia. When planning activities or modifying the physical environment to accommodate the special needs of a person with memory impairment, try to focus on familiar situations which the person is used to. For some people going to a restaurant or going on a trip may be terribly upsetting. In nursing homes, it is important to create a warm and familiar environment that resembles the person's home, with spaces for a living room, kitchen and family room, etc. The decor should include familiar colors, objects and possessions.

CAUSES RELATED TO THE TASK

1. **Task too complicated.** Sometimes we ask people with dementia to do tasks that are too overwhelming and difficult for them, although they may seem simple to us. Getting dressed or brushing teeth are examples of tasks that are very complex because of the many steps involved. Breaking a task down into small, concrete steps is one effective technique which enables a person with dementia to continue to do tasks successfully. (See *Problems With Dressing*, for example.)

2. **Too many steps combined.** Make sure the person is doing one small step at a time. Sometimes caregivers combine several steps together not realizing the impaired person may no longer be able to do two or three steps at one time.

3. **Task not modified for increasing impairments.** As the person's functioning declines, the caregiver may have to do the first few steps of the task to get the person started. Eventually the caregiver may have to do most of the steps him/herself; even then it is important to try to keep the person involved, doing one or two simple steps.

4. **Task unfamiliar.** People with dementia gradually lose their ability to learn new tasks or skills. Try to focus on familiar tasks the person may have done before the onset of the illness, such as washing and drying dishes, making beds, folding laundry, gardening, etc.

CAUSES RELATED TO COMMUNICATION

Communication between the caregiver and the person with dementia is an extremely important - and often difficult - part of the caregiving process. Many times people with dementia become angry or agitated because they do not understand what is expected of them. Or they may be frustrated with their inability to make themselves understood.

Some of the causes of poor communication and some suggestions for better communication are discussed in detail in *The Importance of Good Communication Skills*.

PROBLEM-SOLVING

When you are faced with a difficult behavior or situation, try to understand why this behavior is occurring. What are some of the factors which may be triggering the behavior and that you can change? It is important to try to recognize elements in the environment, the medical situation or problems of communication that may be contributing to the problem.

1. When does the problem occur? It can be helpful to keep a daily log or a record describing the problem or situation. Jot down the time and what happened. In as much detail as possible, think about what was going on right before the behavior occurred. Who was involved? Who was affected by the behavior? What emotion was expressed by the confused person? Anger? Frustration? Fear? How did the caregiver respond? Did the caregiver's approach work? This log can be helpful in identifying a pattern in terms of the time of day or some triggering event. Angry outbursts, for example, may occur at certain times during the day when the person is fatigued, or when there are too many people in the room.

2. Carefully review the four categories described above and try to pinpoint specific causes. Is the problem related to the person's health? To the environment? The task the person may be engaged in? To the style of communication between the caregiver and the person?

3. Develop a list of alternative strategies for responding to the behavior or situation. Be creative. Have someone else look at the situation and give you suggestions. Refer to this manual for additional ideas.

4. Think about the strategies you have identified. Decide on the one you are going to try first. Don't worry if it fails. You are gaining new information about the situation even if the approach doesn't work.

5. Problem solving is a process of trial and error. There are no simple solutions. You may no sooner solve one problem than another develops. Or you may find that your solution works sometimes but not others. Be flexible!

6. Reassure the person after an upsetting situation. Let him/her know that you do understand and care.

7. Remember: The behavior is caused by an organic brain disease. The person is not deliberately trying to be nasty, stubborn, or to annoy you.

8. Don't try to carry all the burden yourself. It is okay to ask for help.

REFERENCES

Weaverdyck, Shelly. Neuropsychological Assessment As a Basis for Intervention in Dementia. In Nancy Mace (ed.) *Dementia Care: Patient, Family and Community*. Baltimore: The Johns Hopkins University Press, 1989. (The conceptualization of the above assessment process is from the work of this author.)

Zarit, Steven; Nancy Orr and Judy Zarit. *The Hidden Victims of AD: Families Under Stress*. New York: New York University Press, 1985.

DOMAINS
FOR
ASSESSMENT & INTERVENTION

PERSON

- General------age; gender, language, occupation, education, goals
- Medical-----diagnoses, history, physical status, medications, pain, discomfort
- Functional---ability to perform ADLs and IADLs, sensory status, motor status
- Emotional---mood, coping status, cycles, expression, sources of pleasure, comfort, & pain
- Social-------significant relationships, ability to converse & interact, preferences
- Cognitive---ability to comprehend, perceive, conduct sophisticated thought processes, express, attend, remember events & information from remote & recent past
- Behavioral--daily schedules & routines, strengths, problematic or difficult behaviors
- Needs-------glasses, hearing aides, walker, wheel chair, medical treatments, diet
- Interests----life aspirations, hobbies, significant events & dates, preferences
- Habits------daily routines, task (e.g., bathing)routines, sleeping habits, exercise, foods
- Talents-----past & current skills & gifts, strengths to draw upon
- Religion----preferences, routines, spiritual resources & rituals
- Approach--responses to interventions/techniques/strategies used in the past to assist or approach the person

Environment

- Physical
- Social
- Emotional
- Cognitive

Caregiver

- Characteristics
- Interactions with person

Task & Daily Schedule

- Familiarity
- Emotional appeal
- Physical demands
- Complexity
- Social context

Source: Weaverdyck, S. Assessment and Care/Service Plans. In National Alzheimer's Association (Ed.) *Key Elements of Dementia Care Manual.* Alzheimer's Association, Chicago, Illinois, 1997.

PROBLEM SOLVING OUTLINE
FOR
DIFFICULT BEHAVIORS

PROBLEM

- **Behavior**
  - What, when, frequency, who is involved
  - Antecedents & consequences
- **Why is the behavior a problem?**
  - Who is raising the concern?
  - Who is in danger or discomfort?
  - Does the behavior need to change? (e.g., can other's exposure or tolerance to behavior be changed rather than the behavior itself?)

GOALS

- **Identify goals of all involved** (including the person doing the behavior)
- **Identify specific objectives with measurable outcomes**

CAUSES

- **Person** (Medical, physical, emotional, cognitive, habits, preferences)
- **Environment**
- **Interaction**
- **Task**

STRATEGIES

- **Results of interventions attempted previously**
- **Brainstorm ideas** (Person, Environment, Interactions, Task)
- **Decide on intervention plan**
  - Add or modify objectives
  - Define steps and conditions
  - Identify who will implement
- **Implement intervention plan**

EVALUATION PROCESS & CRITERIA

- **Identify criteria for success**
- **Communicate with those who saw the behavior as a problem**
- **Document results of interventions**
- **Evaluate and revise interventions as necessary**

Source: Weaverdyck, S. Assessment and Care/Service Plans. In National Alzheimer's Association (Ed.) *Key Elements of Dementia Care Manual.* Alzheimer's Association; Chicago, Illinois, 1997.

Alzheimer's Association, 919 North Michigan Avenue, Suite 1000, Chicago, Illinois 60611-1676 Ph: 1-800-272-3900

PLANNING AN INTERVENTION FOR A DIFFICULT BEHAVIOR

ASSESSMENT

1. **Describe Details of the Behavior** (Be specific and use objective terms; e.g., Mrs. S stuck caregiver's shoulder with open hand when the caregiver was leaning over to tie Mrs. S' shoe." rather than "Mrs. S was combative during care.")
   - Discern a pattern to the behavior by noting:
     - What occurs
     - When it occurs
     - How often it occurs
     - Who else tends to be involved in the situation
   - Describe conditions regarding the behavior.
     - What happens before the incident (antecedents)?
     - What happens after the incident (consequences)?
   - Document a baseline for a period of time.
     - Document the occurrence and conditions of the behavior over time.

2. **How much of a problem is the behavior?**
   - Who is identifying the behavior as a problem?
     - Family member
     - Professional caregiver
     - Person with dementia
   - Who actually experiences the behavior as a problem? Who is in physical or other danger/discomfort because of the behavior?
   - Can the problem be solved by reducing others' exposure to (or by increasing tolerance of) the behavior rather than changing the behavior itself? (e.g., by addressing caregiver perceptions and tolerance of sexual invitations).

3. **Discern why the person is engaging in the behavior (study 1 & 2 above).**
   - How are the person's **cognitive deficits** contributing to the behavior? (e.g., is the person misinterpreting the environment or what someone said?)
   - Did something in the **environment** trigger or contribute to the behavior? (e.g., is there too much stimulation or is there a change in the environment?)
   - Did something in an **interaction** between the person and someone else trigger or contribute to the behavior? (e.g., did the caregiver use sentences that were too long, or did the caregiver move too fast?)
   - Is there something about a **task** the person is expected to perform that is too overwhelming or difficult? (e.g., is the person having trouble keeping the order of the task steps straight?)

- Have the person's **preferences, habits, expectations** been affected? (e.g., is the person used to eating breakfast before taking a bath or shower?)
- What role is the person's **medical, physical and emotional health** playing?

4. Identify conditions likely to increase the effectiveness of interventions.

- Identify successful and unsuccessful interventions attempted in the past.

INTERVENTION PLAN

1. Determine the goal of the intervention.

- Review the person's own life goals, both long-term and immediate.
- Identify the person's own goal for this behavior.
- Identify other people's goals for this behavior.
- Agree on a primary goal (e.g., the goal may be to increase caregiver tolerance of the behavior rather than to reduce the behavior).

2. Brainstorm intervention ideas.

- Consider modification of the:
  environment
  caregiver interactions with the person
  tasks presented to the person
- Accommodate the person's own habits, preferences, cognitive status, physical and emotional status.

3. Decide on an intervention plan.

- Define objectives in very specific terms.
- Define the intervention steps and conditions. (e.g., the caregiver will approach Mrs. S from the front and maintain eye contact).
- Identify the criteria for a successful intervention. (e.g., specify the number of times over a specified period of time, the behavior must occur for the intervention to be seen as effective. How will you know when the intervention is working?
- Communicate with the person who first raised concern about the behavior and with those for whom the behavior was seen to be a problem. Elicit their reactions regarding the success of the intervention.
- Outline a method of evaluation of the intervention plan.
- Evaluate and revise the intervention plan as needed.

Source: Weaverdyck, S. Assessment and Care/Service Plans. In National Alzheimer's Association (Ed.) *Key Elements of Dementia Care Manual.* Alzheimer's Association; Chicago, Illinois, 1997.

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