

MEMORANDUM

Date: October 12, 2011

To: Supervisor Peggy Romo West, Chair, Committee on Health and Human Needs
Supervisor Johnny Thomas, Chair, Committee of Finance and Audit

From: Maria Ledger, Director, Department of Family Care

Subject: Potential Impact of 2012 Capitation Rate on the Milwaukee County
Department of Family Care

The Family Care program integrates home and community-based services, institutional care services (i.e., nursing homes), Medicaid personal care, home health, and other services that were previously funded separately. The Milwaukee County Department of Family Care (MCDFC) currently serves more than 7,700 members.

Capitation Rate Overview

A Capitation Rate is a payment made to an MCO each month for each enrolled Family Care Member that month. It is established by outside independent actuarial firm and covers all services in the benefit package and administration costs of the Managed Care Organization.

The MCO's rate is blended for all target group members (i.e., Developmentally Disabled, Physically Disabled and Frail Elderly) and the payment is the same for every Member. The payment represents a projected average cost across all MCO Family Care Members. The capitation rate may not be used as an upper limit on the cost of services each person receives. Costs may exceed revenue in a given year.

The Department of Health Services (DHS) is responsible for calculating an "actuarially sound rate." An actuarially sound rate is based upon a reasonable projection of the average Per Member Per Month (PMPM) cost to provide the Family Care Benefit to the target population.

DHS currently contracts with PricewaterhouseCoopers, an independent actuarial firm, to calculate rates.

Each MCO is responsible for understanding the rate setting process and rate setting regulations and the cost of doing business, as well as developing a business plan that supports operating within the funding received. The MCO must also supply reliable and timely encounter data to the State after providing services to members and manage their care.

The State uses historical cost data from each MCO for each target group and a statistical model correlates information from two data sources. The statistical model identifies:

- A minimum amount each MCO will get for every Member
- Certain functional characteristics strongly related to costs above the minimum, and
- The level of additional cost associated with each functional characteristic – ‘add-ons’
- All current data from the Long Term Care Functional Screen is considered when identifying ‘add-ons’

After several months of heavy data analysis, each MCO receives one blended Per Member Per Month (PMPM) rate. An MCO’s Capitated Rate is calculated as the minimum amount for all Members, plus add-on amounts for those Members with characteristics related to add-ons.

Capitation rate ranges of all the MCO’s throughout Wisconsin during the past four years have been as follows:

CY 2012: \$2,733 - \$3,469

CY 2011: \$2,668 - \$3,766

CY 2010: \$2,627 - \$3,542

CY 2009: \$2,400 – \$3,489

Preliminary 2012 Capitation Rate for MCDFC

The preliminary 2012 capitation rate for the Milwaukee County Department of Family Care for 2012 is currently set at \$2,733.15. This represents a 2.9% decrease from the 2011 capitation rate of \$2,813.93.

As capitation rates are not finalized yet, the Department of Family Care will submit additional information to the State DHS regarding our cost experience as justification for additional refinement to this rate. We are optimistic our efforts will produce a favorable adjustment. While we are able to maintain solvency without an adjusted rate for 2012, we will advocate on behalf of this program and the members that it serves to insure that reimbursement rates are appropriate and sufficient to maintain the quality of services that are instrumental in serving our most vulnerable citizens.

As the only MCO to remain solvent during expansion and with \$15,867,833 in reserves as of August 31, 2011, we are uniquely positioned to adjust operations as necessary and have already implemented several strategies in 2011 with more to follow in 2012. These strategies will insure that the program is sustainable while continuing to place the emphasis where needed, i.e. on the members we serve. We all understand that services in the community are generally more desirable to members and are also more cost effective. Our plan is to optimize this approach while striving to become more cost effective in the delivery and distribution of services to our members; thus, our overall approach is as follows:

Care Management

- 2011
 - Consolidation of provider network, particularly in the area of care management. 2011 started with 22 contracted agencies under contract.
 - All agencies with smaller caseloads were encouraged to find a way to work together to be sustainable in the face of the State's enrollment caps.
 - One CMU agency has already transitioned their members to other teams and another will complete their transition by October 31st.
- 2012
 - Revision of recommended Case load sizes for care management teams
 - Reduces labor costs of CMUs
 - Begins the transition to work towards changing the model to provide more nursing care as MCDFC moves towards an integrated model
 - Decrease in the number of contracts with care management agencies to 20 teams at a maximum.
 - Refinement of tiered payment methodology for Care Management.
Effective 1/1/2012

Estimated cost savings: Approximately \$2,600,000

Transportation

- 2011
 - Negotiated reduced contract rates with the potential savings of up to 35% with Transit Plus provider to provide Goodwill (day service) rides. Size of the savings is dependent on volume. Current volume reflects a 23% decrease in the cost per ride. *Effective October 1, 2011*
 - Renegotiate existing transportation providers who provide nonmedical rides. *Effective November 1, 2011*
 - CMU teams continue to apply utilization management to care plans resulting in ridership decrease.
- 2012
 - Revision of Residential scope of services to include transportation as part of residential services. 50 are completed and under contract. 382 to be implemented and under contract by 1/1/12.
 - Reduced ridership will occur through newly developed Day Service model within Residential facilities.

Estimated cost savings: Approximately \$2,250,000

Day Center

- 2012
 - Developing a model within residential facilities to enable greater member choice and flexibility. In this model, members would not be required to

go out to a Day Center provider for their active treatment and recreation needs. The residential provider would provide some or all of these services in-house.

- Model would produce cost efficiencies in day services and transportation that would more than offset the added costs incurred by the residential providers.

Estimated cost savings: Approximately \$500,000

Transitioning Members into more appropriate cost effective settings

- 2011
 - Nursing homes: MCDFC Placement Team is currently evaluating all nursing home members, their Resource Utilization Group Scores (RUGS) and their care plans to determine if a more independent and more cost effective residential setting is appropriate and available.
 - Residential Group Homes: MCDFC CMUs, along with MCDFC Placement Team, are evaluating existing members who may have a better fit in a Supported Independent Living (SIL) apartment. This option is more integrated and more cost effective.
 - Bed Hold: New policy would have MCDFC no longer pay residential providers to hold a bed when a member is away.

Estimated cost savings: Approximately \$1,200,000

Other

- 2011
 - Automation of service authorizations – *Effective November 1, 2011*
 - Reduced utilization targeting:
 - All services authorized for MCDFC internal team members
 - Supportive Home Care and Home Health services for all members
 - Previous refinements of Supportive Home Care Assessments saved the program \$4,984,425 in 2010.
- 2012
 - Reductions in authorization of services outside of the Family Care benefit package
 - Guardianships
 - Companions
 - Interpreter Services
 - Rent adjustment
 - Fees charged to new providers for Adult Family Home Certifications
 - Reduction of Best Practice Team staffing through attrition
 - Consolidation of hosting of IT servers
 - Reductions in mileage charges due to consolidation of internal team members
 - Vacant positions to be held open or abolished

Estimated cost savings: Approximately \$1,029,000

Summary

In summary, the preliminary 2012 capitation rate decrease has a projected impact of \$7,511,570 to the 2012 budget based on current enrollment. In anticipation of this projected revenue shortfall the Department of Family Care has successfully identified several areas where cost savings can be realized to offset the shortfall.

Projected 2012 Budget Impact due to rate decrease **(\$7,511,570)**

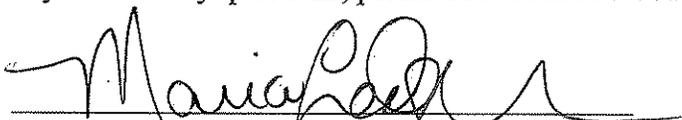
Summary of Savings

Care Management	\$2,600,000
Transportation	\$2,250,000
Day Center	\$ 500,000
Member Transition	\$1,200,000
Other	<u>\$1,029,000</u>
Total Estimated Cost Savings	\$7,579,000

Net Surplus after implementation of cost savings **\$ 67,430**

Because we have implemented some of these strategies in 2011, we expect to be well able to effectively administrate this program within our 2012 capitation rate next year.

If you have any questions, please call me at 287-7610.



Maria Ledger, Director
Milwaukee County Department of Family Care

cc: County Executive Chris Abele
Tia Torhorst
Chairman Lee Holloway
Pam Bryant
Steve Pietroske
Steven Cady
Jennifer Collins
Jodi Mapp
Jim Hodson

County of Milwaukee

INTEROFFICE COMMUNICATION

DATE: October 12, 2011

TO: Sup. Peggy Romo West, Chair, Committee on Health and Human Needs

FROM: Stephanie Sue Stein, Director, Department on Aging

RE: Informational report on participation by Milwaukee County Department on Aging in "Bringing Communities and Technology Together for Healthy Aging" a collaborative five year research grant from the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Department of Health and Human Services

I respectfully request that the attached informational report be scheduled for review by the Committee on Health and Human Needs at its meeting on Wednesday, October 26, 2011.

Introduction

In June 2011, the Milwaukee County Department on Aging was selected by the Wisconsin Bureau of Aging and Disability Resources to be a part of a three-county five year, \$9.5 million research and technology grant initiative. Based on planned project outcomes, which are outlined in this report, the Department's participation in grant activities could assist Milwaukee County seniors with maintaining independence and remaining active in their communities. Milwaukee County was chosen to be involved because of its urbanism, diverse older adult population, and unique ability to garner community partnerships and volunteerism.

Background and Purpose

The five year grant entitled "Bringing Communities and Technology Together for Healthy Aging" was awarded to a collaborative research program led by the Center for Health Enhancement Systems Studies at the University of Wisconsin-Madison (Center). The purpose of the grant is to develop technological innovations that help older adults remain in their homes as long as possible. The grant comes from the federal Agency for Healthcare Research and Quality (AHRQ), whose mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.

This one of a kind research grant is bringing together (1) engineers from the Driving Simulation Laboratory and the Radio-Frequency Identification Device (RFID) Laboratory of the University of Wisconsin – Madison Department of Industrial and Systems Engineering (2) experts from the UW-Madison Mass Communication Research Center, (3) geriatricians, (4) specialists from Wisconsin's Bureau of Aging and Disability Resources and (5) the Wisconsin Institute for Healthy Aging. The collaboration will also include community partners and senior advocates from around the state.

The Milwaukee County Department on Aging (MCDA) was asked to participate in the research study and model project along with Richland County and Waukesha County Aging and Disability Resource Centers. All partners will work together as an Active Aging Research Center to solve the problems that often cause older adults to leave their homes, i.e. falls, unreliable home care, difficulty managing a chronic disease, and declining driving skills.

The project will aim to improve older adults' experiences living at home by making an online support system called CHES (Comprehensive Health Enhancement Support System) available to elders and their caregivers and families. CHES consists of online information and communication tools tailored to chronic and terminal conditions. The system has been shown in clinical trials to improve health behavior, quality of life and even survival in advanced cancer. As a part of this project, a new CHES system called E-CHES will be developed to support older adults and their informal caregivers.

The ultimate goal is to eventually share what is learned from grant activities and study results with the rest of the state and the nation. This study holds great potential for helping older adults continue to live long and productive lives in their own homes. It is also an exciting opportunity for state and local governments to work together with the university to achieve this goal.

Components and Implementation

The Madison research team plans to integrate **E-CHES** with promising monitoring innovations such as global positioning systems (GPS) and radio-frequency identification devices. E-CHES features will be tailored to the older adult or caregiver users' needs and preferences through landline, mobile, tablet, laptop, desktop, and Web-enabled TV devices. Various elements of the system will make driving easier and safer, monitor home health services, encourage older adults to take part in a falls prevention program, and help them communicate with health care providers and family members.

The study will also use process improvement methods developed by the Center to help service providers operate more efficiently and effectively. Thousands of health care providers in communities nationwide have already adopted these practices to improve care for patients and families.

The Wisconsin Institute for Healthy Aging, Milwaukee County Department on Aging, and Richland County and Waukesha County Aging and Disability Resource Centers will implement and demonstrate new approaches based on findings. Focused on identified community needs, the three Wisconsin counties will help develop and pilot innovative technologies over the next five years.

Another component that will be implemented is **Asset Based Community Development (ABCD)**, which is a strategy for sustainable community-driven development. Beyond the mobilization of a particular community, ABCD is concerned with how to link micro-assets to the macro-environment. The appeal of ABCD lies in its premise that communities can drive the development process themselves by identifying and mobilizing existing, but often unrecognized, assets and thereby responding to and creating local economic opportunity.

ABCD activities will build on the assets that are already found in the community and work to mobilize individuals, associations, and institutions to come together to build on their assets, not concentrate on their needs. Early on in the grant period, in one carefully selected community of Milwaukee County, an extensive period of time will be spent on identifying the assets of individuals, associations, and then institutions before they are mobilized to work together to build on the identified assets of all involved. Then the identified assets from the selected community will be matched with others who have an interest or need in that asset. The key is to begin to use what already exists in the community.

All local project activities are being led by regular meetings of a Milwaukee County Active Aging Strategy Committee. The committee functions as an advisory body comprised of 19 individuals from MCDA Area Agency Services and Aging Resource Center, Milwaukee County Commission on Aging commissioners and Advisory Committee members, and lead staff from the Aurora Sinai Medical Center - Center for Senior Health and Longevity; Milwaukee Center for Independence Senior Services; Interfaith Older Adult Programs; UW-Madison Wisconsin Alzheimer's Institute - Milwaukee Office; SET Ministry, Inc.; Center for Communication, Hearing & Deafness; United Community Center; and the Social Development Commission Senior Companion Program.

All committee members have demonstrated commitment to the grant process and are either consumers or are representing agencies and consumers that would greatly benefit from project activities.

Resources and Support

For its involvement, the Milwaukee County Department on Aging received one full-time coordinator to work directly with Milwaukee County, UW-Madison, Wisconsin Bureau of Aging and Disability Resources, and the Wisconsin Center for Healthy Aging to implement the grant for the next 4 ½ years. Since September 26, 2011, the position has been housed in the Department on Aging and orienting to grant activities. The coordinator position is employed and directly paid by the Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR). GWAAR is a nonprofit agency committed to supporting the successful delivery of aging programs and services in 70 counties and 11 tribes in Wisconsin. As one of Wisconsin's three Area Agencies on Aging, GWAAR provides training, technical assistance, and advocacy to ensure the availability and quality of programs and services to meet the changing needs of older people in Wisconsin.

GWAAR will function as the primary employer, administrative, and fiscal agent for all three counties involved in the Active Aging project. Milwaukee County will receive up to \$7,500 annual reimbursable funds for grant support activities. This includes hosting meetings, administrative services, copying, phone, Internet, and MCDA staff travel. Office space, computer use, and some administrative costs will be provided in-kind by the Department. A memorandum of understanding outlining an agreement with Milwaukee County Department on Aging has been developed with Greater Wisconsin Agency on Aging Resources.

Activities to Date

June 24, 2011 – MCDA Area Agency and Resource Center Staff and chairpersons for Milwaukee Commission on Aging Wellness and Advisory Councils participated in a one-day "Bringing Communities and Technology Together for Healthy Aging", introductory grant meeting at the UW—Madison School of Engineering.

August 23, 2011 – The first meeting of the Milwaukee County Active Aging Strategy Committee was held in Milwaukee County. MCDA staff, Strategy Committee members, staff from UW-Madison and Wisconsin Institute for Healthy Aging, and the program officer from the federal Agency for Healthcare Research and Quality participated in a half day meeting. The meeting included an overview of the grant project and the history and information about aging services and resources for Milwaukee County. In addition, a researcher from UW-Madison rode along with a driver for MCDA's Home Delivered Meal Program.

During the afternoon, morning meeting guests participated in site visits at United Community Center and SET Ministry Highland Gardens. At both locations, Madison researchers conducted focus groups with senior center participants and high-rise residents. Additionally, lead researchers met with seven MCDA Area Agency on Aging and Resource Center staff and held a focus group about department services and staff experiences and observations as human service and information and assistance workers.

September 7, 2011 – Active Aging Strategy Committee Members participated in ABCD orientation and planning meeting.

September 26, 2011 – Milwaukee County Active Aging Project Coordinator begins work with MCDA.

September 26, 2011 – Active Aging Strategy Committee members participated in preplanning meeting for ABCD.

September 28, 2011 – Active Aging Strategy Committee members participated in ABCD planning meeting.

October 5, 2011 – Three county Active Aging Project informational cards/brochures are created and finalized.

October 10, 2011 – Active Aging Strategy Committee members participated in ABCD planning meeting.

If you have any questions, please contact me at (414) 289-6876.



Stephanie Sue Stein, Director
Milwaukee County Department on Aging

cc: County Executive Chris Abele
County Board Chairman Lee Holloway
Antionette Thomas-Bailey
Jennifer Collins
Jodi Mapp
Jonette Arms
Chet Kuzminski
Pat Batemon
Gary Portenier
Pat Rogers

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: October 3, 2011

TO: Supervisor Peggy Romo-West, Chairperson, Health and Human Needs Committee

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Prepared by Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: **From the Interim Director, Department of Health and Human Services, submitting an informational report regarding progress of the Mental Health Redesign Task Force**

ISSUE

In April 2011, the County Board of Supervisors passed a Resolution supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign Task Force to provide the County Board with data-driven implementation and planning initiatives (File #11-173). Included in the final Resolution was a directive for the Interim Director, Department of Health and Human Services, and the Administrator, Behavioral Health Division, to create and make appointments to the Mental Health Redesign Task Force from stakeholder organizations. It also requested quarterly reports on the activities of the Task Force.

BACKGROUND

Within the past year, a number of reports, studies and advisory committees have emerged with recommendations related to the future design of the Behavioral Health System in Milwaukee County, including recommendations regarding public and private inpatient, outpatient and community care services. The existing reports and studies represent the work of multiple public and private planning efforts. The formation of this Task Force recognizes that it is now time to coordinate those recommendations and shift the activity to prioritization and implementation of new mental health system design ideas and innovative strategies.

DISCUSSION

The Task Force Co-Chairs, Paula Lucey of BHD and Pete Carlson of Aurora Behavioral Health Services, have launched the Task Force and its executive committee. First efforts

included the development of a charter (attached) based on the County Board resolution, which outlines the work of the Task Force. Ground rules were also established. The Task Force was established to provide all stakeholders and involved parties an opportunity to partner and shape this important work. Such a partnership is essential as this important discussion and work moves forward. Members of the Task Force have varying levels of knowledge about the Milwaukee services therefore the first two meetings focused on orientation to the system and defining the charge of the Task Force. Information was shared related to the services provided by community private hospitals as well as a verbal report on the services provided by Federally Qualified Health Centers (FQHC) with a focus on Health Care of the Homeless.

A time line has also been established to launch the Action Teams and outline expected work products. The timeline is aggressive but the Taskforce has committed to doing their best to achieve the goals. In addition, the Executive Committee is meeting every other week to review the work of the Action Teams and define, set priorities and develop the agenda for the Redesign Task Force group.

Task Force Structure:

The Task Force has Action Teams that focus on five key areas:

- Patient Centered Care
- Continuum of Care
- Community Linkages
- Quality
- Workforce

Maintaining the focus on public/private partnerships, the Executive Committee worked to populate the Action Teams with persons possessing expertise in both the public and private sectors. It was also important to the Executive Committee that the Action Teams have strong consumer involvement.

These five action groups all have co-chairs, one of whom identifies as a consumer of mental health services that report back to the entire Task Force.

The Action Teams and their co-chairs are as follows:

Person Centered Care:

- Objective: To ensure the centrality of recovery principles, consumer choice and trauma-informed care in the redesign process
- Co-Chairs: Beth Ann Burazin (United Health) and Peter Hoeffel (NAMI Milwaukee)

Continuum of Care:

- Objective: To define the approach used to increase community-based services and support decrease reliance on inpatient care
- Co-Chairs: Lee Carroll (Health Care for the Homeless) and Mary Neubauer (Community Advocates)

Community Linkages:

- Objective: To identify and optimize the necessary linkages between behavioral health and external systems, such as housing, law enforcement, medical homes, and vocational opportunities
- Co-Chairs: Kristina Finnel (Mental Health America) and Jim Mathy (DHHS-Housing)

Workforce:

- Objective: To assess the workforce and the necessary skill sets therein in the context of the shifting continuum of care
- Co-Chairs: Scott Gelzer (Faye McBeath Foundation) and TBD

Quality:

- Objective: To define performance standards within the redesigned system – considering the implementation plans of the other Action Teams – and determine how those standards will be monitored
- Co-Chairs: Karen Avery (Independence First) and Henry Kunath (Phoenix Care Systems)

The recommendations compiled from the Community Advisory Board, the New Behavioral Health Facility Study Committee, Chairman Holloway's Mental Health Pilot Project, the HSRI report, the Department of Audit Patient Safety Audit, the Sheriff Site Safety Report, the Mixed Gender Unit Study and 2011 Budget initiatives have been sorted and assigned to one or more Action Teams. The items related to BHD operations or that have already been implemented will not go the Action Teams but will remain the responsibility of BHD administration. The final step will be putting together a fiscal action team to assess the fiscal impact related to the recommendations of the Action Teams and Task Force.

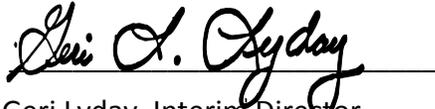
BHD also convened a group of clinical and administrative staff and developed an RFI for enhanced community services. The Executive Committee reviewed the draft RFI and had input into the final product. The RFI will be released the first week in October.

NEXT STEPS

To meet the deadlines defined by the New Behavioral Health Facility Study Committee, a timeline was developed. Each of the Action Teams and the Task Force has specific tasks to complete. We anticipate that the next quarterly report to the committee will represent a defined vision for the Redesigned Behavioral Health Center and have specific timelines and benchmarks of achievement.

RECOMMENDATIONS

This is an informational report only. The next quarterly report will be submitted in January 2012.

A handwritten signature in black ink that reads "Geri Lyday". The signature is written in a cursive style and is positioned above a horizontal line.

Geris Lyday, Interim Director
Department of Health and Human Services

cc: Chris Abele, Milwaukee County Executive
Tia Torhorst, County Executive's Office
Patrick Farley, Administrator - DAS
CJ Pahl, Interim Fiscal & Budget Administrator - DAS
Terrence Cooley, County Board Chief of Staff
Jennifer Collins, County Board Staff
Tia Torhorst, County Executive Office
Jodi Mapp, County Board Staff
Steve Pietroske, Analyst - DAS

Mental Health Redesign and Implementation Task Force Charter

Purpose: To develop and implement a data-driven plan for the effective and sustainable redesign of the mental health system in Milwaukee County

Background and Rationale:

Mental health service delivery in Milwaukee County has been the subject of considerable research and scrutiny in recent years. Numerous public and private entities have issued reports on how to modernize and improve the mental health system generally as well as the Behavioral Health Division specifically, including (but not limited to):

- *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* by Human Services Research Institute in partnership with the Public Policy Forum and the Technical Assistance Collaborative, Inc.
- Reports to the Milwaukee County Board of Supervisors from the Community Advisory Board for Mental Health
- *System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division* by the Milwaukee County Department of Audit
- *Follow-Up Report to BHD Administrator: Mixed-Gender Units* by the Gender Unit Work Group
- *Milwaukee County Executive's Mental Health Vision and Initiative* by Chairman Lee Holloway, Milwaukee County Board of Supervisors
- Reports to the Milwaukee County Board of Supervisors from the New Behavioral Health Facility Study Committee

The Board of Supervisors approved a resolution in April 2011 to create a task force charged with deliberatively evaluating and selectively implementing recommendations contained in the various reports.

Guiding Principles:

- Adherence to SAMHSA recovery principles: Self-Direction, Individualized and Person-Centered, Empowerment, Holistic, Non-Linear, Strengths-Based, Peer Support, Respect, Responsibility, and Hope
- Ensuring access to high quality services and supports in community-based settings
- Reducing reliance on emergency services and unnecessary inpatient care
- Commitment to full inclusion of consumers as well as family members and advocates
- Partnership between public and private stakeholders
- Compliance with the integration mandate of the ADA and *Olmstead v. L.C.*
- Diversity and cultural competency
- Moving beyond the medical model to a philosophy of independent living

Scope and Boundaries:

- Included:
 - Geographic Scope: Milwaukee County (and other inpatient programs within the five-county region)
 - Focus: Redesign of Milwaukee County Behavioral Health Division services in coordination with the reconfiguration and expansion of private and State-sponsored programs and services
 - Age Demographic: Initial focus on adults (including geriatric patients) and transitional youth
 - Range of Services: Inpatient, outpatient, emergency/crisis, case management, peer support, long-term care, residential, prevention, substance abuse services, and community-based services including (but not limited to) CSP, TCM, Day Treatment, and Family Care
 - Clinical Populations: Persons with mental illness and substance abuse, including those with a dual diagnosis and/or developmental disabilities
 - Focus on vulnerable, low-income populations, including the uninsured, Medicaid beneficiaries (and dual eligibles), older adult patients, and persons under emergency detention
 - System and structural redesign of the delivery system
 - Legal and public policy changes associated with emergency detention services
 - *Interaction* with external systems
 - e.g., housing, employment, education, criminal justice, etc.
- Excluded:
 - Areas outside of Milwaukee County (excepting certain other inpatient programs within the five-county region)
 - Day-to-day operations and improvements at the Behavioral Health Division
 - e.g., staffing, TJC certification, health information technology, etc.
 - Children's mental health
 - *Redesign* of external systems
 - e.g., housing, employment, education, criminal justice, etc.

Objectives/Deliverables:

- Review, discuss, prioritize, and implement recommendations from evidence-based plans and proposals
- Improve access to timely and appropriate mental health services
- Expand public and private community-based mental health services
- Reduce unnecessary and costly reliance on inpatient treatment
- Determine and achieve optimal capacities in public and private inpatient facilities and the Hilltop units at the BHD
- Minimize use of emergency detentions
- Improve consumer satisfaction and quality of care
- Achieve system-wide application of principles of recovery and trauma-informed care
- Increase independence, community integration, and quality of life for consumers
- Manage or reduce overall costs within the mental health system
- Garner and maintain support from the governing boards of mental health stakeholder entities, notably those represented on the Task Force
- Achieve and maintain an efficient, well trained workforce through strong recruitment, retention, and continuing education efforts

Outcome Measures:

- Expansion of community-based services
- Shift of inpatient capacity from public to private facilities
- Decreased emergency detentions
- Decreased readmissions
- Establishment of a set of common quality metrics
- Increased application of the recovery model and trauma-informed care
- Increased consumer satisfaction

Team Leadership/Membership:

- Co-Chairs:
 - Pete Carlson – Hospital Representative
 - Paula Lucey – Administrator, Behavioral Health Division
- Members:
 - Karen Avery – Consumer, Focus on Mental Illness
 - Bevan Baker – City of Milwaukee Health Officer
 - Barbara Beckert – Milwaukee Director, Disability Rights Wisconsin
 - Cindy Bentley – Consumer, Focus on Developmental Disability
 - Lee Carroll – FQHC Representative
 - Peg DuBord – Community Provider, Focus on Mental Illness
 - Sarah Fraley – State Director of Medicaid Representative
 - Scott Gelzer – Foundation Representative
 - Chris Hendrickson – State Secretary of Health Representative
 - Edith Hudson – Law Enforcement Representative
 - Jon Lehrmann – Medical College of Wisconsin Representative
 - Geri Lyday – Interim Director of Health and Human Needs
 - Tom Nowak – Community Provider, Focus on Developmental Disability
 - Larry Pheifer – Medical Society of Milwaukee County
 - Yvonne Stueber – Advocate, Focus on Developmental Disability
 - Joy Tapper – Executive Director, Milwaukee Health Care Partnership
 - Tia Torhorst – County Executive Representative
 - Brenda Wesley – Advocate, Focus on Mental Illness
 - Peggy Romo West – Milwaukee County Board of Supervisors

Related Initiatives/Teams:

- Behavioral Health Advisory Committee
- Mental Health Task Force
- Milwaukee Continuum of Care
- Community Advocates – AODA Initiative

Resources Required:

- Project management support
- Technical assistance (fiscal analysis, policy implementation expertise)

Timeframe:

- Quarterly reports to the Committee on Health and Human Needs
- Major report on implementation plans to County Board in January 2012

**County of Milwaukee
Inter-Office Communication**

DATE: October 3, 2011

TO: Supervisor Peggy Romo West, Chairperson, Health & Human Needs Committee

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Prepared by: Jim Kubicek, Director of Crisis Services, Behavioral Health Division

SUBJECT: **From the Interim Director, Department of Health and Human Services, submitting an informational report regarding a crisis bed analysis to determine the number of crisis beds needed in Milwaukee County to alleviate strain on the Psychiatric Crisis Services Admission Center in the Behavioral Health Division**

Background

The 2011 Behavioral Health Division (BHD) Budget included an amendment directing BHD to conduct a crisis bed analysis to survey the needs in Milwaukee County to alleviate strain on the Psychiatric Crisis Services (PCS) Admission Center and build capacity for stabilization and linkages to services in the community. In the amendment, BHD was also directed to explore the possibility of developing a Crisis Resource Center (CRC) in the northern portion of Milwaukee County. BHD was directed to provide quarterly reports to the Board. This is the third quarterly update and includes information as to the progress being made in negotiations with the State of Wisconsin in recognizing “Sub-Acute Community-Based Psychiatric Treatment” as a reimburseable level of care.

Discussion

The first quarter report reviewed the historical context regarding crisis services in Milwaukee County including current capacity (16 crisis respite beds in the community and seven crisis resource center beds) and program design. The second report focused on a number of key metrics aimed at determining the efficacy of the program based on several key metrics, specifically:

- **Impact on Recidivism**

A study was conducted of 100 patients utilizing CRC resources. For these 100 patients, in the six months after the CRC referral, there was a:

- 40% reduction in PCS usage
- 39% reduction in inpatient admissions
- 46% reduction in inpatient bed days

- **Impact on Emergency Detentions:**

- There was a 35% reduction in emergency detentions for these 100 patients after a referral was made to CRC.

- **Determine Specific Indicators Regarding Community Need:**

- Through September 2011, there have been 176 patients that met CRC admission criteria but who were not accepted due to capacity issues.
- Typically the CRC is at their maximum capacity three out of seven days per week, or approximately 40% of the time.

Examine Other Possible Funding Sources

BHD provides \$200,000 per year in funding to the CRC, which accounts for approximately 36% of their overall budget. In addition the CRC is able to generate approximately 28% of their budget through revenue. The remaining 32% of their budget is funded through various grants. These grants are all expiring as of the end of 2011. At this time, BHD is not aware of a viable sustainability plan that has been identified and is, in large part, dependent on negotiations between the CRC and the State of Wisconsin.

Further Exploration of Revenue Options at the State Level

Approximately 50% of the individuals currently using the CRC are members of Medicaid (Title 19) HMOs. These HMOs have indicated that they want to use the CRC as an alternative to inpatient hospitalization and emergency care but, unfortunately the CRC level of care is not a covered service within the HMO capitated rate from the State. Therefore, the HMOs cannot claim patients getting services at the CRC and in many cases the CRC does not receive payment for these services, which results in a sizable amount of unrecognized revenue.

Currently TLS, the fiscal agent for the CRC, is in the final stages of facilitating a proposed Contract Amendment for the State of Wisconsin contracted HMOs to include a "Sub-Acute Community-Based Psychiatric Treatment" level of care as a reimbursable service. This Amendment would be similar to the following:

"The HMOs may use programs offering medically necessary sub-acute psychiatric treatment/recovery center services. These services will include a community-based clinical treatment alternative to emergency room, inpatient hospitalization, and a step-down stabilization from acute inpatient hospitalization. This program is in lieu of inpatient psychiatric hospitalizations, when deemed appropriate by the treatment center admission staff and as authorized as medically necessary by the HMO."

This proposed amendment, if accepted, would be in effect beginning January 1, 2012.

Next Steps

BHD will continue to examine additional programmatic enhancements in order to decrease the number of emergency detentions in Milwaukee County, reduce dependence on PCS and build capacity for stabilization and linkages to services in the community. In addition, BHD is exploring a 24-hour mobile crisis team and a new crisis stabilization model for clients with Developmental Disabilities/Mental Health dual diagnosis.

Recommendation

This is an informational report. No action is necessary.

A handwritten signature in black ink that reads "Geri A. Lyday". The signature is written in a cursive style and is positioned above a horizontal line.

Gerri Lyday, Interim Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Terry Cooley, County Board
Patrick Farley, Director, Department of Administrative Services
CJ Pahl, Interim Assistant Fiscal and Budget Administrator
Steven Pietroske, Fiscal & Management Analyst, DAS
Jennifer Collins, Analyst, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff

COUNTY OF MILWAUKEE
Inter-Office Communication

Date: October 11, 2011

To: Supervisor Peggy West, Chair, Health and Human Needs Committee

From: Geri L. Lyday, Interim Director, Department of Health and Human Services

Subject: **From the Interim Director, Department of Health and Human Services, an Informational Report Regarding the Hilltop Downsizing Initiative**

Introduction

The 2011 Adopted Milwaukee County Department of Health and Human Services (DHHS) Budget includes an initiative that directs the Behavioral Health Division (BHD) to work with the Disabilities Services Division (DSD) to develop a downsizing plan for BHD's Hilltop Rehabilitation Center, a 72-bed Title XIX (*Medicaid*) certified Intermediate Care Facility (ICF-MR) for persons with developmental disabilities.

The DHHS Director is to provide quarterly informational reports to the Committee on Health and Human Needs regarding the progress of this initiative.

Quarterly informational reports were submitted in February and June 2011. This is the third report describing the progress on Hilltop downsizing planning efforts.

Background

An update report was submitted to the County Board in June 2011 detailing progress in the planning of a potential downsizing of BHD Rehabilitation Center Hilltop. In that update it was reported that BHD and the DSD have been working jointly to develop a plan for downsizing. Specific progress included:

DHHS established a Hilltop Downsizing Workgroup consisting of individuals from BHD and DSD which has accomplished the following activities:

1. Developed General Profiles of Hilltop Residents and Individuals with DD served at BHD
 - Information has been reviewed by the Workgroup to determine characteristics of the current Hilltop residents.
 - Data has been collected to determine the use of BHD Psychiatric Crisis and Acute Adult Inpatient services by individuals with developmental disabilities.

2. Determined System Capacity Requirement for Individuals with Developmental Disabilities served at BHD

- Individuals with developmental disabilities are being treated in PCS, OBS and being admitted to Acute Adult Inpatient.
- Community-based crisis, crisis response teams, and short-term stabilization capacity needs to be enhanced and/or expanded.

3. Determined Service Utilization to Determine Trends for the Period 2007-2010

4. Hilltop Screening Subgroup

- The Screening Subgroup developed and utilized a screening tool to assess community placement indicators and identify support needs.

5. Background Research Completed on Best Practices

- Literature review and expert consultation was completed to review other model priority service continuums for individuals with developmental disabilities and mental illness living in the community.

6. Fiscal Information Analysis

- DHHS fiscal staff collected background information to assess the fiscal impact associated with the downsizing of Hilltop.

Current Progress of Workgroup

Analysis of Service Utilization Trends

An analysis was completed to examine the trend in BHD service utilization of individuals who were known to both DSD and BHD during the years 2007 through 2010. Results of this analysis show that the number of consumers with developmental disabilities utilizing BHD services has increased over the period. It appears based on this analysis that individuals who made the transition to Family Care, may have experienced some disruption in supports due to changes in care plans, changes in community living arrangements or other factors including changes in support services provided. This may have contributed to increased numbers of individuals requiring crisis or other BHD services. Prior to the transition to Family Care, many of the individuals had been quite stable during the prior two years while receiving services from the Waiver programs with fewer admissions to BHD's Psychiatric Crisis Services.

This conclusion supports the need for a strong community-based crisis response service system to address periodic support issues that may be addressed while the individual remains in the community-based setting versus utilization of BHD. In addition, alternatives need to be created

to provide more appropriate community-based crisis options for individuals who need to temporarily leave their living situation due to situational or acute crisis episodes.

Preliminary Results of Assessments

Utilizing the new assessment tool, all current Hilltop residents were reviewed to determine behavioral and mental health needs and to evaluate supports that would be required if the individual was to relocate to a community-based living arrangement. The assessment team consisted of both DSD staff/consultants and residential teams from Hilltop consisting of the unit Psychologist, QMRP (Qualified Mental Retardation Professional), OTR (Occupational Therapist Registered) and nursing staff. The assessment teams determined that the group of 66 residents can be characterized in three distinct cohorts.

- The first cohort consists of approximately 24 individuals who could potentially be relocated to community-based living with supports identified by the assessment and with some community provider development. These individuals present similar characteristics as other individuals who have previously relocated from Hilltop to a community-based setting.
- While the second and third groups are not as well defined in terms of the number of individuals, it is anticipated that a second group may be able to relocate with significant development of highly skilled, new community providers to support more significant needs.
- The third group would likely require significant and intensive supports in order to be recommended for community-based services. Considerable new development of services and resources will need to occur before community service can be considered if considered at all. This last cohort of individuals exhibits significantly more challenging behaviors including a history of being included on the sexual offender registry, fire starting and frequent need for five-point restraints.

The DSD assessment team members determined specific characteristics of the consumers living at Hilltop that included:

- The clients of Hilltop present a unique combination of physical care needs most often requiring a licensed nurse to both monitor signs and symptoms, provide treatment and administer medications, both regularly scheduled and PRN or on an as needed basis and remain in contact with their Primary Medical Doctor and the many medical consultants each is treated by.
- Each client in Hilltop has an extensive behavioral treatment program developed by a psychologist that governs the prevention of behaviors, staff response, consequences of behaviors and treatment. Many clients require several staff to physically manage when a behavior manifests into a potentially dangerous situation leading to five-point physical restraint.

- The team is completing a list of approximately 24 candidates for a first phase community placement. These candidates have a wide range of needs, severity of behavioral and mental health issues and skills. All will need service providers that can meet a complex of physical and behavioral needs. Approximately eight individuals have an already assigned Family Care Worker.
- Because of the client needs, the future staff will need to be experienced, highly trained, have immediately available resources and individual emergency response plans.

Assessment staff also recommended numerous program components to provide adequate supports for community-based living options which included:

- Having a formal diversion program in place.
- Availability of a crisis respite house.
- An on-call system for professional staff to be used in emergencies.
- An on-call system for paraprofessional staff as crises develops taxing staff availability.
- Coordinating community-based Psychiatrist with corresponding Psychiatrist at BHD.
- Back-up system at BHD if needed.
- Plan for all staff to be familiar with the Behavioral Treatment Plan and Emergency Response Plan prior to discharge.
- It is recommended that staff should be encouraged to work several shifts/programs at Hilltop prior to discharge.
- It is recommended that staff be trained, prior to working in program, on behavior treatment principles, physical care and individual treatment components.
- Arrangements for Barber and Beautician services are also recommended.
- Providers should not have a history of high staff turn over rates.
- Recommended program components including community resource development services which entail vocational, educational, counseling and recreational services.
- Residential staff and agency vocational and/or day treatment staff should include licensed nursing, licensed psychologist, psychiatrist, behavior specialist and direct care staff.

Other recommendations of components that are suggested to be included in a Request for Proposal included:

- The physical setting or residences identified will need to offer a variety in locations and dwellings from city - urban living to smaller communities, suburban or rural settings. This variety is needed to be responsive to the range of supports and personal characteristics of the client group.
- It is recommended that each client have their own room as time outs are utilized and this may require that the individual have their own space.
- Each house should have more than one multi-purpose rooms and a fenced in yard would be preferred.

- It would be preferred that each house provide space for physical outlets/exercise space and equipment.
- A plan is recommended for all staff to be familiar with the Behavioral Treatment Plan and emergency Response Plan for each consumer prior to discharge.
- It is suggested that at least the first several months after discharge, certain clients may require a 1:1 staff to client ratio.
- Providers should have immediate behavioral specialists as back up in crises.
- The provider should have written protocols for emergencies and crisis.
- Provider Psychologist should have individually written Behavioral Treatment Plan for each client prior to discharge. It is strongly recommended that staff assigned to client must be trained in this plan.

Detailed results of the screening process provided data to better determine the frequency and severity of challenging behaviors and psychiatric symptoms. Dr. Gary Stark, Ph. D., of BHD provided an analysis of the data and targeted key areas to assist the team in identification of critical issues. Attachment 1 includes the results of this analysis. Average frequencies of key behavioral and psychiatric issues were determined and the data shows the reoccurrence rate for those items measured by the assessment tool. Further data analysis will be completed.

It should be noted that the results of the assessment process represent a point in time assessment and may vary based on change in condition or other factors related to individual's treatment planning.

State of Wisconsin Department of Health Services (DHS)

DHHS has initiated dialog with the State of Wisconsin Department of Health Services, Bureau of Long Term Care. The focus is to explore alternatives to support a downsizing effort for Hilltop and to determine funding options, program development alternatives as well as fiscal and programmatic supports available from the State to further the downsizing effort.

Since the expansion of Family Care in Milwaukee County for younger individuals with disabilities, the State has specified guidelines to address the downsizing of ICF-MR facilities. Under Wisconsin Chapter 50 guidelines, it is required that DHS establish a downsizing team comprised of State DHS staff, Aging and Disability Resource Center staff, representatives of advocacy agencies and Family Care Managed Care Organization (MCO) staff. This team identifies individuals to be relocated, develops specific relocation plans and sets timelines for implementation of the community relocations.

Under these established rules, the responsibility for development of community-based supports including residential options and all other needed services lies entirely with the Family Care, MCOs. In Milwaukee County, since Family Care expansion, there has not yet been the opportunity for the new MCOs to oversee development of service providers to address the needs of a group with characteristics similar to those Hilltop consumers identified by the

downsizing workgroup. Further, it is not clear how a crisis response system of care would operate in Milwaukee County given that there is a combination of both public and privately operated MCOs. It is also unclear how a crisis response system would be funded by these entities. As indicated by the downsizing assessment team, it is anticipated that without an effective community-based crisis response system in place to be available for early intervention and to provide community-based alternatives to using BHD for crisis episodes, individuals relocating from Hilltop will not have a high likelihood for successful community living.

Therefore, DHHS believes it is essential that experienced staff should oversee the development of provider community resources and supports to ensure the successful community reintegration for Hilltop residents. Furthermore, DHHS would like to see BHD and DSD staff facilitate this provider expansion and support the CMOs with new resource development, more than the current DHS model allows.

At this time it is unclear if DHS will be able to provide alternative funding options to support this plan. It may be required by DHS to follow the regular guidelines associated with Chapter 50 for the downsizing of and ICF-MR. If DHS is unable to provide alternatives, DHHS will begin to develop a collaborative planning and implementation process and explore the development of adequate community resources to support the relocation effort.

Fiscal Analysis Status

A review of the fiscal information and impact of downsizing Hilltop indicated that complexities associated with indirect costs result in limited reductions in tax levy. It is anticipated that any tax levy reductions in expenditures would need to be dedicated to community-based program development. DHHS will be submitting a report to the County Board during the next Board cycle that illustrates the fiscal issues associated with closing units at BHD and more information regarding Hilltop unit closures will be included in that report.

Next Steps

DSD and Hilltop staff will confirm the results of the assessments and final recommendations for relocations of the first group of individuals determined to be eligible for community relocation will be completed by the next report. It is also anticipated that further information will be available about the remaining groups of individuals from the second and third cohorts and recommendations for needed supports will be completed at that time as well.

DHHS will follow up with State officials to determine funding and program development alternatives to support a downsizing effort. If DHS cannot support alternatives to the prescribed policy on downsizing, DHHS will engage the CMOs to begin planning for the downsizing and additional community provider development in the area of crisis intervention and stabilization.

DHHS will also request authorization to utilize anticipated tax levy reductions resulting from unit downsizing at Hilltop to support community-based program development and expansion in the area of crisis intervention and stabilization.

Recommendation

Given the results of the Hilltop workgroup assessments, fiscal analysis and consultation with the State DHS, it is recommended that BHD initiate closure of one Hilltop unit during CY 2012. While there remain a number of questions regarding adequate community-based service capacity development, it is believed that adequate supports can be developed to provide the necessary services and assistance required to maintain individuals in the community for the first group. Continued exploration will be done to identify the next group with needed resource and timeline.

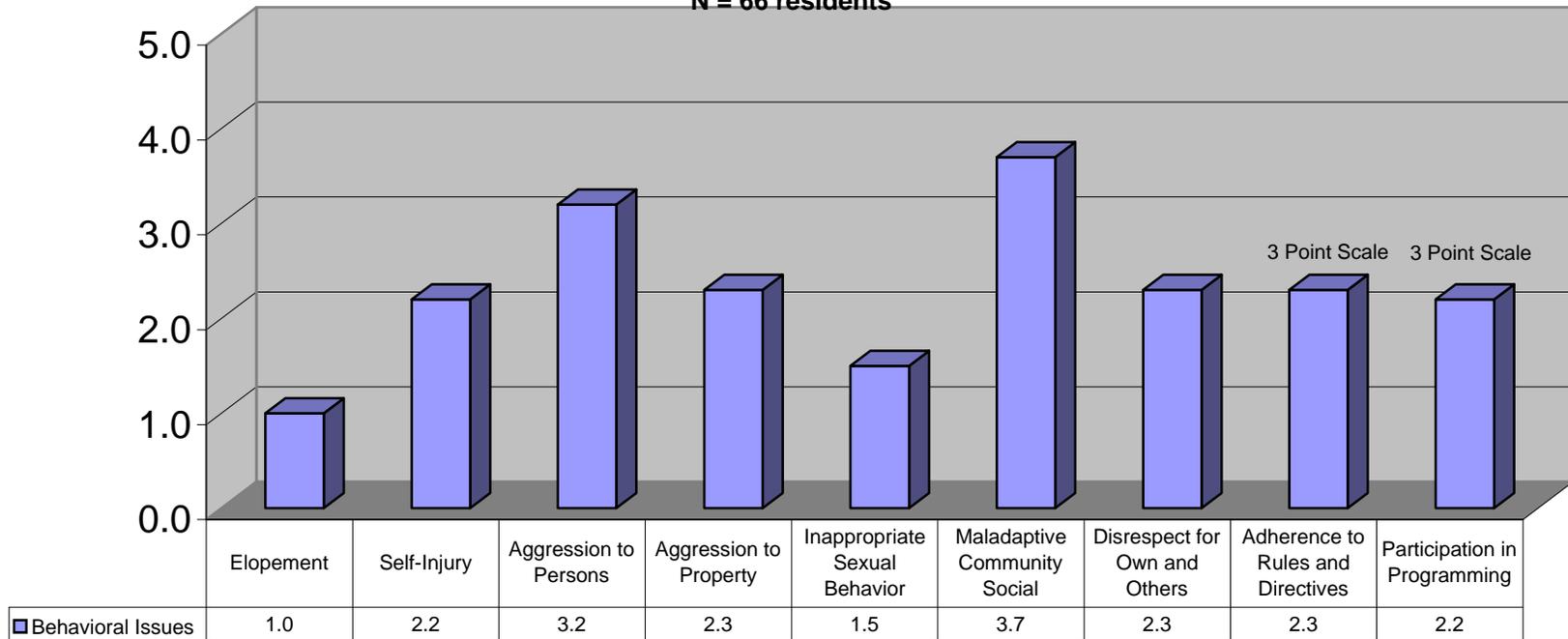


Geris L. Lyday, Interim Director
Department of Health and Human Services

Cc: Chris Abele, County Executive
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Mark Stein, Interim Administrator, DSD

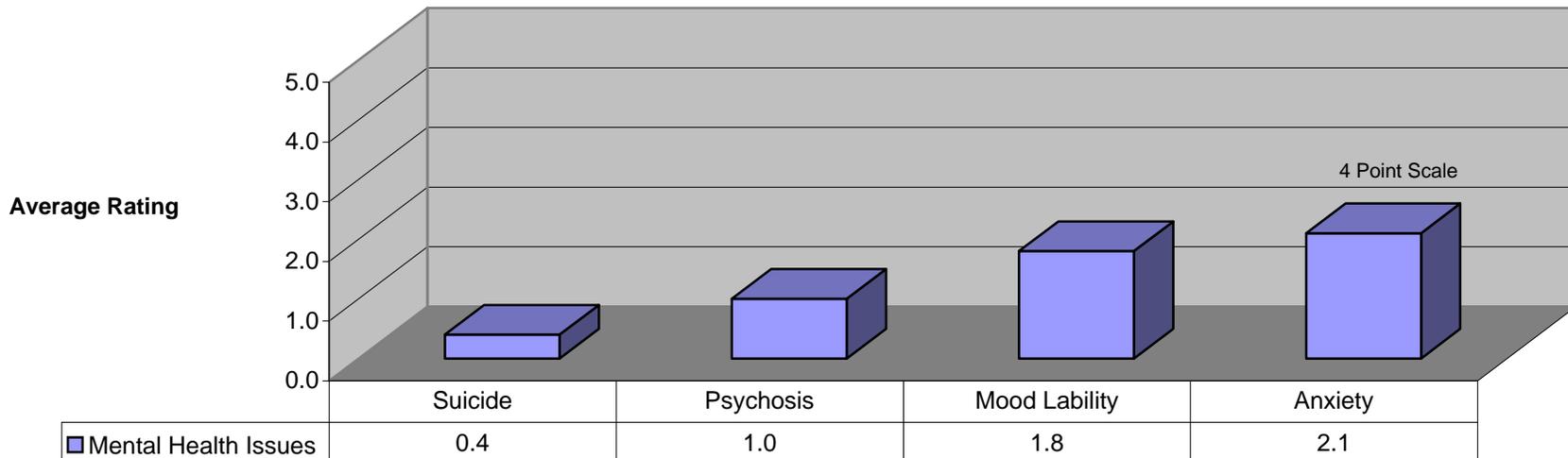
2011 Hilltop Behavioral/Mental Health Supplemental Screen - Behavioral Issues

N = 66 residents



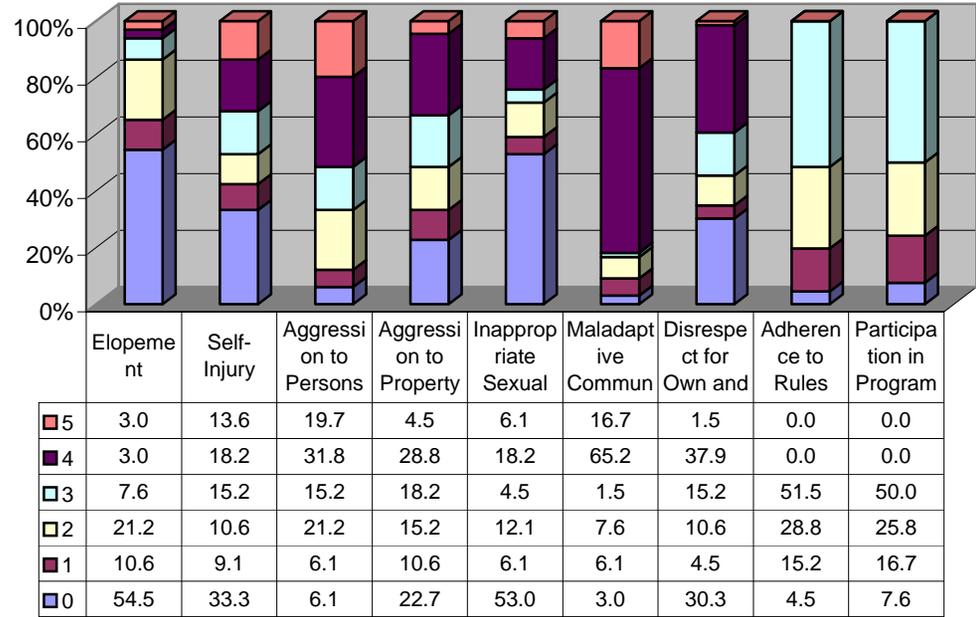
2011 Hilltop Behavioral/Mental Health Supplemental Screen - Mental Health Issues

N = 66 residents



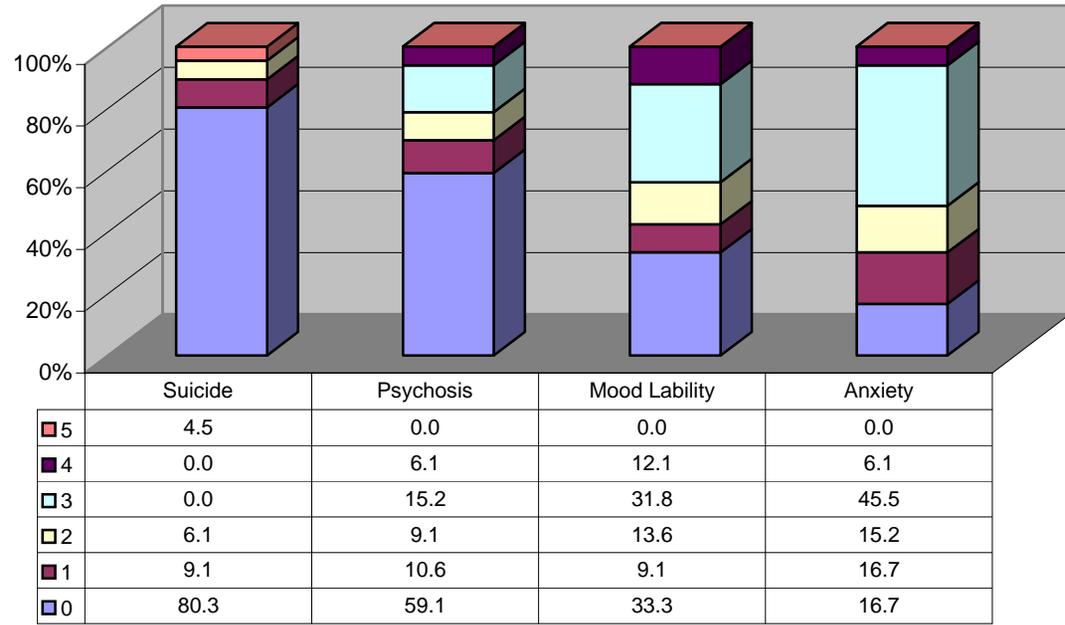
2011 Hilltop Behavioral/Mental Health Supplemental Screen - Behavioral Issues

N = 66 residents



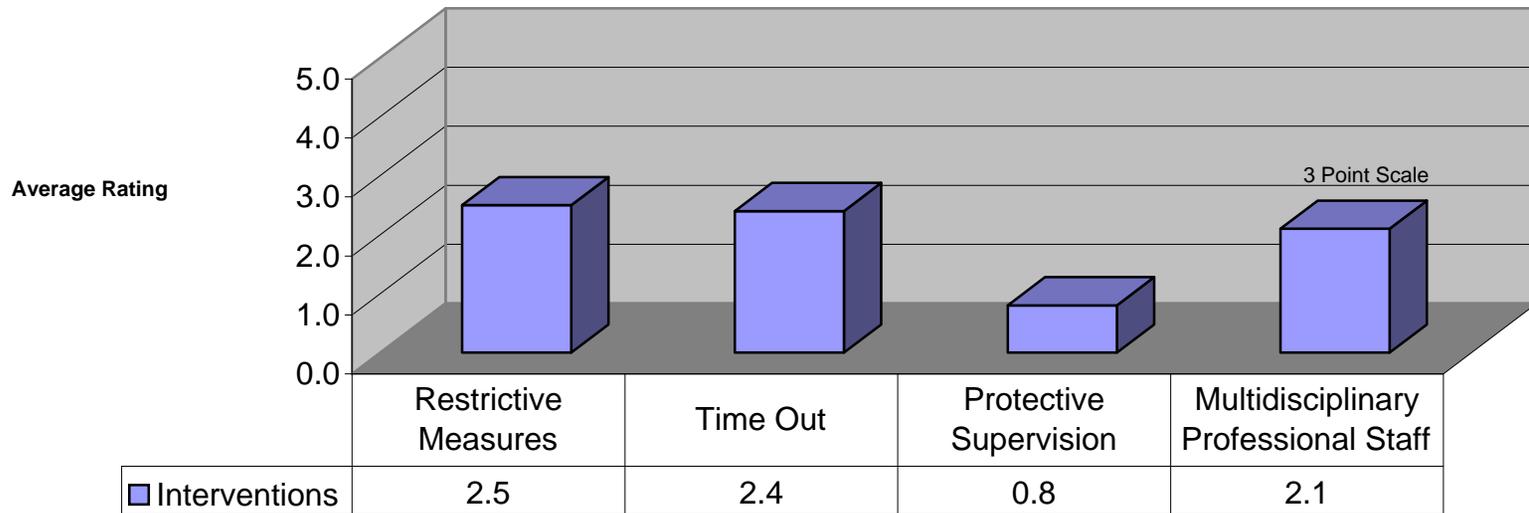
2011 Hilltop Behavioral/Mental Health Supplemental Screen - Mental Health Issues

N = 66 residents



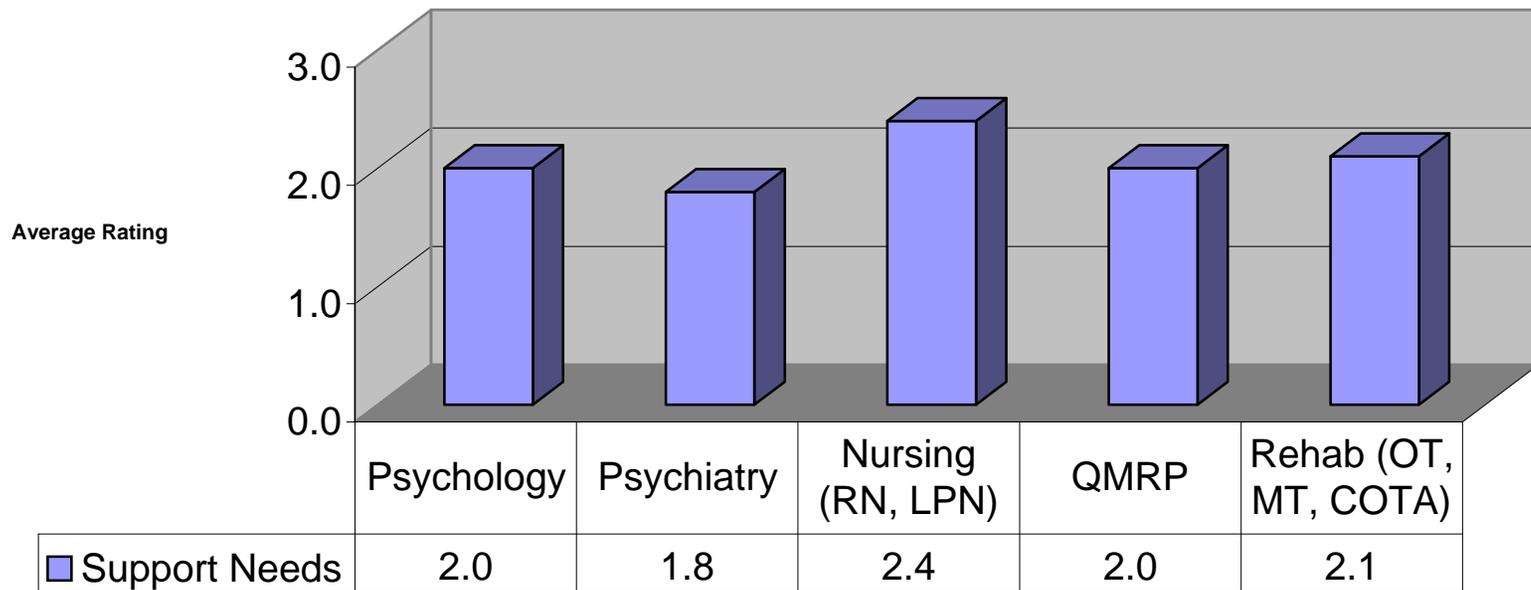
2011 Hilltop Behavioral/Mental Health Supplemental Screen - Interventions

N = 66 residents

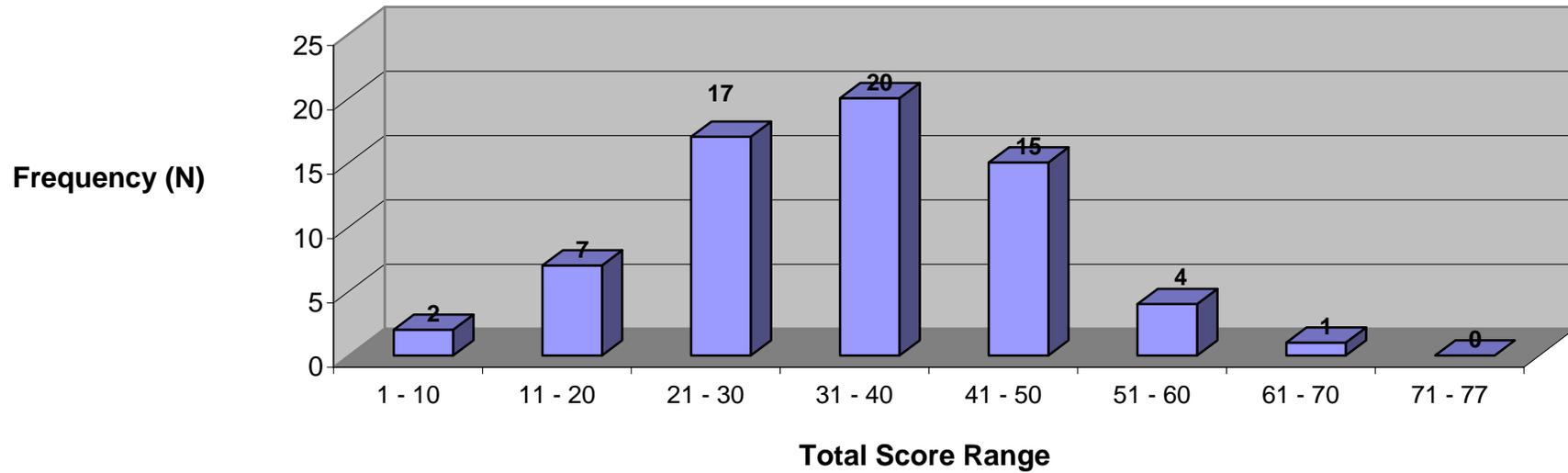


2011 Hilltop Behavioral/Mental Health Supplemental Screen - Multidisciplinary Professional Staff Support

N = 66 residents



2011 Hilltop Behavioral/Mental Health Supplemental Screen - Total Score
 N = 66 residents



2011 Hilltop Behavioral/Mental Health Supplemental Screen - Overall Behavioral Acuity
 N = 66 residents

