



OFFICE OF THE COUNTY EXECUTIVE

Milwaukee County

CHRIS ABELE COUNTY EXECUTIVE

1

Date: June 26, 2012
To: Marina Dimitrijevic, Chairwoman, County Board of Supervisors
From: Chris Abele, County Executive
Subject: Appointment to the Combined Community Services Board

Pursuant to the provisions set forth in Wisconsin State Statute 51.42, Milwaukee County General Ordinance 93.02 and subject to confirmation by your honorable body, I am hereby appointing Lisa Burg to serve on the Combined Community Services Board. Lisa Burg's term will expire on June 1, 2015.

Attached is a copy of her biography for your review.

Your consideration and confirmation will be appreciated.

A handwritten signature in black ink, appearing to read "Chris Abele".

Chris Abele
Milwaukee County Executive

cc: Supervisor Peggy Romo West, Chair, Health and Human Needs Committee
Kelly Bablitch, Chief of Staff, County Board
Hector Colon, Director, Health and Human Services
Jennifer Collins, Analyst, County Board
Jodi Mapp, Clerk, County Board
Lisa Burg

RECEIVED

JAN 19 2011

Disabilities Services Division

3576 S. 43rd St. #27
Milwaukee, WI 53220

January 11, 2012

Ms. Janice Weeden
1220 W. Vilet St. Suite 300
Milwaukee, WI 53205

Dear Ms. Weeden:

I am writing this letter regarding the possibility of serving on the Combined Community Services Board. Luanne McGregor recommended me to you.

I graduated from Devine Savior Holy Angels High School in 1975, and attended the University of Wisconsin - Whitewater. I graduated from UW Whitewater in 1980 with a BA in English and Business. After I graduated. I worked for Allstate Insurance Company in the subrogation Department through 1988. At that time health concerns and complications of my disability made me unable to continue working.

I have tried to stay as active as possible in the community, and have at various times audited classes at UW Milwaukee and taken community outreach classes at Alverno College.

I have a disability and use an electric wheelchair. Although I do not have a recent employment history, I've been involved in an ongoing basis in many disability rights issues, (most recently paratransit) trying to fight for as high a quality of life as possible for myself and others in my situation.

In the area of Disability Services, I feel I would have much to contribute to your board, should you choose to consider me. I would also very much welcome the opportunity to learn from all of you.

Thank you for considering me.

Sincerely,



Lisa Burg
(414) 545-6607



OFFICE OF THE COUNTY EXECUTIVE

Milwaukee County

CHRIS ABELE COUNTY EXECUTIVE

2

Date: June 29, 2012
To: Marina Dimitrijevic, Chairwoman, County Board of Supervisors
From: Chris Abele, County Executive
Subject: Appointment to the Commission for Persons with Disabilities

Pursuant to the provisions set forth in in the General Ordinances of Milwaukee County, Chapter 73 and subject to confirmation by your honorable body, I am hereby appointing Mr. Michael D. Shovers to the Commission for Persons with Disabilities. Mr. Shovers term will expire on December 15, 2013

His resume is attached for your review

Your consideration and confirmation will be appreciated.

Chris Abele
Milwaukee County Executive

cc: Supervisor Peggy West, Chairperson, Health and Human Needs Committee
Milwaukee County Board of Supervisors
Kelly Bablitch, Chief of Staff
Jodi Mapp, Committee Clerk
Don Natzke, Director, Commission for Persons with Disabilities
Michael D. Shovers

Michael D. Shovers
1730 W. Green Tree Rd. #109
Glendale, WI 53209
(414)228-0785 Phone/Fax
(414)702-6453 Cell
mshovers@wi.rr.com
Feb 27, 2009

Atty. Jack Longert, Executive Director
WisPACT, Inc.
802 West Broadway, Suite 214
Madison, WI 53713

Dear Mr. Longert and the WisPACT Board:

Please allow me to introduce myself in this letter, as I have not been in the job market for many years, and no longer have a current resume.

My education includes a B.S. degree in Psychology from the University of Wisconsin, in January, 1967, and several starts at the UW Law School. In college, I worked part time at the UW Memorial Union for nearly four years. After UW, and through the early 1970's, I had several jobs as a computer programmer in the private sector. These employers included J C Penney, the Chicago & Northwestern Railroad, and the Safeway supermarket chain. Later, I was at H&R Block for six seasons as a tax preparer.

It was in the mid-1970's that my multiple chronic health problems caught up to me, and I was forced to discontinue my Law studies, and to apply for Social Security Disability Insurance (SSDI). From the late 1970's to the 1990's, my efforts were concentrated on maintaining my health. A change in medication in the late 1980's brought about some relief, and the period of time between setbacks lengthened.

The early 1990's brought about significant declines in the health of my parents. After all the times they had taken care of me, my responsibilities began to shift to me taking care of them. It started with the making and going to medical appointments with them, conferring with their health providers, and managing medications, insurance claims, and other financial matters. Over the next several years, after my mother suffered an amputation, and my father's mobility was also slowly diminishing, I assumed the role of primary caregiver for both parents. I started doing a full range of household chores and took over all driving duties for them, including grocery and other shopping errands.

When my father had a stroke and went into a nursing home in 2003, it was all of the above and Power of Attorney for their finances. I took my mother to visit him at the nursing home nearly every day, or went by myself. At one point, I was there more than 300 consecutive days. At the nursing home, I got to know nearly every staff member, nearly every resident, and many of the family members that visited their loved ones there. I was Personal Representative for my father with Power of Attorney and actively involved in his care planning. Of course, any major decision was a family matter involving my mother, my two sisters, and myself, but as I was there every day, I was the go-to guy for day-to-day care decisions.

I learned a great deal about nursing home residents' issues during my father's nursing home stay. His room was near the dining room, so we saw a lot of the comings and goings of the other residents. The secure Special Care (Alzheimer's) Unit was right down the hall, so I saw first-hand how the issues that affected those residents were dealt with involving a wide variety of medical conditions. There were also some bus outings which I volunteered to help out on.

In addition, I have had significant experience as a disabled individual living in an able-bodied world, all the while dealing with my own various chronic health issues. Early in 2007, I went in for supposedly minor gall bladder surgery, but after three infections, three additional surgeries, and many other complications, I was too weak to be able to come home for more than six months. After one month at the first hospital, I spent another six weeks at an infectious diseases specialty hospital, and then four months at a nursing home, but not where my father was. During this time, my mother passed away at age 93. Six months after I came home, my father died at age 98.

I feel my qualifications for the position on the WisPACT Board are especially well suited to the role of being an advocate for the low-income elderly and disabled. These qualifications include my education, my limited, but relevant job experience, my life experiences, and my long term contacts with the public assistance programs in Wisconsin, including my time as a nursing home resident.

At age 64, I've been on SSDI since 1976, and am now living on my own. I do all my own household chores and outside errands, with some limitations such as heavy cleaning, which I out-source. At my condominium, I have served on the residents' Board of Directors for about ten years. My experience on the Board includes a total of nine terms as a director, including two terms as Vice-President, and currently, in my sixth term as President, since 2003. Our Board is involved mostly with financial matters, such as authorizing and approving service contracts. The actual work is out-sourced to a management company.

Further, I feel I am uniquely qualified by my experience with the Medicare / Medical Assistance (MA) programs. After first qualifying, I personally handled all my semiannual MA reviews, as well as several appeals. As Personal Representative / Power of Attorney, I handled nearly all the MA issues for my father's five year nursing home stay, and dealt with the complex application process and other issues presented by the new Medicare Part D for both my parents and for myself.

Personally, I'm ambulatory, and I drive, so I'm able to go on my own to shopping and to medical appointments. I get out to a local golf course during the season, and go out with friends occasionally. I spend a lot of time reading, and at the computer, mostly following current events, sports, and one of my life long interests, the weather. For entertainment, I'll watch the news on TV, some sports, the weather, of course, and an occasional movie.

Other personal qualities that I have been made aware of by others are an alleged sense of humor, a good memory, and the abilities to learn quickly, to analyze and solve problems, and to think critically. When I can see a problem, I can usually see a solution. I feel that I can add to the breadth of the Board by serving while being a WisPACT participant, as I can relate the participants' experiences and concerns to the Board.

I look forward to meeting with the WisPACT Board, and welcome any additional questions that may present themselves.

My sincere thanks to all for your consideration.

Michael D. Shovers

Michael D. Shovers
1730 W. Green Tree Rd. #109
Glendale, WI 53209
(414)228-0785 Phone/Fax
(414)702-6453 Cell
mshovers@wi.rr.com

Jan 31, 2012
Mr. Don Natzke, Executive Director
Milwaukee County Commission on Persons with Disabilities
901 N. 9th St., Rm 307 B
Milwaukee, WI 53203

Dear Mr. Natzke:

Please allow me to introduce myself. In this letter, I'm attaching my letter to WisPACT, dated Feb 10, 2009, that served as my application letter/resume for the position of Board Member. In addition, the text below will serve as an update of my various activities as a WisPACT Board member, and Officer.

In addition to the list below, I've also had an average of at least one phone conference per week with the Executive Director (ED). We've discussed various office issues, and worked on the scheduling and agendas for the various BOD and committee meetings.

Thank you for your consideration.

Michael D. Shovers

CHRONOLOGY OF WisPACT ACTIVITIES.

For 2009 - As a Director:

- Mar - Selected by WisPACT Board of Directors (BOD) to be a member of that BOD.
 - Mar - Participated with WisPACT staff and BOD in all-day Strategic Planning Seminar, in Madison.
 - Jun - First regular quarterly meeting of WisPACT BOD by teleconference. Also, regular Jun and Dec BOD meetings by teleconference.
 - Aug - Received call from the WisPACT ED asking if I would be willing to serve as Chair-Elect of WisPACT for 2010.
 - Oct - In-Person Annual Meeting in Madison. Elected by BOD as Chair-Elect. Also, In-Person regular BOD meeting. Under WisPACT by-laws, the Chair-Elect is equivalent to Vice-President, with presumption that the following year the Chair-Elect will be elected Chair. As an Officer, the Chair-Elect also serves on Executive BOD Committee.
 - Oct - Appointed to ED Evaluation Committee. Served through Jan, 2010.
 - Dec - Attended In-Person ED Evaluation Committee meeting, to personally report committee's results, including compensation, to the ED.
- Three trips to Madison for 2009, including one overnight stay.

For 2010 - As a Director and Chair-Elect:

- Jan - Begin term as Chair-Elect. Attended all four regular BOD meetings, the Oct BOD was In-Person, as was the Oct Annual meeting, while the Mar, Jun, and Dec regular BOD meetings were by teleconference, as were all four Executive BOD quarterly meetings by teleconference.
- Oct - Special In-Person meeting of Executive BOD, in Madison.
- Oct - Interim ED begins duties.

Oct - In-Person Annual Meeting in Madison - Elected by BOD as Chair for 2011. Also, In-Person

regular BOD meeting.

Nov - Appointed by Chair to form ED Search Committee. Served through selection of new ED in Feb. Also lead three teleconference Committee meetings.

Dec - Meet in Madison with Interim ED to plan for ED Search Committee. Also, to get acquainted with WisPACT office staff, including meeting with Marketing Specialist.

Three trips to Madison for 2010, with no overnight stays.

For 2011 - As a Director and Chair:

Jan - Begin term as Chair. Duties include supervision of Interim ED.

Throughout the year - Attended nearly all meetings of the various permanent and ad hoc committees, as ex-officio member, by teleconference.

Jan - Lead ED Search Committee's three-day series of interview sessions for ED finalists, in Madison. Also, meet with Interim ED, and informally with other BOD members.

Feb - Lunch meeting in Madison w/ outgoing Chair and Interim ED to set agenda for Executive BOD and regular BOD meetings.

Feb - New ED begins duties. My duties include supervision of new ED.

Feb - Lead first of four Executive BOD quarterly meetings by teleconference. Other three Executive BOD quarterly meetings were in May, Sep, and Nov, all by teleconference.

Mar - Lead first regular BOD quarterly meeting by teleconference. Dec meeting also by teleconference.

Mar - Meet with new ED, in Milwaukee.

Apr - Meet with ED, who interviewed me for WisPACT newsletter, in Madison.

Jun - Lead In-Person regular BOD quarterly meeting, in Madison. Also, meet with ED.

Jun - Attended, along with most WisPACT staff and BOD, an all-day Continuing Legal Education (CLE) seminar co-sponsored by WisPACT and the ElderLaw Section of the Wisconsin State Bar for about 150 attorneys from throughout Wisconsin, in Madison. Dinner meeting with ED, BOD members, WisPACT staff, and CLE Planning Committee. Meeting with ED.

Jul - Attend meeting, in Madison, with Auditor, Finance Committee, to review our auditor's report. Also, lunch meeting with ED. Also, attend meeting with ED and Marketing Specialist, to review marketing plans. Also, meet again with ED.

Aug - Attend lunch meeting, in Madison, with ED, Office Manager, and former Interim ED, to review audit issues.

Sep - Attend lunch meeting, in Madison, with Auditor's Managing Partner, ED, Office Manager, and former Interim ED, to review audit issues.

Oct - Lead In-Person regular BOD quarterly meeting, and Annual meeting, in Madison. Also, meet with ED and WisPACT staff.

Oct - Attended all-day seminar including sessions on Policy Governance and on Strategic Planning, for most WisPACT BOD members, in Madison.

Nov - Attended seminar for WisPACT staff, in Madison, to acquaint them w/ Policy Governance and Strategic Planning objectives as they apply to staff

Dec - Lead last regular BOD quarterly meeting by teleconference.

Nine trips to Madison for 2011, five of which included overnight stays.

From: Tom Heine <hpalex2000@yahoo.com>
To: "Don.Natzke@Milwcnty.com" <Don.Natzke@Milwcnty.com>, M D Shovers <mshovers@wi.rr.com>
Date: 05/17/2012 08:19 PM
Subject: Mike Shovers

Dear Mr Natzky

It is my pleasure to send you a note regarding Michael Shovers in support of his becoming a member of the Commission. In all my 40 some years working with people with disabilities Mike is a shining example of one who cares. He has a passion for problem solving, addressing the needs of the disabled and for educating those of us who are more able than others.

I worked with Mike recently as the Interim Executive Director and President of the Wisconsin Pooled and Community Trust (WisPACT). A statewide Trust for people with disabilities. Mike became the Chair last year and led them through a very difficult transition period. He engaged the Board in training, helped hire a permanent CEO and President, revised numerous policies, and has been very active in educating the public and attorneys regarding the work of the Trust for years.

Should he be appointed to the Commission you will be lucky to have a man of great integrity, sincerity, devotion to the common good, and someone who knows how to deal with finances. An unusual combination all in one person. I am now the Chair elect of WisPACT and feel very comfortable, following one year after Mike stepped down, to take the Chair because he will still be there to help me help the Trust for disabled people in Wisconsin.

Feel free to contact me at 608-236-9590 if you have any questions.

Respectfully,

Tom Heine



May 25, 2012

Mr. Don Natzke, Executive Director
Milwaukee County Commission For Persons With Disabilities
901 N. 9th St., Rm 307 B
Milwaukee WI 53233

Re: Recommendation for Michael Shovers

Dear Mr. Natzke,

I am honored to write this letter of recommendation on behalf of Michael Shovers. We have worked together at WisPACT for over one year when I was the new Executive Director and he was the new Chair of the Board. I know Michael as a committed leader, a passionate advocate for persons with disabilities and an extraordinary human being. Nothing less.

Michael Shovers was Chair of the WisPACT Board of Directors in 2011. He has been a member of the WisPACT Board of Directors since March 2009. He is also our beneficiary.

As Chair, Michael led WisPACT through a year of rapid growth and changes, and the first non-lawyer on our Board to do so - which is an accomplishment in itself! He put in place important policies to guide our growing organization such as investment advisor and caretaker policies. He formed a committee of attorneys to develop a Medicare Set Aside Trust which is a new product that we offer this year. He initiated an exploratory committee of attorneys to study whether pooled special needs trusts can hold IRAs. He participated in every study committee of the Board, including the one charged with developing a broader definition of disability so the organization can serve more persons with disabilities who do not meet the Social Security definition of disability.

Michael challenged the Board to focus on its policy governance role, and supported a Board retreat to train and educate the Board on this issue. Also, WisPACT was faced with a number of complicated personnel issues. He listened, problem-solved, and gave his advice. He visited the WisPACT office in Madison at least nine times last year, including five overnights. On a personal note, I truly do not think I could have made it through my first year as Executive Director without his support and counsel.

Michael's voice as a beneficiary is a plus and gives the Board a needed point of view to consider in its decision-making responsibilities. He is one of the most committed Board members I know. We feel so fortunate to have Michael on our Board. I am confident he will be a great asset representing persons with disabilities on the Commission.

Sincerely,

Olivia M. Wong
Executive Director/President, WisPACT, Inc.
802 W. Broadway Suite 214
Madison, WI 53713
Tel: 608-268-6006 x 201

MILWAUKEE'S PROTECTIVE PAYEE PROGRAM:

*Evaluating its performance and role in
the larger case management system*



Public Policy Forum

moving the region forward

MILWAUKEE'S PROTECTIVE PAYEE PROGRAM:

*Evaluating its performance and role in the larger
case management system*

June 2012

Joe Peterangelo, Researcher

Rob Henken, President
Anneliese Dickman, Research Director



TABLE OF CONTENTS

INTRODUCTION..... 3

PROTECTIVE PAYEE PROGRAM..... 4

 Program Overview 4

 Program Participation 5

 Program Costs and Funding 9

 Program Outcomes 11

 Summary 13

CASE MANAGEMENT SERVICES IN MILWAUKEE COUNTY 14

 Projects for Assistance in the Transition from Homelessness (PATH) 14

 Shelter Plus Care 16

 Permanent Supportive Housing 19

 Targeted Case Management (TCM) 21

 Community Support Program (CSP) 23

 Summary 13

OBSERVATIONS & CONCLUSIONS..... 27

INTRODUCTION

Since 2001, three Milwaukee nonprofit agencies have collaborated to provide a unique service designed to improve the housing stability and financial security of homeless adults with disabilities. The Protective Payee program, administered by Community Advocates, Hope House of Milwaukee, and Salvation Army of Milwaukee County, provides financial oversight, budget counseling, and supportive case management for more than 200 participants annually.

This report was initiated by a request from the directors of the Protective Payee program agencies for the Public Policy Forum to conduct an independent assessment of the program's strengths and weaknesses. We viewed this as an opportunity not only to provide a needed evaluation of a program that is serving hundreds of our region's neediest citizens, but also as a chance to provide Milwaukee-area policymakers and citizens with analysis that would be useful in the context of Milwaukee County's effort to redesign its adult mental health system. A primary goal of that effort is to reduce the County's emphasis on inpatient, long-term and emergency care while enhancing the network of community-based prevention, treatment, and case management services. That approach was encouraged by an October 2010 report authored by the Human Services Research Institute (HSRI) and the Public Policy Forum.¹

In addition to describing the Protective Payee program's design and scope, analyzing its impacts on client housing and health outcomes, and assessing the program's financing, we provide an in-depth examination of how the program fits into the broader spectrum of case management services available in Milwaukee County for the homeless and persons with mental illness.² We hope that this analysis will assist policymakers in determining the appropriate role for the Protective Payee service model in Milwaukee County's changing mental health system.

¹ HSRI: Transforming the Adult Mental Health Care Delivery System in Milwaukee County, October 2010: http://www.hsri.org/files/uploads/publications/Milwaukee_Mental_Health_System_Redesign_Final_Report.pdf

² There is considerable overlap between these two populations due to the high rate of mental illness and substance abuse among homeless individuals.

PROTECTIVE PAYEE PROGRAM

Program Overview

Case management services for adults with mental illness vary widely from program to program, both locally and nationally, with numerous service models targeting distinct populations and providing differing levels of support. The Case Management Society of America defines case management as “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs”, though some case management programs focus primarily on housing rather than health.³

The Protective Payee program’s blending of case management and financial oversight, along with its focus on serving people who are homeless upon entering the program, make the service distinct in Milwaukee County. Several other local agencies provide representative payee services, managing the finances of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) beneficiaries deemed unable to do so independently, but those services do not include supportive case management. Likewise, case management services are available to the homeless and people with mental illness through other agencies, including Milwaukee County’s Behavioral Health Division (BHD), but each serves a slightly different target population, and no other case management program includes a payee component for all clients.⁴

The individuals and families who participate in the Protective Payee program have been mandated by the Social Security Administration to utilize a representative payee. Most new clients enter the program while utilizing shelter or other services from one of the participating agencies or are referred to the program from another agency that serves the homeless. Individuals also can self-refer to the program, when space is available, provided they obtain a recommendation from their doctor.

Since clients who use a payee have been mandated to do so, many clients entering the program already have one in place. By switching their financial management from a family member or stand-alone payee service to a Protective Payee agency, however, they are also able to receive case management services. Also, according to Protective Payee program directors, many clients have had ongoing problems with a family member serving as their payee and mismanaging their finances. The cost of payee services may factor into some clients’ decision to participate as well; while other representative payee services charge their clients \$32 per month, the Protective Payee program is free to its clients.

Program participants work with a case manager to create a budget and an individualized plan for accomplishing specific goals based on the participant’s needs. Those goals always include establishing

³ Case Management Society of America:

<http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx>

⁴ Many Targeted Case Management (TCM) and Community Support Program (CSP) agencies do provide payee services for many of their clients. The PATH program also provides payee services for a small percentage of clients.

and maintaining stable housing and managing money properly. Additional goals vary by client but often focus on improving the client's health outcomes, which may require accessing a primary care physician or therapist and/or reducing or eliminating the use of alcohol or drugs. Many clients set social or educational goals as well.

Since case managers oversee client finances, they generally meet with clients once per week to provide the client with a weekly check, assist with budgeting and problem solving, and support the client to access other needed services. Each month, at least one visit is conducted at the client's home to ensure that his or her housing needs are being met. During and between weekly visits, case managers pay the client's regular bills, advocate for clients by phone and in person, and assist clients with transportation to appointments and shopping, as needed.

Through a review of client case files, we found that clients were seen between two and six times per month, with an average of approximately three or four visits per month, including one home visit. Those clients who are seen less frequently seem to be less in need of assistance and/or receive fewer checks per month because they do not have much income beyond what is needed to pay regular monthly bills. Conversely, a few clients with more severe disabilities require weekly home visits and more intensive support to meet basic needs.

It is worth noting that there is considerable debate among mental health professionals as to whether case management and payee services *ought to be* provided by the same agency, as is done under the Protective Payee program model. Critics argue that blending these services creates a conflict of interest that could cause clients to feel coerced into complying with their case manager's recommendations.⁵ Supporters of the model point to the program's success in stabilizing homeless clients, and to the high level of client satisfaction.

Program Participation

All Protective Payee program clients are homeless upon admission to the program, and nearly all clients also have a mental illness and/or a substance abuse problem. **Table 1** displays information on the disability types of all adults who participated in the Protective Payee program between 2009 and 2011. This data was taken from the Homeless Management Information System (HMIS) database, which is shared by all homeless-serving agencies in Milwaukee and managed by Hope House. Where applicable, this table includes multiple disability types for each individual; thus, while there were a total of 210 adult participants, there are 351 total disabilities listed.

⁵ Journal of Rehabilitation Research & Development, "Assertive community treatment—Issues from scientific and clinical literature with implications for practice": <http://www.rehab.research.va.gov/jour/07/44/6/pdf/rosen.pdf>

Table 1: Program participants' disability types, 2009-2011 (210 total HUD-eligible adults)⁶

Disability Type	Total Adults
Mental Health Problem	127
Alcohol Abuse	49
Physical/Medical Disability	46
<i>No Information Listed</i>	<i>34</i>
Drug Abuse	25
Dual Diagnosis	19
Developmental Disability	16
Physical Disability	12
Learning Disability	7
Both Alcohol and Drug Abuse	4
HIV/AIDS	3
Alzheimer's/Dementia	2
Mental Handicap/Injury	2
Chronic Health Condition	1
Cognitive Disability	1
Hearing Impairment	1
Speech Disorder	1
Vision Impairment	1

As shown in **Table 1**, disability information was listed for 176 of the 210 total adults in the HMIS database. Among those, 171 had a mental illness, a substance abuse problem, or both. Five additional individuals had physical disabilities only. Thus, approximately 97% of program clients suffered from a mental illness and/or substance abuse problem.⁷

As required by the United States Department of Housing and Urban Development (HUD) – which is the primary program funder – all 210 Protective Payee clients in the above sample were homeless upon program admission. Most clients enter the program after staying in emergency shelters or places not meant for habitation, though a small number also enter the program from transitional housing or safe haven programs.⁸ In addition, approximately 30% of the program's clients are considered chronically homeless, as defined by HUD.⁹

HUD's recently-changed definitions of homelessness and chronic homelessness play a critical role in who can access the Protective Payee program and many other services targeted at the homeless. HUD's new definition of homelessness has been relaxed in several ways to include more individuals exiting

⁶ HUD-eligible clients are those who meet HUD's definition of homelessness upon program entry. All three agencies serve additional clients who are not HUD-eligible through financial support from other sources.

⁷ Excludes those with no information listed in the HMIS database.

⁸ Safe haven programs offer temporary housing for homeless adults with mental illness.

⁹ U.S. Department of Housing and Urban Development:

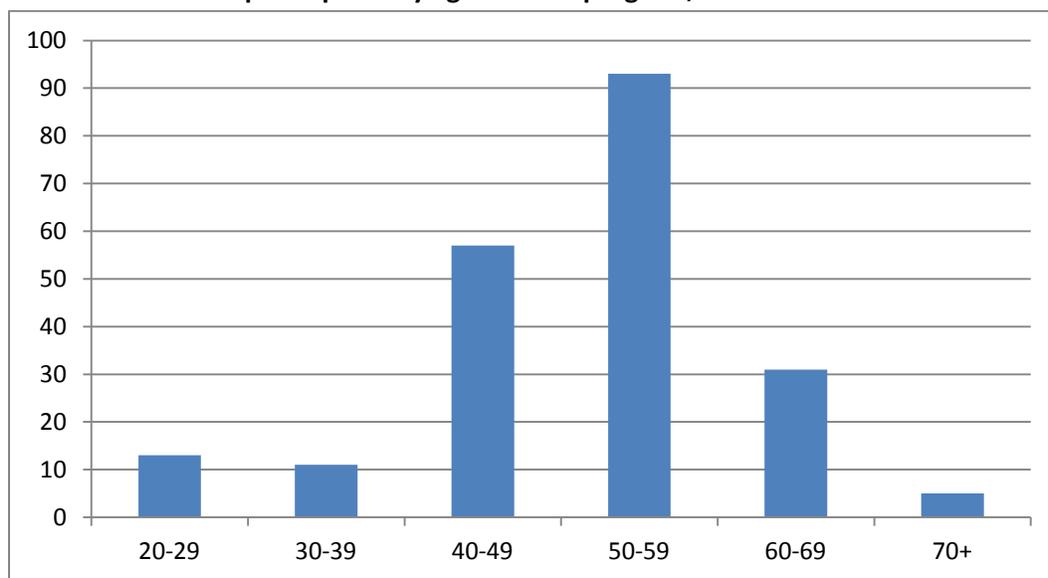
<http://www.hudhre.info/documents/HomelessAssistanceActAmendedbyHEARTH.pdf>

institutions and more people at immediate risk of becoming homeless. This change means that to some extent, more people now qualify for the Protective Payee program.¹⁰

Most Protective Payee clients are single adults, though the program does serve a number of households with children. In 2011, for example, there were a total of 150 HUD-eligible clients served by the program, including 15 (10%) households with children.¹¹ Between 2009 and 2011, the program's adult participants included slightly more men (56%) than women (44%).

Chart 1 shows the age breakdown of adult program participants. Approximately 61% of participants are over the age of 50, which means that program participants are significantly older than both Milwaukee's homeless and general populations. According to the U.S. Census Bureau's 2008-2010 estimates, approximately 29% of Milwaukee County residents are over the age of 50, while the Milwaukee Continuum of Care's 2011 Point in Time survey found that only 30% of Milwaukee's homeless population is over the age of 50.¹²

Chart 1: Number of participants by age of adult program, 2009-2011



Once enrolled in the Protective Payee program, clients tend to participate for several years. **Table 2** shows the distribution of time spent in the program for all 2011 participants. In this case, "Leavers" represent those who left the program for any reason in 2011, while "Stayers" are those who continued to participate in the program as of the end of 2011.

¹⁰ National Alliance to End Homelessness: <http://www.endhomelessness.org/content/article/detail/3006>

¹¹ In 2011, the three agencies served a combined total of 205 cases, including 55 cases not funded by HUD.

¹² The Continuum of Care is a collaboration of public and nonprofit agencies in Milwaukee County that plans, organizes, and evaluates the continuum of services for homeless individuals and families and coordinates Milwaukee County's annual Supportive Housing Program application to HUD (<http://milwaukeeccoc.org>). Additional details on the Milwaukee 2011 Point in Time Survey can be found at <http://milwaukeeccoc.org/MilwaukeePointinTime2011.pdf>.

Table 2: Length of program participation for 2011 participants (both adults and children included)

Length of Participation	Total	Leavers	Stayers
Less than 1 month	11	9	2
1-2 months	3	0	3
2-6 months	16	3	13
6 months to 1 year	16	3	13
1-2 years	24	2	22
2-3 years	15	1	14
3-4 years	15	1	14
4-5 years	22	1	21
More than 5 years	77	12	65
Information Missing	0	0	0
Total	199	32	167

Approximately 39% of all 2011 program clients had been participating in the program for more than five years, and 57% had participated for more than three years.¹³ Among those who left the program during 2011, most left either after many years of participation (38% participated for more than five years) or very soon after entering the program (28% left after less than one month).

Table 3 shows the primary reasons clients have left the Protective Payee program in recent years. Fifteen of the 29 clients (52%) who left the program in 2009 and 2010 did so because the client had “completed” the program, which means consensus had been reached by the client, the case manager, and the Social Security Administration that the client no longer needed a payee.

Table 3: Reason for leaving program

Reason for leaving	2010	2009	Total
Completed program	9	6	15
Non-payment of rent/occupancy charge	0	0	0
Non-compliance with project	1	0	1
Criminal activity / destruction of property / violence	2	0	2
Reached maximum time allowed in project	0	0	0
Needs could not be met by project	2	2	4
Disagreement with rules/persons	2	0	2
Death	2	0	2
Other	2	1	3
Total	20	9	29

The second most frequent reason for leaving the program was “Needs could not be met by project,” which means program services were insufficient for those clients. According to program staff, those clients typically refused to engage with the services offered by the program, and eventually their participation was terminated. Only four clients fell into that category during the two-year period.

¹³ These figures include all program clients, including adults and children.

A majority of clients who leave the Protective Payee program continue to rent an apartment independently. Among the 81 clients who left the program between 2009 and 2011 and whose destination was captured in the HMIS database, 50 (62%) went on to rent an unsubsidized apartment.¹⁴

Table 4 breaks down the housing destinations of clients who left the program during that period.

Table 4: Destination at program exit of clients leaving program after participating for at least 90 days

	2011	2010	2009	Totals
Rental by client, unsubsidized	10	32	8	50
Living with family or friends	4	3	1	8
Deceased	0	4	1	5
Jail or prison	1	1	2	4
Rental by client, subsidized	0	1	2	3
Psychiatric facility	0	1	1	2
Permanent Supportive Housing	0	1	0	1
Transitional housing	0	0	1	1
Safe haven	0	1	0	1
Other	4	1	1	6
Don't Know/Refused	4	7	2	13
Information missing	0	0	7	7
Total	23	52	26	101

Program Costs and Funding

As noted above, because of its focus on serving the homeless, the Protective Payee program qualifies for and receives most of its funding from HUD's Supportive Housing Program, which "is designed to develop supportive housing and services that will allow homeless persons to live as independently as possible."¹⁵

As shown in **Table 5**, HUD funds 80% of the program's costs, while requiring each agency to provide a 20% match.

Table 5: Protective Payee program budgets by agency, 2011

Agency	Staff Salaries	Staff Benefits	Total Expenditures	HUD Revenue	Local Match	Total Revenue
Community Advocates	\$188,609	\$47,152	\$374,102	\$276,282	\$97,820	\$374,102
Hope House	\$91,082	\$24,435	\$135,864	\$96,826	\$39,038	\$140,741
Salvation Army	\$49,206	\$16,383	\$76,262	\$49,601	\$26,661	\$76,262
Totals	\$328,897	\$87,970	\$586,228	\$422,709	\$163,519	\$591,105

Each agency generates the 20% match independently through donations, in-kind contributions, United Way funding, and other sources. Because all three agencies serve additional clients who are not

¹⁴ Excludes those recorded as "Don't Know/Refused" or "Information Missing."

¹⁵ More information about HUD's Supportive Housing Program can be found at:

http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/programs/shp

homeless and, therefore, do not meet HUD eligibility criteria, \$57,842 in additional local dollars were contributed by the participating agencies in 2011. Overall, the local contribution was approximately 28% of total program expenditures.

Community Advocates, which manages the HUD grant for all three agencies, serves more than half of the program's clients overall. **Table 6** shows each agency's 2011 caseload and reveals substantial differences in each agency's total expenditures per client.

Table 6: Program expenditures per client, 2011

Agency	Total Expenditures	Total Cases*	Cost per client
Community Advocates	\$374,102	109	\$3,432
Hope House	\$135,864	49	\$2,773
Salvation Army	\$76,262	47	\$1,623
Total	\$586,228	205	\$2,860

*Includes 150 HUD-funded cases and 55 additional cases funded by other revenue sources

Salvation Army has a far lower cost per client than the other agencies but is currently in the process of hiring an additional case manager. As a result, that agency's cost per client figure likely will rise to align more closely with those of the other agencies in the future. Notably, Salvation Army has the highest number of cases not funded by HUD. In 2011, for example, the agency had 27 cases that were funded by HUD and 20 that were not. Those clients not funded by HUD will be served by the agency's new case manager.

There are considerable differences in the caseloads of each Protective Payee case manager as well, as shown in **Table 7**, which helps explain the difference in per-client expenditures. Community Advocates, for example, makes greater use of supervisors/accounting and its case managers have smaller caseloads. Also, it should be noted that Salvation Army again stands out with a much larger average caseload than the other agencies, but that will change when the new case manager is hired, at which time Salvation Army's average caseload likely will be in line with those of the other agencies.

Table 7: Staffing and caseloads by agency

Agency	Supervisors/ Accounting	Total Cases	Case Managers	Average Caseload
Community Advocates	0.65	109	5	22
Hope House	0.35	49	1.95	25
Salvation Army	0.10	47	1	47
Total	1.10	205	7.95	26

Program Outcomes

HUD requires all Supportive Housing Program (SHP) grantees, including the Protective Payee program, to establish a set of outcome metrics when they submit their application to HUD that meet the SHP's national objectives, and to report on those outcome metrics annually. The objectives set by the Protective Payee program focus on the program's ability to stabilize the housing situation of its clients, but also include several additional measures related to financial literacy, health care, and each client's individual goals. **Table 8** shows those outcome data as reported to HUD by the three Protective Payee agencies over the past three years.

Table 8: Outcome data as reported to U.S. Department of Housing and Urban Development (HUD)

HUD Outcome Metric	2011	2010	2009
New participants obtained permanent housing within 60 days of program entry	92%	88%	95%
Continuing participants maintained housing for one year	87%	95%	97%
Improved money management skills	79%	83%	77%
Made progress toward one goal on their case management plan	97%	98%	97%
New participants saw a primary care physician within 6 months of program entry	86%	92%	80%

The data reported to HUD through the program's annual progress reports appear to indicate the program is highly successful in achieving its core goal: stable housing. More than 90% of all new participants over the past three years have obtained stable, permanent housing within 60 days of entering the program, and an equally high percentage have continued to maintain stable housing for at least one year. There has been some decline on both indicators during the past three years, however, which may bear close monitoring and investigation by program staff.

While HUD has not set a specific benchmark for all five of the above indicators, the Protective Payee program has consistently met the benchmarks it set for itself in its HUD application. For example, the program has set goals that at least 80% of program participants will obtain permanent housing within 60 days of program entry, and that a minimum of 75% of continuing participants will maintain housing for at least one year.

Improving financial literacy and assisting clients to make progress toward their personal goals are other outcome goals reported to HUD. Those metrics are more subjective; the determination of whether a given client has achieved those goals is made by the case manager according to the individual client's case. For example, improved money management is based on the increased ability of the client to manage his or her own finances, and the definition of improvement is based on the budgeting skill level and level of financial responsibility possessed by the client when he or she entered the program.

The prevention of shelter recidivism is another key indicator of program success. According to the HMIS database, a total of 406 individuals (including adults and children) have participated in the Protective

Payee program since the HMIS database was established in 1998.¹⁶ Of those, 13% (53 clients) have returned to a homeless shelter after entering the program, while 87% (353 clients) have not. It is a positive indicator of the program's impact that the vast majority of clients have remained out of the shelter system since entering the program.

Another critical indicator of program quality is client satisfaction. Among the three participating agencies, Salvation Army was the only agency that conducted a client satisfaction survey in 2011. Salvation Army distributed surveys to 39 clients and received 19 back. The results were overwhelmingly positive: 95% of the clients who responded to the survey were happy with their case manager and the program overall. Salvation Army's survey results are promising, though they capture the opinions of only 9% of the 205 adults served by the Protective Payee program in 2011.

Hope House also reported conducting client satisfaction surveys in the past, but has stopped doing so. We would encourage all three agencies to conduct an annual survey of all program clients, as it could help to guide service improvements.

In addition to collecting data tied to the above outcome measures, the three participating programs require their case managers to track additional client data in each client's case file. The content and organization of client case files varies from agency to agency, but all include some common documents, including a confirmation of the client's previous homelessness, the client's Social Security benefit and housing information, and a detailed set of case notes that describe each interaction the case manager has with (or on behalf of) the client.

Through a review of a random sample of 20 case files, which included files from all three agencies and all seven case managers, we were able to analyze how client outcomes are tracked. In doing so, it became clear that the consistency by which outcomes are tracked could be improved. For example, many clients had set goals to attend all of their scheduled medical appointments, but actual visits are not recorded in the case file so it is impossible to know whether the goal has been met. In general, outcomes are tracked more consistently by some agencies – and some case managers – than others.

One way in which outcome tracking could be improved is by sharing and refining the tools each agency has developed for those purposes. For example, Hope House utilizes an "individual case plan" and Community Advocates uses a "case management plan" to document each client's long-term and short-term goals, target dates for achieving the goal, and dates each goal was achieved. The three agencies could collaborate to establish a uniform tracking system and a methodology for ensuring it is consistently maintained for all clients.

Hope House and Community Advocates utilize several additional documents related to client outcomes that could be useful for all three agencies. For example, Hope House uses a "supportive services

¹⁶ All three agencies were offering individual Protective Payee services before joining forces under one federal grant in 2001.

planning worksheet” and a “completed/in process supportive services tracking form,” which describe and track additional services each client needs. The forms identify which individual or agency will provide each service and record the dates each service was accessed. The other two agencies may wish to consider using those documents.

Finally, it is important to note that the “quality” of housing that clients access through the Protective Payee program is not directly addressed by HUD outcome requirements or outcome data collected by the program coordinators. This issue has been raised previously by the local news media and has generated considerable attention by county and city policymakers. It was beyond the scope of this report to assess housing quality, but that question may be worth exploring through additional research.

Summary

It is difficult to evaluate the “success” of the Protective Payee program due to the lack of specific HUD outcome benchmarks and, in some cases, the lack of consistently recorded outcome tracking by case managers. In particular, the extent to which the program is impacting client mental health and recovery outcomes is unclear. Nevertheless, the available data indicate that the program is succeeding in stabilizing housing for a very challenging population: homeless adults with mental illness. The program’s key goals are being met for the vast majority of clients, shelter recidivism is relatively low among program participants, and most individuals who leave the program are going on to live independently in private rental housing.

In order to provide further context with which to view the program’s effectiveness and efficiency, we decided to compare it to other case management-type programs in Milwaukee County that are similar in terms of clientele, services offered, funding sources, and client outcomes. This analysis also offers an opportunity to better understand the role of the Protective Payee program within the greater spectrum of behavioral health-related case management services offered in Milwaukee County.

CASE MANAGEMENT SERVICES IN MILWAUKEE COUNTY

In order to have a clear understanding of the Protective Payee program's scope and impact, it is necessary to view it alongside the other programs offering case management or similar services to the homeless and to individuals with mental illness in Milwaukee County. Analysis of each of those programs also offers policymakers a view of how the overall "system" functions, revealing potential opportunities to improve effectiveness and efficiency and assisting in deliberations on the proper role of the Protective Payee and similar programs moving forward.

The programs analyzed in this section include PATH (Projects for Assistance in the Transition from Homelessness), Shelter Plus Care, Permanent Supportive Housing, Targeted Case Management (TCM), and the Community Support Program (CSP). These programs do not represent an exhaustive list of every case management-type service offered in Milwaukee County, but to the best of our knowledge, they are the largest such programs. We describe each program's scope and scale, while also highlighting areas of similarity and distinction. For each program, we begin with an overview of how the program is operated and funded, as shown below for the Protective Payee program.

PROTECTIVE PAYEE PROGRAM SNAPSHOT

Target Population	Homeless adults with disabilities who receive Social Security benefits
Total Clients Served, 2011	205 cases, including 17 families
Program Intensity	Medium (2-6 visits per month, including at least one monthly home visit)
Total Program Cost, 2011	\$586,228
Funding Sources	HUD; Protective Payee agencies provide a 20% local match

In these program snapshots, "program intensity" is defined based on the breadth of services each program offers as well as the frequency of contact case managers have with clients.¹⁷

Projects for Assistance in the Transition from Homelessness (PATH)

Outreach Community Health Centers (ORCHC) – formerly known as Health Care for the Homeless – offers a case management service for adults with mental illness called the PATH program. PATH serves people who are homeless or at risk of homelessness due to an unstable housing situation; in 2011, 81% of clients were "literally homeless" upon program entry and the rest were considered at "imminent risk

¹⁷ Technical Assistance Collaborative, Inc. "Care Management, Case Management, and Utilization Review in a Managed Care Environment": <http://www.tacinc.org/downloads/caremanagement.pdf>

of homelessness”.¹⁸ The program is funded largely with grant funds provided by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), as well as local match. The PATH program’s case management model is similar to that of the Protective Payee program in that it focuses on cases involving both mental illness and homelessness. PATH does not require clients to have any income, however, and is short-term in nature, focusing on assisting clients to connect with the services they need to transition from homelessness to stable housing and health. Once clients are in stable housing, the program is mandated to stop serving the client within 60 days.

PATH provides intensive case management services for about 50 clients per year, but a far greater number of individuals receive a lower level of services through the program. PATH provides outreach services to shelters and free meal sites and scours city streets to find homeless individuals and assist them to connect (or reconnect) with housing and health care services. Outreach workers also screen individuals for mental health issues and enroll them in PATH, if appropriate. ORCHC conducts street outreach and subcontracts with Community Advocates to provide outreach services at shelters and meal sites.

In 2011, 1,243 individuals received outreach services from PATH, though that number includes some duplicated individuals who were served more than once. Of those, 443 unduplicated individuals were enrolled in the PATH program and 50 received intensive case management services. Thus, a large percentage of the individuals assisted by PATH receive services but are not intensively case managed. This is partially due to limited funding and partially due to the fact that the program enrolls clients with a wide range of abilities/disabilities. Program staff must triage the cases in order to decide who needs the intensive case management and who can be served effectively with a lower level of support.

For those clients who are intensively case managed, PATH focuses on three main areas: housing, income, and psychiatric. For the housing component, case managers assist clients to navigate the complex system of housing options and apply for safe haven, transitional housing, and Permanent Supportive Housing (PSH) programs. The criteria for qualifying for those housing programs vary widely, with factors including demographics, income, homelessness status, disability status, and whether or not the individual is a BHD client. Since most of the programs have wait lists, ongoing support is provided to plan for and coordinate housing over time. One of the strengths of the program, according to the program’s director, is its ability to stay with clients as they transition from the streets or shelters to safe havens, and eventually to permanent housing.

For the income component, case managers assist qualifying clients to apply for Social Security benefits and/or help employable individuals to find work through the Division of Vocational Rehabilitation (DVR), Grand Avenue Club, Goodwill, or by other means. Only about 10% of clients entering the program have any income. PATH also provides representative payee services for about 10 clients at any given time.

¹⁸ HUD’s definition of “literally homeless” is an individual living in a place not meant for human habitation (street, car, abandoned building), an emergency shelter, a safe haven, or a transitional housing facility:
http://www.hudhre.info/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

The final component of PATH case management is psychiatric. Case managers help many clients enroll in Milwaukee County’s TCM or CSP programs through BHD’s centralized intake assessment unit, SAIL.¹⁹ Clients also are referred to community mental health services, rehabilitation services, and alcohol and drug treatment, as needed, or are accompanied to appointments for those services. In 2011, approximately 38% of enrolled clients were connected with community mental health services.²⁰

Many PATH clients ultimately shift to one or more of the other programs examined in this report. Many start by moving into a safe haven, which is temporary, and ultimately find a longer placement in a PSH facility. Some clients eventually are enrolled in TCM or CSP. Those who are homeless or staying in a safe haven and who obtain income are often referred to the Protective Payee program. Ultimately, after six to nine months, most clients move out of the PATH program and into Shelter Plus Care, PSH, transitional housing, or unsubsidized affordable housing.

The converse also occurs, however, in that some clients who are struggling in PSH get referred into PATH. Those clients are considered “at risk” of homelessness because they could lose their housing if they don’t make changes. In those cases, PATH workers step in to provide services specific to mental health in order to enhance the client’s stability.

PATH PROGRAM SNAPSHOT	
Target Population	Adults with mental illness who are homeless or at risk of homelessness; no income required
Total Clients Served, 2011	443 total clients enrolled, including 50 who were intensively case managed
Program Intensity	Low to Medium (clients who are intensively case managed meet with their case manager 1-2 times per week)
Total Program Cost, 2011	\$367,504
Funding Sources	SAMHSA; Outreach Community Health Centers & Community Advocates provide a 33% local match

Shelter Plus Care

Shelter Plus Care (S+C) is a HUD program that offers rent subsidies and supportive case management for homeless individuals and families with permanent, chronic disabilities. Milwaukee County’s Housing Division manages the program locally, and vouchers are awarded to the County through the annual HUD application made by the Milwaukee Continuum of Care. Clients must be homeless upon admission to

¹⁹ Service Access to Independent Living

²⁰ This information was provided by the PATH program director for program year 2011 (7/1/10 until 6/30/11). The percentage of clients PATH connected with community mental health services is below the SAMHSA benchmark of 47% set for these programs in 2011.

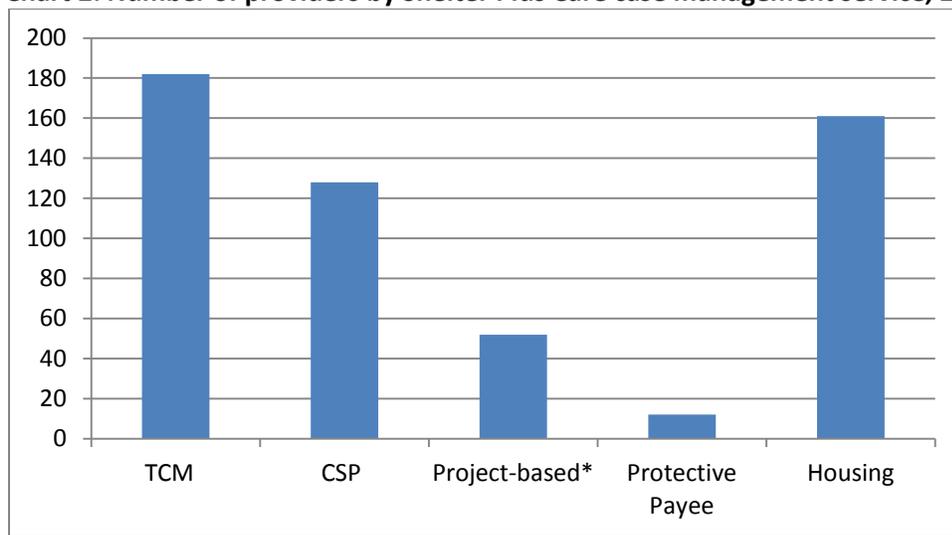
the Shelter Plus Care program and must suffer from serious mental illness, a chronic substance abuse problem, or HIV/AIDS. Through S+C, clients typically contribute approximately 30% of their income toward rent and receive a Housing Assistance Payment that covers the remainder. In 2011, a total of 535 clients received S+C vouchers in Milwaukee County, including 52 who lived in Permanent Supportive Housing projects.

Like the PATH program, S+C differs from the Protective Payee program in that it does not require clients to be Social Security recipients or to have any income, though 397 of the 535 clients (74%) do receive Social Security benefits. If a client has no income, his or her Housing Assistance Payment covers 100% of the contract rent. The County also provides a Utility Reimbursement Payment to the utility company for clients with no income.

Most S+C recipients are part of the My Home Housing Program, which is a tenant-based program that allows participants to live in any housing unit in Milwaukee County. The remaining S+C recipients live in a sponsor-based Permanent Supportive Housing project. The rent subsidy for those participants is attached to the unit rather than the tenant, and funding comes from separate HUD grants. Currently, there are 33 S+C units for chronically homeless adults in the Johnston Center Residences, a 91-unit property owned by Mercy Housing Lakefront, and 12 S+C units in the Capuchin Apartments, a 39-unit property owned by Heartland Housing.

Case management, which is a HUD-required component of Shelter Plus Care, is not provided directly by the program, but rather is provided through BHD’s TCM and CSP programs and through other agencies, including the Protective Payee program agencies. A large number of S+C clients receive housing (rather than mental health) case management through Guest House, Community Advocates or AIDS Resource Center of Wisconsin (ARCW). The number of clients receiving each type of case management in 2011 is shown in **Chart 2**.

Chart 2: Number of providers by Shelter Plus Care case management service, 2011



*Permanent Supportive Housing projects. Case managers for these clients do not have a clinical background and the services are primarily housing-related.

Those clients who are co-enrolled in S+C and the Protective Payee program are able to pay their portion of rent from their monthly Social Security income, and their payee serves as their case manager. One of the Protective Payee agencies, Community Advocates, also offers a separate My Home case management service for S+C clients who do not qualify for the Protective Payee program because they do not receive Social Security benefits. While the clients in that program are included in the Housing total in **Chart 2**, the services those clients receive closely resemble those offered to Community Advocates' Protective Payee clients.

According to one Protective Payee program director, more Protective Payee clients do not participate in the Shelter Plus Care program for a variety of reasons. First, clients have to be homeless when they apply for the program, so those who are already in the Protective Payee program and have found stable housing are no longer eligible. Other barriers include client rental history and landlord flexibility. Landlords have to sign off on receiving a portion of the rent each month from the County and a portion from the client's payee. Many landlords are hesitant to do that, particularly for clients with imperfect rental histories.

Despite the well-documented need for safe, decent and affordable housing for vulnerable individuals in Milwaukee County, the County perennially has been unable to utilize all of its available S+C slots because of limited funding to pay for the program's mandatory case management component. According to the program's coordinator, all of the available vouchers may be used for the first time in 2012, in part because the Protective Payee agencies and other community agencies have taken over case management responsibilities for additional clients. This development may signal a promising breakthrough that could allow the program to serve dozens of additional clients annually, and it may make sense for BHD's mental health redesign deliberations to include exploration of ways to sustain it.

SHELTER PLUS CARE PROGRAM SNAPSHOT

Target Population	Homeless adults with permanent, chronic disabilities; no income required
Total Clients Served, 2011	535, including 52 in Permanent Supportive Housing projects
Program Intensity	Medium to High (varies by client based on source of case management; minimum of two home visits per month)
Total Program Cost, 2011	\$3,330,286*
Funding Sources	HUD, Milwaukee County

* This figure covers the cost of housing subsidies and program administration but does not include the costs related to case management, which is provided by many different agencies.

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is a model of housing designed specifically to enable individuals with disabilities to have access to decent, safe, affordable and permanent housing, and optional support services that help them maintain independence in the community while supporting their recovery from mental illness. PSH developments are typically built or renovated with equity financed by Low-Income Housing Tax Credits (LIHTCs) that are allocated to projects through an annual competition managed by the Wisconsin Housing and Economic Development Authority (WHEDA). Those tax credits provide the single largest source of subsidy that enables the developments to be affordable to persons with incomes below 50% of the area median income. Most PSH developments are further subsidized with HUD project-based Section 8 housing vouchers from local public housing authorities, along with City or County housing trust funds, where available.²¹ Services are funded through annual contracts with Milwaukee County, typically in the form of case management and/or on-site peer support services.²²

In 2011, there were a total of 380 units of Permanent Supportive Housing in Milwaukee County, including approximately 200 that housed clients who received case management through Milwaukee County's TCM or CSP programs. Some PSH projects are specifically targeted toward TCM and CSP clients, while others focus primarily on housing chronically homeless individuals. Several facilities also include affordable units that are not for PSH clients.

In order for a person with no income to qualify for Permanent Supportive Housing facilities that target chronically homeless individuals, they must meet HUD's definition of chronic homelessness: "an unaccompanied, disabled individual who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years."²³ HUD recently refined this definition to identify an "episode" as any period of homelessness lasting at least 15 days.²⁴ In addition, Milwaukee County's Housing Division has established and enforced a standard that each "episode" of homelessness must be separated by at least 15 days. Previously, a person could have used a shelter four times during one week and qualified as chronically homeless. This change makes it more difficult to qualify for those PSH projects.

The approximately 180 clients who are housed in PSH units, but who do not receive case management through TCM or CSP, typically do not receive mental health case management at all and may not be in need of those services. In many cases, however, those clients do benefit from a less intensive, housing-

²¹ A few PSH residents receive a Shelter Plus Care (rather than Section 8) voucher. As with Shelter Plus Care vouchers, Section 8 vouchers allow clients to pay approximately 30% of their income toward rent and receive a subsidy that covers the remainder.

²² Peer support services generally refer to services that provide social, emotional and other support to individuals with mental illness that are delivered by trained individuals who have suffered from mental illness themselves.

²³ U.S. Department of Housing and Urban Development:
<http://www.hudhre.info/documents/DefiningChronicHomeless.pdf>

²⁴ Housing California Fact Sheet: http://www.housingca.org/site/DocServer/fact-sheet_homelessness_fed-definition.pdf?docID=1409

focused case management service offered by the housing project sponsor and/or on-site peer support services. Peer support currently is provided for up to 12 hours per day at four of the eight PSH locations in Milwaukee County, with efforts to expand to the remaining four locations limited by lack of available funding. A small number of PSH clients have no support services beyond their housing subsidy.

Milwaukee County has seen the construction of dozens of new PSH units in recent years following the development of a formal initiative to encourage construction of such units that was launched by Milwaukee’s county executive and mayor in 2006. Numerous public and private entities have worked together to further the initiative, including WHEDA, which has provided low-income tax credits for the developments; the City of Milwaukee Department of City Development, which has offered assistance with zoning, permitting and property transfer; Milwaukee County’s Special Needs Housing Trust Fund, which has provided gap funding to allow projects to be developed; and Milwaukee County’s Housing Division and BHD, which provide funding for supportive services and case management.

The Milwaukee Continuum of Care’s “10-year plan to end homelessness,” which was adopted in early 2010, includes a plan to expand the city’s stock of PSH even more by adding 1,260 additional units over 10 years.²⁵ According to the CoC’s most recent Point in Time survey of the city’s homeless population, which was conducted in January 2011, there were a total of 1,466 homeless adults and children in Milwaukee on that single day and a total of 6,169 unduplicated homeless individuals utilizing emergency or transitional housing during all of 2010.

PERMANENT SUPPORTIVE HOUSING PROGRAM SNAPSHOT	
Target Population	Varies; some projects target the chronically homeless while others focus on persons with mental illness who are receiving case management services from BHD
Total Clients Served, 2011	380 total clients, including 200 receiving case management through Milwaukee County’s TCM or CSP programs
Program Intensity	Low to High (Varies by client based on source of case management)
Total Program Cost, 2011	\$671,000*
Funding Sources	Milwaukee County, HUD, WHEDA, City of Milwaukee (mostly in the form of in-kind support), private development agencies

* This figure includes costs related to on-site peer support services and case management services not covered by TCM or CSP.

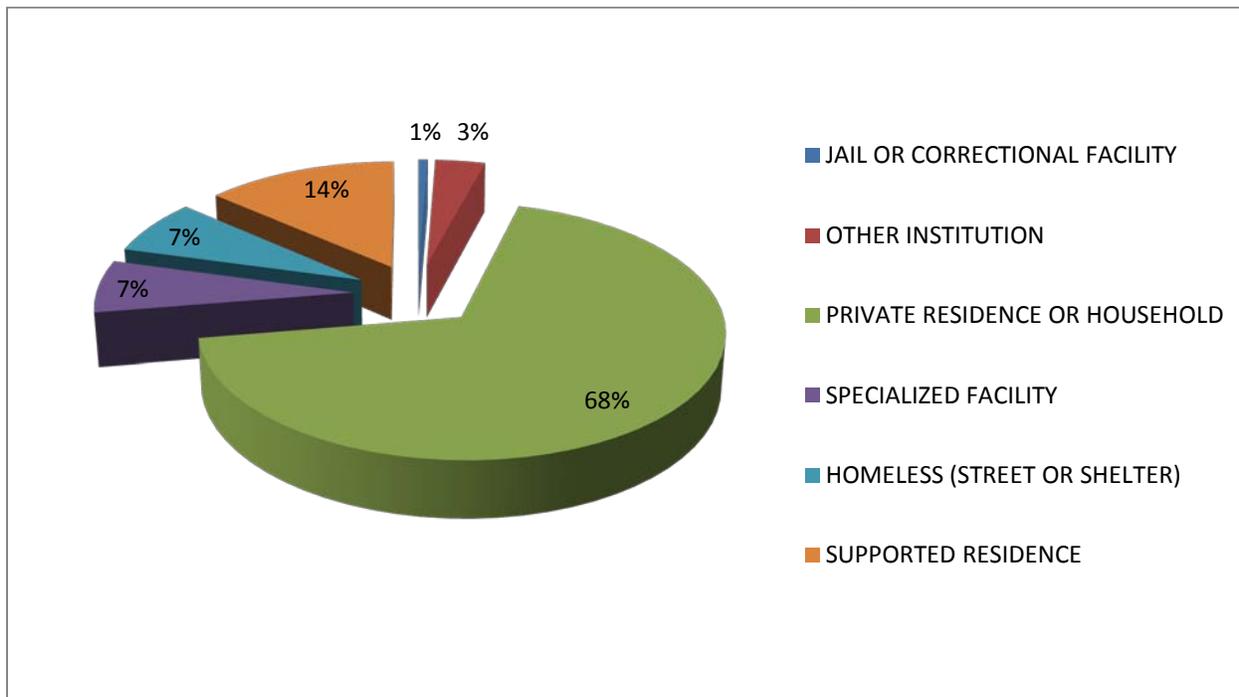
²⁵ Milwaukee Continuum of Care’s 10-year plan to end homelessness: <http://milwaukeeecoc.org/10-Year-Plan.pdf>

Targeted Case Management (TCM)

Milwaukee County's two mental health case management programs are accessed through its centralized intake assessment unit, SAIL. Based on individual needs and availability of open case management slots, clients are placed in either Targeted Case Management (TCM) or the Community Support Program (CSP). The TCM program serves a wide range of adults, including individuals with developmental, physical or sensory disabilities, chronic mental illness, alcohol or drug dependency, and Alzheimer's disease or dementia, through contracts with private agency providers.²⁶ TCM is a less intensive program than CSP and focuses primarily on ongoing monitoring and service coordination.

While all Protective Payee program clients are homeless and receive Social Security benefits when they enter that program, only 68% of current TCM clients receive Social Security benefits and just 7% of the combined TCM and CSP clients were homeless upon program admission. In fact, **Chart 3** shows that 68% of TCM and CSP clients were living in a private residence at the time of program admission. Thus, while many Protective Payee program clients may qualify for TCM, only a small percentage of TCM clients would qualify for the Protective Payee program under its current HUD-funded model.

Chart 3: Client living situation at the time of admission to TCM or CSP (Current caseload)²⁷



The support provided for most clients through TCM, including the frequency of contacts, blend of office and home visits, assistance in identifying and arranging for other needed services, and types of

²⁶ Criteria for TCM program qualification can be found in Wisconsin DHS Chapter 107.32: http://docs.legis.wisconsin.gov/code/admin_code/dhs/107/32

²⁷ This chart was provided by Milwaukee County's Behavioral Health Division.

community-based support, make TCM similar in intensity to the Protective Payee program. The frequency of contacts between TCM clients and case managers is based on each client's individual case plan, though the average is four to eight contacts per month.²⁸

Within the TCM program there is a clinic-based sub-program – known as TCM Level 2 – that is geared toward clients connected with the criminal justice system, many of whom must comply with probation/parole requirements related to treatment. The purpose is to “provide primary clinic-based mental health services to individuals who are not appropriate for primary outreach case management services.”²⁹ In addition to case management, TCM Level 2 includes payee services, housing assistance, and medication dispensing via registered nurses, while involving less frequent contact between case managers and clients. TCM Level 2 services are provided exclusively by one vendor – Wisconsin Community Services (WCS). WCS currently serves 232 TCM Level 2 clients, which represents approximately one fifth of Milwaukee County's TCM client total.

Notably, the average cost per client for TCM and the Protective Payee program is similar: in 2011, the average cost was \$2,979 per TCM client and \$2,859 per Protective Payee client. The average cost per client for TCM Level 2 (roughly \$5,000 per year) is much higher than for the standard Level 1 program, which increases the program average overall. In fact, the standard TCM Level 1 program has a slightly lower cost per client than the Protective Payee program.

It is difficult to make comparisons between TCM and the Protective Payee program, however, for several reasons. The Protective Payee program's primary goal is housing stability, whereas TCM emphasizes mental health management and recovery. The Protective Payee program is specifically challenged by the fact that all of its clients recently have been homeless, while TCM enrolls some clients with no income. In addition, there is a lack of good data on client functioning and illness/symptom measurement at admission and discharge from each program.

The average caseload handled by TCM's 32 contracted case managers is approximately 39 cases, which is significantly higher than the Protective Payee program's average of 26 cases per case manager. However, TCM's average caseload and average cost per client are influenced by the fact that four of the program's case managers serve TCM Level 2 clients exclusively. The TCM Level 2 case managers have an average caseload of 58 clients, while the average caseload for TCM Level 1 case managers is approximately 25 cases.³⁰

TCM and CSP are funded by Title 19 Medicaid (for services deemed reimbursable under Medicaid), Milwaukee County Community Aids funds (a county allocation for human services from the State of Wisconsin, also known as BCA), Institute for Mental Disease funds (for clients with disabilities, through

²⁸ HSRI: Transforming the Adult Mental Health Care Delivery System in Milwaukee County, October 2010: http://www.hsri.org/files/uploads/publications/Milwaukee_Mental_Health_System_Redesign_Final_Report.pdf

²⁹ 2011 BHD Request for Proposal document

³⁰ The overall staff to client ratio for the TCM Level 2 program is 1:23 when case managers, payees, RNs, and housing specialists are all included.

the federal Community Options Program), and Milwaukee County property tax levy. For services that are reimbursable by Medicaid, the federal government pays approximately 60% of the service costs and the County pays the remainder. For clients and services not covered by Medicaid, Milwaukee County covers all service costs through the program’s other funding sources.

TARGETED CASE MANAGEMENT (TCM) PROGRAM SNAPSHOT	
Target Population	Adults with disabilities, chronic mental illness, substance dependency, Alzheimer’s disease or dementia
Total Clients Served, 2011	1,233
Program Intensity	Medium (4-8 visits per month, including both home and office visits)
Total Program Cost, 2011	\$3,673,716
Funding Sources	Medicaid, BCA, IMD, Milwaukee County tax levy

Community Support Program (CSP)

Milwaukee County’s CSP program is the most intensive case management service available in the county and is the only service that includes a clinical treatment component. The criteria to enter CSP are much more restrictive than those for TCM, as CSP is geared toward the most severe cases involving chronic mental illness.³¹

CSP is based on the Assertive Community Treatment (ACT) model of case management, which is “a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness.”³² Based on client needs, treatment services include symptom management or supportive psychotherapy, and family, individual or group psychotherapy. Crisis intervention services also are provided.

CSP’s rehabilitation component offers social and recreational skills training, and assistance in the community with activities of daily living. The program also provides support services, including physical health services, financial support, legal services, transportation services, and assistance with living accommodations.

Milwaukee County’s 110 CSP case managers meet with clients an average of 11-14 times per month, a key indicator of the program’s high intensity.³³ Over 50% of service contacts are provided in the community, in non-office based or non facility-based settings, based on state policy requirements.³⁴

³¹ Criteria for CSP qualification can be found in Wisconsin DHS Chapter 63.08:

https://docs.legis.wisconsin.gov/code/admin_code/dhs/63/08

³² Assertive Community Treatment Association: <http://www.actassociation.org/actModel/>

³³ HSRI: Transforming the Adult Mental Health Care Delivery System in Milwaukee County, October 2010:

http://www.hsri.org/files/uploads/publications/Milwaukee_Mental_Health_System_Redesign_Final_Report.pdf

Milwaukee County currently tracks several outcome metrics for both the CSP and TCM programs, including the mental health National Outcome Measures (NOMs), service utilization and treatment completion. We requested additional information from BHD regarding the specific outcomes measures it tracks and the data associated with those outcomes, but the division did not respond to our request.

COMMUNITY SUPPORT PROGRAM (CSP) SNAPSHOT	
Target Population	Adults with chronic mental illness requiring repeated acute treatment or prolonged periods of institutional care
Total Clients Served, 2011	1,347
Program Intensity	High (11-14 visits per month, including both home and office visits)
Total Program Cost, 2011	\$8,680,263
Funding Sources	Medicaid, BCA, IMD, Milwaukee County tax levy

The information from each of the program snapshots contained in this section is summarized in **Table 9** along with other key information about each of the programs reviewed in this report. This table illustrates the extent to which the programs complement one another or, in some cases, overlap, while highlighting their distinctions in clientele, scope of services, and program intensity.

Additional financial information is included for each program as well, including total clients served and total program cost. Great care should be used in interpreting data in those categories, as they are not intended as a reflection of program efficiency. Indeed, most of the programs are quite distinct in the services they offer and there is considerable co-enrollment between programs. Nevertheless, this information should be a useful starting point for those considering an expansion of case management or case management-type services in Milwaukee County by providing insight into the resources that may be required to do so.

³⁴ Wisconsin DHS Chapter 63.10 (3): https://docs.legis.wisconsin.gov/code/admin_code/dhs/63/10/2/b/3

Table 9: Service Comparison

	Protective Payee Program	PATH Program	Shelter Plus Care	Permanent Supportive Housing	Targeted Case Management (TCM)	Community Support Program (CSP)
Provider	Community Advocates, Hope House, Salvation Army	Outreach Community Health Centers (formerly Health Care for the Homeless)	Milwaukee County	Milwaukee County, City of Milwaukee, private development agencies	Agencies contracted by Milwaukee County	Milwaukee County
Target Population	Homeless adults with disabilities who receive Social Security benefits	Adults with mental illness who are homeless or at risk of homelessness; no income required	Homeless adults with permanent, chronic disabilities; no income required	Varies; some programs target the chronically homeless while others focus on people with mental illness; income required	Adults with disabilities, chronic mental illness, substance dependency, Alzheimer's disease or dementia	Adults with chronic mental illness requiring repeated acute treatment or prolonged periods of institutional care
Services Provided	Representative payee services, budget counseling, advocacy	Housing planning and coordination, referrals to mental health services, advocacy	Housing Assistance Payment subsidizes clients' monthly rent; case management is required by HUD for all S+C recipients	Subsidized housing; On-site peer support services are provided for up to 12 hours per day at many locations	Case assessment, case planning and ongoing monitoring and service coordination	Psychiatric rehabilitation and support
Program Intensity	Medium (2-6 visits per month, including at least one monthly home visit)	Low to Medium (Varies by client; a small fraction of those enrolled receive more intensive services than the majority)	Medium to High (Varies by client based on source of case management; minimum of two monthly home visits)	Low to High (Varies by client based on source of case management)	Medium (4-8 visits per month, including both home and office visits)	High (11-14 visits per month, including both home and office visits)
Outcomes Tracked	Housing stability, money management skills, progress toward personal goals	Housing situation, enrolled clients who receive community mental health services	Currently not tracking; Case management outcome metrics vary by source (TCM, CSP, Protective Payee, etc.)	Inpatient stays, incarcerations, group participation, quality of life indicators	National Outcome Measures (NOMs) for mental health, service utilization, and treatment completion	National Outcome Measures (NOMs) for mental health, service utilization, and treatment completion
Total Clients Served, 2011	205 cases, including 17 families; 12 clients are co-enrolled in Shelter Plus Care	443 total clients enrolled including 50 who were intensively case managed	535, including 182 co-enrolled in TCM, 128 in CSP, 52 in PSH, and 12 in the Protective Payee program	380, including 200 receiving case management through TCM or CSP	1,233	1,347
Total Program Case Management Cost, 2011	\$586,228	\$367,504	\$0 ³⁵	\$671,000 ³⁶	\$3,673,716	\$8,680,263
Funding Sources	HUD; Protective Payee agencies provide a 20% local match	SAMHSA; Outreach Community Health Centers & Community Advocates provide a 33% local match)	HUD, Milwaukee County tax levy; Milwaukee County matches the HUD funding with an equal value of services	Milwaukee County, HUD, City of Milwaukee, private development agencies	Medicaid, BCA (Community Aids, Basic County Allocation), IMD (Institute for Mental Disease) funds, County tax levy	Medicaid, BCA (Community Aids, Basic County Allocation), IMD (Institute for Mental Disease) funds, County tax levy

³⁵ Case management is not provided directly through Shelter Plus Care, but is a required component of the program. Most clients receive case management through TCM or CSP.

³⁶ This figure only includes costs associated with on-site peer support services and case management services not provided by TCM or CSP. Total program costs are greater.

Summary

Overall, we see that close to \$14 million is spent annually on case management or case management-type services for more than 3,000 individuals in Milwaukee County.³⁷ The vast majority of that funding (\$12.4 million) supports Milwaukee County's TCM and CSP programs, and the funding sources are a blend of local, state and federal dollars.

Currently, the Protective Payee program's budget and caseload make it a relatively small player in the overall "system" of case management services in Milwaukee County. Indeed, the Protective Payee program and PATH are two of the smallest programs included in this report, and are the only services that are not managed by Milwaukee County.

We urge BHD and its mental health redesign task force to use this information to consider whether these services collectively function to provide appropriate levels of community-based services that meet the varied needs of individuals who are seeking them, and/or whether there may be ways to more effectively deploy existing and additional mental health and homelessness prevention resources to establish an even better continuum of care.

³⁷ Excludes funding for Shelter Plus Care as the funding for that program is used to support client housing but not the case management component of the program.

OBSERVATIONS & CONCLUSIONS

Analysis of the design, impact, cost and funding sources of the Protective Payee program and five other case management programs for the homeless and persons with mental illness in Milwaukee County leads to several observations:

- **The Protective Payee program appears to be effective in stabilizing housing for homeless individuals with disabilities and could serve as a model for other counties in Wisconsin.**

The vast majority of Protective Payee clients quickly transition into stable housing and maintain stable housing over time, thus meeting the program's core goal. While it is not possible to conclusively determine that the program's success in stabilizing housing for homeless adults with disabilities would allow it to be applied successfully to other populations in Milwaukee County in need of case management services, it does suggest an expanded program or similar programs based on the Protective Payee model could be an effective option for the same clientele in other Wisconsin counties.

Additionally, we were unable to assess the extent to which there are additional homeless individuals with disabilities in Milwaukee County who are not being served by the Protective Payee program currently and could benefit from those services.

- **Increased coordination between case management programs could make it possible to increase enrollment in the Protective Payee and Shelter Plus Care programs, potentially alleviating some demand on Milwaukee County's Behavioral Health Division and serving more clients overall.**

The HUD-funded Shelter Plus Care program requires that all clients receive case management, and most Shelter Plus Care clients currently receive those services from Milwaukee County's TCM and CSP programs. The limited capacity of those programs, however, is a constraining factor on Milwaukee County's ability to provide housing assistance to Milwaukee's substantial homeless population through Shelter Plus Care.³⁸ Since the Protective Payee program also satisfies the Shelter Plus Care case management requirement, it is possible that additional homeless clients could be co-enrolled in Shelter Plus Care and the Protective Payee program at the time of admission to either program, thus expanding the total number of clients served without increasing TCM or CSP admissions.

In order to do so, Milwaukee County and the Protective Payee agencies would need to seek additional funding from HUD or philanthropic sources for the Shelter Plus Care and Protective Payee programs, or the County would have to identify additional local resources. If additional County resources were identified, of course, then the County also could consider adding additional slots to its TCM or CSP programs. While the prospect of additional HUD funding may be unlikely, the County may determine

³⁸ In 2010, a total of 6,169 unduplicated individuals utilized emergency or transitional housing in Milwaukee: <http://milwaukeeecoc.org/MilwaukeePointinTime2011.pdf>

that use of additional local resources to provide stable housing for additional BHD clients would pay off in the form of reduced inpatient and crisis care costs.

It also may be possible to transition more homeless PATH program clients into the Protective Payee program prior to their entry into a stable housing situation. Those clients potentially could be co-enrolled in Shelter Plus Care as well.

In light of ongoing efforts to expand the availability of Permanent Supportive Housing in Milwaukee County, the County's Housing Division and BHD also may wish to consider whether more clients could be placed in PSH with a level of case management akin to the Protective Payee model or with an even less-intensive service. This may benefit not only the clients, but also Permanent Supportive Housing project developers, who may be more welcoming of potential clients knowing they are part of a Protective Payee-type program.

- **The State of Wisconsin's proposed 1937 Community Recovery Services (CRS) Alternative Benefits Plan offers a potential opportunity for Milwaukee County to offer a new, less intensive level of support for certain Medicaid-eligible individuals.**

The Wisconsin Department of Health Services (DHS) currently is in the process of applying to the federal Centers for Medicare and Medicaid Services (CMS) to obtain a Medicaid waiver that will allow the state to offer counties a new funding and service paradigm for providing community-based supports to certain individuals with mental illness. If the plan – known as CRS – is approved, Milwaukee County may be able to offer the new program as soon as July 2012, which would expand the types of community-based support services that could be reimbursed by Medicaid. Though not case management, CRS provides community living supportive services, supported employment, and peer support services, and would represent a new model of service for Milwaukee residents in need of a lower level of community-based support.³⁹

Because previous iterations of CRS have prohibited enrollment caps (including the 1915(i) benefit currently in place in some Wisconsin counties), Milwaukee County has not implemented those services, largely because it was seen as too risky from a fiscal perspective. The risk involves Medicaid's requirement of a local contribution of approximately 40% of total service costs, which could be applied to thousands of additional clients in Milwaukee County who would seek access to the services. It originally was thought that an enrollment cap would be allowed under the 1937 Alternative Benefits Plan, thus allowing BHD to implement the program for existing clients and expand it for new enrollees as local resources become available. Recently, however, CMS objected to the State's proposed enrollment caps, and it is uncertain whether DHS will challenge CMS on that issue.

³⁹ Wisconsin Department of Health Services: http://www.dhs.wisconsin.gov/MH_BCMH/crs/index.htm

In order to qualify for CRS, clients must be eligible for State Plan Medicaid and must meet income and functional eligibility guidelines.⁴⁰ Clients also must reside at home or in the community, so homeless clients are excluded. As with TCM and CSP, Medicaid would cover approximately 60% of the cost of CRS services and Milwaukee County would be responsible for the remainder.

If a CRS plan eventually is implemented in Milwaukee County, it could help to build capacity at the low end of the service intensity spectrum. Since CRS is not technically case management, it may not be sufficient to meet the requirements for Shelter Plus Care clients, but it could potentially work for Permanent Supportive Housing clients and for TCM clients transitioning down to a lower level of support. Consequently, even without the ability to cap enrollment, County officials may wish to consider whether the expansion of these low-intensity community support services also may have the potential to reduce expenditures on inpatient and crisis care, and whether those savings could exceed the County's 40% share of the cost of the new services.

- **In light of concerns that have been raised regarding the limited capacity and flexibility of BHD's two case management programs, enhancing capacity at the lower-intensity end of the spectrum may be a worthwhile strategy to open up space for those in need and better coordinate provision of the most intensive services.**

HSRI's 2010 report, *Transforming the Adult Mental Health Care Delivery System in Milwaukee County*, found that once a client is enrolled in TCM or CSP, he or she tends to remain there for many years, even if his or her condition changes significantly. This was deemed problematic for those TCM and CSP clients who may no longer require the same level or type of services, as well as for those who might benefit even more from one of the two programs than an existing client but who are denied access due to capacity constraints. Consequently, a key recommendation of the report was to explore providing case management services to a larger population by developing a multi-layered continuum of case management care that is flexible and responsive, moving people to higher and lower levels of care over time, as appropriate.

Research has shown that "intensive case management increases costs if provided to consumers who are not high service users, and that long-term case management is usually unnecessary to maintain consumers in the community."⁴¹ A consistent review of client needs for all case management program clients, along with consideration by BHD of possible expanded partnerships with community agencies to make greater use of the low-intensity support services and case management programs described in this report, could help to ensure that individuals are being served by the most appropriate program and that space is available in the County's highly-intensive CSP program for those with the greatest needs.

⁴⁰ State Plan Medicaid includes Supplemental Security Income (SSI)-related Medicaid, Medicaid for non-SSI elderly, blind, or disabled persons, and BadgerCare Plus (BC+) Standard Plan

⁴¹ HSRI: *Transforming the Adult Mental Health Care Delivery System in Milwaukee County*, October 2010: http://www.hsri.org/files/uploads/publications/Milwaukee_Mental_Health_System_Redesign_Final_Report.pdf

- **Positive and stable relationships between clients and case managers are crucial to achieving the primary goal of any case management program: improved client well-being. The ability to preserve those relationships could be built into a more flexible and well-coordinated system of case management services in Milwaukee County.**

While the above discussion reflects the importance of building flexibility into the case management “system” to allow for changes in the intensity of support provided to clients based on their changing needs, it also is essential to keep in mind that case management is a person-centered, recovery-oriented service. Local mental health professionals stress the importance of developing and maintaining constructive, stable relationships between clients and case managers regardless of the intensity of support being provided. Improved coordination between programs could also allow those relationships to be maintained, as desired by the client, even if he or she shifts between programs.

1 By Supervisor Romo West

2 File No. 12-

3
4 (ITEM) A resolution authorizing and directing the Director, Department of Aging, to
5 work with the Intergenerational Council of the Commission on Aging to promote and
6 expand intergenerational programming in Milwaukee County.

7
8 **A RESOLUTION**

9
10 WHEREAS, intergenerational programming seeks to connect individuals of all
11 ages; and

12
13 WHEREAS, such programming allows for the fostering of understanding between
14 communities of youth and older adults, and often results in mutually enriching
15 relationships; and

16
17 WHEREAS, recent events, including the fatal shooting of a 13-year-old by a 75-
18 year-old neighbor highlight the fragility of relationships between individuals, which can
19 be present within diverse communities like Milwaukee County; and

20
21 WHEREAS, opportunities for individuals to connect with those who are different,
22 and those they may not encounter in typical daily life, allow for the growth of social and
23 emotional skills, empathy, and greater understanding of other's needs; and

24
25 WHEREAS, the Milwaukee County Commission on Aging has a Standing
26 Committee, the Intergenerational Council, which *works to promote and strengthen*
27 *solidarity, support and positive interaction among generations in the community*; and

28
29 WHEREAS, the Intergenerational Council has done a lot of great work, including:
30 creating a dialogue between older adults and youth, teaching youth basic knowledge of
31 growing older, including health issues common among older adults like memory
32 loss/dementia, offering tips for communicating with older adults, and promotion of the
33 "Buddy Program," facilitated by St. Ann's Center for Intergenerational Care, where area
34 middle school youth participate in an in-service project interacting and connecting with
35 older adults; and

36
37 WHEREAS, such programming also exposes youth to health care, which may
38 spark an interest in pursuing career opportunities in the growing field of health care; and

39
40 WHEREAS, it behooves Milwaukee County to expand upon this good work, plan
41 more intergenerational activities throughout Milwaukee County, and increase
42 volunteerism of both groups; now, therefore,

43
44 BE IT RESOLVED, that the Director of the Department on Aging, or her
45 designee, is authorized and directed to work with the Intergenerational Council to

46 facilitate a symposium connecting older adults and the agencies which represent them,
47 with youth and area youth groups; and
48

49 BE IT FURTHER RESOLVED, that in addition to facilitating intergenerational
50 conversations, the symposium should seek to achieve the following:

- 51
- 52 ▪ Seek to expand membership on the Intergenerational Council to additional
53 partner agencies within Milwaukee County
- 54
- 55 ▪ Develop a guide sheet of intergenerational activities
- 56
- 57 ▪ Make recommendations for additional intergenerational programming
- 58
- 59 ▪ Develop evaluation and performance measurement tools for
60 intergenerational programming so that future programming can be
61 'evidence-based'
- 62
- 63 ▪ Reach out to other Milwaukee County departments to brainstorm
64 additional intergenerational program opportunities, including:
65
 - 66 ○ The Department of Family Care
 - 67
 - 68 ○ The Department of Health and Human Services-Delinquency and
69 Court Services Division, and Children's Court to seek cooperation
70 with juvenile delinquency agencies to integrate intergenerational
71 activities into Children's Court programming
 - 72

73 ; and
74

75 BE IT FURTHER RESOLVED, that the Milwaukee County Youth Task Force is
76 authorized and directed to discuss intergenerational programming, and include
77 recommendations for intergenerational programming and opportunities in their
78 September 2012 report; and
79

80 BE IT FURTHER RESOLVED, that the Director, Department on Aging, and the
81 Intergenerational Council shall report back to the County Board on the progress of their
82 efforts via the Committee on Health and Human Needs, beginning in the October 2012
83 meeting cycle; subsequent reports shall be submitted at the direction of the Committee
84 on Health and Human Needs.
85
86
87
88

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: July 2, 2012

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: A resolution authorizing and directing the Director, Department on Aging, to work with the Intergenerational Council of the Commission on Aging to promote and expand intergenerational programming in Milwaukee County.

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact
<input checked="" type="checkbox"/> Existing Staff Time Required
<input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below)
<input type="checkbox"/> Absorbed Within Agency's Budget
<input type="checkbox"/> Not Absorbed Within Agency's Budget
<input type="checkbox"/> Decrease Operating Expenditures
<input type="checkbox"/> Increase Operating Revenues
<input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures
<input type="checkbox"/> Decrease Capital Expenditures
<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> Use of contingent funds |
|--|--|

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

This resolution authorizes/directs the Director of the Department on Aging to work with the Intergenerational Council (a standing Committee of the Commission on Aging) to promote and expand intergenerational programming in Milwaukee County, and to report back to the Board with their recommendations beginning in October 2013.

Milwaukee County Department on Aging staff currently attend meetings of the Intergenerational Council, and offer staff support. This resolution anticipates that that work will continue to be needed.

Department/Prepared By Jennifer Collins, County Board Research Staff.

Authorized Signature

 _____

Did DAS-Fiscal Staff Review? Yes No

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

County of Milwaukee

INTEROFFICE COMMUNICATION

DATE: July 2, 2012

TO: Sup. Marina Dimitrijevic, Chairwomen, Milwaukee County Board of Supervisors
Sup. Peggy Romo West, Chairperson, Committee on Health and Human Needs

FROM: Stephanie Sue Stein, Director, Department on Aging

RE: Request for authorization to increase by \$18,171, from \$49,979 to \$68,150, the Professional Services contract with Jennifer Lefebber to serve as Manager of the Department's two Evidence-Based Prevention programs, and to extend the term of the contract from January 1, through September 30, 2012 to January 1, through December 31, 2012

I respectfully request that the attached resolution be scheduled for consideration by the Committee on Health and Human Needs at its meeting on July 18, 2012.

The attached resolution authorizes the Director, Department on Aging, to increase by \$18,171, from \$49,979 to \$68,150, the Professional Services contract with Jennifer Lefebber to serve as Manager of the Department's two Evidence-Based Prevention programs, and to extend the term of the contract from January 1, through September 30, 2012 to January 1, through December 31, 2012. As required under Chapter 56.30, Milwaukee County Code of Ordinances, the Department is seeking authorization for a Professional Services contract exceeding \$50,000.

The Evidence-Based Prevention programs named "Living Well" and "Stepping On" promotes healthy aging by enabling seniors to proactively manage their health. Living Well (Chronic Disease Self-Management) consists of multiple training sessions presented in community settings. The sessions teach seniors (a) techniques to deal with such problems as fatigue, pain, and isolation, (b) appropriate exercises for maintaining and improving strength, flexibility, and endurance, (c) tips on better nutrition and medication management, and (d) communicating effectively with family, friends, and health professionals on health issues. Stepping On teaches behaviors designed to help seniors (a) reduce the risk of falls, (b) improve balance and gain strength, (c) increase home safety measures, and (d) minimize risks from vision impairments and medication side-effects. Over 1,300 seniors have taken advantage of the evidenced based programs, including 200 Spanish-speaking elders.

Since 2008, the Milwaukee County Department on Aging has executed annual professional services contracts with Jennifer Lefebber to manage the Evidence-Based Prevention programs. Over the last four years, she established networks of trained program leaders and connections with host sites where community training sessions are held. Program leaders are community volunteers certified through training from Ms. Lefebber. The certification program involves classes conducted under structured guidelines. In order to maintain their certification as leaders, the volunteers must pass regular fidelity checks to assure they adhere to program protocols. Efforts to increase the number of program leaders (and host sites) are ongoing in order to provide more opportunities for participation.

July 2, 2012
Sup. Marina Dimitrijevic
Sup. Peggy Romo West
Page 2

Finally, Ms. Lefebber conducts outreach presentations for agencies and the general public and acts as a community information resource for other evidence-based programs. All of these efforts are essential to successful implementation of the Living Well initiative.

The Evidence-Based Prevention programs for 2012 have been funded through a grant from the Arthritis Foundation and from Title III-D of the Older Americans Act.

If you have any questions, please contact me at 2-6876.



Stephanie Sue Stein, Director
Milwaukee County Department on Aging

cc: County Executive Chris Abele
Tia Torhorst
Jennifer Collins
Antionette Thomas-Bailey
Jodi Mapp
Jonette Arms
Nubia Serrano
Mary Proctor Brown
Linda Cieslik
Jennifer Lefebber
Gary Portenier
Pat Rogers

Attachments

RESOLUTION

WHEREAS, programs such as fall prevention and chronic disease self-management helps to promote healthy aging by enabling seniors to proactively manage their own health; and

WHEREAS, since 2006, the Milwaukee County Department on Aging has participated in evidence-based prevention programs funded through grants from state, federal, and health-related organizations; and

WHEREAS, starting in 2008, the Department executed a series of professional service contracts with Jennifer Lefeber to manage the Department's evidence-based prevention programs; and

WHEREAS, the prevention programs managed by Ms. Lefeber include Living Well (chronic disease self-management) and Stepping On (fall prevention); and

WHEREAS, the Department's evidence-based prevention programs had been funded at \$49,979 for the period January 1, through September 30, 2012, providing for 1,497 hours of service from Ms. Lefeber; and

WHEREAS, funding has since increased \$18,171 to \$68,150 for the period January 1, through December 31, 2012, providing for 1,947 hours of service from Ms. Lefeber; and

WHEREAS, Chapter 56.30, Milwaukee County Code of Ordinances, requires County Board authorization for professional services contracts totaling \$50,000 or more; now, therefore

BE IT RESOLVED, that the Director, Department on Aging, is hereby authorized to execute an amended professional services contract with Jennifer Lefeber totaling \$68,150 to manage evidence-based prevention programs for the period January 1, through December 31, 2012.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: July 2, 2012

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: Request for authorization to increase by \$18,171, from \$49,979 to \$68,150, the Professional Services contract with Jennifer Lefeber to serve as Manager of the Department's two Evidence-Based Prevention programs, and to extend the term of the contract from January 1, through September 30, 2012 to January 1, through December 31, 2012

FISCAL EFFECT:

- | | |
|---|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact | <input type="checkbox"/> Increase Capital Expenditures |
| <input checked="" type="checkbox"/> Existing Staff Time Required | <input type="checkbox"/> Decrease Capital Expenditures |
| <input checked="" type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below) | <input type="checkbox"/> Increase Capital Revenues |
| <input checked="" type="checkbox"/> Absorbed Within Agency's Budget | <input type="checkbox"/> Decrease Capital Revenues |
| <input type="checkbox"/> Not Absorbed Within Agency's Budget | |
| <input type="checkbox"/> Decrease Operating Expenditures | <input type="checkbox"/> Use of contingent funds |
| <input checked="" type="checkbox"/> Increase Operating Revenues | |
| <input type="checkbox"/> Decrease Operating Revenues | |

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	18,171	
	Revenue	18,171	
	Net Cost	0	
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. ¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

The attached resolution authorizes the Director, Department on Aging, to increase by \$18,171, from \$49,979 to \$68,150, the Professional Services contract with Jennifer Lefeber to serve as Manager of the Department's two Evidence-Based Prevention programs, and to extend the term of the contract from January 1, through September 30, 2012 to January 1, through December 31, 2012. As required under Chapter 56.30, Milwaukee County Code of Ordinances, the Department is seeking authorization for a Professional Services contract exceeding \$50,000.

The Evidence-Based Prevention programs for 2012 have been funded through the Older Americans Act and a grant from the Arthritis Foundation.

This resolution has no fiscal impact on 2012 other than the allocation of staff time required to prepare the accompanying report and resolution.

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Gary W. Portenier, Program Planning Coordinator, Department on Aging



Authorized Signature _____

Did DAS-Fiscal Staff Review? Yes No

COUNTY OF MILWAUKEE
Department of Health and Human Services
INTER-OFFICE COMMUNICATION

DATE: June 19, 2012

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by B. Thomas Wanta, Interim Administrator/Chief Intake Officer – DCSD

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to use the Juvenile Detention Facility as a Short-Term Dispositional Placement as Allowed by State Statutes

Issue

In March 2012, the Department of Health and Human Service (DHHS) - Delinquency and Court Services Division (DCSD) submitted an informational report to the Board related to the status of regional considerations for short-term secure placement options. The Director, DHHS, is now returning to the Board to request authorization to implement a short-term secure placement program within the Milwaukee County Secure Detention Center - juvenile facility as a dispositional placement option for the circuit courts.

Background

The 2011 – 2013 State Budget (Act 32) contains statutory language changes that would allow a juvenile court the ability to place a youth in a local secure detention facility for a period of up to 180 days, if authorized by a county board of supervisors. Prior to Act 32, the juvenile court was limited to a period of up to 30 days, if authorized by a county board of supervisors. In addition to county board approval, placement of a youth adjudicated delinquent in a local secure detention facility beyond 30 days “...the county department shall offer the juvenile alcohol or other drug abuse treatment, counseling, and education services...” as required by the newly created statutory language.

State-wide, and consistent with many national trends, the juvenile justice system has experienced a continuous decline in delinquency referrals. Milwaukee County has seen a decrease in police referrals of approximately 50% since 2000. State Juvenile Correctional placements have decreased State-wide to the point that the State officially closed both the State juvenile correctional facilities operated in Southeastern Wisconsin in July 2011. All secure correctional placements now result in youth being placed at facilities in Irma, Wisconsin. Concurrently, locally operated secure detention facilities have experienced similar trends in their average daily populations as recently highlighted in a Public Policy Forum Research Brief.¹ In 2006, the average daily population for the Milwaukee Juvenile Detention facility was 102 compared to an average daily population of 88 in 2011.

¹ Milwaukee County Detainee Populations at Historic Lows; Public Policy Forum, <http://www.publicpolicyforum.org/pdfs/MilwaukeeCountyDetentionBrief>.

This changing population environment and the recent changes contained in Act 32 have resulted in increasing discussion involving the ability to sustain local detention center operations in light of fiscal challenges and emerging alternatives for repurposing such facilities. For example, La Crosse County has recently started a short-term detention program in their detention facility. Racine has operated a local secure placement utilizing the Racine juvenile detention center since 2003. It is this program, known as Alternatives to Corrections through Education program (ACE), which created informed the language change that was eventually adopted in Act 32.

As mentioned in previous reports, it is important to note that any short-term local secure option is really just one of three important phases – Secure Placement, Transition and Reentry. A key best practice to any removal from the community is that reentry planning begins at the time of initial placement. The primary reasons driving this decision are:

- All youth will return to their community necessitating continued and uninterrupted involvement and support
- Maintaining local control and proximity to community and family members
- Improved reentry service capacity by using local providers and reach-in services
- Maintaining local school systems for educational programming continuity
- Leveraging of existing resources and access to other revenue streams
- Reduction of risk potential associated with trial visits
- Improved oversight of entire service provision, including placement through reentry.

Discussion

In 2010, DCSD experienced 138 youth that were placed in State Corrections. This does not include another 13 youth that were deemed Serious Juvenile Offenders (SJO). As originally conceived in 2009, this alternative option would target non-SJO youth who are at risk for State Corrections and did not have a re-offense. In 2010, this subpopulation represented 28% (n=39) of the placements. This would result in an average of three youth per month if all youth we deemed appropriate for this placement option.

DCSD feels strongly that only those youth identified as “high risk” should be included in the program. The challenge of any alternative program design is ensuring that the proper controls are in place so that only appropriate placements are made, given the intent and design of the program. To determine risk levels for potential youth referred to the program, we will use the Youth Assessment and Screening Instrument (YASI), DCSD’s new validated risk assessment instrument that identifies criminogenic needs as well as protective factors. The Division recently trained all intake and probation staff in the YASI and began implementation of the YASI in May 2012.

DCSD has taken many steps in preparation of implementing a Milwaukee secure-detention option, including:

- Filling vacant funded Human Service Worker positions (anticipated by August 2012)

and a Human Service Worker supervisor position (anticipated July 2012)

- Training staff and community providers in Cognitive Programming and Intervention practices
- Continuing efforts to implement YASI to ensure proper assessment/target population control.
- Considering expansion of Targeted Monitoring Program and or explore electronic monitoring as needed to ensure proper reentry supervision

The key components of the short-term dispositional placement program include:

- Education
- Targeted Monitoring
- Cognitive Programming and Intervention
- Restorative Justice
- Individual AODA Services
- Family Counseling
- Electronic Monitoring

Attachment A provides greater detail about proposed educational programming to be provided by Wauwatosa School District within the detention center. Attachment B provides an overview of the proposed Targeted Monitoring services and Cognitive Programming and Intervention services to be provided by Running Rebels Community Organization.

As described above, youth who continue to present problematic behaviors resulting in a return to court and have already been found to be in need of more restrictive care would be targeted for the pilot. As an alternative to placement with State Corrections, youth would be placed in the secure detention facility for a period not to exceed five months with judicial progress review every 60 days. Services would be delivered based on an individualized case, integrating areas identified through the youth's assessment. To the extent possible, services will be provided that will also continue during transition and reentry to the community. In the event that a youth is in need of a more graduated transition, an existing alternative placement may be utilized. DCSD is also recommending that electronic monitoring is provided as a means of mitigating risk and ensuring public safety. Lastly, DCSD, through emerging information sharing collaborations with law enforcement would work in partnership to ensure all reasonable measures are taken to ensure public safety and success.

In order to fully support these efforts and promote success, DCSD will explore additional technical assistance and, possibly, professional services funding, resulting in improved systems planning and outcomes. Bringing in experts can help jumpstart and maintain momentum as well as provide lessons learned from other jurisdictions including change action planning, layered staff and provider training and system quality improvement efforts.

Recommendation

It is recommended that the County Board of Supervisors authorize the Circuit Courts the ability to place a youth in the Milwaukee County Secure Detention Center facility for a period of up to

180 days.

Fiscal Impact

This initiative has the potential to save funds in the future by avoiding costly State Corrections placements. Due to the nature of the pilot and some upfront investments, DHHS is anticipating no tax levy impact for 2012. A fiscal note form is attached.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Kelly Bablitch, County Board
Pat Farley, Director – DAS
Craig Kammholz – Fiscal & Budget Administrator - DAS
CJ Pahl, Assistant Fiscal and Budget Administrator – DAS
Antoinette Thomas-Bailey, Fiscal and Management Analyst – DAS
Jennifer Collins, County Board Staff
Jodi Mapp, County Board Staff
Judge Marshall Murray, Presiding Children's Court

1
2
3
4 (ITEM *) Report from the Director, Department of Health and Human Services,
5 Requesting Authorization to use the Juvenile Detention Facility as a Short-Term
6 Dispositional Placement as Allowed by State Statutes by recommending adoption of the
7 following:

8
9 **A RESOLUTION**

10
11
12 WHEREAS, in March 2012, the Department of Health and Human Service
13 (DHHS) - Delinquency and Court Services Division (DCSD) submitted an informational
14 report to the Board related to the status of regional considerations for short-term secure
15 placement options and is now returning to the Board to request authorization to
16 implement a short-term secure placement program within the Milwaukee County Secure
17 Detention Center - juvenile facility as a dispositional placement option for the circuit
18 courts; and

19
20 WHEREAS, the 2011 – 2013 State Budget (Act 32) contains statutory language
21 changes that would allow a juvenile court the ability to place a youth in a local secure
22 detention facility for a period of up to 180 days, if authorized by a county board of
23 supervisors; and

24
25 WHEREAS, State-wide, and consistent with many national trends, the juvenile
26 justice system has experienced a continuous decline in delinquency referrals and
27 Milwaukee County has seen a decrease in police referrals of approximately 50% since
28 2000; and

29
30 WHEREAS, State Juvenile Correctional placements have decreased State-wide
31 to the point that the State officially closed both the State juvenile correctional facilities
32 operated in Southeastern Wisconsin in July 2011 and all secure correctional
33 placements now result in youth being placed at facilities in Irma, Wisconsin; and

34
35 WHEREAS, this changing population environment and the recent changes
36 contained in Act 32 have resulted in increasing discussion involving the ability to sustain
37 local detention center operations in light of fiscal challenges and emerging alternatives
38 for repurposing such facilities; and

39
40 WHEREAS, youth who present problematic behaviors resulting in a return to
41 court and have already been found to be in need of more restrictive care would be
42 targeted for the pilot; and

43
44 WHEREAS, as an alternative to placement with State Corrections, youth would
45 be placed in the secure detention facility for a period not to exceed five months with

46 judicial progress review every 60 days and services would be delivered based on an
47 individualized case, integrating areas identified through the youth's assessment; and
48

49 WHEREAS, DCSD, through emerging information sharing collaborations with law
50 enforcement would work in partnership to ensure all reasonable measures are taken to
51 ensure public safety and success.
52

53 WHEREAS, this initiative has the potential to save funds in the future by avoiding
54 costly State Corrections placements but due to the nature of the pilot and some upfront
55 investments, DHHS is anticipating no tax levy impact for 2012; now, therefore,
56

57 BE IT RESOLVED, that the Director, Department of Health and Human Services
58 and the Delinquency and Court Services Division Administrator are directed to
59 implement alternative local secure placement options for adjudicated youth in
60 Milwaukee County; and
61

62 BE IT FURTHER RESOLVED that the County Board of Supervisors authorizes the
63 Circuit Courts to place youth into the Milwaukee County Secure Detention Center facility
64 as a dispositional order for a period not to exceed 180 days pursuant to Wisconsin State
65 statute 938.06(5).
66
67

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 6/19/12

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to use the Juvenile Detention Facility as a Short-Term Dispositional Placement as Allowed by State Statutes

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact
<input checked="" type="checkbox"/> Existing Staff Time Required
<input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below)
<input type="checkbox"/> Absorbed Within Agency's Budget
<input type="checkbox"/> Not Absorbed Within Agency's Budget
<input type="checkbox"/> Decrease Operating Expenditures
<input type="checkbox"/> Increase Operating Revenues
<input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures
<input type="checkbox"/> Decrease Capital Expenditures
<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> Use of contingent funds |
|--|--|

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A) In March 2012, the Department of Health and Human Service (DHHS) - Delinquency and Court Services Division (DCSD) submitted an informational report to the Board related to the status of regional considerations for short-term secure placement options. The Director, DHHS, is now requesting authorization to implement a short-term secure placement program within the Milwaukee County Secure Detention Center - juvenile facility as a dispositional placement option for the circuit courts.

B) DCSD has been planning for this initiative and has made some up front investments in training and technology to help make this possible. Staffing will be covered by existing staff that will be shifted to provide these services and existing contract slots will be dedicated to this service. This initiative has the potential to save funds in the future by avoiding costly State Corrections placements but, due to the nature of the pilot and some additional upfront investments, DHHS is anticipating no tax levy impact for 2012. This initiative was included in the DHHS 2013 Requested Budget and it is anticipated that savings will be realized in that year.

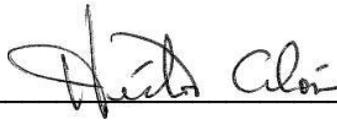
C) There is a no tax levy impact as a result of this action as all costs are included in the 2012 DCSD budget and future savings are also accounted for the the 2013 Requested Budget.

D. No assumptions/interpretations.

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Alexandra Kotze, DHHS Budget Manager

Authorized Signature

A handwritten signature in black ink, appearing to read "Alexandra Kotze", written over a horizontal line.

Did DAS-Fiscal Staff Review?

Yes

No

**Milwaukee County Short-Term Secure Placement Program:
A Proposal for Providing the Education Component by the Wauwatosa School District**

(DRAFT - SUBJECT TO CHANGE)

Proposal

General Background

The Wauwatosa School has a long history and serves a unique role in educating students who reside in out of home placement in one of four facilities located in Wauwatosa, serving students who are hospitalized (2 facilities – medical and psychiatric), residing in temporary shelter, residing in a residential treatment program, or residing in the juvenile detention center while awaiting a disposition from the court. The district began serving the Milwaukee County Children’s Home School (now known as Plank Road School) around 1971; the River Hills School at the Milwaukee County Child and Adolescent Treatment Center in 1977; Children’s Hospital of Wisconsin in 1989; and the Milwaukee County Juvenile Detention Center School in 1995.

All schools offer an educational program, consistent with Department of Public Instruction requirements and beyond, during the school year (188 days) and a six-week summer session.

Detention Center School Standard Programming:The school at the detention center offers classes in reading and English, mathematics, social studies, science, physical education/health and art. All students receive instruction in English/reading and mathematics. Classes are staffed with two teachers per class, allowing students to receive the individualized assistance they need. Students attend class five periods per day. Because students come to class based on their assigned living unit, classes contain students with a wide range of age and academic levels, thus differentiation of instruction is a necessary skill for teachers in this facility to possess and use on a daily basis. Grades are given for work completed in this facility, and academic credit is issued when students attend school for at least 45 days and successfully complete assigned work for the course. When students are enrolled in the facility’s school for an extended period of time, school staff may work with the student’s home school to obtain assignments, allowing students to move forward in the course in which s/he was enrolled prior to admission to the facility.

General Program Description

Credit Recovery - Results of 2011-12 Virtual Pilot Program

At the start of the 2011-12 school year, the Wauwatosa School District piloted virtual courses for a few students who were credit deficient. We enrolled students from both Detention Center School and Plank Road School.

At the time of this narrative, 15 **Plank Road School** students have completed individual courses with a majority number receiving passing grades and earning high school credits.

Students returning to their community schools were in a better position to graduate due to earning credits from standard Wauwatosa programming and credits earned from taking credit recovery virtual courses.

Due to the very short duration of time that the average student spends at **Detention Center School**, 7-10 days, we were not able to run the pilot successfully at that location.

Summary of Request For Detention Center School for Students in the Proposed Short-Term Secure Placement Program

2012 - 13 Virtual Courses Offered

The Wauwatosa School District would like to make the greatest use of our students' 180-day court disposition by engaging this population with virtual course programming. In addition to having a Wauwatosa Teacher assist them in class, we will also have content teachers available, online 24 hours per day, five days per week. Our desire is to replicate the success we have achieved with our virtual programming at Plank Road Schools.

Each student picked for virtual programming would have:

1. At least a 6th grade reading level.
2. Probable length of stay of 180 days.
3. Enrolled in one virtual course (which in itself will be accelerated) with the goal of completing two course per semester in addition to attending either afternoon or morning classes within the regular Detention Center School curriculum.

Need Within the Community

The enrollment at the Detention Center School includes a larger population of students with disabilities than typical in the general school population. While most school districts report a population of students with disabilities of about 11- 15% of the school enrollment, at the detention center and Plank Road School, on any given day, anywhere from 35 – 60% of the students enrolled have IEPs. Of the students with IEPs, a recent review indicates the majority of them are for severe emotional/behavioral disabilities (EBD) or other health impairment (OHI). Of those whose disability is described as OHI, the majority include attention deficit disorder (ADD). It is, therefore, not surprising that many of our students have been unsuccessful in their previous school environments; with a fair number not attending at all. For some students, virtual programming can be positive, preferable alternative to conventional courses because the students find the experience less distracting. For many, socializing at school has not been productive.

Best educational practice and common sense would suggest that with such a wide, diverse range of struggling learners, we need to offer a variety of differentiated educational opportunities. We believe that virtual programming is a very logical, viable option.

Implementation Agreement

Milwaukee County will:

- Determine and agree upon student admission criteria in consultation with Detention Center School.
- Select student candidates that fulfill said criteria.
- Provide location (West 3) and Juvenile Correction Staffing.

Wauwatosa School District will:

- Review student transcript to determine best course selection for credit recovery.
- Schedule students with a goal of combining virtual course(s) with three or four standard classes.
- Assign one teacher to the virtual school.
- Provide connectivity and computers for student usage while here.
- Provide follow-up services via virtual courses until student exits the program and/or is reassigned to a new district.

Evaluation

1. Reports of student status and credits earned will be reported to the Administrator of Delinquency and Court Services Division and to the Superintendent of Milwaukee County Secure Juvenile Detention Center at the end of each semester.
2. In addition, the aforementioned administrators will also receive weekly student progress reports which would list current student grade and percentage of course completion.

**Milwaukee County Short-Term Secure Placement Program:
A Proposal for Providing the Targeted Monitoring Program Component**

Developed in Collaboration with Running Rebels Community Organization

(SUBJECT TO CHANGE)

The core components of Targeted Monitoring provided to participants in the short-term secure placement program include:

1. MONITORING

Monitoring services will be provided by Running Rebels Community Organization to participants while in detention, during home passes, and while placed at home (in the form of school visits, home visits, calling schedule, and curfew checks). The level of monitoring will vary according to the program phase (see #5 below).

The assigned Running Rebels worker (“monitor”) will:

- Be available 24/7
- Respond to crisis when the client is in detention up until 9pm
- Respond to crisis at any given time while the client is in the community
- Appear for all scheduled court hearings
- Provide to the probation agent weekly documentation and weekly phone contacts for updates
- Provide to the client transportation to any Running Rebels programming
- Expose the client to supplemental services at Running Rebels (job prep, tutoring, music program, etc.)
- Have weekly communication with the caregiver while the client is on pass or placed at home

2. JUVENILE COGNITIVE INTERVENTION PROGRAM (JCIP)

JCIP is an evidence-based core group treatment program for juvenile offenders.

- Phase 1 (“Choices”) focuses on the tools needed to make choices that lead to desired outcomes in high-risk situations.
- Phase 2 (“Changes”) prepares the youth to continue on the path of creating changes in his/her behavior by continuing to utilize the skills developed in Phase 1. The focus is placed on identifying and changing the beliefs that lead to unwanted thinking patterns.
- Phase 3 (“Challenges”) is conducted in the community and reinforces the lessons learned in prior phases and focuses on specific reentry challenges.

Phases 1 and 2 will be provided during months 1-5 while the youth is in detention. Groups will be conducted by a Running Rebels facilitator that visits each week day.

Phase 3 will be completed individually with the JCIP trained monitor when the youth is in the community.

3. PRE-RELEASE ASSESSMENT

A pre-release assessment will occur two weeks prior to the projected release date with the program director, supervisor, assigned monitor, JCIP facilitator, and a Juvenile Correctional Officer representative that has had direct engagement with the youth. The purpose of the pre-release assessment is to gauge youth strengths and challenges to reentry, and to evaluate the youth’s readiness for release.

4. INCENTIVES / RECOGNITION OF PROGRESS

Progress at certain milestones will be recognized, such as the following:

- An incentive or recognition of progress by taking the client out for an activity or celebration one day prior to release to send a positive message to both the client and other detained youth participating in the program. The youth is being rewarded for reaching a level that allows for transition out of secure detention. This gesture is viewed to encourage cooperation and created positive dialogue surrounding compliance following detention release.
- Upon completion of the order, the client will receive special acknowledgement in the form of a certificate and a group or individual celebration.

5. A PHASE APPROACH

Months 1 – 5 (Detention)	Months 6 & 7 (Community)	Months 8 & 9 (Community)	Months 10 – 12 (Community)
Phases 1 & 2 of JCIP	Daily school visits	School visits 3 physical days per week and 2 by phone	School visits 2 physical days a week and 1 visit on weekend and others by phone
Monitor will visit at least 2 times per week and once on the weekend. Occasionally will observe JCIP	Home visits 7 days a week	Home visits 4 days a week including 1 on weekend	Home visits 3 days a week, including 1 on weekend
Monitored weekend passes after a minimum of 4 months and/or assessment	Calling schedules occurring every 4 hours and/or if client departs placement	Calling schedules occurring every 4 hours and/or if client departs placement	Calling schedules occurring every 4 hours and/or if client departs placement
Pre-release assessment two weeks prior to projected release date	Daily curfew checks (established at 9 pm, 7 days a week)	Daily curfew checks (established at 9 pm, 7 days a week)	Daily curfew checks (established at 9 pm, 7 days a week)
Outing one day prior to release to recognize progress	JCIP 3 implemented individually with JCIP trained monitor	JCIP 3 implemented individually with JCIP trained monitor	JCIP 3 will continue to conclusion

Advancing to the next phase once the youth is released will be based on compliance with monitoring and other requirements. In the event of non-compliance, action plans will be handled by the probation officers. Additional action plans will be developed by probation officers for those clients that are in the community and are required to return to detention for lack of cooperation.

Date : July 2, 2012
To : Supervisor Peggy West, Chair, Health and Human Needs Committee
From : Chris Lindberg, Chief Information Officer, IMSD
Subject: Informational Report: Electronic Medical Records System for the Department of Human Services, Behavioral Health Division

BACKGROUND

The Information Management Services Division (IMSD) collaborated with the Department of Human Services Behavioral Health Division (BHD) and the Milwaukee County Office of the Sheriff (MCSO) to select an Electronic Medical Records (EMR) system for BHD, and if required, meet the future business need of MCSO.

The EMR project began in August of 2010 with the selection of the Joxel Group, LLC, (TJG) for project management services. Throughout the remainder of 2010 and into third quarter of 2011, business requirements were gathered, a request for proposal issued and the vendor selection process conducted. In conjunction with IMSD, the Department of Administrative Services (DAS) and TJG, BHD selected Netsmart's Avatar product as the Electronic Medical Records system to manage the clinical and financial needs of the business. In September 2011, approval was granted by the County Board of Supervisors and the County Executive to execute the contract with Netsmart Technologies for the EMR.

This report is intended to provide an informational update on the progress of the EMR project and the anticipated phases to complete the project.

ANTICIPATED PROJECT PHASES

The EMR project is broken down into the following four (4) phases:

- Phase 1 - Planning and Design (Complete)
- Phase 2 - RFP Process and Vendor Selection (Complete)
- Phase 3 - Implementation (In process)
- Phase 4 - Closeout and Audit

CURRENT PROJECT STATUS – PHASE 3: IMPLEMENTATION

Phase 3 – Implementation deals with the execution of the Avatar software at BHD. With the complexity of the implementation process and the anticipated change management that this software could bring within BHD, the management and implementation team decided to break the project down in multiple stages of implementation.

- Stage 1 – involves implementing the EMR software to the Crisis business along with some electronic capability to the Acute and Operated Community Services Branch, which constitutes the Community Services Programs as well as Day Treatment. Anticipated completion of Stage 1 is October, 2012.
- Stage 2 – involves implementing the full functionality of the EMR software to the

Acute, Operated Community Services Branch along with Long-term Care. Anticipated completion of Stage 2 is by the second quarter of 2013

- Stage 3 – involves implementing the EMR software to the Operated Community Service Programs. Anticipated completion of Stage 3 is December, 2013.

STAGE 1: Stage 1 of implementation started with the development of an integrated project plan between the Netsmart and the BHD Project Implementation Team, which consists of resources from TJG and assistance from IMSD, as needed. This plan is reviewed on a weekly basis between both teams to ensure that activities and tasks are being addressed and monitored effectively. The team has established various committees to ensure all participants within BHD and outside of BHD are involved in the implementation process and are well informed of accomplishments, challenges, and overall project status. The current committees are as follows:

- Operations Committee – this group consists of BHD directors or designees from Crisis, Acute, and Operated Community Services Branch as well as IMSD.
- Validation Committee – this group consists of administrators, nursing, physicians, psychiatrists, case workers, quality improvement personnel, etc who are actively involved in the decision making process of the system as well in the validation of the new system to BHD.
- Internal Oversight Committee – this group consists of leadership as well as designees from BHD, IMSD, DAS, the Department of Audit and the County Board.

Stage 1 is on track to be complete by October, 2012. A high level status of the project is summarized as follows:

Project Name	BHD EMR Project Implementation	Project Sponsor	Paula Lucey
Project Manager	Sushil Pillai	Overall Project Health	On Track
Project Start Date	January 1, 2012	Expected Completion of all Stages	December 2013
Project Description	Start the EMR Implementation Project in a phased approach to enable an EMR system for BHD that encompasses the Inpatient, Crisis Management, Admissions and Billing, Adult Community Services and Long-term Care.		
Reporting Period	June 2012		
All Stages Project Timeline	<div style="display: flex; align-items: center;"> 0% <div style="flex-grow: 1; position: relative;"> <div style="background-color: green; width: 21%; height: 15px; position: absolute; top: -15px;"></div> <div style="border: 1px solid black; width: 100%; height: 15px; position: absolute; top: 15px;"></div> </div> 100% </div> <p style="text-align: center; margin-top: 5px;">21% Complete</p>		
Significant Accomplishments	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Initial billing process validation has been conducted. The training process was also completed but we will need to wait for a second pass. <input checked="" type="checkbox"/> Data conversion mapping has been completed along with the Balance Forward discussion. We understand the requirements on most aspects of conversion. The 		

	<p>areas that still need discussion are: legal status, level of diagnosis, and financial eligibility.</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> State reporting requirements have been submitted to Netsmart. Initial review of the reports mapping between BHD needs and available system reports have been completed. Netsmart is working with the development team right now, if there are issues, they will contact us. <input checked="" type="checkbox"/> Pyxis test environment has been installed. The interface mapping document has been reviewed by both BHD and CareFusion, there are still some issues which is being addressed by Netsmart.
Key Challenges	<ul style="list-style-type: none"> ➤ Environment issues are causing slowdowns in development effort. ➤ Still rationalizing mapping issues between CareFusion and Netsmart. ➤ System and infrastructure needs are being assessed to determine timeline and budget impacts.
Key Decisions Made	<ul style="list-style-type: none"> ➤ Interfaces will be prioritized and rolled out in a separate track. ➤ Scanning will also be rolled out in a separate track. ➤ Currently there are no GL integration requirements in Phase 1. This process and requirements will be revisited in Phase 3 and a go-forward plan for this will be documented.

Overall Project Status



BHD EMR Implementation



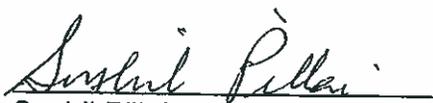
- PM – Admissions process are near completion. Once the environment issues are resolved, this can be completed.
- PM – Billing training was conducted, however, we are requesting an additional session to ensure the complete validation takes place. Netsmart is planning to update the dictionary values in the build environment so that we can complete the validation.
- CWS – Modeling has been slowed down because of environment issues. Progress notes have been built in the build environment. We have validated all Assessment, letters, and other clinical documents with BHD and once the environment issues are addressed, we will start configuring this in the build environment.
- Conversion – Mapping document is complete. We are still validating the extent of information pull for legal status, diagnosis, and financial viability.
- Interface – Pyxis test environment has been installed and communication between IMSD and Netsmart Technical is on-going. We are rationalizing interface mapping between Netsmart and CareFusion. Once that is done, development will build the interface for us to test.
- Reports – Reports mapping between needs and system are near completion. State reporting requirements have been submitted to Netsmart. Their review is completed and they are currently working with development to get reports ready for go live.
- Systems and Network Technical – Requirements are completed. A plan along with action steps is in progress.

Informational reports will be submitted to the Committee of Health and Human Needs on a quarterly basis unless otherwise directed by the committee.

RECOMMENDATION

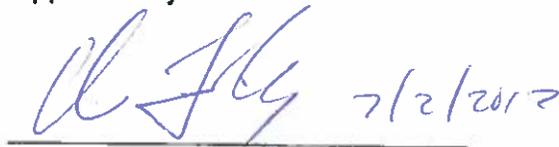
The Director of Behavioral Health Division and the Chief Information Officer respectfully requests this report to be received and placed on file.

Prepared by:



Sushil Pillai
The Joxel Group, LLC

Approved by:



Chris Lindberg
Chief Information Officer, IMSD

cc: County Executive Chris Abele
Amber Moreen, Chief of Staff, County Executive's Office
Chairperson, Marina Dimitrijevic, County Board of Supervisors
Nikiya Harris, Vice Chairperson, Health and Human Needs Committee
Kelly Bablitch, Chief of Staff, County Board of Supervisors
Patrick Farley, Director, Department of Administrative Services
Hector Colon, Director, Health and Human Services
Jeanne Dorff, Deputy Director, Health and Human Services
Paula Lucey, Director, Behavioral Health Division
Jennifer Collins, Health and Human Services Research Analyst
Jodi Mapp, Health and Human Services Committee Clerk
Alexandra Kotze, Fiscal and Management Analyst, Behavioral Health Division
Sushil Pillai, The Joxel Group, LLC

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: June 19, 2012

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by: Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: From the Director, Department of Health and Human Services, Requesting Permission for Milwaukee County to be Added to the State of Wisconsin - Department of Health Services Medicaid State Plan Amendment for Community Recovery Services

Issue

Milwaukee County currently provides Community Support Programs (CSP) as its only psychosocial rehabilitation benefit for Medicaid eligible individuals. Targeted Case Management (TCM) is also available to a “targeted” population of persons with a severe and persistent mental illness and all individuals within that group are eligible to receive that service. CSP is the most comprehensive and intensive community treatment service model and TCM provides primarily referral and monitoring services that include coordination of community-based services. There is a very wide clinical gap between these two services, and for the past few years the Behavioral Health Division (BHD) has been exploring the addition of another psychosocial rehab benefit to smooth the transition between CSP and TCM and create a “ramp” instead of a very large step down in service intensity and delivery. This report is requesting permission to take the first step toward adding Community Recovery Services (CRS) to the array of community services BHD provides.

Background

In 2010, the Health and Human Needs (HHN) Committee heard an informational report from BHD on the benefits and concerns of adding a new CRS, 1915(i), to the continuum of community-based services. This was also at the time when 1915(i) became an entitlement due to the introduction of the Affordable Care Act (ACA) instead of a “capped” Medicaid benefit as it was originally conceived. The entitlement aspect of this benefit led the HHN committee to request further exploration by BHD on ways of limiting the county’s fiscal exposure due to the potential high number of eligible individuals within the county. Because the ACA made CRS an entitlement, the State Department of Health Service (DHS) proposed moving CRS from a 1915(i) waiver to a § 1937 Benchmark Plan via a state plan amendment (SPA) of the Wisconsin Medicaid plan. Since the ACA eliminated the enrollment caps and geographic targeting, a § 1937 Benchmark Plan can potentially add both back. DHS has requested that interested counties submit a letter to them indicating their desire to be included in CRS by July 1, 2012.

A § 1937 Benchmark SPA was submitted by DHS in November 2011 and is currently undergoing revisions for submission to the Centers for Medicaid and Medicare (CMS) services later in July 2012. The State is holding their SPA until after the July HHN Committee meeting to determine if Milwaukee County will be participating in CRS. Some of the differences between the original 1915(i), Post ACA 1915(i) and the § 1937 Benchmark SPA are listed below:

1915(i) Classic	Post – ACA 1915(i)	Proposed CRS 1937 Benchmark Plan
Enrollment Caps	No Enrollment Caps	Enrollment Caps*
Geographic Opt-out	Statewide	Geographic Opt-in
Children & Adults	Children & Adults	Age 14 & Older
<= 150% FPL	<= 150% FPL	<= 150% FPL
CCS Functional level	COP Functional level	CCS or COP Functional level**
Rehabilitative and Habilitative Services	Rehabilitative and Habilitative Services	Rehabilitative Services only

*Unresolved with CMS.

**Will be based on participating county consensus and may be contingent upon CMS’ decision regarding enrollment caps.

Note: “Rehabilitative” services is the process of relearning skills lost through disease or injury, versus “Habilitative” services, the process of acquiring new skills.

Discussion

Approximately 7,000 clients are receiving community-based mental health or substance use disorder services on a daily basis from BHD in Milwaukee County. Initial estimates identified 1,760 current BHD clients that meet the criteria for CRS. Due to the high number of individuals eligible for this benefit, administering CRS is very similar to a managed care program like Family Care. There is an automatic risk reserve statutorily allowed for Family Care yet nothing similar for psychosocial rehabilitation benefits. In May, 2012 the BHD Administrator, BHD staff and Milwaukee County stakeholders met with the State Department of Health Services Administrators from the Divisions of Health Care Access and Accountability and Mental Health and Substance Abuse Services to discuss ways to reduce the County’s fiscal exposure by adding an additional psychosocial rehab benefit and there was a willingness from the State to work with Milwaukee County to address these concerns. Ideas include the development of a risk reserve similar to Family Care. A letter requesting the establishment of a risk reserve was sent to Department of Health Services Secretary Dennis G. Smith (see attached). Obviously, the County Board needs to provide us with approval before moving forward with this program, but we wanted to get some assurance from the State to allow us to set-up a reserve to help mitigate our financial exposure if the board gives grants us authority to move forward.

In addition, the Mental Health Redesign Task Force has recommended strengthening community services and pursuing CRS is a step in that direction. CRS adds a service array that doesn't currently exist by including Supported Employment, Community Living Supportive Services, and using peers as providers. Implementing CRS allows BHD to move the model from sustaining care to a recovery-oriented system of care. In addition, it begins the creation of a true continuum of care in community-based services and adds needed services for clients currently participating in CSP and TCM and creates a recovery path.

Recommendation

It is recommended that the County Board of Supervisors authorize the Director, DHHS, or his designee, to allow Milwaukee County to be added to the State of Wisconsin - Department of Health Services Medicaid State Plan Amendment for Community Recovery Services.

Fiscal Effect

There is no direct tax levy impact related to this action. A fiscal note form is attached.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Kelly Bablitch, County Board
Pat Farley, Director – DAS
Craig Kammholz – Fiscal & Budget Administrator - DAS
CJ Pahl, Assistant Fiscal and Budget Administrator – DAS
Antoinette Thomas-Bailey, Fiscal and Management Analyst – DAS
Jennifer Collins, County Board Staff
Jodi Mapp, County Board Staff

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(ITEM *) Report, From the Director, Department of Health and Human Services, Requesting Permission for Milwaukee County to be Added to the State of Wisconsin - Department of Health Services Medicaid State Plan Amendment for Community Recovery Services by recommending adoption of the following:

A RESOLUTION

WHEREAS, Milwaukee County currently provides Community Support Programs (CSP) as its only psychosocial rehabilitation benefit for Medicaid eligible individuals; and

WHEREAS, Targeted Case Management (TCM) is also available to a “targeted” population of persons with a severe and persistent mental illness and all individuals within that group are eligible to receive that service; and

WHEREAS, there is a very wide clinical gap between these two services, and for the past few years the Behavioral Health Division (BHD) has been exploring the addition of another psychosocial rehab benefit to smooth the transition between CSP and TCM and create a “ramp” instead of a very large step down in service intensity and delivery; and

WHEREAS, in 2010, the Health and Human Needs (HHN) Committee heard an informational report from BHD on the benefits and concerns of adding a new CRS, 1915(i), to the continuum of community-based services; and

WHEREAS, the HHN committee to request further exploration by BHD on ways of limiting the county’s fiscal exposure due to the potential high number of eligible individuals within the county; and

WHEREAS, the State Department of Health Service (DHS) proposed moving CRS from a 1915(i) waiver to a § 1937 Benchmark Plan via a state plan amendment (SPA) of the Wisconsin Medicaid plan since a § 1937 Benchmark Plan can potentially add both back and DHS has requested that interested counties submit a letter to them indicating their desire to be included in CRS by July 1, 2012; and

WHEREAS, initial estimates identified 1,760 current BHD clients that meet the criteria for CRS and due to the high number of individuals eligible for this benefit, administering CRS is very similar to a managed care program like Family Care; and

WHEREAS, in May, 2012 the BHD Administrator, BHD staff and Milwaukee County stakeholders met with the State Department of Health Services Administrators to discuss ways to reduce the County’s fiscal exposure including ideas like the development of a risk reserve similar to Family Care; and

48 WHEREAS, the Mental Health Redesign Task Force has recommended
49 strengthening community services and pursuing CRS is a step in that direction and
50 CRS adds a service array that doesn't currently exist by including Supported
51 Employment, Community Living Supportive Services, and using peers as providers;
52 and

53
54 WHEREAS, there is no fiscal impact related to this action; now, therefore,

55
56 BE IT RESOLVED, that the Director of the Department of Health and Human
57 Services, or his designee, is authorized to allow Milwaukee County to be added to the
58 State of Wisconsin - Department of Health Services Medicaid State Plan Amendment
59 for Community Recovery Services.
60

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 6/19/12

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: Report From the Director, Department of Health and Human Services, Requesting Permission for Milwaukee County to be Added to the State of Wisconsin - Department of Health Services Medicaid State Plan Amendment for Community Recovery Services

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact
<input checked="" type="checkbox"/> Existing Staff Time Required
<input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below)
<input type="checkbox"/> Absorbed Within Agency's Budget
<input type="checkbox"/> Not Absorbed Within Agency's Budget
<input type="checkbox"/> Decrease Operating Expenditures
<input type="checkbox"/> Increase Operating Revenues
<input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures
<input type="checkbox"/> Decrease Capital Expenditures
<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> Use of contingent funds |
|--|--|

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. ¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A) Milwaukee County currently provides Community Support Programs (CSP) as its only psychosocial rehabilitation benefit for Medicaid eligible individuals. Targeted Case Management (TCM) is also available to a "targeted" population of persons with a severe and persistent mental illness and all individuals within that group are eligible to receive that service. There is a very wide clinical gap between these two services, and for the past few years the Behavioral Health Division (BHD) has been exploring the addition of another psychosocial rehab benefit. The Director, Department of Health and Human Service (DHHS), is now requesting permission to be added to the State of Wisconsin - Department of Health Services State Plan Amendment (SPA) for Community Recovery Services (CRS).

B) At this point BHD is only requesting to be added to the SPA so BHD could pursue this option in the future. There is no direct fiscal impact to this step in the process. BHD is currently analyzing the potential fiscal impact of providing these services and pursuing ways to mitigate any fiscal risk (see attached Risk Reserve letter). At a later date, if it is decided to pursue implementation of the CRS benefit in Milwaukee County, another fiscal note will be presented to the policy makers.

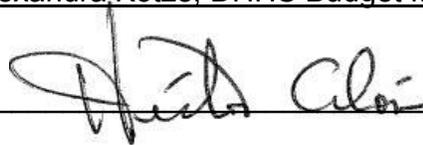
C) There is a no tax levy impact as a result of this action.

D. No assumptions/interpretations.

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Alexandra Kotze, DHHS Budget Manager

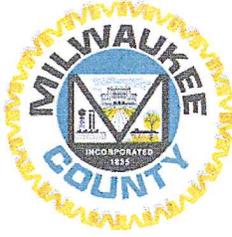
Authorized Signature

A handwritten signature in black ink, appearing to read "Alexandra Kotze", written over a horizontal line.

Did DAS-Fiscal Staff Review?

Yes

No



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Milwaukee County

Héctor Colón MS, OT
Director

June 29, 2012

Dennis G. Smith, Secretary
Department of Health Services
1 W. Wilson Street, Room 650
Madison, WI 53702

Dear Secretary Smith:

Milwaukee County Department of Health and Human Services (DHHS), Behavioral Health Division (BHD) has been participating in a redesign initiative of our behavioral health services over the past 18 months. Many recommendations have been brought forth by our Redesign Task Force on ways to decrease the use of inpatient hospitalization by strengthening the delivery and availability of community-based services. The county has been conducting an impact study on the addition of a psychosocial rehabilitation benefit to the current array of community-based services specifically considering Community Recovery Services (CRS) and/or Comprehensive Community Services (CCS).

Last month staff from BHD and our Milwaukee County partners met with the Administrators from the Divisions of Health Care Access and Accountability and Mental Health and Substance Abuse Services to discuss partnership opportunities between Milwaukee County and the state Department of Health Services for our Medicaid population. One issue that was discussed was the complexity for Milwaukee County in the administration of CRS or CCS. In Milwaukee County approximately 7,000 clients are receiving community-based mental health or substance use disorder services daily. Initial estimates identified 1,760 current BHD clients that meet the criteria for CRS and over 5,000 Medicaid recipients in BHD services eligible for CCS. This is an underestimation for CCS, as it does not take into consideration those eligible individuals receiving services in the Wraparound Milwaukee, Disability Services Division, nor the Department of Aging. Due to the high number of individuals eligible for these benefits, administering CCS and CRS is very similar to a managed care program like Family Care. There is an automatic risk reserve statutorily allowed for Family Care yet nothing similar for these psychosocial rehab benefits. As you know, risk reserves are critically important to guard against unanticipated expenditures, and to ensure the financial viability of managed care organizations or other entities that assume risk. Reducing the county's fiscal exposure for the administration of these benefits is paramount to the success of these services.

1220 W. Vliet Street ▪ Suite 301 ▪ Milwaukee, WI 53203 ▪ 414-289-6817 ▪ Fax 414-289-6844

Wisconsin Chapter 59 has a specific section, 59.60, for counties with a population of 500,000 or more, exclusively Milwaukee County. This section addresses the requirement to deduct “surpluses” from property tax expenditures. The relevant excerpt from this section is italicized below.

59.60(5)(g)

(g) A complete summary of all the budget estimates and a statement of the property tax levy required if funds were appropriated on the basis of these estimates. *In determining the property tax levy required, the director shall deduct from the total estimated expenditures the estimated amount of revenue from sources other than the property tax levy and shall deduct the amount of any surplus at the close of the preceding fiscal year not yet appropriated.* The board, by two-thirds vote, may adopt a resolution before the adoption of the tax levy authorizing the use of the surplus fund in whole or in part as a sinking fund for the redemption or repurchase of bonds or to provide funds for emergency needs under sub. (9), but for no other purposes, except as provided in sub. (13). (emphasis added).

The relevant provision of Section 59.60 is being interpreted by the Milwaukee County Comptroller as potentially precluding the maintenance of a risk reserve necessary for the establishment of this program. Arguably, the risk reserve could be considered a “surplus,” which must be used for other purposes, or placed in a sinking fund for other spending priorities. Although the county can establish a reserve without input from the state, we are seeking written direction from your office clarifying that a risk reserve created for purposes of administering this program is a legitimate program expenditure, rather than a “surplus” that must be expended for other purposes or placed in a “sinking fund.” The establishment of a risk reserve account would provide the additional clarity and specificity that the funds are dedicated, segregated, and available for the sole purpose of protecting against unforeseen or potentially catastrophic CRS program expenditures.

On July 18, 2012 DHHS will be asking our Health and Human Needs Committee to allow Milwaukee County to be included in the state plan amendment for CRS. This will not be the first time that the county has sought such approval. In the past, the greatest reluctance from Health and Human Needs Committee in adopting CRS has been the fiscal exposure for the county due to the high number of eligible individuals for a Medicaid entitlement program. A step in addressing the concerns of the Health and Human Needs Committee is the establishment of a risk reserve. In the spirit of true partnership, I am respectfully requesting that the state Department of Health Services allow Milwaukee County to create a risk reserve for the administration of CRS if approval is given by the County Board to administer this program. The risk reserve will offer the necessary protection of scarce local resources and the assurance that these resources will be available in the future for this benefit and in preparation for CCS for our eligible clients. However, if the Department has other constructs that it can offer or suggest for achieving the same purpose we may be interested in working with you on those as well. Since the board meeting is coming up quickly, having a written response to the request is needed to present to the board prior to the July 18th meeting date.

If you need any additional information or would like to discuss this request further please contact Paula Lucey, BHD Administrator at Paula.Lucey@milwcnty.com or (414) 257-5202, or Susan Gadacz, Adult Community Services Branch Director at Susan.Gadacz@milwcnty.com or (414) 257-7023. I sincerely thank you for your consideration of this request and look forward to partnering with the state Department of Health Services on this and future initiatives that benefit our Medicaid population in Milwaukee County.

Sincerely,

A handwritten signature in black ink, appearing to read "Hector Colon". The signature is fluid and cursive, with the first name "Hector" and last name "Colon" clearly distinguishable.

Héctor Colón, MS OT
Director

cc: Brett Davis, DHS/DHCAA
Linda Harris, DHS/DMHSAS
Paula Lucey, BHD
Alex Kotze, BHD
Susan Gadacz, BHD

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: June 19, 2012

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by: Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Enter into a Professional Services Contract with ZiaPartners, Inc. for 2012 for the Behavioral Health Division

Issue

Section 56.30 of the Milwaukee County Code of General Ordinances requires County Board approval for professional service contracts of \$50,000 or greater. Per Section 56.30, the Director, Department of Health and Human Services (DHHS) and the Administrator, Behavioral Health Division (BHD), are requesting authorization for the BHD to enter into a professional service contract with ZiaPartners, Inc for the provision of technical assistance with the implementation of recommendations from the Mental Health Redesign and Implementation Task Force.

Background

In April 2011, the County Board of Supervisors passed a resolution (File No. 11-173) supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign and Implementation Task Force (“Task Force”) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities. The Task Force commenced monthly meetings in July 2011, and subsequent reports have been presented to the Health and Human Needs Committee. The Task Force is co-chaired by Pete Carlson, Vice President and Chief Administrative Officer of Aurora Psychiatric Services, and Paula Lucey, BHD Administrator.

Over the past several years, various thoughtful and important studies, reports, and committees have made recommendations related to BHD and the mental health system. Over 120 different recommendations were contained in those reports. The first job of the Task Force was to review those recommendations and create a unified vision and direction. Five Action Teams were tasked with addressing key areas of the redesign and how to prioritize and advance select recommendations within those areas.

In January 2012, consistent with a directive from the New Behavioral Health Facility Study Committee, (File No. 11-516), an extensive presentation was made to the Health and Human Needs committee outlining the recommendations of the Task Force. Each Action Team presented the key recommendations from their area. Now that all recommendations have been made, BHD is moving toward implementation and a key component is securing technical assistance.

Discussion

Members of the Task Force participated in the development of a Request for Proposals to procure technical assistance related to the implementation of key recommendations. BHD solicited competitive proposals as detailed on the timeline below:

Milestone	Date
RFP Issued	May 23, 2012
Written Questions Due	May 29, 2012
Responses to Written Questions Posted	June 1, 2012
RFP Responses Due	June 8, 2012
Proposal Evaluation	June 18, 2012
Estimated Contract Start Date*	August 1, 2012
*Or such date mutually agreed upon by County and selected proposer.	

BHD received two proposals and a six-person panel, including consumers and advocates, reviewed and scored the proposals. The panel recommended ZiaPartners, Inc. ZiaPartners has been consulting with Milwaukee County as a part of the federal Access to Recovery Grants to assist the BHD Community Services branch. They have done work with BHD vendors in relation to creating a more welcoming approach in which clients with either or both substance abuse or mental illness could receive consistent care. This effort has been moving forward the last two years. It is anticipated that this will ensure that the efforts occurring in the Redesign and Implementation Task Force and efforts in the Community Services Branch will be synergic.

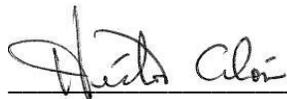
ZiaPartners is based in San Rafael, California and proposes to partner locally with Dr. Janice Wilberg, who has been a respected member of the health and human services community in Milwaukee for many years. BHD is recommending a total contract of \$242,087 with ZiaPartners from August 1, 2012 through July 31, 2013.

Recommendation

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to execute a professional service agreement with ZiaPartners, Inc for \$242,087 from August 1, 2012 through July 31, 2013 as indicated in the attached resolution.

Fiscal Effect

The total recommended amount of \$242,087 is included in BHD's 2012 Budget. A fiscal note form is attached.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Kelly Bablitch, County Board
Pat Farley, Director – DAS

Craig Kammholz – Fiscal & Budget Administrator - DAS
CJ Pahl, Assistant Fiscal and Budget Administrator – DAS
Antoinette Thomas-Bailey, Fiscal and Management Analyst – DAS
Jennifer Collins, County Board Staff
Jodi Mapp, County Board Staff

(ITEM *) Report from the Director, Department of Health and Human Services, Requesting Authorization to Enter into a Professional Services Contract with ZiaPartners, Inc. for 2012 for the Behavioral Health Division, by recommending adoption of the following:

A RESOLUTION

WHEREAS, per Section 56.30 of the Milwaukee County Code of General Ordinances, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to enter into 2012 professional service contracts for the Behavioral Health Division (BHD); and

WHEREAS, In April 2011, the County Board of Supervisors passed a resolution (File No. 11-173) supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign and Implementation Task Force (“Task Force”) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities; and

WHEREAS, members of the Task Force participated in the development of a Request for Proposals to procure technical assistance related to the implementation of key recommendations from the Task Force’s Action Teams; and

WHEREAS, BHD received two proposals and a six-person panel, including consumers and advocates, reviewed and scored the proposals; and

WHEREAS, the panel recommended ZiaPartners, Inc, which is based in San Rafael, California, and ZiaPartners proposes to partner locally with Dr. Janice Wilberg, who has been a respected member of the health and human services community in Milwaukee for many years; now, therefore,

BE IT RESOLVED, that the Director, Department of Health and Human Services, or his designee, is hereby authorized to enter into the professional service contract with the vendor listed and in the amount and term stated below:

<u>Agency and Service</u>	<u>Term</u>	<u>Contract Amount</u>
ZiaPartners (Technical Assistance)	1 year (August 1, 2012 – July 31, 2013)	\$ 242,087 annual

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 6/21/12

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Enter into a Professional Services Contract with ZiaPartners, Inc. for 2012 for the Behavioral Health Division

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact | <input type="checkbox"/> Increase Capital Expenditures |
| <input type="checkbox"/> Existing Staff Time Required | <input type="checkbox"/> Decrease Capital Expenditures |
| <input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below) | <input type="checkbox"/> Increase Capital Revenues |
| <input type="checkbox"/> Absorbed Within Agency's Budget | <input type="checkbox"/> Decrease Capital Revenues |
| <input type="checkbox"/> Not Absorbed Within Agency's Budget | |
| <input type="checkbox"/> Decrease Operating Expenditures | <input type="checkbox"/> Use of contingent funds |
| <input type="checkbox"/> Increase Operating Revenues | |
| <input type="checkbox"/> Decrease Operating Revenues | |

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure		
	Revenue		
	Net Cost		
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A) Section 56.30 of the Milwaukee County Code of General Ordinances requires County Board approval for professional service contracts of \$50,000 or greater. Per Section 56.30, the Director, Department of Health and Human Services (DHHS) and the Administrator, Behavioral Health Division (BHD), are requesting authorization for the BHD to enter into a professional service contract with ZiaPartners, Inc for the provision of technical assistance with the implementation of recommendations from the Mental Health Redesign and Implementation Task Force.

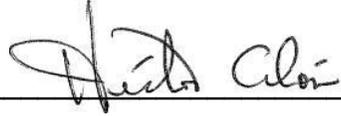
B) BHD is recommending a total contract of \$242,087 with ZiaPartners from August 1, 2012 through July 31, 2013.

C) The total recommended amount of \$242,087 is included in BHD's 2012 Budget; therefore, there is no fiscal impact.

D) None.

¹ If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Maggie Mesaros, BHD

Authorized Signature 

Did DAS-Fiscal Staff Review? Yes No

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: June 19, 2012

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by: Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: **From the Director, Department of Health and Human Services, submitting an informational report regarding the plan to change the implementation of WIS. ADM. CODE DHS 1 at the Behavioral Health Division with respect to the discharge of liability under the Uniform Fee System for the Department of Health Services**

Background

The Uniform Fee System contained in the State of Wisconsin Department of Health Services 1 (DHS 1) regulation requires that the Behavioral Health Division (BHD) bill for services and that the rate billed be based upon actual costs. The regulations strive to strike a balance between the needs of the client and the taxpayer. They provide for computation of a maximum monthly payment (MMP) based upon income and family size and for adjustments where financial hardship exists. Ultimately, parties with no ability to pay and no insurance will not be pursued for payment.

Discussion

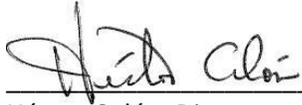
In the past BHD has interpreted DHS 1 in a manner that identified distinct discharge of liability methods depending upon the client's treatment status. Discharge of a liability means that the client no longer is responsible for outstanding amounts owed and BHD writes off the revenue. As required by the regulation, inpatient services are billed at the MMP until the full liability has been met, even when the client is no longer receiving services. If an adult client received inpatient services and has an MMP of \$100 and a liability of \$1,000 at the end of a month, they would be billed \$100 and the remaining liability (\$900) would be added to the liability for the following month until such time as the liability has been paid in full. Discharge of liability for outpatient services and children receiving inpatient services currently differs from the adult inpatient methodology. Clients receiving outpatient services and children receiving inpatient services are billed at the MMP each month and the remainder of the liability for that month is written off. For example, a day treatment program client with an MMP of \$100 may receive \$1,000 in services in a month. At the end of the month, the client will be billed \$100 and the remaining \$900 will be discharged, leaving the client with no remaining liability.

In February 2012, the Office of Corporation Counsel provided BHD with an analysis of the current implementation of DHS 1. Corporation Counsel recommends that BHD revise its billing practices as it implements its new electronic medical record system. They recommend, and BHD concurs, that DHS 1 should be applied in a consistent, equitable manner for discharge of liability regardless of the nature of the services provided. Therefore, beginning this fall with the first phase of implementation of the new electronic medical record system, billing will continue until the liability has been met, unless there are exceptions. This approach will best balance the interest of clients and taxpayers as required by the

Uniform Fee System. BHD is currently analyzing the impacts of this change including developing procedures for approving exceptions, such as where billing would be contrary to treatment goals, as allowed under DHS 1.

Recommendation

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Kelly Bablitch, County Board
Pat Farley, Director – DAS
Craig Kammholz – Fiscal & Budget Administrator - DAS
CJ Pahl, Assistant Fiscal and Budget Administrator – DAS
Antoinette Thomas-Bailey, Fiscal and Management Analyst – DAS
Jennifer Collins, County Board Staff
Jodi Mapp, County Board Staff

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: June 19, 2012

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

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: From the Director, Department of Health and Human Services, Providing an Informational Report on Wraparound Milwaukee's Selection to Provide Assessment and Case Management Services through the Family Intervention Support and Services Program

Issue

The Family Intervention Support and Services (FISS) Program is designed to provide services to adolescents who are experiencing behavioral problems, truancy issues, academic-related problems, runaway behavior and parent/child conflicts. In the past, the State of Wisconsin has contracted with providers for two separate components of the FISS program: assessment services and case management services. Wraparound Milwaukee has been a provider of the case management services for the past eight years. Due to a change in the RFP process in 2012, Wraparound Milwaukee will now contract with the Wisconsin Department of Children and Families for both FISS assessment and case management services.

Background

The Bureau of Milwaukee Child Welfare (BMCW) initiated the FISS program in February 2001 in collaboration with Milwaukee County Children's Court and the Delinquency and Court Services Division. The FISS program's main purpose has been to assess the individual needs of families with an adolescent evidencing behavioral and mental health problems and linking the child and family to appropriate services and resources to avoid court intervention.

In January 2004, the Department of Health and Family Services - Division of Children and Family Services issued a Request for Proposal to solicit a single contractor to provide FISS assessment services and a single provider to provide on-going FISS services to families. The Wraparound Milwaukee Program submitted a proposal and was eventually selected to provide only the on-going FISS services. Wraparound Milwaukee was again chosen by the State to provide these same services in 2008 for another three years. Perez-Pena, Inc. was chosen to provide the initial assessment services for FISS.

In 2012, the Wisconsin Department of Children and Families chose to issue an RFP for a single vendor to provide both the assessment portion of FISS and the actual delivery of on-going services to FISS families. The idea was to improve the continuity of care to families by having a single

provider who would do both services.

Wraparound Milwaukee bid on the newly re-designed RFP for these services and finished first among all submitting agencies. On June 6, 2012 the Wisconsin Department of Children and Families notified BHD of its intent to award the FISS contract to Wraparound Milwaukee.

Milwaukee County families have greatly benefitted from the FISS services provided by Wraparound Milwaukee because of the intensive case management, comprehensive service array available from our Provider Network and ability to link families needing long-term mental health and supportive services for their child and family to Wraparound Milwaukee and particularly our voluntary REACH Program. The State has also been pleased that FISS families can be linked to our mobile crisis team (MUTT) and particularly to crisis 1:1 stabilizers to work with families who need support, skills development and techniques to work with children with serious behavioral needs.

It is estimated there will be 853 assessments annually under the expanded FISS program. The current FISS program has a program coordinator and a full-time psychologist provided by Wraparound Milwaukee and paid for with State and Medicaid funding. In addition, Wraparound Milwaukee contracts with St. Charles Youth and Family Services to provide case management services. St. Charles Youth and Family Services will provide the additional staff needed to offer assessment services through existing contracts.

The expanded FISS program will continue to be housed at BHD in space leased by St. Charles, which is ideally located adjacent to the Mobile Urgent Treatment Team. Assessment hours will include Saturdays, which will give families additional access to scheduling appointments convenient to their work schedules.

BHD currently receives about \$540,000 in revenue for the FISS program. Under the new contract with the State, this amount will be increased to \$746,375 for the period July 1, 2012 to June 30, 2013. The additional revenue and offsetting expenditures for the expanded FISS program will be added to the 2013 Budget. All additional expenditures from the FISS expansion will be covered by State and other revenues, resulting in a zero tax levy impact. If necessary, a fund transfer to recognize this revenue and the related expenditures will be completed later in 2012.

Recommendation

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Kelly Bablich, County Board

Patrick Farley, Director, DAS
Craig Kammholtz, Fiscal & Budget Administrator, DAS
CJ Pahl, Assistant Fiscal & Budget Administrator, DAS
Antionette Thomas-Bailey, Fiscal & Management Analyst, DAS
Jennifer Collins, Analyst, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: June 19, 2012

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by: Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: Status Report from the Director, Department of Health and Human Services, Regarding the Mental Health Redesign and Community Resource Investment

Issue

The 2012 BHD Budget included over \$3 million for a Mental Health Redesign and Community Resource Investment, which included six specific initiatives aimed at expediting the necessary groundwork for a mental health system more reliant on community resources and less reliant on inpatient care: a community-based crisis stabilization program, an additional stabilization house, increased community crisis investment, a crisis resource center expansion, a developmental disabilities-mental health pilot respite program and a quality assurance component. This report provides a status update regarding the actions that have been taken related to those budget initiatives.

Background

Multiple efforts have been undertaken in the past few years to study the existing mental health delivery system in Milwaukee County and offer recommendations for a possible redesign. In the spring of 2011, DHHS was given responsibility for establishing a Mental Health Redesign Task Force to be comprised of stakeholders from the public and private sectors, as well as providers, advocates and consumers. The Task Force was charged with coordinating the recommendations put forth, and prioritizing and implementing the new mental health system design ideas and innovative strategies. One of the points made by the Mental Health Redesign Task Force, as well as numerous other reports, was that in order to achieve the goals of decreased reliance on inpatient care and the Psychiatric Crisis Services area, it was necessary to increase community resources.

In light of this recommendation, the 2012 Budget included funding aimed at expediting the necessary groundwork for a mental health system more reliant on community resources and less reliant on inpatient care, including for programs such as the expansion of the stabilization house program and crisis resource center, development of a discharge assistance program, expansion of the mobile crisis team and initiatives aimed at assisting in the downsizing of Hilltop. BHD has been working on implementing all of these initiatives in 2012.

Discussion

In June 2012, BHD brought forward three recommended contracts. These were based on a Request for Proposals (RFP) let in March 2012 for Stabilization House, the crisis resource center and the Community Linkage and Stabilization Program (CLASP), which is a new level of care that currently does not exist in the service continuum.

All of the recommended programs will provide a safe, welcoming, and recovery-oriented environment, and all services will be delivered in a person-centered, trauma-informed, culturally competent, and recovery-oriented focus of care. The following contracts were recommended:

Stabilization House:

The stabilization house will serve adults who reside in Milwaukee County who live with a mental illness or co-occurring disorder and are in need of further stabilization after an inpatient hospitalization. It is also warranted for individuals who are awaiting a residential placement and require structure and support to ensure a smooth transition into the residential placement. Stabilization house services may also provide temporary supported accommodation for people with mental health needs during a crisis or when they need respite from living at home.

Goals and Desired Outcomes

The primary goals of the Stabilization House programs are:

- Prevent people from going into the hospital when they experience a crisis in their mental health or social circumstances, or need respite accommodation
- Stabilize individuals in a more home-like and less-restrictive environment than a hospital setting
- Provide brief, individualized crisis interventions and support to promote the acquisition of skills necessary to transition to a more permanent living situation
- Assist with linkage to community resources, housing and movement to a more independent living environment in conjunction with the individual and the individual's support network

BHD, based on the County Board action in June, is still reviewing these RFP responses and will return to the Board for final approval later in 2012.

Community Linkages and Stabilization Program (CLASP):

This program will provide post-hospitalization extended support and treatment designed to support consumers' recovery, increase ability to function independently in the community and reduce incidents of emergency room contacts and re-hospitalizations through individual support from a state-certified Peer Specialist.

Goals and Desired Outcomes

The primary goals of CLASP are to:

- Improve quality of life for consumers
- Promote consumers' recovery in the community
- Increase consumers' ability to effectively deal with problems and resolve crises
- Increase consumers' ability manage stressors outside an inpatient hospital setting
- Help consumers navigate between various system access points and levels of care

The CLASP program is an innovation and we expect that it will decrease the recidivism of clients.

BHD recommended that La Causa be awarded the CLASP contract for \$165,000 from July 1, 2012 through December 31, 2012. The program anticipates serving 50 individuals in 2012.

Crisis Resource Center:

A crisis resource center on the north side of Milwaukee County to serve adults who reside in Milwaukee County and who live with a mental illness and are in need of crisis intervention and/or short-term

community-based stabilization rather than hospitalization. The crisis resource center will serve adults with mental illness and may include individuals with a co-occurring substance use disorder who are experiencing psychiatric crises.

Goals and Desired Outcomes

The primary goals of the crisis resource center are:

- Provide early intervention and short-term, intensive, community based services to avoid the need for hospitalization
- Stabilize individuals in the least restrictive environment
- Assist in crisis resolution
- Work with individuals to develop a comprehensive crisis plan
- Connect individuals to peer support from a Certified Peer Specialist
- Link individuals to appropriate community-based resources so that they may live successfully in the community

BHD recommended that Community Advocates be awarded the crisis resource contract for \$425,000 from July 1, 2012 through December 31, 2012. The program anticipates serving approximately 300 individuals in 2012.

BHD has also worked on other 2012 programs and initiatives related to the Mental Health Redesign and Community Resource Investment, including:

The Mental Health Summit – February 2012:

A Mental Health Summit was held on February 14th, to share the recommendations of the Mental Health Task Force Action Teams with the greater community. Approximately 150 people attended. National speakers with expertise in mental health redesign and consumer-driven care were invited to participate. The cost of this program was \$31,664.

Technical Assistance:

Members of the Mental Health Task Force and associated Action Teams have requested technical assistance to implement the recommendations put forth by the group. An RFP was issued in May 2012 to secure that assistance. BHD is submitting a separate Board report for review in July recommending a contract for these services for a total of \$242,087 for ZiaPartners, Inc.

Housing:

Permanent supportive housing has been shown to have a positive impact on the recovery of individuals and their stability. The Housing Division had a supportive housing development come to completion prior to the anticipated date; therefore they did not have funds allocated for client support staff in that building. BHD dedicated \$50,000 to cover the costs related to staffing for these 50 housing units, allowing them to open early.

Next Steps

Consistent with the 2012 Budget and the Mental Health Redesign Task Force recommendations, BHD is anticipating the following additional actions this year.

Mobile Crisis:

BHD has a desire to improve the Chapter 51 Emergency Detention process and procedure. BHD Administrators have been active participants in several legislative council studies attempting to include the option of a clinician having the ability to detain individuals in need of emergency mental health care. This has not been successful to date. BHD is currently investigating an option of having law enforcement join the Mobile Crisis Team so that emergency detention calls would have both a clinical and law enforcement component. BHD is analyzing this option and working on identifying the exact amount of funding needed for this model. BHD will continue to move forward with this initiative and will update the Board in the next status report.

Intellectually Disability Respite Beds:

The Disabilities Services Division issued a Request for Proposals in June 2012 to add a four-bed ADA accessible crisis stabilization home specifically dedicated to clients with developmental disabilities/mental health diagnoses. It is anticipated that this contract will come before the Board in September 2012 and will have an approximate annual cost of \$250,000.

Employment Services:

Employment is an essential component of recovery. To encourage engagement in employment, BHD is planning to work with the Housing Division to launch a major employment initiative. BHD and Housing will report on this initiative to the board in September.

To begin the initiative, BHD/DHHS will host a seminar with employers related to employment of individuals in recovery, especially related to the employment of Certified Peer Specialists. Topics of discussion will include job descriptions for peer specialists, working with employees who have a mental illness, challenges related to employees who have disability benefits and how to avoid any stigma with other employees. The estimated initial seminar cost is \$35,000.

In addition to the seminar, BHD also plans to invest in education for employers related to employment and rehabilitative services in Milwaukee County. The goal of this is to create an infrastructure and prepare employment specialists to implement this model of supportive employment, which is reimbursable from Medicaid. This model, Individual Placement and Support (IPS), was developed at Dartmouth and it is required that a certified trainer complete any model education. BHD anticipates that the cost of this education and development of the infrastructure will be a total of \$175,000 over 2012 and 2013.

Prevention Specialist:

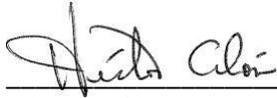
BHD plans to create a new substance abuse and mental health prevention coordinator/specialist position to work to promote mental health wellness throughout the community. The position would focus on primary prevention, early intervention and address prevention activities. BHD plans to bring a request to create this position forward in September and the anticipated cost, including fringe benefits, is approximately \$96,000 annually.

Fiscal Impact

Attachment A includes an overview of 2012 and 2013 committed funding related to this 2012 Budget Initiative.

Recommendation

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Kelly Bablitch, County Board
Pat Farley, Director – DAS
Craig Kammholz – Fiscal & Budget Administrator - DAS
CJ Pahl, Assistant Fiscal and Budget Administrator – DAS
Antoinette Thomas-Bailey, Fiscal and Management Analyst – DAS
Jennifer Collins, County Board Staff
Jodi Mapp, County Board Staff

Mental Health Community Investment Expenditure Tracker

Initiative	2012 Budget	2013 Annual Cost	2012 Amount	Notes
1) CLASP	\$ 405,870			
7.5 FTE Peer Specialist Positions - contract	\$ 250,000	\$ 250,000	\$ 125,000	July 1 start date (2012)
1 FTE Peer Specialist Coordinator - contract	\$ 80,000	\$ 80,000	\$ 40,000	July 1 start date (2012)
1 FTE Stabilization Coordinator - BHD staff	\$ 75,870	\$ 75,870	\$ 31,613	Estimated Fill - August 1
Funds Remaining		\$ -	\$ 209,258	
2) 8-bed Crisis Respite & Staff	\$ 363,800			
Additional Crisis Respite Facility - contract	\$ 250,000	\$ 298,000	\$ 149,000	July 1 start date (2012)
1.5 FTE of BHESC	\$ 113,800	\$ 113,800	\$ 47,417	Estimated Fill - August 1
Funds Remaining		\$ (48,000)	\$ 167,383	
3) Community Crisis Options	\$ 330,000			
RN 2	\$ 95,000	\$ 95,000	\$ 23,750	Estimated Fill - Oct 1
PSW	\$ 85,000	\$ 85,000	\$ 21,250	Estimated Fill - Oct 1
MPD - Mobile Crisis	\$ 150,000	\$ 150,000	\$ 37,500	Establish contract with MPD for one police officer on Mobile Crisis team.
Funds Remaining		\$ -	\$ 247,500	
4) Up to 2 North Side Crisis Intervention Programs	\$ 1,400,000			
Crisis Resource Center contract		\$ 850,000	\$ 425,000	July 1 start date (2012)
Crisis Resource Center upfront costs		\$ -	\$ 100,000	One time cost
Funds Remaining		\$ 550,000	\$ 875,000	
5) Quality Assurance	\$ 85,352			
Quality Assurance Coordinator		\$ 85,352	\$ 35,563	Estimated Fill - August 1
Funds Remaining		\$ -	\$ 49,789	
6) DD-Mental Health Pilot Respite Program	\$ 448,040			
Contracts	\$ 110,000	\$ 250,000	\$ 62,500	Oct 1 start date (2012)
Staffing	\$ 338,040	\$ 198,040	\$ 49,510	Estimated Fill - Oct 1
Funds Remaining		\$ -	\$ 336,030	
7) Other Expenditures				
Special Needs Housing		\$ (74,714)	\$ (50,000)	2012 - Contract for early opening of facility. 2013 - New Community Intervention Specialist position in Housing.
Budget Adjustment		\$ (100,000)	\$ (100,000)	This is not reflected in 2012 Budget narrative.
Redesign Summit		\$ -	\$ (31,664)	One time cost
Cost increase adjustment		\$ (50,000)		Technical adjustment for inflation
Technical Assistance		\$ -	\$ (250,000)	One time cost
Employment Services Seminar		\$ -	\$ (35,000)	One time cost
IPS Training for Employers		\$ (87,500)	\$ (125,000)	
Behavioral Health Prevention Coordinator		\$ (96,000)	\$ (24,000)	Estimated Fill - Oct 1
8) Potential Expenditures				
Waisman Center consulting		\$ -	\$ (100,000)	One time cost
Peer Specialist Initiative		\$ -	\$ (200,000)	One time cost
Employment in Recovery programming		\$ -	\$ (25,000)	One time cost
TOTAL FUNDS REMAINING		\$93,786	\$944,296	

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: June 26, 2012

TO: Supervisor Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: **Report, from the Director, Department of Health and Human Services, on the status of the 2012 Purchase of Service Contract and Audit recommendations related to Our Space for the Behavioral Health Division**

Issue

Per the request of the Director, Department of Health and Human Services, and the Administrator, Behavioral Health Division, the Department of Audit completed a review of the Our Space contract related to peer support services. The audit results were presented at the June Health and Human Needs Committee and, at that time, the Committee requested monthly reports on the status of the contract, implementation of the audit recommendations and status of the other recommendations suggested by community agencies.

Discussion

Shortly before the December meeting of the Health and Human Needs Committee, it was brought to the attention of the BHD administration that there were some issues with the Our Space contract. BHD met with Our Space and the individuals who brought the concerns forward, and all parties agreed with a BHD developed plan to conduct an audit of the Peer Support component of the Our Space contract. To ensure that these valuable services were maintained for BHD clients while the concerns were reviewed, BHD recommended, and the Board approved, a four-month contract for Our Space from January 1 – April 30, 2012 for a total of \$116,054. BHD then returned to the Board in March 2012 and asked to extend the Peer Support service area of the Our Space contract through June 30, 2012, since the audit was still pending. That was approved and services for clients have continued without interruption.

Audit released their final review of the Our Space issues in May 2012. No audit results suggested that Our Space should not continue to provide Peer Support services to BHD through their purchase of service contract. The Audit was submitted to the County Board in the June cycle and, due to the completion of the audit, BHD also requested to extend the Peer Support portion of the Our Space contract through December 31, 2012. Extensive testimony occurred and the committee requested a monthly report from BHD to ensure that the recommendations from Audit were implemented.

This report seeks to establish the format of those monthly reports. As the time between the initial committee meeting and this report is quite short, this report will only share the items that will be included in future reports. Below is a list of the recommendations from Audit and the community authors, and each month the status of this recommendation will be updated. The Department will share the monthly reports with Audit to ensure that they are aware of the progress.

	RECOMMENDATION	SOURCE	STATUS
1	Establish, with input from Our Space and local advocacy groups, criteria for inclusion in peer support services contracts for screening candidates for Peer Specialist positions. DHS 12.06, Wisc. Adm. Code provides guidance in this area	Audit	BHD will include this requirement in RFP to be released in July 2012
2	Require that Our Space produce current background checks on all employees past the four year re-check period	Audit	This has been requested by BHD
3	Establish a protocol under contract provision #2 (Staffing and Delivery of Services) to review Peer Specialist assignments on a regular basis	Audit	BHD will meet with the Our Space operations manager to review this on a regular schedule
4	Develop a mechanism to monitor and enforce background check requirements with contracted agencies	Audit	BHD is working on this with Contract Administration and the Community Services Branch
5	Modify the Our Space Whistleblower Protection policy and obtain DHHS - Contract Administration's written confirmation that the policy meets all contractual requirements prior to having the revised policy approved by the Our Space board	Audit	Our Space Board has approved a new Whistleblower policy. The policy is attached to audit as part of the Our Space response. COMPLETED
6	Distribute copies of Our Space's written Grievance and Whistleblower Protection Policies to all current and future Our Space Peer Specialists, and provide awareness training regarding same.	Audit	BHD will survey all Peer Specialists in the fall to ensure this is complete.
7	Obtain and retain required employee signatures acknowledging receipt and understanding of the Our Space Whistleblower Policy	Audit	Our Space has indicated that this will be done by September. BHD will monitor to ensure receipt.
8	Seek the cooperation of supportive housing owners to conduct on-site	Audit	BHD and the DHHS Housing Division will meet and develop a strategy to

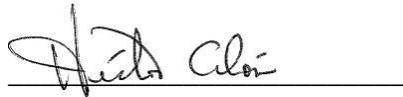
	security reviews of supportive housing units serving Milwaukee County mental health consumers, possibly enlisting the Office of the Sheriff		address this.
9	Identify resources that could potentially be marshaled to address any security concerns/deficiencies identified from on-site security reviews	Audit	BHD and the DHHS Housing Division will meet and develop a strategy to address this.
10	Work collaboratively with Our Space Management, supportive housing unit owners and any other community resources identified to address any security concerns identified in the on-site reviews	Audit	BHD and the DHHS Housing Division will meet and develop a strategy to address this.
11	Distribute benefits counseling information to all current Peer Specialists as a reminder and incorporate same in the Our Space Employee Handbook	Audit	Our Space has indicated that this is Complete. BHD will obtain Documentation.
12	Quality Assurance	Community Authors	BHD and Contract Administration will review all quality assurance provisions in the contract to ensure they are comprehensive
13	Education for employers related to role of Peer Specialists	Community Authors	BHD Community Services Branch plans to invest in a new employer training that will address this issue and will also secure technical assistance for Our Space on the key element within the Wisconsin Peer Specialist Employer Guide.
14	Conflict of Interests	Community Authors	BHD and Contract Administration will review all conflict of interest Provisions in the contract
15	Complaints/ issues from clients regarding Peer Specialists		BHD will report any complaints/issues Immediately, including the proposed resolution
16	Concerns from Peer Specialists brought forth to BHD administration		BHD will notify the vendor and work with all parties to identify a solution

As noted above, in addition to the specific recommendations, BHD will monitor any concerns from clients regarding the Peer Specialists and any concerns brought forth from the Peer Specialists regarding their employment.

Lastly, it was requested that surveys be done regarding of the current Peer Specialists related to their perception of their employment and a survey be done with the clients related to their interactions with Peer Specialists. BHD administration will work on this and report back to the Board in the September cycle.

Recommendation

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Tia Torhorst, County Executive's Office
Kelly Bablich, County Board
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