

# ASSESSING THE FINANCIAL OUTLOOK OF MILWAUKEE COUNTY'S BEHAVIORAL HEALTH DIVISION

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## ABOUT THE PUBLIC POLICY FORUM

Milwaukee-based Public Policy Forum – which was established in 1913 as a local government watchdog – is a nonpartisan, nonprofit organization dedicated to enhancing the effectiveness of government and the development of southeastern Wisconsin through objective research of regional public policy issues.

### EDITOR'S NOTE

This report was undertaken as part of a technical assistance project commissioned by the Milwaukee County Department of Health and Human Services (DHHS) for the purpose of enhancing the department's understanding of fiscal trends and challenges faced by its Behavioral Health Division (BHD), and advising it on strategies for maximizing the opportunities presented by the Affordable Care Act. The research for this report was conducted from April through September 2012, and the report was delivered to the department in October 2012.

Subsequent to the report's delivery, the authors met several times over several months with County officials to discuss and review the report's findings and those of a complimentary report written by Community Advocates' Public Policy Institute. Although the report is of a technical assistance nature, it is being published now for broad consumption because of its relevance to public deliberations about the future of Milwaukee County's Mental Health Complex. Though the research in this report is now nearly five months old, it remains timely and still speaks accurately to the current fiscal challenges facing BHD. We hope that it will be useful for policymakers, stakeholders and citizens as they consider options for improving mental health care in Milwaukee County.

### ACKNOWLEDGMENTS

Report authors would like to thank the leadership and staff of DHHS and BHD for their assistance in providing budget and programmatic information and patiently answering our questions. We especially appreciate the many hours of assistance provided by BHD Administrator Paula Lucey and DHHS Budget Manager Alex Kotze. We would also like to thank Community Advocates and its Public Policy Institute for subcontracting with the Forum to produce this report and for working with us on the overall technical assistance project.

Finally, the Forum would like to acknowledge the generosity of our 2013 Pillars of Public Policy and Sentinels of Civil Conduct, who have made generous grants to support our research in commemoration of our 100<sup>th</sup> anniversary celebration in 2013.

**Pillars of Public Policy:** Helen Bader Foundation, Herzfeld Foundation, Northwestern Mutual, Wisconsin Energy Foundation

**Sentinels of Civil Conduct:** BMO Harris Bank N.A., Baird, Potawatomi Bingo Casino



# TABLE OF CONTENTS

INTRODUCTION..... 4

BACKGROUND..... 6

BHD FISCAL TRENDS..... 8

    Five-Year Comprehensive View..... 8

    Three-Year Focused View ..... 9

BHD 2012 ADOPTED BUDGET AND YEAR-TO-DATE EXPERIENCE ..... 23

BHD 2013 BUDGET REQUEST ..... 27

LOOKING TOWARD THE FUTURE..... 30

    Expenditures..... 30

    Revenues..... 36



## INTRODUCTION

The Public Policy Forum has partnered with Community Advocates' Public Policy Institute in a project designed to advise Milwaukee County's Behavioral Health Division (BHD) on ways to strategically prepare for implementation of the Affordable Care Act (ACA). That project was launched in April 2012 with the financial support of BHD and the Milwaukee County Department of Health and Human Services (DHHS).

A central element of planning for ACA implementation is understanding and assessing BHD's current fiscal condition and challenges. The Forum's role in the project was to conduct such an assessment as a means of informing deliberations about possibilities for maximizing revenue impacts associated with ACA. Those may include opportunities to secure health insurance coverage for uninsured individuals currently being served by BHD, and to broaden coverage for those currently covered by the state's Badger Care program or other public funding sources.

The need for an outside, independent assessment of BHD's fiscal condition also was dictated by the mental health redesign process currently being conducted by BHD. That process involves a community-wide planning effort to review findings from several programmatic analyses of mental health services in Milwaukee County (including a comprehensive report by the Human Services Resources Institute co-authored by the Public Policy Forum), and to recommend strategies for implementing redesign initiatives. A particular focus is the need to devise ways to enhance community-based mental health services in conjunction with possible downsizing of BHD's inpatient and nursing home facilities.

Several work groups have been formed by the county's Mental Health Redesign Task Force to address specific areas of programmatic concern, and several broad programmatic recommendations have been issued. Thus far, however, the planning process has not included a component to identify and weave BHD's financial challenges and opportunities into redesign planning. Consequently, another important objective of this report is to provide a baseline fiscal assessment that can be used to inform the mental health redesign process and ensure that programmatic recommendations are accompanied by a fundamental understanding of BHD's current financial constraints and prospects.

After a background section that outlines BHD's general funding and programmatic structure, this paper is divided into four primary sections:

- The first analyzes actual expenditure and revenue data from the 2009-2011 period – broken down by key service areas and revenue sources – to provide perspective on fiscal trends and how they impact BHD's long-term financial picture.
- The second analyzes BHD's fiscal performance during the first several months of 2012 to gain insight into the financial impacts of recent efforts to revamp inpatient services and initiate enhanced community-based services, and how those efforts have affected the division's financial condition and outlook.



- The third analyzes BHD’s 2013 requested budget to provide even greater perspective on the challenges posed by recent fiscal trends and the impacts of efforts to initiate one of the key components of mental health redesign – the downsizing of BHD’s inpatient and nursing home capacity and the transfer of resulting savings to community-based services.
- Finally, the fourth section ties the three separate pieces of analysis together by offering several overall observations and conclusions.

As noted above, the purpose of this paper is not to critique BHD’s fiscal management, but instead to objectively analyze its financial challenges and opportunities so that Milwaukee County budget officials and policymakers – as well as the dozens of public and private sector individuals who are devoting their time to the county’s mental health redesign process – will have an independent fiscal assessment with which to consider programmatic changes moving forward.



## BACKGROUND

BHD provides a variety of inpatient, emergency and community-based care and treatment to children and adults with mental health and substance abuse disorders. The county's role is dictated primarily by the Wisconsin Statutes, which specifically assign to Milwaukee County government responsibility for the "management, operation, maintenance and improvement of human services" in the county, including mental health treatment and alcohol and substance abuse services (Section 46.21).

Section 51.42 of the Wisconsin Statutes lays out more specifically the mandated role for Milwaukee County pertaining to the provision of behavioral health services:

*"The county board of supervisors has the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services. This primary responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds."*

The county has interpreted this language as a legal requirement to provide immediate emergency services for persons with mental illness and substance abuse disorders. That interpretation, in turn, has been defined as a requirement that the county also provide a broad range of inpatient, long-term care and outpatient services to indigent persons in order to curtail the need for emergency services and meet the more general statutory language pertaining to well-being, treatment and care. Notably, private health systems and hospitals also have taken into account this interpretation and have considered it to be Milwaukee County's ultimate responsibility to provide for the care of indigent individuals with mental health and substance abuse disorders.

At its Mental Health Complex, Milwaukee County owns and runs an inpatient hospital consisting of five licensed units (one of which is for children and adolescents); two nursing home facilities (a 70-bed nursing home for individuals with complex needs who require long-term treatment and a 72-bed facility for individuals diagnosed with both developmental disability and serious behavioral health needs); a Psychiatric Crisis Service (PCS) that serves persons in need of emergency mental health treatment, more than 60% of whom typically are brought in by law enforcement on an Emergency Detention; a mental health Access Clinic; and an Observation Unit. It also contracts for a wide variety of community-based services, including targeted case management, community support programs, community residential services, outpatient treatment, substance abuse treatment and recovery support, crisis respite, and specialized services for children and adolescents.

The total expenditure budget for BHD in 2012 is \$188 million, making it the second largest organizational unit in Milwaukee County government after the Family Care program's Care Management Organization (CMO). BHD's 2012 property tax levy is \$61 million, again ranking it second after the Office of the Sheriff. Other key revenue sources are state/federal revenue and direct reimbursement from patient care.



BHD also is one of the county's largest functions in terms of individuals served. For example, on an annual basis, BHD typically handles close to 4,000 inpatient and 13,000 PCS admissions, provides or administers services to more than 2,000 individuals in case management programs, and administers community-based substance abuse services to more than 4,500 individuals.

Finally, BHD is the second largest county organizational unit in terms of its number of employees (first is the sheriff), with 810 full-time equivalent employees (FTEs) budgeted in 2012.



## BHD FISCAL TRENDS

### Five-Year Comprehensive View

**Table 1** shows BHD's actual expenditure, revenue and FTE history from 2007 to 2011. For ease of comparison, expenditures and revenues for the County Health Programs Division (CHP) have been subtracted from these figures for 2010 and 2011. CHP was formerly a separate organizational unit in the county budget but was moved under the jurisdiction of BHD in 2010. The division once housed the General Assistance Medical Program (GAMP) but today consists only of the Emergency Medical Services (EMS) program and is now known as the EMS division.

**Table 1: BHD actual expenditures and revenues, 2007-2011**

	2007	2008	2009	2010	2011
Personal Services w/out fringe	46,989,819	48,480,607	48,219,354	45,225,202	46,382,064
Employee fringe benefits	28,154,850	28,231,671	27,801,100	31,864,059	31,990,379
Services	9,843,915	10,084,964	9,661,202	16,936,471	19,394,747
Commodities	7,857,374	8,187,375	9,703,573	6,235,906	7,079,988
Other charges*	71,835,699	73,111,172	77,179,643	75,129,393	74,371,405
Debt and depreciation	-	-	-	-	-
Capital outlay	127,715	82,792	63,672	77,706	325,256
Capital contra	-	-	-	-	-
County service charges	38,239,417	41,409,987	38,185,131	37,784,722	40,421,891
Abatements	(31,329,741)	(34,523,950)	(32,732,183)	(32,681,691)	(35,170,135)
<b>Total Expenditures</b>	<b>171,719,048</b>	<b>175,064,618</b>	<b>178,081,492</b>	<b>180,571,767</b>	<b>184,795,596</b>
Direct revenue	63,542,361	57,361,571	60,144,434	60,278,188	61,355,869
State and federal revenue	62,415,021	58,353,670	59,686,856	61,227,168	61,584,993
Indirect revenue	2,101,285	10,700,698	8,958,796	9,932,388	10,002,135
<b>Total Revenues</b>	<b>128,058,667</b>	<b>126,415,939</b>	<b>128,790,086</b>	<b>131,437,744</b>	<b>132,942,996</b>
<b>Property Tax Levy</b>	<b>43,660,381</b>	<b>48,648,679</b>	<b>49,291,406</b>	<b>49,134,023</b>	<b>51,852,600</b>
<b>FTE positions</b>	<b>877</b>	<b>891</b>	<b>851</b>	<b>802</b>	<b>817</b>

Source: BHD BRASS fiscal reports

\* Other charges is the biggest expenditure line item because it includes the division's huge portfolio of service contracts with community-based providers for services ranging from outpatient psychiatric care, to case management, to substance abuse treatment.

This high-level view of BHD's five-year fiscal trends reveals several observations and questions, including the following:

- BHD's total expenditures increased by \$13 million (7.6%) over the five-year period (which certainly is respectable given the general rate of health care inflation), while its non-property tax revenues increased by only \$5 million (3.8%), producing a need for an \$8 million (19%) increase in its property tax levy allocation. What is the cause of this discrepancy between the rate of growth of costs versus non-property tax revenues, and is the division's continued reliance on property taxes to fill the gap sustainable?



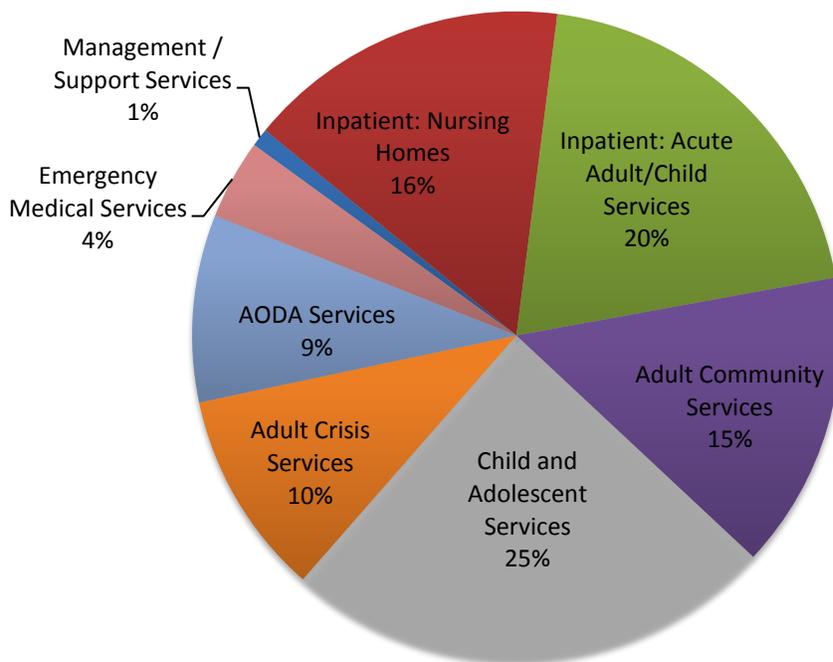
- Despite substantial increases in fringe benefit and other personnel costs countywide, BHD has kept those costs in check by reducing FTEs. Presumably, that has occurred largely because of initiatives during this period to contract out housekeeping, dietary and other services, which is reflected by the increased expenditures for services in 2010 and 2011. Are there additional strategies that might be pursued to keep a lid on personnel costs in future years, or must BHD’s challenged revenue streams absorb annual pay and benefit increases in future years that will be similar in magnitude to other county departments?
- Given the rate of health care inflation, can an entity that exists largely to provide or secure health care services for indigent individuals on behalf of the state and federal governments survive financially when its state and federal revenue streams are stagnant?

### Three-Year Focused View

#### Expenditures

In Milwaukee County’s published budget documents, BHD’s budget is broken down into eight distinct cost centers: Management/Support Services; Nursing Facility Services; Acute Adult/Child Inpatient Services; Adult Community Services; Child and Adolescent Services; Adult Crisis Services; AODA Services; and Emergency Medical Services. The share of BHD’s expenditure budget devoted to each of those cost centers in 2011 is shown in **Figure 1**.

**Figure 1 – BHD 2011 expenditures by cost center**



Source: Actual 2011 breakdown taken from BHD’s 2013 Requested Budget narrative



For the purposes of this analysis, we focus only on four of the eight BHD cost centers that are directly relevant to the county's mental health redesign planning. The four that are excluded are Child and Adolescent Services, which essentially consists of BHD's Wraparound program, a comprehensive array of community-based behavioral health services for children and adolescents that are administered under an innovative reimbursement system using state and federal funding (and involving no county property tax levy); AODA services, which also involve limited county property tax levy (because of various federal and state grant revenues) and which largely rely on dedicated funding streams that fall outside of the purview of mental health redesign planning<sup>1</sup>; EMS, which also falls outside of the purview of mental health redesign; and Management and Support Services, which comprises only a small portion of BHD's direct expenditure budget.<sup>2</sup>

Subtracting those programs leaves us with four cost centers totaling approximately \$117 million in budgeted expenditures in the 2012 budget that are the subject of this analysis. Those cost centers also account for about 91% of BHD's total budgeted property tax levy, making them the critical areas for trend analysis and deliberation in the context of the county's structural deficit and annual budgetary pressures.

To further explore those areas of BHD's budget, we conducted a detailed examination of the last three years of actual expenditure and revenue data, broken down by the four primary categories of mental health services that will be most impacted by ACA and that are the primary subject of adult mental health redesign efforts: inpatient, nursing homes, psychiatric crisis services, and community services. It is important to note that the first three categories relate primarily to services that are conducted onsite at BHD's Mental Health Complex, while the fourth category consists of services that are provided either by BHD or contracted providers in the community. This is an important distinction in the context of mental health redesign, which is focused in part on shifting additional BHD services from the Mental Health Complex into community settings.

For purposes of our analysis, we further break down the four primary service categories into subcategories, as described below:

- **Inpatient** – This category is broken down into the subcategories of acute adult inpatient, which encompasses services associated with BHD's four licensed inpatient units (current combined average daily census of about 70 patients); and child and adolescent inpatient, which encompasses services associated with BHD's single Children's and Adolescent Inpatient Unit (CAIS – current average daily census of about seven patients).
- **Psychiatric Crisis Services (PCS)** – This category encompasses services associated with BHD's mental health emergency room, which admits about 13,000 patients per year; its

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<sup>1</sup> While mental health and AODA services traditionally have been funded under distinct revenue streams and have existed as distinct program areas in BHD's budget, a new initiative aimed at coordinating service delivery for the substantial percentage of BHD consumers who suffer from co-occurring disorders may alter that paradigm in the future.

<sup>2</sup> Management and support services are a substantial cost in BHD's budget, but the costs for those services are spread out among BHD's various cost centers. This dynamic receives considerable discussion in the final section of this report, which explains how management and support costs are distributed to distinct operational areas in BHD's budget, thus impacting the financial status of those areas of operation.



onsite mental health access clinic and observation unit; and its mobile crisis teams, which directly support onsite crisis operations. We exclude community-based crisis respite beds and crisis resource centers operated by community agencies, as well as other community-based crisis services that are typically included in this service category by BHD. Instead, those services are shown as an independent line item under the community services category. We organize the services in this manner to isolate crisis-related expenditures that are occurring primarily at the Mental Health Complex versus those that are taking place at community-based sites.

- **Nursing Homes** – This category is broken down per BHD’s two long-term care facilities located at its Mental Health Complex: Hilltop, which provides care to individuals with a dual diagnosis of developmental disability and serious behavioral health conditions (current average daily census of about 64 patients); and Rehab Central, which serves individuals who have complex and interacting medical, rehabilitative and psychosocial needs (current average daily census of about 66 patients).
- **Community Services** – This category is broken down into six primary categories of community-based mental health services: Day Treatment, which provides therapeutic services on an outpatient basis to about 13 patients daily; Community Support Program (CSP), which provides high-intensity case management services to more than 1,300 people with chronic mental illness annually; Targeted Case Management (TCM), which provides medium-intensity case management services to more than 1,200 people annually; Service Access to Independent Living (SAIL), which is the centralized intake assessment unit at BHD that assesses the needs of individuals and facilitates their access to community-based services and supports; community-based crisis services, which during the 2009-2011 timeframe consisted largely of three eight-bed crisis stabilization centers and a community-based crisis resource center; and “Other community services,” which contains all other BHD-administered mental health community services not included in the five categories above, including community-based residential facilities, outpatient treatment, and prevention and intervention services.

**Table 2** shows actual expenditures for these programs and services for the 2009-2011 timeframe, while **Figures 2, 3, 4** and **5** depict those expenditure totals in a series of bar graphs.

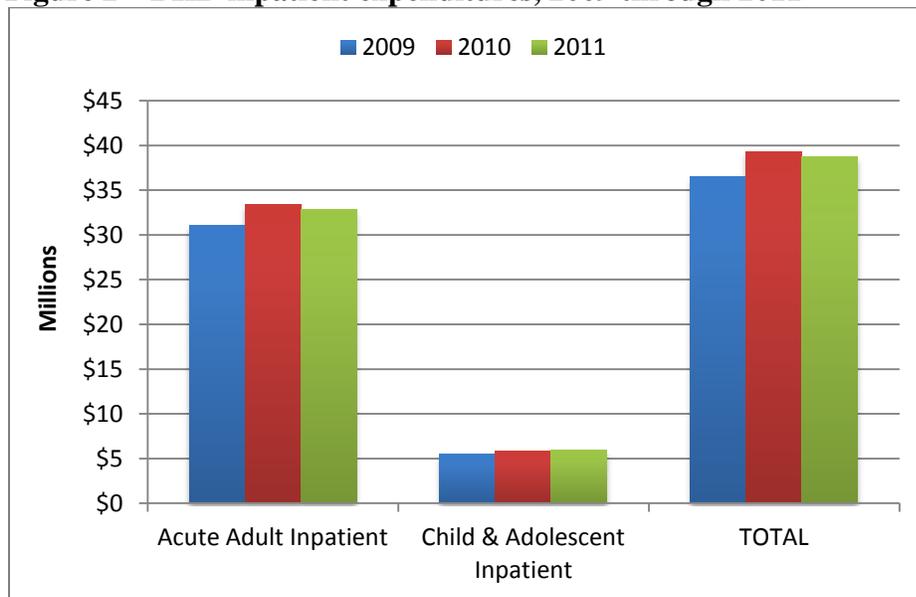


**Table 2 – BHD expenditures in “four key service areas” (inpatient, PCS, nursing home and community services), 2009-2011**

	2009	2010	2011	2009-2011 Change	
<b>INPATIENT</b>					
Acute Adult Inpatient	31,034,465	33,418,023	32,789,264	1,754,798	5.7%
Child & Adolescent Inpatient	5,455,167	5,845,757	5,939,470	484,303	8.9%
<b>TOTAL</b>	<b>36,489,632</b>	<b>39,263,779</b>	<b>38,728,733</b>	<b>2,239,101</b>	<b>6.1%</b>
<b>PSYCHIATRIC CRISIS SERVICES</b>					
<b>TOTAL</b>	<b>16,656,843</b>	<b>16,870,442</b>	<b>18,962,747</b>	<b>2,305,905</b>	<b>13.8%</b>
<b>NURSING HOME</b>					
Hilltop	15,200,977	15,349,238	16,691,928	1,490,952	9.8%
Rehab Central	13,689,632	13,303,236	14,311,442	621,810	4.5%
<b>TOTAL</b>	<b>28,890,609</b>	<b>28,652,474</b>	<b>31,003,370</b>	<b>2,112,761</b>	<b>7.3%</b>
<b>COMMUNITY SERVICES</b>					
Day Treatment	2,175,128	1,904,575	2,182,728	7,600	0.3%
CSP	9,407,231	9,854,590	10,178,138	770,907	8.2%
TCM	4,826,990	4,349,195	4,132,733	-694,257	-14.4%
SAIL	3,939,731	3,660,956	3,442,126	-497,604	-12.6%
Community-based crisis services	520,644	1,100,935	739,530	218,886	42.0%
Other community services	7,944,084	7,532,043	8,606,986	662,902	8.3%
<b>TOTAL</b>	<b>28,813,808</b>	<b>28,402,295</b>	<b>29,282,242</b>	<b>468,434</b>	<b>1.6%</b>
<b>TOTAL BHD EXPS</b>	<b>110,850,892</b>	<b>113,188,991</b>	<b>117,977,093</b>	<b>7,126,201</b>	<b>6.4%</b>

Source: BHD BRASS fiscal reports; BHD's report on community services branch contract expenditures by service area

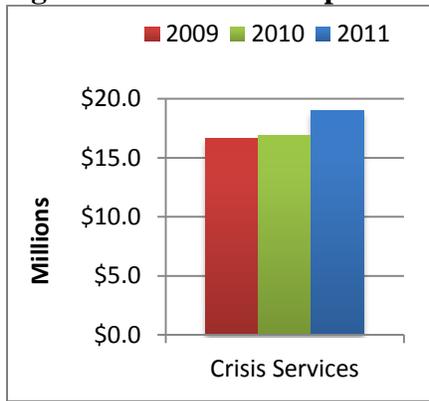
**Figure 2 – BHD inpatient expenditures, 2009 through 2011**



Source: BHD BRASS fiscal reports

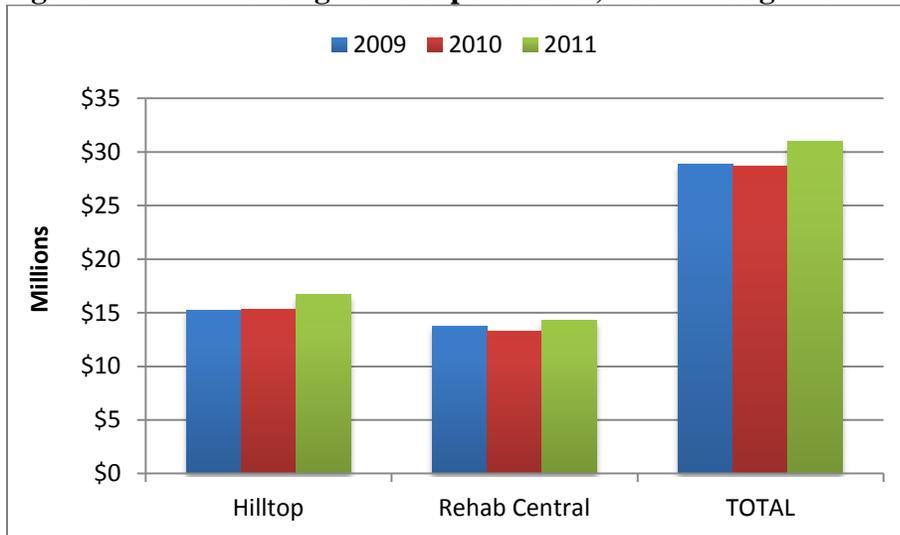


**Figure 3 – BHD PCS expenditures, 2009 through 2011**



Source: BHD BRASS fiscal reports

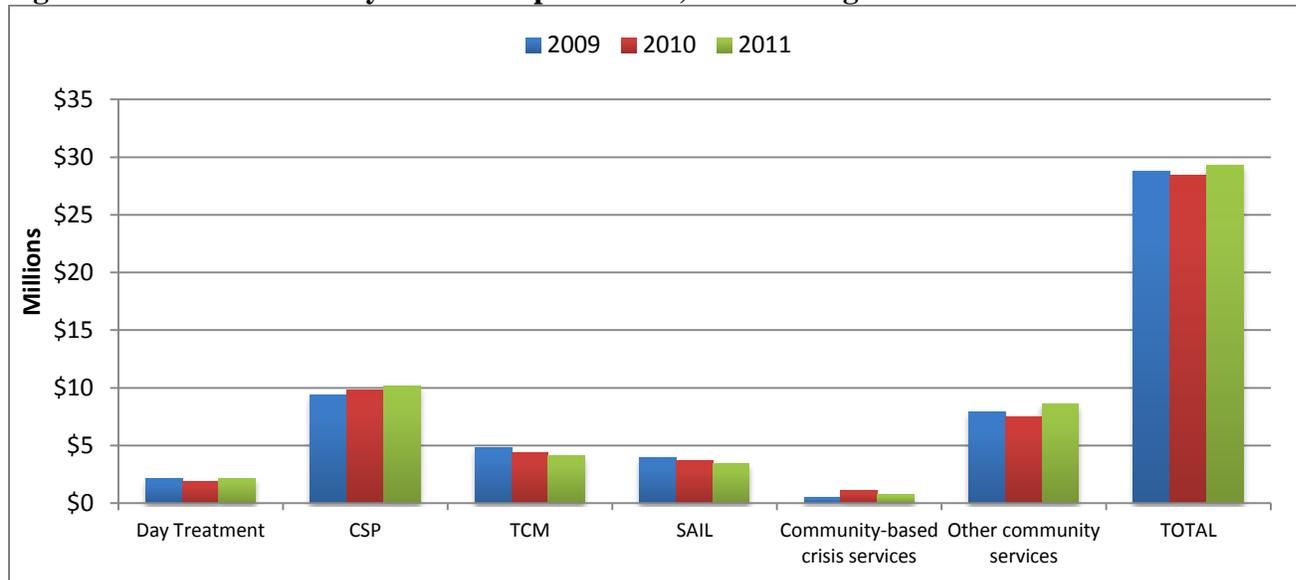
**Figure 4 – BHD nursing home expenditures, 2009 through 2011**



Source: BHD BRASS fiscal reports



**Figure 5 – BHD community services expenditures, 2009 through 2011**



Source: BHD BRASS fiscal reports; BHD's report on community services branch contract expenditures by service area

Examining BHD’s inpatient, PCS, nursing home, and community-based services expenditures from this perspective reveals that all four service categories experienced expenditure increases in the 2009-2011 timeframe. It is worth noting, however, that inpatient, PCS, and nursing home expenditures rose at a faster rate than those for community services (6.1%, 13.8% and 7.3% for inpatient, crisis and nursing homes respectively, versus 1.6% for community services). In fact, we see that expenditures for the three service areas that largely comprise Mental Health Complex operations increased 8.1% over the period.

That finding is not surprising given the context in which BHD was operating during the three-year period.<sup>3</sup> In early 2010, a patient incident at the Mental Health Complex led to an investigation by the federal Center for Medicare and Medicaid Services and a threat to cut off federal reimbursement to BHD, which was lifted shortly thereafter following a series of physical and programmatic improvements. Those improvements involved considerable increases in security, physical plant improvements and enhanced one-on-one staffing levels, as well as increased expenditures in the 2011 budget for major maintenance (\$500,000), new clinical positions (\$1.9 million), quality assurance/staff education (\$562,000), and overtime (\$675,000). Those expenditure increases were allocated across several service categories within the Mental Health Complex, including PCS and Hilltop (where the patient incident occurred). In addition, since 2009, BHD has been working to restore its Joint Commission accreditation, an undertaking that involves several physical and staffing improvements to its onsite operations.

<sup>3</sup> We were curious about whether increases in BHD’s share of Milwaukee County “legacy costs” (i.e. costs related to the county’s pension and retiree health care obligations) were a major contributor to the expenditure increases in the predominantly county-staffed functions housed at the Mental Health Complex, but our analysis showed that BHD’s overall legacy benefits actually decreased from \$15.2 million in 2010 to \$14 million in 2011.



At the same time, BHD took several steps during that period to reduce Mental Health Complex-related overhead costs in an effort to offset the expenditure increases cited above, including initiatives to outsource both dietary and housekeeping services. In fact, had it not been for those initiatives, the total increases observed for inpatient, PCS and nursing home services from 2009 to 2011 would have been at least \$2 to \$3 million higher.

The fact that these key mental health service areas were granted a nearly \$7 million increase during a time when Milwaukee County was struggling with severe budgetary challenges may have reflected the intense scrutiny under which the division was operating during this period. Indeed, it could be argued that the county had little choice but to invest additional resources given the attention of state and federal regulators and the general public.

A key question today is whether annual increases of this magnitude can be sustained, and whether they need to be. To the extent that BHD was able to use this “opportunity” to shore up its staffing levels and physical plant at the Mental Health Complex, then it is possible that the need for future annual increases in the 4% range for services at the Complex will diminish. If that is the case, then the county as a whole may experience some limited relief, or it is possible that resources that would have been targeted for onsite operations could be shifted to community-based services.

On the other hand, given general trends in health care inflation and the fact that BHD now has taken advantage of some of its biggest opportunities for overhead reductions, it may not be possible for the county to avoid annual increases of this magnitude to maintain appropriate service quality without significant changes to Mental Health Complex operations. In future sections of this report, we will examine how BHD grappled with this issue in its 2012 budget and 2013 budget request.

### Locally Allocated Resources

The use of total expenditure data to analyze how BHD cost trends are impacting Milwaukee County’s overall finances is somewhat limited by the fact that many of the inpatient, nursing home and community services provided by BHD are supported (at least in part) by cost-based reimbursement from federal funding sources like Medicaid and Medicare. Consequently, depending on the reimbursement rates established by the federal and state governments, at least some of the annual inflationary cost increases associated with those services are matched by increases in outside revenue, thus decreasing the negative impact on the county’s bottom line.

It is important, therefore, to examine trends in the use of locally allocated resources to support mental health services, as it is the competition for those limited resources among the county’s various functions that dominates annual budget deliberations. The property tax levy is by far the county’s largest source of locally allocated funding at \$275 million in the 2012 budget. Other major revenue streams that are allocated at the discretion of the county executive and county board are the sales tax (\$64 million) and state shared revenue (\$31 million).

Under the county’s budget methodology, those revenue sources are blended in that the total amount of property tax levy that is shown in departmental budgets actually includes *all* non-

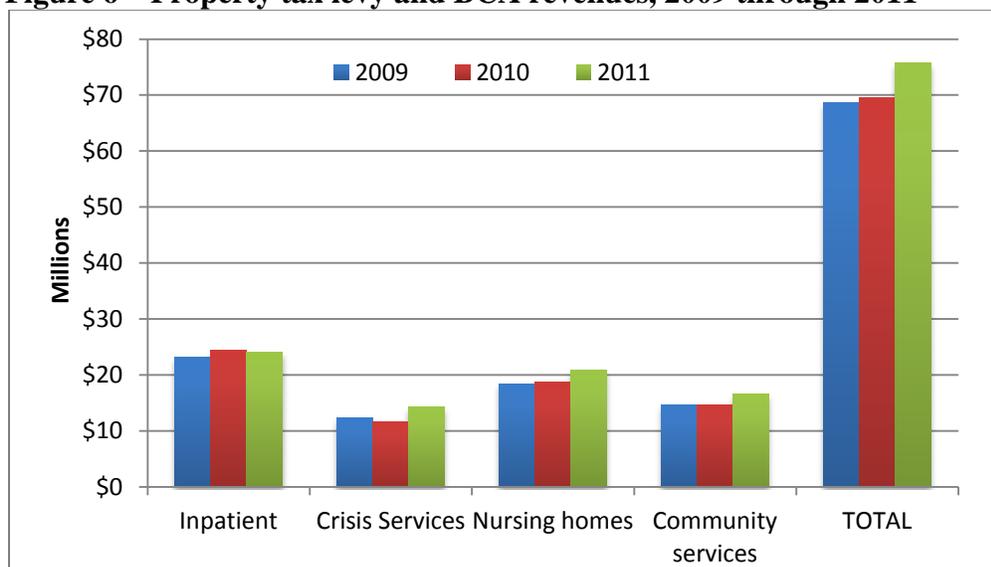


departmental revenues. While the specifics of this allocation methodology are complicated and not directly germane to this analysis, what is most relevant is that given the numerous and varied demands on the county’s limited locally allocated sources of revenue (which only comprise about 30% of its overall budget), the need for increased property tax levy allocations to meet growing costs for mental health services creates a significant financial challenge.

An analysis that only tracks BHD’s annual property tax allocations as a means of assessing that challenge will not take into account, however, the interplay in BHD’s budget between property tax levy and its Basic County Allocation (BCA) from the state’s Community Aids program. Community Aids is a source of somewhat flexible funding provided by the State of Wisconsin that can be used at counties’ discretion for certain *health and human services* programs and services. In 2012, Milwaukee County will use about two-thirds of its \$35 million BCA allocation to support BHD programs and services, with the remainder allocated to other DHHS divisions.<sup>4</sup> BCA is combined with property tax levy in this analysis because BHD uses these sources interchangeably to pay for services that are not covered with other forms of reimbursement or grant revenue.

In **Figure 6**, we show the combined property tax levy and BCA dedicated to the four major mental health service areas in the 2009-2011 timeframe. This analysis shows increases in combined levy and BCA for all four service areas during the period, with an \$800,000 increase for inpatient, \$2.1 million for crisis services and \$2.5 million each for nursing homes and community services. Combined, the four services experienced an 11.7% increase in property tax/BCA expenditures from 2009 to 2011, or an average of about 5.8% per year.

**Figure 6 – Property tax levy and BCA revenues, 2009 through 2011**



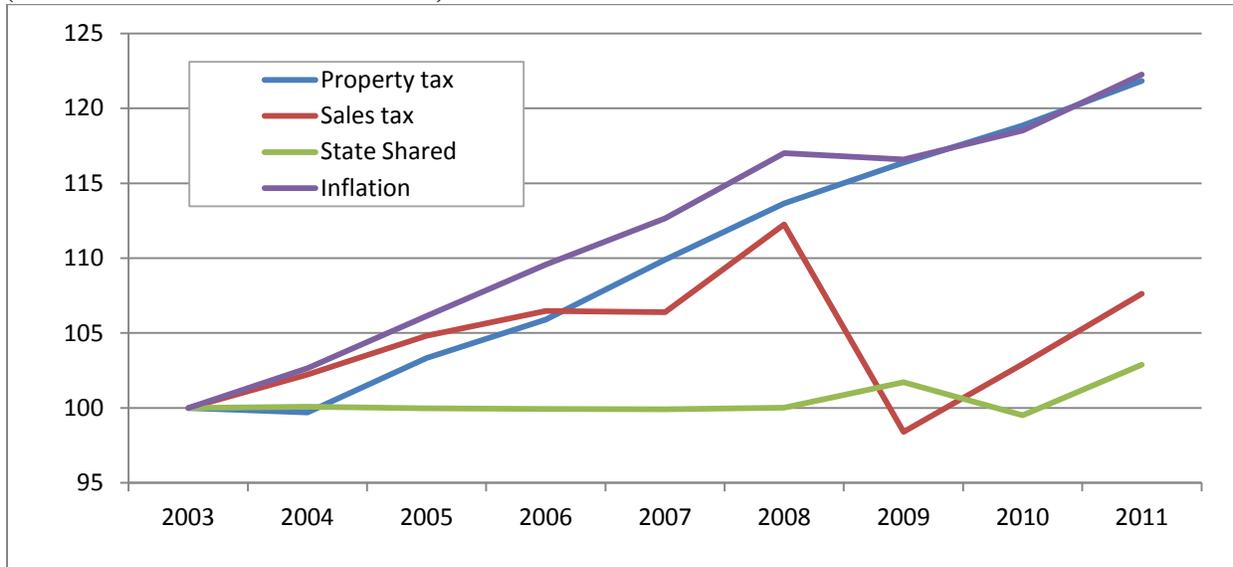
Source: BHD BRASS fiscal reports

<sup>4</sup> The county gradually has shifted a greater proportion of its BCA to BHD during the past five years, as the allocation used to be roughly split between BHD and other DHHS divisions. This is in part because program responsibilities in other parts of DHHS have diminished with the state’s takeover of the Income Maintenance function. The County’s total BCA allocation has been largely flat for most of the past decade, and has actually declined in recent years because of the Income Maintenance shift and a 10% cut in the 2011-13 State budget.



On its face, even an annual increase in local mental health care-related expenditures in the 6% range should not raise eyebrows in light of the magnitude of overall health care inflation in southeast Wisconsin and the nation. For Milwaukee County government, however, such annual increases are quite problematic, as the county’s major sources of locally-allocated revenues that support such expenditures – the property tax, sales tax, and state shared revenue – generally have lagged even general inflation, as shown in **Figure 7**.

**Figure 7: Milwaukee County local tax revenues, shared revenue, and inflation, 2003 to 2011 (Actual revenues indexed to 100)**



Source: Milwaukee County Department of Administrative Services

### Patient Care Revenue

To gain further insight into why such substantial increases in property tax/BCA allocations were required to support mental health services over the three-year period, we next examine the other major revenue source that supports BHD’s mental health programs and services: reimbursement revenue from state, federal and commercial insurance sources that is directly linked to services provided. **Table 3** shows the amounts and sources of “patient care” revenue received by all BHD programs and services during the 2009-2011 timeframe,<sup>5</sup> while **Figure 8** shows each source as a proportion of BHD’s total patient care revenue pie.

<sup>5</sup> It is important to note that the annual figures cited in this table reflect the cash received in each respective year, but not necessarily the year in which the service was provided.

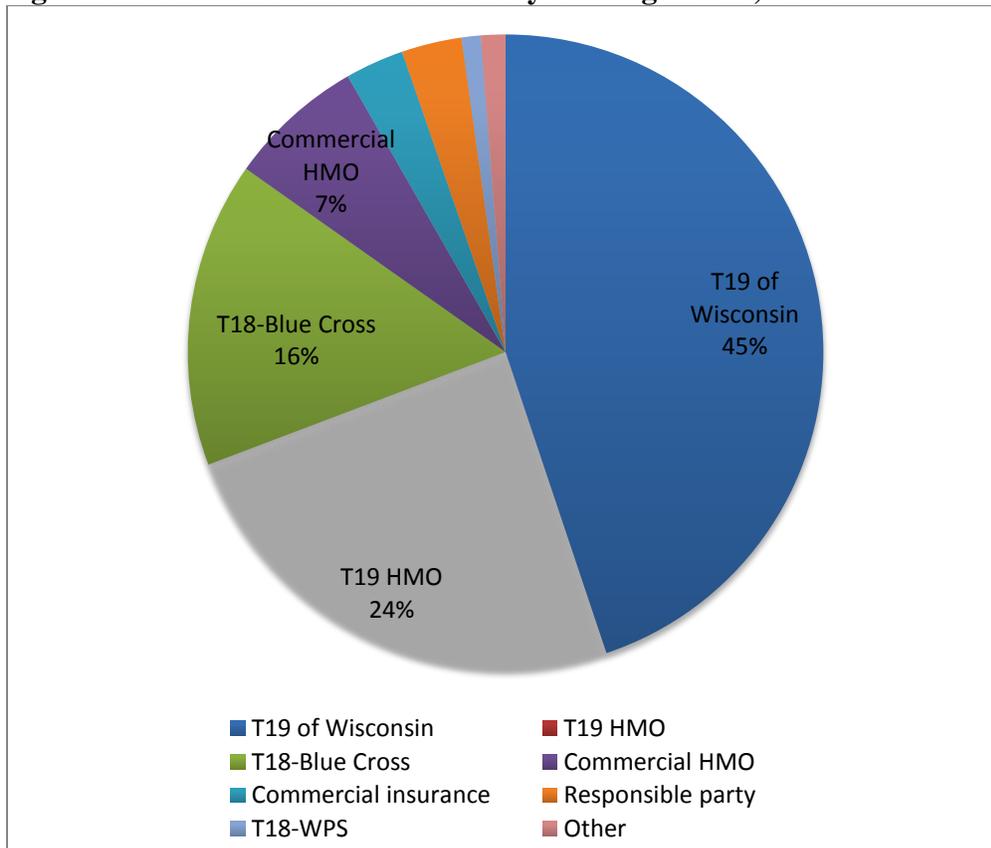


**Table 3 – BHD patient care revenue, 2009 through 2011**

Funding source	2009	2010	2011
T19 of Wisconsin	15,019,389	16,298,445	14,718,765
T19 HMO	5,776,795	6,267,783	7,997,044
T18-Blue Cross	4,483,380	4,635,423	5,105,472
Commercial HMO	2,096,014	1,700,714	2,277,934
Commercial insurance	1,188,006	1,191,066	979,821
Responsible party	1,081,616	1,065,721	1,005,125
T18-WPS	381,260	425,838	318,453
Other	282,796	544,038	409,585
	<b>30,309,256</b>	<b>32,129,028</b>	<b>32,812,199</b>

Source: BHD 2011 & 2012 quarterly Fiscal and Program Dashboard reports

**Figure 8 – Patient care cash received by funding source, 2011**



Source: BHD 2011 & 2012 quarterly Fiscal and Program Dashboard reports

The largest source of patient care revenue is the Medicaid program (T19). BHD receives Medicaid revenues directly from the state for patients who are Medicaid-eligible, and from private HMO’s that manage the care of Medicaid-eligible individuals under contract with the state. The second largest source is T18, which refers to the federal Medicare program.



In **Table 4**, we isolate patient care revenue that collectively stemmed only from inpatient, PCS, nursing home, and community services, and show those three-year revenue trends in comparison to the other major sources of revenue that support those services. **This table shows the essence of BHD’s fiscal challenge: the growth in patient care and “other” revenues did not keep pace with BHD’s mental health expenditure needs over the 2009-2011 period, thus necessitating a \$7.8 million increase in property tax/BCA expenditures during the period.**<sup>6</sup>

**Table 4 – BHD major revenue sources supporting four key service areas, 2009-2011**

	2009	2010	2011	Change
Property tax levy	45,218,046	47,040,830	53,358,487	8,140,442
BCA	21,723,931	21,624,670	21,412,170	-311,761
Patient care revenue	26,888,697	27,784,854	28,564,170	1,675,473
Other	14,990,968	15,187,181	13,274,236	-1,716,732
<b>TOTAL</b>	<b>108,821,642</b>	<b>111,637,535</b>	<b>116,609,063</b>	<b>7,787,422</b>

Source: BHD BRASS fiscal reports

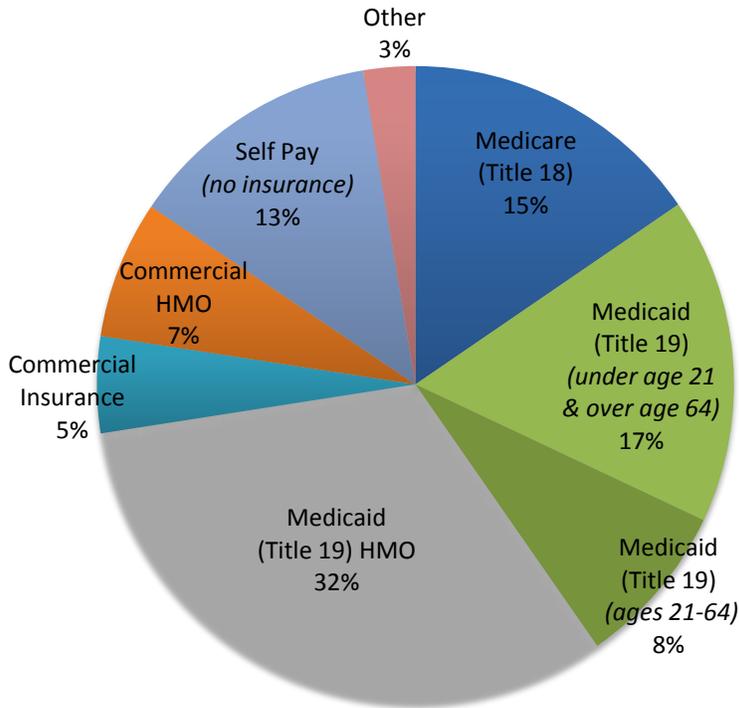
As is the case with nearly all public and private health care providers that serve low-income populations, the amount of patient care revenue received by BHD is far less than the cost of services provided. This discrepancy is based on four primary factors: 1) a sizable percentage of BHD’s clients lack any form of insurance coverage and the means to pay for services out of their own pockets; 2) not all of the services provided by BHD are eligible for reimbursement from Medicaid, Medicare or private insurance plans; 3) even for those services that are covered, public and private insurance plans often do not reimburse at rates that reflect BHD’s costs; and 4) for various reasons linked to the proficiency of its billing capabilities, BHD has not been able to collect all reimbursement to which it is entitled.

**Figures 9 and 10** provide additional perspective by breaking down BHD’s inpatient and crisis admissions by health insurance payer source. This information shows that about 13% of all patients admitted to inpatient units and 26% admitted to PCS lack any form of health insurance. In addition, another 8% of inpatient admissions have Medicaid coverage but fall between the ages of 21 and 64, which means that BHD cannot receive reimbursement because of its “IMD exclusion” (discussed in greater detail below).

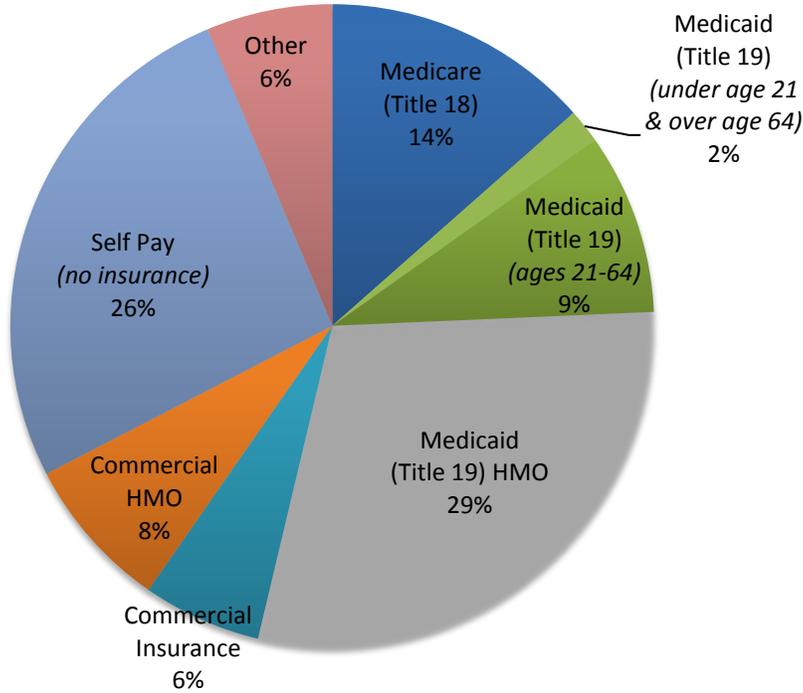
<sup>6</sup> Other revenues include a variety of miscellaneous revenue sources, including federal Community Options Program (COP) funds, state grants, reimbursement from the Wisconsin Medicaid Cost Report (WIMCR) program, Potawatomi revenue, and Institute for Mental Disease revenue from the state that reflects the cost of serving certain patients in the community who otherwise would qualify for inpatient/nursing home care.



**Figure 9: Inpatient admissions by health insurance payer source, 2011**

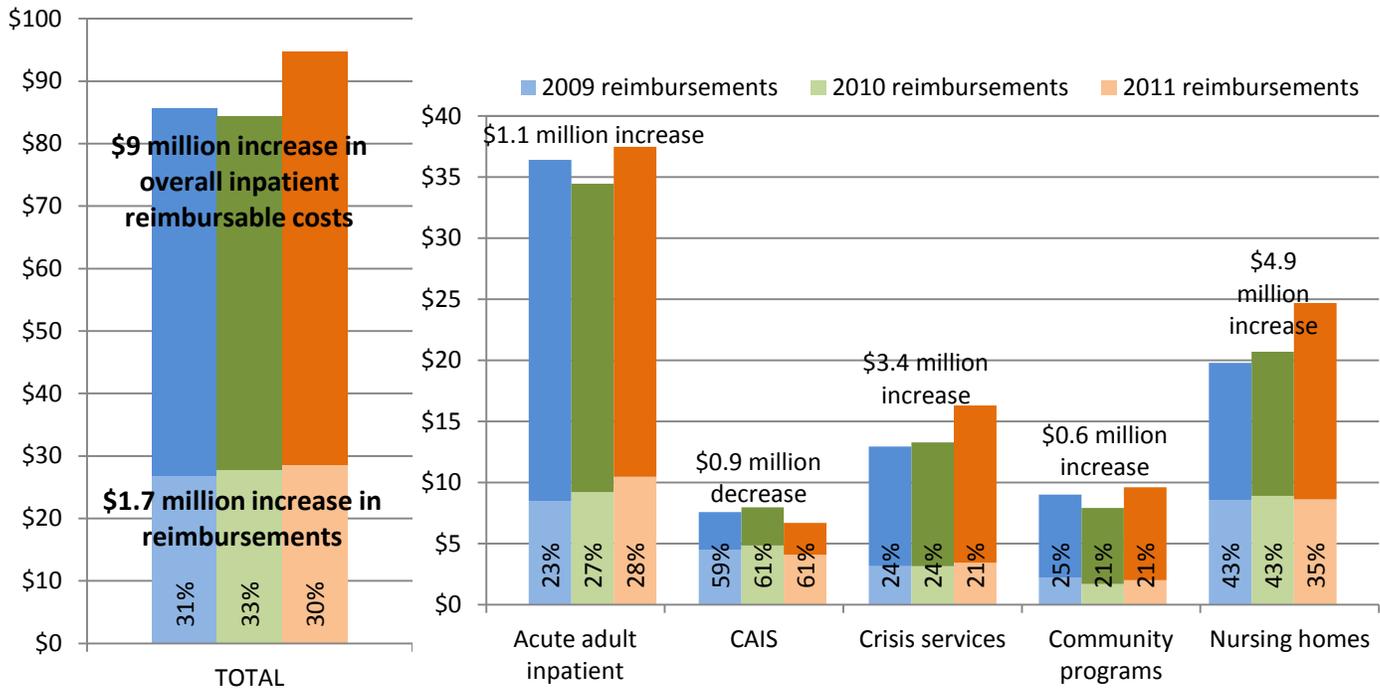


**Figure 10: Psychiatric Crisis Service admissions by health insurance payer source, 2011**



In **Figure 11**, we show the discrepancy between BHD billable services and patient care revenue collections by showing actual patient care revenue collected by BHD from 2009 through 2011 versus patient care costs for the various categories of mental health services.

**Figure 11: Inpatient revenue reimbursement by category, 2009 through 2011**



Source: BHD 2011 & 2012 quarterly Fiscal and Program Dashboard reports

Taken together, these figures reinforce the fact that BHD receives patient care reimbursement for only a fraction of its patient care costs, and that reimbursable costs have been growing at a much faster clip than actual reimbursements. Even more important, they also highlight the difficulty the division may have in reversing this problem by showing the sizable percentage of uninsured patients; and the even greater percentage who are covered by Medicaid, which is a funding source that is heavily influenced by the fiscal challenges facing both the federal and state governments.

BHD’s largest source of Medicaid reimbursement – shown above as T19 of Wisconsin revenue – consists of several subcategories, the largest of which is reimbursement based on rates established annually by the Wisconsin Department of Health Services (DHS) for emergency, inpatient, nursing home and day treatment services provided to Medicaid-eligible individuals at the Mental Health Complex.<sup>7</sup> As shown in **Table 3** above, BHD’s T19 reimbursement from the state increased substantially from 2009 to 2010, but then decreased even more substantially from 2010 to 2011.

<sup>7</sup> BHD and its contract vendors also receive smaller amounts of Medicaid reimbursement on roughly a 60% federal/40% local basis for certain case management and related community services. This revenue is not included in the T19 of Wisconsin revenue category.



Any efforts that BHD might wish to undertake to increase its receipt of T19 revenue from the state are impacted by the following challenges:

- BHD’s inpatient operation is classified under federal guidelines as an “Institute for Mental Disease (IMD),” which prohibits it from collecting state Medicaid reimbursement for inpatient services provided to individuals between the ages of 21 and 64, even if those individuals are enrolled in Medicaid. This so-called “IMD exclusion” once prevented BHD from collecting several million dollars of Medicaid revenue per year, though that amount has declined recently because of BHD’s ability to collect T19 HMO reimbursement from managed care organizations for individuals served at the Mental Health Complex who are enrolled in one of the state’s Medicaid managed care programs.<sup>8</sup>
- The reimbursement rate for various inpatient and emergency procedures is established by the state DHS and can be impacted by the state’s own budget challenges. Furthermore, the rate often is established late in the calendar year, which means BHD can be subject to mid-year budget deficits that are beyond its control when the state establishes new reimbursement rates that are lower than anticipated and applies those rates retroactively.
- Certain types of Medicaid eligibility – particularly for components of the Badger Care program – are established by DHS and can impact the number of individuals served by BHD for whom Medicaid reimbursement is even an option.

As will be discussed later in this report, despite these challenges, BHD is taking several steps to enhance its collection of T19 revenue – both directly from the state and federal Medicaid programs, and from the private HMOs that provide managed care services for thousands of Milwaukee County Medicaid recipients. This is a logical undertaking for which the division should be applauded given that it would appear to be the most elastic of BHD’s major revenue sources (in contrast to the property tax and BCA) and the one over which it has the greatest internal control. Whether that potential elasticity will allow patient care revenues to grow rapidly enough to meet BHD’s mental health expenditure needs is a critical question, as is what additional steps might be taken given the implementation of ACA to bolster those efforts.

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<sup>8</sup> The IMD exclusion is predicated on the federal government’s concern that local and state governments that run inpatient mental health facilities will inappropriately steer clients into inpatient settings to avail themselves of Medicaid reimbursement, as opposed to serving individuals in the community with services that may not be eligible for similar levels of federal reimbursement.



## BHD 2012 ADOPTED BUDGET AND YEAR-TO-DATE EXPERIENCE

BHD's 2012 adopted budget was highlighted by a handful of far-reaching initiatives that reflected a substantial shift in the nature of inpatient operations, a commitment to investing more heavily in community-based services in keeping with the principles of early mental health redesign planning, and a continuation of efforts to shore up both the quality of Mental Health Complex operations and the accuracy of certain key revenue projections.

**Table 5** provides an overview of BHD's 2012 budget, as compared to actual spending and revenues in 2011. For the sake of consistency with previous tables in this report, we deduct expenditures and revenues related to Emergency Medical Services.

**Table 5: BHD 2012 Adopted Budget and 2011 Actual Expenditures and Revenues**

	2011A	2012B
Personal Services w/out fringe	46,382,064	45,085,763
Employee fringe benefits	31,990,379	30,368,100
Services	19,394,747	15,524,539
Commodities	7,079,988	5,949,492
Other charges	74,371,405	78,509,772
Debt and depreciation	-	-
Capital outlay	325,256	410,000
Capital contra	-	-
County service charges	40,421,891	42,526,368
Abatements	(35,170,135)	(37,236,708)
<b>Total Expenditures</b>	<b>184,795,596</b>	<b>181,137,326</b>
Direct revenue	61,355,869	58,064,298
State and federal revenue	61,584,993	58,019,971
Indirect revenue	10,002,135	9,800,590
<b>Total Revenues</b>	<b>132,942,996</b>	<b>125,884,859</b>
<b>Property Tax Levy</b>	<b>51,852,600</b>	<b>55,252,467</b>

Source: BHD BRASS fiscal reports

This broad budgetary snapshot reveals several notable points regarding the manner in which county and BHD officials responded to the fiscal trends observed in the previous three years, as well as the new momentum of mental health redesign planning:

- BHD was able to secure an additional \$3.4 million in property tax levy in the 2012 budget. Approximately \$3 million of that amount was inserted in the budget to fund a series of initiatives linked to community resource investment consistent with mental health redesign recommendations.
- The budget projected continued substantial challenges on the revenue side, with both direct revenue and state/federal revenue projected to decline by more than \$3 million from 2011 actual amounts. Reductions in BCA and adult mental health community services funds from the state were partially responsible, as were efforts to adjust certain revenue accounts to



better reflect recent experience. On the positive side, BHD budgeted for a \$250,000 increase in WIMCR revenue resulting from an effort to maximize that revenue source with the help of an outside consultant.

- BHD’s personnel and fringe benefit costs both were budgeted to decline by more than \$1 million from 2011 actual spending levels, despite the full-year impact of an initiative begun in 2011 to increase the salaries of psychiatrists and psychologists. One cause of the decline was an initiative to outsource the remainder of the TCM caseload. BHD also benefited from cost-saving changes to the county’s employee health care package.

In **Table 6**, we drill down further into BHD’s 2012 budget by breaking down budgeted expenditures in the four major mental health expenditure categories analyzed in the previous section of this report. The table compares 2012 budgeted expenditure levels with actual expenditure data from the previous three years and 2011 budgeted amounts.

**Table 6: BHD 2012 Adopted Budget Expenditures in Four Key Service Areas**

	2009	2010	2011	2011B	2012B
<b>INPATIENT</b>					
Acute Adult Inpatient	31,034,465	33,418,023	32,789,264	32,809,336	32,138,850
Child & Adolescent Inpatient	5,455,167	5,845,757	5,939,470	5,797,415	5,543,000
<b>TOTAL</b>	<b>36,489,632</b>	<b>39,263,779</b>	<b>38,728,733</b>	<b>38,606,751</b>	<b>37,681,850</b>
<b>PSYCHIATRIC CRISIS SERVICES</b>					
<b>TOTAL</b>	<b>16,656,843</b>	<b>16,870,442</b>	<b>18,962,747</b>	<b>17,178,229</b>	<b>18,099,822</b>
<b>NURSING HOME</b>					
Hilltop	15,200,977	15,349,238	16,691,928	14,253,348	14,518,649
Rehab Central	13,689,632	13,303,236	14,311,442	11,742,044	13,089,851
<b>TOTAL</b>	<b>28,890,609</b>	<b>28,652,474</b>	<b>31,003,370</b>	<b>25,995,392</b>	<b>27,608,500</b>
<b>COMMUNITY SERVICES</b>					
Day Treatment	2,175,128	1,904,575	2,182,728	2,325,711	2,298,886
CSP	9,407,231	9,854,590	10,178,138	10,085,680	9,886,580
TCM	4,826,990	4,349,195	4,132,733	4,589,382	3,646,050
SAIL	3,939,731	3,660,956	3,442,126	4,605,016	4,138,156
Community-based crisis services	520,644	1,100,935	739,530	812,635	2,692,635
Other community services	7,944,084	7,532,043	8,606,986	9,415,535	9,744,007
<b>TOTAL</b>	<b>28,813,808</b>	<b>28,402,295</b>	<b>29,282,242</b>	<b>31,833,959</b>	<b>32,406,313</b>
<b>TOTAL BHD EXPS</b>	<b>110,850,892</b>	<b>113,188,991</b>	<b>117,977,093</b>	<b>113,614,330</b>	<b>115,796,486</b>

Source: BHD BRASS fiscal reports

Attributing too much significance to one-year differences in expenditures in various cost centers at BHD is risky because such differences often can result from changes in methodology for allocating internal service charges among BHD’s various centers, or other accounting changes. Nevertheless, examining the change between 2011 and 2012 expenditures in the context of some of the division’s 2012 budget priorities reveals the following observations:



- Despite a realignment of inpatient operations that reduced adult acute inpatient capacity from 96 to 85 beds (11.5%), adult inpatient expenditures were budgeted to decrease by only about \$600,000 (2%) from the previous year's actual and budgeted amounts. This likely resulted from a number of factors, including the need to accommodate inflationary increases in fixed costs, and the fact that newly realigned inpatient units – while producing a substantial decline in bed capacity – also incorporated the need for enhanced levels of treatment that precluded sharp reductions in staffing levels. It is important to note that BHD officials viewed the creation of new intensive treatment and women's treatment units as quality improvement initiatives, as opposed to cost-cutting strategies. Still, the 2012 budget shows that as BHD looks to the future, reductions in bed capacity may not necessarily produce substantial savings that can be reinvested in community-based services, at least to the extent that no units are fully closed.<sup>9</sup>
- While BHD was able to budget for an \$800,000 reduction at PCS for 2012 when compared to 2011 actual spending, the 2012 budgeted amount was almost \$1 million higher for PCS than the 2011 budgeted total, and substantially higher than actual spending in the two years before that. Thus, it appears the need to devote additional resources to PCS continued to be a fiscal challenge for the division.<sup>10</sup>
- Similarly, while budgeted nursing home expenditures in 2012 were substantially below actual expenditures in 2011, they were \$1.6 million higher than 2011 budgeted amounts. This shows that when county and BHD officials formulated and adopted the 2012 budget (using the 2011 budget as their base), the need to devote additional resources to BHD's nursing home facilities also continued to be a major fiscal challenge.
- In the end, the county's desire to jump-start mental health redesign by allocating an additional \$3 million to community services (most of which shows up in the community-based crisis services line above) required an additional allocation of *property tax levy resources*, as shown in **Table 5**. Fiscal savings achieved by outsourcing TCM services, enhancing WIMCR revenues, reducing funding for BHD's information technology vendor (made possible by a new electronic medical records initiative), and implementing new cost-saving strategies for pharmacy and dietary services did not free up resources for community reinvestment, but instead were used to keep up with the demands of Mental Health Complex operations. This is similar to the budget paradigm faced by BHD in previous years.

An analysis of actual spending and revenues through the first six months of 2012 also reveals that several of the fiscal challenges that confronted BHD in 2009-2011 remain pressing today. The division's second quarter fiscal report projects a year-end deficit of \$1.7 million. Of greatest concern are a projected \$770,000 deficit in patient care revenue and a \$1 million deficit in

<sup>9</sup> Another important variable in determining the financial savings that might be achieved via reductions in bed capacity is the acuity levels of the remaining patient population. For example, to the extent that reductions in inpatient capacity are achieved by transferring patients of relatively low acuity to private hospitals, thus leaving a patient population at the Mental Health Complex with proportionately greater acuity levels, corresponding reductions in staffing may not be possible.

<sup>10</sup> It should be recognized that efforts during the past three years to update BHD's cost allocation methodologies and to otherwise "clean up" accounting procedures may have impacted PCS expenditures and may modify the conclusion that service-related expenditure increases at PCS have been a major cost driver.



personnel expenditures despite a remarkable reduction in the average daily adult inpatient census from the 85 projected in the budget to 69. This would appear to indicate that a vastly reduced inpatient census has logically produced a decline in revenues, but has not been met with a corresponding decrease in inpatient expenditures.

In addition, despite BHD's commendable efforts to address longstanding areas of budgetary imbalance, it is notable that deficits again are forecast in overtime (\$209,000), wages (\$800,000) and "other revenues" (\$368,000). Collectively, these projections may indicate that the division's efforts to fill gaps in areas that have created substantial mid-year deficits in previous years – while resulting in significant improvement – have not yet achieved complete success.

It is too early to comprehensively analyze BHD's 2012 revenue performance, but there are a couple of bright spots. One is a projected \$377,000 surplus in WIMCR revenue, which reflects BHD's strategic approach to improving its cost reporting, and which may have even greater future potential given that several new strategies recommended by an outside consultant have yet to be implemented. Another is continued improvements cited by BHD fiscal officials in overall revenue collection strategies, which will be aided by full implementation of an electronic medical records (EMR) system and efforts to generate greater revenue from state-contracted HMOs and the Family Care program. The second quarter report likely does not fully capture the impact of those improvements, and BHD officials have expressed optimism that they will help the division reduce or eliminate the patient care revenue deficit by the end of the year.

Overall, from the perspective of BHD's mental health redesign planning, perhaps the most cautionary financial conclusion from BHD's 2012 budget and actual experience to date are that 1) a substantially reduced inpatient census at the Mental Health Complex has not freed up resources for reinvestment in community-based services; and 2) the continued existence of a structural deficit logically would make areas of structural imbalance the first target for any savings that eventually might be realized by downsizing Mental Health Complex operations.

Again, it is important to note that the creation of new specialized adult inpatient units and the reduction in census contained in the budget were not designed to produce budgetary savings, but instead responded to longstanding operational challenges that may have impacted the quality of inpatient care. It is apparent, however, that the reduction in inpatient revenues resulting from the lower census has exceeded BHD's ability to reduce costs, a reality that logically stems from the fact that the division still is staffing four distinct inpatient units (and thus has not been able to achieve substantial reductions in overhead), and that it has invested in higher staffing levels, compensation and other necessities required to improve care. In addition, the acuity levels of those being served at the Mental Health Complex likely has increased over time as the division has reached agreement with private health systems to care for patients of lower acuity.

Hence, an overriding takeaway is that without substantial changes in either the scope of operations or revenue performance, BHD likely will require an additional property tax levy allocation again in 2013 to address a remaining structural budget hole and accommodate inflationary increases in wages, benefits, commodities, and other fixed costs. If additional investments in community-based care also are desired, then an even more substantial property tax increase would be required.



## BHD 2013 BUDGET REQUEST

Analyzing the challenges faced by BHD in preparing its 2013 requested budget crystallizes the division's overriding fiscal challenges. As has been the norm for Milwaukee County during the past decade, at the beginning of the county's 2013 budget process in April 2012, departments were instructed by the central budget office to develop budgets that would require no additional property tax levy from their 2012 budgeted amount. Furthermore, they were instructed to do so while absorbing centrally allocated increases in wages and benefits (both for active employees and to account for BHD's share of countywide legacy costs).

Consequently, as BHD officials and fiscal staff set out to develop their 2013 budget request, they immediately were confronted not only with leftover problems discussed above from 2012 and prior years, but they also were required to address a \$4.6 million net increase in wage and benefit increases required to support 2012 staffing levels. **Table 7** shows how the four major service areas analyzed in this report fared in response to those challenges by comparing expenditure levels in the 2013 requested budget with those of previous years.

**Table 7: BHD 2013 Requested Budget in Four Key Service Areas**

	2009	2010	2011	2012B	2013R
<b>INPATIENT</b>					
Acute Adult Inpatient	31,034,465	33,418,023	32,789,264	32,138,850	30,789,044
Child & Adolescent Inpatient	5,455,167	5,845,757	5,939,470	5,543,000	5,906,910
<b>TOTAL</b>	<b>36,489,632</b>	<b>39,263,779</b>	<b>38,728,733</b>	<b>37,681,850</b>	<b>36,695,954</b>
<b>PSYCHIATRIC CRISIS SERVICES</b>					
<b>TOTAL</b>	<b>16,656,843</b>	<b>16,870,442</b>	<b>18,962,747</b>	<b>18,099,822</b>	<b>19,219,364</b>
<b>NURSING HOME</b>					
Hilltop	15,200,977	15,349,238	16,691,928	14,518,649	13,689,945
Rehab Central	13,689,632	13,303,236	14,311,442	13,089,851	13,345,141
<b>TOTAL</b>	<b>28,890,609</b>	<b>28,652,474</b>	<b>31,003,370</b>	<b>27,608,500</b>	<b>27,035,086</b>
<b>COMMUNITY SERVICES</b>					
Day Treatment	2,175,128	1,904,575	2,182,728	2,298,886	2,556,485
CSP	9,407,231	9,854,590	10,178,138	9,886,584	9,698,895
TCM	4,826,990	4,349,195	4,132,733	3,739,931	3,499,852
SAIL	3,939,731	3,660,956	3,442,126	4,138,156	4,247,423
Community-based crisis services	520,644	1,100,935	739,530	2,692,635	2,617,921
Other community services	7,944,084	7,532,043	8,606,986	9,650,122	9,687,950
<b>TOTAL</b>	<b>28,813,808</b>	<b>28,402,295</b>	<b>29,282,242</b>	<b>32,406,313</b>	<b>32,308,526</b>
<b>TOTAL BHD EXPS</b>	<b>110,850,892</b>	<b>113,188,991</b>	<b>117,977,093</b>	<b>115,796,486</b>	<b>115,258,930</b>

Source: BHD BRASS fiscal reports



This snapshot analysis reveals the following:

- After a substantial increase in spending on community services in the 2012 budget, the 2013 request essentially maintains community services expenditures at the 2012 level. The table above shows a slight decrease, but that is in part attributable to reduced expenditures from outsourcing the Downtown CSP caseload.
- BHD was able to reduce expenditures from 2012 budgeted levels on acute inpatient and nursing homes. This largely resulted from two downsizing initiatives that are discussed in greater detail below.
- The trend of increased expenditures on PCS continues in the 2013 budget request, with an increase of \$1.2 million over the 2012 budgeted amount. This may be attributed, in part, to efforts to transform the former Crisis Walk-in Clinic at the Complex to a Mental Health Access Center, which provides a broader array of services.

A deeper examination reveals the following major fiscal strategies employed by BHD and DHHS officials in their 2013 budget request that help explain these observations.

- In addition to the fiscal challenges posed by wage and benefit increases for BHD's workforce, the division was required to accommodate more than \$500,000 in additional Mental Health Complex costs linked to increased dietary, security, maintenance and utility costs and decreased space rental revenues. In addition, the requested budget includes \$1.3 million related to the completion of the EMR project.
- BHD officials continued their effort to "clean up" various expenditure and revenue accounts to better reflect actual experience and reduce the structural deficit going forward. While those steps exacerbated the division's overall budgetary challenge in 2013, they reflect a commendable effort that has occurred over the past several years to eliminate budget holes caused by inaccurate or outdated budgeting and accounting. Some expenditure adjustments were included in the Mental Health Complex cost increases cited above, while a major revenue reduction was a \$300,000 adjustment linked to an earlier revenue maximization initiative.
- BHD's BCA allocation for 2013 was decreased by \$1.8 million to account for the state's decision to "intercept" \$2.7 million of BCA related to its takeover of Income Maintenance programs, as opposed to charging the county that amount in property tax levy. Because the move was tax levy neutral in DHHS' overall budget, BHD's requested budget includes an additional \$1.4 million in property tax levy, which helps offset the BCA reduction but still leaves the division \$400,000 short.
- BHD included two major revenue increases in its requested budget to help bridge the budget gaps cited above: a \$2.4 million increase in WIMCR revenue (offset by a \$192,000 consultant fee) attributed to cost report improvements suggested by its consultant; and a \$1.1 million increase in patient care revenue from Family Care CMOs to support nursing home clients who are eligible to be enrolled in the program. Both initiatives are laudatory from a



financial perspective, but it should be noted that the amounts of additional anticipated revenues from each are speculative.

- BHD also included two major Mental Health Complex downsizing initiatives to reduce expenditures: elimination of one unit (24 beds) from the Rehabilitation Center-Hilltop long-term care facility, which is expected to produce \$195,000 in savings in 2013 and eliminate 30 FTEs (annual savings will be substantially higher in 2014 and beyond, as the unit would not be closed until July 1); and elimination of one 24-bed acute inpatient unit (effective April 1, 2013), producing a savings of \$875,000 and eliminating 32.5 FTEs.
- The requested budget includes an initiative to outsource the division's Downtown CSP program, for a net savings of nearly \$400,000. This may represent one of the last substantive outsourcing opportunities for BHD short of outsourcing direct Mental Health Complex clinical services (the division also operates one remaining CSP on Milwaukee's south side).

Overall, it is telling and quite familiar that despite accumulating \$1.4 million in savings from downsizing initiatives and \$3.3 million in additional revenue from two new revenue maximization initiatives, BHD found itself with next to nothing to invest in mental health redesign-generated community resource recommendations (an investment of \$50,000 was included in the requested budget for this purpose). As in previous years, BHD's fixed costs in the areas of personnel and physical plant required substantial additional resources, so savings generated from outsourcing, revenue maximization and – unique to 2013 – a substantial downsizing of inpatient and nursing home units were steered toward those areas. Anything left over was used to plug structural gaps observed in previous years.

From a financial perspective, operating in this fashion is both necessary and appropriate, and BHD officials should be credited for developing cost-cutting and revenue-generating strategies to plug holes and accommodate fixed cost increases without additional property tax levy support. From a programmatic perspective, however, the goal of using Mental Health Complex downsizing savings to enhance community-based care has remained highly challenging.



## LOOKING TOWARD THE FUTURE

The overriding purpose of this analysis was to analyze BHD's overall financial condition, as defined primarily by its need for increasing amounts of Milwaukee County property tax levy that exceeds expected annual growth in the levy. Only after conducting that analysis can we consider the primary question posed by the adult mental health redesign initiative, which is whether a gradual downsizing of Mental Health Complex operations might not only allow BHD to achieve fiscal stability, but also produce sufficient savings to sustain a meaningful expansion of community-based services.

Based on the data provided by BHD, it appears that recent actions to downsize inpatient capacity; outsource housekeeping, dietary and case management services; and maximize patient care and cost reporting revenue have allowed BHD to substantially reduce longstanding structural holes in its budget (at least on paper – some revenue projections still are uncertain). If indeed that is the case, then the question moving forward is whether additional expenditure reduction and revenue maximization strategies are available that might allow BHD to offset its annual increases in personnel and fixed overhead costs with only inflationary increases in its share of the county's locally allocated resources. We analyze that question below from the separate perspectives of both the expenditure and revenue sides of the budget ledger.

### Expenditures

BHD's ability to control annual expenditure increases at the Mental Health Complex may hinge on the following:

- 1) **Taming cost pressures at PCS.** As discussed earlier, it is logical and intuitive that PCS costs would have grown substantially during the past three years because of efforts to enhance staffing levels/compensation and shore up the physical plant following increased scrutiny of Mental Health Complex operations. It also is logical that PCS costs would have increased more dramatically than acute inpatient and nursing home costs because offsetting savings related to the dietary and housekeeping initiatives would not have been as substantial. Still, we see that after a 13.8% increase in actual PCS expenditures from 2009 to 2011, BHD has been required to budget \$1 million (or in excess of 5%) increases over the previous year's budgeted amounts in both 2012 and in its 2013 budget request. It is important to note that those increases are not being driven by increases in PCS visits or admissions, which have been relatively stable over the past four years.

BHD fiscal officials believe the sizable increase from 2009 to 2011 not only was caused by beefed up staffing, security, etc., but also may have resulted from the way certain expenditures on Mental Health Complex improvements were categorized. This reflects an overriding problem observed during the course of this analysis that it is very difficult to pinpoint cost pressures and their potential causes at BHD because budgeting and accounting procedures often change from year to year.

Regardless of the extent to which significant increases in PCS expenditures can be attributed to accounting issues, an important question is whether PCS operations have stabilized to the



point that substantial enhancements of clinical staff should not be necessary in the foreseeable future. If that is the case, and if recent sizeable investments in community-based crisis services significantly reduce the demand for such services at the Mental Health Complex, then there may even be potential to reduce PCS expenditures in future years. During the past year, BHD has opened a second community-based crisis resource center, created an enhanced Mental Health Access Clinic, and established a new Community Linkages and Stabilization Program, each of which holds promise to reduce activity levels at PCS. BHD officials may wish to further analyze the potential for expenditure reduction strategies to correspond with lower activity levels and factor that potential into budget and mental health redesign planning.

- 2) **Realizing substantial relief from inpatient and Hilltop unit closures.** Perhaps the most important near-term fiscal question for BHD is whether the ongoing annual savings in staffing and overhead produced by the closure of one acute inpatient unit and one unit at Hilltop in 2013 (assuming those requests are adopted in the budget) will allow those major cost centers to stop being the biggest annual drain on BHD's overall budget. Because the two proposed unit closures will not occur until mid-year, some additional savings also should materialize in 2014 that may be available to help fund community enhancements. The larger question, however, is whether after these steps are taken, will Mental Health Complex operations be "right-sized" to the extent that annual increases in fixed costs going forward can be covered by increases in patient care or other non-property tax revenues.

Unfortunately, our analysis of the cost savings projected by BHD from its unit closures reveals that is unlikely to be the case. **Table 8** reproduces figures from a BHD work document used to develop the 2013 budget request that show initial projected cost savings that would result from the closure of one of the four adult acute inpatient units as of April 1, 2013. This information shows that BHD initially projected an annual expenditure savings of \$2.5 million and an annual property tax levy savings of \$1 million out of total expenditure amounts of \$30.3 million and \$23.8 million respectively. The lower property tax levy savings is caused by the estimated loss of \$1.5 million of patient care revenue associated with the reduced census.<sup>11</sup>

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<sup>11</sup> The savings amount of \$875,224 cited in the requested budget differs from the amount shown in the table because of changes that occurred when this and other initiatives were plugged into the county's budgeting system (BRASS). We use the budget figures shown in the table because this was the information that could be readily provided to us by BHD. We are confident that even if we had access to and used the BRASS numbers, our overall findings would have been the same. Also, we focus on the closure of an adult inpatient unit in this analysis, but the findings generally are the same for the closure of a Hilltop unit.



**Table 8: Projected Annualized Savings from Closing One Acute Treatment Unit**

	2013 Baseline	2013 Request w/1 Closure	9-Month Savings
Personal Services	18,235,808	16,284,336	1,951,472
Services	545,291	443,049	102,242
Commodities	1,687,691	1,371,249	316,442
Other charges	1,040,505	1,040,410	95
Capital outlay	30,000	24,375	5,625
Crosscharges	11,331,451	11,168,882	162,569
<b>Total Expenditures</b>	<b>32,870,746</b>	<b>30,332,301</b>	<b>2,538,445</b>
Direct revenue	7,990,558	6,492,328	(1,498,230)
State and federal revenue	-	-	-
<b>Total Revenues</b>	<b>7,990,558</b>	<b>6,492,328</b>	<b>(1,498,230)</b>
<b>Property Tax Levy</b>	<b>24,880,188</b>	<b>23,839,973</b>	<b>1,040,215</b>

Source: Work document provided BHD fiscal staff

The paramount question is why BHD is able to realize only a 4% savings in property tax levy when it is reducing its bed capacity by 27% (24 of 88 beds). That BHD would not be able to reduce its levy by a percentage that is directly proportional to the reduction in beds makes intuitive sense given that substantial overhead and infrastructure needs remain for the three units, and that it is impossible to reduce costs for items like heating, maintenance and housekeeping on a proportional basis. Still, reason would dictate that savings of greater than \$1 million out of a \$24 million property tax levy allocation should be achievable with the closure of one of four adult inpatient units for nine months of the year.

Deeper analysis reveals that the cause for this discrepancy is the internal and external crosscharges that are allocated to the acute adult inpatient budget. While **Table 8** shows substantial savings in personnel costs and commodities that are along the lines of what might be expected from the closure of one unit, BHD estimates only a \$163,000 (1.4%) savings from its \$11.3 million crosscharge allocation. This finding obviously suggests the need for a deeper understanding of the nature of BHD’s internal and external crosscharges and the methodology for allocating those costs, which we will attempt to convey briefly here.

BHD’s 2012 budget includes a total of \$43.5 million in crosscharges. Of that amount, about \$6.2 million reflects BHD’s charges for services provided by other county government departments (e.g. information technology support, central payroll and accounting, legal services, architectural and engineering services, laundry services, sewer/water) or its share of certain general county government costs that are budgeted centrally (e.g. worker’s compensation, insurance services, computer mainframe charges). The remaining \$37 million consists of BHD’s internal overhead/administrative costs that are allocated to each major subunit of the division proportional to that unit’s share of BHD’s overall budget.<sup>12</sup> Those costs are delineated by administrative/overhead cost center in **Table 9**.

<sup>12</sup> About 20% of this \$37 million consists of “legacy” costs that will remain an obligation of Milwaukee County regardless of whether the personnel costs associated with the internal services are reduced or even eliminated.



**Table 9: BHD Administrative/Overhead Cost Centers**

Cost Center	2012 Allocation
Central Admin	4,800,995
Psychiatry Admin	851,806
Psychology Admin	363,993
Nursing Admin	2,061,109
Organizational Dev	1,274,137
Personnel and Payroll	826,479
Quality Mgmt	614,646
Education	974,057
Security	687,479
Legal Services	442,993
Support Services Admin	70,775
Dietary	3,383,789
Storeroom	363,525
Pharmacy	97,659
Clerical Pool	801,182
Facilities Maintenance Admin	2,809,744
Facilities Maintenance Psych Hosp	3,507,418
Housekeeping	2,368,655
Linen	536,242
Facility Maintenance Day Hosp	440,000
Fiscal Admin	1,375,133
Fiscal Services	883,689
Accounts Receivable	1,459,634
Admissions	961,127
Mgmt Information	2,007,558
Medical Records	1,500,106
Staffing Office	611,167

Understanding the nature of these charges and their prominence in BHD’s adult acute inpatient budget makes it easier to understand why the savings produced by the closure of more than a quarter of BHD’s adult inpatient beds are relatively meager. For example, support functions like accounts receivable, fiscal services and overall administration logically cannot be cut at the same ratio as inpatient beds (e.g. if there are six accountants serving all of BHD, it may not be possible to cut even one of those positions just because an inpatient unit is closing). In addition, costs for maintaining and operating the physical plant – like heating, water/sewer, groundskeeping, minor maintenance, security – would not diminish significantly as long as Mental Health Complex operations remain at their current location. Similarly, any reductions in the county’s central service costs that accrue from the reduction in positions associated with one unit either are nonexistent or very small, and BHD’s share of such savings is even smaller.

Consequently, it appears that from a fiscal perspective, the closure of a single acute adult inpatient unit and a single unit at Hilltop (which produces an even smaller estimated annualized savings of \$239,000) should be viewed similar to the outsourcing of dietary and housekeeping services at BHD. These are steps that address BHD’s immediate budget



challenges and, in the process, decrease baseline operations spending. That puts the division in a better position to combat inflationary fixed cost pressures in the future, but it appears that the small decrease in baseline spending only makes a small dent in the overall structural problem, and that it certainly does not free up substantial resources for community investment.

This analysis also raises several important questions and potential action steps for the future, including the following:

- Has BHD conducted a thorough examination of the cost centers that comprise the \$37 million in internal crosscharges to determine whether the impending closure of both an inpatient and Hilltop unit could produce more sizeable savings?
- If the closure of two units would not produce substantial savings in internal overhead and administration, then how much additional downsizing would that take? Should BHD be establishing a plan to engage in additional downsizing that might correspond with its ability to realize significant savings in administration and overhead?
- Would a new, smaller facility substantially reduce physical plant-related costs, or would many of those costs remain in a new county-owned facility because they are tied to the county's larger cost allocation methodology? If many of those costs would remain, might it be best for the county to focus on further consolidating operations at the existing Complex, as opposed to pursuing a new county-owned facility?

The answer to those questions are imperative in determining BHD's fiscal future. If it turns out that closing additional units above those proposed in 2013 (if even possible from a patient care perspective) would produce only incremental cost savings because of BHD's overhead realities, then county leaders face a difficult dilemma. They either must recognize that providing inpatient, long-term care and emergency mental health services to a largely indigent population is a money-loser and budget for that reality, or they will have to consider getting out of the hospital and long-term care business entirely.

It also is difficult, after reviewing BHD's administrative/overhead costs, to avoid asking whether BHD would be better off contracting for the inpatient and long-term care beds it deems necessary with one or more of the private hospital systems, which presumably would have the ability to operate with a far less expensive administrative/overhead burden. That would particularly be the case for a private system that already has a robust administrative/overhead infrastructure and that could fold BHD's operations into that infrastructure for a reasonable additional cost. Of course, a critical question is whether a qualified private sector provider that has the clinical capacity to appropriately care for BHD's most acute patients exists, and whether that provider (or providers) would be willing to contract with BHD for those services under reasonable terms.



- 3) **Controlling annual increases in personnel costs.** Even with the closure of two units and the proposed outsourcing of the Downtown CSP caseload, BHD will continue to have the second largest workforce of any organizational unit in county government. Consequently, the division remains highly susceptible to having Milwaukee County's overall personnel costs drive its financial future.

One of the relatively surprising findings of this analysis is that county "legacy" and other fringe benefit costs not only were *not* a driver of increased property tax allocations for BHD from 2009 through 2012, but that the division actually benefited financially from countywide health care changes, thus freeing up resources for other initiatives. It appears that may change in 2013, however, as BHD was required to absorb more than \$3 million in increased pension and retiree health care costs in its 2013 requested budget.

As the Public Policy Forum has explained in several Milwaukee County fiscal analyses in recent years, county legacy costs (and any increases in those costs) are not budgeted centrally, but instead are allocated to departments based on their proportion of the county's active workforce. Consequently, labor-intensive departments like BHD suffer most from overall increases in the cost of health care or the size of the county's unfunded pension liability, and they also are penalized when substantial workforce reductions occur in other parts of county government.

BHD's downsizing and outsourcing initiatives – as well as changes implemented by the county to reduce the employer share of health care and pension costs – have benefited it financially in recent years because of this methodology, but its capacity to avail itself of personnel reduction strategies may be somewhat exhausted after 2013, unless it continues with Mental Health Complex downsizing. Consequently, if county fiscal officials continue their current methodology for allocating legacy costs – and those costs continue to substantially outrun inflation – then any funding prioritization they may wish to give to mental health-related community investments likely would need to take a backseat to efforts to keep up with rising personnel costs.

At the very least, our analysis suggests it is inappropriate to treat BHD's Mental Health Complex operations like other county departments by allocating increasing shares of legacy costs to the division, while insisting that it comply with flat or reduced property tax levy directives. In addition to failing to recognize the unique inflation-related cost pressures faced by BHD (such as rising pharmaceutical costs), this policy fails to recognize its unique workforce demands. In a hospital setting, it is impossible to maintain vacancies in key medical and nursing positions, and it is unrealistic to expect BHD to compete with private health systems for medical personnel within an antiquated compensation structure that is predicated on the salary structure of the rest of county government, as opposed to the regional health care industry. The willingness of policymakers and fiscal officials to recognize that BHD's Mental Health Complex operations merit different budgetary treatment may be particularly important given that BHD's outsourcing and revenue maximization strategies soon may be exhausted.



## Revenues

Similarly, there are a handful of key imperatives on the revenue side that will determine BHD's fiscal future.

- 1) Preparing realistic short-term and multi-year revenue projections.** BHD has been plagued for more than a decade by an inability to reliably estimate major patient care revenue streams on an annual basis, thus placing the division in great danger of running mid-year budget deficits and precluding its ability to engage in thoughtful long-range fiscal planning. In many respects, the fault for this predicament does not lie with BHD, but with its reliance on state and federal reimbursement rates that can shift significantly from year to year, and that often are not even established until after BHD has adopted its annual budget or is well into its fiscal year.

Nevertheless, BHD could improve its fiscal plight by 1) better documenting and explaining the complexity of its major revenue projections to the central budget office and elected officials so they have a better understanding of the need to manage the division's financial risk; 2) modeling annual and multi-year revenue scenarios and incorporating those scenarios into annual and multi-year programmatic decision-making; and 3) refraining from plugging uncertain revenue estimates into annual budgets, which only serves to exacerbate its revenue uncertainty.

To their credit (as discussed above), BHD officials have made a concerted effort in recent years to fill known revenue gaps and enhance the reliability of revenue collections and projections with the EMR implementation and the use of cost reporting consultants. New risk also has been created in recent years, however, from inserting uncertain revenue projections associated with those strategies and other revenue maximization initiatives into annual budget requests.

For a variety of reasons – including the transition to EMR and the intense workload of BHD's small fiscal staff – we were not able to secure the data needed to dig deeply into BHD's revenue picture for this analysis. We would recommend that going forward, the division do that digging itself and paint a clear picture of each of its major revenue streams and revenue initiatives. That should include analysis of potential threats and opportunities regarding its patient mix – which has changed significantly in recent years because of efforts to transfer growing numbers of patients to private health systems – and both short-term and multi-year forecasts. That information should be provided at least annually for key decision-makers in DAS, the county executive's office and the county board.

- 2) Continuing efforts to improve its revenue collection acumen.** We are impressed with the manner in which BHD has focused in recent years on improving and enhancing its billing processes and procedures, as well as with its ability to secure resources to invest in EMR and cost reporting consultants. This reflects a conclusion – which is supported by our analysis – that enhancing patient care revenues is one of the most important long-term strategies BHD can pursue from a financial perspective, given the dim prospects for additional general



support from the State of Wisconsin, and the desire to use any increases in property tax levy for enhancement of community-based services.

While there is no question that EMR and other strategies currently being pursued by BHD fiscal staff have potential to produce several million dollars of increased revenue annually, it will be important for the division to attempt to quantify the difference such improvements may make. As explained above, our capacity to do so for this analysis was limited by lack of data.

Let us assume, however, that even after accounting for the increases in WIMCR and EMR-generated revenue that are contained in the 2013 requested budgeted, there is potential to further increase patient care revenue by 10-15% per year, or about another \$4-5 million annually. That, of course, would be a significant infusion of additional revenue for BHD, but in light of its remaining structural problems and the division's fixed cost pressures, it still is questionable whether it would be enough to obviate the need for increased property tax revenue and allow for increased investments in community-based services.

Another important revenue collection initiative involves the division's efforts to extract greater levels of reimbursement from Family Care CMOs for eligible individuals housed at Hilltop. Again, this initiative makes sense from numerous perspectives. If it is viewed by BHD as a key piece of its long-term fiscal puzzle, however, then it should be accompanied by realistic estimates of its revenue enhancement potential, as well as transparent information for DAS and policymakers regarding key barriers and how those might be overcome. A key issue for BHD, for example, will be its ability to work with guardians of those housed at Hilltop to convince them that enrollment in Family Care and a community-based approach to care for their loved ones is appropriate. BHD may wish to lay out that challenge for fiscal officials and policymakers to promote a better understanding of the revenue potential associated with its Family Care strategy, as well as the potential impact on long-term downsizing plans.

- 3) Responding to the ACA and changes in Medicaid.** As discussed in the Introduction, a secondary purpose of this analysis – in addition to providing a baseline assessment of BHD's fiscal condition to assist mental health redesign deliberations – is to inform consideration about potential opportunities related to implementation of the Affordable Care Act. We find that ACA has considerable potential to benefit BHD by reducing its volume of uninsured patients. At the same time, however, potential major changes in Medicaid reimbursement rates that may result from federal and state budget challenges pose a considerable potential threat.

With regard to the ACA, our analysis shows that roughly 23% of all admissions to inpatient and PCS in 2011 (a total of 3,842 admissions) lacked an insurance source. Given that BHD's total billable costs in 2011 for inpatient and PCS services were about \$60 million, if ACA implementation substantially reduced that number, then several million dollars of additional revenue could materialize.



To illustrate that point, let's assume that ACA implementation cut the number of uninsured admissions to inpatient and PCS in half, or by roughly 1,900 admissions. It is not possible to discern BHD's potential cost recovery for the additional covered admissions because we do not know the level of insurance coverage that would be provided. We do know, however, that in 2011, BHD's reimbursement rates for adult inpatient, CAIS and PCS services were 23%, 56%, and 24% respectively. Those rates do not reflect reimbursement rates for covered patients because they include the uninsured population, so we would need to bump them up a bit. If we do so by assuming that BHD could have received reimbursement for 40% of its billable costs for an additional 1,900 individuals in 2011, at an average billable cost of \$3,698 per admission (this is the actual 2011 average for these three service categories combined), then we can estimate that BHD hypothetically could have collected an additional \$2.8 million in reimbursement revenue under our assumed scenario.

In addition to providing coverage to significant numbers of additional patients, ACA also could positively impact BHD's revenue streams by eliminating or modifying the IMD exclusion; expanding Medicaid coverage to additional behavioral health-related services; or enhancing Medicaid reimbursement rates for certain services. Conversely, if federal and state budget challenges necessitate further limitations on Medicaid coverage for certain services (such as TCM, which almost became a non-reimbursable service several years ago), or a reduction in current reimbursement rates, then any gains realized by reducing the uninsured population could be negated.

It is too early to tell how ACA implementation will impact these questions, or whether the law will be implemented in its current form at all. Our analysis does give a sense of the financial stakes that may be involved, however, and the need for BHD to be closely monitoring these issues and incorporating various scenarios into its fiscal and redesign planning.



COUNTY OF MILWAUKEE  
Inter-Office Communication



DATE: February 18, 2013

TO: Supervisor Dimitrijevic, County Board Chairwoman

FROM: Don Natzke, Director, DAS-Office for Persons with Disabilities

SUBJECT: **Capital Improvement Committee Process – 5 Yr Program Submission (2014 – 2018) for the DAS-Office for Persons with Disabilities**

Issue

Milwaukee County Ordinance 36.04 requires all Departments to submit five-year capital improvement program (Program) requests to their respective standing committees. Standing committees shall then submit Programs along with recommendations to the newly created Capital Improvements Committee (CIC).

Background

The purpose of the CIC is to develop a Program for the entire County and establish criteria on how each capital project will be evaluated. The ordinance also requires Departments to submit Programs to their respective standing committees, which will then forward their recommendations to the CIC.

Request

The DAS-Office for Persons with Disabilities has evaluated its anticipated capital needs. The attached includes the Department's outstanding capital needs prioritized within each program area. Requested capital projects assume current operations.

Don Natzke  
Director, DAS-Office for Persons with Disabilities

Cc: Chris Abele, County Executive  
Amber Moreen, Chief of Staff, County Executive's Office  
Kelly Bablitch, Chief of Staff, County Board  
Michael Mayo, Sr., Chair, Transportation, Public Works, and Transit Committee  
Willie Johnson, Jr., Co-Chair, Finance Personnel, and Audit Committee  
David Cullen, Co-Chair, Finance Personnel, and Audit Committee  
TBD, Chair, Capital Improvements Committee  
TBD, CEX Appointee #1, Capital Improvements Committee  
TBD, CEX Appointee #2, Capital Improvements Committee  
Craig Kammholz, Fiscal & Budget Director, DAS  
Brian Dranzik, Interim Director, Department of Transportation  
Scott Manske, Comptroller  
Vince Masterson, Strategic Asset Coordinator, DAS  
Chris Lindberg, CIO, IMSD  
Laurie Panella, Deputy CIO, IMSD  
Pamela Bryant, Capital Finance Manager, Comptroller's Office  
Justin Rodriguez, Capital Finance Analyst, Comptroller's Office  
Gregory High, Director, AE&ES-FM-DAS

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4 (ITEM \*) A resolution to authorize the attached Five Year Capital Improvements  
5 Program for the Department of Administrative Services-Office For Persons with  
6 Disabilities to be recommended to the Capital Improvement Committee (CIC):

7  
8 **A RESOLUTION**  
9

10 WHEREAS, the 2013 Adopted Capital Improvements Budget includes the  
11 creation of a Capital Improvements Committee (CIC); and  
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13 WHEREAS, ordinance 36.04 was also approved in 2013, which codified the  
14 creation, composition, duties, reports, and staffing of the CIC; and  
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16 WHEREAS, the purpose of the CIC is to develop a Five Year Program for the  
17 entire County and establish criteria on how each capital project will be evaluated; and  
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19 WHEREAS, the ordinance also requires Departments to submit Five Year  
20 Programs to their respective standing committees, which will then forward their  
21 recommendations to the CIC; and  
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23 WHEREAS, The Department of Department of Administrative Services-Office For  
24 Persons with Disabilities has evaluated its anticipated maintenance and facility needs;  
25 and  
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27 WHEREAS, the attached Five Year Program includes the department's  
28 outstanding capital needs, listed in priority order; now, therefore,  
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30 BE IT RESOLVED, the attached Five Year Program (Exhibit A) is recommended  
31 to the CIC.  
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### Attachment A

DAS-Office For Persons with Disabilities 2014						
Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description/Annual Operating Impact
1	New	Wil-O-Way Grant Recreation Center Window Replacement	\$49,900	\$0	\$49,900	Replace existing single pane windows with insulating units.
2	New	Wil-O-Way Underwood Exterior Wall Rehabilitation	\$44,872	\$0	\$44,872	Replace deteriorated exterior wall with new construction and insulation at the Wil-O-Way Underwood building
<b>Total</b>			<b>\$94,772</b>	<b>\$0</b>	<b>\$94,772</b>	
Department Name 2015						
Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
1	XXXXX	Example	\$0	\$0	\$0	
<b>Total</b>			<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	
Department Name 2016						
Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
1	XXXXX	Example	\$0	\$0	\$0	
<b>Total</b>			<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	
Department Name 2017						
Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
1	XXXXX	Example	\$0	\$0	\$0	
<b>Total</b>			<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	
Department Name 2018						
Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
1	XXXXX	Example	\$0	\$0	\$0	
<b>Total</b>			<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	

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## MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 2/18/13

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Submission of the DAS-Office For Persons with Disabilities 5 Year (2014 – 2018) Capital Improvement Program

**FISCAL EFFECT:**

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><input type="checkbox"/> Decrease Operating Expenditures<br><input type="checkbox"/> Increase Operating Revenues<br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><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
<b>Operating Budget</b>	Expenditure		
	Revenue		
	Net Cost		
<b>Capital Improvement Budget</b>	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.<sup>1</sup> 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 Ordinance 36.04 requires all Departments to submit 5 Year Capital Improvement Program requests to their respective standing committee. The standing committee shall then submit the Program along with its recommendations to the Capital Improvements Committee (CIC).

This fiscal note is for initial submission of the Milwaukee County Department of Transportation's 5 Year (2014 – 2018) Capital Improvement Program.

- B. There are no direct costs or savings associated with the 5 Yr. Capital Improvement Program at this time as this item is only proposed for initial policymaker consideration. Any formal appropriation related to this 5 Year Program would occur in the future as part of the 2014 Capital Budget process.
- C. There are no budgetary costs or savings associated with the 5 Yr. Capital Improvement Program at this time as this item is only proposed for initial policymaker consideration. Any formal appropriation related to this 5 Year Program would occur in the future as part of the 2014 Capital Budget process.
- D. The projects included in the 5 Year Program are estimated based upon information that is currently available. The projects proposed and the final projects adopted as part of the 2014 Capital Budget process may vary. Refer to Items B and C for additional assumptions regarding formal appropriation of the projects proposed.

Department/Prepared By Don Natzke, Director, DAS-Office For Persons with Disabilities

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<sup>1</sup> 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.

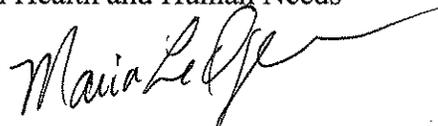
<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.



**MILWAUKEE COUNTY  
INTER-OFFICE MEMORANDUM**

**Date:** February 21, 2013

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

**From:** Maria Ledger, Director, Department of Family Care 

**Subject:** Report on the Milwaukee County Department of Family Care Community Relocations

The Family Care program integrates home and community-based services, institutional care services (i.e., nursing homes), Medicaid personal care, home health, and other services that were previously funded separately. The Milwaukee County Department of Family Care (MCDFC) Managed Care Organization (MCO) currently serves more than 7,893 members.

The Department has provided previous updates to the Board on our success in helping older adults and younger people with disabilities return to small community residential settings from institutional settings.

The Department has a very effective process in place to insure that these residential transitions are as comprehensive and well planned as possible.

After an individual enrolls into the Milwaukee County Department of Family Care MCO, they are assigned to an Interdisciplinary Team (IDT), comprised of no less than a care manager and a nurse. The IDT and the member then put together a Member Centered Plan. The Plan is compiled from worksheets completed by the nurse and/or the care manager in these areas:

- Advance Directives
- Behavioral Health/Cognition/Communication/Restrictive Measures
- Cardiovascular
- Caregiver Strain Tool
- Depression Screening
- Diabetes
- EENT (Eyes, Ears, Nose, and Throat)
- Employment
- Environmental/Community Integration/Safety
- Financial
- Gastro Intestinal
- GU / GYN
- Medication Management and Administration
- Musculoskeletal
- Neurological
- Nutrition and Fluids

- Pain
- Respiratory
- Social HX/Support Network/Spirituality
- Support Contacts
- Wound and Skin

In each of the areas noted above, the Member Centered Plan details the following:

- Member Assessment
- Member Strengths or Identified Barriers; their Outcomes
- Member Role in Meeting Outcomes
- Identified Risks/Concerns or Clinical/Functional Outcomes
- Member desire to address this concern at this time
- Interventions, Existing Supports or Supports Needed to Maintain or Achieve Desired Outcomes

An outcome is a desirable situation, condition, or circumstance that maximizes a member's highest level of independence or that a member identifies as important to him/her. Examples of outcomes might include such things as maintaining or improving independence (e.g. "remain in my own home"); maintaining or improving health (e.g. "stay out of the hospital"); or in some other way maintaining or improving quality of life. Outcomes are not "things." A scooter is not an outcome whereas being more mobile in the community is.

For people whose desired outcome is living in a more integrated setting, the IDT works with the Department's Placement Team to work towards that change. This Placement Team is comprised of Registered Nurses who assist our IDTs in identifying appropriate community settings for members.

In 2011, the IDTs, in conjunction with the Placement Team, relocated 570 members from nursing homes to the community.

In 2012, 758 MCDFC members were relocated to the community from Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities for persons with Mental Retardation (ICFsMRs).

It should be noted that in 2012, 12 of the individuals referenced above relocated from either the Milwaukee County Behavioral Health Division (BHD) Hilltop or Central facilities. The majority of these community relocations (10 of the 12) occurred before the BHD downsizing was announced and reflect the Department of Family Care's ongoing commitment to providing services in the most independent and cost effective setting to meet members' outcomes.

One of the individuals who moved to a group home from BHD in 2012 had a history of institutionalization dating back to 1944. He is now in a small group home, and attends a day program every day.

Another is a 22-year-old year old young man living in a group home and attending an intensively staffed day program each day.

MCDFC is fortunate to have a very active and experienced Contracts Division. These staff have successfully negotiated cost effective contracts with over 950 providers. While the MCO continues to add new providers as needed, existing providers have been more than willing to increase their capacity to meet the needs of new enrollees if necessary.

The Department of Family Care recognizes that while we must be good stewards of public dollars, we must also closely monitor the quality of services provided. One of the ways in which we do so is through the member satisfaction survey.

Throughout 2012, 1,985 members were surveyed about their satisfaction with the MCDFC Family Care program. Of the members surveyed, 619 members (31%) responded and provided the following information about the quality of the program:

- 93% of members surveyed are happy with the quality of the services they receive
- 91% of members surveyed would recommend the MCDFC MCO to a friend
- 95% and 91% of members surveyed receive help from their CM and RN when they need it
- 95% and 94% of members surveyed report their CM and RN listen to their concerns

The Department recently became aware of another facility in Milwaukee that will be filing a relocation plan with the State. The Department is committed to working cooperatively with members, families, the State, the facilities and our sister Departments to help our members achieve successful community placements from this facility as well as from BHD and all other contracted nursing homes.

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



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Maria Ledger, Director  
Milwaukee County Department of Family Care

cc: County Executive Chris Abele  
Chairwoman Marina Dimitrijevic, Milwaukee County Board of Supervisors  
Amber Moreen, Chief of Staff, Office of the County Executive  
Raisa Koltun, Director of Legislative Affairs, Office of the County Executive  
Steven Cady, Fiscal and Budget Analyst, Milwaukee County Bd. of Supervisors  
Jennifer Collins, Research Analyst, Milwaukee County Board of Supervisors  
Jodi Mapp, Committee Clerk, Milwaukee County Board of Supervisors  
Jim Hodson, Chief Financial Officer, MCDFC

**County of Milwaukee**  
**INTEROFFICE COMMUNICATION**

**DATE:** February 18, 2013

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

**FROM:** Stephanie Sue Stein, Director, Milwaukee County Department on Aging

**RE:** Request for authorization to increase awards for two contracts with Goodwill Industries of Southeastern Wisconsin, Inc., and one contract with United Community Center, Inc., for services provided in 2012 under contracts originally authorized by the County Board under File No. 12-22 (a)(a)

I respectfully request that the attached resolution be scheduled for consideration by the Committee on Health and Human Needs at its meeting on March 13, 2013.

The attached resolution authorizes the Director, Department on Aging, to increase awards for two contracts with Goodwill Industries of Southeastern Wisconsin, Inc., and one contract with United Community Center, Inc., for services provided in 2012 under contracts originally authorized by the County Board under File No. 12-22 (a)(a). The proposed changes are as follows:

1. Increase by \$10,306, from \$944,262 to \$954,568, the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Case Management and Delivery Services for Home Delivered Meals; and
2. Increase by \$14,655, from \$275,500 to \$290,155, the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Nutrition Site Supervision (Multiple Sites); and
3. Increase by \$4,960, from \$373,189 to \$378,149, the contract with United Community Center, Inc., to provide Programs in United Community Center Senior Center

The Department awards funds to provider agencies based on the availability of federal, state, and local funds, allowable costs, recent usage by older persons of programs and services, anticipated changes in service demand, and other factors. As with many contractual services, actual participation is a function of service availability, client needs, weather, and other factors that cannot be precisely known at the time contracts are awarded. When additional funds become available, the Department seeks to use those funds to fully reimburse vendors for the services they provide.

The proposed increases in awards result primarily from higher labor, food, or fuel costs than originally budgeted. The increases in awards will be funded through allocations from the federal Older Americans Act.

February 18, 2013  
Sup. Marina Dimitrijevic  
Sup. Peggy Romo West  
Page 2

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  
Raisa Koltun  
Antionette Thomas-Bailey  
Jennifer Collins  
Jonette Arms  
Thomas Condella  
Mary Proctor Brown  
Diane Beckley  
Beth Monrial Zatarski  
Gary Portenier  
Pat Rogers

Attachments

## RESOLUTION

WHEREAS, on December 15, 2011, the Milwaukee County Board of Supervisors authorized the Director, Department on Aging, to execute contracts to provide programs and services for the period January 1, through December 31, 2012 [File No. 12-22 (a)(a)]; and

WHEREAS, the Department awards funds to provider agencies based on the availability of federal, state, and local funds, allowable costs, recent usage by older persons of the programs and services provided, anticipated changes in service demand, and allowable costs; and

WHEREAS, the actual amount of services that occur under a specific contract is a function of available services, changes in the number of participants, evolving client needs, weather, and other factors that cannot be precisely known when contracts are awarded; and

WHEREAS, if additional funds become available, the Department seeks to use those funds to fully reimburse vendors for the services provided to eligible older persons, and for one-time expenditures designed to enhance the quality of programs and services provided; and

WHEREAS, the actual cost to provide contractual services in three 2012 program and service contracts exceed the amounts originally awarded; and

WHEREAS, the Department has identified sufficient funds to increase awards to the three 2012 contracts; and

WHEREAS, the Department recommends increasing awards for the following contractual services based on actual costs and to amend the awards as follows:

1. Increase by \$10,306, from \$944,262 to \$954,568, the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Case Management and Delivery Services for Home Delivered Meals; and
2. Increase by \$14,655, from \$275,500 to \$290,155, the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Nutrition Site Supervision

Services (Multiple Sites); and

3. Increase by \$4,960, from \$373,189 to \$378,149, the contract with United Community Center, Inc., to provide Programs in United Community Center Senior center; now, therefore

BE IT RESOLVED, that the Director, Department on Aging, is hereby authorized to increase awards in the 2012 program and service contracts listed above, and in the recommended.

**MILWAUKEE COUNTY FISCAL NOTE FORM**

**DATE:** February 24, 2013

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Request for authorization to increase awards for two contracts with Goodwill Industries of Southeastern Wisconsin, Inc., and one contract with United Community Center, Inc., for services provided in 2012 under contracts originally authorized by the County Board under File No. 12-22 (a)(a)

**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 type="checkbox"/> Increase Operating Expenditures<br>(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.*

	<b>Expenditure or Revenue Category</b>	<b>Current Year</b>	<b>Subsequent Year</b>
<b>Operating Budget</b>	Expenditure	29,921	
	Revenue	29,921	
	Net Cost	0	
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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:

(1) Increase by \$10,306, from \$944,262 to \$944,568, the 2012 contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Case Management and Delivery Services for Home Delivered Meals authorized under File No. 12-22.

(2) Increase by \$14,655, from \$275,500 to \$290,155, the 2012 contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Nutrition Site Supervision Services (Multiple Sites) authorized under File No. 12-22.

(3) Increase by \$4,960, from \$373,189 to \$378,155, the 2012 contract with United Community Center, Inc., to provide Programs in United Community Center Senior Center authorized under File No. 12-22.

The increases are funded through available allocations (2012) in Title III-C-1 of the Older Americans Act.

This resolution has no net fiscal impact on 2013 other than the allocation of staff time required to prepare the accompanying report and resolution.

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Department/Prepared By: Department on Aging / Gary W. Portenier

Authorized Signature \_\_\_\_\_

Did DAS-Fiscal Staff Review?  Yes  No

Did CDBP Review?<sup>2</sup>  Yes  No  Not Required

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<sup>1</sup> 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.

<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.

**County of Milwaukee**  
INTEROFFICE COMMUNICATION

DATE: February 20, 2013

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, Milwaukee County Department on Aging

RE: Request for authorization to increase by \$34,140, from \$1,258,867 to \$1,293,007, the 2013 contract with Interfaith Older Adults Program, Inc., to provide Programs in Clinton and Bernice Rose Park, McGovern Park, Washington Park, Wilson Park, and Lawrence P. Kelly Senior Centers, originally authorized under File No. 13-19

I respectfully request that the attached resolution be scheduled for consideration by the Committee on Health and Human Needs at its meeting on March 13, 2013.

The attached resolution authorizes the Director, Department on Aging, to increase by \$34,140, from \$1,258,867 to \$1,293,007, the 2013 contract with Interfaith Older Adults Programs, Inc., to provide Programs in Clinton and Bernice Rose Park, McGovern Park, Washington Park, Wilson Park, and Lawrence P. Kelly Senior Centers, originally authorized under File No. 13-19.

The Department on Aging, in collaboration with University of Wisconsin-Milwaukee College of Health Sciences, offers the **Wellness Works** older adult fitness program at five senior center locations. Since 2001, Department on Aging has provided oversight of the program, including budgeting, professional services contracting, and coordination of services. The UWM College of Health Sciences has performed day-to-day administration of the program, providing students in human kinetics the opportunity to assist seniors in use of fitness equipment. The program also includes research on the impact of physical activity on healthy aging.

While the collaboration between UWM and Department on Aging will continue, Interfaith Older Adult Programs, Inc. will take over the day-to-day administration of **Wellness Works**, including the provision for a Fitness Center Coordinator. UWM will continue conducting research and provide students to assist seniors in using fitness equipment. The proposed amendment funds the Coordinator position and related administrative costs.

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  
Raisa Koltun

Sup. Marina Dimitrijevic  
Sup. Peggy Romo West  
February 20, 2013  
Page 2

cc: Antionette Thomas-Bailey  
Jennifer Collins  
Jonette Arms  
Thomas Condella  
Mary Proctor Brown  
Diane Beckley  
Randall Kohl  
Gary Portenier  
Pat Rogers

## RESOLUTION

WHEREAS, the Milwaukee County Department on Aging, in collaboration with University of Wisconsin-Milwaukee (UWM) College on Health Sciences, has provided, since 2001, the **Wellness Works** older adult fitness program at several senior center locations; and

WHEREAS, the Department has provided general oversight of **Wellness Works**, including budgeting, professional services contracting, and overall coordination of services; and

WHEREAS, UWM has performed day-to-day program administration of **Wellness Works**, providing students in human kinetics an opportunity to assist seniors in their use of fitness equipment; and

WHEREAS, **Wellness Works** offered UWM researchers the opportunity to study the effectiveness of physical activity on healthy aging; and

WHEREAS, while the collaboration between Department on Aging and UWM College of Health Sciences will continue, including participation by students, UWM will focus attention primarily on the research aspects of the program; and

WHEREAS, on December 16, 2012, the Milwaukee County Board of Supervisors authorized the Director, Department on Aging, to execute contracts to provide programs and services for the period January 1, through December 31, 2013 [File No. 13-19]; and

WHEREAS, File No. 13-19 included an award of \$1,258,867 to Interfaith Older Adult Programs, Inc., to provide Programs in Clinton and Bernice Rose Park, McGovern Park, Washington Park, Wilson Park, and Lawrence P. Kelly Senior Centers; and

WHEREAS, increasing the Programs in Clinton and Bernice Rose Park, McGovern Park, Washington Park, Wilson Park, and Lawrence P. Kelly Senior Centers award by \$34,140, from \$1,258,867 to \$1,293,007, enables Interfaith Older Adult Programs, Inc., to assume day-to-day administration of **Wellness Works**; and

WHEREAS, the proposed change will enhance coordination of programming at the centers; now, therefore

BE IT RESOLVED, that Director, Department on Aging, is hereby authorized to increase by \$34,140, from \$1,258,867 to \$1,293,007, the 2013 contract with Interfaith Older Adult Programs, Inc., to provide Programs in Clinton and Bernice Rose Park, McGovern Park, Washington Park, Wilson Park, and Lawrence P. Kelly Senior Centers.

**MILWAUKEE COUNTY FISCAL NOTE FORM**

**DATE:** February 20, 2013

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Request for authorization to increase by \$34,140, from \$1,258,867 to \$1,293,007, the 2013 contract with Interfaith Older Adults Program, Inc., to provide Programs in Clinton and Bernice Rose Park, McGovern Park, Washington Park, Wilson Park, and Lawrence P. Kelly Senior Centers, originally authorized under File No. 13-19

**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 type="checkbox"/> Increase Operating Expenditures<br>(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.*

	<b>Expenditure or Revenue Category</b>	<b>Current Year</b>	<b>Subsequent Year</b>
<b>Operating Budget</b>	Expenditure	0	
	Revenue	0	
	Net Cost	0	
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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.

Request for authorization to increase by \$34,140, from \$1,258,867 to \$1,293,007, the 2013 contract with Interfaith Older Adults Program, Inc., to provide Programs in Clinton and Bernice Rose Park, McGovern Park, Washington Park, Wilson Park, and Lawrence P. Kelly Senior Centers, originally authorized under File No. 13-19.

Interfaith Older Adult Programs, Inc. is assuming the day-to-day administration of **Wellness Works**, including the provision for a Fitness Center Coordinator. The proposed amendment funds the Coordinator position and related administrative costs.

This resolution has no net fiscal impact on 2013 other than the allocation of staff time required to prepare the accompanying report and resolution.

---

Department/Prepared By: Department on Aging / Gary W. Portenier

Authorized Signature \_\_\_\_\_

Did DAS-Fiscal Staff Review?  Yes  No

Did CDBP Review?<sup>2</sup>  Yes  No  Not Required

---

<sup>1</sup> 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.

<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.

County of Milwaukee  
INTEROFFICE MEMO

DATE: February 18, 2013  
 TO: Supervisor Marina Dimitrijevic, County Board Chairwoman  
 Supervisor Peggy Romo West, Chair, Committee on Health and Human Needs  
 FROM: Stephanie Sue Stein, Director, Department on Aging  
 SUBJECT: **Capital Improvement Committee Process**

Issue

Milwaukee County Ordinance 36.04 requires all Departments to submit five-year capital improvement program (Program) requests to their respective standing committees. Standing committees shall then submit Programs along with recommendations to the newly created Capital Improvements Committee (CIC).

Background

The purpose of the CIC is to develop a Program for the entire County and establish criteria on how each capital project will be evaluated. The ordinance also requires Departments to submit Programs to their respective standing committees, which will then forward their recommendations to the CIC.

Request

The Department on Aging has responsibility for facility and program management of five county-owned senior centers. The Department on Aging has evaluated its anticipated maintenance and facility needs. The attached includes the Department's outstanding capital needs, listed in priority order.

Description of major items/long term vision

The Five-Year Capital Improvements Plan will allow the Department on Aging to address its senior center infrastructure needs and effectively manage major maintenance and capital improvements for the five county-owned senior centers, including Kelly, McGovern Park, Rose Park, Washington Park and Wilson Park. The capital plan is designed with intentions to provide vigilance to address issues that exist in these older facilities with regards to compliance as applicable to building codes and operational regulations including the Americans with Disabilities Act (ADA), fire and safety codes, health and environmental control and licensing standards.

Renewed federal and state attention to health, wellness and prevention has prompted increased vigilance toward safety. Basic infrastructure improvements include projects that address life safety issues for program participants, staff, visitors as well as the general public. Improvements also include building or renovating existing systems and sections to enhance the visitor experience. Visible deterioration of features is evident. The significances of not addressing these issues can have opposing influences on efficient operations, cost effectiveness and the safety of the public.

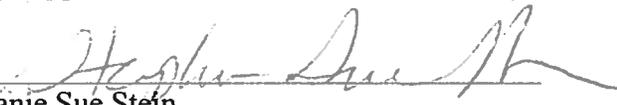
The 2014-2018 Capital Improvement Program - Senior Center Infrastructure, anticipated for several years, reflects Department on Aging's desire to complete a number of varied projects. Most of the improvements will tend to yield energy savings as well as lessen the intensive maintenance required. These include:

- Complete final phase-in roof project began in 2009; replace another roof along with flashing and other protection items that have reached useful life and caused water damage to roof decks, beams and fascia boards. Replacement will halt deterioration, mitigate water damage and promote building integrity and energy enhancement.
- Renovate restroom; upgrade ADA deficiencies for the remaining non-ADA and minimum compliant men and women restrooms and provide extra sensory touch mechanisms to ADA door openers.

Disabled and frail consumers have difficulty opening the doors and the extra sensory touch will prevent the need for keeping restroom doors open and provide required personal privacy.

- Replace existing deteriorated doors and frames to full ADA compliance to reduce air infiltration, restore functionality and aesthetic appeal. Replace exterior windows, for which some have leaks and others do not open. Replacements will properly weather proof and prevent further water damage during rain and snow storms, prevent leaks and make the facilities more safe, energy efficient and mitigate fire hazards.
- Upgrade/replace fire protection and emergency notification systems, failing communication systems, and cooling infrastructure in accordance to building codes: multiple code compliant fire rated door assemblies and fire separation walls and fire service window; the installation or upgrade of fire alarm systems; public address and telephone voicemail systems; and HVAC equipment in lieu of ineffective cooling units. Projects will bring fire protection and emergency systems up to code, prevent major service interruptions, improve life safety systems and functionality, and reduce on-going maintenance costs.
- Construct additional exits, upgrade to code facility evacuation in prime utilization areas having only one entrance and exit. The access renovation will facilitate better entering and exiting by older adult participants, staff, public safety personnel as well as visitors in cases of emergencies.
- Renovate stairway and stage steps to bring into code compliance.
- Complete replacement of outdated lighting assemblies, floor and ceiling tiles, and exterior facility siding.

These projects anticipate further utilization allowance for future reliability of safe and maintainable facilities to promote visionary, collaborative and community-oriented accommodations to serve as community focal points to help support the needs of Milwaukee County's older adult population and the community at large.

  
Stephanie Sue Stein  
Director, Department on Aging

Cc: Chris Abele, County Executive  
Amber Moreen, Chief of Staff, County Executive's Office  
Kelly Bablitch, Chief of Staff, County Board  
Michael Mayo, Sr., Chair, Transportation, Public Works, and Transit Committee  
Willie Johnson, Jr., Co-Chair, Finance Personnel, and Audit Committee  
David Cullen, Co-Chair, Finance Personnel, and Audit Committee  
TBD, Chair, Capital Improvements Committee  
TBD, CEX Appointee #1, Capital Improvements Committee  
TBD, CEX Appointee #2, Capital Improvements Committee  
Don Tyler, Director Administrative Services, DAS  
Craig Kammholz, Fiscal & Budget Director, DAS  
Brian Dranzik, Interim Director, Department of Transportation  
Scott Manske, Comptroller  
Vince Masterson, Strategic Asset Coordinator, DAS  
Chris Lindberg, CIO, IMSD  
Laurie Panella, Deputy CIO, IMSD  
Pamela Bryant, Capital Finance Manager, Comptroller's Office  
Justin Rodriguez, Capital Finance Analyst, Comptroller's Office  
Gregory High, Director, AE&ES-FM-DAS

Department Name Department on Aging  
2014

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description/Annual Operating Impact
1	WXXXX	Washington Park Senior Center - Roof Replacement Continuation	\$244,562	\$0	\$244,562	2009 began sectional roof replacement phase-in approach; complete remaining roof sections - damaged decking and other roofing items to be removed and replaced with new roofing, decking and related roofing components.
2		Washington Park Senior Center - Lobby Restroom ADA Renovation	\$123,400		\$123,400	Upgrade ADA deficiencies for the remaining non-ADA and minimum compliant men and women restrooms located in the main lobby. Provide extra sensory touch mechanism to ADA door openers to better assist aging population and prevent the need for keeping restroom doors open and provide required personal privacy.
3		County-owned Senior Centers – Exterior Door Replacement	\$201,735		\$201,735	Replace existing deteriorated doors and frames with full ADA compliancy; reduce air infiltration, restore functionality and aesthetic appeal.
4		Rose Senior Center – Multipurpose Room Fire Separations	\$87,513		\$87,513	In accordance to Wisconsin Administrative Code, provide a fire rated door assembly, remove and block up second floor window, provide automatic closing fire service window and provide a protected discharge (VFA assessment).
5		Rose Senior Center – Access Corridor II Renovation	\$162,892		\$162,892	Provide building compliant second floor corridor fire separation walls and replace first and second floor door assemblies in accordance to building code (VFA). Currently door assemblies are not fire rated labeled fire door assemblies. The doors are equipped with closers that prevent automatic closure.
6		Rose Senior Center – Access Corridor Renovation	\$30,888		\$30,888	Provide an additional exterior exit to eliminate a dead end corridor in Administrative staff area, currently none compliant with Wisconsin Administrative Code.
7		Kelly Nutrition Center – Dining Hall Access Renovation	\$20,200		\$20,200	Provide an additional exterior exit to eliminate a one way entry/exit corridor dining hall of the Nutrition Building. Eliminate a possible none compliant Wisconsin Administrative Code issue. The Nutrition Building dining hall currently has only one entrance/exit into this area of the building, in the event of a fire there are no other exits in the dining hall other than windows.
8		Rose Senior Center – Interior Stairway Renovation	\$18,011		\$18,011	Provide building compliant guard height and spacing, provide solid risers and provide continuity and handrail in accordance to Wisconsin Administrative Code. Currently guard spacing is greater than required regulation, handrails are not continuous and lack compliant cross section or grip and handrail ends and stair has open risers
9		Rose Senior Center – Backstage Step Improvements	\$19,949		\$19,949	Provide compliant stair treads and handrails backstage steps (VFA 2000)
					\$0	
Total 2014			\$909,150	\$0	\$909,150	

Department Name Department on Aging  
2015

Rank	Project Num	Project Name	Total Cost	Reimbursement	County Finan	Project Description
1	WXXXX	Rose Senior Center Roof	\$350,000	\$0	\$350,000	Including flashing and other roof protection items. Roof has reached its useful life and water damage is threatened in N. W. corner of building. Building integrity and energy enhancement.
2		Sen. Centers Power Access door hardware options	\$21,000		\$21,000	Increase ADA requirements to accommodate light touch of frail elders with walkers canes, etc. This user friendly hardware on exterior doors creates a welcoming environment for all abilities of the ever growing senior population. ADA Accessibility enhancement.
3		Sen. Centers Public Address Systems	\$79,000		\$79,000	Evacuation alerts not reaching all rooms in buildings with current systems creating a safety threat. Repair or replacement enhances life safety and building functionality.
4		Washington Park Chiller Assembly	\$15,000		\$15,000	Chiller to be compliant with current cooling tower, allowing for computerized operation of both units and greater energy efficiency.
5		Washington Park, Rose and McGovern - Phone Systems with Voicemail	\$33,000		\$33,000	Specs to match most recently installed phone system at Kelly Center, making all systems congruent with one another. Systems in operation have exceeded useful life. Improvements will eliminate unsightly loose wiring, rooms inaccessible by phone extensions and outdated systems unable to accept voicemail. Functionality and safety enhancement.
6					\$0	
					\$0	
					\$0	
					\$0	
					\$0	
					\$0	
					\$0	
					\$0	
<b>Total</b>			<b>\$498,000</b>	<b>\$0</b>	<b>\$498,000</b>	







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(ITEM \*) A resolution to authorize the attached Five Year Capital Improvements Program for the Department on Aging to be recommended to the Capital Improvement Committee (CIC):

**A RESOLUTION**

WHEREAS, the 2013 Adopted Capital Improvements Budget includes the creation of a Capital Improvements Committee (CIC); and

WHEREAS, ordinance 36.04 was also approved in 2013, which codified the creation, composition, duties, reports, and staffing of the CIC; and

WHEREAS, the purpose of the CIC is to develop a Five Year Program for the entire County and establish criteria on how each capital project will be evaluated; and

WHEREAS, the ordinance also requires Departments to submit Five Year Programs to their respective standing committees, which will then forward their recommendations to the CIC; and

WHEREAS, The Department on Aging has evaluated its anticipated maintenance and facility needs; and

WHEREAS, the attached Five Year Program includes the department's outstanding capital needs, listed in priority order; now, therefore,

BE IT RESOLVED, the attached Five Year Program (Exhibit A) is recommended to the CIC.

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**Attachment A**  
**(Insert Five Year Program Spreadsheets)**

Department Name Department on Aging  
2014

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description/Annual Operating Impact
1	WXXXX	Washington Park Senior Center - Roof Replacement Continuation	\$244,562	\$0	\$244,562	2009 began sectional roof replacement phase-in approach; complete remaining roof sections - damaged decking and other roofing items to be removed and replaced with new roofing, decking and related roofing components.
2		Washington Park Senior Center - Lobby Restroom ADA Renovation	\$123,400		\$123,400	Upgrade ADA deficiencies for the remaining non-ADA and minimum compliant men and women restrooms located in the main lobby. Provide extra sensory touch mechanism to ADA door openers to better assist aging population and prevent the need for keeping restroom doors open and provide required personal privacy.
3		County-owned Senior Centers - Exterior Door Replacement	\$201,735		\$201,735	Replace existing deteriorated doors and frames with full ADA compliancy; reduce air infiltration, restore functionality and aesthetic appeal.
4		Rose Senior Center - Multipurpose Room Fire Separations	\$87,513		\$87,513	In accordance to Wisconsin Administrative Code, provide a fire rated door assembly, remove and block up second floor window, provide automatic closing fire service window and provide a protected discharge (VFA assessment).
5		Rose Senior Center - Access Corridor II Renovation	\$162,892		\$162,892	Provide building compliant second floor corridor fire separation walls and replace first and second floor door assemblies in accordance to building code (VFA). Currently door assemblies are not fire rated labeled fire door assemblies. The doors are equipped with closers that prevent automatic closure.
6		Rose Senior Center - Access Corridor Renovation	\$30,888		\$30,888	Provide an additional exterior exit to eliminate a dead end corridor in Administrative staff area, currently none compliant with Wisconsin Administrative Code.
7		Kelly Nutrition Center - Dining Hall Access Renovation	\$20,200		\$20,200	Provide an additional exterior exit to eliminate a one way entry/exit corridor dining hall of the Nutrition Building. Eliminate a possible none compliant Wisconsin Administrative Code issue. The Nutrition Building dining hall currently has only one entrance/exit into this area of the building, in the event of a fire there are no other exits in the dining hall other than windows.
8		Rose Senior Center - Interior Stairway Renovation	\$18,011		\$18,011	Provide building compliant guard height and spacing, provide solid risers and provide continuity and handrail in accordance to Wisconsin Administrative Code. Currently guard spacing is greater than required regulation, handrails are not continuous and lack compliant cross section or grip and handrail ends and stair has open risers
9		Rose Senior Center - Backstage Step Improvements	\$19,949		\$19,949	Provide compliant stair treads and handrails backstage steps (VFA 2000)
					\$0	
<b>Total 2014</b>			<b>\$909,150</b>	<b>\$0</b>	<b>\$909,150</b>	

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Department Name Department on Aging  
2015

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description/Annual Operating Impact
1	WXXXX	Rose Senior Center Roof	\$350,000	\$0	\$350,000	Including flashing and other roof protection items. Roof has reached it's useful life and water damage is threatened in N. W. corner of building. Building integrity and energy enhancement.
2		Sen. Centers Power Access door hardware options	\$21,000		\$21,000	Increase ADA requirements to accommodate light touch of frail elders with walkers canes, etc. This user friendly hardware on exterior doors creates a welcoming environment for all abilities of the ever growing senior population. ADA Accessibility enhancement.
3		Sen. Centers Public Address Systems	\$79,000		\$79,000	Evacuation alerts not reaching all rooms in buildings with current systems creating a safety threat. Repair or replacement enhances life safety and building functionality.
4		Washington Park Chiller Assembly	\$15,000		\$15,000	Chiller to be compliant with current cooling tower, allowing for computerized operation of both units and greater energy efficiency.
5		Washington Park, Rose and McGovern - Phone Systems with Voicemail	\$33,000		\$33,000	Specs to match most recently installed phone system at Kelly Center, making all systems congruent with one another. Systems in operation have exceeded useful life. Improvements will eliminate unsightly loose wiring, rooms inaccessible by phone extensions and outdated systems unable to accept voicemail. Functionality and safety enhancement.
					\$0	
Total 2015			\$498,000	\$0	\$498,000	

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Department Name Department on Aging  
2016

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description/Annual Operating Impact
1	WXXXX	Sen. Centers repair or replace all windows and	\$255,000	\$0	\$255,000	Windows in some buildings do not open creating fire hazard. Energy efficient operation in season change impeded because of lack of proper window operation.
2		McGovern Fire System Provide Addressable	\$33,000		\$33,000	Current system is obsolete, not addressable and often inoperable. Building integrity and safe evacuation and life safety will be enhanced with new alarm system.
3		Kelly provide HVAC unit	\$15,000		\$15,000	Window units not energy efficient, recommended 15 ton unit would enhance building functionality.
4		Washington computer automation for HVAC system	\$3,900		\$3,900	Computer automation to maintain digital HVAC settings would also allow for remote access, monitoring and adjustments 24 hours.
					\$0	
Total 2016			\$306,900	\$0	\$306,900	

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Department Name Department on Aging  
2017

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description/Annual Operating Impact
1	WX00X	Sen. Centers provide access lighting	\$262,000	\$0	\$262,000	Current T12 system now obsolete and no longer manufactured, upgrade to T8 required. Replacement of entire lighting assembly including ballasts, fixtures, bulbs and occupancy sensors at all centers will enhance functionality, safety, building integrity, and energy efficiency.
2		McGovern replace flooring and ceilings	\$198,000		\$198,000	Replacement of aged flooring and ceilings will enhance building integrity. Ceiling upgrades in some areas will likely stabilize room temperatures enhancing energy efficient operation of HVAC system.
					\$0	
Total 2017			\$460,000	\$0	\$460,000	

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Department Name Department on Aging  
2018

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description/Annual Operating Impact
1		Wilson replace exterior siding	\$179,000		\$179,000	Siding deteriorated around entire building especially N.W. side. Replacement will enhance energy efficiency and building integrity.
2		Kelly SC replace bathrooms near fitness center with ADA compliant	\$315,000		\$315,000	Current bathrooms near fitness center are obsolete, often inoperable, and not fully ADA compliant. Replacement will meet ADA Accessibility Compliance and enhance functionality.
3					\$0	
					\$0	
Total 2018			\$494,000	\$0	\$494,000	

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## MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 2/18/13

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Submission of the Milwaukee County Department of Transportation 5 Year (2014 – 2018) Capital Improvement Program

**FISCAL EFFECT:**

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|---|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><input type="checkbox"/> Decrease Operating Expenditures<br><input type="checkbox"/> Increase Operating Revenues<br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><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
<b>Operating Budget</b>	Expenditure		
	Revenue		
	Net Cost		
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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 Ordinance 36.04 requires all Departments to submit 5 Year Capital Improvement Program requests to their respective standing committee. The standing committee shall then submit the Program along with its recommendations to the Capital Improvements Committee (CIC).

This fiscal note is for initial submission of the Milwaukee County Department of Transportation's 5 Year (2014 – 2018) Capital Improvement Program.

- B. There are no direct costs or savings associated with the 5 Yr. Capital Improvement Program at this time as this item is only proposed for initial policymaker consideration. Any formal appropriation related to this 5 Year Program would occur in the future as part of the 2014 Capital Budget process.
- C. There are no budgetary costs or savings associated with the 5 Yr. Capital Improvement Program at this time as this item is only proposed for initial policymaker consideration. Any formal appropriation related to this 5 Year Program would occur in the future as part of the 2014 Capital Budget process.
- D. The projects included in the 5 Year Program are estimated based upon information that is currently available. The projects proposed and the final projects adopted as part of the 2014 Capital Budget process may vary. Refer to Items B and C for additional assumptions regarding formal appropriation of the projects proposed.

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<sup>1</sup> 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.

<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.

Department/Prepared By Department on Aging by Mary Proctor Brown

Authorized Signature

A handwritten signature in black ink, appearing to read "Mary Proctor Brown", is written over a horizontal line.

Did DAS-Fiscal Staff Review?  Yes  No

Did CBDP Review?<sup>2</sup>  Yes  No  Not Required

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** February 25, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

**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 2013 professional services contract with Pharmerica for pharmacy services at the Behavioral Health Division**

**Issue**

Section 56.30 of the Milwaukee County Code of General Ordinances requires County Board approval for professional services contracts of \$50,000 or greater. Per Section 56.30, the Director of the Department of Health and Human Services (DHHS) is requesting authorization for the Behavioral Health Division (BHD) to enter into a professional services contract with Pharmerica pharmacy for the purpose of providing pharmaceutical services in 2013.

**Background**

BHD is mandated to ensure the availability of pharmaceutical services to patients and clients in its acute inpatient, long term care (LTC), crisis emergency room and community-based programs. For the past eight years, pharmacy services have been provided by Roeschens Omnicare.

In October 2012, BHD published a Request for Proposals (RFP) to solicit bids from private vendors for pharmaceutical services. To develop the RFP, BHD received assistance from an independent consultant with expertise in pharmaceutical pricing and business operations. Vendors were given the opportunity to submit proposals for one or more service options as detailed below:

**Option 1: Pharmacy for Acute Care, Outpatient and LTC Services provided at BHD Hospital**

Provide Acute, Long Term Care and Outpatient Pharmacy services utilizing BHD Pharmacy facilities including BHD Pharmacy IT Systems; maintain drug master and formulary file for patient billing; and provide Inventory and Purchasing using Milwaukee County or State approved vendors and suppliers. Provide necessary and adequate staffing approved by the hospital with appropriate licenses.

**Option 2: Acute Care Pharmacy and Outpatient Service Only at BHD Hospital**

Provide Acute Care and Outpatient Services Only utilizing BHD Pharmacy facilities and BHD Pharmacy IT Systems; maintain drug master and formulary file for patient billing; and provide Inventory and Purchasing using Milwaukee County or State approved vendors and suppliers. Provide necessary and adequate staffing approved by the hospital with appropriate licenses.

**Option 3: Acute Care Pharmacy and Outpatient Services at BHD Hospital and LTC Services at Off Site Pharmacy**

Provide Acute Care and Long Term Care Services utilizing BHD Pharmacy facilities for Acute Services utilizing BHD Pharmacy IT Systems, Maintain Pharmacy Inventory and Purchasing using Milwaukee County approved vendors; and provide necessary and adequate staffing approved by the hospital with appropriate licenses. Provide Long Term Care Pharmacy services outside of BHD in a separate Closed Door Pharmacy, including billing third party payors.

**Option 4: Long Term Care Services Only at Off Site Pharmacy**

Provide Long Term Care Pharmacy services outside of the hospital in a separate Closed Door Pharmacy, including billing third party payors utilizing a vendor supplied Pharmacy IT System.

BHD received three proposals which were reviewed by an RFP panel consisting of County and outside representatives. These proposals addressed different combinations of options one to four described above. Interviews were conducted with the top two vendors and, based on the panel review, BHD is recommending a contract for Option 3 with Pharmerica. The proposal submitted by Pharmerica met or exceeded the evaluation criteria identified in the RFP. One major distinction between this contract and previous contracts is that BHD will now hold the pharmacy licensure, purchase all non-LTC medication and do its own billing for all non-LTC medication. It is believed that this will streamline the process and also result in some fiscal advantages, particularly in light of the billing capability of BHD's new Electronic Medical Record System.

BHD is recommending an initial contract award for the period April 14, 2013 to December 31, 2013. The contract allows for up to three additional renewals for one-year periods assuming all terms of the contract are met and performance standards are adhered to. Barring poor or non-performance on the contract, BHD anticipates recommending an extension of the contract to the end of 2014 to the County Board as part of the December 2013 cycle.

BHD is also exploring implementing the pharmacy component to the EMR. The software provider for this program is RX Connect, which is a subcontractor of Netsmart, BHD's EMR provider. This pharmacy system would greatly assist in fully integrating the BHD EMR and pharmacy services. Once a decision is reached, BHD will seek County Board approval of this component of the EMR.

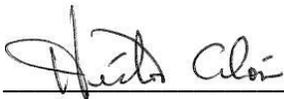
**Fiscal Effect**

BHD is recommending a pro-rated contract amount for 2013 of \$938,035 (annual amount of \$1,324,289) for the period of April 14 to December 31, 2013. BHD's 2013 Budget includes sufficient funding for this contract. BHD will be closely monitoring pharmacy expenditures under the new contract and currently anticipates that the budgeted amounts will be sufficient to cover the cost of the recommended pharmacy contract for the remainder of 2013 as well as the medications purchased by BHD. A fiscal note form is attached.

**Recommendation**

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to execute a professional services contract with Pharmerica for the period of April 14, 2013 through December 31, 2013 in an amount not to exceed \$938,035 (annual amount of \$1,324,289). Approval of this recommendation will enable the Behavioral Health Division to continue providing pharmacy services to patients and clients in accordance with State and Federal law.

Respectfully Submitted,



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Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, County Board  
Don Tyler, 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

(ITEM) Report from the Director, Department of Health and Human Services, requesting authorization to enter into a 2013 professional services contract with Pharmerica for pharmacy services at 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 a 2013 professional services contract with Pharmerica for pharmacy services, in the amount of \$938,035 (annual amount of \$1,324,289); and

WHEREAS, State and Federal law mandates that BHD ensure the availability of pharmaceutical services to patients and clients in its acute inpatient, long term care (LTC), crisis emergency room and community-based programs; and

WHEREAS, in October 2012, BHD published a Request for Proposals (RFP) to solicit bids from private vendors for pharmaceutical services and vendors were given the opportunity to submit proposals for one or more of the service options described below:

- Option 1: Pharmacy for Acute Care, Outpatient and LTC Services provided at BHD Hospital
- Option 2: Acute Care Pharmacy and Outpatient Service Only at BHD Hospital
- Option 3: Acute Care Pharmacy and Outpatient Services at BHD Hospital and LTC Services at Off Site Pharmacy
- Option 4: Long Term Care Services Only at Off Site Pharmacy

; and

WHEREAS, BHD received three proposals which were reviewed by an RFP panel consisting of County and outside representatives and interviews were conducted with the top two vendors; and

WHEREAS, based on the panel's review, BHD is recommending a contract for Option 3 with Pharmerica whose proposal met or exceeded the evaluation criteria identified in the RFP; and

WHEREAS, as required by the proposed contract, BHD will hold the pharmacy licensure, purchase all non-LTC medication and do its own billing for all non-LTC medication thus allowing BHD to maximize its billing capability under its new Electronic Medical Record System; and

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WHEREAS, BHD is recommending an initial contract award for the period April 14, 2013 to December 31, 2013 with three, one-year renewals assuming all terms of the contract are met; and

WHEREAS, there is no budgetary impact associated with this request, as funding for this contract is included in the 2013 Budget; now, therefore,

BE IT RESOLVED, that the Director of the Department of Health and Human Services, or his designee, is hereby authorized to enter into a 2013 professional services contract as follows:

<b><u>Vendor</u></b>	<b><u>Term</u></b>	<b><u>Contract Amount</u></b>
Pharmerica	April 14, 2013 – Dec. 31, 2013 (2014, 2015 and 2016)	\$938,035 (annual amount of \$1,324,289)

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** 2/25/13

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report from the Director, Department of Health and Human Services, requesting authorization to enter into a 2013 professional services contract with Pharmerica for pharmacy services at the Behavioral Health Division

**FISCAL EFFECT:**

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| <input checked="" type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><input type="checkbox"/> Decrease Operating Expenditures<br><input type="checkbox"/> Increase Operating Revenues<br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><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
<b>Operating Budget</b>	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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.) Approval of the request would permit the DHHS-Behavioral Health Division to enter into a 2013 professional services contract for pharmacy services.

B.) The requested professional services contract anticipates expenditures of \$938,035 (annual amount of \$1,324,289) with Pharmerica.

C.) Sufficient funds in the amount of \$4,151,398 are included in BHD's 2013 Adopted Budget for pharmacy services. These funds are budgeted in various organizational units within division 6300 and account 7770 and will be used for this contract as well as purchasing of actual drugs.

D. This fiscal note assumes expenditures cannot exceed the amounts authorized for the professional services contract.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature 

Did DAS-Fiscal Staff Review?  Yes  No  
Did CDBP Staff Review?  Yes  No  Not Required

<sup>1</sup> 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**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** March 5, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

**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 Allow the Planning Council to Enter into an Agreement with Horizon Healthcare, Office of Consumer Affairs, to administer the activities for the Peer Specialist Pipeline Initiative as part of the Mental Health Redesign**

**Issue**

In October 2012, the Department of Health and Human Services (DHHS) – Behavioral Health Division (BHD) received authority from the County Board (File 12-709) to enter into a professional services contract with Planning Council for Health and Human Services starting November 1, 2012 through December 31, 2013 for \$1,114,290 to provide specific programs related to the Mental Health Redesign Initiative. The programs were Peer Specialist Pipeline, Step-Down Housing Alternative, Case Management Expansion, Individual Placement and Support (IPS) Employment, and Supportive Housing Units. BHD is now returning to the Board to request authorization to allow the Planning Council to release funds for to Horizon Healthcare, Office of Consumer Affairs, for administration of the Peer Pipeline Initiative for the time frame April 1, 2013 through December 31, 2013.

**Discussion**

The 2012 BHD Budget included over \$3 million for a Mental Health Redesign and Community Resource Investment, which included specific initiatives aimed at expediting the necessary groundwork for a mental health system more reliant on community resources and less reliant on inpatient care. One of the priorities for these funds and of the Mental Health Redesign Taskforce is the development of the peer specialist network. As of January 2013, there were 52 Certified Peer Specialist (CPS) in Milwaukee County. The goal of the Peer Specialist Pipeline Initiative is to improve and systematize the training, certification, ongoing professional development, and employment opportunities for CPS in order to expand and maintain this workforce that is essential to person-centered care and recovery for persons with mental illness. It is critical to develop a centralized entity information, training, and employment opportunities for CPS. BHD, in partnership with various stakeholders including the state Department of Health Services, provider organizations, advocacy groups, and Certified Peer

Specialists identified the following activities and services that would fully expend the \$200,000 allocation for the Certified Peer Specialist Pipeline Program.

**1. Four (4) Peer Specialist Training Sessions**

Provide training using an approved peer specialist curriculum to interested Milwaukee County residents with lived experience to become Certified Peer Specialists. Each session would train approximately 20 individuals. One session would be specifically dedicated to Spanish-speaking individuals and interpreters with the goal of increasing the number of bilingual Spanish speaking CPS' in Milwaukee County.

**2. Study Groups and Financial Assistance with the CPS Examination**

The peer specialist certification examination is offered three times per year for individuals that successfully complete the approved training curriculum. The peer specialist study groups would be held prior to each examination date and hosted at Our Space, Inc. Financial assistance to pay for the examination would be made available to those that completed the training, participated in the study group, and are in the greatest financial need.

**3. Peer Support and Peer Mentors**

Often times, additional supports are needed for newly employed CPS as they begin their jobs. This would create support groups to be held at various locations throughout Milwaukee such as Grand Avenue Club, NAMI, Mental Health America, etc., to allow for dialogue, problem solving, support, and mentoring from other CPS' that have encountered similar employment situations.

**4. Advanced Peer Support Worker Training**

Host a five (5) day advanced peer specialist training that includes a review of baseline skills for CPS', group facilitation skills, ethics and boundaries, documentation training, peers as evaluators of services, and dealing with conflict and grievances at work and within the role as CPS'.

**5. Peer Supervision Model**

Offer a specialized training for clinicians and/or peer supervisors who supervise CPS'. This workshop will explore: peer support - its role and who qualifies to be a peer specialist; what adjustments are needed for successful integration of peer support into existing behavioral health services; supervision styles and qualifications of peer support specialist supervisors and strategies for long term success (including theoretical frameworks within which to supervise peer support specialists); and, practical solutions to challenges and barriers using case examples and real life situations.

**6. Web-based Clearinghouse**

This is a web page that would be hosted on Mental Health America of Wisconsin's (MHA) website. It would be specifically dedicated to all peer specialist activities for Milwaukee County. The web page would be created in collaboration and with input from CPS'. The content

of the web page would include but is not limited to: training and workshops dates and locations, support group opportunities, mentorship opportunities and requests, MHA's resource guide, and other resources that would be a benefit to CPS's within the context of their job responsibilities, employment opportunities for job seekers, and a central location for employers to post job opportunities.

### **7. Employer Summit**

Building on the successful Peer Specialist Employer Summit held last September 2012, this summit would specifically train employers on the newly created Employer Tool Kit. The tool kit was developed by Access to Independence (ATI) to address concerns and strategies for hiring and employing CPS' from the employer's perspective.

### **8. Professional Development**

A Certified Peer Specialist has an annual continuing education requirement that must be met. The professional development would address the topics of, Emotional CPR, the neuroscience of addiction, recovery components, and offer CPS' scholarship opportunities to attend the annual Crisis Intervention and the Mental Health and Alcohol and Other Drug Abuse conferences sponsored by the University of Wisconsin - Stevens Point.

### **9. WRAP Train the Trainer**

The Wellness Recovery Action Plan (WRAP) developed by Mary Ellen Copeland and delivered by the Copeland Institute would be brought to Milwaukee County. This would be a train the trainer model to provide CPS' a valuable tool - the WRAP, that could be used by people who are dealing with mental health and other kinds of health challenges, and by people who want to attain the highest possible level of wellness.

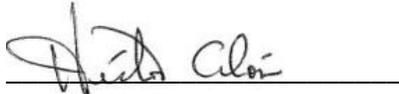
### **Fiscal Effect**

BHD will oversee this contract to ensure that Horizon Healthcare adheres to the performance measures and contract administration requirements and oversight currently included in all purchase of services contracts with the Department of Health and Human Services. The total funds allocated to the Planning Council include \$200,000 for this initiative therefore there is no tax levy impact. A fiscal note form is attached.

### **Recommendation**

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to allow the Planning Council to enter into an agreement with Horizon Healthcare, Office of Consumer Affairs to act as the fiscal agent for the administration of the Peer Pipeline Initiative activities for the time period of April 1, 2013 through December 31, 2013 in the amount of \$200,000.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Héctor Colón", is written over a horizontal line.

Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, County Board  
Don Tyler, 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

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(ITEM \*) A resolution to allow the Planning Council to enter into an agreement with Horizon Healthcare, Office of Consumer Affairs, to administer the activities for the Peer Specialist Pipeline Initiative as part of the Mental Health Redesign Initiative

**A RESOLUTION**

WHEREAS, in October 2012, the Department of Health and Human Services (DHHS) – Behavioral Health Division (BHD) received authority from the County Board (File 12-709) to enter into a professional services contract with Planning Council for Health and Human Services starting November 1, 2012 through December 31, 2013 for \$1,114,290 to provide specific programs related to the Mental Health Redesign Initiative; and

WHEREAS, the programs were Peer Specialist Pipeline, Step-Down Housing Alternative, Case Management Expansion, Individual Placement and Support (IPS) Employment, and Supportive Housing Units; and

WHEREAS, BHD is now returning to the Board to request authorization to allow the Planning Council to release funds for to Horizon Healthcare, Office of Consumer Affairs, for administration of the Peer Pipeline Initiative for the time frame April 1, 2013 through December 31, 2013; and

WHEREAS, the goal of which is to cultivate a well-trained peer specialist workforce necessary for person-centered care and recovery for those with mental illness; and

WHEREAS, through the peer pipeline initiative a critical and centralized clearinghouse will be established that will provide information, training, and employment opportunities for CPS;

WHEREAS, BHD, in partnership with various stakeholders, including the state Department of Health Services (DHS), provider organizations, advocacy groups, and Certified Peer Specialists identified the following activities and services that would fully expend the allocation for the Certified Peer Specialist Pipeline Program:

- Four Peer Specialist Training Sessions
- Study Groups and Financial Assistance with the CPS Examination
- Peer Support and Peer Mentors
- Advanced Peer Support Worker Training
- Peer Supervision Model
- Web-based Clearinghouse
- Employer Summit
- Professional Development
- Wellness Recovery Action Plan (WRAP) Train the Trainer

; now, therefore,

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BE IT RESOLVED that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to allow the Planning Council to enter into an agreement with Horizon Healthcare, Office of Consumer Affairs to act as the fiscal agent for the administration of the Peer Pipeline Initiative activities for the time period of April 1, 2013 through December 31, 2013 in the amount of \$200,000

**MILWAUKEE COUNTY FISCAL NOTE FORM**

**DATE:** 2/18/13

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report, from the Director, Department of Health and Human Services, Requesting Authorization to Allow the Planning Council to Enter into an Agreement with Horizon Healthcare, Office of Consumer Affairs, to administer the activities for the Peer Specialist Pipeline Initiative as part of the Mental Health Redesign

**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<br>(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.*

	<b>Expenditure or Revenue Category</b>	<b>Current Year</b>	<b>Subsequent Year</b>
<b>Operating Budget</b>	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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. The Director of the Department of Health and Human Services (DHHS) is requesting authorization to allow the Planning Council to release funds to Horizon Healthcare, Office of Consumer Affairs, for administration of the Peer Pipeline Initiative for the time frame April 1, 2013 through December 31, 2013 in the Behavioral Health Division (BHD).

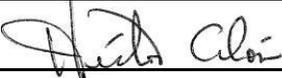
Approval of the recommended contract allocation will allow BHD to cultivate a well-trained peer specialist workforce necessary for person-centered care and recovery for those with mental illness.

B. The total allocated for this one-time initiative is \$200,000.

C. There is no tax levy impact associated with approval of this request in 2013 as funds sufficient to cover associated expenditures are included as part of the \$1.1 million balance in Mental Health Community Reinvestment funds (File 12-709) authorized in October 2012 by the County Board.

D. No assumptions are made.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature 

Did DAS-Fiscal Staff Review?  Yes  No

Did CDPB Staff Review?  Yes  No  Not Required

<sup>1</sup> 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**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** February 25, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

**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 Increase the Purchase of Services Contracts with Milwaukee Mental Health Associates and Bell Therapy/Phoenix Health Care to administer the activities for the expansion of case management services as part of the Mental Health Redesign at the Behavioral Health Division**

**Issue**

In October 2012, the Department of Health and Human Services (DHHS) – Behavioral Health Division (BHD) received authority from the County Board (File 12-709) to enter into a professional services contract with Planning Council for Health and Human Services starting November 1, 2012 through December 31, 2013 for \$1,114,290 to provide specific programs related to the Mental Health Redesign Initiative. The programs were Peer Specialist Pipeline, Step-Down Housing Alternative, Case Management Expansion, Individual Placement and Support (IPS) Employment, and Supportive Housing Units. BHD planned to come to the Board for approval and then have the Planning Council establish agreements with specified vendors for all of the above mentioned services using these funds. Due to the nature of Targeted Case Management (TCM) services, which are billable Medicaid benefits and are a carve-out benefit, the County is responsible for the nonfederal share for the cost of the services. The nonfederal share **must** be public funds and private agencies may not provide the nonfederal share for TCM services. Therefore BHD is requesting that the Board allow the Planning Council to release these specific funds back to BHD for case management services and then allow DHHS-BHD, under Section 46.09 of the Milwaukee County Code of General Ordinances which requires County Board approval for the purchase of human services from nongovernmental vendors, to increase the purchase of services contracts with Milwaukee Mental Health Associates (MMHA) and Bell Therapy/Phoenix Health Care for Targeted Case Management Services (TCM) from April 1, 2013 through December 31, 2013. Case management expansion is a goal of the Mental Health and Redesign Implementation Task Force.

**Discussion**

TCM is a modality of mental health practice that addresses the overall maintenance of a person with mental illness. This modality includes, but is not limited to, addressing the individual's physical, psychological and social environment with the goal of facilitating personal health,

community participation, empowerment and supporting an individual's recovery. Funds were dedicated to case management expansion as part of the above mentioned Mental Health Community Reinvestment funds. In addition, in December 2012 the County Board approved the creation of a "Targeted Case Management Step-Down model" (File 13-25) herein referred to as Recovery Case Management. BHD is now requesting an increase to various purchase of service contracts to reflect both the case management expansion and the Recovery Case Management initiatives. Input and recommendations to address the case management expansion were sought and obtained from the Continuum of Care Action Team of the Mental Health Redesign and Implementation Task Force. The co-chairs and members of that action team are in agreement with the following recommendations for case management expansion.

Currently, BHD has a wait list for TCM Level I services of nearly thirty (30) individuals. This is the first time in over a year that a wait list exists for TCM Level I. Placing those individuals on the wait list into immediate care is of the utmost importance to their health and overall well-being. Utilizing the results of the TCM request for proposal issued by the Department of Health and Human Services in July 2012; BHD is recommending adding Bell Therapy/Phoenix Healthcare as a Level I TCM provider and ensuring adequate funding to assume two caseloads of clients to immediately alleviate the TCM wait list issue. Caseloads in TCM Level I are established at a 1:25 ratio. The recommended contract with Bell Therapy/Phoenix Healthcare would allow for an additional 50 slots for TCM Level I care.

Often times, there are clients who require less intensive services than what is provided in TCM Level I. As detailed in the 2013 Budget, BHD is requesting to pilot a less intensive level of TCM called Recovery Case Management for individuals who require case management services as a condition of their residential living arrangement such as shelter plus care, permanent supported housing or a supported apartment. BHD is recommending adding Milwaukee Mental Health Associates as the Recovery Case Management provider and ensuring adequate funding for one caseload of clients at a newly established ratio of 1:40. MMHA would realign their existing case management caseloads and identify those clients that could benefit from the Recovery Case Management level of care.

### **Fiscal Effect**

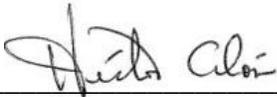
Funds for these services are included in the Planning Council allocation and the 2013 Budget. Based on the requirement that the nonfederal share must be public funds and private agencies may not provide the nonfederal share for TCM services, BHD is requesting that \$125,000 in funds be directed from the Planning Council to BHD, with \$100,000 going to Bell Therapy/Phoenix Health Care for TCM Level 1 and \$25,000 going to MMHA for Recovery Case Management. In addition BHD is requesting that \$25,000 in 2013 Budgeted funds be allocated to the Recovery Case Management pilot program. BHD will oversee these contracts to ensure that Bell Therapy/Phoenix Health Care and MMHA adheres to the performance measures and contract administration requirements and oversight currently included in all purchase of services contracts with the Department of Health and Human Services.

**Recommendation**

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, to allow the Planning Council to release \$125,000 to the Behavioral Health Division for case management expansion to ensure that the nonfederal share for case management is public funds.

It is further recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to increase the purchase of services contract with Bell Therapy/Phoenix Healthcare by \$100,000 for TCM Level I expansion for the time period of April 1, 2013 through December 31, 2013 and to increase the purchase of service contract for Milwaukee Mental Health Associates by \$50,000 for TCM – Recovery Case Management for the time period of April 1, 2013 through December 31, 2013.

Respectfully Submitted,



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Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, County Board  
Don Tyler, 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

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(ITEM \*) From the Director, Department of Health and Human Services, Requesting Authorization to Increase the Purchase of Service Contracts with Milwaukee Mental Health Associates and Bell Therapy/Phoenix Health Care to administer the activities for the expansion of case management services as part of the Mental Health Redesign at the Behavioral Health Division by adopting the following resolution:

**A RESOLUTION**

WHEREAS, in October 2012, the Department of Health and Human Services (DHHS) – Behavioral Health Division (BHD) received authority from the County Board (File 12-709) to enter into a professional services contract with Planning Council for Health and Human Services starting November 1, 2012 through December 31, 2013 for \$1,114,290 to provide specific programs related to the Mental Health Redesign Initiative; and

WHEREAS, the programs were Peer Specialist Pipeline, Step-Down Housing Alternative, Case Management Expansion, Individual Placement and Support (IPS) Employment, and Supportive Housing Units; and

WHEREAS, due to the nature of Targeted Case Management (TCM) services, which are billable Medicaid benefits and are a carve-out benefit, the County is responsible for the nonfederal share for the cost of the services and the nonfederal share must be public funds and private agencies may not provide the nonfederal share for TCM services; and

WHEREAS, BHD is requesting that the Board allow the Planning Council to release these specific funds back to BHD for case management services and then allow DHHS-BHD, under Section 46.09 of the Milwaukee County Code of General Ordinances which requires County Board approval for the purchase of human services from nongovernmental vendors, to increase the purchase of services contracts with Milwaukee Mental Health Associates (MMHA) and Bell Therapy/Phoenix Health Care for Targeted Case Management Services (TCM) from April 1, 2013 through December 31, 2013; and

WHEREAS, case management expansion is a goal of the Mental Health and Redesign Implementation Task Force; and

WHEREAS, TCM is a modality of mental health practice that addresses the overall maintenance of a person with mental illness including addressing the individual’s physical, psychological and social environment with the goal of facilitating personal health, community participation, empowerment and supporting an individual’s recovery; and

44 WHEREAS, after not experiencing a wait list in over a year, BHD currently has a wait list  
45 for TCM Level I services of nearly 30 individuals placing those individuals on the wait list into  
46 immediate care is critical to their health and overall well-being; and  
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48 WHEREAS, Utilizing the results of the TCM request for proposal (RFP) issued by the  
49 Department of Health and Human Services (DHHS) in July 2012; BHD is recommending adding  
50 Bell Therapy/Phoenix Healthcare as a Level I TCM provider to immediately alleviate and allow  
51 for an additional 50 slots for TCM Level I care; and  
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53 WHEREAS, BHD wishes to pilot a less intensive level of TCM called Recovery Case  
54 Management for individuals who require case management services as a condition of their  
55 residential living arrangement and for this initiative BHD recommends Milwaukee Mental  
56 Health Associates as the Recovery Case Management; and  
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58 WHEREAS, funds for these services are included in the Planning Council allocation and  
59 the 2013 Budget therefore no tax levy is needed; now, therefore,  
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61 BE IT RESOLVED, that the Milwaukee County Board of Supervisors authorize the  
62 Director, DHHS, or his designee, to allow the Planning Council to release \$125,000 to the  
63 Behavioral Health Division for case management expansion to ensure that the nonfederal share  
64 for case management is public funds; and  
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66 BE IT FURTHER RESOLVED, that the Milwaukee County Board of Supervisors authorize  
67 the Director, DHHS, or his designee, to increase the purchase of services contract with Bell  
68 Therapy/Phoenix Healthcare by \$100,000 for TCM Level I expansion for the time period of April  
69 1, 2013 through December 31, 2013 and to increase the purchase of service contract for  
70 Milwaukee Mental Health Associates by \$50,000 for TCM – Recovery Case Management for the  
71 time period of April 1, 2013 through December 31, 2013.  
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## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** 2/25/13

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report from the Director, Department of Health and Human Services, Requesting Authorization to Increase the Purchase of Services Contracts with Milwaukee Mental Health Associates and Bell Therapy/Phoenix Health Care to administer the activities for the expansion of case management services as part of the Mental Health Redesign at the Behavioral Health Division

**FISCAL EFFECT:**

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| <input checked="" type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><input type="checkbox"/> Decrease Operating Expenditures<br><input type="checkbox"/> Increase Operating Revenues<br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><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
<b>Operating Budget</b>	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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. The Director of the Department of Health and Human Services (DHHS) is requesting that the Board allow the Planning Council to release these specific funds back to BHD for case management services. DHHS is further requesting, under Section 46.09 of the Milwaukee County Code of General Ordinances which requires County Board approval for the purchase of human services from nongovernmental vendors, an increase to the purchase of services contracts with Milwaukee Mental Health Associates (MMHA) and Bell Therapy/Phoenix Health Care for Targeted Case Management Services (TCM) from April 1, 2013 through December 31, 2013.

After not experiencing a wait list in over a year, BHD currently has a wait list for TCM Level I services of nearly 30 individuals. Placing those individuals on the wait list into immediate care is of the utmost importance to their health and overall well-being.

**B.** Total 2013 expenditures included in this request are \$100,000 for Bell Therapy/Phoenix Health Care and \$50,000 for Milwaukee Mental Health Associates. Funds for these services are included in the Planning Council allocation and the 2013 Budget. The resolution authorizes BHD to allocate \$125,000 from the Planning Council to BHD, with \$100,000 going to Bell Therapy/Phoenix Health Care for TCM Level 1 and \$25,000 going to MMHA for Recovery Case Management. In addition, BHD is requesting that \$25,000 in 2013 Budgeted funds be allocated to the Recovery Case Management pilot program.

C. There is no tax levy impact associated with approval of this request in 2013 as funds sufficient to cover associated expenditures are included as part of the \$1.1 million balance in Mental Health Community Reinvestment funds (File 12-709) authorized in October 2012 by the County Board and the 2013 Budget.

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<sup>1</sup> 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.

D. No assumptions are made.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature 

Did DAS-Fiscal Staff Review?  Yes  No

Did CDPB Staff Review?  Yes  No  Not Required

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** February 25, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

**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 establish Purchase of Services Contracts with four Neighborhood Centers: Silver Springs, Northcott, UMOS, and The Urban League to administer the *Celebrating Families* selective preventative intervention within the Behavioral Health Division**

**Issue**

Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. No contract or contract adjustment shall take effect until approved by resolution of the County Board. Per Section 46.09, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to enter into purchase of service contracts with the following neighborhood centers in Milwaukee: Silver Springs, Northcott, UMOS, and The Urban League.

**Discussion**

Over the past year the Community Services Branch of BHD has been increasing their partnership opportunities with the State Department of Children and Families and the Bureau of Milwaukee Child Welfare (BMCW). One of the most recent partnership initiatives has been the Fatherhood Project. The Fatherhood Project is a workforce preparation initiative that also places special emphasis on the role of fathers within the family structure. There is a great need for strengthening family functioning and dynamics in a family impacted by substance use in the household. Therefore the use of the *Celebrating Families!*<sup>™</sup> model is recommended to achieve this need. The model is developed for children of alcoholics/addicts and their parents, many of whom have learning difficulties or cognitive deficits. *Celebrating Families!*<sup>™</sup> is based on recent research about brain chemistry, including skills, education, risk and resiliency factors, and asset development. Emphasis is also placed on the importance of community service and individual spirituality. The Community Services Branch will ensure that the *Celebrating Families!*<sup>™</sup> selective preventative intervention program is available at four neighborhood centers that are participating in the Fatherhood Project and are partners with BMCW. Those neighborhood centers are: Silver Springs, Northcott, UMOS, and The Urban League. The *Celebrating Families!*<sup>™</sup> curriculum is an evidence based cognitive behavioral, support group model written for families in which one or both parents have a serious problem with alcohol or other drugs

and in where there is a high risk for domestic violence, child abuse, or neglect. The program would be delivered at the neighborhood centers and made available for families participating in the Fatherhood Project and/or BMCW.

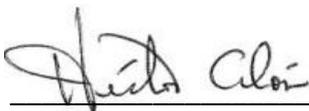
**Fiscal Effect**

Total funds for these four purchase of service contracts will be allocated from funding received from BMCW for substance abuse prevention and treatment activities. BMCW has listed the vendors for this initiative in the contract issued to BHD (See Attachment). BHD will administer these contracts for quality compliance and outcome reporting. The funding is federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and has no tax levy impact. A fiscal note form is attached.

**Recommendation**

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to execute purchase of services contracts with Silver Springs, Northcott, UMOS, and The Urban League neighborhood centers for the period of April 1, 2013 through December 31, 2013 in the amount of \$50,000 for each agency for a total amount of \$200,000.

Respectfully Submitted,



Héctor Colón, Director  
Department of Health and Human Services

- cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, County Board  
Don Tyler, 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

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(ITEM \*) Report, from the Director, Department of Health and Human Services, Requesting Authorization to establish Purchase of Services Contracts with four Neighborhood Centers: Silver Springs, Northcott, UMOS, and The Urban League to administer the Celebrating Families selective preventative intervention within the Behavioral Health Division, by recommending adoption of the following:

**A RESOLUTION**

WHEREAS, per Section 46.09 of the Milwaukee County Code of General Ordinances, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to establish purchase of service contracts between the Behavioral Health Division and four Neighborhood Centers (Silver Spring, Northcott, UMOS, and The Urban League), to administer the Celebrating Families!™ selective preventative intervention program; and

WHEREAS, there is a great need for strengthening family functioning and dynamics in families impacted by substance use in the household; and

WHEREAS, the Celebrating Families!™ model was developed for children of alcoholics/addicts and their parents, where many such children have learning differences and/or cognitive deficits; and

WHEREAS, Celebrating Families!™ is grounded in recent research about brain chemistry and is an evidence based cognitive-behavioral, support group model.; and

WHEREAS, the Celebrating Families!™ curriculum is written for families in which one or both parents have a serious problem with alcohol or other drugs and where there is a high risk for domestic violence, child abuse, or neglect; and

WHEREAS, total expenditures included in this request are \$200.000; and

WHEREAS, there is no tax levy impact associated with approval of this request as funds to cover the related expenditures will be allocated from revenue received from the State Bureau of Milwaukee Child Welfare (BMCW) for substance abuse prevention and treatment activities; now, therefore,

BE IT RESOLVED, that the Director of the Department of Health and Human Services, or his designee, is authorized to enter into 2013 purchase of service contracts with the following provider agencies for the time period of April 1 through December 31, 2013, in the amounts specified below

<u>Agency</u>	<u>Service</u>	<u>2013 Contract</u>
Silver Spring Neighborhood Center	Celebrating Families!™	50,000

49	Northcott Neighborhood Center	Celebrating Families!™	50,000
50			
51	UMOS	Celebrating Families!™	50,000
52			
53	Milwaukee Urban League	Celebrating Families!™	50,000
54			
55		<b><u>TOTAL</u></b>	<b><u>200,000</u></b>
56			

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** February 25, 2013

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report, from the Director, Department of Health and Human Services, Requesting Authorization to establish Purchase of Services Contracts with four Neighborhood Centers: Silver Springs, Northcott, UMOs, and The Urban League to administer the *Celebrating Families* selective preventative intervention within the Behavioral Health Division

**FISCAL EFFECT:**

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|---|--|
| <input type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input checked="" type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input checked="" type="checkbox"/> Not Absorbed Within Agency's Budget<br><input type="checkbox"/> Decrease Operating Expenditures<br><input checked="" type="checkbox"/> Increase Operating Revenues<br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><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
<b>Operating Budget</b>	Expenditure	200,000	0
	Revenue	200,000	0
	Net Cost	0	0
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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. The Director of the Department of Health and Human Services (DHHS) is requesting authorization to establish purchase of service contracts between the Behavioral Health Division and four Neighborhood Centers (Silver Spring, Northcott, UMOS, and The Urban League), to administer the Celebrating Families!<sup>TM</sup> selective preventative intervention program for the period April 1, 2013 through December 31, 2013.

Approval of this request will allow the Behavioral Health Division to assist in strengthening the family functioning and dynamics in household's impacted by substance abuse and comply with the contract requirements between BHD and the Bureau of Milwaukee Child Welfare (BMCW) (see attachment).

The Celebrating Families!<sup>TM</sup> model was developed for children of alcoholics/addicts and their parents, where many such children have learning differences and/or cognitive deficits. Celebrating Families!<sup>TM</sup> is grounded in recent research about brain chemistry, and the curriculum is an evidence based cognitive-behavioral, support group model written for families in which one or both parents have a serious problem with alcohol or other drugs and where there is a high risk for domestic violence, child abuse, or neglect.

B. Total expenditures included in this request are \$200,000.

C. There is no tax levy impact associated with approval of this request as funds to cover the related expenditures will be allocated from funding received from the State Bureau of Milwaukee Child Welfare for substance abuse prevention and treatment activities. A fund transfer will be submitted later in 2013 to recognize receipt of this revenue.

D. No assumptions are made.

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<sup>1</sup> 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 Thomas F. Lewandowski, Fiscal & Management Analyst

Authorized Signature 

Did DAS-Fiscal Staff Review?  Yes  No

Did CDPB Staff Review?  Yes  No  Not Required

## **2013 BMCW Service Overview for Treatment and Primary AODA Prevention Services with the Milwaukee County Behavioral Health Division, Community Services Branch**

BMCW clients needing treatment for a substance use disorder and currently connected and served by the Bureau, CSSW and/or IFS will be enrolled in the Wiser Choice Substance Abuse Services System. The existing referral process for IFS and CSSW to refer BMCW clients to Wiser Choice will be utilized.

The clients will choose to receive their Wiser Choice Comprehensive Screening at either the IMPACT or M&S Clinical Services Central Intake Unit (CIU). Clients will be connected with a peer to assist with the initial appointment at the CIU and to the provider once treatment need is assessed. At the CIU Levels of Care (LOC) will be determined. For first time Wiser Choice clients they will receive a Recovery Checkup staff person and service that will be funded with ATR. Clients will receive a Recovery Support Coordinator (RSC) and will receive care coordination services. Based on needs identified during the Comprehensive Screen, the client will select a treatment provider aligned with the recommended LOC. In addition, based on needs identification the client may receive placement and voucher for Recovery Support Services.

### **Direct Treatment Costs**

Milwaukee County, Wiser Choice, operates a braided voucher system for all substance abuse services. Included within this category are all the treatment and recovery support services that will be purchased with vouchers. Clients will enter the service delivery system based on their assessed need of intensity of care within available cost bands. (*Note: as most service packages include more than one level of care, the cost bands "Total Treatment" are actually overestimated, yet fall well within the SAMHSA-published reasonable ranges.*) Based on the anticipated total number of clients to be served January 1, 2013 through December 31, 2013 (100) and the budgeted cost of \$500,000 for direct Substance Abuse Services, the unit cost per client (all services) is \$4,167 in BMCW service dollars.

### **Primary AODA Prevention**

Community Services Branch will ensure that the *Celebrating Families!*<sup>™</sup> selective preventative intervention program is available at four neighborhood centers. Those neighborhood centers are: Silver Springs, Northcott, UMOS, and The Urban League. The *Celebrating Families!*<sup>™</sup> curriculum is an evidence based cognitive behavioral, support group model written for families in which one or both parents have a serious problem with alcohol or other drugs and in which there is a high risk for domestic violence, child abuse, or neglect.

Numerous studies have shown that a simple screening, intervention, and referral program will provide people with the help they need and greatly alleviate the damage of risky and problem drinking and drug use. For many people, this early screening and brief intervention is enough to help them significantly decrease their alcohol and drug use. A verbal alcohol and drug screen consisting of from 4 to 12 questions that effectively identifies people who are at risk for alcohol and drug abuse even at the earliest stages. Studies show that the SBIR programs **S**creening, **B**rief Intervention, and **R**eferral is more effective than urine or breath tests and laboratory findings, which fail to pick up on signs of early problems. SBIR serves as an indicated AODA preventive measure that can address risky behaviors before people do harm or become addicted. SBIR will be made available at Silver Spring neighborhood center and at Federally Qualified Health Centers (FQHC) such as 16<sup>th</sup> Street Clinic, Aurora, and Outreach Community Health Centers to serve the child welfare and W-2 client population.

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** February 25, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

**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 increase the Purchase of Services Contract with Milwaukee Mental Health Associates to administer a protective payee program for the Behavioral Health Division**

**Issue**

Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. No contract or contract adjustment shall take effect until approved by resolution of the County Board. Per Section 46.09, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase the purchase of service contract with Milwaukee Mental Health Associates for protective payee services for clients in the Behavioral Health Division (BHD).

**Discussion**

BHD sponsors a protective payee program for clients that require assistance with financial management services to ensure that they have adequate resources throughout the entire month and the ability to learn money management skills to eventually assume these responsibilities. A payee is an individual or organization appointed by the Social Security Administration (SSA) to receive Social Security and/or SSI benefits for someone who cannot manage or direct someone else to manage his or her money. The main responsibilities of a payee are to use the benefits to pay for the current and foreseeable needs of the client and properly save any benefits not needed to meet current needs. A payee acts on behalf of the client and is responsible for everything related to benefits that a capable beneficiary would do for himself or herself. SSA encourages payees to go beyond just managing finances and to be actively involved in the client's life. The payee has to document the services that they provide to a client and must also keep records of expenses. When SSA requests a report, a payee must provide an accounting to SSA of how benefits were used or saved.

Utilizing the results of the Targeted Case Management (TCM) request for proposal issued by the Department of Health and Human Services in July 2012; BHD is recommending Milwaukee Mental Health Associates (MMHA) as the agency to administer the protective payee program

sponsored by BHD. MMHA is also a Community Support Program (CSP) and TCM agency and has years of experience acting in the role of protective payee for many of the clients in both CSP and TCM that they operate.

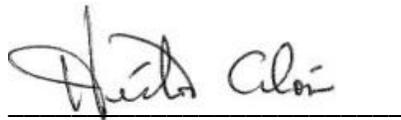
**Fiscal Effect**

Total funds of \$9,462 for this program will be allocated from the overall purchase of service funds in the 2013 budget. Funds for this service are included in the 2013 Budget therefore there is no tax levy effect. A fiscal note form is attached.

**Recommendation**

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to increase the purchase of services contract with Milwaukee Mental Health Associates for protective payee program by \$9,462 for the time period of May 1, 2013 – December 31, 2013.

Respectfully Submitted,



Héctor Colón, Director  
Department of Health and Human Services

- cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, County Board  
Don Tyler, 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

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(ITEM \*) Report, from the Director, Department of Health and Human Services, Requesting Authorization to increase the Purchase of Services Contract with Milwaukee Mental Health Associates to administer a protective payee program for the Behavioral Health Division, by recommending adoption of the following:

**A RESOLUTION**

WHEREAS, per Section 46.09 of the Milwaukee County Code of General Ordinances, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase the existing purchase of service contract between Milwaukee Mental Health Associates and the Behavioral Health Division, for the purpose of administering the Protective Payee Program; and

WHEREAS, some consumers who receive Social Security and/or Supplemental Security Income (SSI) benefits require assistance in the management of these resources; and

WHEREAS, the Social Security Administration (SSA) authorizes the appointment of an individual or organization to receive Social Security and/or SSI benefits on behalf of an individual who cannot manage his or her money; and

WHEREAS, Milwaukee Mental Health Associates has existing 2013 contracts to provide Community Support Program (CSP) services and Targeted Case Management (TCM) services; and

WHEREAS, MMHA has years of experience acting in the role of Protective Payee for many of the clients they serve in the CSP and TCM programs they operate; and

WHEREAS, total expenditures included in this request are \$9,462; and

WHEREAS, there is no tax levy impact associated with approval of this request because associated expenditures are included in the 2013 BHD Budget; now, therefore,

BE IT RESOLVED, that the Director of the Department of Health and Human Services, or his designee, is authorized to increase the existing purchase of service contract between Milwaukee Mental Health Associates (MMHA) and the Behavioral Health Division in the amount of \$9,462, for the purpose of administering the Protective Payee Program for the period of May 1, 2013 through December 31, 2013.

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** February 25, 2013

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report, from the Director, Department of Health and Human Services, Requesting Authorization to increase the Purchase of Services Contract with Milwaukee Mental Health Associates to administer a protective payee program for the Behavioral Health Division

**FISCAL EFFECT:**

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| <input type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input checked="" type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input checked="" type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><br><input type="checkbox"/> Decrease Operating Expenditures<br><br><input type="checkbox"/> Increase Operating Revenues<br><br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><br><input type="checkbox"/> Decrease Capital Expenditures<br><br><input type="checkbox"/> Increase Capital Revenues<br><br><input type="checkbox"/> Decrease Capital Revenues<br><br><input type="checkbox"/> Use of contingent funds |
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*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
<b>Operating Budget</b>	Expenditure	9,462	0
	Revenue	0	0
	Net Cost	9,462	0
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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. The Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase the existing Purchase of Services contract between Milwaukee Mental Health Associates and the Behavioral Health Division, for the purpose of administering the Protective Payee Program for the period May 1, 2013 through December 31, 2013.

Approval of this request will allow the Behavioral Health Division to provide consumers who receive Social Security and/or Supplemental Security Income (SSI), and who need assistance in the management of these resources, the necessary support to ensure their financial stability in accordance with Social Security Administration regulations.

B. Total expenditures included in this request are \$9,462. Milwaukee Mental Health Associates (MMHA) has an existing 2013 contract in the amount of \$472,947 to provide Community Support Program (CSP) services and an existing 2013 contract in the amount of \$213,723 as a provider of Targeted Case Management (TCM) services. The addition of this Protective Payee Program contract brings MMHA's total to \$696,132.

C. Total funds of \$9,462 for this program will be allocated from the overall purchase of service funds in the 2013 budget. Funds for this service are included in the 2013 Budget therefore there is no tax levy effect.

D. No assumptions are made.

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<sup>1</sup> 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 Thomas F. Lewandowski, Fiscal & Management Analyst

Authorized Signature 

Did DAS-Fiscal Staff Review?  Yes  No

Did CDPB Staff Review?  Yes  No  Not Required

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
INTER-OFFICE COMMUNICATION

**DATE:** February 11, 2013

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

**FROM:** Héctor Colón, Director, Department of Health and Human Services  
*Prepared by Paula Lucey, Administrator, Behavioral Health Division, on behalf of the Mental Health Redesign and Implementation Task Force*

**SUBJECT:** **An informational report from the Director, Department of Health and Human Services, on the implementation plan and current activities of the Mental Health Redesign and Implementation Task Force**

**Issue**

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 (Redesign Task Force) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities.

In December 2012, the Committee on Health and Human Needs requested further reporting from the Department of Health and Human Services (DHHS) and the Behavioral Health Division (BHD) on the implementation plan developed by the Redesign Task Force and County staff in collaboration with community stakeholders and contracted technical assistance providers. The Committee also requested monthly informational reporting on the activities of the Redesign Task Force.

**Background**

The Redesign Task Force first convened in 2011, establishing a charter and delegating five Action Teams to prioritize recommendations for system enhancements within the key areas of Person-Centered Care, Continuum of Care, Community Linkages, Workforce, and Quality. The co-chairs of the Action Teams initially presented their prioritized recommendations to the Committee on Health and Human Needs in January 2012 and at a public summit in February 2012, where consultants from the Human Service Research Institute (HSRI) provided feedback and guidance. BHD leadership, the Redesign Task Force, and its Executive Committee resolved in March 2012 to seek technical assistance for the process of implementing the affirmed recommendations. The ensuing RFP led to a professional services contract with ZiaPartners, Inc., which took effect in September 2012. The consultants have worked with leaders from DHHS, BHD, and the Redesign Task Force and Action Teams since that time, and Wilberg Community Planning, LLC, has provided regular on-site technical assistance as a subcontractor.

In December 2012, the DHHS Director and BHD Administrator presented an informational report to the Committee on Health and Human Needs on the progress and activities of the Redesign Task Force, including a framework for planning, tracking, and recording progress on all redesign implementation

activities, including those already accomplished or underway. The implementation activities were thereafter to be framed within SMART Goals – Specific, Measurable, Attainable, Realistic, and Timebound – to promote greater accountability and clearer reporting.

### **Discussion**

Each Action Team (AT) met in January to discuss the SMART Goals and other matters. The Continuum of Care AT consulted with Sue Gadacz (BHD Adult Community Services) on potential pathways toward implementing Community Recovery Services in Milwaukee County. The team also provided input on the allocation of Community Investment funds earmarked for case management.

Jim Mathy (Housing Administrator) worked with community partners to fulfill another Community Linkages AT recommendation; the Housing Division will contract with Our Space and Milwaukee Center for Independence to provide services at a new “step-down” level of housing. The team is pursuing ways to support the Community Justice Council’s data link between the behavioral health and criminal justice systems.

The Workforce AT researched and discussed the education and credentialing standards for Certified Peer Specialists in Wisconsin. Additional work is needed to establish a baseline for target objectives related to utilizing Certified Peer Specialists. Sue Gadacz met with a group of Certified Peer Specialists and other community partners on how to use the earmarked Community Reinvestment funds to effectively establish a “pipeline” for peers to be trained, certified, and employed in appropriate roles in the mental health system.

The Quality AT and County staff are providing input to Dr. Andrew Keller and the TriWest Group in their ongoing development of a pictorial system map and a community data dashboard.

The Person-Centered Care AT discussed more outreach and public education with suggestions to work with churches and schools and to utilize the stories of individuals with positive experiences receiving services. The team is also eager to flesh out the idea of County Supervisors hosting public education forums in their districts.

Staff and consultants are working with interested parties to initiate the Resource Strategy Team.

The Redesign Task Force met on February 6 at Highland Commons in West Allis. The primary focus of the meeting was to collaboratively revise and finalize the SMART Goals document. Co-chairs from each AT presented feedback from their teams to the full Redesign Task Force. Following the meeting, the technical assistance team worked with County staff to ensure that the timelines and numerical targets were feasible and meaningful. The completed document represents substantial input from diverse stakeholders, collected by e-mail, online surveys, telephone, and numerous face-to-face meetings.

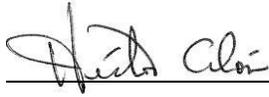
### **Next steps**

These SMART Goals clearly outline targets, tactics, and responsible parties for redesign-related initiatives and enhancements for 2013 and 2014. Because the SMART Goals are oriented toward future activities, they are not necessarily inclusive of various redesign-related enhancements that have already been partially or wholly achieved since 2011 by the Behavioral Health Division, Housing Division, Disabilities Services Division, and other community partners. Periodic progress reports to the County Board on behalf of the Redesign Task Force will maintain a record of redesign-related accomplishments.

Upcoming meetings of the Redesign Task Force are March 6 and April 3, 3:00 to 5:00 (location TBD). Contact David Johnson for more information (414-257-5255 or [david.johnson@milwcnty.com](mailto:david.johnson@milwcnty.com)).

**Recommendation**

This is an informational report. No action is necessary.



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Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, Chief of Staff, County Board  
Don Tyler, Director, DAS  
Craig Kammholz, Fiscal & Budget Administrator, DAS  
CJ Pahl, Assistant Fiscal & Budget Administrator, DAS  
Antionette Thomas-Bailey, Fiscal & Budget Analyst, DAS  
Jennifer Collins, County Board Analyst

# Mental Health Redesign SMART<sup>1</sup> Goals: 2013 – 2014



## TIMEFRAME

Redesign is about designing a system that promotes life and hope for people in Milwaukee County with mental health needs by transitioning to a more fully community-based system of care. Redesign is as a multi-year process with ambitious targets. Initial SMART Goal implementation is focused on identifying attainable and measurable goals/objectives that can be achieved within the next 12-18 months.

There will then be Annual Updates of the SMART Goals to define measurable progress toward the highest possible standards for all services.

<sup>1</sup> Specific, Measurable, Attainable, Realistic, and Time-bound

## SCOPE

The Mental Health Redesign addresses the improvement of mental health services for Milwaukee County residents served by public and private systems and organizations. Initial SMART Goals focus heavily on changes in the public sector system operated by the Milwaukee County Department of Health and Human Services while implementation planning continues on broader communitywide improvements involving major hospital systems, provider organizations, advocates, and persons with lived experience. Monthly progress reports on the SMART Goals and Improvement Areas will continue to be made to the County Board and the community.

## ORGANIZATION OF SMART GOALS

Goals are organized into five improvement areas consistent with the monthly progress reports that have been provided on the Redesign process:

- 1) System of Care
- 2) Crisis System Redesign
- 3) Continuum of Community-Based Services
- 4) Integrated Multi-System Partnerships
- 5) Reduction of Inpatient Utilization

## SMART Goal 2013-2014

### one

#### Improvement Area 1 – System of Care

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

#### Improve consumer satisfaction and recovery outcomes by:

- Providing services that are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable;
- Improving system-wide implementation of such services;
- Increasing the use of self-directed recovery action plans;
- Completing the functional integration of substance use disorder and mental health service components of the Milwaukee County Community Services Branch; and
- Using person-centered experiences to inform system improvement.

#### PERFORMANCE TARGETS

##### By July 2014:

- 1) Consumer satisfaction as measured by the MHSIP (Mental Health Statistics Improvement Program) Consumer Survey will show measurable improvement for Milwaukee County Behavioral Health Division's Acute Adult Inpatient and Community Services Branch, including residential, supported apartments, community support programs, targeted case management programs, and day treatment with the long range goal of meeting/exceeding the National Research Institute consumer satisfaction standards.
- 2) Consumer satisfaction as measured by the Vital Voices consumer satisfaction interviews will show measurable improvement for Milwaukee County Crisis Services.
- 3) 80% of Milwaukee County Behavioral Health Division directly operated services and contracted services will demonstrate adherence to the Mental Health Redesign Core Competencies relative to the principles of person-centered care. (See Goal 3)
- 4) Integration of substance use disorder and mental health services in the Milwaukee County will be achieved.
- 5) Consistent mechanism for using person-centered stories in quality improvement is established.

#### TACTICAL OBJECTIVES

- 1.1 Review MHSIP and Vital Voices survey instruments to determine if enhancements are required to capture person-centered principles.
- 1.2 Continue implementation of evidence-based practices to improve the extent to which services are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable; and anchor those improvements in policy and contract.
- 1.3 Coordinate the activities of MC3 (Milwaukee County Co-Occurring Cadre) Evaluation Subcommittee with the efforts of the Redesign Quality Action Team to insure representation of person-centered stories in quality improvement.
- 1.4 Develop and implement strategies to increase the use of self-directed recovery action plans by establishing a baseline of current use, identifying training opportunities, and measuring adoption by peers.
- 1.5 Lead the integration of substance use disorder and mental health services into a co-occurring capable system by functionally integrating SAIL and Wiser Choice at the Community Services Branch and provider levels.

#### RESPONSIBILITY

**Lead BHD Staff:**  
Jennifer Wittwer

**Action Team Involvement:**  
Person-Centered and Quality

**Partners:**  
Persons with lived experience; Community Services Branch; MC3; providers; Vital Voices; Families United; Mental Health Task Force

**two**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Promote stigma reduction in Milwaukee County through:**

- Evidence-based MH/AODA stigma reduction public education presentations that include presentations by persons with lived experience to over 1000 residents in Milwaukee County supervisor districts.
- Partnering with community efforts already underway led by NAMI, Rogers Memorial Hospital, and the Center for Urban Population Health Project Launch.

2

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Presentations are conducted in 18 supervisor districts with an average of 55 residents in attendance at each (total of 1,000 residents).
- 2) Stigma reduction message is received by a minimum of 20,000 Milwaukee County residents.

**TACTICAL OBJECTIVES**

- 2.1 Develop a program to be delivered within each supervisor district that includes an evidence-based stigma reduction model and a presentation by one or more persons with lived experience.
- 2.2 Provide support and technical assistance to community efforts to reduce stigma.

**RESPONSIBILITY**

**Lead BHD Staff:**  
E. Marie Broussard  
**Action Team Involvement:**  
Person-Centered  
**Partners:**  
Milwaukee County Supervisors; Mental Health Task Force; NAMI; Rogers Memorial Hospital; Center for Urban Population Health; Persons with lived experience

**three**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Improve the quality of the mental health workforce through:**

- a. Implementation of workforce competencies aligned with person-centered care;
- b. Improved mental health nursing recruitment and retention;
- c. Improved recruitment and retention of psychiatrists; and
- d. Improved workforce diversity and cultural competency.

3

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Establish person-centered workforce competencies.
- 2) 50% of Milwaukee County contracted behavioral health providers will adopt person-centered workforce competencies.
- 3) Plan to improve the retention of mental health nurses is completed.
- 4) One (1) training slot is established for the 2014-2015 involving a partnership of the Medical College of Wisconsin Department of Psychiatry and the Milwaukee County Behavioral Health Division.
- 5) A baseline on the current racial/ethnic composition of the mental health workforce is established.

**TACTICAL OBJECTIVES**

- 3.1 Develop person-centered workforce competencies that are recovery-oriented, trauma-informed, co-occurring capable, and culturally-competent.
- 3.2 Develop and implement a plan to introduce the competencies to public and private entities and achieve their adoption.
- 3.3 Develop and implement a plan to improve the quality and retention of mental health nurses.
- 3.4 Establish a sustainable partnership between the Medical College of Wisconsin and Milwaukee County to support the annual commitment of one (1) training slot.
- 3.5 Work with representatives of underserved and underrepresented populations to improve the recruitment and retention of mental health professionals from those community sectors.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Lora Dooley  
**Action Team Involvement:**  
Workforce and Person-Centered  
**Partners:**  
Nursing's Voice; Faye McBeath Foundation; University of Wisconsin-Milwaukee; Medical College of Wisconsin; Employers

**four**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Expand the network of Certified Peer Specialists who are well trained, appropriately compensated, and effectively engaged with peers and whose services are eligible for Medicaid reimbursement by:**

- Increasing the number Certified Peer Specialists;
- Recruiting and training Certified Peer Specialists with bilingual (Spanish) capability;
- Increasing the number of programs that employ Certified Peer Specialists;
- Establishing a Certified Peer Specialist-operated program; and
- Advocating for quality in the delivery of Certified Peer Specialist services.

4

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Increase the number of Certified Peer Specialists by 20% (10) over the 2013 baseline of 52 Certified Peer Specialists.
- 2) Increase the number of programs meeting identified target for employing Certified Peer Specialists by from the 2013 baseline of eight (8) programs to fifteen (15) programs.
- 3) Implement one (1) Certified Peer Specialist-operated program.

**TACTICAL OBJECTIVES**

- 4.1 Continue implementation of the Certified Peer Specialist Pipeline program supported by the Community Services Branch.
- 4.2 Establish a web-based clearinghouse to post Certified Peer Specialist opportunities.
- 4.3 Using the fall 2012 Employer Summit as the model, continue efforts to improve employers' effective utilization of Certified Peer Specialists in their programs.
- 4.4 Continue to incorporate targets for Certified Peer Specialist employment into policy and contracts.
- 4.5 Support the provision of Certified Peer Specialist training using state-approved curricula.
- 4.6 Develop and implement a plan to establish a program operated by Certified Peer Specialists.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jennifer Bergersen  
**Action Team Involvement:**  
Workforce  
**Partners:**  
Persons with lived experience; Certified Peer Specialist Training Programs; Wisconsin Peer Specialist Employment Initiative

**five**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Improve the coordination and flexibility of public and private funding committed to mental health services.**

5

**PERFORMANCE TARGETS**

**By October 2013:**

- 1) Redesign Task Force will complete an analysis (mapping) of public and private resources that support mental health services including analysis of Affordable Care Act implications.

**By January 2014:**

- 2) Milwaukee County will approve implementation of CRS (Community Recovery Services) consistent with the Wisconsin Medicaid State Plan Amendment under 1915 (i) to create more flexible application of Medicaid waiver funding within appropriate fiscal constraints.

**TACTICAL OBJECTIVES**

- 5.1 Establish Resource Strategy Team comprised of finance experts from foundations, private hospital systems, Milwaukee County, State of Wisconsin, and the Public Policy Forum.
- 5.2 Publish a report on Mental Health Redesign Financing for dissemination and discussion by key stakeholders.
- 5.3 Designate the Continuum of Care Action Team or form a new CRS Planning Workgroup to advise Milwaukee County on the design of CRS.
- 5.4 Conduct a review of program and fiscal data to inform the development of the CRS implementation plan.
- 5.5 Submit the CRS implementation plan to the Milwaukee County Board for review and approval.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jim Kubicek and Alex Kotze  
**Action Team Involvement:**  
Resource Strategy and Continuum of Care  
**Partners:**  
Wisconsin Department of Health Services

**six**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Establish a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals.**

6

**PERFORMANCE TARGETS**

**By October 2013:**

- 1) Publish and widely disseminate the first annual Milwaukee County Mental Health Dashboard and Community Progress Report to chart progress on Redesign SMART Goals.

**TACTICAL OBJECTIVES**

- 6.1 Establish public/private system quality indicators aligned with the overall system vision.
- 6.2 Identify and coordinate existing data sets and data sources.
- 6.3 Determine how to include consumer experiences in the improvement process.
- 6.4 Identify how improvement targets in SMART Goals will be measured and reported.
- 6.5 Create information-sharing agreements.
- 6.6 Prepare initial format for review and modification.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Sue Gadacz  
**Action Team Involvement:**  
Quality Action Team  
**Partners:**  
Persons with lived experience; Data providers

**seven**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Develop a structure for ongoing system improvement and oversight of the Mental Health Redesign process.**

7

**PERFORMANCE TARGETS**

**By January 2014:**

- 1) Define and implement a formal partnership structure and process for continuing system improvement that will review progress, address implementation challenges, and pursue opportunities for further enhancement of the Milwaukee County community mental health system.

**TACTICAL OBJECTIVES**

- 7.1 Review current membership, charter, and functioning of the Redesign TF.
- 7.2 Determine need for and objectives of ongoing system improvement partnership.
- 7.3 Describe and draft a proposed charter, membership, and accountability of the proposed continuing structure.
- 7.4 Identify a mechanism for formalizing and implementing the continuing structure and process.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Paula Lucey with the Redesign Task Force  
**Action Team Involvement:**  
NA  
**Partners:** NA

eight

**Improvement Area 2 – Crisis System Redesign**

Creating and sustaining a community-based continuum of crisis services to reduce involuntary commitments and undue reliance on acute inpatient care.

**Improve crisis access and response to reduce Emergency Detentions (Chapter 51, Involuntary Commitment for Treatment).**

8

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) The number of Emergency Detentions at the Milwaukee County Behavioral Health Division will decrease by 10% (720) from the 2012 baseline of 7,204 Emergency Detentions.
- 2) The percentage of crisis intervention events which are voluntary will increase from 43.2% (2012 baseline) to 48.9% or greater.
- 3) The number of individuals seen at the Milwaukee County Psychiatric Crisis Service (PCS) who have person-centered crisis plans will increase by 30% over the 2012 baseline of 136.
- 4) Maintain high volume of Access Clinic service at 2012 baseline of 6,536 visits.

**TACTICAL OBJECTIVES**

- 8.1 Develop a partnership between the Redesign Task Force and the current implementation process for developing an integrated, welcoming crisis continuum of care.
- 8.2 Support the increased utilization of person-centered crisis plans for the prevention of, and early intervention in, crisis situations through training and technical assistance provided countywide.
- 8.3 Prioritize expansion of the availability and responsiveness of mobile crisis services as well as other community crisis diversion services including walk-in services, clubhouse, and crisis bed options of all types.
- 8.4 Facilitate earlier access to assistance for a crisis situation for individuals and families through improved public information on how to access the range of crisis intervention services in the community.
- 8.5 Improve the capacity of law enforcement (Milwaukee Police Department, Sheriff's Office, and municipal police departments) to effectively intervene in crisis situations through expanded Crisis Intervention Training.
- 8.6 Identify and improve policies and procedures related to crisis response in contracted services to reduce the likelihood that crisis events lead to emergency detention.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Amy Lorenz

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience; community crisis services providers; mobile crisis services; private hospital systems/emergency departments; law enforcement; Community Intervention

nine

**Improvement Area 3 – Continuum of Community-Based Services**

Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

**Improve the flexible availability and continuity of community-based recovery supports.**

9

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Establish a continuum of Targeted Case Management (TCM) services that includes four components: Intensive, Crisis, Level I (regular case management), and Recovery.
- 2) Increase the number of TCM slots by 6% (90) over the 2012 baseline of 1,472 slots.
- 3) Establish two additional psycho-social rehabilitation benefits (Community Recovery Services (CRS) and Community Support Services (CSS)) to provide flexible recovery support in the community.

**TACTICAL OBJECTIVES**

- 9.1 Develop, pilot and implement a mechanism for flexible utilization management that supports individualized matching of service intensity with the continuum of case management and other recovery supports.
- 9.2 Develop, pilot and implement procedures to move from higher to lower levels of support (and conversely) in response to changing circumstances, e.g. crisis.
- 9.3 Organize a flexible continuum of community recovery supports to be made available to eligible individuals through CRS and CSS.
- 9.4 Establish metrics to assess the financial and program impacts of this approach.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Sue Gadacz

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience; Milwaukee County Community Services Branch; Community providers

ten

**Improvement Area 3 – Continuum of Community-Based Services**

Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

**Improve the success of community transitions after psychiatric hospital admission.**

10

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) The percentage of individuals who are discharged from Milwaukee County Psychiatric Crisis Service (PCS) who return to PCS within 90 days will decrease from the 2012 baseline of 32.2% to 27.0%.
- 2) The percentage of individuals who are discharged from Milwaukee County Acute Adult Inpatient Services who return to that service within 90 days will decrease from the 2012 baseline of 24.1% to 22.0%.

**TACTICAL OBJECTIVES**

- 10.1 Establish a flexible, community-based continuum of care that includes formal services and informal community supports. (Goal 9)
- 10.2 Maintain and strengthen crisis prevention, intervention, and diversion services in the community. (Goal 8)
- 10.3 Establish a partnership between Redesign Task Force efforts and existing discharge and transition planning improvement activities at the Behavioral Health Division and private hospital partners.
- 10.4 Work in partnership with inpatient, crisis, community, housing, and peer support providers to develop and implement an improvement plan for facilitating transitions from any hospital in the county.
- 10.5 Develop and implement a plan to track 90 day readmission data for all hospital partners.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Director of Acute Services (TBA)

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience; public and private hospitals; community providers; crisis prevention and intervention services; peer support providers; housing providers

eleven

**Improvement Area 3 – Continuum of Community-Based Services**

Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

**Improve the economic security of persons with mental illness by increasing utilization of disability-related benefits including SSI/SSDI and Medicaid.**

11

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) There will be a measurable increase in the number of persons who receive assistance in completing SSI/SSDI applications.
- 2) There will be a measurable increase in the number of persons whose applications for SSI/SSDI are approved.

**TACTICAL OBJECTIVES**

- 11.1 Establish a 2012 baseline for the number of persons who received assistance in completing SSI/SSDI applications.
- 11.2 Establish a 2012 baseline for the number of persons whose SSI/SSDI applications were approved.
- 11.3 Develop a partnership involving the Social Security Administration, benefits counseling programs, SOAR trainers, Protective Payee providers, and persons with lived experience to develop, pilot and implement a plan to improve access to application assistance.
- 11.4 Increase access to recovery-oriented Protective Payee services for people needed this service.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jena Scherer

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience, SSI/SSDI application assistance providers, Protective Payee programs, Social Security Administration, community providers

twelve

**Improvement Area 4 – Integrated Multi-System Partnerships**

Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

**Increase the number of individuals with mental illness who are engaged in employment, education, or other vocational-related activities.**

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) The percentage of mental health consumers enrolled in SAIL who are employed will increase from the 2012 baseline of .03% employed and .06% looking for work (at 6 month follow-up) to 1.0% employed and 2.0% looking for work.
- 2) The percentage of persons enrolled in Wlser Choice who are employed full or part time will increase from the 2012 baseline of 26.7% (at 6 month followUp) to 28.0%.

**TACTICAL OBJECTIVES**

- 12.1 Begin implementation of the IPS (Individual Placement and Support) Program by the Community Services Branch and its partners.
- 12.2 Establish a partnership with community mental health services providers, employment service providers, Milwaukee Area Workforce Investment Board, Division of Vocational Rehabilitation, Department of Workforce Development, and employers to identify and address barriers to employment for persons with mental illness.
- 12.3 Continue work on CRS implementation to obtain support for evidence-based employment practices.
- 12.4 Utilize Medicaid-supported benefits to assist persons in job and school readiness and employment and education support.
- 12.5 Work with the Social Security Administration to develop a strategy to address concerns regarding loss of benefits due to employment.
- 12.6 Leverage existing partnerships with employers and schools to create expanded options.
- 12.7 Align employment efforts with the expansion of Certified Peer Specialist network. (Goal 4)
- 12.8 Involve employers and employment assistance providers (public and private) in stigma reduction activities. (Goal 2)
- 12.9 Fund a job creation project using Milwaukee County CDBG dollars.

**RESPONSIBILITY**

**Lead BHD/DHHS Staff:**  
Sue Gadacz and Jim Mathy

**Action Team Involvement:**  
Community Linkages

**Partners:**  
Persons with lived experience, Community Services Branch, Milwaukee Area Workforce Investment Board, Time Exchange, Flexible Workforce Coalition, Division of Vocational Rehabilitation, Department of Workforce Development, employers, schools and colleges

12

thirteen

**Improvement Area 4 – Integrated Multi-System Partnerships**

Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

**Improve access to, and retention in, recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately/unsafely housed.**

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Achieve a 10% measurable increase in the number of persons discharged from inpatient services and CBRFs that transition to supportive housing compared to 2012 baseline.
- 2) Increase the percentage of consumers in Milwaukee County (HUD-supported) Shelter + Care who are retained for six months or more from the 2012 baseline of 88% to 90%.
- 3) Create 25 new units of permanent supportive housing for persons with mental illness.
- 4) Achieve a measurable decrease in the number of persons who are identified as homeless in the Homeless Management Information System who were previously tenants in Milwaukee County (HUD-supported) Shelter + Care.

**TACTICAL OBJECTIVES**

- 13.1 Organize existing supportive housing resources including Permanent Supportive Housing, Shelter + Care, group homes, step-down housing, and other residential resources into a flexible, recovery-oriented continuum that is responsive to persons' needs and preferences.
- 13.2 Develop the role of the Community Intervention Specialist in assisting with access to housing and retention in housing for people at risk.
- 13.3 Develop, pilot and implement an intervention approach to provide additional provider, peer and family support services for those at risk of housing loss.
- 13.4 Improve the capability of supportive housing to provide person-centered, co-occurring capable services in partnership with MC3.
- 13.5 Develop new housing options specifically for young adults transitioning from foster care.
- 13.6 Advocate for increased Section 8 and other housing supports.
- 13.7 Maintain and develop strong partnerships with nonprofit and private housing developers, WHEDA, banks, county and city housing trust funds, and other key stakeholders focused on the development of new supportive housing.

**RESPONSIBILITY**

**Lead BHD/DHHS Staff:**  
Jim Mathy

**Action Team Involvement:**  
Community Linkages

**Partners:**  
Milwaukee County Housing Division, Milwaukee Continuum of Care, MC3, WHEDA, banks, housing trust funds, CDBG/HOME, providers, persons with lived experience

13

**fourteen**

**Improvement Area 4 – Integrated Multi-System Partnerships**

Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

**Improve criminal justice and mental health system collaboration to reduce inappropriate incarceration of people with mental illness by:**

- Establishing a data link between the Milwaukee County criminal justice system and Behavioral Health Division that respects privacy and confidentiality requirements and helps prevent inappropriate incarceration of persons with mental illness; and
- Supporting a continuum of criminal justice diversion services for persons with behavioral health needs.
- Participating in the Community Justice Council as the primary vehicle for communication and planning.

14

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) There is an operating data link that allows individuals with behavioral health needs who have police contact to be diverted to crisis intervention services and the data link has been used successfully for that purpose.

**TACTICAL OBJECTIVES**

- 14.1 Monitor the development of the data link project being implemented by the Milwaukee Community Justice Council and offer assistance when appropriate.
- 14.2 Participate in effort to explore additional diversion initiatives including a mental health court and other evidence-based practices that promote diversion of persons with mental health needs.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jim Kubicek

**Action Team Involvement:**  
Community Linkages

**Partners:**  
Community Justice Council

**fifteen**

**Improvement Area 5 – Reduction of Inpatient Utilization**

Supporting a recovery-oriented system that permits the reduction of both acute care utilization and long-term care bed utilization.

**Reduce the number of people who experience acute hospital admissions through improved access to, and utilization of, non-hospital crisis intervention and diversion services for people in mental health crisis.**

15

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Reduce admissions to Milwaukee County Behavioral Health Division Acute Adult Inpatient Service by 15% (248) over 2012 baseline of 1,650.
- 2) Reduce the percentage of persons who are readmitted to the Milwaukee County Behavioral Health Division Acute Adult Inpatient Services within 90 days of discharge from the 2012 baseline of 24.1% to 22.0%.

**TACTICAL OBJECTIVES**

- 15.1 Successfully implement to tactical objectives in Goals 8, 9, 10, 13, and 14.
- 15.2 Involve all types of providers in the partnership to reduce admissions including crisis services, peer support, clubhouse, case management, and informal community supports.
- 15.3 Focus on improvement of policies, procedures and practices that facilitate early access to crisis intervention by community providers and law enforcement, continuity of care, diversion from hospitalization into crisis resource centers, and rapid step down from hospitalization into intermediate levels of support. (Goal 8)
- 15.4 Develop a countywide mechanism for triaging bed availability and flow between high and lower systems of care.
- 15.5 Develop a plan for collecting baseline data and tracking hospital diversion and utilization percentages across the county.

**RESPONSIBILITY**

**Lead BHD Staff:** Amy Lorenz and Director of Acute Services (TBA)

**Action Team Involvement:** Continuum of Care

**Partners:** Persons with lived experience, Behavioral Health Division, private hospital systems, providers, crisis services, faith-based and other community-based resources, law enforcement

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
INTER-OFFICE COMMUNICATION

**DATE:** March 4, 2013

**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, on behalf of the  
Mental Health Redesign and Implementation Task Force*

**SUBJECT:** **From the Director, Department of Health and Human Services, requesting authorization for the Behavioral Health Division to implement the initiatives outlined in the Mental Health Redesign SMART Goals**

**Issue**

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 (Redesign Task Force) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities.

In December 2012, the Committee on Health and Human Needs passed a resolution (File No. 12-1003) receiving and placing on file an informational report from the DHHS Director and BHD Administrator regarding the progress and activity of the Redesign Task Force, including an action-oriented implementation plan. The Committee further requested an actionable report to authorize the implementation plan with specific objectives and target dates. Monthly informational reporting on the activities of the Redesign Task Force was also requested.

**Background**

The Redesign Task Force first convened in 2011, establishing a charter and delegating five Action Teams to prioritize recommendations for system enhancements within the key areas of Person-Centered Care, Continuum of Care, Community Linkages, Workforce, and Quality. The Action Team co-chairs presented their prioritized recommendations to the Committee on Health and Human Needs in January 2012 and at a public summit in February 2012, where consultants from the Human Service Research Institute (HSRI) provided feedback and guidance. BHD leadership, the Redesign Task Force, and its Executive Committee resolved in March 2012 to seek technical assistance for the process of implementing the affirmed recommendations. The ensuing RFP led to a professional services contract with ZiaPartners, Inc., which took effect in September 2012. The consultants have worked with leaders from DHHS, BHD, and the Redesign Task Force and Action Teams since that time, and Wilberg Community Planning, LLC, has provided regular on-site technical assistance as a subcontractor.

In December 2012, the DHHS Director and BHD Administrator presented an informational report to the Committee on Health and Human Needs on the progress and activities of the Redesign Task Force, including a framework for planning, tracking, and recording progress on all redesign implementation activities. The implementation activities were thereafter to be framed within SMART Goals – Specific, Measurable, Attainable, Realistic, and Timebound – to promote accountability and clear reporting.

## **Discussion**

Each Action Team (AT) met in January to finalize the SMART Goals and discuss other matters. The Continuum of Care AT consulted with BHD Community Services Director Susan Gadacz on potential pathways toward implementing Community Recovery Services in Milwaukee County. The team also provided input on the allocation of Community Investment funds earmarked for case management.

Jim Mathy (Housing Administrator) worked with community partners to fulfill another Community Linkages AT recommendation; the Housing Division will contract with Our Space and Milwaukee Center for Independence to provide services at a new “step-down” level of housing. The team is pursuing ways to support the Community Justice Council in maintaining a data link between the behavioral health and criminal justice systems.

The Workforce AT researched and discussed the education and credentialing standards for Certified Peer Specialists in Wisconsin. Additional work is needed to establish a baseline for target objectives related to utilizing Certified Peer Specialists. Ms. Gadacz met with a group of Certified Peer Specialists and other community partners on how to use the earmarked Community Reinvestment funds to effectively establish a “pipeline” for peers to be trained, certified, and employed in appropriate roles in the mental health system.

The Quality AT and County staff are providing input to Dr. Andrew Keller and the TriWest Group in their ongoing development of a pictorial system map and a community data dashboard.

The Person-Centered Care AT discussed more outreach and public education with suggestions to work with churches and schools and to utilize the stories of individuals with positive experiences receiving services. The team is also eager to flesh out the idea of County Supervisors hosting public education forums in their districts. In addition, staff and consultants are working with interested parties to establish a Resource Strategy Team.

The Redesign Task Force met on February 6 at Highland Commons in West Allis. The primary focus of the meeting was to collaboratively revise and finalize the SMART Goals document. Co-chairs from each AT presented feedback from their teams to the full Redesign Task Force. Following the meeting, the technical assistance team worked with County staff to ensure that the timelines and numerical targets were feasible and meaningful. The completed document represents substantial input from diverse stakeholders, collected by e-mail, online surveys, telephone, and numerous face-to-face meetings.

## **Next steps**

These SMART Goals outline targets, tactics, and responsible parties (including “BHD Lead Staff” to provide support for each of the goals) for redesign-related initiatives and enhancements to be achieved in 2013 and 2014. Because the SMART Goals are oriented toward future activities, they are not necessarily inclusive of various redesign-related enhancements that have already been partially or wholly achieved since 2011 by the Behavioral Health Division, Housing Division, Disabilities Services Division, and other community partners. Periodic progress reports to the County Board on behalf of the Redesign Task Force will maintain a record of redesign-related accomplishments.

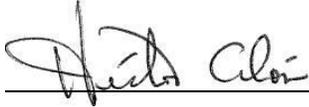
## **Recommendation**

It is recommended that the County Board of Supervisors authorize the DHHS Director and the BHD Administrator to implement the initiatives outlined in the Mental Health Redesign SMART Goals in collaboration with the Redesign Task Force and community stakeholders.

**Fiscal Effect**

No fiscal effect is anticipated as a result of this action. A fiscal note is attached.

Respectfully submitted,



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Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, Chief of Staff, County Board  
Don Tyler, Director, DAS  
Craig Kammholz, Fiscal & Budget Administrator, DAS  
CJ Pahl, Assistant Fiscal & Budget Administrator, DAS  
Antionette Thomas-Bailey, Fiscal & Budget Analyst, DAS  
Jennifer Collins, County Board Analyst

1  
2  
3  
4 (ITEM \*) Report from the Director, Department of Health and Human Services,  
5 requesting authorization for the Behavioral Health Division to implement the initiatives  
6 outlined in the Mental Health Redesign SMART (Specific, Measurable, Attainable,  
7 Realistic, and Timebound) Goals document, by recommending adoption of the  
8 following:

9  
10 **A RESOLUTION**

11  
12 WHEREAS, the Director of the Department of Health and Human Services (DHHS)  
13 is requesting authorization for the Behavioral Health Division (BHD) to implement the  
14 initiatives outlined in the Mental Health Redesign SMART (Specific, Measurable,  
15 Attainable, Realistic, and Timebound) Goals document; and

16  
17 WHEREAS, in April 2011, the County Board of Supervisors passed a resolution  
18 (File No. 11-173) supporting efforts to redesign the Milwaukee County mental health  
19 system and creating a Mental Health Redesign and Implementation Task Force  
20 (Redesign Task Force) to provide the Board with data-driven implementation and  
21 planning initiatives based on the recommendations of various public and private entities;  
22 and

23  
24 WHEREAS, the Redesign Task Force first convened in 2011, establishing a charter  
25 and delegating five Action Teams to prioritize recommendations for system  
26 enhancements within the key areas of Person-Centered Care, Continuum of Care,  
27 Community Linkages, Workforce, and Quality; and

28  
29 WHEREAS, the Action Team co-chairs presented their prioritized recommendations  
30 to the Committee on Health and Human Needs in January 2012 and at a public summit  
31 in February 2012, where consultants from the Human Service Research Institute (HSRI)  
32 provided feedback and guidance; and

33  
34 WHEREAS, BHD leadership, the Redesign Task Force, and its Executive  
35 Committee resolved in March 2012 to seek technical assistance for the process of  
36 implementing the affirmed recommendations with the ensuing request for proposals  
37 (RFP) leading to a professional services contract with ZiaPartners, Inc., which took  
38 effect in September 2012; and

39  
40 WHEREAS, the consultants have worked with leaders from DHHS, BHD, and the  
41 Redesign Task Force and Action Teams since that time; and Wilberg Community  
42 Planning, LLC, has provided regular on-site technical assistance as a subcontractor;  
43 and

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45 WHEREAS, in December 2012, the DHHS Director and BHD Administrator  
46 presented an informational report to the Committee on Health and Human Needs on the  
47 progress and activities of the Redesign Task Force, including a framework for planning,  
48 tracking, and recording progress on all redesign implementation activities; and

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WHEREAS, this was followed up by meetings of each Action Team as well as the Redesign Task Force to collaboratively revise and finalize the SMART Goals; and

WHEREAS, these SMART Goals outline targets, tactics, and responsible parties (including "BHD Lead Staff" to provide support for each of the goals) for redesign-related initiatives and enhancements to be achieved in 2013 and 2014; and

WHEREAS, the use of extensive staff time will be required; and

WHEREAS, there are no direct expenditures related to approval of this request; and

WHEREAS, any future specific initiative related to this request that will require an expenditure of funds will be brought before the County Board in accordance with existing requirements; and

WHEREAS, there is no tax levy impact associated with approval of this request; now, therefore,

BE IT RESOLVED, that the Director of the Department of Health and Human Services, or his designee, is authorized to implement the initiatives outlined in the Mental Health Redesign SMART (Specific, Measurable, Attainable, Realistic, and Timebound) Goals document in collaboration with the Redesign Task Force and community stakeholders.

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** March 4, 2013

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report from the Director, Department of Health and Human Services, Requesting Authorization for the Behavioral Health Division to Implement the Initiatives Outlined in the Mental Health Redesign SMART (Specific, Measurable, Attainable, Realistic, and Timebound) Goals

**FISCAL EFFECT:**

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact<br><input checked="" type="checkbox"/> Existing Staff Time Required<br><input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><br><input type="checkbox"/> Decrease Operating Expenditures<br><br><input type="checkbox"/> Increase Operating Revenues<br><br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><br><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
<b>Operating Budget</b>	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
<b>Capital Improvement Budget</b>	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. <sup>1</sup> 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. The Director of the Department of Health and Human Services (DHHS) is requesting authorization for the Behavioral Health Division (BHD) to implement the initiatives outlined in the Mental Health Redesign SMART (Specific, Measurable, Attainable, Realistic, and Timebound) Goals.

Approval of this request will allow BHD to embark on the multi-year process of system redesign as outlined in the accompanying Mental Health Redesign Task Force SMART Goals pdf document.

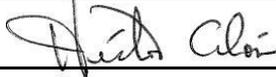
B. While the use of extensive staff time will be required, there are no direct expenditures related to approval of this request. Any future specific initiatives that will require an expenditure of funds will be brought before the County Board in accordance with existing requirements.

C. There is no tax levy impact associated with approval of this request.

D. No assumptions are made.

Department/Prepared By Thomas F. Lewandowski, Fiscal & Management Analyst

Authorized Signature



Did DAS-Fiscal Staff Review?  Yes  No

Did CDPB Staff Review?  Yes  No  Not Required

<sup>1</sup> 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.

# Mental Health Redesign SMART<sup>1</sup> Goals: 2013 – 2014



## TIMEFRAME

Redesign is about designing a system that promotes life and hope for people in Milwaukee County with mental health needs by transitioning to a more fully community-based system of care. Redesign is as a multi-year process with ambitious targets. Initial SMART Goal implementation is focused on identifying attainable and measurable goals/objectives that can be achieved within the next 12-18 months.

There will then be Annual Updates of the SMART Goals to define measurable progress toward the highest possible standards for all services.

<sup>1</sup> Specific, Measurable, Attainable, Realistic, and Time-bound

## SCOPE

The Mental Health Redesign addresses the improvement of mental health services for Milwaukee County residents served by public and private systems and organizations. Initial SMART Goals focus heavily on changes in the public sector system operated by the Milwaukee County Department of Health and Human Services while implementation planning continues on broader communitywide improvements involving major hospital systems, provider organizations, advocates, and persons with lived experience. Monthly progress reports on the SMART Goals and Improvement Areas will continue to be made to the County Board and the community.

## ORGANIZATION OF SMART GOALS

Goals are organized into five improvement areas consistent with the monthly progress reports that have been provided on the Redesign process:

- 1) System of Care
- 2) Crisis System Redesign
- 3) Continuum of Community-Based Services
- 4) Integrated Multi-System Partnerships
- 5) Reduction of Inpatient Utilization

## SMART Goal 2013-2014

### one

#### Improvement Area 1 – System of Care

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

#### Improve consumer satisfaction and recovery outcomes by:

- Providing services that are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable;
- Improving system-wide implementation of such services;
- Increasing the use of self-directed recovery action plans;
- Completing the functional integration of substance use disorder and mental health service components of the Milwaukee County Community Services Branch; and
- Using person-centered experiences to inform system improvement.

#### PERFORMANCE TARGETS

##### By July 2014:

- 1) Consumer satisfaction as measured by the MHSIP (Mental Health Statistics Improvement Program) Consumer Survey will show measurable improvement for Milwaukee County Behavioral Health Division's Acute Adult Inpatient and Community Services Branch, including residential, supported apartments, community support programs, targeted case management programs, and day treatment with the long range goal of meeting/exceeding the National Research Institute consumer satisfaction standards.
- 2) Consumer satisfaction as measured by the Vital Voices consumer satisfaction interviews will show measurable improvement for Milwaukee County Crisis Services.
- 3) 80% of Milwaukee County Behavioral Health Division directly operated services and contracted services will demonstrate adherence to the Mental Health Redesign Core Competencies relative to the principles of person-centered care. (See Goal 3)
- 4) Integration of substance use disorder and mental health services in the Milwaukee County will be achieved.
- 5) Consistent mechanism for using person-centered stories in quality improvement is established.

#### TACTICAL OBJECTIVES

- 1.1 Review MHSIP and Vital Voices survey instruments to determine if enhancements are required to capture person-centered principles.
- 1.2 Continue implementation of evidence-based practices to improve the extent to which services are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable; and anchor those improvements in policy and contract.
- 1.3 Coordinate the activities of MC3 (Milwaukee County Co-Occurring Cadre) Evaluation Subcommittee with the efforts of the Redesign Quality Action Team to insure representation of person-centered stories in quality improvement.
- 1.4 Develop and implement strategies to increase the use of self-directed recovery action plans by establishing a baseline of current use, identifying training opportunities, and measuring adoption by peers.
- 1.5 Lead the integration of substance use disorder and mental health services into a co-occurring capable system by functionally integrating SAIL and Wiser Choice at the Community Services Branch and provider levels.

#### RESPONSIBILITY

**Lead BHD Staff:**  
Jennifer Wittwer

**Action Team Involvement:**  
Person-Centered and Quality

**Partners:**  
Persons with lived experience; Community Services Branch; MC3; providers; Vital Voices; Families United; Mental Health Task Force

**two**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Promote stigma reduction in Milwaukee County through:**

- Evidence-based MH/AODA stigma reduction public education presentations that include presentations by persons with lived experience to over 1000 residents in Milwaukee County supervisor districts.
- Partnering with community efforts already underway led by NAMI, Rogers Memorial Hospital, and the Center for Urban Population Health Project Launch.

2

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Presentations are conducted in 18 supervisor districts with an average of 55 residents in attendance at each (total of 1,000 residents).
- 2) Stigma reduction message is received by a minimum of 20,000 Milwaukee County residents.

**TACTICAL OBJECTIVES**

- 2.1 Develop a program to be delivered within each supervisor district that includes an evidence-based stigma reduction model and a presentation by one or more persons with lived experience.
- 2.2 Provide support and technical assistance to community efforts to reduce stigma.

**RESPONSIBILITY**

**Lead BHD Staff:**  
E. Marie Broussard

**Action Team Involvement:**  
Person-Centered

**Partners:**  
Milwaukee County Supervisors; Mental Health Task Force; NAMI; Rogers Memorial Hospital; Center for Urban Population Health; Persons with lived experience

**three**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Improve the quality of the mental health workforce through:**

- a. Implementation of workforce competencies aligned with person-centered care;
- b. Improved mental health nursing recruitment and retention;
- c. Improved recruitment and retention of psychiatrists; and
- d. Improved workforce diversity and cultural competency.

3

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Establish person-centered workforce competencies.
- 2) 50% of Milwaukee County contracted behavioral health providers will adopt person-centered workforce competencies.
- 3) Plan to improve the retention of mental health nurses is completed.
- 4) One (1) training slot is established for the 2014-2015 involving a partnership of the Medical College of Wisconsin Department of Psychiatry and the Milwaukee County Behavioral Health Division.
- 5) A baseline on the current racial/ethnic composition of the mental health workforce is established.

**TACTICAL OBJECTIVES**

- 3.1 Develop person-centered workforce competencies that are recovery-oriented, trauma-informed, co-occurring capable, and culturally-competent.
- 3.2 Develop and implement a plan to introduce the competencies to public and private entities and achieve their adoption.
- 3.3 Develop and implement a plan to improve the quality and retention of mental health nurses.
- 3.4 Establish a sustainable partnership between the Medical College of Wisconsin and Milwaukee County to support the annual commitment of one (1) training slot.
- 3.5 Work with representatives of underserved and underrepresented populations to improve the recruitment and retention of mental health professionals from those community sectors.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Lora Dooley

**Action Team Involvement:**  
Workforce and Person-Centered

**Partners:**  
Nursing's Voice; Faye McBeath Foundation; University of Wisconsin-Milwaukee; Medical College of Wisconsin; Employers

**four**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Expand the network of Certified Peer Specialists who are well trained, appropriately compensated, and effectively engaged with peers and whose services are eligible for Medicaid reimbursement by:**

- Increasing the number Certified Peer Specialists;
- Recruiting and training Certified Peer Specialists with bilingual (Spanish) capability;
- Increasing the number of programs that employ Certified Peer Specialists;
- Establishing a Certified Peer Specialist-operated program; and
- Advocating for quality in the delivery of Certified Peer Specialist services.

4

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Increase the number of Certified Peer Specialists by 20% (10) over the 2013 baseline of 52 Certified Peer Specialists.
- 2) Increase the number of programs meeting identified target for employing Certified Peer Specialists by from the 2013 baseline of eight (8) programs to fifteen (15) programs.
- 3) Implement one (1) Certified Peer Specialist-operated program.

**TACTICAL OBJECTIVES**

- 4.1 Continue implementation of the Certified Peer Specialist Pipeline program supported by the Community Services Branch.
- 4.2 Establish a web-based clearinghouse to post Certified Peer Specialist opportunities.
- 4.3 Using the fall 2012 Employer Summit as the model, continue efforts to improve employers' effective utilization of Certified Peer Specialists in their programs.
- 4.4 Continue to incorporate targets for Certified Peer Specialist employment into policy and contracts.
- 4.5 Support the provision of Certified Peer Specialist training using state-approved curricula.
- 4.6 Develop and implement a plan to establish a program operated by Certified Peer Specialists.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jennifer Bergersen

**Action Team Involvement:**  
Workforce

**Partners:**  
Persons with lived experience; Certified Peer Specialist Training Programs; Wisconsin Peer Specialist Employment Initiative

**five**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Improve the coordination and flexibility of public and private funding committed to mental health services.**

5

**PERFORMANCE TARGETS**

**By October 2013:**

- 1) Redesign Task Force will complete an analysis (mapping) of public and private resources that support mental health services including analysis of Affordable Care Act implications.

**By January 2014:**

- 2) Milwaukee County will approve implementation of CRS (Community Recovery Services) consistent with the Wisconsin Medicaid State Plan Amendment under 1915 (i) to create more flexible application of Medicaid waiver funding within appropriate fiscal constraints.

**TACTICAL OBJECTIVES**

- 5.1 Establish Resource Strategy Team comprised of finance experts from foundations, private hospital systems, Milwaukee County, State of Wisconsin, and the Public Policy Forum.
- 5.2 Publish a report on Mental Health Redesign Financing for dissemination and discussion by key stakeholders.
- 5.3 Designate the Continuum of Care Action Team or form a new CRS Planning Workgroup to advise Milwaukee County on the design of CRS.
- 5.4 Conduct a review of program and fiscal data to inform the development of the CRS implementation plan.
- 5.5 Submit the CRS implementation plan to the Milwaukee County Board for review and approval.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jim Kubicek and Alex Kotze  
**Action Team Involvement:**  
Resource Strategy and Continuum of Care  
**Partners:**  
Wisconsin Department of Health Services

**six**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Establish a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals.**

6

**PERFORMANCE TARGETS**

**By October 2013:**

- 1) Publish and widely disseminate the first annual Milwaukee County Mental Health Dashboard and Community Progress Report to chart progress on Redesign SMART Goals.

**TACTICAL OBJECTIVES**

- 6.1 Establish public/private system quality indicators aligned with the overall system vision.
- 6.2 Identify and coordinate existing data sets and data sources.
- 6.3 Determine how to include consumer experiences in the improvement process.
- 6.4 Identify how improvement targets in SMART Goals will be measured and reported.
- 6.5 Create information-sharing agreements.
- 6.6 Prepare initial format for review and modification.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Sue Gadacz  
**Action Team Involvement:**  
Quality Action Team  
**Partners:**  
Persons with lived experience; Data providers

**seven**

**Improvement Area 1 – System of Care**

Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

**Develop a structure for ongoing system improvement and oversight of the Mental Health Redesign process.**

7

**PERFORMANCE TARGETS**

**By January 2014:**

- 1) Define and implement a formal partnership structure and process for continuing system improvement that will review progress, address implementation challenges, and pursue opportunities for further enhancement of the Milwaukee County community mental health system.

**TACTICAL OBJECTIVES**

- 7.1 Review current membership, charter, and functioning of the Redesign TF.
- 7.2 Determine need for and objectives of ongoing system improvement partnership.
- 7.3 Describe and draft a proposed charter, membership, and accountability of the proposed continuing structure.
- 7.4 Identify a mechanism for formalizing and implementing the continuing structure and process.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Paula Lucey with the Redesign Task Force  
**Action Team Involvement:**  
NA  
**Partners:** NA

eight

**Improvement Area 2 – Crisis System Redesign**

Creating and sustaining a community-based continuum of crisis services to reduce involuntary commitments and undue reliance on acute inpatient care.

**Improve crisis access and response to reduce Emergency Detentions (Chapter 51, Involuntary Commitment for Treatment).**

8

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) The number of Emergency Detentions at the Milwaukee County Behavioral Health Division will decrease by 10% (720) from the 2012 baseline of 7,204 Emergency Detentions.
- 2) The percentage of crisis intervention events which are voluntary will increase from 43.2% (2012 baseline) to 48.9% or greater.
- 3) The number of individuals seen at the Milwaukee County Psychiatric Crisis Service (PCS) who have person-centered crisis plans will increase by 30% over the 2012 baseline of 136.
- 4) Maintain high volume of Access Clinic service at 2012 baseline of 6,536 visits.

**TACTICAL OBJECTIVES**

- 8.1 Develop a partnership between the Redesign Task Force and the current implementation process for developing an integrated, welcoming crisis continuum of care.
- 8.2 Support the increased utilization of person-centered crisis plans for the prevention of, and early intervention in, crisis situations through training and technical assistance provided countywide.
- 8.3 Prioritize expansion of the availability and responsiveness of mobile crisis services as well as other community crisis diversion services including walk-in services, clubhouse, and crisis bed options of all types.
- 8.4 Facilitate earlier access to assistance for a crisis situation for individuals and families through improved public information on how to access the range of crisis intervention services in the community.
- 8.5 Improve the capacity of law enforcement (Milwaukee Police Department, Sheriff's Office, and municipal police departments) to effectively intervene in crisis situations through expanded Crisis Intervention Training.
- 8.6 Identify and improve policies and procedures related to crisis response in contracted services to reduce the likelihood that crisis events lead to emergency detention.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Amy Lorenz

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience; community crisis services providers; mobile crisis services; private hospital systems/ emergency departments; law enforcement; Community Intervention

nine

**Improvement Area 3 – Continuum of Community-Based Services**

Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

**Improve the flexible availability and continuity of community-based recovery supports.**

9

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Establish a continuum of Targeted Case Management (TCM) services that includes four components: Intensive, Crisis, Level I (regular case management), and Recovery.
- 2) Increase the number of TCM slots by 6% (90) over the 2012 baseline of 1,472 slots.
- 3) Establish two additional psycho-social rehabilitation benefits (Community Recovery Services (CRS) and Community Support Services (CSS)) to provide flexible recovery support in the community.

**TACTICAL OBJECTIVES**

- 9.1 Develop, pilot and implement a mechanism for flexible utilization management that supports individualized matching of service intensity with the continuum of case management and other recovery supports.
- 9.2 Develop, pilot and implement procedures to move from higher to lower levels of support (and conversely) in response to changing circumstances, e.g. crisis.
- 9.3 Organize a flexible continuum of community recovery supports to be made available to eligible individuals through CRS and CSS.
- 9.4 Establish metrics to assess the financial and program impacts of this approach.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Sue Gadacz

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience; Milwaukee County Community Services Branch; Community providers

ten

**Improvement Area 3 – Continuum of Community-Based Services**

Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

**Improve the success of community transitions after psychiatric hospital admission.**

10

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) The percentage of individuals who are discharged from Milwaukee County Psychiatric Crisis Service (PCS) who return to PCS within 90 days will decrease from the 2012 baseline of 32.2% to 27.0%.
- 2) The percentage of individuals who are discharged from Milwaukee County Acute Adult Inpatient Services who return to that service within 90 days will decrease from the 2012 baseline of 24.1% to 22.0%.

**TACTICAL OBJECTIVES**

- 10.1 Establish a flexible, community-based continuum of care that includes formal services and informal community supports. (Goal 9)
- 10.2 Maintain and strengthen crisis prevention, intervention, and diversion services in the community. (Goal 8)
- 10.3 Establish a partnership between Redesign Task Force efforts and existing discharge and transition planning improvement activities at the Behavioral Health Division and private hospital partners.
- 10.4 Work in partnership with inpatient, crisis, community, housing, and peer support providers to develop and implement an improvement plan for facilitating transitions from any hospital in the county.
- 10.5 Develop and implement a plan to track 90 day readmission data for all hospital partners.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Director of Acute Services (TBA)

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience; public and private hospitals; community providers; crisis prevention and intervention services; peer support providers; housing providers

eleven

**Improvement Area 3 – Continuum of Community-Based Services**

Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

**Improve the economic security of persons with mental illness by increasing utilization of disability-related benefits including SSI/SSDI and Medicaid.**

11

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) There will be a measurable increase in the number of persons who receive assistance in completing SSI/SSDI applications.
- 2) There will be a measurable increase in the number of persons whose applications for SSI/SSDI are approved.

**TACTICAL OBJECTIVES**

- 11.1 Establish a 2012 baseline for the number of persons who received assistance in completing SSI/SSDI applications.
- 11.2 Establish a 2012 baseline for the number of persons whose SSI/SSDI applications were approved.
- 11.3 Develop a partnership involving the Social Security Administration, benefits counseling programs, SOAR trainers, Protective Payee providers, and persons with lived experience to develop, pilot and implement a plan to improve access to application assistance.
- 11.4 Increase access to recovery-oriented Protective Payee services for people needed this service.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jena Scherer

**Action Team Involvement:**  
Continuum of Care

**Partners:**  
Persons with lived experience, SSI/SSDI application assistance providers, Protective Payee programs, Social Security Administration, community providers

twelve

**Improvement Area 4 – Integrated Multi-System Partnerships**

Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

**Increase the number of individuals with mental illness who are engaged in employment, education, or other vocational-related activities.**

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) The percentage of mental health consumers enrolled in SAIL who are employed will increase from the 2012 baseline of .03% employed and .06% looking for work (at 6 month follow-up) to 1.0% employed and 2.0% looking for work.
- 2) The percentage of persons enrolled in Wlser Choice who are employed full or part time will increase from the 2012 baseline of 26.7% (at 6 month followUp) to 28.0%.

**TACTICAL OBJECTIVES**

- 12.1 Begin implementation of the IPS (Individual Placement and Support) Program by the Community Services Branch and its partners.
- 12.2 Establish a partnership with community mental health services providers, employment service providers, Milwaukee Area Workforce Investment Board, Division of Vocational Rehabilitation, Department of Workforce Development, and employers to identify and address barriers to employment for persons with mental illness.
- 12.3 Continue work on CRS implementation to obtain support for evidence-based employment practices.
- 12.4 Utilize Medicaid-supported benefits to assist persons in job and school readiness and employment and education support.
- 12.5 Work with the Social Security Administration to develop a strategy to address concerns regarding loss of benefits due to employment.
- 12.6 Leverage existing partnerships with employers and schools to create expanded options.
- 12.7 Align employment efforts with the expansion of Certified Peer Specialist network. (Goal 4)
- 12.8 Involve employers and employment assistance providers (public and private) in stigma reduction activities. (Goal 2)
- 12.9 Fund a job creation project using Milwaukee County CDBG dollars.

**RESPONSIBILITY**

**Lead BHD/DHHS Staff:**  
Sue Gadacz and Jim Mathy

**Action Team Involvement:**  
Community Linkages

**Partners:**  
Persons with lived experience, Community Services Branch, Milwaukee Area Workforce Investment Board, Time Exchange, Flexible Workforce Coalition, Division of Vocational Rehabilitation, Department of Workforce Development, employers, schools and colleges

12

thirteen

**Improvement Area 4 – Integrated Multi-System Partnerships**

Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

**Improve access to, and retention in, recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately/unsafely housed.**

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Achieve a 10% measurable increase in the number of persons discharged from inpatient services and CBRFs that transition to supportive housing compared to 2012 baseline.
- 2) Increase the percentage of consumers in Milwaukee County (HUD-supported) Shelter + Care who are retained for six months or more from the 2012 baseline of 88% to 90%.
- 3) Create 25 new units of permanent supportive housing for persons with mental illness.
- 4) Achieve a measurable decrease in the number of persons who are identified as homeless in the Homeless Management Information System who were previously tenants in Milwaukee County (HUD-supported) Shelter + Care.

**TACTICAL OBJECTIVES**

- 13.1 Organize existing supportive housing resources including Permanent Supportive Housing, Shelter + Care, group homes, step-down housing, and other residential resources into a flexible, recovery-oriented continuum that is responsive to persons' needs and preferences.
- 13.2 Develop the role of the Community Intervention Specialist in assisting with access to housing and retention in housing for people at risk.
- 13.3 Develop, pilot and implement an intervention approach to provide additional provider, peer and family support services for those at risk of housing loss.
- 13.4 Improve the capability of supportive housing to provide person-centered, co-occurring capable services in partnership with MC3.
- 13.5 Develop new housing options specifically for young adults transitioning from foster care.
- 13.6 Advocate for increased Section 8 and other housing supports.
- 13.7 Maintain and develop strong partnerships with nonprofit and private housing developers, WHEDA, banks, county and city housing trust funds, and other key stakeholders focused on the development of new supportive housing.

**RESPONSIBILITY**

**Lead BHD/DHHS Staff:**  
Jim Mathy

**Action Team Involvement:**  
Community Linkages

**Partners:**  
Milwaukee County Housing Division, Milwaukee Continuum of Care, MC3, WHEDA, banks, housing trust funds, CDBG/HOME, providers, persons with lived experience

13

**fourteen**

**Improvement Area 4 – Integrated Multi-System Partnerships**

Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

**Improve criminal justice and mental health system collaboration to reduce inappropriate incarceration of people with mental illness by:**

- Establishing a data link between the Milwaukee County criminal justice system and Behavioral Health Division that respects privacy and confidentiality requirements and helps prevent inappropriate incarceration of persons with mental illness; and
- Supporting a continuum of criminal justice diversion services for persons with behavioral health needs.
- Participating in the Community Justice Council as the primary vehicle for communication and planning.

14

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) There is an operating data link that allows individuals with behavioral health needs who have police contact to be diverted to crisis intervention services and the data link has been used successfully for that purpose.

**TACTICAL OBJECTIVES**

- 14.1 Monitor the development of the data link project being implemented by the Milwaukee Community Justice Council and offer assistance when appropriate.
- 14.2 Participate in effort to explore additional diversion initiatives including a mental health court and other evidence-based practices that promote diversion of persons with mental health needs.

**RESPONSIBILITY**

**Lead BHD Staff:**  
Jim Kubicek

**Action Team Involvement:**  
Community Linkages

**Partners:**  
Community Justice Council

**fifteen**

**Improvement Area 5 – Reduction of Inpatient Utilization**

Supporting a recovery-oriented system that permits the reduction of both acute care utilization and long-term care bed utilization.

**Reduce the number of people who experience acute hospital admissions through improved access to, and utilization of, non-hospital crisis intervention and diversion services for people in mental health crisis.**

15

**PERFORMANCE TARGETS**

**By July 2014:**

- 1) Reduce admissions to Milwaukee County Behavioral Health Division Acute Adult Inpatient Service by 15% (248) over 2012 baseline of 1,650.
- 2) Reduce the percentage of persons who are readmitted to the Milwaukee County Behavioral Health Division Acute Adult Inpatient Services within 90 days of discharge from the 2012 baseline of 24.1% to 22.0%.

**TACTICAL OBJECTIVES**

- 15.1 Successfully implement to tactical objectives in Goals 8, 9, 10, 13, and 14.
- 15.2 Involve all types of providers in the partnership to reduce admissions including crisis services, peer support, clubhouse, case management, and informal community supports.
- 15.3 Focus on improvement of policies, procedures and practices that facilitate early access to crisis intervention by community providers and law enforcement, continuity of care, diversion from hospitalization into crisis resource centers, and rapid step down from hospitalization into intermediate levels of support. (Goal 8)
- 15.4 Develop a countywide mechanism for triaging bed availability and flow between high and lower systems of care.
- 15.5 Develop a plan for collecting baseline data and tracking hospital diversion and utilization percentages across the county.

**RESPONSIBILITY**

**Lead BHD Staff:** Amy Lorenz and Director of Acute Services (TBA)

**Action Team Involvement:**  
Continuum of Care

**Partners:** Persons with lived experience, Behavioral Health Division, private hospital systems, providers, crisis services, faith-based and other community-based resources, law enforcement

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
INTER-OFFICE COMMUNICATION

**DATE:** February 13, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

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

**SUBJECT:** **Informational Report from the Director, Department of Health and Human Services, on the Access Clinic and Mental Health Outpatient (MHOP) Services operated by the Behavioral Health Division**

**Background**

The Access Clinic is a behavioral health clinic that provides psychiatric services to uninsured adults in Milwaukee County and serves as an entry point to the outpatient mental health system. This model allows the Behavioral Health Division (BHD) to direct the “front door” access for outpatient services via assessments at the clinic. As a bridge to the community for mental health services, the clinic offers crisis intervention, assessment, and /or referrals to community providers. The following informational report is provided at the request of the Health and Human Needs Committee to provide more information about the background, design and operation of the clinic, as well as outcomes it has achieved for Milwaukee County residents.

**Discussion**

The Access Clinic was originally opened in 1991 as the Central Walk-In Clinic (CWIC) and was created as a result of a re-design of the Milwaukee County operated outpatient mental health clinics. At that time, other Milwaukee County outpatient clinics were being closed and/or downsized, which necessitated the creation of a walk-in clinic to meet the service needs of the community and as a requirement of Wisconsin Administrative, Code DHS 34, Emergency Mental Health Service Programs. The original design was focused on a walk-in service for people to access psychiatric services such as assessment for medication, outpatient therapy, brief case management, and other various community services. Additionally, the clinic’s close proximity to the Psychiatric Crisis Services (PCS) afforded the opportunity to serve as a diversion for PCS and the hospital.

Over time the clinic evolved into a medical model, where all individuals presenting for services were assessed for medication evaluation and management and there was no longer a therapy component to the service array. Due to this, a limited number of people could be seen each day based upon prescriber coverage. This led to people being declined services and being asked to return another day. Additionally, the model created significant wait times (up to 5 hours at the highest peaks), which lead to very poor customer satisfaction.

### *Redesign and the NEW Access Clinic*

In 2010, BHD reviewed the CWIC model and determined that a shift was needed from a medication management model to an outpatient therapy model. To ensure adequate and efficient outpatient resources for the uninsured population and to provide co-occurring, trauma-informed services, a mental health outpatient services appropriation was included in the 2011 BHD Budget.

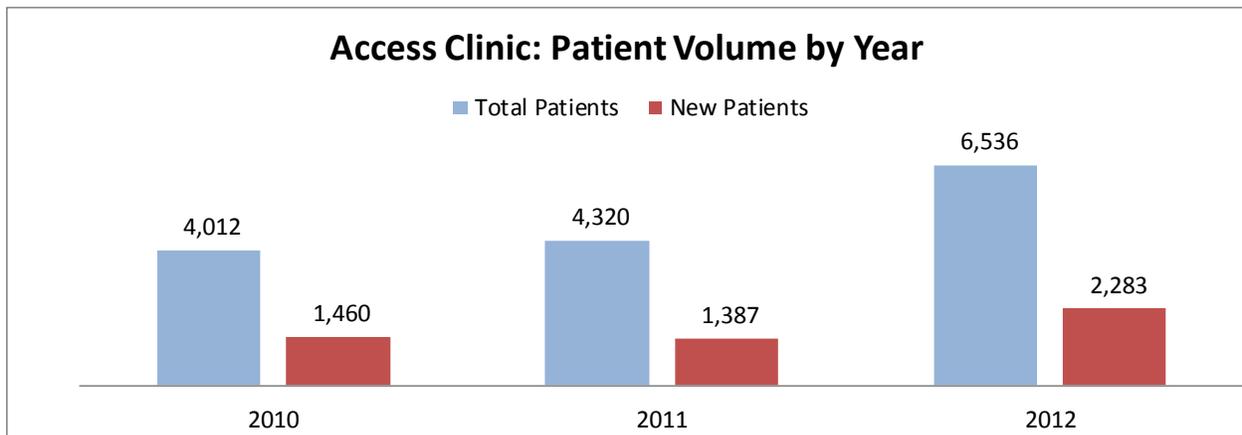
In November 2011, BHD implemented a complete redesign of CWIC and the new service was renamed the Access Clinic. The Access Clinic was designed to provide greater access to outpatient behavioral health services by adding a therapy component to the service array. The primary changes to the program were:

- All individuals who present for services at the clinic see a clinician for assessment the same day. At the assessment, individuals have their clinical needs assessed and a referral for services, whether for therapy, medical assessment or both.
- Individuals now have access to co-occurring outpatient therapy at one of seven outpatient clinics certified in both AODA and mental health treatment.
- If a referral for medication evaluation is needed, an appointment is given for the individual to return and see the prescriber.

### *Outcomes*

The re-design of the Access Clinic created the following improvements:

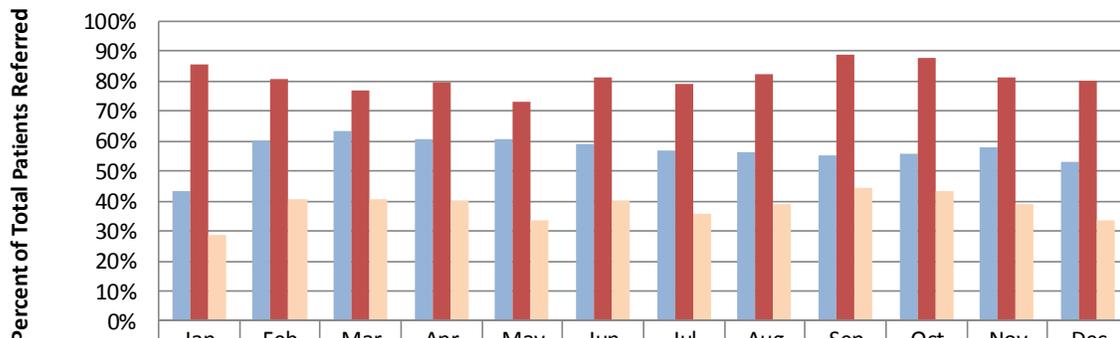
- A significant decrease in those individuals unable to be assessed. Since November 2011, approximately 24 individuals were not able to be assessed on the day they presented for services. Prior to the clinic re-design, 2 to 15 people would not receive assessment **daily**.
- A significant increase in the number of individuals able to be served. In 2012, there was a 61% increase in the number of new patients served in the Access Clinic, and a 34% increase in the overall number of patients served.



- Individuals can now receive co-occurring, trauma-informed outpatient therapy services that were previously not offered. Every month more than 50% of those individuals presenting for services are being referred for therapy services. Prior to the re-design, no individuals were receiving therapy services.

## Access Clinic: Clinician Referrals 2012

\*\*"Both" category includes patients from  
"Receiving Therapy" and "Receiving Meds" categories



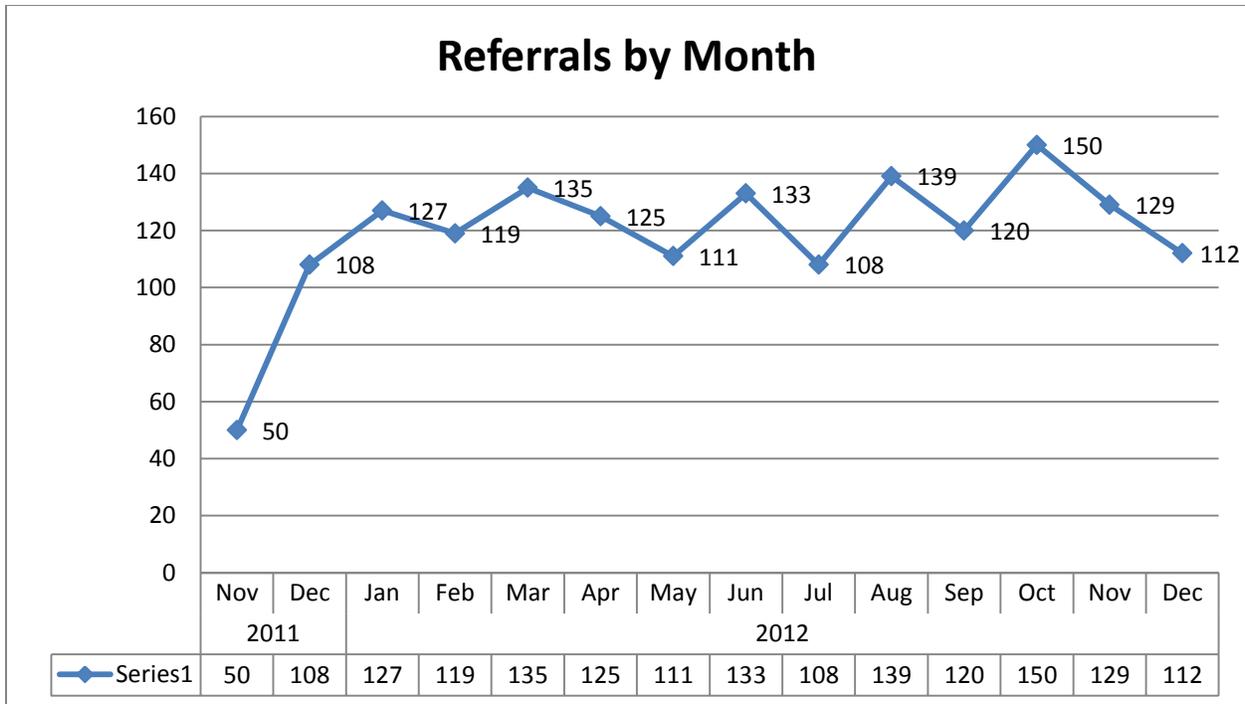
Receiving Therapy	43%	60%	64%	61%	60%	59%	57%	56%	55%	56%	58%	53%
Receiving Meds	86%	80%	77%	80%	73%	81%	79%	82%	89%	88%	81%	80%
Both	29%	41%	41%	40%	34%	40%	36%	39%	44%	43%	39%	33%

- Referrals for medication evaluation have also decreased by an average of 19% during 2012.
- As of January 2012, individuals referred for medication evaluation are able to be seen by a Psychiatrist or Psychiatric Advanced Practice Nurse in the clinic in seven days or less. The average referral appointment wait time in the community for individuals with insurance is 4-8 weeks.
- A significant reduction in wait times, especially for those individuals returning for services as they are now given appointments. This allows for a much more timely and person-centered care approach.

### *Mental Health Outpatient (MHOP) Services*

In the 2011 Budget, \$360,000 was allocated for the Mental Health Outpatient Program (MHOP). Through collaboration with Psychiatric Crisis Services (PCS) and Community Services Branch (CSB), MHOP services were designed and implemented. To achieve this, collaboration with 12 WisserChoice service providers, that hold dual-certification under Wisconsin Administrative Code, DHS 35, Outpatient Mental Health Clinics, and AODA certification under Wisconsin Administrative Code, DHS 75, Community Substance Abuse Service Standards, was necessary. Now, in the Access Clinic, when an individual is identified as needing therapy services, the individual then self-selects from the 12 providers for therapy services, which are spread out geographically across Milwaukee.

The original goal of the MHOP services was to expand services to 200-250 people. Between November 2011 and December 2012, there have been 1,666 referrals for MHOP services. 72% of those individuals referred for therapy showed up for their scheduled appointment.



After the creation of the MHOP services, BHD identified an additional need for case management services. Due to this, in partnership with the CSB, Recovery Support Coordinator (RSC) services were added to the array of services offered in the Access Clinic. To date 16 individuals have been referred for RSC services through this program.

Based on the success of the MHOP programs, funding for these services were maintained in the 2012 Budget and are expanded with an additional \$80,000 in the 2013 Budget. This will allow BHD to continue to meet demand for this program.

#### *Service Array*

The Access Clinic offers the following services to individuals:

- Mental Health Assessment/Evaluation
- Psychiatric Assessment
- Medication Evaluation
- Crisis Stabilization
- Outpatient Individual Therapy
- Group Therapy
- Access to Co-Occurring, Trauma-Informed Services
- Recovery Support Coordination
- Referrals for Community Services

#### *Looking Forward*

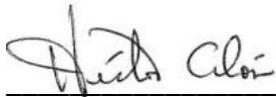
The Access Clinic and MHOP services have begun their second year of expanded services. Due to the program's success of referring and engaging individuals, BHD plans to expand services to increase access

to assessment, therapy and RSC services for Milwaukee County residents. Additionally, through continued collaboration with PCS and CSB, BHD is exploring other possible re-design efforts to benefit individuals in need of co-occurring services such as assessment unification and expansion. Finally, BHD will continue to expand to increase service providers who offer culturally diverse and culturally competent services.

**Recommendation**

This is an informational report only. No action is necessary.

Respectfully Submitted,



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Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, County Board  
Don Tyler, 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:** February 25, 2013

**TO:** Supervisor Peggy Romo West, Chair Health and Human Needs Committee

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

**SUBJECT:** **Informational Report from the Director, Department of Health and Human Services, on the Relocation of Residents in the Center for Independence and Development (Formerly Hilltop)**

**Background**

The 2013 Adopted Budget includes an initiative to downsize the Center for Independence and Development (CID) (formerly Hilltop) by 24 beds. Currently, Hilltop consists of three units of 24 beds each. The budget reflects a reduction of 12 beds by April 1, 2013 and an additional 12 beds by July 1, 2013.

Last August, BHD submitted a notice of intent to downsize the CID to the State of Wisconsin as required by section 50.03(14) of the Wisconsin Statutes. This notice of intent or relocation plan was approved effective September 10, 2012.

**Discussion**

In conjunction with the Disabilities Services Division (DSD) and the Department on Aging (MCDA), the Behavioral Health Division (BHD) has been working to permanently close the 24 beds by conducting options counseling with guardians. In addition, BHD has also engaged the Family Care Managed Care Organizations (MCOs) which are responsible for developing individualized service plans for all persons who will be relocated. The overall goal of this collaborative effort is to create an integrated system of care with a focus on community residence and appropriate support services.

The downsizing process is strictly governed by the State Department of Health Services' (DHS) Resident Relocation and Procedure Manual which prescribes the role of a relocation committee in identifying community placements for residents. This committee meets on a biweekly basis and consists of members from BHD, DSD – Disability Resource Center, MCDA, DHS relocation officials, State Ombudsman, Disability Rights Wisconsin, and the MCOs. The meeting is facilitated by a representative appointed by DHS. The process is meant to ensure that proper discharge planning occurs in collaboration with all interested parties.

The team began meeting in September to review each resident's relocation plan and identify potential community placements. The Family Care MCOs and their teams are charged with working with the families, guardians and BHD staff to identify resources to meet the unique needs of each person identified to be transitioned. Some guardians have expressed concerns but these are being addressed on a case-by-case basis. This is a person-centered planning process that requires the identification of personal outcomes, choices for living arrangements and the supportive services needed.

As of mid-February, six CID beds are vacant. The Relocation Committee must discharge six additional clients to meet the April 1 benchmark. BHD is optimistic that it will meet our targeted budget goal. BHD will continue to partner with all participants and pursue placements as opportunities are presented by Family Care and the MCOs.

In terms of the impact to personnel, BHD anticipates absorbing the majority of CID staff in vacancies elsewhere in the division.

### **Resident Community Transition Initiatives**

The transition process for residents is being supported by a number of initiatives intended to address the needs of residents as they are relocated to the community.

#### **The Model Apartment Program (MAP)**

In mid-February, BHD opened a model apartment to provide opportunities for residents to practice skills such as personal care, household chores, handling money, use of community resources and coping, among others. Residents are being integrated into the program by following a curriculum prepared by a clinical interdisciplinary team lead by Dr. Gary Stark, Clinical Program Director.

The efficiency apartment includes a small dinette, living room, and bedroom. The apartment is one of the focal points of extensive training along with expanded community integration opportunities.

#### **Crisis Respite Expansion**

During 2012, DSD undertook a request for proposals (RFP) process to expand its existing level of crisis respite services to aid former CID residents placed in the community. Crisis respite home services provide a temporary alternative living arrangement to diffuse a crisis situation brought on by behavioral challenges or other circumstances. These services will allow CID residents to receive support without requiring them to be admitted to BHD's Psychiatric Crisis Service. Once the individual receives crisis services he or she can then return to his or her community placement.

A contract has now been executed and DSD's existing capacity of crisis beds has increased from four to eight beds which are fully accessible. DSD has received excellent cooperation in the utilization of the crisis respite beds and the last information obtained indicated that all eight beds were being occupied.

#### **Mobile Crisis Team Expansion**

BHD has been working with the Waisman Center to develop intensive crisis mobile team supports to provide enhanced services in the community for persons with both intellectual disabilities and mental illness. It is the intention to enter into an agreement with the Waisman Center for consultation services that will help develop the enhanced crisis capacity. A team of staff from both BHD and DSD will be meeting with Waisman Center staff in February to begin implementation of these expanded services.

The next step will then be for the Waisman Center consultants to complete an assessment and prepare recommendations for system improvements of the current service delivery system. These recommendations may include the following:

- Creating capacity to provide ongoing behavioral consultation, training, and support

- Creating an outpatient clinic design that provides psychiatric services for individuals with developmental disabilities and potential direction for creation of such a clinic in Milwaukee
- Establishing effective crisis capacity and needed service components
- Expanding current service providers' confidence and capabilities to improve positive behavioral outcomes for individuals being served
- Identifying future training needs and completing some identified trainings for service providers

It is anticipated that the new services would be available to community providers serving individuals relocated from CID. The goal is to support individuals in crisis so that they can remain in the community in lieu of being admitted to BHD's Psychiatric Crisis Service.

### **Next Steps**

The next few months will focus on successfully placing CID residents and closing the remaining beds in order to meet the 24-bed reduction by July 1, 2013.

### **Recommendation**

This is an informational report. No action is necessary.



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Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablitch, County Board  
Don Tyler, 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:** February 25, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

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

**SUBJECT:** **Informational Report from the Director, Department of Health and Human Services, on the Status of the State Plan Amendment for Community Recovery Services (CRS) 1937 Medicaid Benchmark Plan**

**Issue**

In July 2012, the Health and Human Needs Committee (HHN) and the Milwaukee County Board of Supervisors approved adding Milwaukee County to the state plan amendment (SPA) for the 1937 Medicaid Benchmark Plan for CRS (File Number 12-575). Since that time the Behavioral Health Division has been in close contact with the State regarding the progress of the SPA. After a delay at the State Department of Health Services, the SPA was submitted in October 2012. The plan has not been approved by the Centers for Medicaid and Medicare Services (CMS) and it appears as though it may take years to resolve an issue raised by CMS for its approval.

**Discussion**

There is a significant and rather problematic delay with the 1937 SPA at the federal/state level that may have an impact on implementation of the program in Milwaukee County. CMS has asked the state to withdraw its SPA for CRS and resubmit it for two reasons: 1) To address CMS' identified cost reporting issues between the state and all the counties; and, 2) So the clock resets itself. The bigger issue is regarding the cost reporting. CMS has asked the State to completely overhaul how counties complete their report to the State for all Medicaid locally matched services. The State is arguing that the requested changes are not related to cost reporting but in fact are related to accounting principles and practices. The State is also arguing that in order to make the requested CMS changes it would take at least a decade to change this practice as all counties would need to implement an entirely new cost reporting system that is based on accounting practices and not included in the currently utilized cost reporting system. In order to make the requested changes to Medicaid cost reporting, the State anticipates that it will easily take years. Obviously this leaves Milwaukee County in quite a dilemma for the implementation of CRS.

The SPA that the State submitted for CRS was in essence requesting one thing, to move the program from one section in the Social Security Act - 1915i - to a different section, 1937. From a

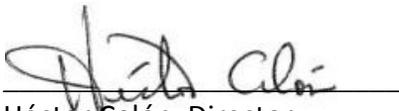
programmatically standpoint the services and individuals eligible for CRS services did not change. CRS is a co-participation benefit and would add two additional services: supported employment and community living support services; and, one additional provider: a certified peer specialist for clients already participating in BHD programs. In 2010, Milwaukee County's application was approved by the State to implement 1915i. At that time, the County lacked Board approval to implement the program. Both 1915i and 1937 are entitlements and it was presented to the Board in July under the framework of an entitlement.

Waiting a decade for resolution to the SPA for the 1937 Benchmark Plan is not a good solution for Milwaukee County. Therefore, BHD has asked the Continuum of Care Action Team of the Mental Health Redesign and Implementation Task Force to be the lead committee in exploring the risks and benefits of implementing CRS under 1915i as opposed to waiting for the cost reporting issues to be resolved between the State and CMS. A summary of its findings will be presented at the April 2013 HHN Committee meeting for further action if warranted.

**Recommendation**

This is an informational report. No action is necessary.

Respectfully Submitted,



Héctor Colón, Director  
Department of Health and Human Services

- cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Kelly Bablich, County Board  
Don Tyler, Director, DAS  
Craig Kammholtz, Fiscal & Budget Administrator, DAS  
CJ Pahl, Assistant Fiscal & Budget Administrator, DAS  
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Jennifer Collins, Analyst, County Board Staff  
Jodi Mapp, Committee Clerk, County Board Staff

**COUNTY OF MILWAUKEE  
INTER-OFFICE COMMUNICATION**

**DATE:** February 25, 2013

**TO:** Supervisor Marina Dimitrijevic, Chairperson – Milwaukee County Board

**FROM:** Héctor Colón, Director, Department of Health and Human Services  
*Prepared by Alexandra Kotze, DHHS Budget Manager*

**SUBJECT:** **Report from the Director, Department of Health and Human Services, Requesting Submittal of a Five-Year Capital Improvements Plan for the Department of Health and Human Services to the Capital Improvements Committee**

**Issue**

Milwaukee County Ordinance 36.04 requires all departments to submit Five-Year Capital Improvements Plan (Five-Year Plan) requests to their respective standing committees. Standing committees shall then submit Five-Year Plans along with recommendations to the newly-created Capital Improvements Committee (CIC). This report includes the Five-Year Plan for the Department of Health and Human Services (DHHS), including the Behavioral Health Division (BHD) and the Emergency Medical Services (EMS) Division.

**Background**

The 2013 Adopted Capital Improvements Budget includes the creation of a Capital Improvements Committee (CIC). Ordinance 36.04 was also approved in 2013, which codified the creation, composition, duties, reports and staffing of the CIC. The purpose of the CIC is to develop a Five-Year Plan for the entire County and establish criteria on how each capital project will be evaluated. The ordinance also requires Departments to submit Five-Year Plans to their respective standing committees, which will then forward their recommendations to the CIC.

**Discussion**

DHHS has evaluated its anticipated maintenance, IMSD and facility needs for the Marcia P. Coggs Building, the Mental Health Hospital Facility, and the Delinquency and Court Services (DCSD) Building. The attached Five-Year Plan includes several outstanding capital needs, listed in priority order. The requested capital projects assume current operations.

For many years, there has been discussion about BHD moving to a new facility. During that time, understandably, limited investments were made in the physical plant. This capital plan is intended to inform policymakers as to the overall infrastructure investment required assuming no change in our current operations. For 2014, over \$18 million in capital projects have been identified for the Coggs Center, BHD and DCSD.

However, in light of the recent CBRE facilities study and the County Executive's plan to transition BHD's long-term care programs to the community, some projects within this capital plan may require revised scopes and reassessment. Again, the department is performing the necessary due diligence by identifying these projects so that policymakers can be fully informed. The complete Five-Year Capital Plan will only be pursued if we continue operating BHD and Coggs for the foreseeable future.

Below is a summary of each project by Division and priority.

**Department of Health and Human Services (DHHS)**

**2014 Priority 1: Marcia P. Coggs Center HVAC System Retrofits - Phase 2 (\$2,820,000)**

DHHS is requesting to continue its HVAC replacement project on the first and second floors of the building. The third floor and part of the second floor are being completed in 2013 as part of Phase 1 of this capital project. This project will improve the air handling and temperature distribution as well as address facility operations issues such as the energy consumption increases that have occurred in recent years. Phase 2 of this project continues the work begun in Phase 1.

However, this project now needs to be reviewed in light of the recent CBRE facilities study which recommends the sale of some county-owned properties.

**2014 Priority 2: Medical Services Space Updates at the Detention Center (\$62,100)**

DHHS is requesting to expand the current medical area within the Detention Center for the Delinquency and Court Services Division (DCSD). In the 2012 State of Wisconsin annual inspection it was reported: "As noted in past inspections, the physical space available to health care staff continues to be a concern to this office. The amount of space provided to medical staff remains insufficient to ensure confidentiality." The State suggested that DCSD look into moving the medical staff area or expanding it. DHHS is requesting to expand the medical unit space into an adjacent classroom. This renovation will include moving walls and reconfiguring space and should resolve the confidentiality issue for DCSD.

**2014 Priority 3: Business Intelligence Tool in DCSD (\$1,340,587)**

DCSD is requesting the same business intelligence tool that the Sheriff's Office currently utilizes. The cost reflects a municipal license, software/hardware and labor that would allow DCSD to report from multiple data sources and support an evidence-based programming initiative that will be underway in 2013.

**2014 Priority 3: Updating Security Door and Intercom Control System at DCSD (\$126,720)**

DCSD is requesting to upgrade the Children's Court security door and intercom system. The original system was installed in the mid 1990's, and in 2004 some changes and additions were implemented. DCSD is requesting an upgrade of existing control electronics hardware and refurbishment of the existing control panels installed for the Detention and Sheriff's Adult hold area, which operate the security doors, cells and intercom system.

**2015 Priority 1: OnBase Document Management System for the Housing Division (\$148,709)**

The Housing Division is requesting to invest in OnBase, a document management solution, to support Section 8 and Community Development Block Grant (CDBG) programs. The requirements of the system are: (1) storing the applications and the program eligibility documentation with Section 8 storage requirements for up to seven years and CDBG storage requirements, which are currently unlimited; and (2) Addressing any workflow needs for the application process for both programs. The system will not include any billing or payment requirements since that functionality is done through Housing's Yardi system.

**2016 Priority 1: DHHS Security Camera System Upgrade and Expansion (\$1,227,339)**

DHHS is requesting to upgrade two outdated and unstable camera systems into one comprehensive system at the Coggs Center that conforms to the Milwaukee County IMSD

standards. In addition, DCSD is requesting to expand the security camera system at Delinquency and Court Services to cover all parking lots and 'blind areas' surrounding the detention facility. This will address public safety issues. This camera system is the same platform as the Milwaukee County Sheriff's Office and will allow for support from public safety agencies.

In light of the recent CBRE facilities study, the scope of this project could change depending upon the future plans for the Cogs Center.

#### **Behavioral Health Division (BHD)**

##### **2014 Priority 1: Nurse Call System – Unit 53B (\$123,750)**

BHD is requesting the installation of the Dukane nurse call system for the Child and Adolescent Inpatient Services (CAIS) program. From 2009-2011, the nurse call system throughout BHD was replaced through a capital project. However, this area was not included on the original project scope. BHD is now requesting to install the same system in this area to address patient and life safety concerns.

##### **2014 Priority 2: BHD Roof Repair (\$1,261,035)**

The scope of this project includes replacement of roofing material, gutters, downspouts, and skylight panels. The roof has exceeded its useful life, according to a report prepared by VFA, a company that conducts building assessments. Replacement could provide utility savings as well as ongoing maintenance savings. BHD is currently patching leaks in the building and in 2012 spent an estimated \$135,000 for emergency repairs to the Day Hospital portion of the roof.

Given this project's significant capital investment, it may need to be reassessed in light of the proposed programmatic changes at BHD.

##### **2014 Priority 3: BHD Energy Efficiency Project – HVAC Air Distribution Upgrade and Window Replacement (\$9,947,804)**

This project would necessitate the upgrade of 18 Air Handling Systems that serve patient units in the psychiatric hospital at BHD and is expected to improve the air handling and temperature distribution at BHD. The existing air handling system is past its useful life, according to the report produced by VFA. BHD is also requesting to replace 150 windows which are over 30 years old. Both the HVAC and window replacement are expected to result in utility savings.

Given its substantial cost, this particular capital project must be assessed in light of the potential programmatic changes at BHD. Though these improvements would be necessary assuming the current state of operations, this significant investment of capital dollars may no longer be financially advantageous.

##### **2014 Priority 4: BHD Parking Lot Repaving (\$2,070,300)**

Overall, the existing parking lots at BHD are in extremely poor condition. In fact, the VFA report indicates that the lots were past their useful life ten years ago. BHD has addressed parking lot deficiencies on an emergency basis for the past several years out of its operating budget to avoid future trip and fall hazards.

There are three areas in particular BHD is requesting be repaved – 1) parking lots X32 & X32A (\$1,027,100) 2) the roadway from the Psych Hospital loading dock to 92<sup>nd</sup> St (\$624,300) and 3) lot X4 at the Food Service building (\$418,900). Construction plans for the State's Zoo Interchange project include eliminating portions of the County's parking lot adjacent to

Watertown Plank Road where X32 and X32A parking lots are located. Therefore, this estimate addresses only those areas not impacted by the Watertown Plank construction.

Given the potential programmatic changes over the next few years, BHD will work to identify the most critical of the three paving projects so that the most immediate and pressing paving needs can be addressed.

**2014 Priority 5: Panic Alarm System Replacement and Upgrade (\$516,000)**

BHD is requesting to replace the panic alarm system (PA system) in the Psychiatric Hospital and 9201 Watertown Plank Rd building. This serves all BHD patient units and offices throughout the building. The panic alarm system, installed 25 years ago, is used to transmit calls for emergency response to personal safety situations in offices and areas where individual BHD staff meets with clients who may pose a threat to the safety of staff. There have been problems keeping the segments of the panic alarm system consistently operational. During system testing, segments are found to be inoperative because replacement parts are no longer available leaving BHD with a partially functioning system. A new system is needed to provide reliable service.

Similar to other system-wide projects, the scope of this project may need to be revised in light of the proposed programmatic changes at BHD.

**2014 Priority 6: BHD Security Camera System Upgrade and Expansion of Coverage (\$453,679)**

BHD is requesting to upgrade the current BHD security system to conform to the existing Milwaukee County IMSD standards. In addition, BHD is requesting to expand the security camera system throughout BHD to cover various hallways, common areas, parking lots and other outdoor areas at the facility to address public safety issues. This camera system has the same platform as Milwaukee County Sheriff's Office and will allow for support from public safety agencies. BHD will work with IMSD to identify the highest priority areas based on the changes being proposed for the next few years.

**2015 Priority 1: Public Address System Replacement and Upgrade (\$68,625)**

BHD is requesting to replace the public address system (PA system) in the Psychiatric Hospital and 9201 Watertown Plank Rd building. The PA system is used to transmit emergency announcements throughout the buildings, including patient units, offices and all other tenants at BHD. The PA system is original to the building so replacement parts are no longer available. The replacement system will also expand announcement coverage to rooms and suites that presently do not hear the announcements, which is expected to improve staff response time in those areas. BHD will work with DPW to identify the highest priority areas based on the changes being proposed over the next few years.

**2016 Priority 1: Install Critical Electrical System Separators (\$229,200)**

BHD is requesting to install critical electrical system separators at the Mental Health Complex for the emergency electrical system to comply with current electrical code. This is the result of the State conducting an inspection of recent work at BHD and suggesting that BHD needs to add a dedicated electrical line to the server room and pharmacy related to the Emergency Medical Records (EMR) system.

The regulations now state that facilities should have regular electric lines, separate lines for life safety items (i.e. fire alarm system), and a critical branch for essential items not related to life safety (such as the EMR). Although the initial work will provide separate electrical for the server

room and the pharmacy, the system is designed to provide emergency power for HVAC in order to keep the building habitable in case of extended electrical outages or water outages.

Given that this project is not being requested until 2016, there is sufficient time to assess its scope and placement within BHD's capital program.

**2016 Priority 2: BHD Main Entrance Building Settling Issue Repair (cost to be determined)**

BHD has become aware that due to major settling issues, the bathrooms at the main entrance of the facility are no longer usable. BHD is proposing to repair the settling and renovate the bathrooms near the main entrance of the Mental Health Facility. Currently, the bathrooms are closed. Therefore, BHD is proposing to remove floor slab that has settled as well as the existing walls and install new walls, plumbing and electrical so bathrooms are ADA compliant.

Similar to the electrical project above, there is sufficient time to assess this project's scope and placement within BHD's capital program.

**Emergency Medical Services (EMS)**

**2014 Priority 1: EMS Video Conferencing (\$162,674)**

EMS is requesting to expand EMS' video conferencing system. As a result of expansion within the EMS system, very limited expansion of EMS Education Center Staff, and decreased local and county operating budgets, EMS needs to expand their video conferencing system. The current pilot system is very limited in terms of flexibility and in the number of users at eight.

EMS needs to develop the infrastructure to reach up to 45-50 locations at one time, archive the EMS classes for electronic retrieval at a later time and be able to host several meetings at the same time. EMS would have two host locations; one at the education center to deliver educational content to area fire stations and one at the EMS Medical Command Communications Center to manage medical briefings to EMS providers and collaborate with Emergency Management and hospitals during disasters. The County would purchase a "bridge" which would allow multiple partner agencies to run meetings at one time in separate meeting rooms. The cost reflects a server and licenses for each site.

**2015 Priority 1: EMS Communications Center Equipment Upgrade (\$675,869)**

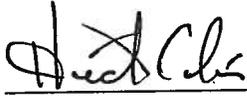
EMS is requesting to upgrade the EMS Communications Center Equipment. The EMS Medical Communication Center is responsible for receiving mission critical emergency medical information both via voice as well as data from EMS agencies (fire department and private ambulances and medical helicopter services) as well as communicating this information to area hospitals. In addition, the EMS Medical Communications Center communicates with emergency management at the local, state and federal levels and is an active participant during multi-casualty and disaster events.

The equipment required to carry out the mission critical communication activities involves a number of components. The main component is the communication work stations which were last replaced in 2000 and are reaching the end of their life. In addition, the system includes state EMS radio system equipment, aviation radio equipment, battery back equipment to be used if power failures occur, as well as equipment to link the EMS Medical Communication Center, located in a non-County facility, to the Milwaukee County computer network.

**Recommendation**

It is recommended that the Health and Human Needs Committee forward the Five-Year Plan recommendations, as outlined in this report, to the Capital Improvements Committee for consideration.

Respectfully Submitted,



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Héctor Colón, Director  
Department of Health and Human Services

Cc: Chris Abele, County Executive  
Amber Moreen, Chief of Staff, County Executive's Office  
Kelly Bablitch, Chief of Staff, County Board  
Michael Mayo, Sr., Chair, Transportation, Public Works, and Transit Committee  
Willie Johnson, Jr., Co-Chair, Finance Personnel, and Audit Committee  
David Cullen, Co-Chair, Finance Personnel, and Audit Committee  
TBD, Chair, Capital Improvements Committee  
TBD, CEX Appointee #1, Capital Improvements Committee  
TBD, CEX Appointee #2, Capital Improvements Committee  
Don Tyler, Director - DAS  
Craig Kammholz, Fiscal & Budget Director, DAS  
Brian Dranzik, Interim Director, Department of Transportation  
Scott Manske, Comptroller  
Vince Masterson, Strategic Asset Coordinator, DAS  
Chris Lindberg, CIO, IMSD  
Laurie Panella, Deputy CIO, IMSD  
Pamela Bryant, Capital Finance Manager, Comptroller's Office  
Justin Rodriguez, Capital Finance Analyst, Comptroller's Office  
Gregory High, Director, AE&ES-FM-DAS

## MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 2/25/13

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Submission of the Milwaukee County Department of Health and Human Services' 5 Year (2014 – 2018) Capital Improvements Program

**FISCAL EFFECT:**

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><input type="checkbox"/> Decrease Operating Expenditures<br><input type="checkbox"/> Increase Operating Revenues<br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><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
<b>Operating Budget</b>	Expenditure		
	Revenue		
	Net Cost		
<b>Capital Improvement Budget</b>	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.<sup>1</sup> 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 Ordinance 36.04 requires all Departments to submit 5 Year Capital Improvements Program requests to their respective standing committee. The standing committee shall then submit the Program along with its recommendations to the Capital Improvements Committee (CIC).

This fiscal note is for initial submission of the Milwaukee County Department of Health and Human Services' 5 Year (2014 – 2018) Capital Improvements Program.

- B. There are no direct costs or savings associated with the 5 Yr. Capital Improvements Program at this time as this item is only proposed for initial policymaker consideration. Any formal appropriation related to this 5 Year Program would occur in the future as part of the 2014 Capital Budget process.
- C. There are no budgetary costs or savings associated with the 5 Yr. Capital Improvements Program at this time as this item is only proposed for initial policymaker consideration. Any formal appropriation related to this 5 Year Program would occur in the future as part of the 2014 Capital Budget process.
- D. The projects included in the 5 Year Program are estimated based upon information that is currently available. The projects proposed and the final projects adopted as part of the 2014 Capital Budget process may vary. Refer to Items B and C for additional assumptions regarding formal appropriation of the projects proposed.

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<sup>1</sup> 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.

<sup>2</sup> Community Business Development Partners' review is required on all professional service and public work construction contracts.

Department/Prepared By Clare O'Brien, DHHS Fiscal and Management Analyst

Authorized Signature 

Did DAS-Fiscal Staff Review?  Yes  No

Did CBDP Review?<sup>2</sup>  Yes  No  Not Required

(ITEM \*) A resolution to authorize the attached Five Year Capital Improvements Program for the Department of Health and Human Services to be recommended to the Capital Improvement Committee (CIC):

**A RESOLUTION**

WHEREAS, the 2013 Adopted Capital Improvements Budget includes the creation of a Capital Improvements Committee (CIC); and

WHEREAS, ordinance 36.04 was also approved in 2013, which codified the creation, composition, duties, reports, and staffing of the CIC; and

WHEREAS, the purpose of the CIC is to develop a Five Year Program for the entire County and establish criteria on how each capital project will be evaluated; and

WHEREAS, the ordinance also requires Departments to submit Five Year Programs to their respective standing committees, which will then forward their recommendations to the CIC; and

WHEREAS, The Department of Health and Human Services has evaluated its anticipated maintenance and facility needs; and

WHEREAS, the attached Five Year Program includes the department's outstanding capital needs, listed in priority order; now, therefore,

BE IT RESOLVED, the attached Five Year Program (Exhibit A) is recommended to the CIC.

**Five Year Program Spreadsheet on Next Page**

**Attachment A**

Department of Health and Human Services  
2014

Exhibit A

Rank	Project Number	Project Name	Total Cost	Reimbursement Rev	County Financing	Project Description/Annual Operating Impact
	<b>DHHS</b>					
1	WS032	DHHS HVAC System Retrofits Phase 2	\$2,820,000	\$0	\$2,820,000	This project will improve the air handling and temperature distribution at Coggs and address some of the energy consumption increases that have occurred in recent years.
2		Medical Services Space Updates	\$62,100		\$62,100	As cited by the State in the last 5 inspections, due to confidentiality concerns, the Medical Unit space needs to be expanded. This will expand the current space into the adjacent classroom at Delinquency and Court Services (DCSD).
3		Business Intelligence Tool	\$1,340,587		\$1,340,587	DCSD is requesting to install the same business intelligence tool that MCSO utilizes, which would allow DCSD to report from multiple data sources and support the evidence based programming initiative that will be underway in 2013.
4		Update Security Door and Intercom Control	\$126,720		\$126,720	DCSD is requesting an upgrade of existing control electronics hardware and refurbishment of the existing control panels installed for the Detention and Sheriff's Adult hold area, which operate the security doors, cells and intercom system
	<b>BHD</b>					
1		Nurse Call System - 53B	\$123,750		\$123,750	Replace the Nurse Call system on Unit 53B to meet standards and be consistent with the rest of BHD.
2	WE04001	BHD Roof Repair	\$1,261,035		\$1,261,035	This project would correct deterioration in various locations. Temporary patching has been occurring until a permanent solution has been identified.

3	WE04101 and WE04201	BHD Energy Efficiency - Psychiatric Hospital HVAC Air Distribution Upgrade and Window Replacement	\$9,947,804		\$9,947,804	BHD is proposing to replace 150 windows(\$284,804) and upgrade the aging HVAC system(\$9,663,000) at the Mental Health Complex. This project will improve the air handling and temperature distribution in the Psychiatric Hospital at BHD and address some of the energy consumption increases that have occurred in recent years.
4		Parking Lot Repaving	\$2,070,300		\$2,070,300	Repave parking lots to address trip and fall hazards for which BHD has previously been cited. Temporary patches have been installed but a permanent solution is needed. The paving includes Lots 32 & 32A, roadway from Psych Hospital loading dock to 92nd St and lot X4 at the Food Service building.
5		Replace Panic Alarm System	\$516,000		\$516,000	BHD is requesting to replace the panic alarm system (PA system) in the Psychiatric Hospital and 9201 Watertown Plank Rd building. This serves all BHD patient units and offices throughout the building. The panic alarm system was installed 25 years ago. Replacement parts are no longer available.
6		Security Camera System	\$453,679		\$453,679	Upgrade and expansion of security camera system to conform with Milwaukee County IT standards.
	EMS					
1	WE04901	Video Conferencing	\$162,674		\$162,674	EMS needs to expand their video conferencing system to respond to growing technological needs.
					\$0	
<b>Total</b>			\$18,884,649	\$0	\$18,884,649	

**Department of Health and Human Services  
2015**

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
	DHHS					
1		OnBase - Document Management System	\$148,709		\$148,709	This project will provide a document management solution to support Housing Section 8 and CDBG programs to store the applications and the program eligibility documentation, and assist with workflow needs for the application process.

	BHD					
1		Replace Public Address System	\$68,625		\$68,625	BHD is requesting to replace the public address system (PA system) in the Psychiatric Hospital and 9201 Watertown Plank Rd building. This serves patient units, offices and all other tenants at BHD. The PA system is original to the building. Replacement parts are no longer available.
	EMS					
1		Replacement of EMS Medical Communication Center equipment	\$675,869		\$675,869	Communications equipment at the EMS Medical Communication Center is reaching its end of life use. Additionally Mil. Co. EMS leases space for the Communication Center from Froedtert Hospital (FH). Remodeling plans for FH may include evicting EMS Communication Center, requiring relocating to another facility. This will require purchasing new communications equipment.
<b>Total</b>			<b>\$893,203</b>	<b>\$0</b>	<b>\$893,203</b>	

**Department of Health and Human Services  
2016**

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
	DHHS					
1		Security Camera System Upgrade and Expansion	\$1,227,339		\$1,227,339	This project will replace the two existing camera systems at Coggs with one comprehensive system. It will also expand the DCSD camera coverage to the parking lots and outside areas to address public safety concerns.
	BHD					
1		Install Critical Electrical System Separators	\$229,200		\$229,200	An appropriation for 2016 is requested to install critical electrical system separators at the Mental Health Complex for the Emergency Electrical system to comply with current electrical code. This is the result of the State conducting an inspection of recent work at BHD and suggesting that BHD needs to add a dedicated electrical line to the server room and pharmacy related to the EMR.

2	Building Settling Repair	TBD		TBD	An appropriation for 2016 is requested to repair a building settling issue. BHD has become aware that, due to major settling issues, the bathrooms at the main entrance of the facility are no longer usable. BHD is proposing to repair the settling and renovate the bathrooms near the main entrance of the Mental Health Facility.
<b>Total</b>			<b>\$1,456,539</b>	<b>\$0</b>	<b>\$1,456,539</b>

**Department of Health and Human Services  
2017**

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
1		NONE		\$0	\$0	
<b>Total</b>			<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	

**Department of Health and Human Services  
2018**

Rank	Project Number	Project Name	Total Cost	Reimbursement Revenue	County Financing	Project Description
1		NONE	\$0	\$0	\$0	
<b>Total</b>			<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	



# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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2012 REVIEW

2012 was a year of change and it was also a year of many triumphs for the Milwaukee County Department of Health & Human Services (DHHS). It is my pleasure to share with you the many accomplishments the department completed in the last year. Our goals were reached by instituting reforms throughout the divisions. We also placed a focus on partnership and collaboration.

I want to thank Milwaukee County Executive Chris Abele for giving me the honor to serve in his Cabinet. His effort to reach across party lines and to provide sustainable and efficient delivery of the best quality service has been exemplary. I also want to thank Mr. Abele and the members of the Milwaukee County Board of Supervisors for their support of DHHS. A big thank you to all of our staff, private hospitals, community-based partners, advocates and consumers who help us carry out our mission. It is our collective pursuit of excellence that helped make 2012 a great year for DHHS.

As director of DHHS, one of my initial objectives was to create a shared workplace culture that defined our values, strengthened teamwork and implemented performance management tools to help us achieve our goals. This shared workplace culture has played an important role in helping our department feel encouraged, engaged and energized. We formed this culture through a process that involved DHHS division administrators and members of their leadership teams. In addition, input was gathered from staff across all divisions in the department. Through this collaboration, we proposed the following values for DHHS:

- We respect the dignity and worth of each individual we serve and with whom we work
- We act with honesty and integrity, adhering to the highest standards of moral and ethical principles through our professional and personal behavior
- We strive for excellence, implementing the best practices and measuring performance toward optimal outcomes
- We work collaboratively, fostering partnerships with others in our service networks and with the community
- We are good stewards of the resources entrusted to us, using them efficiently and effectively to fulfill our mission
- We honor cultural diversity and are culturally competent and sensitive

Employees in every division pledged to uphold these values and are incorporating them into their daily work.

Teamwork has been a high priority for our department. We are working together to help each other fulfill our department and each individual division's goals. Some examples of great teamwork this year included the collaboration amongst the DHHS divisions contributing to our mental health redesign efforts, responding to emergency fire and threat situations at the Coggs building, and general sharing of best practices that are resulting in better efficiencies across divisions.

Together we put in place performance management tools to help us convert our mission, values and goals into action. All of our department goals have been translated into a format that makes them specific, measurable, achievable, realistic and time-bound. Implementation plans are in place to help

us monitor progress. Performance evaluations have been instituted across the department with the goal of ensuring better communication, accountability and success for all employees.

I am pleased to share some of our accomplishments and our plans to continue meeting and exceeding our goals in the future. We are looking forward to leveraging and expanding our public/private partnerships, technology and data driven analysis to ensure the long-term sustainability of programs needed to meet the needs of the most vulnerable in this community.

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## **BEHAVIORAL HEALTH DIVISION**

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The Behavioral Health Division (BHD) is fully committed to reforming mental health care in Milwaukee County and transitioning from institutional care to a community-based system while continuing to provide the best quality of care for clients. Caring for those in need of mental health care services is one of the most critical responsibilities of DHHS. Several key steps required to reach the community care goal were put into place during 2012.

In January, Action Teams presented recommendations from their areas to the Milwaukee County Board of Supervisors Committee on Health & Human Needs. A comprehensive presentation was also made at a public summit in February. The Redesign Task Force resolved to seek technical assistance in implementing affirmed recommendations and that led to a service agreement with ZiaPartners, Inc. and Wilberg Community Planning LLC. The recommendations are also being converted into SMART (specific, measurable, achievable, realistic and time-bound) goals with processes in place to track progress.

Consistent with our redesign efforts, the 2012 BHD budget included \$3 Million in community investment funding aimed at improving the community support for residents in need of mental health services. Those funds were used to enter agreements with several organizations that provide community based programs. Those programs include:

- **Community Linkages & Stabilization Program (CLASP)**  
This program provides extended support and treatment for individuals who are post-hospitalization. Certified Peer Specialists work with clinical coordinators to provide treatment designed to support recovery, increase a client's ability to function independently in the community and reduce incidents of emergency room contacts and re-hospitalization.
- **Crisis Resource Center (CRC)**  
The CRC provides a safe, recovery-oriented environment for people in need of stabilization and peer support to prevent hospitalization. This includes adults with mental illness and individuals with co-occurring substance abuse issues who are experiencing psychiatric crises.
- **Stabilization House**  
Stabilization House is an alternative to psychiatric inpatient hospitalization for individuals with serious and persistent mental illness. The home services adults who are in need of

further stabilization after an inpatient hospitalization. It is also used by individuals who require structure and support to ensure a smooth transition into residential placement. Stabilization House may also provide temporary accommodations for people with mental health needs during a crisis or when they need respite from living at home.

- Individual Placement & Support (IPS)  
IPS is an evidence-based practice of supported employment that helps individuals with severe mental illness or co-occurring disorders obtain employment.
- Peer Specialists  
As part of the Mental Health Redesign, work continues to develop the peer specialist network and to increase consumer participation in BHD activities.
- Wellness Recovery Action Plan (WRAP)  
WRAP allows consumers to make decisions about their own care in advance of any crisis situation.

Upgrades designed to improve patient experiences and care at the BHD Psychiatric Crisis Services (PCS) Admission center were completed in November of 2012. The enhancements are part of the ongoing effort to provide more person-centered and trauma-informed care. Updated features help staff immediately assess patient needs and reduce or eliminate wait times. The new features include a new triage area, an additional workstation and a children's waiting area. PCS serves about 14,000 people every year. The center is open 24 hours per day, 7 days per week and provides psychiatric emergency services including assessment, crisis intervention and medication.

In the ongoing effort to provide the best patient care, BHD reconfigured its acute care units and bed occupancy. One acute unit was taken out of operation in late 2012. The decision to close one unit was based on several factors including increased community programming, a declining census, fewer emergency visits and increased partnerships with community hospital providers. These improvements are consistent with recommendations from the Mental Health Redesign Task Force.

New treatment units are now available for BHD patients. Female patients now have the option of being in the Women's Treatment Unit (WTU). WTU offers a combination of effective trauma informed therapies to create an environment that is sensitive and therapeutic for patients. Clients who are the most challenging with behavioral needs are now housed in the Intensive Treatment Unit (ITU). This unit provides a safe place to provide rapid and effective stabilization for patients who are judged to be at high risk for aggressive and disruptive behaviors. The creation of these new units provides more effective care for specialized populations served by BHD. This allows the Acute Treatment Units to offer more specific programming including:

- Unit community meetings
- Medication & symptom management groups
- Community resource groups
- Music & occupational therapy

- Recovery planning sessions
- Spirituality groups & contacts
- Medication therapy
- Education in managing other medical conditions

Acute units also offer interventions for patients whose needs are best served in a general care environment.

All BHD clinical staff received 16 hours of training to be certified in the Mandt System. Mandt is an advocacy-based curriculum for building healthy relationships through positive behavior support in a trauma sensitive setting. After the training, rates of seclusion and restraint use were reduced significantly at BHD.

BHD launched its new electronic medical records (EMR) system in December of 2012. The improved system will increase the overall efficiency and improve billing and collections processes at BHD. It also helps staff better manage inpatient, outpatient and substance abuse programs effectively.

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## **EMERGENCY MEDICAL SERVICES**

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Emergency Medical Services (EMS) is an essential part of Milwaukee County's health care community. EMS is a nationally respected group that has been recognized for high survival rates of cardiac patients among other achievements. The division administers critical emergency medicine in pre-hospital settings. EMS is also responsible for administering the operation and maintenance of county-wide emergency medical services through agreements with county municipalities.

In 2012, four-year contracts were negotiated with nine Milwaukee County Municipalities and the North Shore Fire Department. Those contracts will help assure the future development of the EMS System. The contracts also include improvements that will enhance the EMS system and continue providing high quality out-of-hospital emergency medical care.

EMS put the following changes in place in 2012:

- Performance Measuring - An updated performance measure program was developed to help monitor system performances of EMS providers from contracting fire departments. The program will also help maintain a high quality EMS system and help strengthen accountability throughout the EMS system.
- EMS Education upgrades - Staff partnered with area fire departments to redesign the model of delivering EMS education. Using a web-conferencing platform helped Milwaukee County EMS save area fire departments more than \$100,000 in overtime costs the first semester it was put in place.

- Internet Based Conferences - EMS initiated the use of web-based streaming conferencing to connect with stakeholders. The online meetings will save travel time and thousands of dollars.
- Radio System Redesign - Work is underway to upgrade the emergency medical services radio system. The redesign will result in significant cost savings.
- Funding for Defibrillators - Capital funding was secured to replace aging cardiac monitor defibrillators. New monitors will make better use of wireless technologies and enhance patient care.
- Medication Tracking - A new internet platform database is being used to track federally controlled medications administered by area paramedics. The database allows EMS system administrators to better track medication administration and ensures they are meeting federal guidelines.
- Electronic Records - EMS assisted area fire departments convert patient medical records from paper to electronic formats.
- Cardiac Arrest Research - Pre-hospital research in the area of cardiac arrest and resuscitation of trauma patients was done at EMS. That research was used to help verify medical practices that are scientifically evidence based.
- EMS Progress Reports - Emergency medical services system benchmarks were prepared and results were shared with EMS stakeholders.

EMS is dedicated to efficiently and effectively deploying human resources and providing high quality education to municipal fire department staff. As part of that effort the division began work in 2013 to develop a video conferencing system. Such a system will greatly improve the quality of delivery of EMS education while reducing salary costs.

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## **DISABILITIES SERVICES DIVISION**

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The Disabilities Services Division (DSD) is dedicated to enhancing the quality of life for individuals with physical, sensory and developmental disabilities. Reforms made to the division's Disability Resource Center (DRC) led to the elimination of a 35-year waiting list. On November 1, 2012, the DRC reached entitlement status. That change eliminated the waiting list of over 3,000 individuals with disabilities and completed implementation of a three-year project to expand Family Care. This significant milestone is a paradigm shift for the service delivery system in Milwaukee County and provides badly needed services to help individuals live independently in the community. Staff worked overtime, reprioritized their duties and rose to the occasion to get this done. The Intake Unit received in excess of 26,000 calls to our call center and we provided disability benefits services to over 1,200 individuals in 2012.

Over the past two years, DSD has eliminated a 500-person waiting list for children with disabilities and their families. DSD served 264 families in the Children's Long Term Support (CLTS) Waiver, 462 families in the Autism Waiver and 749 families in the Family Support Program in 2012. The division continues to respond to the needs of families of children on the Autism Spectrum by helping 88 children to be placed on the waiting list for services and taking 78 children off of the waiting list for Intensive Autism services.

In 2012 the division embarked on a joint initiative with the Behavioral Health Division to downsize the Center for Independence & Development (formerly known as Hilltop). The planning process has begun with the goal of relocating 12 individuals by April 2013. As part of another related initiative to help support the Center for Independence & Development (CID) project, DSD expanded the Crisis Respite Home program from four to eight beds in 2012. This will allow more individuals to receive services quickly while remaining in the community and avoiding hospitalization.

The Division will be completing a system gap analysis initiative for 2013. The project design and funding was approved in 2012 and there will be significant review of the gaps in services for persons with intellectual disabilities.

The DSD Birth-to-Three Program is an early intervention program for children with developmental delays and disabilities ages birth to 3 and their families. In 2012 the program maintained nearly 100% compliance with key federal performance indicators while serving more than 3,000 individuals and families. DSD has undergone a significant program financial review of Birth-To-Three contracted agencies and will be moving toward performance based contracts in 2013. The division was able to redirect \$150,000 in new funding to the Birth-To-Three program for 2013.

DSD had 100% compliance with timely submittal of WATTS reports to the court system. This is an annual process for individuals who have a protective placement orders in place by the court. DSD staff members perform reviews to ensure those individuals are living in the least restrictive and most integrated settings possible. The Division has over 600 cases that are processed yearly.

DSD established the new 2012 Minority Intern Program and had two wonderful students. Both expressed that they enjoyed their individual experience and learned a lot about the Disabilities Services Division and the Birth-to-Three Program. One student is a sophomore at Knox College in Galesburg, Illinois. She is majoring in Spanish and her minor is social services. She plans to become a bilingual speech pathologist after graduation. The second student is currently enrolled in the Human Services Program at MATC. She is fluent in English and Hmong. She will enroll in a 4-year college for social work after completing courses at MATC.

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## **DELINQUENCY & COURT SERVICES DIVISION**

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The Milwaukee County Delinquency & Court Services Division (DCSD) continues to move forward with efforts to reduce recidivism in Milwaukee County and to offer viable substitutes to detaining youth. In 2012 DCSD teamed up with the Annie E. Casey foundation to implement new juvenile justice system reforms. The county is one of only three sites in the state of Wisconsin chosen to

participate in the foundation's Juvenile Detention Alternatives Initiative (JDAI). The program has successfully reduced the number of youth in confinement while maintaining or improving public safety in other states across the country.

DCSD received a \$725,000 federal grant to develop and implement new tools that will enable officials to make informed decisions about resources and services for youth. The grant was awarded when the Office of Juvenile Justice & Delinquency Prevention (OJJDP) chose Milwaukee as one of the 2012 participants in the Juvenile Justice Reform and Reinvestment Demonstration Program. The program provides funding to states and communities to test an evidence-based juvenile justice reform initiative.

In mid-2012 DCSD commissioned the help of the Public Policy Forum to review its approach to measuring juvenile recidivism and to provide recommendations for improvement and moving toward more evidence based programming. The Forum found that the division had intensified efforts to improve recidivism measures in order to better analyze, improve and disseminate information to justice system leaders and elected officials. The study also concluded *"Milwaukee County's Delinquency and Court Services Division takes its charge to measure recidivism seriously and is committed to improvement."*

The new Milwaukee County Accountability Program (MCAP) was launched in 2012. MCAP is designed to allow qualified youth to stay close to home instead of being sent to a Juvenile Correction Institution four hours away from Milwaukee. Youth in the program are placed in the secure detention center for up to five months and undergo a period of aftercare in the community under probation supervision. Families are also encouraged to become more involved through MCAP. Support and structure from family members are needed to meet the requirements. There are currently 12 youth enrolled in the program. MCAP features several key services including:

- Education – Wauwatosa Public Schools provide classes in reading & English, math, social studies, science, physical education/health and art. Credits earned are transferable to the child's local school district.
- Juvenile Cognitive Intervention Programming – Running Rebels Community Organization runs daily groups to help youth change their thought process in order to make better choices.
- Family Counseling – All MCAP participants are expected to participate in weekly counseling sessions. These sessions include parents/guardians when possible.
- AODA Education & Counseling - Alcohol & drug abuse counseling is provided to help participants understand the effects of substance abuse.
- Restorative Justice – Groups will be provided to help youth build a sense of community within the program, examine their behavior and learn new skills.

- Targeted Monitoring – Participants will be assigned to a monitor from Running Rebels Community Organization.
- Electronic Monitoring – GPS monitoring will be required during home passes and upon initial release to the community.
- 72-Hour Hold – Youth on aftercare status will be subject to holds in secure detention for investigation of any alleged violations of the rules of their supervision.

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## HOUSING DIVISION

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The Housing Division is responsible for coordinating and overseeing federal housing and community development funds awarded to Milwaukee County. During 2012 the division overhauled several programs, making them more efficient and effective. Those reforms received national recognition and the Housing Division was the recipient of the U.S. Department of Housing and Urban Development (HUD) “Turning the Ocean Liner Around” award. The division was acknowledged for having the most improved program and structure for the CDBG and HOME programs.

Enhancements made to the CDBG program include:

- Developing a citizen participation plan
- Improving the application process and providing training sessions for recipients
- Creating an expert panel to make recommendations based on an independent, objective scoring system
- Designing a compliance manual for sub-recipients

HOME program changes include:

- Putting new policy and procedures in place
- Retraining employees on regulations
- Implementing a conflict of interest policy
- Pre-construction meetings with contractors and homeowners
- Increasing public outreach and education efforts

More than 6,000 low income families in Milwaukee County are currently being removed from a Section 8 waiting list. This waiting list has been in place since 2001. A new administrative plan for the program helped the division accomplish this goal. Milwaukee County had been operating on an outdated plan from 1999.

The Division partnered on the creation of 111 new supporting housing units for mental health consumers in 2012. Eighty of the units were located outside the city of Milwaukee and were the first permanent supportive housing units to be located in Milwaukee County suburbs.

Housing was successful in the implementation of several Mental Health Redesign initiatives including:

- Securing additional funds for on-site services at Highland Commons. This step helps meet the redesign goal of increasing permanent supportive housing.
- CDBG funds were used to provide peer support services in permanent supportive housing, meeting the goal of increasing the role of peer support.
- An RFP was completed for Pathways to Permanent Housing, a new housing model designed as an alternative to community based residential facilities. This model will assist consumers with living in a least restrictive setting as they work to secure permanent supportive housing.

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## MANAGEMENT SERVICES DIVISION

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The Contract Administration team of the Management Services Division is responsible for administering funds under the Wisconsin Home Energy Assistance Program (WHEAP). This program helps low-income individuals and families in Milwaukee County pay their home heating and electric bills during the heating season and provides crisis energy assistance during the entire year. WHEAP also funds improvements to homes and apartments to make them more energy efficient. In the 2012 fiscal year \$30,423,389 in home energy assistance funds was paid out to nearly 55,000 eligible Milwaukee County households. More than 9,800 households received energy crisis assistance that totaled \$3,160,854 for the year.

Contract Administration also administers WHEAP funding under the IMPACT Community Information Line (2-1-1) service - a centralized access point for people in need during times of personal crisis or community disaster. This program is a 24-hour contact and referral service that provides access to a comprehensive database containing more than 5,500 community programs for residents seeking social services in Milwaukee County. In the first six months of 2012, IMPACT 2-1-1 served a total of 84,445 customers, which included 16,791 online database search sessions and 67,654 telephone calls for an average of 14,074 clients served per month.

During the heating season, Milwaukee County residents are directed to call 2-1-1 if they are experiencing a loss of heat after business hours. 2-1-1 tries to determine the reason for loss of heat and determine if there are life-threatening conditions present. Additionally, 2-1-1 helps clients understand eligibility for the WHEAP Emergency Furnace Program. If life threatening conditions exist, an energy assistance agency will contact clients within 18 hours to complete an application and conduct a troubleshooting safety check. 2-1-1 provides referrals to both SDC and Community Advocates for regular energy assistance and the WHEAP crisis program.

To date, through November of 2012, 2-1-1 provided assistance in response to:

- 4,954 utility bill payment assistance requests

- 474 weatherization requests
- 223 furnace repair requests

Contract Administration was the 2012 recipient of the Community Business Development Partners *Good Citizens Award*. The honor was presented for their outstanding commitment to fulfilling the Disadvantaged Business Enterprise program goals. The unit was also recognized for taking a partnership approach to champion the program creatively and consistently.

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## FISCAL & OPERATIONS

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DHHS staff in the fiscal and operations worked with all divisions throughout the year to help improve systems and boost revenues. Some of their most significant accomplishments include:

- Reduced BHD revenue write-offs with change of services billing process
- Boosted revenue & improved collection results by improving follow-up systems
- Dramatically improved Housing Division fiscal controls to satisfy HUD requirements
- Completed transition of uncollectible data from Housing Division to Department of Administrative Services to maximize Tax Refund Intercept Program (TRIP) collections
- Worked closely with Program, Audit & Contract Management to significantly reduce pharmacy cost and completed an RFP for improved long-term cost efficiencies

These combined efforts led to improved 2012 financial results for DHHS and BHD, as well as sustainable revenue increases and expense reductions moving forward. In 2012, these billing and collection changes will yield between \$500,000 and \$1million in increased patient revenue. The reforms are anticipated to yield an addition \$2 million in 2013.

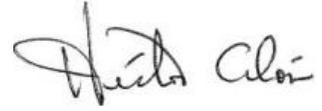
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## LOOKING AHEAD

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We are looking forward to another exciting and successful year. As we move into 2013 our plan is to continue to improve staff competencies and leadership through professional development. We will also examine program, business and financial practices to ensure we are approaching our operations in the most efficient and effective way possible. Work is underway to continue the movement towards best practices and evidence-based decision making. DHHS is strengthening quality assurance with community based partners by moving towards performance-based contracts which will ensure quality service, accountability and positive outcomes. We look forward to continuing the

work we do to secure human services for individuals and families who need assistance living healthy, independent lives in the community.

A handwritten signature in black ink that reads "Hilda Colon". The signature is written in a cursive style.