MILWAUKEE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health Division
Behavioral Health Division (Wraparound Milwaukee)
Delinquency & Court Services Division
Disabilities Services Division
Economic Support Division
Housing Division

YEAR 2009
PURCHASE OF SERVICE GUIDELINES
PROGRAM REQUIREMENTS

Issued July, 2008

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Program Requirements

Delinquency & Court Services (Continued)

The following are continuing programs not open to competitive proposals:

2009 TENTATIVE CONTRACT ALLOCATIONS

BEHAVIORAL HEALTH DIVISION

Recommended Programs	2009 * Tentative Allocations
Service Access and Prevention[C2]	$2,568,173
Inpatient and Institutional Care: Detox[C3]	$2,898,250
Community Treatment (Outpatient)[C2]	$3,692,300
Community Living Support[C1]	$ 717,063
Community Based Residential Programs[C3]	$4,388,020
Targeted Case Management[C1]	$3,159,391
Community Support Programs[C2]	$3,636,033

***Final 2009 allocations are contingent on the 2009 adopted budget.**

Behavioral Health Division has three-year program contract cycles. They are as follows:

		Applications Open In	For Contract Year
Cycle I	Community Living Support Programs	2009	2010
Cycle II	Central Intake Unit	2010	2011
	Service Access Prevention - MH/AODA	2010	2011
Cycle III	Secure Emergency Detoxification	2011	2012

Programs are only required to submit full applications for panel review once every three years. Assuming satisfactory performance and the continued availability of funds, agencies submit abbreviated applications and are given a one-year contract extension during each year their proposals are not being reviewed by a full panel.

For 2009, only Cycle III programs are open for competitive proposals. New, full applications will be accepted for Cycle III programs only.

An abbreviated review will be performed on Cycle I and II programs. Cycle I and II programs should follow the Final Submission procedures outlined in the Technical Requirements manual.

2009 TENTATIVE CONTRACT ALLOCATIONS

BEHAVIORAL HEALTH DIVISION
CHILD & ADOLESCENT COMMUNITY SERVICES BRANCH –
WRAPAROUND MILWAUKEE

Recommended Programs	**2009 * Tentative Allocations**
Care Coordination Contract amount may vary based on service volume method of payment is case rate	$TBD
Family Advocacy Services	$310,000
Mobile Crisis Services – Crisis/Respite Group Home for Adolescent Boys 12-17	$358,000
Mobile Urgent Treatment Team – Crisis Support Services and Short-Term Case Management	$TBD

The Child & Adolescent Community Services Branch and the Wraparound Milwaukee Program have a three year contract cycle. All current organizations providing services to this Branch and Wraparound Milwaukee are required to submit annual applications. Complete application including a full panel review of the application are required prior to renewal at the beginning of a three year cycle. Assuming satisfactory performance and continued availability of funds, programs are given two one-year contract extensions. During the two years of those extensions, applications are not reviewed by a full panel. In 2009, all of the above listed programs are subject to a full application and full panel review.

***Final 2009 allocations are contingent on the 2009 adopted budget.**

2009 TENTATIVE CONTRACT ALLOCATIONS

DELINQUENCY & COURT SERVICES DIVISION

The following list includes the programs for which DCSD is issuing a Request For Proposal (RFP) for contract year 2009. These programs are open for competitive application. Agencies seeking to contract for the provision of the following programs are required to submit a **complete application** package that includes all of the documents and formats as defined in the Y*ear 2009 Purchase of Service Guidelines – Technical Requirements* **and** the *Year 2009 Purchase of Service Guidelines – Program Requirements.*

Recommended Programs

Program Number	Program Name	2009* Tentative Allocation
DCSD 001	Day Treatment Program	$1,207,920
DCSD 003	Firearms Supervision Program	$756,677
DCSD 004	First Time Juvenile Offender Program (FTJOP) Tracking	$430,000
DCSD 005	Foster Care Licensing and Case Management	$125,000
DCSD 006	Group Care (30-32 Beds)	$1,273,834 to $1,358,756

IMPORTANT: DCSD 012 (**Detention Psychiatric Nursing Services**) and DCSD 013 (**Detention Physician and Medical Services**) are open for competitive bid. They are included in the *RFP – PSA* (Professional Services) section of this CD RFP.

DCSD 012	Detention Psychiatric Nursing Services
DCSD 013	Detention Physician and Medical Services

Programs Not Open for Competitive Bid

The following Delinquency & Court Services Division programs currently fall within a multi-year contracting cycle and **are not open** to new provider agencies. The current provider agencies for these services must file a **partial application for each program** that includes all the items listed under FINAL SUBMISSION plus the Authorization To File for 2009. Please refer to the *Year 2009 Purchase of Service Guidelines – Technical Requirements*.

Program Number	Program Name	2009* Tentative Allocation
DCSD 008	Level 2 In-Home Monitoring Services	$1,145,436
DCSD 009	Serious Chronic Offender Program	$555,467
DCSD 010	Adolescent Sex Offender Treatment Program	$134,912
DCSD 011	Shelter Care	$2,146,289

***Final 2009 allocations are contingent on the 2009 adopted budget.**

2009 TENTATIVE CONTRACT ALLOCATIONS

DISABILITIES SERVICES DIVISION

Recommended Programs	2009 * Tentative Allocations
COMMUNITY LIVING SUPPORT	
DSD 012CR - Crisis Respite Home [C1]	$250,000
DSD 011 - Recreation [C1]	$173,516
	$423,516
DEVELOPMENTAL DISABILITIES - CHILDREN	
DSD 009 - Early Intervention - Birth to Three [C1]	$4,550,024
DSD 012 - Respite [C1]	$ 37,977
	$4,588,001
GRAND TOTAL	**$5,011,517**

***Final 2009 allocations are contingent on the 2009 adopted budget.**

Disabilities Services Division has three-year program contract cycles. Only Cycle 1 [(C1)] programs are open for competitive bid in the 2009 contract process. New applications will be accepted for Cycle 1 programs only.

All agencies that are in the second or third year of a multi-year contract cycle (non-cycle 1 programs) in 2009 are not open for competitive proposals. Agencies that are currently in a multi-year contract cycle (do not require a competitive panel review), **must** submit **all** the items listed under FINAL SUBMISSION, **plus** the Authorization To File (Item 3) as found in the Application Contents section of the *Purchase of Service Guidelines - Technical Requirement.*

The following are continuing programs in a multi-year cycle and are not open to competitive proposals

WORK AND DAY SERVICES
- DSD 007 - Day Services
- DSD 008 - Day Services - Integrative Community Based
- DSD 006 - Work Services

EMPLOYMENT PROGRAMS
- DSD 010 - Employment Options

Because of the unknown impact of the planned expansion of Family Care** in Milwaukee County, DSD is recommending new contracts in 2009 for six (6) months at 1/2 of the current 2008 funding level for the above programs in a multi-year contract cycle.

In addition, agencies that are **not** currently in a multi-year contract cycle, but have contracts for the following services are also being recommended for new contracts in 2009 for six (6) months at 1/2 of the current 2008 funding level:

ADVOCACY

DSD 005 - Advocacy
DSD 005 - Advocacy/Consumer Education

COMMUNITY LIVING SUPPORT

DSD 012 - Respite - Adult
DSD 014 - Assertive Case Intervention

COMMUNITY RESIDENTIAL

DSD 015 - Supportive Living Options
DSD 016 - Supported Parenting
DSD 017 - Person-Centered Planning
DSD 018 - Targeted Case Management

WORK AND DAY SERVICES

Wait List Initiative

The above agencies **must** also submit **all** the items listed under FINAL SUBMISSION, **plus** the Authorization To File (Item 3) as found the Application Contents section of the *Purchase of Service Guidelines - Technical Requirements*

All submissions, regardless of contract cycle year, must be received by the DHHS **no later than 4:30 p.m. on Friday, September 5, 2008.**

**The Milwaukee County Department of Health and Human Services Disabilities Services Division (DSD) is anticipating implementation of the project to expand Family Care in Milwaukee County for adults under the age of 60 during CY 2009. Once this implementation begins, it will be the policy of DSD that any person receiving services provided under a DSD purchase of service contract who is eligible for Family Care, will be offered the option to enroll in the Family Care program to obtain needed services. Any individual eligible for Family Care who elects not to enroll in that program or another Long Term Care option, will no longer have services available under purchase of service contract funding. In addition, all DSD purchase of service providers should be aware that after implementation of Family Care expansion, funding formerly provided to support individuals determined eligible for the Family Care program will not be allocated for the same services and contracts will be reduced correspondingly to support only those individuals determined ineligible for Family Care. Therefore, providers should begin to plan appropriately for budget adjustments. The process for identifying who is Family Care eligible and who is not has begun. The goal is to have all individuals and corresponding allocations completed by the time of contract recommendations in December of 2008. The Division will be working closely with each provider affected by this transition. It should also be noted that it has not been determined to what extent DSD will be able to continue funding for existing purchase of service contracts after implementation of the Family Care expansion project.

2009 TENTATIVE CONTRACT ALLOCATIONS

HOUSING DIVISION

Recommended Programs	**2009 * Tentative Allocations**
Transitional Housing Program (THP) Management	$ 75,000
Supported Apartment Program	$288,016
Resident Management at West Samaria	$ 72,500
	$435,516

***Final 2009 allocations are contingent on the 2009 adopted budget.**

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Section 1
Behavioral Health Division

YEAR 2009
PURCHASE OF SERVICE GUIDELINES
PROGRAM REQUIREMENTS

Issued July, 2008

2009 Purchase of Service Contracts
Behavioral Health Division

The Milwaukee County BHD Adult Community Services Branch is embarking on a process of system transformation to more effectively and efficiently meet the mental health and co-occurring needs of consumers who are currently within our service system. As the result of a new Medicaid initiative that could potentially generate significant cost savings, Milwaukee County intends to convert direct service contracts in 2009 to fee-for-service agreements. The purpose of moving to fee-for-service agreements is to maximize revenue and align the infrastructure of the community mental health and substance abuse systems to develop an integrated system.

Background

States have a new option to use Medicaid funds for home and community based services (HCBS) for people considered disabled by a mental illness without their needing to obtain a waiver from the federal government. The Deficit Reduction Act of 2005 added a new section 1915(i) to the Social Security Act that allows states the option to provide HCBS using the state plan amendment process. A significant advantage of the state plan option in comparison to the waiver is that states do not have to demonstrate budget neutrality. It has been nearly impossible for states to secure HCBS waivers for adults aged 22-64 with a mental illness because they could not meet the waiver requirement for budget neutrality.

Key elements of the new service option include:

The HCBS state plan option services package can include: case management; homemaker services; home health aide services; personal care services; adult day health services; habilitation services; respite care; and day treatment and other partial hospitalization services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. States are not required to provide the entire array in their service package.

Individuals are eligible for the HCBS state plan option only if they have income no more than 150% of the poverty level and are eligible for Medicaid.

The needs-based criteria for the HCBS option must be less stringent than the level of care required for an institution (i.e., nursing facility, hospital, or ICF/MR). Wisconsin will use the functional screen to comply with the needs-based criteria, and enrollment will be limited to those consumers who need a TCM level of care. If enrollment exceeds what the state projects, a state may modify the needs-based criteria.

Milwaukee County began working with the State this past spring in anticipation of applying for the HCBS state plan option. At this time, it is believed the state plan amendment, if approved, will be effective by July 1, 2009 and Milwaukee County will receive statutory authority to operate 1915(i) by January 1, 2010. Some services could be “back-billed” to the state plan amendment approval date. There are significant financial advantages in implementing 1915(i), including:

Services would be cost reimbursable. Milwaukee County would set the rates for 1915(i)

services on an actual cost basis, including 7% County administrative costs. This could potentially save BHD a significant amount of money, because the Federal Financial Participation (the amount Medicaid actually pays to providers) would be much greater as a result. However, different limitations apply for clinic services (i.e. outpatient and day treatment). The State agreed to continue to cover the costs related to day treatment and outpatient.

Services could be bundled together to reimburse at a residential level of care. This is significant to Milwaukee County, because currently the County reimburses 100% of the cost since Medicaid does not cover residential care. With the implementation of 1915(i), the County could draw down Federal Financial Participation (minus room and board).

Developing a Fee-for-Service Network

Mental health contracts providing direct client services will be converted to fee-for-service agreements in 2009 to take advantage of the newly enhanced Medicaid Federal Financial Participation revenue stream available via 1915(i) in 2010. 2009 will be a transition year to move the following contracts to fee-for-service: *Outpatient, Community Based Residential Programs*, and *Case Management* (i.e. CSP, TCM, & S+C). The Mental Health Advisory Council to the BHD Community Services Branch, consisting of consumers and contracted providers, has recommended the following timeline to convert programs to fee-for-service:

July 1, 2009: Community Based Residential Programs
September 1, 2009: Case Management Programs
December 1, 2009: Outpatient Programs

2009 contracts will be executed with providers for a partial year based on the timeline above or until the conversion to fee-for-service takes place. The balance of money that would otherwise have been used to fund the contracts for the entire year will be set aside as the fund source to purchase services once the conversions take place.

Another significant benefit of implementing fee-for service agreements is that the community mental health and substance abuse delivery systems will be much more closely aligned in terms of infrastructure and business processes. Historically, individuals with co-occurring mental health and substance use disorders received sequential or parallel treatment from the separate mental health and substance abuse treatment systems, resulting in fragmented and duplicative care. Establishing the same management information platform for both systems sets the stage to pursue co-occurring integrated care, and create clinical, operational, and cost efficiencies within one system. Some of the service descriptions contained in this RFP represent additional steps toward pursuing this endeavor.

Behavioral Health Division
Information Systems Requirements

Service Reporting Transitions

As outlined in other areas of the RFP 2009 will be a year of changes and transitions. We will see continued use of newer methods of file transfer continue to hopefully improve our data transfer needs and reduce level of effort on both the provider and BHD.

The move to a fee for service method of payment in many service categories this too will create the opportunity for us to enable additional enhancements in our service capture methods. We will move to the use of the CMHC BUI [web based] method of service entry that we've begun to use within WIser Choice. This will enable providers with the tools necessary to manage treatment episode, service requests and service entry at a detail level.

Data Requirements

The selected contractor will be required to comply with the Behavioral Health Division's (BHD) Management Information System data needs. This data includes, but is not limited to, consumer registration data, service data, agency financial data, performance measurement data and data required by the State of Wisconsin, including Human Services Reporting System (HSRS), etc. The contractor will have the sufficient technological capacity to adapt agency data systems as necessary to accommodate any and all changes to data reporting requirements as required by BHD. Changes have included, but are not limited to, compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards and the Remote Access Project data collection and reporting requirements.

All electronic data files required will meet BHD file format requirements (in the development phase). Should modifications to these requirements be necessary, the contractor will comply with any required modifications to meet these requirements as requested by BHD within 90 days of written notification. Failure to comply with required reporting requirements will result in withholding of payment.

The contractor will be required to report all necessary information in a timely manner consistent with the needs of BHD.

Hardware, Software and Procedural Requirements

The contractor will also need to meet the minimum computer hardware and software standards as specified by both the BHD and the Milwaukee County Information Management Services Division.

Our current usage of web based access to the CMHC MIS in both mental health and substance abuse the minimum requirements are that all personal computer equipment used to access CMHC should be at least a Pentium IV or Athlon XP Pro, 512 MB of memory, CD-ROM drive or access to network CD-ROM for installation, 300 MB of free disk space or

higher for installation and working space during processing, 800 x 600 SVGA display with 256 colors and 16MB of video RAM, Parallel port, TCP/IP Ethernet connection of 10BT, 14" color monitor capable of SVGA display running Windows 2000 Professional or Windows XP Professional. Microsoft Internet Explorer 6.0 or higher.

Each computer should also have a 56K modem installed but broadband access is recommend for best performance. Required software includes Microsoft Office.

The contractor will also be required to allow the installation of a VPN [Virtual Private Network] client and BHD provided FTP client for access to the BHD local area network for service reporting purposes if required.

The contractor will be required to complete and submit a User Login Request form and Confidentiality Statement for each agency employee requiring access to the BHD primary database or local area network. BHD will provide the technical support to establish connectivity to the BHD local area network and primary database. The contractor will be solely responsible for subsequent technical support. BHD Management Information Staff will not provide on-going technical support to contract agencies.

Please complete the *Information System Requirement Checklist* and attach to your proposal.

Outpatient Reporting Requirements

The following three files are to be submitted once a month for all clients served under the vendor's contract with the Milwaukee County Behavioral Health Division (MCBHD). The files are due on the 8th of the month and must contain all clients served during the previous month (files 1 and 2) and all services provided during the previous month (file 3). The files should be delimited text files (a separate delimited text file for each of the three files), and must be transmitted to MCBHD's secure server electronically.

FILE 1: DEMOGRAPHIC INFORMATION (1 record per client)

Item	Data Type	Length	Format	Required?
Agency's unique client ID	Alpha	20	Right-justify	Y
MHD's unique medical record number	Numeric	9	Include leading zeroes	N
Date of last contact	Date	10	MM/DD/YYYY	Y
Client last name	Alpha	20		Y
Client first name	Alpha	20		Y
Client middle name	Alpha	20		N
Street address	Alpha	26		N
Additional address info (apt. #, etc)	Alpha	26		N
City	Alpha	20		N
State	Alpha	2		N
Zip code	Alpha	10		N
County	Alpha	2	01-Milwaukee 02-Ozaukee 03-Racine 04-Walworth 05-Washington 06-Waukesha 98-Other 99-Unknown	N (We will default to 01 if none is supplied)
Birth date	Date	10	MM/DD/YYYY	Y
Sex	Alpha	1	M or F	Y
Ethnic code	Alpha	2	A-Asian B-African American H-Hispanic I-American Indian W-White	N
Social Security number	Alpha	11	999-99-9999	Y
Marital status	Alpha	1	D-Divorced M-Married S-Single W-Widowed X-Separated U-Unknown	N

Medical Assistance Number	Numeric	10		N

FILE 2: EPISODE OF CARE/HSRS INFORMATION (1 record per client)

Item	Data Type	Length	Format	Required?
Agency's unique client ID	Alpha	20	Right-justify	Y
Service open date	Date	10	MM/DD/YYYY	Y
Reporting Unit	Numeric	3	xxx	Y
Discharge date	Date	10	MM/DD/YYYY	Yes if Client is discharged. Otherwise No
Client characteristic 1	Alpha	2	See table below for list of valid values	N (We will default to 99 if none is supplied)
Client characteristic 2	Alpha	2	See table below for list of valid values	N
Client characteristic 3	Alpha	2	See table below for list of valid values	N
Commitment status	Alpha	2	01-Voluntary 02-Voluntary w/Settlement Agreement 03-Involuntary Civil - Ch. 51 04-Involuntary Civil - Ch. 55 05-Involuntary Criminal	Y
Number of children	Numeric	2		N (We will default to 0 if none is supplied)
Number of children living w/client	Numeric	2		N (We will default to 0 if none is supplied)
Severity/BRC Target Population	Alpha	2	H- In Need of Ongoing, High Intensity, Comprehensive Services L- In Need of Ongoing, Low Intensity Services S- In Need of Short-term Situational Services	Y

Presenting problem 1	Alpha	3	ABU-Abuse/ assault/ rape victim ACT-Activity level difficulties ADL-Problems coping w/daily activity AFF-Affective disturbance ALC-Alcohol CJS-Criminal justice system involvement DAO-Dangerous to others DRU-Drugs ED-Emergency detention FAM-Marital/ family problem NTR-Nutritional PHY-Medical/ somatic RUN-Runaway behavior SI – Suicide attempt/threat/ danger SOC-Social/ interpersonal THO-Thought disturbance	Y
Presenting problem 2	Alpha	3	Same codes as above	N
Presenting problem 3	Alpha	3	Same codes as above	N
DSM IV Axis I Primary Diagnosis	Alpha	5	No decimal	Either Axis I primary or Axis II primary is required
DSM IV Axis I Secondary Diagnosis	Alpha	5	No decimal	N
DSM IV Axis I Tertiary Diagnosis	Alpha	5	No decimal	N
DSM IV Axis II Primary Diagnosis	Alpha	5	No decimal	Either Axis I primary or Axis II primary required

DSM IV Axis II Secondary Diagnosis	Alpha	5	No decimal	N
DSM IV Axis II Tertiary Diagnosis	Alpha	5	No decimal	N
DSM IV Axis III Primary Diagnosis	Alpha	5	No decimal	N
DSM IV Axis III Secondary Diagnosis	Alpha	5	No decimal	N
DSM IV Axis III Tertiary Diagnosis	Alpha	5	No decimal	N
Closing Reason	Alpha	2	01-Completed Treatment - Major Improvement 02-Completed Treatment - Moderate Improvement 03-Completed Treatment - No positive change 04-Transferred to another community based resource 05-Administratively discontinued service (no contact with agency for 90 days) 06-Referred 07-Withdrew against staff advice 08-Funding/Authorization expired 09-Incarcerated (local jail/prison) 10-Entered Nursing Home or Institutional Care (IMD, CCI, etc.) 11-No Probable Cause 99-Death	Yes when discharge date is present (Client is discharged). Otherwise No

FILE 3: EVENT INFORMATION (1 record per service provided)

Item	Data Type	Length	Format	Required?
Agency's unique client ID	Alpha	20	Right-justify	Y
Staff ID	Numeric	6	9902 for MCW 9927 for Recovery	Y
Staff type	Alpha	2	01-Psychiatrist 02-Physician 03-Psychologist 04-Psych Social Worker 05-Case Worker 06-M/H Assistant 07-O/T Registered 08-O/T Assistant 09-Recreation Therapist 10-Music Therapist 11-Cert. O/T Assistant 12-Psych Resident 13-Registered Nurse 14-Registered Nurse Master 15-AODA Counselor 16-Rehab Counselor	Y
Reporting unit	Numeric	3	610,611-MCW 625-Recovery	Y
Date of service	Date	10	MM/DD/YYYY	Y
Time of service	Time	5	HH:MM (time of day - military)	Y

Service code	Alpha	6	90782-Injection 90801-Psych Diagnostic 90804-Ind. Therapy 20-30 min. 90805-Ind. Therapy w/E&M, 20-30 min. 90806-Ind. Therapy 45-50 min. 90807-Ind. Therapy w/E&M, 45-50 min. 90808-Ind. Therapy 75-80 min. 90809-Ind. Therapy w/E&M, 75-80 min. 90847-Family Therapy 90853-Group Therapy 90862-Medication Mgmt 96100-Psych. Testing 99361-Case Management	Y
Duration	Time	5	HH:MM (length of time)	Y
Location code	Numeric	1	1-At Center 2-Client's Home 3-Other Hospital 4-Court/Jail 5-School 6-EAP Client's Office 7-Community 9-Other Location	N (We will default to 1)

Recipient code	Numeric	1	1-Client Only 2-Collaterals Only 3-Family Member(s) Only 4-Client and Collateral(s) 5-Client & Family Member(s) 6-Client & Family & Collaterals 7-Telephone Contact 8-Staff Only 9-No Recipient	N (We will default to 1)

Requirements for Mental Health Contracts Only
Residential, Case Management and Community Support Programs

On the 6th of each month after 1:00 PM, BHD will provide for contract agencies a list, in the form of a text file, of Client/Patient/Consumer that have an open episode on CMHC with that agency. A separate list will be provided for each provider/site/funding source combination for each Client/Patient/Consumer in a file on BHD's file Server, to be retrieved by FTP via a VPN connection. This information is updated by agency staff through Registration and Assessment Packet (RAP) through CMHC BUI web based entry. The text file created for each contract agency each month will contain:

Item	Data Type	Length
SCRIPTS Case Number	Alpha	10
Client Last Name	Alpha	26
Client First Name	Alpha	26
Social Security Number	Numeric	9
MHC Medical Record Number	Numeric	9
CMHC Staff ID	Numeric	4
CMHC Reporting Unit	Numeric	4

SCRIPTS Case Number - this is the ID that contract agencies previously used to identify client to SAIL.
MHC Medical Record Number - CMHC/MIS system of identifying the client. This field is provided on the file to enable the contract agency to include it in their file to us thus tying the service information to the correct client in the CMHC/MIS system.
Staff ID- Required by CMHC/MIS and will be used as a generic staff ID to indicate that the service was provided by a contract agency. Contract agencies will not have to indicate specifically which staff member provided the service.
Reporting Unit - Required by CMHC/MIS. Indicates where (i.e. under what provider/site/funding source) the service was provided. One or more reporting units have been set up for each contract agency in the system.

On the 11th of each month before 4:00 PM, the contract agencies use the above text file of Client/Patient/Consumer, add the service information, and return a text file to BHD. Service

information is reported in summary rather than detail - i.e. the agency reports total number of units for the month, using the last day of the month as Date of Service. The information must be in the following format. All fields are required.

Item	Data Type	Length
MHC Medical Record Number	Numeric	9
CMHC Staff ID	Numeric	4
CMHC Reporting Unit	Numeric	4
Date of Service	Date	MMDDYYYY
Service Duration	Numeric	In days, hours or 15-minute increments, depending on the service.
Service Code	Alpha	3

The first three fields are the information that the MHD text file originally provided. The remaining fields must be filled in by the agency:

Date of Service - The last day of the reporting month.
Service Duration - Equals number of units of service. This should be entered as whole number units of service, i.e., units = days for residential services; hours for day treatment and work services; quarter-hour increments for CSP's and other outpatient services.
Service Code - Service codes as assigned by BHD – SAIL Service Manager – Information Services

BHD requires agencies to report electronically and will work with each agency to facilitate this process. Contract Agencies will have a variety of options available to them for completing this process. The only requirement is that the returned file must have the format outlined above.

Option 1: Use a spreadsheet
Import the provided text file into a spreadsheet, add the service information in the spreadsheet and create a file to be returned to us. The Behavioral Health Division (BHD) Information Systems staff will provide a standard spreadsheet for agency use.

Option 2: Use database software
Import the provided text file into a database application, add the service information in the database application and create a text file to be returned.

Option 3: Create an extract file from their own computer system
Extract the service information from a contract agency computer system into a file to be sent to BHD. The agency must develop their own extract and must be able to provide the data in the format described in the table above.

BEHAVIORAL HEALTH DIVISION
Information System Requirement Checklist

Agency Name _____

Person filling out form _____

Contact Number _____

Contact E-mail _____

As of _____(date) the agency computers have…
Processors

☐ Pentium IV or Athlon XP Pro or better
☐ Less than Pentium IV or Athlon XP Pro Memory
☐ 512 MB or more
☐ Less than 512 MB Internet Connectivity
☐ Broadband Internet access
☐ 56K modem
☐ Both (56K modem and Broadband)
☐ Less than 56K modem, or no Internet connectivity

As of _____(date) the agency computers use…
Web Browser

☐ Internet Explorer 6.0 or higher
☐ Less than Internet Explorer 6.0 or another web browser Software
☐ Microsoft Office
☐ Not Microsoft Office

Signed _____

Dated _____

Cycle III Programs
2009 Contract Year
Contracts Open for Competitive Proposals

Secure Emergency Detoxification
Program # A007

Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. Detoxification seeks to minimize the physical harm caused by the abuse of substances. Supervised detoxification may prevent potentially life-threatening complications that might appear if the patient were left untreated. At the same time, detoxification is a form of palliative care for those who want to become abstinent. For some patients, it represents a point of first contact with the treatment system and the first step to recovery. Detoxification alone is not defined as substance abuse treatment and rehabilitation per se, but it is a basic component of the substance abuse treatment system. Treatment and rehabilitation involves a constellation of ongoing therapeutic services ultimately intended to promote recovery for substance abuse patients. Therefore, a critical component of the detoxification service, in addition to evaluation and stabilization, is preparing the patient for entry into substance abuse treatment by stressing the importance of following through with the complete continuum of care.

Milwaukee County will fund two components of the detoxification program, social detoxification and medical detoxification. NOTE: *Applicant agencies are required to submit a separate logic model, program description, evaluation plan, client characteristic data, and program volume data for each component. Applicant agencies are also required to identify the daily maximum capacity for each component, and this must be clearly stated in the first sentence of the respective component/program description.*

Accessibility

The detoxification program shall be included in the telephone directory and have an information number listed in order to describe the scope of services available to the public. Brochures describing the detoxification program shall be distributed to general hospitals, social service agencies and to other potential referral agents (i.e. criminal justice system). The program must facilitate access for physically handicapped persons and be accessible to non-English speaking individuals.

Detoxification Advisory Council

A Detoxification Advisory Council shall be established to ensure the needs of residents are being sufficiently met, and resources are coordinated and being efficiently utilized. Members of the council must include representation from the general hospital system, MCBHD Crisis Services Branch, MCBHD Community Services Branch, MCBHD Legal Unit, the police district in which the facility is located, former consumer(s) of detoxification services, a

substance abuse treatment provider not affiliated with the applicant agency, a mental health treatment provider not affiliated with the applicant agency, and a homeless shelter provider. Other representation may be added, including the criminal justice system, other municipal police districts, and other social service agencies. The council is required to meet quarterly. The detoxification program is expected to incorporate quality improvement projects identified by the council into future evaluation plans. The applicant agency is required to include current or proposed membership within the medical detoxification program description of their application, as well as tentative meeting dates for the term of the contract.

Crisis Stabilization Services

The detoxification program is expected to be a stabilization service provider as defined in HFS 34.22 (4). The contractor will be required to work with Milwaukee County to fulfill the requirements of HFS 34 to bill Medicaid for covered services. Milwaukee County will provide the initial orientation training required by HFS 34. The contractor will be required to develop ongoing training (including subsequent orientation training for staff hired after the Milwaukee County initial orientation), as well as maintain training records in accordance with HFS 34.

Information Management and Payment

The contractor is required to input accurate and timely information on patient demographics, episode and service data. This information supports all state and county reporting requirements related to performance monitoring, service reporting, service payment. The program will be paid on the lesser of net expenses or net units earned, and this is determined by the number of units of service that have been calculated by the system based on the episode information. The contractor is required to report complete information for both components of the program

Training

The contractor must provide SAMHSA published in-service training on either TIP 35 (Enhancing Motivation for Change) or TIP 42 (Substance Abuse Treatment for Persons with Co-occurring Disorders) to all medical, clinical and paraprofessional staff. Applicant agencies must identify in their application which TIP training curriculum they will use, and provide a schedule of all training that will be conducted in 2009 (including training mandated by HFS 75, HFS 83, HFS 34, etc.). The contractor is required to include a training update in their biannual report.

Memorandum of Understanding

Due to the direct interrelationship between the contracted agency and the Behavioral Health Division, a Memorandum of Understanding (MOU) will be developed. The purpose of the MOU will be to clearly define roles and responsibilities for each party. Issues to be addressed in the MOU will include: clinical and treatment expectations, referral and transportation mechanisms between BHD and the contracted provider, contract monitoring, and legal responsibilities of BHD and the contracted agency with regard to civil detention and commitment proceedings.

Licensing

The program is required to obtain two licenses in order to operate the secure emergency detoxification program: HFS 75.07 medically monitored residential detoxification service and HFS 75.09 residential intoxication monitoring service. Both licenses must be obtained before a contract with Milwaukee County can be executed. However, applicant agencies may submit

a copy of their pending application to the Wisconsin Division of Quality Assurance (DQA) for the required licenses in lieu of the actual licenses to receive consideration from Milwaukee County. Either copies of current valid licenses or a copy of the application for licensure submitted to DQA must be contained in Section 1, Item #10 "Agency Licenses and Certifications" of the Milwaukee County application.

Social Detoxification

Program Description

This program component is required to be licensed under HFS 75.09, and adheres to the criteria of an ASAM Level III.2-D. Social detoxification is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for patients who are intoxicated or experiencing withdrawal from alcohol and/or sedative-hypnotics, and who are not in need of emergency medical or psychiatric care. It does not involve the administration of pharmacologic interventions to manage the detoxification protocol. It is characterized by its emphasis on social and emotional support, including availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems. If at any time during the course of the patient's stay in this component complications arise requiring admission to a hospital, that transfer shall be coordinated by staff, including transportation.

Target Population

The target population includes Milwaukee County residents' age 18 or older that meets the ASAM diagnostic admission criteria for a Level III.2-D service. Referrals include municipal police departments, homeless individuals referred by community agencies, social service agencies, family and self-referrals.

ASAM Dimensional Criteria[1]

The patient is evaluated as having a Risk Rating of 2 per the multidimensional risk matrix of the ASAM PPC-2R, which indicates the patient is experiencing some difficulty in tolerating and coping with withdrawal discomfort. Alternatively, the patient's level of intoxication or withdrawal may be severe, but responds to support and treatment sufficiently that the patient does not pose an imminent danger to self or others. Note that the patient's service needs should be considered in each ASAM Dimension. The interaction between Dimension 1 and other ASAM Dimensions may increase or decrease the overall level of severity or function. If the patient's symptoms intensify to a Risk Rating of 3 after admission to social detoxification, then the patient shall be transferred to the medical detoxification component.

Clinical Programming

A range of cognitive, behavioral, medical, mental health and other therapies based on the patient's assessed needs in ASAM Dimensions 2 through 6 and documented in the individualized treatment plan are administered to the patient on an individual or group basis. These are designed to enhance the patient's understanding of addiction, the completion of the detoxification process and appropriate referral for continuing treatment. This should include motivational enhancement therapy, health education services, and services to

[1] The Risk Rating and associated Level of Care placement recommendation contained in this service description deviates from the published ASAM PPC-2R. The ASAM Dimensional Criteria contained in this RFP reflect the most current ASAM recommendations for Dimension 1, currently in pre-publication at the time this RFP is published.

families and significant others. Applicant agencies need to identify the therapeutic modalities of the proposed social detoxification component that foster engagement in continued treatment and recovery.

Evaluation
In addition to the service evaluation elements required under HFS 75.03, applicant agencies must include treatment recidivism and retention in treatment in their evaluation plan**.**

Medical Detoxification

Program Description
This program component is required to be licensed under HFS 75.07, and adheres to the criteria of an ASAM Level III.7-D. Medical detoxification is an organized service delivered by a multi-disciplinary team of medical, nursing and clinical professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a secure (locked) facility. A physician is available to assess the patient in person within 24 hours of admission and thereafter as medically necessary. Psychiatric services are available through consultation within 8 hours by telephone or 24 hours in person. A registered nurse conducts an alcohol or other drug-focused nursing assessment at the time of admission. An appropriately credentialed and licensed nurse is responsible for monitoring the patient's progress and for medication administration. The intensity of nursing care and observation is sufficient to meet patient needs. Clinical staff are knowledgeable about the biological and psychosocial dimensions of substance dependence and mental disorders and have specialized training in behavior management techniques.

The applicant agency is required to employ or contract with one of the following to provide clinical supervision to medical detoxification staff in accordance with HFS 34.21 (8): a board-certified or eligible psychiatrist, a licensed psychologist, psychology or psychiatric resident with 1500 hours of supervised clinical experience, certified independent social worker, master's prepared psychiatric nurse with 3000 hours of supervised clinical experience, licensed professional counselor, master's level clinician with 3000 hours of supervised clinical experience, or post-master's level clinician intern with 1500 hours of supervised clinical experience.

The medical detoxification provider is required to admit patients detained through an Emergency Detention, Treatment Director's Supplement, Re-Detention, Three Party Petition, and Protective Custody in accordance with Wisconsin Statute Chapter 51. A thorough knowledge of Chapter 51 detention and commitment procedures as they are enacted in Milwaukee County is required. Applicant agencies must include in their budget the provision of 24-hour transportation between the applicant agency and Milwaukee County Behavioral Health Division – Psychiatric Crisis Service (PCS) for around the clock admissions and transfers, as well as transportation and escort services to Milwaukee County Behavioral Health Division for commitment proceedings. Applicant agencies must also include in their budget for the provision of pharmacologic interventions to manage withdrawal from a variety of substances, as well as commonly prescribed psychotropic medications and medications to manage medical complications. The program is required to continue administration of medications initiated in PCS, and provide a two-business day supply of medications upon discharge to facilitate transfer to another treatment provider.

Target Population
The target population includes Milwaukee County residents' age 18 or older that meets the ASAM diagnostic admission criteria for a Level III.7-D service. Referrals include municipal police departments, homeless individuals referred by community agencies, social service agencies, family or self-referrals, hospitals, and PCS. Included is the provision of an examination in accordance with s. 51.45 (11) (c), Stats.

Persons who exhibit homicidal or suicidal ideation due to substance abuse or substance abuse with mental illness are brought to PCS for assessment, evaluation, and treatment. This may include a history of recent homicidal or suicidal attempts, but does not require a one-on-one suicide watch. It is clear that for many persons the use of substances is a causal factor in the homicidal or suicidal ideation, and they do not have a mental illness that requires inpatient mental health treatment. Most often patients are brought in by law enforcement, either as an Emergency Detention or other police hold. Those patients who present a danger to themselves or others due to substance abuse or substance abuse with mental illness will be considered appropriate for medical detoxification.

ASAM Dimensional Criteria

The patient is evaluated as having a Risk Rating of 3 per the multidimensional risk matrix of the ASAM PPC-2R, which indicates the patient demonstrates poor ability to tolerate and cope with withdrawal discomfort. Severe signs and symptoms of intoxication indicate that the patient may pose an imminent danger to self or others. There are severe signs and symptoms, or risk of severe but manageable withdrawal. Additionally, many patients may have prolonged withdrawal signs and symptoms, or "protracted abstinence syndrome" that is exacerbating conditions in other Dimensions, particularly Dimensions 2 and 3. For example, the patient may have moderate to severe psychiatric decompensation (involving paranoia, compulsive behaviors, severe depression, and moderate psychotic symptoms such as hallucinations and delusions) upon discontinuation of drugs of abuse. Note that the patient's service needs should be considered in each ASAM Dimension. The interaction between Dimension 1 and other ASAM Dimensions may increase or decrease the overall level of severity or function.

In Dimension 2, the patient may have moderate to severe active and potentially destabilizing medical problems (e.g. either acute such as nausea and intermittent vomiting from gastritis, or chronic such as severe hypertension). The patient demonstrates poor ability to tolerate and cope with physical problems, and/or his or her general health condition is poor. Severe medical problems (such as severe pain requiring medication or brittle diabetes) are present but stable.

In Dimension 3, symptoms of a co-occurring psychiatric disorder are moderate to severe. The patient demonstrates frequent impulses to harm self or others that are potentially destabilizing, but the patient is not imminently dangerous in a 24-hour setting. The patient may also demonstrate uncontrolled behavior, confusion, or disorientation, which limit the patient's capacity for self-care. Recovery efforts are negatively affected by the patient's emotional, behavioral or cognitive problems in significant and distracting ways, up to and including inability to focus on recovery efforts. Acute course of illness dominates the clinical presentation so that symptoms may involve impaired reality testing, communication, thought

processes, judgment, or attention to personal hygiene. The patient has limited ability to follow through with treatment recommendations, thus demonstrating risk of and vulnerability to dangerous consequences.

If the patient's symptoms intensify to a Risk Rating of 4 after admission to medical detoxification, then the patient shall be transferred to an emergency room of a general hospital for medical treatment or to PCS for psychiatric treatment.

Clinical Programming

A range of cognitive, behavioral, medical, mental health and other therapies based on the patient's assessed needs in ASAM Dimensions 2 through 6 and documented in the individualized treatment plan are administered to the patient on an individual and group basis. These are designed to enhance the patient's understanding of addiction, the completion of the detoxification process and appropriate referral for continuing treatment. This should include clinical and didactic motivational enhancement strategies, health education services, and services to families and significant others. The application must demonstrate a person-centered planning process incorporating staged interventions consistent with the trans-theoretical model of change, and contain a schedule of individual and group sessions seven days a week.

Evaluation

In addition to the service evaluation elements required under HFS 75.03, applicant agencies must include treatment recidivism and retention in treatment in their evaluation plan. Also, each applicant agency must submit a completed Comorbidity Program Audit and Self-Survey (COMPASS™) (located at:
http://www.county.milwaukee.gov/ImageLibrary/Groups/Everyone/SAIL_AODA/COMPASS_BlackWhite.pdf),
and identify quality improvement project(s) that will be undertaken as a result of the audit tool. The contractor will be required to report on their identified project(s) in their biannual reports.

Community Based Residential Programs
Program # M011

Community Based Residential Programs (CBRF) or group homes provide services to persons having a serious and persistent mental illness with a living environment that: 1) provides the support necessary for an individual to live as independently as possible in a structured group residential setting; 2) continually promotes the acquisition of skills necessary for the consumer to transition to more independent living; and 3) actively pursues movement to a more independent living environment in conjunction with the consumer and other members of the consumer's support network.

While residing in the community based residential facility, consumers will actively participate in development of his/her individual service plan, goals, and means to achieve them. It is also expected that the community based residential facility staff and other members of the consumer's support network will offer the consumer the means to acquire or further develop the skills necessary to function more independently.

Services provided by CBRFs will include the provision of twenty-four hour supervision, the provision of meals and dietary management, individual counseling, support groups, medication education and monitoring, financial management (benefit advocacy and representative payee-ship), care coordination, and crisis prevention. These services will be provided by the community-based residential facility staff in conjunction with other members of the consumer's support network.

If a CBRF resident is assigned to a case management agency, the group home staff will collaborate with the case manager when developing the individual service plan. A copy of the case management agency treatment plan will be readily available to group home staff (in the consumer's CBRF record) and all treatment plans will identify agency/individual accountabilities. The CBRF staff will be responsible for a minimum of one contact with case manager, or assigned agency representative, per week to discuss issues related to consumer's treatment.

In addition to these services, CBRF providers will develop programming for a minimum of five groups, which will be made available to consumers. Staff will be trained to facilitate these groups and choice of groups will be determined by the needs of consumers residing in the individual agency's community-based residential facilities. Suggestions for groups would include, but are not limited to, life skills, anger management, dual diagnosis, spirituality, stress management, recovery, medication education/symptom management, leisure skills, and social skills.

Upon admission to the group home and at Individual Service Plan Evaluations, a set of discharge criteria must be established. It is important that this set of discharge criteria be specific as to the level of functioning the resident must obtain in order to live in a less restrictive setting in the community. This criterion needs to outline the steps that the individual must achieve in order for discharge to take place. Criterion must be individualized and measurable. This criterion must be established and maybe included in the individual service plan and reviewed at the same interval as this plan.

Community-Based Residential Program – Other Requirements

1. Enrollment into a community-based residential program is implemented through a referral from the Behavioral Health Division's Service Access to Independent Living (SAIL) Unit. The SAIL Unit will assess the need for community-based residential care and make referrals to contracted service provider. When a consumer is in an acute care setting, the residential provider agency will do a face-to-face assessment within 72 hours after receipt of the referral packet from SAIL.

2. All Behavioral Health Division contracted community-based residential facilities must be licensed by the State of Wisconsin under Wisconsin Administrative Code HFS 83.

3. Consumers residing in a community-based residential facility are subject to the ability to pay provisions of Wisconsin Administrative Code HFS 1, Uniform Fee System, which requires that consumers in a non-medical residential program are liable for the cost of their care based upon their ability to pay CBRF Program Requirements.

Crisis Services in the Community Based Residential Program

1. Staff capability, infrastructure, and financial resources to provide "Crisis Services", under HFS 34, "Emergency Mental Health Service Programs".
2. Plan and process for identification of persons who are experiencing a mental health crisis or are in a situation likely to turn into a mental health crisis if more intensive supportive services are not provided.
3. Submission of Prior Authorizations for the provision of Crisis services to individuals who are in need of crisis services residing in the Community Based Residential Program.
4. Plan for following billing guidelines as described in Wisconsin Medicaid Provider Handbook Part H, Division VI for "crisis intervention services".

Family Care and the Community Based Residential Program

All clients over 59 ½ years of age and older receiving residential services will be referred by the Community Based Residential Program (CBRF) to Family Care within 5 days business days of notification by the Behavioral Health Division, Community Services Branch. The CBRF will inform the Behavioral Health Division, Community Services Branch of the member's Family Care enrollment date within 5 days of acknowledgement from Family Care that the individual is enrolled. The CBRF will utilize the Family Care Referral Tracking Form to notify the Behavioral Health Division, Community Services Branch of the following:

- **Client's acceptance/refusal of family care screen,**
- **Reason for refusal of family care screen and/or services,**
- **Date of family care screen,**
- **Functional and financial eligibility,**
- **Client's acceptance/refusal of family care services,**
- **Family care enrollment date.**

For those individuals not found functionally and/or financially eligible for Family Care services, the clinical coordinator or designee will review these cases every six months to determine if there are any changes in the client's financial and/or functional capacity. Additionally, for those individuals who refuse to be screened by the Milwaukee County Department on Aging Resource Center or for those individuals who refuse Family Care services even though they were found eligible, their cases will be reviewed every six months and individuals will be encouraged to take advantage of the long term care support services available to them through Family Care.

CBRF Admission Policy

It is the policy of the BHD that individuals referred for CBRF placement by SAIL will have an evaluation completed and a decision regarding admission will be reported to SAIL (per HFS 83 Guidelines) within three business days of receipt of that referral.

CBRF Inpatient Contact and Collaboration Policy

It is the policy of the Behavioral Health Division that, when a CBRF resident is admitted to a psychiatric inpatient unit, the CBRF residential coordinator responsible for that client must contact the appropriate inpatient team within one business day of the admission in order to develop a plan of discharge. The CBRF residential coordinator and inpatient social worker will collaborate immediately to share information and identify interventions relevant to the course of treatment. When the CBRF staff meets with the resident/treatment team on the Behavioral Health Division Inpatient Unit, the Community Services Consultation Note will be completed regarding the contact. When completed, the Community Services Consultation Note will be given to the Behavioral Health Division Inpatient Unit Staff.

CBRF Service Utilization Policy

It is the policy of the Behavioral Health Division that CBRF's have a service utilization review process to identify consumers who might be candidates to transition to less restrictive residential settings in accordance with CBRF discharge criteria and HFS 83 standards and to effect those transitions when appropriate. This also involves participating in a Utilization Review Process in collaboration with Behavioral Health Division, Community Services Branch. CBRF 's that have consumers receiving case management services are to have a service utilization review process to identify goals of the CBRF placement, length of placement, and identify candidates to transition to less intensive models of housing when appropriate.

CBRF Static (Actual) Capacity

It is the policy of the Behavioral Health Division that CBRF's will include in the RFP application the actual number of client's to be served in each facility or location.

Unit of Service

One day of care in a community-based residential facility equals a unit of service.

Documentation

1. Resident case records maintained by the agency shall include daily attendance logs.
2. All case records must maintain the Individual Service Plan for each individual.
3. Participation in planned treatment groups must be documented within the client record and include the type of group and duration of time provided.
4. Individual Service Plans must be completed within 30 days of admission to the group home.
5. Client files must demonstrate coordination with the assigned case manager.

Crisis Respite Programs
Program # M011A

The Crisis Respite program provides services to persons having a serious and persistent mental illness with a living environment that: 1) provides the support necessary for an individual to live as independently as possible in a structured group residential setting; 2) continually promotes the acquisition of skills necessary for the consumer to transition to more independent living; and 3) actively pursues movement to a more independent living environment in conjunction with the consumer and other members of the consumer's support network. The Crisis Respite House is an alternative to psychiatric inpatient hospitalization, which expands the continuum of services, intervention, and support for individuals in crisis. Crisis Respite provides a less restrictive and more normal environment in which to treat and support persons in crisis.

While residing at Crisis Respite, the consumer will actively participate in development of his/her service plan, goals and means to achieve them. It is also expected that the community based residential facility (CBRF) staff and other members of the consumer's support network will offer the consumer the means to acquire or further develop the skills necessary to function more independently.

Services provided by Crisis Respite will include the provision of twenty-four hour supervision, the provision of meals and dietary management, individual counseling, medication education and monitoring, care coordination, and crisis prevention. These services will be provided by the community-based residential facility staff in conjunction with other members of the consumer's support network and the Behavioral Health Division's Mobile Crisis Team.

If a Crisis Respite resident is assigned to a case management agency, the community based residential facility (CBRF) staff will collaborate with the case manager when developing the individual service plan. A copy of the case management agency treatment plan will be readily available to group home staff (in the consumer's CBRF record) and all treatment plans will identify agency/individual accountabilities. The Crisis Respite staff or Behavioral Health Division Mobile Crisis Team will be responsible for a minimum of one contact with case manager, or assigned agency representative, per week to discuss issues related to consumer's treatment.

Upon admission to the group home and at Individual Service Plan Evaluations, a set of discharge criteria must be established. It is important that this set of discharge criteria be specific as to the level of functioning the resident must obtain in order to live in a less restrictive setting in the community. This criterion needs to outline the steps that the individual must achieve in order for discharge to take place. Criterion must be individualized and measurable. This criterion must be established and may be included in the individual service plan and reviewed at the same interval as this plan.

Crisis Respite Services – Other Requirements

Enrollment into Crisis Respite is implemented through a referral to the Behavioral Health Division's Mobile Crisis Team at 414-257-7222. The Mobile Crisis Team will assess the need for community-based residential care and make referrals to contracted service provider.

All Behavioral Health Division contracted community-based residential facilities must be licensed by the State of Wisconsin under Wisconsin Administrative Code HFS 83.

Consumers residing in a community-based residential facility are subject to the ability to pay provisions of Wisconsin Administrative Code HFS 1, Uniform Fee System, which requires that consumers in a non-medical residential program are liable for the cost of their care based upon their ability to pay CBRF Program Requirements.

Crisis Services in the Crisis Respite Program

Staff capability, infrastructure, and financial resources to provide "Crisis Services", under HFS 34, "Emergency Mental Health Service Programs".
Plan and process for identification of persons who are experiencing a mental health crisis, or are in a situation likely to turn into a mental health crisis, if more intensive supportive services are not provided.
Plan for following billing guidelines as described in Wisconsin Medicaid Provider Handbook Part H, Division VI for "crisis intervention services".

Unit of Service

One day of care in a community-based residential facility equals a unit of service.

Documentation

Resident case records maintained by the agency shall include daily attendance logs.
All case records must maintain the Individual Service Plan for each individual.
Individual Service Plans must be completed within 30 days of admission to the group home.

Client files must demonstrate coordination with the assigned case manager**.**

Other Cycle Programs
2009 Contract Year
Continuing Contractors Only (not open for competitive bid)

The following descriptions were originally published or amended for the listed programs in previous RFP years and are being reprinted for reference by the agencies currently under contract.

Cycle I

Community Living Support Services Program

PROTECTIVE PAYEE PROGRAM #M008

Protective payee programs provide services to individuals who have a primary mental illness and require assistance with financial management in order to live independently in the community. They do not require residential or case management services but may need representative payeeships, financial counseling, budget teaching and referral for any additional entitlement.

Protective payee programs are expected to work toward having consumers gradually assume more control over their own finances, with the goal of eventual independence in financial management, in keeping with the skills and abilities of the individuals. The program is also expected to document the anticipated outcomes and monitor progress toward those outcomes.

Access

Access to contracted payee ship services is achieved through referral from SAIL-Service Access to Independent Living. For agencies with existing caseloads, SAIL will use the referral process to fill cases lost to attrition or division.

Unit of Service

The unit of service for protective payee services is one-quarter hour of direct service time. Direct service time is staff time spent in providing service to the program participants, which includes face-to-face contacts (office or field), and time spent in documenting services. Not included in direct service time are staff meetings, in-services, etc. Direct service time also includes collateral contacts which are face-to-face or by phone. Collateral contacts are those individuals involved by virtue of their relationship to the program participant, i.e., family, physician, and other service providers.

Documentation

Service time must be documented through an entry in the case notes. All records for individuals served must be kept in a central file with documentation, which includes: date of contact, type of contact (face-to-face, phone, collateral, etc.) and length of contact. A case plan must include income, monthly budget and disbursements, anticipated outcomes and methods used to attain outcomes, as well as progress towards achievement of outcomes.

PSYCHOLOGICAL DROP IN CENTER #M009

Psychosocial clubs serve as points of soft entry for individuals experiencing severe and persistent mental illness. They are based on the concept of involvement and acceptance as a required component of engagement in broader community membership. Clubs are meant for individuals with severe and persistent mental illness living in the community and in need of social experiences and movement toward recovery.

Members of the club volunteer their time to participate in the planning and carrying out of club activities, which include: social/recreational groups, community outings, and travel/tour activities. While members are free to select elements of the offerings, they are encouraged to be an integral part of the planning and growth of meaningful activities, as well as providing mentorship for new members. The club also needs to contain some elements of prevocational activity, i.e., a job club, so that individuals have an opportunity for enhanced movement toward recovery.

In order to ensure that individuals experiencing severe and persistent mental illness are welcome within the club, and that adequate numbers of members are served, it is essential that outreach be done to programs serving that population, i.e., CSP and TCM. Vendors are encouraged to explore transportation options to make programs more accessible. They are also encouraged to have Board members who can assist with fund raising, legal issues and community support.

Target Population

The primary population to be considered for this program is persons with severe and persistent mental illness; in particular those referred by Behavioral Health Division providers.

Unit of Service

Vendors will be reimbursed for expenses up to 1/12(one-twelfth) of the annualized contract per month. The reimbursement will be for actual expenses or 1/12(one-twelfth) of the contract amount; whichever is lower, based upon a review of the vendor's monthly billing statement. The format of the billing statement will be determined by Behavioral Health Division and may include program, occupancy costs, equipment costs and other expenses found to be appropriate. The billing statement shall be submitted on a monthly basis.

Documentation

Financial records/ CPA audit, annual report of numbers of members served and sources of referrals.

PSYCHOLOGICAL REHABILITATION PROGRAM (CLUBHOUSE MODEL) #M010

The Clubhouse Psychosocial Rehabilitation Program is a model of psychiatric rehabilitation, which operates as a club with participants as members, rather than clients. Central to its philosophy is the belief that work is important for all people and that people experiencing mental illness, even severe illness, have potential to grow and develop and to make productive contributions to the community. Parallel to the importance of work, individuals have a need to have opportunities for socialization. The clubhouse provides a place for social interchange, relationships and social support in the evenings, on weekends and especially on holidays.

The clubhouse is to have significant representation of their membership on the Board. It is also expected that members will have full membership in the planning processes and all other operations of the club. Because entry to a club may be difficult for some potential members, it is important that there are other members available and able to mentor incoming members. It is also important to have a flexible entry process, allowing for individualized needs to be met.

While work is an essential part of the clubhouse model, prevocational and engagement efforts need to be available and tailored to the individual's needs. It is anticipated that with increased socialization opportunities, individual isolation will decrease, members will be more willing to consider the other opportunities the club has to offer and begin the journey toward recovery and full community membership.

Target Population

The primary population to be considered for this program is persons with severe and persistent mental illness; in particular those referred by Behavioral Health Division providers.

Unit of Service

The vendor will be reimbursed for expenses up to 1/12(one-twelfth) of the annualized contract per month. The reimbursement will be for the actual expenses of the 1/12(one-twelfth) or the contract amount; whichever is lower, based upon a review of the vendor's monthly billing statement. The format of the billing statement will be determined by the Behavioral Health Division and may include program staff, occupancy costs, equipment costs and other expenses found to be appropriate. The billing statement shall be submitted on a monthly basis.

Documentation

Required reports include Financial records/CPA audit, annual report of numbers of members served and sources of referrals.

Targeted Case Management Program (TCM) Program # M013 & #M014

Definition

Targeted case management is a modality of mental health practice which addresses the overall maintenance of a person with mental illness including his / her physical, psychological and social environment with the goal of facilitating physical survival, personal health, community participation and recovery from or adaptation to mental illness. Targeted case management puts primary emphasis on a therapeutic relationship and continuity of care.

Target population

Persons served by TCM services have Axis I and/or Axis II diagnoses without the severity or persistence that qualifies them for a CSP and yet have a disorder requiring more than outpatient or ambulatory therapy. The target population is at high risk for re-hospitalization or for drifting into the chronic young adult population and/ or often have concomitant substance abuse, developmental disorders, organic illness and homelessness. Persons who are served by the program must:

- Be a Milwaukee county resident;
- Be at least 18 years of age and if over the age of 60 have been screened for Family Care;
- Have an Axis I diagnosis with either psychotic or major affective disorder or an Axis II diagnosis in cluster A or B, based on DSM-IV;
- Have demonstrated functional limitation in the last six months in one or more of the following areas: housing, employment, medication management, court mandated mental health services, money management, or symptom escalation to the point of requiring emergency intervention or hospitalization; and
- Be screened and found eligible for services through a SAIL assessment.

Program levels

There are two levels of targeted case management services:

1. **Level I** (standard) TCM, **Program #M013**. Applicants are expected to provide outreach case management and must refer to the "Behavioral Health Division's Standards of Practice for Targeted Case Management (TCM)" for further information regarding TCM program requirements, e.g., admission timeliness, staff to client ratios, services to be provided, billing and staff professional requirements. The Standards of Practice are available at the BHD Service Access to Independent Living (SAIL) office, 9201 Watertown Plank Road, (414)-257-8095.

2. **Level II** (clinic-based) TCM, **Program #M014**. Applicants are expected to provide primary clinic-based mental health services to individuals who are not appropriate for primary

outreach case management services. Individuals served in this program will have a primary serious and persistent mental illness. Programs must meet the following requirements:

- Case managers will maintain a caseload of sixty (60) consumers;
- Case managers will practice with a team approach to assure adequate coverage, team collaboration and provider support;
- Services need to be available forty (40) hours per week with on-call coverage after regular hours; and
- All documentation must meet the requirement.

In addition to mental health services, the program will provide:

- Essential payee ship and money management services
- Linkage to other health and social services
- A minimum of four outreach (in-home) visits and eight face-to-face visits per year

Program Requirements

In the application, the first two sentences of the program description must clearly state:

- **the program's static capacity** (i.e. on any given day, the maximum number of people enrolled and receiving services through this contract)
- **the program's expansion plan, identified by the number of case managers**

Please include specifics in the narrative on how the following would be met:

Service Access

- SAIL referrals on individuals hospitalized on BHD inpatient units will have service initiated within 24, working, day hours.
- SAIL referrals on individuals in the community will have service initiated within 72, working day, hours unless otherwise indicated on the referral.
- In cases where there is difficulty accessing an individual the case manager will contact the SAIL Care Coordinator to develop strategies on how to meet and serve the consumer.
- Within 24, working day, hours of notification of a consumer admission to the BHD, the program is expected to contact the respective inpatient or Observation unit to collaborate on a discharge plan.
- Emergency on-call services 24/7/365.

Case Management No Contact Policy

- Programs are required to follow the protocol idenitifed in the "BHD Case Management No Contact Policy" developed and adopted in June 2007 in situations when a consumer misses an appointment or is unable to be reached. These practice guidelines incorporate clinical consultation, communication, client preference, and documentation and provide a

risk management framework and assessment procedure for case managers to utilize for the determination of the appropriate course of action.

Inpatient & Community Case Management Collaboration Standard of Practice

- Developed and adopted in 9/2005.
- Adherence to the standard that when a client is admitted to a psychiatric inpatient unit, the community provider/case manager must contact the appropriate inpatient treatment team within 24 hours of notification of the hospital admission in order to develop a plan of discharge.
- Case managers are to meet with hospital unit staff and the patient at a minimum of once per week, and more often when clinically indicated.
- Active collaboration with case managers and significant others by the hospital social worker in each patient's treatment and discharge planning ensures that all available information and expertise is considered to ensure the best patient outcome
- Community Services Consultation Notes due upon each contact. The original copy of form is to be given to the assigned unit social worker. If unavailable, form should be placed in the designated unit social worker's mailbox. The yellow copy of form should be maintained for inclusion in the client's file.
- Indication of the precipitating events/issues that have occurred with your client prior to this hospitalization should be included in the CSC Note.

Utilization Review

- Policy and process to identify clients who are candidates to transition to less intensive as well as more intensive models of service or support in accordance with TCM discharge criteria as established by SAIL and the TCM network.
- Policy and process for identifying and referring clients who turn 60 years of age to Family Care.

Quality Assurance and Quality Improvement

- Develop program performance indicators, how they will be measured, and a corresponding quality improvement plan.
- Submit these outcomes and quality improvement plan in two separate 6-month reports for the periods: January 1-June 30, 2009 and July 1-December, 2009. Reports will be due 6 weeks later on: August 14, 2009 and February 12, 2010, respectively.

Contract Management

- Programs are expected to maximize third party revenue, including billing for Crisis Case Management services.

Crisis Case Management

- Staff capability, infrastructure, and financial resources to provide "Crisis Case Management Services (CCM)", known as "Linkage and Coordination Services" under HFS 34, "Emergency Mental Health Service Programs".
- Plan and process for identification of persons who are experiencing a mental health crisis

or are in a situation likely to turn into a mental health crisis if more intensive supportive services are not provided.

- Submission of Prior Authorizations for the provision of CCM services to individuals who are in need of crisis services.
- Plan for following billing guidelines as described in Wisconsin Medicaid Provider Handbook Part H, Division VI for “crisis intervention services”.

Units of Service (UOS)

A unit of service is one quarter hour (1/4) of direct service time. Direct service is the time spent providing service to program participants, which includes: face-to-face contacts (office or community), collateral contacts telephone contacts, consumer staffing sessions, and time spent in service documentation. Direct service time does not include indirect time such as that spent in staff meetings, in-service training, etc.

Documentation

Files/records must be maintained on each consumer, kept in a secured central file/record area and include all written documentation:

- Comprehensive assessment
- Case plan and case plan reviews per clinical standards, collaboration and identification of those involved, including signature of the consumer.
- Integration between the assessment, treatment plan, service delivery and progress reporting
- Evidence of a strength assessment and strength based service approach
- Stated consumer preference(s)
- Evidence of recovery focused goals, treatment plan and service delivery
- Evidence that a method is in place to assure that all services submitted for payment have met corresponding requirements and are present in the chart.
- Case notes must be executed for all direct service provision and include: the name of the recipient, full name and title of the person who made the contact, date of the contact, the type of the contact (face to face, collateral, phone, etc.), the content of the contact, and the number of units (the length of contact).

Community Living Support Services
SHELTER PLUS CARE Program # M015

Definition

The Shelter Plus Care (S+C) Program is a U.S Department of Housing and Urban Development (HUD) initiative which funds housing agencies to provide rent subsidies for low income, homeless individuals with special needs. S+C regulations require that individuals receiving housing assistance under this program also receive appropriate support services which help them secure and maintain permanent housing. S+C enables homeless individuals to secure permanent housing of their choice accompanied by supportive services funded through other sources. Milwaukee County Behavioral Health Division is a S+C grant recipient and in cooperation with Milwaukee County Housing administers a S+C Tenant Based Program known as My Home. For S+C purposes special needs target populations are people living with severe mental illness, AODA, or HIV/AIDS.

The goal of the Milwaukee County S+C Program is to break the cycle of homelessness and to provide permanent housing for target populations. To accomplish this, Milwaukee County and various service providers make a long-term commitment to the coordination of housing benefits and support services. Several providers who are selected to be a partner in My Home must assess the special needs of the individual, prepare a service plan for the individual, provide case management for the individual, and assist the individual in fulfilling responsibilities in order to maintain permanent housing. Further, the service provider must provide long-term case management which addresses the changing needs of the individual and work closely with Milwaukee County Housing Division to ensure the individual is successful in housing.

To meet the goal of permanent housing, the homeless individual and Milwaukee County also make long-term commitments. The homeless individual agrees to participate in the housing program, work with a case manager (CM), fulfill all responsibilities, and comply with the service plan prepared in collaboration with the case manager. Milwaukee County agrees to determine the income eligibility of the individual, inspect the property, administer the housing subsidies, work closely with the case manager and client, and develop procedures which accommodate the case manager and the client.

Target Population

S+C exists to serve homeless individuals with disabilities that meet HUD guidelines and have been verified by an M.D. In some circumstances this may include families. The three disabilities specifically targeted by the S+C program are:

- Serious mental illness
- Chronic alcohol and/or other drug abuse
- AIDS or related diseases

Homelessness

The HUD definition for the S+C program specifically targets homeless persons who are either:

- sleeping in places not meant for human habitation, such as cars, parks, sidewalks, and abandoned or condemned buildings, or are sleeping in emergency shelters
- staying in transitional housing for homeless individuals

Access

Engagement of individuals is on the streets, in emergency shelters, and at meal programs. Once identified, either by referral or outreach, an attempt is made to engage the individuals in a relationship.

Program Standards

HUD requires that for each grant dollar expended for housing, a matching amount must be spent in providing support services for the client/tenant. This match requirement is on a per grant basis and necesitates a long-term commitment to the provision of support services. Additional requirements are:

- compliance with all Section 504, ADA, and Fair Housing Laws
- submission of Monthly Servce Match Reports, Outcome Reports, and any other report(s) that may be required for the administration of the S+C Program
- attendance at all meetings necessary for the ongoing administration of the S+C Program
- client meetings to address any tenancy deficiencies, preparation of client corrective action plans to support successful tenancy

Case Management Standards

The success of a client in the S+C Program is often dependent upon the quality of the CM. The level of CM services that are required at various times during the clients' participation in the S+C Program may vary and is at the discretion of the CM to make that determination and provision. CM is responsible for the following:

- Assessment – to assure that the client is homeless, has a target population diagnosis, is income eligible and ready for independent living with appropriate supports.
- Service Plan – to address each client's individual needs and should include a plan for assuring that the client is receiving appropriate services so that housing

is maintained.

- Role in Housing Process – to assist the client in every aspect of the housing process. May mean collecting the necessary information for the eligibility interview, working with the landlord, making sure necessary paperwork is returned to the Housing Division Office.
- Maintaining Housing - to be actively involved in assisting the client in fulfilling all of the housing responsibilites. There should be daily contact with the client until the case manager is certain that the client is stable and comfortable in housing, At a minimum, an in-home visit should occur once each week. Any issues that may arise should be addressed with a plan, i.e. housekeeping, neighbor relations, etc.
- Communications with the Landlord – CM should be in regualr contact with the landlord and be responsive to the landlord if contacted about a concern in a timely manner.
- Communications with the My Home Housing Office – if problems should arise that cannot be worked out with the landlord and client, the CM should contact the My Home Housing Representative to discuss and pursue resolution of the isssue.
- The Case Manager As Proxy – every CM must sign a Proxy form for the client, and is authorized and is expected to fulfill the housing responsibilities on the behalf of the client.
- Annual Recertification Process – approximately four months prior to the lease expiration, the My Home Housing Program will mail a notice to the CM and the client. It is the responsibility of the CM to assure that all responsibilities are taken care of.
- Case Manager as Emergency Contact Person – the name of the CM and the respective agency will be listed on the lease, and may be the first person contacted in the event of an emergency.

Capacity

In the application, the first sentence of the program description must clearly state the agency's static capacity (i.e. on any given day, the maximum number of people enrolled and receiving services through this contract).

Staff

Indicate the number of staff in F.T.E.s who will be serving clients in the S+C Program, and their respective roles.

Unit of Service

The unit of service is one-quarter hour of direct service time. Direct service time is staff time spent in providing service to the client, which includes face-to-face contacts (office or field), and time spent in documenting services. Not included in direct service time are staff meetings, in-services, etc. Direct service time also includes collateral contacts which are face-to-face or by phone. Collateral contacts are those individuals involved by virtue of their relationship to the program participant, i.e., family, physician, and other service providers.

Documentation

Files must be maintained on each client and should be kept in a central file. Files should include all written documentation, including the assessment, service plan, and case notes. A service plan must include income, monthly budget and disbursements, anticipated outcomes and methods used to attain outcomes, as well as progress towards achievement of outcomes**.** Case notes must include date of contact, type of contact (face-to-face, phone, collateral, etc.), length of contact and all support and services provided to the client that are reported on the monthly Service Match Report.

Intake and Assessment: Central Intake Unit (CIU)
Program #A005

PROGRAM DESCRIPTION: Central Intake Unit

Client Eligibility

The Central Intake Unit screens individuals to determine if they meet the eligibility criteria for BHD AODA services. Services can be provided to individuals who:

- Reside in Milwaukee County;
- Are at least 18 years of age (with the exception that pregnant females of any age are eligible);
- Meet diagnostic criteria for a substance dependence disorder;
- Are part of the target population; and
- Are screened and authorized for services by a BHD Central Intake Unit or BHD staff.

The Central Intake Unit staff also assists those individuals who did meet the eligibility criteria for BHD AODA paid services access other community treatment/services (Non-WIser Choice referral). Referral and light case management services can be provided to individuals who:

- Meet diagnostic criteria for a substance abuse disorder; and
- Are screened and may not be authorized for BHD paid services (see policy on limit of times clients may reenter the system).
- Are screened and may not be appropriate for BHD paid services.

Target Population

BHD is targeting two populations:

1) The General Population of Milwaukee County.

2) Criminal Justice Population:

- a) incarcerated individuals that are reentering the Milwaukee community from prison and
- b) persons on probation or parole supervision who are facing revocation proceedings and imprisonment, and who can be safely supervised in the community while benefiting from AODA treatment and recovery support services as an alternative to revocation, and.
- c) individuals considered for pre-charging diversion, deferred prosecution and deferred sentencing options; persons reentering the Milwaukee community from jail confinement; and those involved in the Milwaukee County felony drug court alternative to prison programs.
- d) other criminal justice populations as identified.

Definition of Central Intake Unit Services

1. Deliver Central Intake Unit services according to BHD policies and procedures and consistent with Federal and State confidentiality and patient rights laws and regulations.
2. Oversee the operation and provision of mobile capacity.
3. Provide services in strict adherence with ASI and ASAM training, level of Care Recommendations and Informed Choice as per BHD policies
4. Identify, secure (purchase or lease), furnish and equip the CIU site(s).
5. Provide intake/screening services for all individuals seeking County-funded AODA services. Annual volume is projected at approximately 2,500 intake/screenings per year.
6. For those clients not able to receive a WIser Choice comprehensive screen, conduct a non-WIser Choice screen to determine what needs may be able to be met on the client's behalf until such time that the client may receive a full WIser Choice comprehensive screen.
7. Conduct a computer-assisted interview in real time (expected to not exceed 2 hours per client) with each client to:
   a) provide an orientation about AODA system services;
   b) advise the client of the provisions of HFS 1, HFS 92, HFS 94, the federal Health Insurance Portability and Accountability Act (HIPAA), Confidentiality of Drug and Alcohol Patient Records (42 CFR Part 2) and rules related to county funding;
   c) determine eligibility for Milwaukee County funded AODA treatment, which includes a preliminary Temporary Assistance for Needy Families (TANF) screen;
   d) provide referral to other community resources if the client does not have a need for AODA services or is ineligible for Milwaukee County funding.
   e) if the client meets technical eligibility criteria, perform a comprehensive screening for AODA clinical and recovery support needs in order to determine:
      - if there is a need for AODA treatment and if so;
      - the most appropriate level of treatment; and
      - what other services may be needed to support recovery.
8. Enter client data into the BHD computerized information system in real time and update as necessary.
9. Assist each client, to make an informed choice of a BHD-approved provider for clinical treatment and recovery support coordination. Choice will be informed by data shared with the client from the comprehensive screening, as well as profiles of individual providers. Under the terms of the Milwaukee WIser Choice program the CIU must help each client choose from among two or more providers qualified to render each service needed by the client, among them at least one provider to which the client has no religious objection. If no provider is available, the CIU will follow BHD's wait list process.
10. Obtain the client's signature on the appropriate consent forms.
11. Schedule an appointment with the BHD-approved AODA treatment provider chosen by the client.
12. Connect the client with the selected recovery support coordination agency at

the time of screening, if so indicated per established criteria.

13. In the case of a client with emergent needs, work closely with the recovery support coordinator to assure that appropriate services are accessed immediately and/or contact the appropriate BHD staff to request authorized emergency services on behalf of the client.
14. For each identified service, enter a request via the computerized BHD information system for the issuance of a voucher to pay for the service. Upon confirmation from the provider that the client has presented for service, submit the request to BHD for approval.
15. Manage the CIU wait list according to BHD policies and procedures, and in collaboration with other identified CIU's, BHD and service providers.
16. Provide initial and ongoing training for CIU employees to include instruction on the administration of the ASI, ASAM and CIU clinical policies and procedures. **Describe in detail the agency capability and training plan for all new hires and existing employees (if applicable). This description must include how you will provide on-going clinical oversight and case sampling, documented supervision, quality assurance and fidelity.**
17. Attend all BHD-mandated related trainings and monthly provider operation's meetings.
18. Participate in the continuing development of policies and procedures for the operation of the CIU.
19. Develop and implement procedures that have been approved by Milwaukee County including:
    a. Emergency procedures for the conveyance of persons to emergency medical facilities when necessary;
    b. Management of belligerent and aggressive persons; and
    c. Procedures to implement BHD's Appeal Processes for both clients and treatment providers.
20. Receive data from the State-approved vendor for IDP assessments (expected volume of 1,100 per year) and enter it into BHD's information system. It is estimated that entry for each assessment will take approximately 15 minutes. (IMPACT only).

REQUIREMENTS OF THE CENTRAL INTAKE UNIT PROVIDER

Operations

1. Operations. Manage the operations of the Central Intake Unit according to BHD policies and procedures. Adherence to all BHD communications is expected as to assure consistent business processes across all sites.
2. All fixed- and mobile-site locations are to be on a bus line, and facilities must meet Americans with Disabilities Act (ADA) requirements. Each site must provide interview areas that assure privacy and confidentiality.
3. Mobile Capacity. In order to maximize system access for clients, the agency will have mobile capacity for conducting intake and screening at locations throughout Milwaukee. Through discussion with BHD, the agency will develop a plan to allocate mobile services to fixed-site locations convenient for clients. (IMPACT only)
4. Equipment. The CIU must have adequate TDD/TTY, phone system, fax

capability and computer equipment sufficient to meet the IT requirements, and laptop computer(s) to support mobile capacity.

5. Hours of Operation. In addition to normal, weekday hours of operation (e.g. 8:00 a.m. to 4:30 p.m.), the applicant will be required to have hours of operation that provide for access at least one evening a week and Saturday mornings. Mobile Capacity must be available during normal, weekday business hours. Intake services are available on a walk-in basis and by appointment when appropriate or identified by BHD staff. The applicant must include all expected CIU closings for the year (holidays, etc) and how they will inform the public of such closings.
6. Use of Best Practices for Comprehensive Screening. The CIU Operations Management Agencies will use instruments and processes approved by BHD for conducting the comprehensive screening. At this time, screening protocol includes the Addiction Severity Index (ASI) with Supplemental Items followed by application of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R); as well as the Clinical Institute Withdrawal Assessment (CIWA), and other identified instruments as needed upon BHD approval.
7. Staffing. The CIU agency will implement a staffing plan sufficient for conducting 3,200 intake/screenings annually for the hours of operation listed above. The Central Intake Unit's staff must reflect the cultural, ethnic, gender and linguistic characteristics of the community area it serves. A minimum of one staff must be English/Spanish bilingual, and as needed, provision must be made to communicate with Limited English Proficiency (LEP) clients. All CIU's must have means for communicating with Blind, Deaf and Deaf and Hard of Hearing clients.
8. Staff Qualifications.
    a. Persons conducting the comprehensive screening must possess:
        - a minimum of a Bachelor's degree in Social Work, Psychology, Nursing or a related human services field, and two years full-time work experience and demonstrated competencies in clinical interviewing, assessment and knowledge of substance use disorders;
        - alternatively, a minimum of a Certified Substance Abuse Counselor (CSAC) certification or equivalent from the Department of Regulation and Licensing with at least three years of experience as an AODA counselor and demonstrated competencies in clinical interviewing, assessment and knowledge of substance use disorders;
        - in addition to the demonstrated competencies for substance use disorders, knowledge and experience of mental health disorders is preferred.
        1. The clinical ability to effectively administer and interpret instruments used in the comprehensive screening; and
        2. Sufficient computer skills to administer the computer-assisted interview and to enter data into the BHD information system.
    b. At least one staff person, in a supervisory position, must be a licensed Master's level behavioral health professional with a degree in Social Work, Psychology, Nursing or other human service profession with experience and demonstrated competencies in clinical interviewing and assessment and

knowledge of substance use disorders (knowledge and experience of mental health disorders is preferred). **For this position, describe in detail the capability and plan for the provision of direct supervision of screeners during normal business hours.** The CIU Supervisor must be available on-site for the support and direction of the CIU staff, and available to BHD staff as needed.

9. Client Choice. Under the terms of the Access to Recovery program, SAMHSA requires that clients be ensured "genuine, free and independent choice" of provider for all clinical treatment and recovery support services. For the purposes of the Access to Recovery program, choice is defined as "a client being able to choose from among two or more providers qualified to render the services needed by the client, among them at least one provider to which the client has no religious objection." The CIU Operations Management Agency and its staff must implement practices to assure that clients have informed choice. CIU staff must take all measures to assure that the assistance they provide clients in the selection process is based entirely on the client's reported needs and preferences, rather than on any bias in favor of or against any particular provider. Acceptance of any form of compensation, monetary or other, in return for steering a client toward choosing a particular provider is prohibited.
10. Confidentiality. The CIU agency and its staff must have a thorough understanding of and policies/procedures to comply with Wisconsin patient rights (Wisconsin Administrative Code HFS 94) and confidentiality regulations (HFS 92); the Code of Federal Regulations, 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records; and the Privacy and Security Rules of the federal Health Insurance Portability and Accountability Act (HIPAA).
11. WIser Choice Operations Meetings/Training: actively participate in monthly CIU Supervisor operations meeting facilitated by BHD. Actively participate and represent the CIU during regularly scheduled Outpatient/Day treatment and Residential treatment providers operations meetings, ongoing training for existing and new staff on ASAM PPC 2R, attendance at all BHD facilitated CIU Screening in-services, and other meetings as identified.
12. Quality Assurance and Quality Improvement. Develop program performance indicators, how they will be measured and a corresponding quality improvement plan. Submit these outcomes and quality improvement plan in 2 separate 6-month reports for the periods January 1 – June 30, 2009 and July 1 – December 31, 2009. Reports will be due 6 weeks later on August 14, 2009 and February 12, 2009 respectively.
13. Reporting Requirements:
    Quarterly reports must be submitted documenting training and in-services held with staff, non-WIser Choice screens completed,
    - January 15 (quarterly and end-of-year report)
    - April 15
    - July 15
    - October 15

CYCLE II

Service Access and Prevention - AODA
Program #A001

Two programs will be funded in this area.

This program area consists of a variety of services designed to increase the community's understanding of substance abuse issues, prevention, and intervention strategies. Applicants applying for this program must meet the requirements of HFS 75.04 (see Program Definitions).

1) A program will be funded that has an emphasis in the Category of "Selective Measures" with a primary focus on adolescents.

The program will solicit vendors to plan and implement prevention programs that build on the public health framework and understand the relationship between substance abuse problems, the individual, and the environment.

The proposed programs will incorporate researched prevention strategies in their program and design. The programs will fund projects that clearly target the juvenile population relative to AODA prevention and specific interventions.

- **Primary Interventions** should target general population groups, mass media, school-based health curriculum, without reference to those at particular risk. All members of a community, not just specific individuals or groups within a community, benefits from a universal prevention effort.

- **Selective Interventions** should target those who are at greater-than-average risk for substance use, mentoring programs aimed at children with school performance or behavioral problems. Targeted individuals are identified on the basis of the nature and number of risk factors of substance use to which they may be exposed.

- **Other Selective Interventions** should be focused on juveniles who may already display signs of substance use or alcohol abuse. The other selective interventions should be designed to prevent the onset of regular or heavy substance use via utilizing parenting programs and other interventions.

Services proposed, including methods for measuring outcomes, must meet the requirements of HFS 75.04 (1) – (5).

The second program funded must have an extensive history working with HIV prevention, care, treatment and research programs.

2) A second program will be funded that has a focus in the Category of "Indicated Measures," with an identified "high-risk group that require assistance in accessing the appropriate AODA treatment or service.

The program must be able to provide service to thousands of people with HIV/AIDS and conduct thousands of prevention contacts.

Care and Treatment Programs:

- Medical Care – Operate outpatient HIV medical clinics led by Board Certified Infectious Disease physicians and health care professionals. The medical clinics must be able to serve hundreds of HIV positive patients.

- Dental Care – Operate HIV-dedicated dental clinic, led by dentists and dental professionals who provide comprehensive care to hundreds of patients.

- Mental Health Therapy – Operate a mental health clinic, led by therapists who provide counseling and psychotherapy to consumers.

- Social Work Case Management – Case management program must serve hundreds of HIV/AIDS clients through a statewide team of social workers.

- Housing – Provide residential housing, rent assistance, and housing counseling. Provide housing counseling service to hundreds of clients and rent subsidy and utility assistance and resources to HIV clients across Wisconsin.

- Legal Assistance – The legal program should be led by attorneys who can provide legal representation and consultation for hundreds of clients.

- Food Service - Assist with food program that includes pantries and voucher services to assure access to nutritional foods and provide HIV-positive clients and their households with food services.

- Transportation Assistance – Provide transportation assistance to people living with HIV and AIDS in the form of bus tickets, bus passes, and gift cards.

HIV Prevention Programs:

- Clean Needle Exchange for injection drug users (IDUs) – Operate a clean needle exchange program in seven communities statewide – Madison and Beloit in the southern region, Milwaukee, Kenosha and Racine in the southeast region, Appleton and Green Bay in the northeast region, and Wausau in the northern region, - serving thousands of injection drug users and exchanging thousands of needles.
- Provide prevention outreach, individual and group interventions for these populations

at high risk for HIV.

- Alcohol and Drug Treatment –Operate a state-licensed alcohol and drug treatment program utilizing a harm reduction model.

This program area should be able to assist hundreds of people at any given time throughout the year.

CYCLE II

Service Access and Prevention – Mental Health
Program #M001

This program consists of a variety of services designed to increase the community's awareness and understanding of chronic mental illness, and to provide information on what resources are available to assist and support individuals and families. There are four main service areas.

Advocacy Program # M001-A

These are services designed to assist individuals and their families obtain or maintain access to appropriate community resources.

Information and Referral Services Program # M001-IR

These are services designed to assist individuals and their families in obtaining information and linking them with appropriate public and private resources.

Prevention Services Program # M001-P

These are services designed to provide information, education and training to individuals, their families, and the general public in regard to the causes of disabling conditions, and the means to prevent or ameliorate their causes.

Intake & Assessment Services Program # M001-IA

These are services designed to screen and assess individuals for mental health problems, to make treatment recommendations, and to provide short-term counseling interventions

Outpatient Treatment Program Program #M002

Introduction

It is the intent of the Behavioral Health Division to modify the provision of mental health outpatient treatment services to include substance abuse treatment services to persons presenting with a serious and persistent mental illness and a co-occurring substance use disorder.

The development of integrated services is an expectation of outpatient providers. The development of Co-Occurring Disorder (COD) capacity among outpatient as well as among other "level of care" providers will occur through a collaborative approach emphasizing "Best Practices" within the field. It is our expectation that outpatient providers will engage with BHD in the development of COD capacity shortly after initiation of a purchase of service contract.

Statement of Need

Research has confirmed that people with co-occurring substance use and mental health disorders are a large, significantly under served population. They have multiple service needs that cut across a variety of service systems, making it difficult to navigate the systems due to impaired functioning and/or cognitive limitations, as well as potentially receiving duplicative services from different systems due to lack of coordination. While there are ample studies supporting the efficacy of integrated treatment for individuals with co-occurring disorders, separate service systems have been unable to meet their needs.

Individuals with co-occurring psychiatric and substance use disorders are increasingly recognized as a population that is highly prevalent in both addiction and mental health service systems, and associated with poor outcomes and higher costs in multiple domains. In addition, they have long been recognized to be "system misfits" in systems of care that have been designed to treat one disorder only or only one disorder at a time**.**

Currently our vision is that all programs and clinicians will develop core capability, within the context of their existing program design, to more effectively service individuals with co-occurring needs by providing appropriately matched interventions and using established best practices for these populations. This RFP for mental health outpatient services represents the first step in implementing a COD service delivery system.

Core COD Values

According to SAMHSA, there are six guiding principles that serve as fundamental building blocks for programs in treating clients with COD, and they are equally applicable to both mental health and substance abuse agencies:

1. Employ a recovery perspective.
    a) Develop a treatment plan that provides for continuity of care over time.
    b) Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process.
2. Adopt a multi-problem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.

5. Plan for the client's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.
    a) Building community
    b) Reintegration with family and community

QUALIFICATION FOR RESPONDENTS:

- Current mental health (MH) Certification under Wisconsin Administrative Code, HFS 61.91, Outpatient Psychotherapy Clinic Standards
- Current substance abuse (SA) certification under HFS 75.13 Outpatient Treatment Service.

Eligibility Standards of Consumers

- Milwaukee County Resident
- Age 18 or older
- Without current insurance benefits for mental health outpatient services (BHD is the payor of last resort)
- Meets financial payment obligations as determined by HFS 1
- Meets criteria for a DSM IV mental health diagnosis

Target Population

Within this list, the provider must have the capacity to prioritize access to individuals who have the greatest level of urgency**.**

- Individuals identified in the BHD Crisis Walk-In Center (CWIC) who are in crisis, are highly likely to have COD, in various stages of change for SA and MH, and are uninsured.
- Individuals, as above, in other BHD acute inpatient or crisis services, who meet similar characteristics.
- These are individuals who need varying levels of service. Individuals in need of adult mental health outpatient have an array of diagnoses including the majority of individuals experiencing affective disorders such as major depression, bipolar disorder, and some situational depressions. The remaining individuals are persons who experience major thought disorders such as schizophrenia. It is estimated that sixty to eighty percent of individuals served in MH outpatient have an accompanying substance use disorder.
- It has been the BHD's past experience that the utilization of adult mental health outpatient services is primarily as follows: medication management only, medication management along with individual and or group therapy and those receiving therapy only. Research demonstrates that therapy, in addition to medication prescription and management is an important adjunct in the treatment of many persons having a serious and persistent mental illness or co-occurring disorder, and is associated with improved outcomes.

Required Service Array

The goal is to develop a flexible array of MH services, designed for a cohort of clients who have a high prevalence of co-morbidity, and who are not necessarily motivated to change. Creative approaches to engaging peer support services for MH and/or SA are welcomed. The services involve:

1. Engagement in continuing care, with empathic, hopeful, integrated relationships,

including some outreach capacity for consumers referred from BHD crisis or inpatient care.

2. Screening, assessment and diagnostic evaluation, with capacity to provide data for both mental health and substance use.
3. Access to a clinical TEAM that shares responsibility for a cohort of consumers.
4. Situational (office-based) case management model.
5. Individual and group counseling for MH and/or SA needs, including motivational interviewing, as indicated.
6. Ensure recovery-oriented principles are incorporated into all aspects care.
7. Psychological evaluation and assessment when indicated.
8. Psychopharmacologic assessment and treatment, including clozapine and injections, and provision of access to medications for uninsured clients. Flexible group and team strategies to provide medication services and to reduce no shows are strongly encouraged.
    a. Use of County-contracted or 501(b) pharmacy for all medications.
    b. Developing Patient Assistance Program capacity for meds.
9. Laboratory services, licensed and accessible, either provided or contracted.
10. Assistance with benefit/insurance acquisition in partnership with the County.
11. Appointments within 2 weeks for persons referred by BHD inpatient units, and within 30 days for persons referred by CWIC or for qualified persons seeking services directly from the community and authorized by BHD.
12. Scheduled “walk-in” times for enrolled service recipients who have missed their scheduled appointment(s).
13. Emergency “on-call” services 24/7/365 (note that on-call services are not defined as the BHD crisis line or 911).

Program Description Requirements

In the application, the first sentence of the program description must clearly state the agencies’ static capacity (i.e. on any given day, the maximum number of people enrolled and receiving services through this contract). The following items also need to be addressed in the application. Applicants are encouraged to use creativity in responding to this request.

1. Describe in detail how you will provide each of the required clinical services.
2. How will the program employ a team (i.e. multi-disciplinary) concept and collaborative approach to provide the required services using best practices and incorporating the core COD values in all aspects of treatment?
3. Identify the make-up of the team and functions of the team.
4. How will you collaborate with other providers, including primary health care and BHD?
5. How will the program integrate the principles of recovery into the provision of outpatient treatment and how will the provider partner with the consumer in the attainment of recovery?
6. Explain in detail your quality assurance plan, including clinical supervision.
7. How would you facilitate the idea that clients would be maintained in an integrated relationship once they are engaged in MH OP care, so that receiving the SA services at another separate parallel site are not encouraged.
8. Describe how you will transition clients who acquire benefits so that there is no gap in services.
9. Identify which Medicaid HMOs you are affiliated with and your ability to maintain a Medicaid caseload.

Applicants must include in their budget proposal the cost for all pharmacy services, including medications. Medications and pharmacy costs cannot exceed the BHD-contracted pharmacy rates of Roeschen's Pharmacy.

Information Management and Payment
The contractor is required to input accurate and timely information on patient demographics, episode and service data. This information supports all state and county reporting requirements related to performance monitoring, service reporting, service payment. The program will be paid on the lesser of net expenses or net units earned, and this is determined by the number of units of service that have been calculated by the system based on the episode information.

Evaluation
Each applicant agency must submit an Integrated Dual Disorders Treatment (IDDT) Fidelity Scale Score Sheet within the evaluation section of the application (located at: http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTFidelityScaleAJ1_04.pdf) , and identify quality improvement project(s) that will be undertaken as a result of the IDDT Fidelity Score. The contractor will be required to report on their identified project(s) in their biannual reports.

Additionally, each applicant agency is required to submit a quality improvement plan addressing how they will ensure appointments are available within 2 weeks for persons referred by BHD inpatient units, and within 30 days for persons referred by CWIC. Progress on their quality improvement plan will be communicated during outpatient operations meetings held at BHD every other month.

Memorandum of Understanding
Due to the direct interrelationship between the contracted agency and the Behavioral Health Division, a Memorandum of Understanding (MOU) will be developed. The purpose of the MOU will be to clearly define roles and responsibilities for each party. Issues to be addressed in the MOU will include: clinical and treatment expectations, referrals from BHD to the contracted provider and contract monitoring.

CYCLE II

Community Support Program (CSP)
Program # M012

General Proposal Requirements

Definition

This program represents the most comprehensive and intensive community treatment service model. A Community Support Program or "CSP" is a coordinated care and treatment program that provides a comprehensive range of treatment, rehabilitation and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement individualized participant centered treatment, rehabilitation and support service in the community where participants live, work, and socialize. Treatment and rehabilitation services are individually tailored with each participant through relationship building, individualized assessment and planning, and active involvement with participants to achieve individual goals, to better manage symptoms, to maintain hope and optimism, and to live and work in community settings of their choice.

Target Population

- Be a Milwaukee County resident;
- Be at least 18 years of age and under the age of 60;
- If over the age of 60, client can receive CSP services paid through the Department on Aging -Family Care
- Meet the diagnostic and functional criteria outlined in Wisconsin Administrative Code HFS 63;

Program Requirements

CSP Admission Policy

- It is the policy of the BHD that individuals hospitalized on psychiatric inpatient units and referred to a CSP by SAIL will be admitted (per HFS 63 guidelines) to that CSP within three business days of receipt of that referral.
- If the individual is in the community, the CSP will admit individual within seven business days of receipt of that referral.

CSP Inpatient Contact Policy

- It is the policy of the BHD that, when a CSP client is admitted to a psychiatric inpatient unit, the CSP which serves that client must contact the appropriate inpatient treatment team within 24 hours of notification of the admision in order to develop a plan of discharge.

CSP Service Utilization Policy

- It is the policy of the BHD that Community Support Programs have a service utilization review process to identify consumers who might be candidates to transition to less intensive models of community support and in accordance with CSP discharge criteria and HFS 63 standards to effect those transitions when appropriate.
- Community Support Programs to include a policy and process for identifying and referring individuals who turn 60 years of age to Family Care.
- Community Support Programs that have CSP consumers also residing in a CBRF are to have a service utilization review process to identify goals of the CBRF placement, length of placement and identify candidates to transition to less intensive models of housing when appropriate.

Case Management No Contact Policy

- It is the policy of the BHD that Community Support Programs utilize a risk management framework and assessment procedure in the event a consumer misses an appointment or is unable to be reached, as to assess and determine the appropriate course of action.
- These case management practice guidelines are to incorporate clinical consultation, communication, client preference and documentation as required elements.

CSP Family Care Utilization Policy

- All clients over 59 ½ years of age and older receiving case management services will be referred to family care within 5 business days of notification by the Community Services Branch (CSB).
- The CSP will inform the CSB of member's enrollment within 5 business days of acknowledgement from Family Care that the individual is enrolled.
- The CSP will utilize the *Family Care Referral Tracking Form* to notify the CSB of the following: client's acceptance/refusal of family care screen, reason for refusal of family care screen and/or services, date of family care screen, functional and financial eligibility, client's acceptance/refusal of family care services, and family care enrollment date.
- For those individuals not found functionally and/or financially eligible for family care services, the clinical coordinator or designee will review these cases every six months to determine if there are any changes in the client's financial and/or functional capacity.
- For those individuals who decline to be screened by the resource center or for those individuals who decline family care services even though they were found eligible, their cases will be reviewed every six months. Individuals will be encouraged to take advantage of the long term care support services offered.
- The CSP will notify family care (Care Management Unit -CMU) of any status change such as contact information, discharge, and etc. in a timely fashion.
- If the individual being referred to family care does not currently have Medicaid benefits, the CSP will actively assist the individual in applying for benefits, follow-up with the application process, and submit updates to the field office.
- Family Care will develop a mechanism to notify both the CSB and the CSP of the client's enrollment date, functional/financial eligibility and ineligibility, disenrollment, team staffing, and/or any status change in a timely fashion.

Inpatient & Community Case Management Collaboration Standard of Practice

- It is the policy of BHD-CSB that the case manager is responsible for maintaining a clinical treatment relationship with their client on a continuing basis whether the client is in the hospital, in the community, or involved with other agencies.
- The case manager is responsible for collaborating in the discharge planning process with the inpatient treatment team. Timely collabortion and quality information sharing among all professionals ensures care continuity and is good practice. Case managers are to meet with hospital unit staff and the patient at a minimum of once per week, and more often when clinically indicated.
- The case manager will collaborate with the inpatient social worker to assist in identifying interventions relevant to the course of treatment, ensure a well developed discharge plan and transition back into the community.
- When meeting with the client/team on the unit, the case manager will complete the *Community Services Consultation Note.*

CSP Crisis Respite Collaboration Policy

- When a client is placed at the Crisis Respite House, the case manager will collaborate with the crisis service clinician to strategize a well developed discharge plan and transition back into the community, this will include, but not limited to, establishing appropriate and safe community housing.
- While a client is at the Crisis Respite House, the case manager are to meet with crisis service clinicians and the patient at a minimum of once per week, and more often when clinically indicated.
- When meeting with the client at the crisis respite house, the case manager will complete the *Community Services Consultation Note.*

Experience and Qualifications of the Organization

Within each proposal, relative to experience and qualifications of the organization:

a. Explain how the delivery of CSP services relates to the mission of the organization and commitment to providing this type of comprehensive community based services

b. Describe the organization's experience and capabilities in providing Community Support Programs within a state certified CSP as defined in HFS 63, Wisconsin Administrative Code. Emphasize experiences in providing core psychiatric services as provided by an interdisciplinary team including assessment and the provision of comprehensive community based services in keeping with HFS 63 specifications

c. Describe how HFS 63 and C.S.P. Medicaid billing requirements will be met and maintained.

Program Content and Methodology

In the application, the first sentence of the program description must clearly state the agencies' static capacity (i.e. on any given day, the maximum number of people enrolled and receiving services through this contract).

Within each proposal, relative to treatment methodology:

a. Describe throughout the treatment program narrative how HFS 63, HFS 94, Medicaid billing and HIPAA standards will be met in the development, implementation, evaluation and monitoring of the provision of C.S.P. services.

b. Describe how comprehensive assessment and treatment of all psychiatric needs, including primary and secondary diagnoses will be implemented.

c. Describe how the program will work collaboratively with the participants toward the goals of achieving greater levels of independence through a better understanding of and self management of the symptoms, increasing problem solving abilities, expanding the use of natural supports, and supporting wellness activities.

c. Describe the composition of the proposed treatment team, the respective roles they will be performing, how teaming will occur, amount of psychiatric time available to serve participants, and the case management staff to participant ratio.

d. Describe how the participants symptom status and psychotropic medications will be monitored along with the ability to provide higher level of responses as needed in a timely manner. Include a discussion as to how advance directives and crisis planning in keeping with the participants' preferences could be implemented.

e. Explain how crisis responses will occur during regular working hours, after hours, and weekends.

f. Describe how the inclusion of comprehensive treatment of individuals with cooccurring mental illness and substance abuse disorders will occur.

g. In conjunction with the participant, explain how active collaboration will occur as needed with all other essential providers outside of the CSP, such as with primary health (including dental care whenever possible); inpatient, nursing home, and correctional settings; supervised living; psychotherapy; work services; etc.

h. Explain how productive and meaningful roles such as paid and volunteer work, supported education, parenting and parenting assistance, and other fulfilling activities will be facilitated in keeping with the desires, skills, and abilities of the participants.

i. Describe how assistance will be provided to participants in housing, social relationships, and activities of daily living, leading towards a greater sense of personal well being and community inclusion.

j. Describe how participants residing in supervised living arrangements will receive assistance leading towards more independent living.

k. Specify how recovery and the incorporation of recovery principles in all treatment services will be implemented. Address the following areas:

(1) Developing and implementing consumer centered treatment plans with full

Participants' involvement and input throughout the process including the participants' signing the plan.

(2) Having participants and family members involved on committees and boards, paying for their involvement as appropriate, and providing the training and mentoring to facilitate more fully their participation in these roles.

(3) Inclusion of participants' families as valued, respected, and integral parts of the overall treatment in accordance with desires of the participants.

(4) Helping to foster personal recovery for each participant by providing messages of hope and inspiration, affording choices, and understanding the importance of personal responsibility and accountability throughout the treatment process.

(5) Developing peer and natural supports with family members and significant others.

(6) Assuring participants involvement in program evaluation that includes satisfaction and participant outcomes.

(7) Working in conjunction with participants to reduce stigma in all of the forms it is manifested.

(8) Providing education and training to enhance participation in these various capacities and roles.

(9) Hiring participants as providers.

l. Project how much staff time will be spent in face-to-face clinical contact in the community.

m. Describe how accommodations will be made to work with people who are deaf or hard of hearing in keeping with their special developmental and communication needs.

n. Describe how the delivery of culturally competent services will be provided.

Quality Assurance and Quality Improvement

Within each proposal, applicants will be required to:

a. Explain how the organization will provide leadership and will monitor the program's day to day operation providing sufficient staff, training and clinical expertise, and participant and family support.

b. Describe the organization's performance indicators for this program and how they will be evaluated.

c. Describe how consumer and family satisfaction with the program will be evaluated.

d. Explain what experience the bidder can demonstrate in providing an effective quality assurance and improvement program.

e. Describe the areas to be addressed in an ongoing quality improvement plan.

Mandatory Requirements

The following general requirements are mandatory and must be complied with.

a. HFS 63, Wisconsin Administrative Code
b. HFS 94 (Patients Rights), Wisconsin Administrative Code
c. Wisconsin Medical Assistance Provider Handbook, Mental Health and Alcohol and Other Drug Abuse Services Handbook, Part H, Division II
d. Health Insurance Portability and Accountability Act of 1996 (HIPAA), privacy rule 45 CFR Parts 160 and 164.
e. Be able to achieve CSP certification in keeping with HFS 63 and in a timely manner.

Unit of Service

A unit of service is one-quarter (1/4) hour of direct service time. Direct service is the time spent providing services to consumers, which include face-to-face contact (office or community) collateral contacts, telephone contacts, consumer staffing, and time spent in service documentation. Direct service time does not include indirect time such as that spent in staff meeting, in-service training, etc.

Documentation

The agency must collect information required for the BHD data reporting structures. The information required related to demographics, episode of care, State's Human Service Reporting System (HSRS), and service information. See File Layout For Contract Agency Interface**.**

Assessments and treatment plans must be present in the case record maintained by the agency.

Services must be documented through an entry in the case record. The documentation must include:
(a) date of service;
(b) type of service;
(c) length of service contact;
(d) who the service contact was with;
(e) location of service; and
(f) description of the contact.

CYCLE II

WIserChoice Provider Resource Center Program # M016

PROGRAM DESCRIPTION:

The resource center is devoted to the capacity-building needs of faith and grassroots community based organizations interested in joining the provider network and to support those providers who are already in the provider network. The WIser Choice Provider Resource Center will continue to support current and potentially new WIser Choice providers by providing TA on such topics as Payroll and Taxes, developing Business Plans, Marketing Your Business, board development, collaboration and partnership, etc. The focus is to not only improve the clinical/programmatic skills of the WIser Choice providers, but to develop their organizational capacity with regard to such areas as board governance, policies and procedures, diversifying funding streams, community collaboration and the marketing of their services to the community. The provider resource center is required to be centrally located and easily accessible to accommodate meetings, trainings, client engagement activities, resource fairs/networking opportunities, technical support, and operate a community-based resource center.

REQUIREMENTS/SERVICES OF THE WISER CHOICE PROVIDER RESOURCE CENTER PROVIDER:

1. Identify, secure (purchase or lease), furnish and equip the appropriate site keeping in mind that a central location is essential to meet the multi purpose needs and services provided on behalf of the Provider Resource Center.
2. The Resource Center should be on a bus line, and facilities must meet Americans with Disabilities Act (ADA) requirements.
3. Manage the day-to-day operations of the Provider Resource Center, to include the maintenance and upkeep of the site and all equipment.
4. Organize and facilitate the use of the Provider Resource Center, working closely with BHD staff to report over utilization, under utilization, etc.
5. Develop and maintain a resource library, which includes community-based agencies, and the services they provide in order to support providers and/or any clients that may enter the resource center off the street.
6. Conduct quarterly needs assessment surveys for training topics to support the training needs of providers and their staff. Work with BHD staff to identify participants, trainers and other resources that may be needed.
7. Work with BHD staff to develop and market planned activities/events for contract year.
8. Coordinate and implement BHD and CSAT sponsored TA and training activities.
9. Work with providers to help develop and produce marketing materials for their agency for the use of marketing their services to WIser Choice clients and other network providers (i.e. CIU staff and RSC staff).
10. Work collaboratively with BHD staff to report concerns and/or issues that are brought to the attention of resource center staff that relate to the operations of

WIser Choice and work to create solutions.

11. The WIser Choice Provider Resource Center must have adequate TDD/TTY, phone system, fax capability and computer equipment sufficient to meet the IT requirements of CMHC, BHD's information management system.
12. The WIser Choice Provider Resource Center will be adequately staffed to ensure that all aspects of the application can be successfully fulfilled. Provisions must be made to communicate with Limited English Proficiency (LEP) clients. The resource center must also have means for communicating with vision impaired and with Deaf, Deaf/Blind and Hard of Hearing clients.
13. Staff responsible for the day-to-day operations must actively participate in WIser Choice providers meetings to get a sense of the needs and issues of providers in order to tailor services provided at the resource center and/or the identification of TA opportunities and topics. Facilitate the WIser Choice Recovery Support Service providers operations meetings on a bi-monthly basis, in collaboration with BHD staff.
14. Develop program performance indicators, how they will be measured and a corresponding quality improvement plan. Submit these outcomes and quality improvement plan in 2 separate 6-month reports for the periods January 1 – June 30, 2009 and July 1 – December 31, 2009. Reports will be due 6 weeks later on August 14, 2009 and February 12, 2009 respectively.
15. Monthly reports must be submitted documenting training and in-services provided and identification of those in attendance, as well as other activities provided to providers and the use of the WIser Choice Resource Center. Monthly reports should also include outreach efforts that have been made on behalf of engaging providers in the WIser Choice treatment system.

CYCLE II

Training (Mental Health and WIser Choice Provider networks)
Program # M017

The target audience will be comprised of staff from the Community Services Branch provider networks (mental health, WIser Choice), to include such service areas as clinical services, targeted case management, community support programs, community based residential providers, psychosocial organizations, peer support specialists, advocacy organizations, recovery support coordination and central intake unit staff.

Program Description

This program component fulfills various training needs for the Community Services Branch/Service Access for Independent Living (SAIL) and its respective provider networks.

1. Training may be a requirement of a funding source, such as the Division of Mental Health and Substance Abuse Services' (DMHSAS) funding for alcohol and other drug abuse (AODA) treatment, care coordination, and recovery services for Temporary Assistance for Needy Families (TANF) eligible families. The TANF grant specific training requirements include trauma identification and resolution, and screening for fetal alcohol spectrum disorders (FASD).

2. Training may be required of existing providers as well as those who enter into a Purchase of Service Contract/Agreement with BHD. The *'Basics of Community Treatment'* (BCT) is designed for case management providers in the Community Services Branch network, as well as groupings of WIser Choice providers. These training sessions may include, but are not limited to:

    - Overview of MCBHD Community Services Branch
    - Recovery Philosophy
    - Case Management and Recovery Support Coordination
    - Mental Health Disorders
    - Alcohol & Drug Addiction, and Co-Occurring Disorders
    - Psychopharmacology
    - Legal Issues
    - Crisis Intervention
    - Financial and Medical Entitlement Programs
    - Psychosocial and Community Supports
    - Housing Programs (MH/AODA)
    - Interface With Criminal Justice System

Applicant must describe what type of training/in-services will be provided to enhance the provider network, explain how those services will be delivered, describe the process of assessing training needs, describe how the concept of 'recovery,' as identified by the Governor's Blue Ribbon Commission on Mental Health and AODA 's

cores values, is incorporated into the training plan. All training/in-services should reflect knowledge of appropriate state certification, licensing, and/or Behavioral Health Division practice standards as identified in this document

1. Trauma identification and resolution: "Risking Connection" curriculum

'*Risking Connection*' is a curriculum for training service providers at all levels for work with survivors of sexual and physical abuse trauma. It is not a manualized treatment approach, but it provides a framework that can be used in a range of settings and formats. This curriculum is based in a trauma theory: constructivist self-development theory, which shares many basic assumptions with other current theories and approaches to treating survivors. This trauma framework assumes that "just as people can harm each other deeply, so they can also help each other profoundly – relationships can be transforming and healing".

Recommended Trainers

DMHSAS (Department of Mental Health and Substance Abuse Services) sponsored a 5-day Risking Connection Master Trainer Training in 2002, conducted by Sidran Traumatic Stress Foundation. '*Risking Connection*' is the State's recommended training in trauma responsive treatment curriculum for the Milwaukee AODA TANF grant, the Statewide Urban/Rural Women's AODA Project. List of the Milwaukee County provider staff that attended and completed the Master Trainer Training, will made available to the contractor.

Rates

Rates suggested by the State to pay the trainers:

- Hourly rate $200.00, per trainer
- Each module: 2 trainers X 2 hours = $800.00
- Total training: 5 modules provided by a team of 2 trainers = $2, 000.00

2. Fetal Alcohol Spectrum Disorders: Understanding the Physical, Cognitive, and Behavioral Effects of Prenatal Alcohol Exposure

Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term used to describe the range of effects that can occur in individuals who were prenatally exposed to alcohol. These effects may be physical, mental, behavioral and or learning disabilities. FASD represent a leading cause of mental retardation and learning disabilities in children seen in pediatric offices today. This training provides an overview of FASD and describes a model program, the Family Empowerment Network (FEN). FEN is an information, referral, and support network for children and families affected by Fetal Alcohol Spectrum Disorders (FASD) and the professionals who serve them. FEN's mission includes: (a) increasing awareness about FASD by providing education, training and resources to families, providers, and the general public; (b) providing support and referrals to families affected; and (c) increasing opportunities for diagnosis and intervention.

Recommended Trainer

Dr. Georgiana Wilton is the State's recommended trainer in the area of FASD. Dr. Wilton has done previous training for our providers, and it has been very well received. Georgiana Wilton, PhD, is an Associate Scientist for Family Empowerment Network (UW School of Medicine and Public Health, Department of Family Medicine)

Rates
Rates suggested by the State to pay the trainer:

- All Day training = $400.00 – $500.00

Training Plan
Applicant agencies must develop the training plan and submit it to BHD for approval. The training plan must identify which training curriculum will be used, who the trainer(s) will be, and provide an outline of all training/in-services that will be conducted in 2009.

Since providers which are recipients of funds allocated to BHD must be in compliance with all Federal, State and County rules (which include Americans with Disabilities Act, Civil Rights Act, Education Amendments, and Rehabilitation Act, and with Wisconsin State Statute 51.46, ensuring pregnant women first priority to treatment services), other training may needed to be developed for the network.

The contractor is required to keep training and attendance records, a training update, and to report on successes and challenges or general accomplishments on a quarterly basis. Other activities include: securing training site, sending invitations and reminders, planning and preparing materials/handouts, providing certificates of attendance and attending to all training logistics (such as parking information and directions, booking trainer(s), assisting with audiovisuals, etc).

Reporting Requirements

As a recipient of these funds, you are required to comply with reporting requirements on a quarterly basis. **The contractor will be required to report on this project. The quarterly reports and a final year-end report are due:**

- January 15 (end-of-year report)
- April 15
- July 15 (semi-annual report)
- October 15

Accessibility

The provider must ensure that all training sessions will be at a facility with access for physically handicapped persons and will be accessible to non-English speaking individuals.

Billing
The contractor is required to submit accurate and timely billing information

Target Population

The target population includes all SAIL providers (mental health and WIser Choice), and community partners (i.e. community agencies, social service agencies, DOC, Child Welfare, etc)

Evaluation
Applicant agencies must include an evaluation plan that includes evaluation forms and feedback process for each training session.

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Section 2
Behavioral Health Division
Wraparound Milwaukee

YEAR 2009
PURCHASE OF SERVICE GUIDELINES
PROGRAM REQUIREMENTS

Issued July, 2008

Care Coordination Services
#WM01

General Proposal Requirements

1. Definition

Wraparound Milwaukee is a unique type of Managed Care Organization that provides and arranges care for children with serious emotional and mental health needs and for their families. Central to the provision and coordination of services to children/families in this program are care coordinators. Working under "wraparound" philosophy of care and unique set of values that emphasizes individualized, strength-based, family-focused, community-based and culturally competent care; care coordinators provide the following:

a. Provide case management type services for youth and their families.
b. Facilitate care planning teams called child & family teams.
c. Help families and the teams develop the individualized Plan of Care (POC) based on the child/family strengths and needs.
d. Help identify and assist family to obtain mental health, social and support services from the Wraparound Provider Network.
e. Help identify and access informal supports and community resources for the youth and family.
f. Provide or secure emergency crisis services and help develop crisis/safety plans.
g. Prepare and submit Plans of Care (POC) and Service Authorization Requests (SARs) utilizing the Internet-based IT System called Synthesis.
h. Monitor and document the provision and quality of services through the child & family team, by holding at least monthly CFT meetings, revising and submitting a new Plan of Care every 90 days, completing crisis and regular progress notes, etc.
i. Collaborate with system partners, Child Welfare, Juvenile Justice, Education, etc.
j. Develop and provide reports to the court as required and in collaboration with Child Welfare and Juvenile Justice.
k. Testify and participate in court hearings as required.
l. Work with family organization who supports Wraparound Milwaukee.
m. Participate in meetings, trainings, mandatory in-services, planned and required by Wraparound Milwaukee.

2. Target Population

Eligible youth are those who are seriously emotionally disturbed (SED) who meet the State Medicaid criteria are referred to the care coordination agency by Wraparound Milwaukee, and are court-ordered in the program under a Delinquency finding or CHIPS (Child in Need of Protection or Services). Specific criteria to meet the SED definition include:

a. DSM-IV Diagnosis
b. Involved in two or more service systems.
c. Have a mental health condition which has persisted for at least six months

and is likely to persist for a year or longer.

d. Has some functional impairment due to their emotional/mental health needs at home, at school or in the community.
e. Is at risk of institutional placement in a residential treatment facility, correctional facility or psychiatric inpatient facility.

3. Other Program Requirements

Wraparound Milwaukee is currently contracting with eight agencies to provide care coordination services. Depending on the quality of organizations applications, and program needs it is likely that Wraparound will again consider contracting with eight agencies. However, Milwaukee County and Wraparound Milwaukee retains the right to determine the number of agencies in 2009 from which it will purchase care coordination services. Additionally, if an expanded number of slots from the capitated agreement Wraparound has with Medicaid are approved in 2009 for the non-court ordered youth in the REACH program, Wraparound Milwaukee would utilize the results of this request for proposal and the overall ranking of scores from the review of the applications to determine additional care coordination agencies for that program. Those agencies submitting the highest ranked proposals would be selected to also provide additional REACH care coordination services. Otherwise, the anticipated number of regular, court-involved Child Welfare or Delinquency referred youth needing care coordination services will average approximately 650-670 per day. The average number of care coordinators that the applicant agency could plan for is 8-10 per agency. All agencies are required to have one full-time dedicated supervisor who does not carry a regular caseload of families and a lead worker that supports and can fill in for the supervisor who may maintain a caseload of only 4-5 families.

The ratio of care coordinators to families is ideally 1:9 to 1:10; however, it is possible due to services demand, that care coordinators might have to carry additional 1-2 families. Wraparound Milwaukee will do everything possible to assign families to care coordination agencies so they do not exceed the 1:9 to 1:10 ratio.

4. Experience and Qualifications of the Organization

Within each proposal, the applicant shall describe:

a. How the delivery of care coordination services relates to the mission of the organization and commitment to providing comprehensive, community-based services to children with serious emotional needs and their families.
b. Describe the organization experience and capabilities in providing care coordination or case management with this population of children and adolescents with serious emotional disturbance (SED). Emphasize knowledge and experience with Wraparound principles and approaches, working in a family directed care management model, working with Child Welfare and Juvenile Justice agencies, and understanding of juvenile court practices.
c. Describe the organization experience and knowledge in working in a managed care model; working with case rate reimbursement and knowledge of requirements of Medicaid for documentation of services and billing.
d. For existing care coordination agencies, the applicant should document and

describe the results of past performance on the semi-annual and annual performance reviews. The applicant's ability to implement corrective action plans when needed to improve performance should also be described.

e. For applicants without prior care coordination contracts, information about past performance may be gathered based on other contracts or fee-for-service experience. Information taken into consideration would also include performance reviews and/or evaluations of applicant organizations conducted by State or Federal accreditation entities. Note: documented non-performance or non-compliance under previous contracts or under fee-for-service will be taken into consideration in the review of applicants proposals.

5. Program Content

The applicant shall demonstrate in their narrative a thorough understanding of Wraparound philosophy, values and approaches and how those values, philosophy and approaches are used to serve the target population. The applicant must also demonstrate their knowledge of how the service delivery system for SED youth is structured and how it functions in Milwaukee County's Wraparound Program.

Specifically, the applicant organization must address their understanding, knowledge and ability to provide care coordination services that:

a. Build on child and family strengths to meet needs.
b. Identify how effective child and family teams are developed, implemented and maintained.
c. Describe how an individualized care plan is developed.
d. How care plans that are developed demonstrate best fit for the culture and preferences of the family.
e. How they will ensure there is parent choice in the development of the care plan.
f. Identify the process for moving the family toward independence.
g. Define how children will be cared for in the context of their families.
h. How they will demonstrate unconditional care for children and families.
i. How services will be coordinated with other systems including Child Welfare, Juvenile Justice, education, etc.
j. How the care coordination organization will effectively work with the court system i.e. judiciary, district attorneys, public defenders, etc.
k. How the organization will support youth involvement in Wraparound so that care plans are youth guided and that youth are involved with other peers who share similar issues i.e. peer support groups, recreational activities, outings, etc.
l. Describe how the organization will support and advocate for families; how they collaborate with the parent advocacy organization; how families are brought together for activities, training caregiver, peer support, etc.

6. Out comes and Performance Improvement

Within each proposal, the applicant organization will describe their understanding, knowledge and commitment to quality assurance/quality improvement to include:

a. Describe the performance improvement process in place and/or a system for implementing Wraparound Milwaukee's QA/QI findings and requirements. This should include:
    - Measurement of outcomes
    - Analysis and improvement of the service delivery process
    - Employer evaluation and corrective action measures
    - Consumer/community evaluation and feed back
b. The applicant agency must demonstrate how they use performance improvement information to improve service delivery and program management. This should include actual examples.

7. Staff Development and Retention

The agency must demonstrate an ability to provide necessary staff, lead workers and supervisors. The applicant must describe how their salary and fringe benefit structure is competitive with other care coordination agencies and with other systems doing comparable work. The applicant must describe any training and staff development activities beyond that provided as part of the Wraparound Milwaukee certification training.

a. The applicant demonstrates a clear understanding of commitment to staff retention with a plan for how that will be achieved.

8. Budget Justification and Unit of Service

Care Coordination agencies are reimbursed on a daily case rate basis. That rate for 2009 is $24.50 per day per case. Average caseload size is 9-10 cases although service demand may impact on that number. Wraparound Milwaukee does not guarantee any specific volume of referrals. The applicant must submit all required Milwaukee County budget documents, anticipated revenues and expenditures including anticipated employee costs i.e. salary and fringe benefits by position. The specific Milwaukee County requirements for contract agencies submitting applications to provide services can be found in "Year 2009 Purchase of Service Guidelines Technical Requirements Audit and Reporting"

a. Applicant must clearly demonstrate through past experience their ability to provide these care coordination services within a case rate method of reimbursement. This includes having adequate financial reserves to assume financial risk since the volume of referrals cannot be guaranteed.

Family Advocacy Services
#WM02

General Proposal Requirements

1. Definition

Family advocacy services are provided to support families enrolled in the Wraparound Milwaukee Program who have a child (children) with a serious emotional or mental health need. The family advocate is usually a parent or other caregiver who has cared for a child with a serious emotional problem. They are also persons with additional training in the Wraparound philosophy and approach and possess knowledge and expertise in understanding how the needs of these children may affect the caregiver and how they can offer effective support to the families of children who are considered SED.

The family advocacy organization helps families to also understand and exercise their rights to secure specialized mental health and other services for their child with complex behavioral health needs. The family advocacy organization ensures the provision of quality services for families enrolled in Wraparound Milwaukee. They are also responsible in assisting in accessing families to community resources as well as making sure families become the primary decision makers regarding their family's future.

2. Target Population

Youth with serious emotional and mental health needs and their families enrolled in the Wraparound Milwaukee and REACH Programs.

3. Program Requirements

Agencies applying must be organized as a 501(c)(3) organization with a Federal Tax ID on file with the Internal Revenue Service. Other Not-For-Profit or For-Profit agencies may apply but agencies providing other services under contract to the Behavioral Health Division – Wraparound Milwaukee Program must create the advocacy component as a separate entity to avoid conflict of interest issues in the delivery of advocacy services versus other network services.

Additionally, the family advocacy organization must have an affiliation agreement or sign an affiliation agreement within 60 days of receiving the contract for these services with the National Federation of Families Organization.

The family advocacy organization must be minimally staffed with a full-time director and may be staffed by other paid employees and/or utilize family advocates on a stipend and/or voluntary basis. The staffing plan should be described under the program content and methodology section of this proposal. Family advocacy organization must also provide a full-time educational advocate with specific training and expertise in supporting and helping families obtain or modify Individualized Education Plans (IEP's) for their child and secure appropriate educational placements. This also includes advocating for children who have been suspended or expelled to return and/or find an appropriate school placement. If additional educational advocacy are to be provided this should be described in the applicant's

proposal.

4. Experience and Qualifications of the Organization

Within each proposal, relative to experience and qualifications of the organization;

a. Describe the applicant's experience in providing advocacy services and how the delivery of these services relates to the mission of the organization and commitment to the principles of Wraparound.
b. Describe the organization's experience in recruiting, training and utilizing parents and caregivers as advocates, organizing parent support groups, designing, distributing and collecting information for surveys, serving on committees, developing newsletters, organizing family activities, providing educational advocacy and other activities related to providing services under this service area.
c. Organization must identify an existing office site for their advocacy program with locations and physical layout that is easily accessible to families.

5. Program Content and Methodology

The applicant organization should describe how they plan to develop, organize, implement and sustain each of the following activities:

<u>Under Family Advocacy</u>

a. Recruit, hire and train parents as 1:1 advocates for families with youth who are SED enrolled in Wraparound Milwaukee.
b. Develop and implement parent support groups, including types of groups, skill building goals and objectives, frequency of the groups, how parents will be recruited, use of paid stipend or other compensation paid to promote attendance.
c. Plan for training and orientating families in Wraparound process.
d. Describe how parents will be recruited to participate on committees, work groups, etc.
e. How and what type of family activities will be planned and implemented and how other community organizations will be involved in helping to sponsor these activities.
f. Describe how the applicant agency will provide crisis support services to families in need in collaboration with the Mobile Urgent Treatment Team and Care Coordinators.
g. Describe how applicant will develop such services as transportation, day care, respite or other services to support families. These could be developed through a volunteer network or development of paid services and applicant should describe their methodology and approach to providing or arranging for these services.
h. Applicant should describe how they plan to collaborate with other community agencies and organizations to support families, sponsor activities and advocate for families. Describe the type of collaborative efforts that have been or will be planned and developed.

i. Describe agencies plan for designing, planning and implementing satisfaction surveys, needs assessment/attainment scales, conducting focus groups or other activities to involve parents in evaluating the delivery of Wraparound services.
j. Describe how applicant will develop new sources of funding through grants, foundations to help sustain the organization and to diversify funding sources.

Under Educational Advocacy

a. Describe how applicant agency will provide educational advocacy services to youth who are SED and their families - the content of the educational advocacy program.
b. Describe how educational advocates will review, modify and develop Individual Educational Plans for qualifying youth and how they will collaborate and engage special education staff in Milwaukee Public Schools and other school systems to meet needs of youth in Wraparound.
c. Describe how applicant's educational advocates will engage parents and care coordinators in identifying, assisting and meeting the educational needs of designated youth. What type of education services will be provided to support and engage students who have been suspended or expelled.
d. Describe what type of training and orientation programs will be designed, developed and provided to parents and care coordinators to help them effectively understand special education laws and regulations and to better advocate for children to obtain appropriate educational placement and services.
e. Describe how education advocates will design and develop educational alternatives to minimize use of day treatment programs and support programming within regular or special education programs.

6. Unit of Service

This is an expense based contract based up to the total available funds allocated in the 2009 Wraparound budget for this program. The applicant must provide a budget that is accurate and detailed. The budget must describe all full and part time staff, contract positions and amount to be spent for stipends to reimburse participating parents.

Crisis/Respite Group Home for Adolescent Boys 12-17
#WM03

General Proposal Requirements

1. Definition

The Wraparound Milwaukee Program is a unique type of managed care program serving children with serious emotional disturbance (SED) and providing an array of community-based mental health and supportive services. The Mobile Urgent Treatment Team is a component of the program that was created to help children and adolescents in crisis. A crisis is any situation in which a child's behavior escalates beyond the usual coping and problem solving ability of the parent or caregiver and threatens the stability of the child and community.

Crisis services are mainly funded through Medicaid under HFS34. One component of the crisis services under HFS34.22(4) are optional stabilization services. One type of stabilization service is such term placement in a group home setting to achieve stabilization of a child in crisis, reduce the threat of more restrictive psychiatric hospital or residential treatment, initiate treatment and link the child to follow-up services in the community.

Wraparound Milwaukee and the Mobile Urgent Treatment Team currently operate one eight group home for adolescent boys ages 12-17 and seeks to re-bid those services for 2009.

2. Target Population

Youth placed in the crisis/respite group home must be adolescent boys 12-17 years of age who are experiencing a mental health crisis placing them at risk of permanent removal from their current living situation and placement in a more restrictive level of care including a psychiatric hospital or residential treatment placement. Crisis/respite homes may also be used as a transitional step for adolescents out of those more restrictive placements until placement at home or in a more permanent setting can be arranged. Average stays in a crisis group home are 1-14 days. Youth placed in the crisis/respite group home must be under a court order and be either an adjudicated delinquent youth or a child under a CHIPS order (Child in Need of Protection and Services). All children admitted to a crisis bed in this group home must be referred to the home and placed under the authorization of the Mobile Urgent Treatment Team (MUTT).

3. Program Requirements

a. The applicant must show evidence of having a current home licensed under HFS57 with a capacity to serve 8 boys. Preference is for homes that have single bedrooms (one occupant per room) or who have the capacity to separate boys who cannot share a room with another child due to behavioral reasons.
b. The group home and staff must be knowledgeable with and meet all the requirements of HFS34 related to the training/orientation of staff, clinical supervision, writing, updating and reviewing crisis plans documentation requirements such as progress notes and other HFS34 requirements to be eligible for Medicaid crisis reimbursement.

c. The group home must be willing to agree to a no reject or eject policy related to placements.

4. Qualification and Experience of Applicant

a. The applicant organization must demonstrate experience in working with highly complex need youth with very serious emotional, mental health and behavioral issues who are experiencing a crisis. Previous operation of a crisis group home resources is desirable.
b. The applicant organization must have a current licensed group facility available at the time of panel review.
c. The applicant must demonstrate how providing the crisis/respite group home is consistent with the mission of their agency and what special expertise, resources and training they possess to successfully operate a facility for high risk, high needs SED youth.
d. The applicant agency must describe their experience in working under HFS34 and their history in performing or capturing Medicaid reimbursement for Wraparound Milwaukee.

5. Program content

The applicant should clearly describe the content and operation of the crisis/respite program including all of the following:

a. Describe applicant's plan for adequate 24 hour staffing and supervision of residents. Distinguish the difference between staffing and operating a crisis/respite resource from a regular group home.
b. Describe applicant's plan for a structured unit management system of care that is fair, reasonable, consistent and related to behavior.
c. How applicant plans to incorporate individualized strength-based approach in the home consistent with Wraparound principles and values. How will applicant ensure the preparation, regular review and updating of crisis safety plans.
d. Describe clinical services and consultation available to staff in the home. Will individual or group counseling services be available.
e. How will applicant coordinate with the MUTT team, care coordinators, Bureau of Milwaukee Child Welfare workers and probation staff.
f. Describe the content, frequency etc. of the training/orientation program for staff.
g. Describe plan for children to attend their regular public school or otherwise receive education services.
h. The applicant agency must have plans to ensure regular and emergency medical care including the ability and written plan for distribution of medication.
i. The agency applying must describe how they will transport or arrange the transportation of residents to go to school, medical appointments, court or other purposes.
j. The applicant must describe how they will manage difficult or aggressive behaviors and how they will achieve a no eject, no reject policy.

k. Describe what type of recreational activities will be available to youth.
l. The applicant shall describe how they will maintain records, document for Medicaid crisis reimbursement purposes and provide reports or information to MUTT or Wraparound care coordinators.
m. Applicant must have and share their written policies and procedures for their program.

6. Quality Assurance/Quality Improvement

The applicant must cooperate with Wraparound Milwaukee and MUTT related to performing regular audits of crisis services that MUTT bills to Medicaid. Applicant must agree to provide all documentation related to staff qualifications, training, crisis plans and progress notes for review.

Complaints/grievances related to the care of any youth are subject to review and audit by the Wraparound Quality Assurance Office**.**

7. Unit Rate

The reimbursement method for the group home will be expense based on the total funds allocated for this program. The 2008 allocated funds were $358,000.

Mobile Urgent Treatment Team – Crisis Support Services and Short-Term Case Management
#WM04

General Proposal Requirements

1. Definition

The Behavioral Health Division – Wraparound Milwaukee Program operates a child/adolescent crisis intervention service for Milwaukee County families called the Mobile Urgent Treatment Team. That team provides crisis intervention services to families with a child experiencing a mental health or emotional crisis. Crisis means a situation caused by a mental health disorder that results in a high level of stress or anxiety for the child, parents or caregiver, which cannot be resolved by the available coping mechanisms of the child or those persons who provide ordinary care or support for the child and threaten the removal of the child from his or her home.

The purpose of the MUTT team is to:

a. Stabilize children/adolescents in the community in their natural environment through provision of mental health crisis intervention services.
b. Divert children/adolescents from potential inpatient psychiatric admission to area hospitals by providing community-based crisis intervention, stabilization services, short-term case management services.
c. Provide consultation to Wraparound Care Coordinators on effective strategies to deal with and or prevent a crisis, including developing crisis safety plans.
d. Linking youth to appropriate mental health services in the community for on-going mental health care.

2. Target Population

The target population include all Milwaukee County residents with a child experiencing a mental health crisis. Dedicated mobile crisis service teams serve the Bureau of Milwaukee Child Welfare Foster Care System and the Milwaukee Public School System. Additionally, all 800 enrolled Wraparound Milwaukee youth are automatically eligible for Mobile Urgent Treatment Team services.

The expected volume of service would be 1500-2000 face-to-face contacts annually and about 3000-3500 annual phone contacts and triage.

Additional contacts/responsibility for the MUTT Team are the oversight of the 8 bed crisis group home, gate keeping responsibility to review and authorize all requests for Wraparound Milwaukee enrolled youth at risk of inpatient psychiatric care, the provision and oversight of 1:1 crisis in-home stabilizers and auditing of any treatment foster home or group home providing crisis stabilization services for Wraparound and reimburse by Medicaid.

3. Program Requirements

The Mobile Urgent Treatment Team consists of a Director, two Milwaukee County clinical psychologists, consulting psychiatrist, one nurse and six MSW social workers. As a component of the crisis services, there are additional crisis counselors and social workers that are needed for crisis response, assessment, treatment, stabilization, referral to on-going mental health agencies, short-term case management and monitoring/assessment of crisis resources such as the crisis group home and crisis 1:1 stabilizer.

For 2009 Milwaukee County Wraparound is again seeking one (1) qualified agency to provide these crisis intervention and support services.

The applicant agency must furnish up to 12 master's level, licensed social workers or other clinicians with a minimum of two years experience in working with youth with mental health needs, preferably in a setting where they work with youth experiencing mental health crisis. One to two additional workers may possess a BA/BS degree and serve to support the clinical treatment staff.

These crisis and case management services are provided under the supervision and direction of the Director of the Mobile Urgent Treatment Team or under the Assistant Director of the MUTT Team in the absence of the Director.

Additionally, all crisis staff provided by the applicant organization must conform to the requirements of HFS34 Emergency Mental Health Services Program as it relates to qualifications, training, and supervision of the staff providing mobile crisis services for the contractor. HFS34 governs the certification and operation of emergency crisis services for adults and children.

Specific to the duties of the mobile crisis staff provided by the applicant agency for the MUTT Team are:

a. On site answering of phone calls to determine nature and severity of crisis and whether a home visit is required.
b. Accompanying county crisis workers or other contract staff on calls in the community and providing assistance in the assessment and immediate stabilization and care of children/adolescents in crisis and their families.
c. Participating in the development of crisis/safety plans.
d. Identifying community agencies and services to refer families for on-going mental health treatment.
e. Providing transportation to take child to a temporary crisis/respite group home, or to or from the inpatient hospital or other placement setting.
f. Provide short-term case management services to stabilize family and prevent future crisis situations.
g. Participate in multi-agency staffing and serve on child and family teams.
h. Audit treatment foster care and group home agencies providing crisis stabilization services for Milwaukee County youth.
i. Prepare and maintain records, prepare, review and update progress notes and crisis/safety plans and provide statistics and other data as required by Wraparound.

j. Work with Child Welfare, case managers and foster families and with regular and special education teachers, counselors, social workers, etc.

4. Qualifications and Experience

The applicant agency demonstrates at least two years of experience in providing crisis intervention services to children and adolescents with serious emotional and mental health needs. Applicant can furnish at least 12 MS or MSW, licensed social workers within 30 days of receiving the contract award. The applicant has experience in providing mental health and supportive services on a 24 hour per day, seven days per week basis.

The applicant organization must describe how the provision of crisis services is consistent with the mission of the organization.

Applicant must be able to demonstrate the staff providing crisis services have knowledge, skills, and experience in the following areas:

a. Assessment and treatment of youth in a mental health crisis.
b. Effective phone answering and triage skills under crisis condition.
c. Knowledge and experience in use of community resources.
d. Knowledge of Wraparound philosophy and approach.
e. Experience performing case management services for the target population.
f. Ability to transport children and families in agency vehicles or personal cars.
g. Experience working with other child serving systems, particularly Child Welfare, Juvenile Justice and education.

5. Program Content

The applicant agency must demonstrate a thorough understanding of the mental health needs of children with serious emotional and mental health needs and the techniques, strategies and approaches to effectively assessing, treating and stabilizing children/adolescents and their families experiencing a mental health crisis. The applicant must describe how they will provide all of the following services for the MUTT program:

a. Crisis assessment, response plans and development of crisis/safety plans for youth and their families.
b. How they utilize the Wraparound approach, individualized care, strength-based, needs focused, etc. in developing crisis plans and providing crisis services.
c. How community resources, both formal and informal are identified, accessed and delivered for families in crisis.
d. What is the applicant's plan for delivery short-term case management services (under 30 days) to families.
e. How will families be involved in the development of crisis plans and delivery of services to families.
f. How will the applicant utilize optional crisis stabilization services for families such as 1:1 crisis stabilization or crisis/respite group home.
g. Describe how the applicant organization will participate in and support child

and family teams related to crisis services.

h. Describe how applicant organization will coordinate and collaborate with Child Welfare, Juvenile Justice and Education. (Note: specific focus should be on stabilizing youth in foster homes and school classrooms.)
i. How the applicant organization will ensure compliance with all aspects of HFS34 related to staff qualifications, training, supervision, and documentation of services.

6. Unit of Payment

Unit of reimbursement is this agreement will be expenses based on the total 2009 budget allocation for this program. This takes into account expected revenue from Medicaid, Child Welfare, and Milwaukee Public Schools**.**

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Section 3
Delinquency & Court Services Division

YEAR 2009
PURCHASE OF SERVICE GUIDELINES
PROGRAM REQUIREMENTS

Issued July, 2008

DELINQUENCY AND COURT SERVICES DIVISION

INTRODUCTION AND INSTRUCTIONS

The Delinquency and Court Services Division's mission is to promote community safety by efficiently providing youth accountability and developmentally appropriate intervention services. The Division provides intake, probation supervision, intervention, and placement services to youth, and their families, who are the subjects of Milwaukee County delinquency proceedings.

The Delinquency and Court Services Division (DCSD) provides direct services and contracts for specific programs and services that meet the individual needs of juveniles, ages 10 through 16, who enter the Juvenile Court system. The primary goals for these programs and services are: (1) to provide for the community's safety by reducing the risk factors associated with delinquent behavior; (2) to ensure that juveniles are held accountable for their behaviors and court expectations; and (3) to build systems and programs that cultivate life skills and personal responsibilities within our youth. In meeting these goals we create the opportunity for every youth to become a healthy and contributing member of the community.

Services that are purchased by the Delinquency and Court Services Division are allocated to match the priorities of our service area and to manage the available resources. Substantial effort has gone into applying for grants that supplement state and county funding. The Division attempts to utilize its funds to provide a broad continuum of services for juveniles. Services range from early intervention programs, including the First Time Juvenile Offender Program, to community-based alternatives that can divert juveniles from a commitment to the State's Juvenile Correctional Institutions. The Division will continue to develop and support service models that are culturally competent, culturally diverse, and will meet the needs of our youth and their families.

For calendar year 2009, we have placed multiple programs within the RFP for Delinquency and Court Services. The remaining programs fall within multi-year contracting cycles and, based upon service needs and priorities, will be included in the RFP for a subsequent contract year.

Special Instructions: **The following program elements should be addressed within the Program section of your application if applicable.**

Service/Treatment Process:

1. List and define the program activities, purpose of the activity, and the anticipated size, structure, and schedule of the activity.

2. Describe the sequence of program activities, including counseling and treatment, if applicable. Indicate the length of time in each phase of the activity and the criteria used to move youth from one phase to the next.

3. If counseling or treatment is a program component:

- Describe how and when individualized plans, goals, and operationalized strategies are developed and reviewed. Identify by position who is involved in this process.

- Provide a detailed description of the issues and topics to be addressed in counseling.

- Provide a description of the theory of change or treatment model that will be utilized. Address specific service needs of dual-diagnosis youth.

4. Describe agreements and working collaborations with other community agencies that will provide services to the target population. Describe the qualifications of the agencies and service providers. Include any letters of agreement.

Admissions:

1. Describe the process for screening (if applicable) and admitting youth to the program. Begin with the initial contact and include all activities that occur.

2. Describe in detail the program's intake and assessment process. If applicable, describe the involvement of any specialists such as a medical director, psychologist, or clinicians.

3. Identify program referral sources other than Milwaukee County Children's Court. Indicate the anticipated number of referrals each source will generate.

Discharges:

1. If discharge decisions are made by anyone other than Children's Court staff, identify the decision-maker by position and describe the proposed basis for discharge decisions.

2. Describe the discharge process. Address aftercare services and post-discharge monitoring, if applicable.

3. Identify community-based services with which discharged youth may be connected.

Important Note Regarding Program Evaluations:

If applying as an incumbent, summarize the process and results of your 2007-2008 program evaluation. Discuss any changes made to the program as a result of the evaluation.

For agencies under contract in 2009, Delinquency and Court Services Division requires a single, annual program evaluation report for the period July 1, 2008 – June 30, 2009. The report is due August 1, 2009.

For Delinquency and Court Services, the evaluation reports should be submitted to:

David Emerson, Contract Services Coordinator
Milwaukee County Children's Court Center
10201 Watertown Plank Road
Wauwatosa, WI 53226

Funding Note for 2009:

As in recent years, the uncertainties of funding for 2009 may result in significant changes in the structure or funding of our programs by the time the applications are due for submission in September. Applicants should contact the Division and check the Milwaukee County DHHS website for updates to the RFP prior to writing and submitting a proposal. Inquiries should be made to Michelle Naples at telephone (414) 257-5725 or email michelle.naples@milwcnty.com

2009 Application Requirements and Uniform Program Numbers
Delinquency and Court Services Division (DCSD)

The following list includes the programs for which DCSD is issuing a Request For Proposal (RFP) for contract year 2009 and are open for competitive application. Agencies seeking to contract for the provision of the following programs are required to submit a **complete application** package that includes all of the documents and formats as defined in the Y*ear 2009 Purchase of Service Guidelines – Technical Requirements* **and** the *Year 2009 Purchase of Service Guidelines – Program Requirements.*

New applicants should include an action plan and time frame for program start-up as part of the Program section of the application.

DCSD 001 – Day Treatment Program
DCSD 003 – Firearm Supervision Program
DCSD 004 – First Time Juvenile Offender Program (FTJOP) – Tracking
DCSD 005 – Foster Care Licensing and Case Management
DCSD 006 – Group Care

The following programs are also open for competitive bid in 2009. However agencies seeking to contract for the provision of these programs are required to submit a **complete application** package that includes all of the documents and formats as defined in the Y*ear 2009 RFP – PSA* (Professional Services*)* section of this CD. The requirements relating to

Professional Services apply to these two programs.

DCSD 012 - Detention Psychiatric Nursing Services
DCSD 013 - Detention Physician and Medical Services

The following programs currently fall within a multi-year contracting cycle and **are not open** to new provider agencies. The current provider agencies for these services must file a **partial application for each program** that includes all the items listed under FINAL SUBMISSION plus the Authorization To File for 2009. Please refer to the *Year 2009 Purchase of Service Guidelines – Technical Requirements*.

DCSD 008 – Level 2 In-Home Monitoring Program
DCSD 009 – Serious Chronic Offender Program
DCSD 010 – Adolescent Sex Offender Treatment Program
DCSD 011 – Shelter Care

Partial applications for programs that fall within a multi-year contracting cycle are due the same date as the complete application for programs that are included in the 2009 RFP.

DAY TREATMENT PROGRAM Program DCSD 001

The Delinquency and Court Services Division's Day Treatment Program is a non-clinical program that involves the Milwaukee County Children's Court, the Day Treatment providers, the Milwaukee Public Schools (MPS), and other community resources. Day Treatment provides on-site schooling and other services to meet the multiple needs of youth and their families.

Day Treatment is designed to enhance community safety, to ensure youth accountability, and to cultivate the skills that enable a youth to participate positively in the larger community. The program may allow students to attend off site schools prior to the expiration of their court order for Day Treatment. Each program site will be funded in multiples of 15 slots.

Milwaukee County is requesting innovative proposals that minimize or mitigate risk factors associated with increased probability of additional delinquency-related behavior. Describe how your program will individualize services within a structured setting to meet the needs of youth who present varying levels of risk (low to high) for re-offending. When describing your program, please reference specific evidence-based components of your program including supporting research.

PROGRAM APPLICATION

Applicants must address all program elements listed in the following two places:

1. Section 2, Program Application, located in the *Year 2009 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2009 Purchase of Service Guidelines - Program Requirements.*

The following outline includes program-specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

Target Population

Day Treatment serves as a community-based alternative to out-of-home placements including residential or correctional facilities. Client families may present various functional problems such as drug and alcohol use, mental health, or other etiologies. The program targets youth ages 12-17 and applicants must be able to accept the following youth:

- Adjudicated Delinquent youth under Department supervision.
- Wraparound Milwaukee Clients under Department supervision.
- Aftercare youth under Division of Juvenile Corrections supervision.

Expected Outcomes

The actual program goals for Day Treatment Program may be mutually developed and agreed upon by Milwaukee County and your agency. Milwaukee County has established the following outcomes-based quality measures:

Outcome 1: Average daily attendance plus excused absences will equal 75% of total Day Treatment days of service.
Indicator: Attendance and excused absence totals as reported on Day Treatment monthly invoices.

Outcome 2: 60% of the youth who are enrolled in Day Treatment will complete the program.
Indicator: Number and percent of youth who complete the program.

Outcome 3: 95% of the youth who complete the Day Treatment program will be enrolled in a school or a job training program upon discharge.
Indicator: Number and percent of youth enrolled in school or job training program upon discharge.

Note: Because of the relationship between Milwaukee County, the Day Treatment programs, and MPS, the academic performance will be assessed by MPS.

Specific Program Activities

Provide a schedule of the program's **hours of operation** for both MPS school days and non-school days (including the summer months).

In addition please provide a **daily schedule** for counseling and other program-related activities.

Describe the rooms at your facility where these activities will take place. Identify which staff positions will facilitate or monitor the activities. The program model must develop and integrate these specific components:

Service Related

1. Bi-Lingual capability for program sites that work with Spanish speaking families.

2. Initial assessment, service plans, progress reports, discharge summaries.

- Written assessments and service plans completed with copies forwarded to Children's Court Probation and/or Wraparound staff within 45 days of intake. Include a sample copy of your assessment and service plan template along with your application.

- Staffing Reviews with copies forwarded to Probation and/or Wraparound staff.

- Discharge Summaries completed with copies forwarded to Probation and/or

Wraparound staff within 10 days of the discharge.

3. Availability of direct (face-to-face) counseling including Youth, Family, and Group work. Youth enrolled to Day Treatment should have, at a minimum, one scheduled, individual meeting per week with a counselor, mentor, or other qualified program staff member.

   Recommended topics for counseling include Empathy Building, Relationship Violence, Errors in Thinking, Anger Management, Conflict Resolution, AODA education, etc. Describe the space that is available for private counseling.

Note: Social workers and counselors must be available to accommodate the schedules of working parents.

4. Job Preparedness training.

5. AODA identification, including drug and alcohol screening (urine analysis) that supports service plan goals.

6. Programming during summer vacation, winter, and spring breaks, and other days when MPS is not in session.

7. Program representation at court hearings and Wraparound team meetings as requested.

8. Structured response to client absenteeism. Please list the staff and process comprising your program's response.

9. Public transportation to and from the program.

10. Allowance and level system for students.

11. City of Milwaukee code compliance for all Day Treatment facilities.

In addition please describe any training that is provided to program staff in the area of **crisis intervention** or **violence prevention**. Submit copies of agency guidelines regarding student **suspensions**, and **physical restraints.**

Education Related

School is provided through a relationship with MPS and must include the following elements:

1. Class sizes that are no larger than 15 students.

2. A core academic curriculum plus Health and Human Sexuality, Physical Education, and Art. **Summer school is to be included**.

3. Certification to accept students with Special Education Needs.

4. The ability for students to complete a full semester of academic credits each semester.

5. Arrangements for MPS support staff to provide:

   - Diagnostic assessments of Special Education and At Risk students.
   - Development and monitoring of the Individual Education Plan (IEP).
   - Monitoring of program compliance with federal and state guidelines for Special Education and At Risk students.
   - Monitoring of the overall education program including lesson planning.
   - Consultation and technical assistance regarding the transition of students returning to regular MPS and alternative MPS programs.

Note: Describe the process by which your staff will work with MPS to ensure the successful transition of students who are returning to regular MPS and alternative MPS programs.

Staffing Related

- **An agency social worker, counselor, or case manager will be assigned to each student and family unit.**

- The program coordinator or the social work supervisor must have a graduate level degree in a human services related major.

- Staff using the title "Social Worker" must be certified to practice Social Work by the State of Wisconsin, Department of Regulation and Licensing.

Documentation

Individual case files must include at a minimum:

- Initial family and child assessments and service plans.

- Staffing reports and service plan updates.

- Counseling notes and contact sheets that include the date and time of the contact, the name of the person contacted, the type of contact (face-to-face, phone, collateral), and the signature or initials of the worker providing the contact.

- Incident reports

Funding

MPS provides for the education related services and costs of MPS students enrolled in Day Treatment by separate agreements through MPS Partnership Schools. Milwaukee County, by separate agreement, currently reimburses MPS for non-District or expelled MPS students who are enrolled in the Day Treatment Program.

Reimbursement

Providers will be reimbursed on a fee-for-service basis based upon a daily unit rate. Monthly reimbursement will be limited to a cumulative 1/12 of the 2009 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific (Rate X Unit) Rate Statement must be submitted following the end of each calendar month according to DHHS policy.

Contract Duration

This contract will be for calendar year 2009, with the option to extend the contract in each of the two subsequent years.

FIREARM SUPERVISION PROGRAM Program DCSD 003

The Firearm Supervision Program began in July 1999 and serves as a specialized program for youth on probation. The program was originally funded in large part through a Juvenile Accountability Incentive Block Grant made available through the Office of Justice Assistance. Although that funding has decreased significantly over the years, the program has remained through local funding. The program is designed to serve youth living in the community who are placed on probation due to offenses that involve a firearm but may also include aftercare youth who are under Division of Juvenile Corrections Supervision. All referrals to Court that may involve a firearm are screened by the District Attorney's office, and then eligible cases involving a firearm are vertically prosecuted by one of the District Attorneys. Most of the youth entering the program are ages 15 and 16. Ninety-five percent or more are male, and 75% are African-American.

DHHS is requesting proposals from agencies to primarily provide one-on-one monitoring services for approximately 60 youth at any one time. Intensive monitoring services are provided for the youth during the first six months, with a reduced level of monitoring provided for the remainder of the youth's probationary period. Additional service components must also be provided, as described within this RFP.

The agency that is selected to provide this program may receive supplemental funding as approved and authorized by the Milwaukee County Board to provide prevention and aftercare services for youth and families enrolled in this program. Upon award, a separate plan for the use of those funds will be required for this pilot project.

PROGRAM APPLICATION

Applicants must address all program elements listed in the following two places:

1. Section 2, Program Application, located in the *Year 2009 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2009 Purchase of Service Guidelines - Program Requirements.*

The following outline includes program-specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

The program was designed to address the specific issues of youth involved with firearms. These youth frequently are older and likely have had previous encounters with law enforcement. All youth referred to the program have been adjudicated and are serving a probationary period under the supervision of a probation officer.

Juveniles selected for the program shall be accepted and assigned to a Monitor employed by the agency receiving the contract. Each program participant will receive a minimum of 26 weeks of intensive monitoring services (**Phase 1**), with less intensive services being provided for the remainder of the youth's probation period (**Phase 2**).

The Monitor and Probation Officer will set up an initial meeting with the juvenile and his/her parents to discuss all matters related to accountability and court conditions.

Monitoring activities will include counseling, crisis intervention, offering support to the juvenile and parent(s), enabling the juvenile to attend and make progress in school, introducing the juvenile to alternative activities, and assisting the juvenile to complete any required community service. Monitors are expected to get to know each juvenile's teachers and other school staff so that they can get regular updates on the juvenile's school attendance and academic progress. Monitors will spend time outside of school hours with the juveniles both one on one and in small groups. Monitors are expected to show the juveniles alternative ways to spend their free time.

Routine communication between the Probation Officer and Monitor is critical to the success of the program. The Monitor must work closely with the assigned Probation Officer to coordinate their efforts and to share information on the juvenile's progress. Monitors will be expected to collect data on each juvenile and prepare written reports on each juvenile's progress to be shared with the Probation Officer. Juveniles who do not comply with the program and the conditions of probation may be returned to court for a revision in their orders and/or removal from the program.

Agencies submitting proposals for this contract are encouraged to include programming in the application for participants when school is not in session (vacations and after school). Group sessions for juveniles in the program are intended to provide knowledge, personal assistance, recreation and insight, as well as providing opportunities for juveniles to interact with agency staff and to meet others in the program. Academic, AODA, anger management, thinking/decision-making processes, health issues, job readiness, school and community behavior, concerns for victims, computer skills training and recreational issues must be addressed. Attendance at these sessions is mandatory on the part of the youth.

Program Goals

The program has several goals, which include the reduction of recidivism, keeping youth in school, and providing services to assist in the achievement of those goals. Specific goals and objectives should be developed to address these general goals. The discussion should identify how the goals and objectives will be measured and evaluated.

Criteria for successful program completion may include:

- Improve school attendance and grades
- Decrease school-related problems
- Completion of job applications
- Participating in activities coordinated by the monitoring agency without further incident
- Attending meetings with Probation Officer
- Active and positive participation in planned activities
- Increased understanding of victims concerns
- No subsequent offenses committed while in the program

Expected Outcomes

The Firearms Program services are expected to be a productive alternative to a correctional placement by holding youth accountable and minimizing a youth's risk for re-offense.

Outcome 1:Program Completion
Indicator: Number and percent of youth who complete the program.
Indicator: Number and percent of youth who complete service plans goals.

Outcome 2: Improved school attendance and performance.
Indicator: Number and percent of youth who demonstrate an improvement in school attendance.
Indicator: Number and percent of youth who demonstrate an improvement in school performance.

Outcome 3:Improved behavior, attitudes, and understanding of offense dynamics by enrolled youth.
Indicator: Number and percent of youth who demonstrate improved accountability.
Indicator: Number and percent of youth who can demonstrate recognition of high-risk behaviors.
Indicator: Number and percent of youth who demonstrate improved decision-making.

Outcome 4: Improved family functioning and understanding of offense dynamics.
Indicator: Number and percent of families that can recognize high-risk behaviors of their youth**.**

Outcome 5: Compliance with Court Conditions
Indicator: Number and percent of active youth who are not subsequently court-ordered to Department of Corrections**.**

Specific Program Activities

Monitor Activities
Monitors shall be reflective of the culture and ethnicity of the juveniles they serve. A Monitor shall be assigned to each juvenile from the same zip code or neighborhood. Exceptions to this policy may be allowed on a case-specific basis. Monitors are limited to working with 5 youth at one time. Monitors must have access to the family's home until 11:00 pm in order to provide monitoring.

PHASE 1 (First 26 weeks)

- Verifying the juvenile's enrollment in school and monitoring his/her attendance and performance. Visits to the school will be made daily for the first 13 weeks and 3 times per week the second 13 weeks.
- Spending time in face-to-face contact with each juvenile. A face-to-face contact with the youth will be done every day, including weekends, during the first 13 weeks. Contact is reduced to 5 times per week during the second 13 weeks. The

contract will require monitoring staff to spend an average of 10 hours each week in face to face contacts, keeping track of and keeping records on each juvenile.

PHASE 2 (Remainder of Probationary Period)

- Verifying the juvenile's enrollment in school and monitoring his/her attendance and performance. Visits to the school will be made once per week, with daily contacts made by phone.
- Spending time in face-to-face contact with each juvenile. A face-to-face contact with the youth will be done once per week, either one-on-one or in one of the group settings.

BOTH PHASES 1 & 2

- Work with school staff to identify barriers that may keep the juvenile from achieving in school; assist in removing barriers.
- Daily curfew checks with the youth by phone.
- Maintain continued knowledge of whereabouts of the youth. Youth is responsible for calling when leaving home, school, work, etc.
- Exposing the juvenile to 3 or 4 alternative activities per week, which will assist in keeping the juvenile out of trouble.
- Providing support to the parent(s).
- Being available 24 hours a day, seven days a week by pager or cell phone.
- Faxing weekly reports to the Probation Officer.
- One phone contact per week with the Probation Officer on each youth.
- Attending court hearings with the juvenile as requested by the Probation Officer, District Attorney, or Judge.

Staffing Related

Monitoring staff should be experienced in the delivery of social services to juveniles and their families. Individual monitors may reflect various specialized skills. Monitors are required to have a high school degree or equivalent.

Agency proposals should include a description of how monitoring staff will be supervised. Supervisory staff should have a minimum of two years experience supervising monitoring/tracking staff in programs for youthful offenders. In addition, the supervisor(s) should have a minimum of five years experience working in programs serving juvenile delinquents. A college/university degree is preferred. The supervisor will be responsible for the day-to-day operation of the program including reviewing the number of contacts between Monitors and each juvenile and ensuring that Monitors are responsive to the needs of participants.

Documentation

Documentation and data recording requirements will be determined by Milwaukee County.

Individual case files must include:

- Service Authorization and referral forms.
- Initial client and family intake forms.
- Initial client and family assessments and service plans.
- Counseling notes or contact sheets to include the date of contact, the name of person contacted, services provided, and the type of the contact (e.g. face-to-face, phone, collateral, etc.).
- Consent forms.
- Incident reports.
- Discharge summaries.

Reimbursement

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2009 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to DHHS policies.

Contract Duration

This contract will be for calendar year 2009, with the option to extend the contract in each of the two subsequent years.

FIRST TIME JUVENILE OFFENDER PROGRAM (FTJOP) TRACKING Program DCSD 004

The First Time Juvenile Offender Program is a diversion program for youth who would otherwise be subject to a delinquency petition and subsequent court proceedings. This program serves youth ages 10 through 16, who are identified by the Delinquency and Court Services Division, the District Attorney's Office and/or the Courts, as candidates for the program.

Youth are offered the option of taking part in this program, usually under a Deferred Prosecution Agreement (DPA). A DPA, under Wis. Statutes, is an agreement between the District Attorney's office, DHHS, a youth and his/her family or legal custodian regarding services and/or conditions. Youth are usually placed in the First Time Juvenile Offender Program for a period of six months from their completed intake. However, they may be extended for longer periods without court review. If there are concerns about the compliance of the youth, DHHS can re-refer the case to the District Attorney's office, which may petition the court on the pending offense(s).

During the 12-month period of May 2007 – April 2008, tracking services were provided to 691 youth and their families. During the same period of time, the average caseload per agency was 90 youth per month.

This program will operate under Fee-For-Service agreements and will be awarded to a maximum of two vendors. At least one program (staff and services) must be located north of I-94 and at least one program (staff and services) must be located south of I-94. This will make our services more visible and available on both the north and south sectors of Milwaukee County.

Because the program continues to develop its reliance on the electronic transmission of information, all Tracking agencies must have computers and e-mail access available to each of its Trackers.

PROGRAM APPLICATION

Applicants must address all program elements listed in the following two places:

1. Section 2, Program Application, located in the *Year 2009 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2009 Purchase of Service Guidelines - Program Requirements.*

The following outline includes program-specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

The FTJOP is designed to serve youth under the overall responsibility of a Tracker. Each youth will be enrolled in the program for a minimum of six months, which can be extended if necessary. Each Tracker will be assigned a maximum of 27 youth to monitor at any one

time, unless an increase is pre-approved by DCSD.

In order to provide all youth and families with individualized service plans, tracking agencies must also indicate their willingness to provide tracking services to youth not enrolled in the FTJOP as requested by DCSD and not to exceed the requirements contained within this service description.

The program design for Tracker agencies has several specific requirements that must be addressed by agencies submitting proposals:

1. Tracking agencies must emphasize “empowering families”. This concept is defined as assisting families to select their own service providers and to empower families to be responsible for decision-making in regards to their child.

2. Tracking agencies must develop individual service plans using Children’s Court Services Network (CCSN) approved agencies and must actively monitor participation in these services.

3. Tracking agencies selected to provide services:

    a. will receive referrals through a First Time Juvenile Offender Program Staffing held each Wednesday morning. The FTJOP Supervisor will assign cases with consultation from the Tracking Agency.

    b. must agree to accept all referrals made by the FTJOP Supervisor.

    c. must agree not to close or terminate an assigned case from services without the approval of the FTJOP Supervisor.

4. Program evaluation is essential to measure the effectiveness of this model for first time juvenile offenders. Tracking Agencies must indicate that they will agree to collect and provide the FTJOP with the required data and reports including defined outcome objectives.

5. Because Tracking Agencies will be meeting with youth and families in a variety of settings, including homes that are located in high crime areas, the agency must include a safety plan that describes how the safety of their employees will be ensured.

6. Cultural competence is a keystone to this program since many of the youth to be served come from minority communities. One goal of the FTJOP is to create a culturally competent service system. Recruiting, hiring and retaining minority and bilingual staff is key to achieving cultural competence. Each Tracking Agency should include in their application the strategies used to enhance the development of culturally competent Trackers.

7. Trackers’ work hours should meet the needs of youth and working families with an emphasis on maximizing face-to-face contacts.

Expected Outcomes

The program has two primary goals: (1) to reduce the rate of recidivism of youth enrolled, and (2) to maintain or increase school attendance and academic achievement. This is accomplished by providing an individualized and coordinated set of services to address the specific needs of each youth.

Outcome 1: 75% of all youth enrolled in FTJOP will successfully complete the program.
Indicator: Number and percent of youth who complete the program.
Indicator: Number and percent of youth who complete service plans goals.

Outcome 2: 75% of all youth enrolled in the FTJOP will not re-offend during their 6-months in the program.
Indicator: Number and percent of youth who do not re-offend while enrolled in the program.

Outcome 3: 75% of all youth enrolled in the FTJOP will maintain, and preferably improve, their school attendance and grade point average.
Indicator: Number and percent of youth who demonstrate an improvement in school attendance.
Indicator: Number and percent of youth who demonstrate an improvement in school performance.

Specific Program Activities

Tracking agencies will provide the following services or activities:

1. Provide appropriate staff to attend a weekly staffing where cases will be assigned to a Tracking agency.

2. Work with the youth who are referred to the program (and their families) to ensure that these program requirements are completed:

    - Community Education Class
    - Community Service Hours
    - Letter of Apology

3. Utilize information provided by a DCSD Intake Specialist and interact with the family to help assess the youth and family's service needs.

4. Involve the family in the selection of the CCSN agencies that will provide services.

5. Provide ongoing monitoring and support to ensure the youth's participation in services.

6. Prepare a written Service Plan (separate from the Intake Specialist's Service Plan/Program Referral Form and the Service Plan Authorization Form) that summarizes the assessed needs of the youth and family, the services to be provided and monitored, and the short and long-term goals.

7. Assist the youth with scheduling the first appointment and with any problems that occur during the DPA.

8. Assist with transportation arrangements and with monitoring the youth and family's program-related attendance and participation.

9. Submit a monthly Tracking Report that identifies the actual services that the youth and family received and summarizes the tracking contacts for the month.

10. Monitor the provision of services and recommend service plan changes to CCSN Administration. This includes monitoring service expiration dates and requesting extensions to avoid interruptions in services.

11. Recommend new services or resources to be added to the CCSN when identified.

12. Monitor and report the youth's school attendance and performance. If problems are identified, the tracking agency should recommend modifications to the service plan.

13. Serve as a liaison between the youth/family and the CCSN service providers.

Staffing Related

Trackers hired after 1/1/2009 must possess a BA/BS in Social Work or related field (with approval of CCSN Administration). The Tracker Supervisor must possess a BA/BS in Social Work or related field (with approval of CCSN Administration) and have a minimum of 2 years experience with programs that serve juvenile delinquents. The Tracker Supervisor (or designee) will be required to be available for Wednesday staffing meetings.

Documentation

Documentation for the program includes (but is not limited to) the following:

- FTJOP Service Plan/Program Referral Form
- CCSN Service Plan Authorization Form (SPAF)
- CCSN Service Plan Amendment
- Service Plan

The FTJOP Service Plan/Program Referral Form is a document that is developed by Division staff and includes the initial set of approved services. Following their initial meeting with the youth and family, Tracking agencies must completely fill in the SPAF (including added services) and must also complete an individualized Service Plan.

The SPAF will be reviewed and approved by CCSN staff prior to the start of services with CCSN staff having final approval over all services. The SPAF must be submitted to CCSN within three weeks of the Tracking agency receiving the referral. All CCSN Service Plan Amendments must be reviewed and approved by CCSN Staff. Ongoing reviews of the Service Plan should be completed by the Tracking agency.

Individual FTJOP case files must be kept in a locked cabinet and must include:

- Case referral documents from Children's Court.
- FTJOP agency intake forms (including signed consents).
- FTJOP Service Plan/Program Referral Form
- CCSN Service Plan Authorization Form (SPAF)
- CCSN Service Plan Amendment
- Individualized Service Plan summarizing needs, services, and goals
- Monthly CCSN Tracking reports and monthly Network Provider reports.
- Case contact sheets that include the date of the contact, the name of the person contacted, the type of contact (face-to-face, phone, collateral, etc.), and the signatures of the worker providing the contact and the worker's supervisor.
- Court related documents.
- Incident reports.

Reimbursement

Tracker Agencies will be reimbursed for documented tracking services on a fee-for-service basis. The unit rate is $2.90 per 1/10 hour (6 min.) of service provided to an individual case (youth/family). Tracker agencies will be reimbursed for a maximum of forty-two (42) hours for each youth during a six-month period.

Special Budget Requirement

For this program, the following budget forms are required with the Initial Submission and with the Final Submission:

- Form 1
- Forms 2, 2A and 2B

The complete budget package, as identified in the Application Contents of this RFP, is not required.

Contract Duration

This contract will be for calendar year 2009, with the option to extend the contract in each of the two subsequent years.

FOSTER CARE LICENSING AND CASE MANAGEMENT Program DCSD 005

The majority of Milwaukee County juveniles who are placed in foster care are CHIPS cases and are therefore the responsibility of the State of Wisconsin. However a small number of juveniles who are adjudicated delinquent are also placed in foster care. It is our intention to contract for the recruitment and licensing of foster homes and for the case management services for delinquent juveniles who are placed in foster care. Youth who are placed outside the parental home and into the home of a relative may also require case management services. Based upon our experience, we anticipate that five to ten homes for delinquent juveniles will require licensing in one year.

While the recruitment of foster homes is sometimes necessary, experience has shown that many delinquent juveniles are already residing outside the biological home when they appear in court, having found other living arrangements. Many of these arrangements have subsequently become licensed foster homes for the specific juvenile. In these cases, it is necessary only to complete the home study and determine its appropriateness for providing foster care for the specific child.

This program will operate under a Fee-For-Service agreement and will be awarded to a single vendor.

PROGRAM APPLICATION

Applicants must address all program elements listed in the following two places:

1. Section 2, Program Application, located in the *Year 2009 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2009 Purchase of Service Guidelines - Program Requirements.*

The following outline includes program-specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

Expected Outcomes

Outcome 1: To maintain the availability of up to three foster homes for delinquent youth ages 10-16.
Indicator: Number of foster homes available to DCSD according to monthly agency records.

Outcome 2: To provide foster care case management for an average of three adjudicated juveniles at any one time.
Indicator: Number of case management units and number of recipient families according to monthly DCSD invoices.

Specific Program Activities

This program RFP has two major components:

- The recruitment and licensing of homes to provide foster care for juveniles, acknowledging that many juveniles find their own homes.

- The provision of case management services for delinquent youth in foster care or relative placement.

The following activities are required components of the program and should be addressed in the RFP:

1. Recruitment of homes to provide foster care for delinquent juveniles.
2. Perform licensing studies.
3. Relicense foster homes as necessary.
4. Provide foster parent training.
5. Provide case management services to ensure adequate service delivery to the juvenile based upon demonstrated need.
6. Maintain records as applicable for foster parents and foster children.
7. Provide payments to foster parents.

Licensing Plan and Support

The contracting agency must be certified as a Child Placing Agency by the State of Wisconsin. Agency staff must have a working knowledge of State of Wisconsin requirements for licensing foster homes. Please describe the process your agency uses to recruit and license foster homes, including those homes found by the youth themselves. Also, please address what is available for training and support assistance for foster parents, as the contracting agency will also be responsible for the continued maintenance and support of the foster home or relative placement.

Case Management

The contracting agency will be responsible to provide ongoing case management to an average of three adjudicated juveniles at any one time.

Staffing Related

Licensing and case management staff must be familiar with State of Wisconsin foster home licensing procedures and requirements and with appropriate case management practices for foster homes.

Documentation

Foster home files must include the following:

- Assessment and licensing plans.

- Caregiver background checks consistent with Milwaukee County contract requirements and State of Wisconsin Foster Home licensing requirements.
- Employment verification.
- Insurance verifications.
- Incident reports.
- Foster home study.
- Contact sheets, including date of contact, name of person contacted, content of contact, and type of contact (telephone, face-to-face, etc.).

Agency files must include the following:

- State Child Placing License.
- Applicable State of Wisconsin foster care licensing requirements and administrative codes.
- Incident reports.
- Procedure for setting foster care rates.
- Case management standards.

Individual files for each juvenile in foster care must include the following:

- A visitation plan.
- A permanency plan.
- Documentation of case management activities.
- Contact sheets, including date of contact, name of person contacted, content of contact, and type of contact.

Special Budget Requirement

For this program, the following budget forms are required with the Initial Submission and with the Final Submission:

- Form 1
- Forms 2, 2A and 2B

The complete budget package, as identified in the Application Contents of this RFP, is not required.

Reimbursement

1. Foster Home Recruitment and Licensing

The provider agency may bill DCSD the agreed upon rate for the recruitment and licensing of foster homes that are reserved for the potential use by DCSD.

Payment for Foster Home Recruitment and Licensing will be based upon a per-license flat fee, not to exceed $2,500. The Contractor will submit an itemized, detailed, and recipient-specific invoice for completed Milwaukee County DCSD related licenses. Payment for Foster Home Recruitment and Licensing is included in the allocation for the Foster Home Licensing and Case Management Program.

2. Case Management

Case Management will be reimbursed on a fee-for-service basis based upon a daily unit rate of $92.00 per recipient family.

3. Foster Home Payments

Milwaukee County will reimburse the provider agency for the cost of foster home payments. Payments to the foster home parent will be made by the provider agency. Foster care payments made by the contract agency directly to foster parents during the month under the Milwaukee County DCSD contract are included in the Case Management Daily Rate. The applicant shall submit a foster home "daily rate" schedule that will apply to juveniles in foster care. If the payment rate is variable, please outline how the variable rate will be applied. Please address your agency's policies relating to the payment of any ancillary charges.

4. Pre-License Foster Home Costs

The agency will also be reimbursed, with prior approval of Milwaukee County DCSD, for Pre-License foster home payment costs up to a maximum of ten days or retroactive to the date of the court order for placement.

Monthly reimbursements for each program component (excluding payments for #4, Pre-License Foster Home Costs) will be limited to a cumulative 1/12 of the 2009 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific (Rate X Unit) Rate Statement must be submitted following the end of each calendar month according to DHHS policy.

Contract Duration

This contract will be for calendar year 2009, with the option to extend the contract in each of the two subsequent years.

GROUP CARE Program DCSD 006

Group Homes provide 24 hour a day community based living for youth who are experiencing problems with their families, schools, and in the community. These youth are unable to establish or maintain close functional family relationships and need an alternative living arrangement.

All youth placed into Group Care are adjudicated delinquent and are ordered to Group Care by Milwaukee County Children's Court.

The Delinquency and Court Services Division will be accepting proposals in anticipation of awarding contracts for 30-32 beds (four 8-bed awards and/or three 8-bed awards plus one fractional 8-bed award) of Group Care for male youth. The Division may have a need for additional beds, including beds for girls. However, DCSD will purchase those beds on a fee-for-service basis and therefore they are not included in this RFP. The programs must have the ability to identify and case manage youth who present mental health issues, emotional disturbances and/or AODA problems.

Milwaukee County encourages Group Care providers to continue to develop their vision, mission, values, beliefs and principles. Providers are encouraged to:

- Assist the youth to develop the skills to live in the community.
- Help to integrate the youth into the community's social and economic life.
- Surround the youth with adults that are energized and passionate about their future.
- Promote family involvement in all aspects of services and the child's life.

The applicant must be able to accept the following youth:

- Adjudicated Delinquent youth under Department supervision.
- Wraparound Milwaukee Clients under Department supervision.
- Aftercare youth under Division of Juvenile Corrections Supervision.

PROGRAM APPLICATION

Applicants must address all program elements listed in the following two places:

1. Section 2, Program Application, located in the *Year 2009 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2009 Purchase of Service Guidelines - Program Requirements.*

The following outline includes program-specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application. The Group Care program seeks to:

- Achieve reunification with the natural family by breaking down identified barriers.
- Develop an appropriate long-term plan for youth for whom family reunification is not possible.

Expected Outcomes

Outcome 1: 80% of group home residents will improve their school attendance.
Indicator: Number and percent of youth who demonstrate the defined improvement in school attendance.

Outcome 2: 80% of group home residents will raise their grade point average (GPA) from previous semesters.
Indicator: Number and percent of youth who demonstrate an improvement in their GPA.

Outcome 3: 75% of residents age 16 and older will complete an independent living program prior to successful discharge from Group Care.
Indicator: Number and percent of residents who complete an independent living program prior to successful discharge from Group Care.

Specific Program Activities

The program has ultimate responsibility for overseeing and providing supervision of their residents on a 24-hour/day basis. The resident is to be supervised directly by group home staff or by appropriate school or parental figures at all times.

The program description should include methods to address the specific needs of individual group home residents. The description should also address the family involvement necessary to meet defined program outcomes.

1. Provide counseling by the group home social worker:
   - Individual: One hour per week
   - Group (involving all residents): One hour per week
   - Family: At least 50 minutes every two weeks

2. Complete primary casework responsibilities including all court activities (reviews, extensions, etc.), assessments and referral needs of the residents and their families.

3. Provide individualized Service Planning and Crisis Planning.

   - Develop and maintain an initial assessment and crisis safety plan for each youth. Youth enrolled in Wraparound will have a plan that is developed by the crisis coordinator. Group home staff members are expected to participate in this development.

   - Provide the required crisis plan reviews and service updates to the crisis plan, unless the youth is enrolled in Wraparound.

- Maintain a daily log and progress notes for each youth that documents daily contacts.

4. Staff development, training, and supervision.

   - Provide a written and comprehensive staff orientation and training plan that is consistent with the requirements as determined by the Mobile Urgent Treatment Team (MUTT).

   - Provide on-going orientation, staff development training, and training logs for each staff member. While not all inclusive, staff orientation and training can include approaches to empathy building, relationship violence, errors in thinking, anger management, conflict resolution, etc.

   - Provide documented weekly clinical supervision of non-clinical staff by an agency employee or contracted provider who meets the requirements as determined by the Mobile Urgent Treatment Team (MUTT).

5. Develop and maintain an Interagency Agreement with Wraparound Milwaukee.

6. Compute non-room and board costs from total facility costs.

7. Maintain a signed consent for release of information for MUTT Team.

8. Establish and maintain a working relationship with the MUTT Team.

9. Provide an independent living program (for residents 16 and over).

10. **Provide menu planning and meal preparations that will occur within the group home and will include the participation of the residents. Weekly menus shall be posted. Cost-effective meal alternatives and snacks should be available to residents. For those residents excluded from school, meals are to be provided for both breakfast and lunch, not to exceed 6 hours between meals.**

11. Arrange for or provide vocational education, job readiness training, and tutorial services.

12. Provide for scheduled, age appropriate recreational activities.

13. Provide programming to increase awareness of victim rights.

14. Ensure that annual medical and dental exams are completed for all residents.

15. Enable participation in extra-curricular school activities.

16. Develop written group home rules and written disciplinary protocols.

17. Provide structured, goal-oriented educational programming for residents who are not enrolled in school.

18. Provide documented psychological or psychiatric review or consultation for clients who require such services.

19. Establish a working community advisory committee prior to initial licensure.

    Note: In accordance with Wisconsin Statutes, Chapter 72, Laws of 1981, representatives of the proposed group home's neighborhood and local governmental units must be included. The committee is to continue functioning after licensure.

20. **Monitor youth leaving the group home on a pass. Youth leaving the group home on a pass shall have a specific destination and reason for the event. Any deviation from that must be pre-approved by the DCSD Group Home Liaison.**

21. **Report incidents involving residents, staff, or police to the proper authorities, including the DCSD group home liaison, by the next business day. A written report needs to be received by the DCSD group home liaison within 36 hours of the incident. State and County workers investigating an incident are to be admitted to the group home upon request.**

22. **Complete a monthly case staffing and progress report for each resident. Reports shall include service goals, case contacts, and operationalized intervention strategies for each identified service issue.**

Staffing Related

1. The vendor must ensure that at least one staff person per shift is awake and on the premises at all times.

2. Direct service staff must have at least one-year of experience working with juveniles.

   New employees must receive appropriate training within their first year of service.

3. The social worker must meet the requirements Milwaukee County has established for its Human Service Workers and be experienced in group and individual counseling of adolescents.

4. If the social worker is not an MSW, then the direct supervisor of the social worker must be. Waivers of this requirement will be considered by DCSD on an individual basis for advanced degrees in other human service related disciplines. This does not replace the certification requirements for clinical staff as determined by the Mobile Urgent Treatment Team (MUTT).

Unit of Service

One unit of service is one bed space for one overnight stay with physical presence in the group home at midnight.

Documentation and Confidentiality

Individual case files must include:

- Initial family and child assessments and service plans.
- Crisis safety plans and updates.
- Resident daily logs.
- Resident staffing reports, and service plan updates.
- Counseling notes and contact sheets that include the date and time of the contact, the name of the person contacted, the type of contact (face-to-face, phone, collateral, etc.), and the signature of the worker providing the contact.
- Court documents.
- Incident reports.
- Discharge summaries.

Agency files are to include:

- State regulations and requirements
- Incident reports
- Written procedures for (1) maintenance of client confidentiality, (2) storage of client files, (3) client access to records, and (4) procedures for transfer of records to other treatment providers.

Reimbursement

Reimbursement is based on actual program expenses and is paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2009 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to DHHS policy.

Contract Duration

This contract will be for calendar year 2009, with the option to extend the contract in each of the two subsequent years.

The following programs currently fall within a multi-year contracting cycle and are not open to new provider agencies. The current provider agencies for these services must file a partial application for each program that includes all the items listed under FINAL SUBMISSION plus the Authorization To File for 2009. Please refer to the *Year 2009 Purchase of Service Guidelines – Technical Requirements*.

LEVEL 2 IN-HOME MONITORING SERVICES Program DCSD 008

The Level 2 In-Home Monitoring Program is a pre-dispositional monitoring program that is designed to serve both male and female youth. The program will primarily serve youth pending court for alleged delinquency. As requested by the Division, other youth involved in Children's Court Center matters may be placed at the discretion of the Division. The program provides intensive in-home services to youth and their families in an effort to support parental home supervision, to avoid additional offenses and to appear for their court hearings. Youth are court ordered into this program and remain until the time of disposition or discontinuation of services is deemed appropriate by the court. The program is based on the belief that juveniles who remain connected with their families, schools, peers, employers, and with other community resources, have an increased opportunity to avoid further contact with the juvenile justice system. This is accomplished through structured supervision, program support and counseling, advocacy and the availability of 24-hour crisis intervention.

The 2008 program is designed to cover 96 youth at any one time.

This program may be divided between two vendors.

PROGRAM DESIGN

Applicants must address all program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements.*

The following outline includes "program" specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

Program Description

The service delivery system should include the number and type of staff used to provide program services. The design should also include a daily/weekly schedule to show that all program components are addressed and include parent participation.

Needs and Problems

Provide a detailed description of how your program will address the special needs of this target population. This should include direct service activities that at a minimum must include the required components (listed in the Specific Activities section). Youth generally identified as appropriate for this program are those who have not committed a serious offense such as sexual assault, homicide or drug dealing and are not considered a significant runaway risk.

Specific Program Activities

A brief description of minimum required components is described below. The scope of services is not limited to these specific descriptions.

Supervision/Tracking

The supervision component of the program provides the foundation from which all other services are delivered. Two contacts per day are expected and are to be face-to-face unless otherwise described or approved.

- The provider must perform at least one school contact per day (employment contact if not attending school) on weekdays and a home contact during the day on weekends.

- The provider must know the whereabouts of youth at all times making necessary the development of a reporting/call-in plan to ensure the adequate tracking of youth under supervision.

Counseling

Counseling services, including individual, group and family counseling, or the combination thereof, should be based on the youth's needs. Counseling services should be a minimum of five (5) hours per week.

- Individual counseling should be available to all youth. It may be in the form of structured counseling sessions or integrated into any of the other program components. Counseling can include anger management, communication skills, appropriate decision-making and self-esteem.

- Family counseling should be available to all families. The need for family counseling can be addressed in several ways, including scheduled private family sessions with the Clinician, referral to a community resource, or spontaneous sessions with the Caseworker as the result of a particular problem or issue.

- Group counseling should be available to all youth. Youth should participate in a minimum of two (2), one-hour group counseling sessions per week. The Clinician and Caseworkers must facilitate the groups. Group sessions should deal with a variety of issues such as anger management, adolescent sexuality, problem solving, appropriate decision-making and self-esteem. The primary goal of group counseling should be to develop positive behavioral changes.

Crisis Intervention

Crisis intervention services must be provided 24 hours a day on a daily basis. Clinicians or Caseworkers may provide the crisis intervention services, with oversight and guidance provided by the Clinician. The agency under contract should maintain a relationship with local law enforcement and the Mobile Urgent Treatment Team to properly respond to any crisis that creates a risk of harm or safety.

Family Dynamics

The entire family should have some involvement with the program in order to make the youth's experience more successful. The goal is to help families meet their own needs by

improving interpersonal relationships and the parenting skills of the parents.

Educational Services
For youth enrolled in an educational program, the Caseworker will be responsible for meeting with the appropriate school representatives in order to build a positive working relationship and to better serve the academic needs of the youth. The Caseworker must visit the assigned school daily as part of the required face-to-face contact. If the youth is not enrolled in school when placed in the program, the agency under contract must work closely with the school system to transition the youth back into an educational program.

The agency under contract should also provide one-on-one tutoring services to youth who require these services.

Pre-Vocational Services
Pre-vocational services should be available for youth who would benefit from them. Life skills and job readiness training should be offered to increase participants' chances of finding employment.

Recreational Programming
All youth in the program should be required to participate in structured therapeutic recreational activity at least once per week. Youth should be exposed to various activities to learn alternative ways to spend their free time and promote engagement with the program.

Transportation
The agency under contract must provide transportation for youth to and from counseling sessions, court, educational and medical appointments and recreational activities.

Staffing Pattern
The Caseworker staff shall meet the criteria required by Milwaukee County DHHS for Human Service Worker and the Clinician must be licensed by the State of Wisconsin. A written description of the agency's initial orientation plan and ongoing staff development activities should be included with the application.

Written Reports and Documentation
Documentation requirements will be determined by Milwaukee County.

The provider shall maintain an accurate daily census of all active youth and discharges as requested by Division staff.

A progress report on each youth placed in the program must be submitted to the Children's Court Center on a weekly basis. In addition, a detailed report to the court must be completed for each youth and submitted in advance of the scheduled court hearing. The formats for progress reports and for reports to the court will be determined by Milwaukee County.

The agency will maintain individual case files. An initial case plan/contract will be developed with the participation of the youth and their family.

Goals

The goal of the Level 2-In-Home Monitoring Program is to maintain youth within their parental or relative home, ensure court appearances, and reduce the likelihood of re-offense.

Expected Outcomes

Outcome: Program Completion

- Indicator: Number and percent of youth that complete the program.
- Indicator: Number and percent of youth that participate in at least 5 hours of counseling per week.
- Indicator: Number and percent of youth that actively engage in recreational activities.

Outcome: Compliance with Court Conditions

- Indicator: Number and percent of active youth that attend scheduled court hearings.
- Indicator: Number and percent of youth discharged as a result of the issuance of a warrant.

Reimbursement

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to Milwaukee County DHHS policy.

This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

Correction and Clarification Update 7/23/2007

LEVEL 2 IN-HOME MONITORING SERVICES Program DCSD 008

Prior to revision read:

The 2008 program is designed to cover 96 youth at any one time.

This program may be divided between two vendors.

Revised to read:

The 2008 program has tentative funding to serve a minimum of 100 youth at any one time reflecting an increase in the 2008 requested allocation. Historically the program has been divided between two vendors serving our North and Side youth and families. Funding awards are allocated based upon the percentage of slots designated to each service area. Subject to change, based on service area needs, the current allocations are North side 42% and South side 58%.

SERIOUS CHRONIC OFFENDER PROGRAM Program DCSD 009

The Serious Chronic Offender Program is designed to provide neighborhood-based mentoring and advocacy services to 45 youth who have been adjudicated delinquent and who are on stayed orders of commitment. The program employs an advocate or advocate team to work with each youth. The program will provide substantial intervention in the youth's life, will occupy a substantial amount of otherwise unsupervised time, and will provide enough supervision to protect the community.

The Serious Chronic Offender Program reflects a belief that even the most troubled youth have compensating strengths and capabilities that can be developed and enhanced through supervision, structure, and support. A major program objective is to help youth and their families develop their ability to function without routine contact with law enforcement and to live a positive life within their home and community.

The program is a collaboration that includes the courts, probation staff, and other community-based organizations. It is essential that all components work together to ensure that youth remain in compliance with the program. Communication between involved agencies is essential to ensure the program's effectiveness.

This contract will be awarded to a single vendor.

PROGRAM DESIGN

Applicants must address all program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements.*

The following outline includes program specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

Program Description

Discuss the service delivery model to be used in serving 45 youth that have been identified by the courts as potentially requiring removal from the community for placement in corrections. Please address the following:

- How will your program complete the intake process and complete the initial assessment and service plan document?
- What is the role of the advocate or mentor with the family and other community agencies and resources?
- How will the agency address any supplementary service needs?

- How will client employment training and employment searches be conducted?
- How will inherent transportation issues be managed or coordinated?
- What experience does your agency have with background checks and the recruitment and employment of mentors? How have problems been resolved?
- How is staff training to be provided by your agency? What topics and certifications will be included in your employee in-service training program?
- What other components will be included in your program design (e.g. Group Counseling, Case Staffing, Crisis Intervention, etc.)?
- How will the program utilize the supplemental funds identified in "specific program activities" below? Applicants must provide a separate budget itemizing their anticipated expenses.

Needs and Problems

Identify and discuss the issues surrounding youth that are identified in this target population and in need of close supervision. How will your program's design address these issues to avoid the need for a more restrictive placement?

Target Population

The youth are adjudicated delinquent and ordered to community supervision including probation supervision. The majority of the youth, either by the severity of their behavior or the reoccurrence of behavior, have been determined to be a high enough risk to warrant placement within a correctional facility. Based upon previous experience, approximately 95% of the youth served will be male minorities.

Agency Experience

Discuss your agency's experience in providing mentoring services and in providing the described services to the target population. Include any documentation that demonstrates the effectiveness of the delivery model.

Specific Program Activities

An individual assessment and service plan document is to be developed on each youth and family.

Service plan reviews should occur at minimum of every 90 days by the Program Supervisor at a scheduled in-home or office conference with appropriate agency staff in attendance.

Youth referred to the program will receive an average of 13 hours of face-to-face contact weekly that includes group services provided to the youth as part of the program.

A minimum of one face-to-face contact with the youth or family should occur daily.

Advocates and mentors will be responsible for the following activities:

- Enrolling the youth in school and monitoring school attendance and progress.
- Involving the youth in positive activities that will assist in keeping the youth out of trouble.
- Engaging the youth and family in program activities and providing the required hours of face-to-face contact.
- Assisting the youth with the development of job-seeking skills and in obtaining

employment.
- Providing supportive services to the parents.
- Attending all court hearings involving the youth.
- Providing 24 hour, seven days per week crisis intervention, either by pager or telephone.

In addition to the core program activities described above, the program has available separate funds in the amount of $60,000 that may be used to provide supplemental services or personnel that directly support the youth and their families in their successful completion of the program. These services include, but are not limited to:

- Family Assistance Funds to stabilize basic needs.
- Parenting Assistance to develop parenting skills and knowledge.
- Job Preparation and Employment skills building.
- Child Care to support engagement in therapeutic services and/or activities.

Agreement With Other Community Agencies

If this program is to be operated in collaboration with another agency, please supply complete information about the agency and how they will be involved in the delivery of services. Please include signed letters of agreement.

Staffing Pattern

The Program Supervisor must have a Bachelor's Degree in Social Work, Criminal Justice, or related field (a waiver may be requested). The ideal candidate will have at least 2 years of experience working with delinquent youth.

The Program Supervisor will be responsible for the operation of the program and provide coordination with the Children's Court Liaison assigned to the program.

Youth advocates and mentors should be experienced in the delivery of social services to youth and families. Individual advocates and mentors may reflect various specialized skills. Advocates and mentors are required to have a high school degree or equivalent and have additional training or certification in youth care or social work.

At least one of the advocates must reside in the youth's zip code or neighborhood.

Admission and Discharge Procedures:

Milwaukee County staff determines program referrals and discharges. Referrals will originate with the assigned Probation Officer or Intake Specialist (subject to an appropriate court order). A copy of the court report, along with the dispositional order or docket sheet, will be provided to the contract agency.

The program staff is to contact the youth and family within two business days of a referral. The program is expected to actively attempt to complete the intake through both face-to-face and telephone contacts.

Youth who do not comply with the program or conditions of probation established by the court may be returned to court. Probation staff may file a petition that requests a revision of the order, sanctions, or a lift of the stayed order for correctional placement. Program staff will

provide written documentation and maintain ongoing communications with probation staff.

Documentation
The Division will determine documentation and data collection requirements.

Individual case files must include:

- Service Authorization and referral forms.
- Initial client and family intake forms.
- Initial client and family assessments and service plans.
- Counseling notes or contact sheets to include the date of contact, the name of person contacted, services provided, and the type of the contact (e.g. face-to-face, phone, collateral, etc.).
- Consent forms.
- Incident reports.

Please include copies of proposed forms and document formats with your application.

Goals
The Serious Chronic Offender Program services are expected to be an intensive alternative to a correctional placement by holding youth accountable and minimizing a youth's risk for re-offense. These services are a targeted enhancement to regular probation services.

Expected Outcomes
Outcome: Program Completion
Indicator: Number and percent of youth that complete the program.
Indicator: Number and percent of youth that complete service plans goals.

Outcome: Improved school attendance and performance.
Indicator: Number and percent of youth that demonstrate an improvement in school attendance.
Indicator: Number and percent of youth that demonstrate an improvement in school performance.

Outcome: Improved youth behavior, attitudes, and understanding of offense dynamics.
Indicator: Number and percent of youth that demonstrate improved accountability.
Indicator: Number and percent of youth that can demonstrate recognition of high-risk behaviors.
Indicator: Number and percent of youth that demonstrate improved decision-making.

Outcome: Improved family functioning and understanding of offense dynamics.
Indicator: Number and percent of families that can recognize high-risk behaviors of their youth.

Outcome: Compliance with Court Conditions
Indicator: Number and percent of active youth that do not re-offend while in the program.

Indicator: Number and percent of active youth that do not have a request to lift a stay of corrections filed.

Reimbursement

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to DHHS policy.

This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

ADOLESCENT SEX OFFENDER TREATMENT PROGRAM DCSD 010

The Adolescent Sex Offender Treatment Program (ASOTP) serves the needs of adolescent children whose treatment needs can be met in a structured, community-based setting. Proposals will be assessed, in part, on the agency's ability to determine the child's appropriate sub-group as an offender. In addition, the program should be able to provide, on a case-specific basis, various treatment modalities and service options.

Children who are referred to this program reside throughout Milwaukee County. Therefore preference will be given to agencies that offer multiple service sites or who are able to collaborate with other agencies to provide neighborhood-based services. In addition, preference will be given to agencies that utilize 3rd party payees including private insurance, T-19, or grant money to expand services or to offset Milwaukee County's allocation.

This contract will be awarded to a single vendor.

PROGRAM DESIGN

Applicants must address all program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements.*

The following outline includes specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

Program Description

Discuss the service delivery model to be used in serving 80 adolescent sex offenders. If the model uses a phase system, define who will be responsible for services during each phase and the amount of direct service time afforded each youth. Include a discussion of the curriculum to be used and include any appropriate supporting documents. The program design should also address its ability to deal with age differences and the different types of sexual assault.

Needs and Problems

Describe the difficulties inherent in treating juvenile sex offenders and discuss your agency's philosophy towards treatment. Include an outline of the proposed treatment modalities (e.g. In-Patient, Group, Individual, and Family treatment) and describe the specific therapeutic models being proposed and to be used for the majority of youth.

Agencies under consideration should demonstrate their understanding of the community's need for safety.

Target Population
Discuss the program's target population within the context of the ages, severity of the offenses, and various family histories and dynamics. Discuss strategies for overcoming the inherent difficulties in engaging individual children and families in the treatment process.

Agency Experience
Discuss the agency's experience in providing services to the target population and in treating emergent or established disorders. Include data or reports that demonstrate the effectiveness of the delivery model.

Program Activities
1. Assessment of the child and family to identify the child's sub-group as an offender.

2. Group, Individual, and Family therapy as determined to meet the treatment needs of the specific child and family.

Note: Please list and discuss the group counseling activities included in your treatment model.

3. Relapse Prevention programming and implementation of an individualized Safety Plan that is specific to the needs of each child. Safety Plans involve the family, are regularly reviewed and updated, and are written. An initial Safety Plan will be completed within 30 days of intake into the program. A final Safety Plan will be in place upon discharge from the program.

4. Bilingual capability to work with Spanish speaking families.

5. Home visits when necessary to engage the family in treatment services.

6. Access to community-based mentoring programs where available.

7. Transportation planning (may include public transportation).

8. Bi-monthly staffing of currently active cases.

9. Ongoing consultation and communication with Probation Officers and/or Care Coordinators.

Documentation
Individual case files must include:

- Initial family and child assessments
- Individualized treatment plans
- Operationalized treatment goals
- Client staffing reports and treatment plan updates

- Counseling notes and contact sheets that include date of contact, name of person contacted, type (face to face, phone, collateral, etc.)
- Written Safety Plan including final plan
- Court and referral documents
- Incident reports

Goals

ASOTP services are expected to provide a structured intervention to reduce a youth's risk of re-offense by addressing factors identified and potentially contributing to the youth's presenting behavior.

Expected Outcomes

Outcome: Program Completion

Indicator: Number and percent of youth that complete the program.

Indicator: Number and percent of youth that have an initial safety plan in place.

Indicator: Number and percent of youth that have a final safety plan in place at the time of discharge.

Outcome: Improved youth behavior and reduction of risk.

Indicator: Number and percent of youth that demonstrate responsibility for their behavior.

Indicator: Number and percent of youth that demonstrate empathy for their victims.

Outcome: Improved family understanding of offense dynamics and ability to manage youth behavior.

Indicator: Number and percent of families that can recognize high-risk behaviors of their youth.

Indicator: Number and percent of families that engage in and understand their youth's relapse prevention plan.

Reimbursement

Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to DHHS policy.

This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

SHELTER CARE Program DCSD 011

Shelter care is a short-term (typically 30 days) non-secure, supervised residential program as defined and regulated under HFS 59. The program will primarily serve youth pending court for alleged delinquency. As requested by the Division, other youth involved in Children's Court Center matters may be placed at the discretion of the Division.

In addition to the above-described services, providers must be able to demonstrate the ability and willingness to enter into the following collaborative agreements.

- Providers must lease facility space located at 9501 West Watertown Plank Road, Buildings D and E, which is part of the Milwaukee County Behavioral Health Division (BHD) complex, formerly known as CATC. This facility is currently licensed for 64 shelter care beds.

- Providers must be willing to work with the Wauwatosa School District that provides on-grounds educational programming for youth temporarily housed on county grounds.

This contract will be awarded to a single vendor.

PROGRAM DESIGN

Applicants must address all general program elements listed in the following two places:

1. Section 3, Program Design, located in the *Year 2008 Purchase of Service Guidelines - Technical Requirements.*

2. "Introduction and Instructions", located in the front of the Delinquency and Court Services Division's section of the *Year 2008 Purchase of Service Guidelines - Program Requirements.*

The following outline includes "program" specific information and responses required by the Delinquency and Court Services Division. This information should be addressed in the appropriate section of your application.

Program Description

Shelter Care for 44 Males and 20 Females

The provider must be able to provide 24-hour supervised care.

Each unit is capable of housing up to 24 youth. Lease costs, available from Milwaukee County DHHS, include utilities, grounds maintenance, major equipment and building repair costs, overhead and depreciation costs (building, equipment and furniture amortization cost), use of the gym and employee parking. The cost of meals and laundry are not included. The vendor will also be responsible for coordinating the use of common-use areas with the BHD-CATC Administrator.

The provider proposing to provide temporary shelter as described above must demonstrate

the ability to have a license to provide shelter from the State Department of Health & Social Services.

Education

An on-site school program will be provided by the Wauwatosa School System on the CATC premises. The provider will be responsible for supervision of the youth during the noon lunch hour and other periods when school is not in session. Provider staff must also provide crisis intervention assistance when requested, handle acute disruptive problems, participate in school conferences, attend school orientation, and be available to school authorities when requested.

Placement Criteria

Youth can only be placed in the program if they are referred and approved for placement by the Division and if one of the following criteria is met:

1. There is a court order for custody under s. 938.19(1)(c) or s. 938.21(4)(b) Wis. Statutes,

2. An intake worker placement decision is made pursuant to s. 938.205 Wis. Statutes,

3. There is an emergency change of placement under s. 938.357(2) Wis. Stats., subject to further court action for placement elsewhere,

4. There is an emergency change of placement under s. 48.357(2) Wis. Stats., subject to further court action for placement elsewhere,

5. A signed voluntary placement agreement.

Specific Program Activities

- The provider must accept youth for placement 24 hours a day, seven days a week.

- The provider must have the ability to be on-call and available to transport youth to and from the Detention Center/Court Center at all times and to a medical provider as necessary.

- The provider must fully comply with all current provisions and revisions of "The Temporary Shelter Care Policy and Procedures" published by Milwaukee County DHHS that is available from Division staff.

- The provider must have staff members awake and alert throughout the night.

- The provider shall have responsibility to directly notify the Bureau of Milwaukee Child Welfare if any abuse is suspected either within the Shelter, or upon return of a youth from the outside and shall be responsible for reporting missing/runaway youth to appropriate law enforcement.

- The provider shall maintain an accurate daily census of all active youth and discharges

as requested by Division staff.

- The provider must report on a monthly basis any changes in staff providing direct care.

Staffing Pattern
Direct service staff must possess a high school diploma and have three years experience working with juveniles. Four years experience with programs serving juveniles may be substituted for a high school degree. The provider must be able to document staff experience at the request of the Division. The application should include a written description of the provider's orientation plan for new staff and ongoing staff development programs.

Documentation
Documentation requirements will be determined by Milwaukee County and will include any requirements of the State of Wisconsin's regulatory guidelines.

Goals
Shelter care services are expected to provide a safe, monitored environment for youth awaiting court hearings, placement in foster care, group care, residential treatment care, or pending return home.

Expected Outcomes

Outcome: Program Completion
Indicator: Number and percent of youth that complete the program.
Indicator: Number and percent of critical incidents filed (Number of critical incidents / Total actual days of care).

Outcome: Compliance with Court Conditions
Indicator: Number and percent of active youth that attend scheduled court hearings.
Indicator: Number and percent of youth discharged as a result of AWOL.

Reimbursement
Reimbursement is based on actual program expenses and paid monthly. Monthly reimbursement will be limited to a cumulative 1/12 of the 2008 Milwaukee County approved contract allocation. Annual reimbursements may not exceed actual program expenses or the total contract allocation. A program specific Revenue and Expense Statement must be submitted following the end of each calendar month according to Milwaukee County DHHS policy.

This contract will be for calendar year 2008, with the option to extend the contract for two additional years.

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Section 4
Disabilities Services Division

YEAR 2009
PURCHASE OF SERVICE GUIDELINES
PROGRAM REQUIREMENTS

Issued July, 2008

VISION, MISSION & GUIDING PRINICIPLES

Vision for the Milwaukee County Disabilities Services Division

All persons with disabilities and their support networks will have maximum individual choice and access to resources leading to full participation in all aspects of community life.

Mission of the Milwaukee County Disabilities Services Division

Our mission is to enhance the quality of life for all individuals with physical, sensory and developmental disabilities and their support networks living in Milwaukee County by addressing their needs and providing individualized opportunities for persons to participate in the community with dignity and respect, while acknowledging their cultural differences and values.

Guiding Principles

Independence: Everyone has a right to do what they want and need to do to function in society.
Achievement of the highest level of independence
Continuum: Need to provide a continuum of services
Real Choice: Self Determination
Nurturing Relationships/Friendships
Strengths Based vs. Needs Based
Respectful and Fully Accessible
Equality and Rights for All
Participation in the Mainstream
High Quality staff, providers, services, options
Maximum flexibility
Individualized, Person-Centered, Culturally Competent
Collaboration and Partnership
Values cultural and ethnic diversity
Emphasizes Home and Community Based programs and services
People have the ability to live where they want to live, and have opportunities to work and recreate
Total acceptance in the community, no stigma
Involvement of consumers in the planning process
Comprehensive grievance system, systemic method to resolve issues
Continuing grievance system, systemic method to resolve issues
Continuing community education and advocacy
All stakeholders as advocates
Allocation of sufficient resources
Successful outcomes or each individual

The premise of this approach rests on flexible supports for individuals with disabilities changing through life stages, starting at birth through childhood, adult living and senior years. Services and supports at these critical stages require unique consideration, assessment, planning and intervention to offer appropriate supports to the individuals and families. Providing flexible supports and allowing for changes through life's stages promotes a continued presence in the community, encourages higher achievement levels and successful outcomes for each individual served.

Developmental Disabilities staff expects all providers of services to be familiar with, and aware of, the following in regards to service delivery:

Selected Providers:

- must be familiar with developmental disabilities condition and have a basic understanding of the cognitive issues and current service philosophy;
- should be knowledgeable in the person-centered and/or person-directed service planning model;
- must strive for cultural and social competencies, i.e., ethnic, religious or gender factors;
- should be open and seek to address stated preferences of consumer/guardian family;
- should have knowledge of the inclusion philosophy;
- should have knowledge of program design and service implementation in natural environments;
- must be interested in and willing to support or provide reasonable flexibility in service to meet the different consumer needs of the population;
- must be interested in seeking utilization of generic resources for community awareness and participation on behalf of the consumer;
- must be able to plan, coordinate and/or provide transportation services to meet transportation needs (to include the use of family, friends, public transportation, specialized service, or leasing of a vehicle;)
- must be able to plan and collaborate services with other providers and exhibit a cooperative spirit.
- All providers must communicate with designated county staff and other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents as defined in the Medicaid Waivers Manual, Chapter IX.

PROPOSAL SUBMISSION REQUIREMENTS (Applies to all DSD programs up for competitive bid):

Service/Treatment Process

For each program for which you are submitting a competitive proposal:

(1) List and define each program's activities, purpose of the activity, and the usual size, structure, and schedule of activities or groups.

(2) Describe the sequence of program activities, including counseling and/or treatment, if applicable. Indicate the phases of service/treatment, the length of time in each phase, and the criteria used to determine movement from one phase to another.

(3) Describe how and when individualized client treatment plans, goals, and objectives are developed, monitored, and reviewed. Identify by position categories, staff that is involved in this process.

Describe formal relationships and informal arrangements used to leverage resources with other community agencies or programs providing services to the target population. Describe the qualifications of agencies and other professionals. Include copies of letters of agreements, as applicable.

If applying as an incumbent, summarize the process and results of the previous year's evaluation report submitted to DSD. Include any changes made in the program as a result of the evaluation.

CRISIS RESPITE HOME #DSD012CR

INTRODUCTION

The Milwaukee County Department of Health and Human Services Disabilities Services Division (DSD) is seeking proposals to develop a coordinated system of residential treatment and social service supports to aid individuals who experience co-occurring developmental disabilities and mental health conditions or chronic behavioral challenges. The goal for this Request for Proposals (RFP) is to create a Crisis Respite Home (CRH) that will provide a short-term stay to address consumer's crisis needs. The intent is to develop and utilize a community-based setting deterring the consumer from institutional care. The Crisis Respite Home will link to support services and personnel at DSD and the Milwaukee County Behavioral Health Division (BHD) to form a structure and system of professional crisis supports.

BACKGROUND INFORMATION

State Statue 51.42 provides the administrative policy that directs counties to plan and implement community services for adults with developmental disabilities. This legislation established DSD's responsibility to respond to the service needs of adults with developmental disabilities through a variety of habilitative, rehabilitative and preventive services. The intent of the statute is to enable adults with disabilities to live and participate in community settings geared at developing, providing and monitoring resources that address the safety, specialized supports and quality of life aspects of community living.

Consequently, the DSD's mission is to enhance the quality of life for all individuals with physical, sensory, and developmental disabilities living in Milwaukee County and their support networks by addressing their needs and providing individuals with opportunities to participate in the community with dignity and respect while acknowledging their cultural differences and values.

Through the role of supporting individuals in community services, DSD purchases a variety of services for adults. Several thousand participants are supported each year in services that promote consumer's ability to reside in natural settings, provide productive paid work, meaningful activities, and offer opportunities for social interaction with others.

Although over 200 different agencies are under contract for services, DSD continues to strive to provide appropriate, timely support to adults with developmental disabilities in behavioral crises.

SERVICE DESIGN

DSD and BHD's vision of the CRH is to provide services that address inappropriate, dysfunctional and high-risk behaviors presented by an individual with a disability residing in a community-residential setting where feasible.

Therefore addressing the behaviors in natural homes will provide the stability needed and offer the caregiver(s) support, respite and an opportunity to develop strategies which address behavioral difficulties. The goal of the community intervention is to return the individual to their home or primary residence.
Currently, these behaviors present barriers to the individual continuing occupancy in their home, thus an out-of-home alternative is pursued often seeking services from BHD Psychiatric Crisis Services (PCS). Offering an out-of-home short-term support arrangement, and diverting individuals from institutional care is the primary goal of this initiative. When successful, the crisis plan resulting from admission to the Crisis Respite Home will be utilized as an intervention and not a conduit to a change of residence.

The CRH is an intervention/prevention service model of delivery. By offering a community home location to de-escalate exacerbated behavioral difficulties with experienced staff and supervision, both DSD and BHD view this arrangement as the most optimum in addressing the behaviors and supporting caregivers through a difficult period. The plan for a team approach will enable professional support and consultation during and after the crisis with focus on decreasing or preventing future episodes. The consumer will return to their home and routine as quickly as possible with strategies to alter challenging behaviors. DSD and BHD staff collectively recognizes the importance of intervention, planning and monitoring after the trauma. Consequently, a component of this new initiative will be a team approach of the two Divisions working directly with the residential vendor on coping with challenging behaviors and strategy development for the home setting.

Important elements for this Crises-Respite Home service are:

- A close collaborative, professional relationship with all parties on behalf of the person and primary home site.
- Accurate data gathering on persons served and review for fine tuning the services as well as tracking program outcomes.
- Participation by the involved parties in a review of the crises and future planning with the caregiver, family or significant others.
- Periodic follow-up to assist with maintaining client stability in the home and community.

The primary objectives of the community-based CRH service are threefold:

1. Develop a home and support model that provides a community residential option paired with experience professional guidance to address crises.
2. Develop a residential component to the existing services designed to divert individuals from inpatient care and create a consultative support model.
3. Create a new service that offers short-term stay for adults as a new addition to the service network.

DSD is seeking a provider to:

- Develop and integrate a team approach with DSD and BHD's active involvement in the home service delivery model.
- Accept only referrals made through DSD.
- Provide 24-hour supervision when clients are present in the home.
- Provide flexible staff pattern (home manager) to meet at various locations to aid

with follow-up monitoring and support of a resident or to assess an individual for admission. Develop staff capacity to visit the home of a participant(s) of the CRH.
- Provide hours of operation for the home/primary staff from 8 a.m. to 6 p.m., Monday through Friday.
- Install a phone system with availability to staff on weekdays 8 a.m. to 6 p.m., and weekends 8 a.m. to noon via cell phone for DSD and BHD contact.

DSD has made a commitment to continue development of its contracted services provider network in response to the increasing demand for emergency/crisis services. This commitment includes the need for on-going strategies to provide the highest quality emergency/crisis services in the least restrictive setting of the consumer's choice. In this effort to fully support individuals in community-based alternative care settings, it is necessary to provide a full continuum of care including emergency/crisis amelioration services.

The successful applicant will demonstrate the ability to develop professional Medicaid Crisis Intervention and Stabilization services provided by agency staff. Medicaid revenues billed under HFS 34 and will be maximized utilizing the existing Milwaukee County certification in collaboration with BHD Psychiatric Crisis Services to ensure that services are fully implemented. Revenues earned will offset professional staff and program costs and should be included in the applicant's proposal. Staff from BHD Crisis Mobile Team may be utilized to assist in program development and implementation. Application budgets should reflect projected revenues and costs associated with the provision of crisis and stabilization services.

TARGET GROUP

Consumers to be considered for the CRH by design are developmentally disabled with secondary conditions of mental health diagnosis or current patterns of emotional instability. The conditions/characteristics typically seen are:

- Impulsive behavioral outburst patterns.
- Physical aggression.
- Self-abusive behavior.
- Property destruction.
- Threatening behavior toward others.
- Running away from home setting.
- Striking others.
- Refusal for go to appointments.
- Withdrawal from participating in the home programming socializing with others.

Individuals may reside with family, significant others or in DSD supported homes including group homes, adult family homes or apartment settings. Candidates to be served in this home may be active in the DSD Long Term Support system, transition school services (18 to 21) or wait-listed for services.
Individuals admitted to the CRH will be reviewed by DSD and BHD, screened by the residential treatment provider and receive formal authorization for admission from DSD. In addition to having a developmental disability, the candidate must meet and pass the

State of Wisconsin Long-Term Care Functional Screen for DD-level of care to receive on-going support.

Service Outcomes to be achieved by the CRH:

1. Reduce the number of admissions of adults with developmental disabilities in PCS, Acute inpatient or Observation services.

2. Reduce the length of stay of adults who are inpatient at mental health/psychiatric hospitals.

3. Expand residential support service in the network of community-based resources by providing a facility offering short-term stays for stabilization.

4. Provide linkage and follow-up services for adults admitted to the home and their respective home and caregiver.

PROVIDER EXPERIENCE

Agencies or independent owner/operators with intent to apply for acquiring the bid to operate the CRH must have the listed experience. Provider qualifications and experience must meet the basic criteria for DSD consideration.

A Provider must be:

- Familiar with developmental disabilities conditions and have a basic understanding of the cognitive issues and current service philosophy.

- Knowledgeable in the person-centered and/or person-directed service planning model.

- Accommodating and strive for cultural and social competencies, i.e., ethnic, religious or gender factors.

- Interested in and willing to support or provide reasonable flexibility in service to meet the different consumer needs of the population.

- Able to plan services and collaborate with other providers and exhibit a cooperative spirit.

Specialized Background for this RFP: (provide detail in application narrative)

- 5 years of experience with the provision of residential services.
- 5 years of experience in service provision for adults with developmental disabilities.
- 3 years of experience in service provision for adults with mental health or chronic behavioral challenges.

- 3 years of experience working with adults with disabilities in crisis intervention and stabilization.
- 3 years of experience working with families through informal and formal counseling and guidance services.

Agency/provider applying to operate this home should:

- Submit a letter of intent to collaborate with DSD and BHD on the service delivery model.
- Have a home that is licensed by the state and completed (or in process) and in compliance with the city occupancy regulations.
- Plan on-site staff supervision/availability 24 hours per day when the site is occupied - although it is anticipated that some clients may have day or work programming.
- Have lead staff with experience in behavioral plans and flexible scheduling attend meetings, visit other residences and participate in follow-up support plans.
- Identify and demonstrate linkage to "critical" services (clinical supports) typically needed for crisis stabilization.

WORK PLAN

Agency/providers responding to this RFP need to include a Work Plan that details functions and timelines to address organization and opening of the CRH.

Respond to each of the listed items in the narrative.

- Provide details of the home (type, license, etc.), to serve as the crisis respite site.
- Explain the home characteristics, the neighborhood and any assets the home has to meet the needs/interest of the specialized target group
- Describe home bed-capacity and special details or features.
- Identify the proposed staffing pattern and experience, including proposed schedule, home coverage and any other information pertinent to operating this home.
- Identify administrative personnel to assist with the home operations and responsibilities.
- Provide acknowledgement that the agency is fully aware of the disabilities, conditions and characteristics identified in *target* groups, thus demonstrate an understanding of persons to be served in this site/home.
- Identify the home adaptation and modifications that *currently exist* or may be needed to address the specialize services to be provided.
- Outline the approach/procedure the agency plans to use in collaborating with the person's permanent setting/living arrangement.
- Develop crisis intervention capacity under HFS 34 to include professional staff necessary to implement and deliver all crisis and follow-up services.

Interested parties should seek to incorporate best practices guidelines and place a high value on the following characteristics:

- Individualized review and person-centered planning.
- Smaller living arrangements result in higher likelihood for success.
- Community-based support model versus institutional care.

- Offers support to families and existing residential caregivers and providers.
- Offers flexible professional support in community or natural setting versus therapeutic support in office or hospital settings.

A cover letter should accompany each proposal, which indicates the name of the individual who should be contacted if clarification of the proposal's content is necessary and specifies the agency representative of the firm to meet with the County for a formal interview if requested.

An in-person presentation of the proposal to the County may be required. All expenses incurred by the firm for the completion of this proposal including, but not limited to, interviewing, in-person presentations and clerical expenses are to be paid by the firm.

COMMUNITY LIVING SUPPORT

RECREATION #DSD011

Recreation programming for developmentally disabled children and adults provides integrated or specialized opportunities for social interaction, self-expression and entertainment. Programs should be designed to maintain motor skills and develop recreational interest of consumers. Consumers are offered opportunities to socialize with peers and other people who are not disabled while increasing recreational experiences. Participants receive an individualized screening and thus, participate in independent and/or group activities accordingly. Activities are selected based on personal choice or skill.

The goal of recreational resources is to introduce the consumers to a variety of activities and experiences with the intent of these experiences being transferred to general community living activities by the person with their peers, families or other significant individuals.

Recreational services also design and facilitate integrative recreation. For several consumers this service focuses on assessing and enrolling their participation in generic recreation and educational activities in the community. Services are provided on a one to one or a small group basis, and implemented based on a personal assessment.

Recreation Administrative Service Requirements:

Three (3) times per year the recreational provider and administrative entity will provide an in service to community providers on recreational activities in the Milwaukee community, leisure skill development and implementation, and facilitating integrated recreation.

Two (2) times per year the recreation agency (ies) will participate in a DD system discussion session with DSD staff to review consumer issues, discuss service outcomes, unmet and under-served consumer needs, and future service planning.

Unit of Service

The vendor will be reimbursed for expenses up to 1/12 (one-twelfth) of the annualized contract per month. The reimbursement will be for the actual expenses or 1/12 (one-twelfth) of the contract amount, whichever is lower, based upon a review of the vendor's monthly billing statement. The format of the billing statement will be determined by the Disabilities Services Division and may include program staff, occupancy costs, equipment costs and other expenses found to be appropriate. The billing statement shall be submitted on a monthly basis.

Documentation

Financial records/CPA audit.

DEVELOPMENTAL DISABILITIES-CHILDREN

EARLY INTERVENTION BIRTH TO THREE SERVICES FOR CHILDREN # DSD009

Early intervention programs are provided in accordance with the requirements of the Individuals with Disabilities Act (IDEA) and WI Administrative Code, HFS 90. Early Intervention programs are designed to enhance parents'/caregivers' ability to meet the unique developmental needs of their child and to enhance the overall development of the child within the context of the child's family and community.

The principles that guide this program are:

1. A child's optimal development depends on their being viewed first as children and second as children with a problem or disability.

2. A child's greatest resource is their family.

3. Parents are partners in any activity that serves their children.

4. Children are best supported within the context of family and the family is best supported within the context of the community.

5. Professionals are most effective when they can work as a team member with parents and others.

6. Collaboration is the best way to provide comprehensive services.

7. Early intervention enhances the development of children.

These principles were adopted by the State Interagency Coordinating Council and reflect the values that guide implementation of the Birth to Three Program.

The Milwaukee County Department of Health and Human Services, Birth to Three Program is the lead agency. DHHS maintains central intake functions. New referrals are assigned to agencies for evaluation, assessment, eligibility determination, plan development and on-going services.

All families participating in the early intervention programs work with a service coordinator. The service coordinator is the primary contact for the family from the time of referral to the time of transition from Birth to Three Program. The service coordinator arranges for evaluation, assessment, and development of the IFSP. The service coordinator is responsible for ensuring that families understand their rights within the program.

The evaluation team for Birth to Three must include a service coordinator and at least two

qualified professionals (per HFS 90). The parent/surrogate parent/guardian is a member of the evaluation team.
The team reviews existing evaluations, performs additional evaluations which may be necessary, observes the child in their home or community environment and completes individual written reports. The evaluation provides information about the child's current developmental functioning and determines the child's eligibility for services. If the child is eligible, the family and the team develop an Individual Family Service Plan (IFSP) based on the family's identified concerns and priorities regarding the child's development. The IFSP must be developed within 45 days from the date of referral. The IFSP includes specific activities to address the family's priorities regarding their child's development. Services listed on the IFSP should be initiated in a timely manner. A Child Outcomes Summary Worksheet with program entry information will also be completed at this time. The service coordinator assists the family in obtaining the recommended services. The IFSP is reviewed/revised with the family at least every six months.

The Evaluation Team Report, the IFSP, and the Child Outcomes Summary Worksheet are submitted to DHHS Birth to Three Program staff for review and authorization of services.

Services provided to children/families are based on the concerns and priorities identified in the IFSP. The services should promote community integration for children with developmental disabilities and/or delays. The services should be provided within the context of the family/child's daily routines. Services may include: education, occupational therapy, physical therapy, speech therapy, psychology, assistive technology, nutrition, social work, parent education and support, and transportation. Service coordination is provided for all eligible children and their families. Service delivery can include: individual service, group activities, consultation activities with family and providers, and parent education activities.

Services should be designed to meet the family's needs, schedules, and their priorities regarding their child's development. All agencies should describe in their application how their program design will provide services within the context of the child and family's daily routines.

If the IFSP team considers provision of services in other than the child's natural environment, the program must have sufficient documentation to support the team's decision that the child and family outcomes could not be met by providing services in the natural environment. The documentation should include an explanation of how the IFSP team made this determination, how the goals and strategies will be generalized to other environments and what supports are needed to serve the child within the home and community environment.

Early Intervention Birth to Three Program Requirements

1. Address all Disabilities Services and HFS 90 Early Intervention requirements related to evaluation, development, implementation and revision of the Individual Family Service Plan (IFSP), service coordination, obtaining informed parent/guardian/surrogate parent consent and ensuring that the parent/child rights are maintained.

2. Make available appropriate qualified staff for evaluation of children referred by the Birth to Three DHHS Intake staff. Staff should meet the personnel and training requirements of HFS 90.

3. Make available appropriate qualified staff for the provision of services to children and families within the context of their daily routines.

4. Make available appropriate qualified staff to provide service coordination, to develop and monitor the IFSP with the family and to link families with appropriate services and resources. Per HFS 90, Service Coordinators are required to participate in at least 5 hours of training each year related to early intervention. Service coordinators should also be knowledgeable of community resources for children and families.

5. Address the agency's plan for family participation in evaluation, IFSP development and provision of services.

6. Review the IFSP with the family at least every six months.

7. Transition children at age three to appropriate school and community resources.

8. Provide a representative to receive referrals for the agency at the DHHS Collaborative Intake meeting.

9. Have adequate billing procedures to ensure that third party revenues are maximized and the Birth to Three cost share system is implemented.

10. Have adequate written information available for non-English speaking families, e.g., program descriptions, service descriptions, primary policies and guidelines for participants.

11. Submit National Child Outcomes entry and exit data.

12. Submit annual National Family Outcomes data.

Agency Reporting

1. On a semi-annual basis each agency must provide a narrative on transition and discharge of children from the program. The final report for the year should include the six months data and the yearly total.

2. Each agency will submit a semi-annual report listing training activities for service coordinators and any assistance needed from DHHS & State Birth to Three staff that would enhance service coordinator skills and knowledge of resources.

3. Each agency must provide a yearly summary of parent education activities, using the following format:

Date(s)	Activity	Topic	Location	# Parents Attended

4. Each agency must provide a yearly summary highlighting successes in providing services within the context of the community and listing any barriers to implementation of their program design.

5. Each agency must identify and submit three (3) personal stories identifying the service outcome and client/family benefit from the service.

6. Each agency must describe staffing shortages and/or challenges and their action plans to alleviate the issues.

Program Performance Data

1. Individuals with Disabilities Education Act (IDEA) 2004 revisions require states to provide **Child and Family outcome data** demonstrating the impact of early intervention. The primary focus of Federal and State monitoring activities is on improving education results and functional outcomes for all children with disabilities.

   The Office of Special Education Programs (OSEP) in the U.S. Department of Education has taken stronger actions to enforce the IDEA by issuing the first set of state-level determinations for Part C, Birth-to-Three Program. The determinations were based on fourteen federally defined indicators required under federal statute as part of ongoing efforts to improve results for children and youth with disabilities.

   OSEP has required states to enforce IDEA by making local determinations annually on the performance of each early intervention program under Part C. States are required to consider a county's performance on compliance indicators based in part on **Child and Family Outcomes** and other performance data.

   The compliance indicators are:

   1) Percent of infants and toddlers with Individualized Family Service Plans (IFSP's) who receive early intervention service on their IFSP's in a timely manner (within 30 days). State target: 100%.

   2) Percent of infants and toddlers with IFSP's who primarily receive early intervention services in the home or in programs for typically developing children. State target: 95.68%.

   3) Percent of infants and toddlers with IFSP's who demonstrate positive social emotional skills, acquisition and use of knowledge and skills, and use of appropriate behaviors. State target: not yet determined.

   4) Percent of families participating in Part C who report that early intervention services have helped the family. State target: not yet determined.

   5) Percent of infants and toddlers from birth to age 1 with IFSP's compared to birthrate. State target: 1.13% of birthrate.

6) Percent of infants and toddlers from birth to age 3 with IFSP's. State target: 2.80% of birthrate.

7) Percent of eligible infants and toddlers with IFSP's for whom evaluation was completed within 45 days. State target: 100%.

8) Percent of children exiting Part C who received timely transition planning. State target: 100%.

In October and November of 2007, the DSD Birth-to-Three program was evaluated by the State. Milwaukee County received a local determination of "needs assistance" on several indicators. Determinations of program compliance by counties will be provided annually, and states must apply enforcement actions after a county's overall determination of "needs assistance" results for two consecutive years. These compliance indicators have been in existence for at least five years. It is essential to ensure that contracted Birth-To-Three providers meet all compliance indicators in order to avoid a second year determination of "needs assistance."

The State and County have jointly developed individual agency Performance Improvement Plans (PIP's). These PIP's are mandatory to ensure compliance with federal indicators. The individual PIP's were based upon an agency's compliance with the performance indicators. 2009 Birth-To-Three contract allocations will be based upon provider agencies' ability to comply with these indicators per the plans.

All Birth to Three Program provider agencies will be required to collect and submit entry, ongoing and exit data for each eligible child receiving services. The data will reflect achievement/progress toward the following **Child Outcomes**:

a. Children have positive social-emotional skills (including positive relationships.

b. Children acquire and use knowledge and skills (including early language/communication).

c. Children will take appropriate actions to meet their needs.

Information will be collected for each child by the evaluation team and submitted on a Child Outcomes Summary Worksheet. The worksheet will be submitted to DHHS at least twice: entry data will be recorded at the time of IFSP development and exit data will be collected when the child is discharged from the program after a minimum of six months participation.

2. **Family Outcome** information will be collected and submitted to DHHS on an annual basis in the form of a survey. The survey responses will reflect achievement/progress toward the following Family Outcomes:

a. Families understand their child's strengths, abilities, and special needs.

b. Families know their rights and advocate effectively for their children.

c. Families help their child develop and learn.

d. Families have support systems.

e. Families' access desired services, programs and activities in their community.

Unit of Service

For all Birth to Three programs a unit of service is one-quarter hour of direct service time.

Direct service time is staff time spent in providing service to the program participants, which includes face-to-face contacts (office or field), collateral contracts, telephone contacts, client staffings, and time spent in documentation of service provision. (Direct service does not include indirect time such as that spent at staff meetings, in service training, vacations, etc.)

Collateral contacts are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc.

Reimbursement for group services is based on one hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

Documentation

Direct service time must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact; (b) the type of contact (face-to-face, collateral, phone, etc.); (c) who the contact was with; (d) the content of the contact; and (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

RESPITE CARE - CHILDREN #DSD012

Respite care is designed to provide for a substitute caregiver when an interval of rest or relief is needed by the primary care giver. Respite may be provided in the family's home, in a licensed foster home for children, or in a certified adult family home.

Agency Requirement-Respite Care

1) Semi-annually, the provider will produce a survey on un-met family/individual needs, in addition to, other service trends or needs identified.

2) Semi-annually, the provider will submit a report indicating service utilization and program participants' satisfaction.

3) Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

Unit of Service

A unit of service is one hour of direct service time.

Direct service time is staff time spent in providing service to the program participants which includes face-to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffings and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in service training, vacation, etc.)

Collateral contacts are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc.

Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

Documentation

Direct service time must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face. collateral, phone, etc.), (c) who the contact was with, (d) the content of the contract, and (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

FOLLOWING PROGRAMS NOT OPEN FOR COMPETIVE PROPOSAL

Disabilities Services Division has three-year program contract cycles. Only Cycle 1 (C1) programs are open for competitive proposal in the 2009 contract process. New applications will be accepted for Cycle 1 programs only.

All agencies that are in the second or third year of a multi-year contract cycle (non-cycle 1 programs) **in 2009 are not open for competitive proposals**. Agencies that are currently in a multi-year contract cycle (do not require a competitive, panel review), but **must** submit **all** the items listed under FINAL SUBMISSION, the Authorization To File (Item 3), **plus the semiannual evaluation report** as found in the Application Contents section of the *Purchase of Service Guidelines - Technical Requirement.* **The following programs are currently in a multi-year contract cycle:**

WORK AND DAY SERVICES

DSD 007 - Day Services
DSD 008 - Day Services - Integrative Community Based
DSD 006 - Work Services

EMPLOYMENT PROGRAMS

DSD 010 - Employment Options

Because of the unknown impact of the planned expansion of Family Care****** in Milwaukee County, DSD is recommending new contracts in 2009 for six (6) months at 1/2 of the current 2008 funding level for the above programs in a multi-year contract cycle.

In addition, agencies that are **not** currently in a multi-year contract cycle, but have contracts for the following services are also being recommended for new contracts in 2009 for six (6) months at 1/2 of the current 2008 funding level:

ADVOCACY

DSD 005 - Advocacy
DSD 005 - Advocacy/Consumer Education

COMMUNITY LIVING SUPPORT

DSD 012 - Respite - Adult
DSD 014 - Assertive Case Intervention

COMMUNITY RESIDENTIAL

DSD 015 - Supportive Living Options
DSD 016 - Supported Parenting
DSD 017 - Person-Centered Planning
DSD 018 - Targeted Case Management

WORK AND DAY SERVICES

Wait List Initiative

The above agencies **must** also submit **all** the items listed under FINAL SUBMISSION, the Authorization To File (Item 3), **plus the semiannual evaluation report** as found the Application Contents section of the *Purchase of Service Guidelines - Technical Requirements*

All Initial Submissions, regardless of contract cycle year, must be received by the DHHS **no later than 4:30 p.m. on Friday, September 5, 2008. Final Submissions are due Friday, December 12, 2008.**

**The Milwaukee County Department of Health and Human Services Disabilities Services Division (DSD) is anticipating implementation of the project to expand Family Care in Milwaukee County for adults under the age of 60 during CY 2009. Once this implementation begins, it will be the policy of DSD that any person receiving services provided under a DSD purchase of service contract who is eligible for Family Care, will be offered the option to enroll in the Family Care program to obtain needed services. Any individual eligible for Family Care who elects not to enroll in that program or another Long Term Care option, will no longer have services available under purchase of service contract funding. In addition, all DSD purchase of service providers should be aware that after implementation of Family Care expansion, funding formerly provided to support individuals determined eligible for the Family Care program will not be allocated for the same services and contracts will be reduced correspondingly to support only those individuals determined ineligible for Family Care. Therefore, providers should begin to plan appropriately for budget adjustments. The process for identifying who is Family Care eligible and who is not has begun. The goal is to have all individuals and corresponding allocations completed by the time of contract recommendations in December of 2008. The Division will be working closely with each provider affected by this transition. It should also be noted that it has not been determined to what extent DSD will be able to continue funding for existing purchase of service contracts after implementation of the Family Care expansion project.

WORK AND DAY SERVICES

This program area includes employment, and center based work and day service programming for adults and children. Programs available to developmentally disabled adults include work and day services facility-based, and employment in the community, or integrated community day programming. The day center service programs are available for adults and children (age 0-2 years) with developmental disabilities or delays.

In the adult service system, there are four guiding principles shaping the work and day service delivery system. These principles are:

Guiding Principles

- Structured work and/or day services are essential components of an adult's daily living experiences.

- Work and/or day service activities generally and preferably occur in designated settings different from the home environment.

- Participation in work and/or day services presents opportunities to learn new tasks, acquire new information, earn income, establish friendships, and learn new routines germane to the environment and expectations of that setting.

- Work and/or day service activities should offer integration, inter-personal and social interactions and have specified performance expectations.

Note: Principles for Children's Services are in the early intervention section.

WORK PROGRAMS # DSD006

Adult work service programs provide opportunities for paid work to consumers with a wide range of DD conditions and support needs. This range includes individuals with minimal, moderate and severe cognitive challenges, in addition to consumers with very specialized needs, i.e., challenging behaviors, medically fragile or limited mobility. Critical for participation in this area is the consumer's interest in the program, their ability to learn and attend to tasks, behavioral concerns and personal attitude towards work.

Work service programming offers a variety of paid work projects from various community businesses that present commensurate wages to participants. Variations in work group sizes and work environments are utilized to offer flexibility and change in work format. Several work locations exist to address the needs of consumers throughout the county.

A component of work programs is a focus on work related behaviors. These activities include

assisting the program participant in understanding the meaning, value and demands of a work environment, in addition to modifying or developing positive work attitudes and appropriate work behaviors. Emphasis is on developing work skills and increasing the person's productivity to maximize earnings ~~to~~ and become more independent.
All programs provide:

- training in performing work tasks;
- training in work or appropriate social behaviors;
- Monitoring of participant's progress; and,
- an informational resource for the participant, families and/or significant others.

Funding emphasis will be placed on purchasing services that offer supports to consumers with significant support needs - physical, emotional or social domain, and services with an integrated community based focus- day activity and work.

Agency Administrative Requirements

Review of individual referrals for applicant's appropriateness for services should be completed within 30 days of receipt of referral. Written disposition should be submitted to Disabilities Services.

Notify Disabilities Services verbally and in writing of significant problems and submit a discharge/termination summary to the Contract Administrator.

The agency must issue a Consumer Satisfaction Survey and provide a written summary of the results to the Contract Administrator.

Agency must identify and submit three (3) personal stories identifying the service outcome and client benefits.

Work Program Requirements

1. Develop an Individual Service Plan (ISP) with each program participant based on an assessment, which addresses his/her needs including program/treatment goals, specifies client and program responsibilities, methods to be used to reach treatment goals, and time frames for completion.

   Provide appropriate services and ongoing monitoring of progress toward attaining SP goals, institute changes as needed, and provide discharge planning, if warranted.

   Assess program participant's potential for community employment at least semiannually. Placement or referral for employment shall be made when indicated. The ISP must include a statement regarding whether or not community employment is a goal and, if so, a projected time to reach the goal must be included.

4. Review the participant's progress at least every six months and maintain written documentation of participant's progress in the case file.

Provide transportation or coordinate transportation for persons unable to use public transportation. Individuals able to utilize public transportation are responsible for their own transportation. This includes individuals who have the capacity to benefit from mobility training. All new enrollees must receive a mobility screening, if not already using public transportation.

6. Occupational skill training programs shall have written curricula, be time limited, and deemed appropriate to each individual participant.

7. Refer participants to needed community services as appropriate and encourage and support the individual's integration into community life through, self-help, advocacy and recreational opportunities.

8. Provide case management and counseling for individuals as needed. Refer to psychological, alcohol and drug abuse, or other specialized counseling as appropriate to assist with interpersonal and community living problems.

9. Provide or facilitate training/ in-service on the elements of self determination to participants.

10. Provide information on specialized and integrative recreational and/or educational activities to facilitate participants involvement in the community.

Expected Outcomes

Developmental Disabilities expects the following outcomes:

- Clients maintain or increase general (not job specific) work skills as identified in client's service plan.

- Clients maintain or increase work appropriate social interaction as identified in client's service plan or agency work standard.

- Clients maintain or increase productivity.

- Clients meet the standards for participation in Supported Employment.

Key supporting indicators for these outcomes include:

1. Number of consumers referred or targeted for Employment Programs;

2. Number of consumers placed on the Wait List for Employment;

3. Hours worked vs. program time;

4. Total wages paid to consumers/year;

5. Number of consumers maintained in jobs from the previous year;

6. Number of participants who participated in integrated community work during the calendar year.

The agency must prepare and submit a report indicating various client outcomes acquired as a result of their participation in this service (e.g. increase wages, acquire new job skill, individuals' goal achieved.)

ADULT DAY SERVICES # DSD007

Adult facility-based day services offer individuals with developmental disabilities the opportunities to develop, maintain and/or maximize an individual's independent skill level in areas of self care, physical and emotional growth, mobility, community education, community transportation, socialization, recreation and leisure, functional education and prevocational skills. Services can be facility-based or integrative community based. The guiding principles that apply to Adult Day Services are;

1. Structured day services provide critical life skills. Through orientation, training and integration individuals are afforded the opportunity to enhance their quality of life and independent skills.

2. Day services generally and preferably occurs in settings other than the home environment to facilitate social development and learn new skills. Services occur in programs designed for training with professional personnel.

3. Day service programming offers persons not interested in work a social, learning environment thus, facilitates choice and variety in experiences.

4. Day service programming offers a supervised, safe, and accepting environment in which challenges of all types can be explored and addressed to offer optimum support. This type of programming/ service heightens attention to the task or skill to be developed, rather than the usual characteristic or challenge.

Emphasis in this service area is on:

- presenting experiences that offer a variety of opportunities to interact with others in various settings and activities;

- participating in tasks or activities that can be transferred or used in daily community living;

- providing experiences to teach effective utilization and participation in integrated community tasks; and

- building skills that increase self independence and advocacy for the consumer and family.

Consumers with a broad range of disabling conditions and support needs are active in this service area. Several of the programs serve consumers with significant functional adaptive

needs, physical disabilities, and/or have challenging social or emotional behaviors. Programs can be designed for specific sub-groups that could include special medical needs, hearing and/or visually challenged. Tasks must be age appropriate, and where feasible, site appropriate.

Important variables for programming are consumer and family service preference, the abilities of the individual, and their personal interest and needs. Consumers must be addressed with respect and supported rather than directed. Agencies facilitating this service must balance these variables with the support structure needed to allow the consumer to maximize their choice, development and benefit from the service.
Similar to work services, facility-based day services is provided in a rehabilitation center setting offering the staff and physical structure necessary to respond to the specific needs of the participants. These services vary in type and frequency of groups, group size, and location.

Agency Administrative Requirements

Review of individual referrals for applicant's appropriateness for services should be completed within 30 days of receipt of referral. Written disposition should be submitted to Disabilities Services.

Notify Disabilities Services verbally and in writing of significant problems and submit a discharge/termination summary to the Contract Administrator.

A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to the Contract Administrator.

Agency must identify and submit three (3) personal stories identifying the service outcome and client benefits.

Expected Outcomes

Developmental Disabilities expects the following outcomes:

- Clients maintain or increase independent skill level in self-care / functional skills as identified in client's service plan.

- Clients maintain or increase independent skill level in mobility as identified in client's service plan.

- Clients maintain or increase independent skill level in socialization as identified in client's service plan.

- Clients increase pre-vocational skills.

- Clients generalize acquired skills to other settings.

Key supporting indicators for these outcomes include:

1. Number placed into Work Services or an Employment Program;

2. Number placed on the Wait List for Work or Employment;

3. Number of individuals who participate in Integrated Community Based Activities without staff support;

4. Number of individuals who participate in Integrated Small Group Community Based Activities with staff support;

5. Percentage of contract utilization;

6. Number of participants who meet the identified goal(s) as established by the semi-annual staffing.

The agency must prepare and submit a report indicating various client outcomes acquired as a result of their participation in this service (e.g, increase wages, acquire new job skill, individuals' goal achieved).

ADULT DAY SERVICES - Integrative Community Based #DSD008

The integrative community day service model is a sub-category of the day service program area. The philosophy of this model is that consumers should be able to participate in natural, typical adult opportunities, however, due to their cognitive, physical or emotional and social needs, the consumers lack the ability, opportunity or judgment needed to participate. The service offers the consumer who desires an alternative day service model the choice to learn and experience their community at large. It enables flexibility in activity, structured program time, location and peer group.

The program framework is based on a person-centered/directed planning process. A review of the participant's abilities, interests and general personal and social needs should be completed for goal development. Family or significant input may also be included, if appropriate, to assist with planning activities that are meaningful and beneficial for the consumer. Emphasis should be placed on tasks that can be generalized or reinforced by the family or home setting.

The purpose is:

- to increase consumer choice in work and/or day options;
- to provide an understanding and education to the consumers on their community;
- to increase participation of consumers in their community enabling them to utilize typical public and private services on an independent or small group level.

Activities will include, but are not limited to the following:

- educational tasks;
- recreational and leisure tasks;
- volunteer tasks;
- self advocacy training and experiences;
- community living experiences i.e., utilizing generic resources, shopping, eating out, library use, special events etc.

Agencies planning to bid for this service must include specific information on activities or tasks related to linkages with community agencies and organizations, public facilities, and businesses etc., outlining the plan to provide community orientation and personal development activities.

Individual participants must express or demonstrate interest in this service for admission.

Agency Expectations

- The provider should be experienced in the person-centered and/or person-directed service planning model.
- The provider must be interested and willing to support a flexible service style.
- The provider must be able to support maximum utilization of generic resources.

Agency Administrative Requirements

Review of individual referrals for applicant's appropriateness for services should be completed within 30 days of receipt of referral. Written disposition should be submitted to Disabilities Services.

Notify Disabilities Services verbally and in writing of significant problems and submit a discharge/termination summary to the Contract Administrator.

A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to the Contract Administrator.

Agency must identify and submit three (3) personal stories identifying the service outcome and client benefits.

Service Requirements

1. Develop a comprehensive Individual Service Plan (ISP) with each program participant based on an assessment, which addresses his/her needs, specifies client and program responsibilities, methods to be used to reach service goals, and time frames for completion.

2. Provide appropriate services and ongoing monitoring of progress toward attaining ISP goals, institute changes as needed, and provide for discharge planning. Coordinate semiannual staffing with appropriate parties to review status.

3. Maintain written documentation in case files of contacts, visits, and telephone conversations with program participants, service providers, and significant others. Maintain communication and coordination with other service providers.

4. Provide transportation or coordinate transportation for persons unable to use public transportation. Individuals able to utilize public transportation are responsible for their own transportation. This includes individuals who have the capacity to benefit from mobility training once it is provided.

5. Refer to needed community services as appropriate.

6. Provide informal counseling for individuals as needed. Refer to psychological, alcohol and drug abuse, or other counseling as appropriate.

7. Encourage and support the individual's involvement in community life, activities, self-help, and advocacy programs.

8. Utilize the Personal Planning Inventory tool or similar data to identify the participant's interest in his/her community; to record ongoing community awareness; and to document the consumers' use of community settings and services.

Expected Outcomes

Developmental Disabilities expects the following outcomes:

- Clients increase awareness of community resources.
- Clients increase utilization of public and private services in their community.
- Clients generalize acquired skills to other home and community living situations.
- Clients maintain or increase independent skill level in mobility as identified in client's service plan.

Key supporting indicators for these outcomes include:

1. Number and type of services engaged;

2. Number of consumers placed into/served through an Integrative Community Program model;

Number of consumers referred for work/day alternatives or placed on the wait list; and,

4. Number of consumers referred for employment or placed on the wait list.

The agency must prepare and submit a report indicating various client outcomes acquired as a result of their participation in this service (e.g. increase wages, acquire new job skill, individuals' goal achieved.)

ADVOCACY

ADVOCACY/CONSUMER EDUCATION #DSD005*

Services are designed to assist individuals and their families speak for their interest and needs, and to promote community sensitivity and responsiveness to disability issues. Self-advocacy, parental, guardian and/or significant other advocacy should promote opportunities to share experiences, learn client/disability rights information, and work on self-expression of disability issues. These areas focus on obtaining or maintaining access to community resources to enhance community living, acquire specialized services, in addition to addressing service needs and gaps. Advocacy effort is also intended to be a support network to, and for, adults with disabilities and their families aiding with system change initiatives.

Service emphasis should reflect a shift to self-advocacy. Program designs must include elements of training and support to persons with disabilities in person directed and centered planning, fundamentals of self-determination, social/peer relationship building, and self and system advocacy. Parental and family linkages are anticipated to continue through support groups, or through focus group discussions.

Secondly, of equal importance is consumer education. This area seeks to provide training to participants in adult services, waitlisted and/or transitioning from school services on information regarding understanding adult service systems, identification of how to share their respective interest, needs, abilities and challenges in order to express and participate in supports/services on their behalf. Furthermore, the agency is expected to provide or coordinate training forums on self-determination and person directed supports, community education, core service areas, and personal safety, with the goal of enabling the consumer to engage in a self-directed support model.

Advocacy Service Requirements:

1. Advocacy

The agency will provide or coordinate self-advocacy training for individuals with developmental disabilities, coordinate parental, guardian and significant other advocacy training on behalf of consumers with DD.

Two (2) times per year the agency will provide or coordinate system advocacy training for consumers and significant others.

Two (2) times per year the agency will facilitate person-directed education and training to self-advocates, and their families, agency staff providing services to persons with disabilities.

Two (2) times per year the advocacy agency (ies) will participate in a DD system discussion session with DSD staff to review consumer issues, discuss service outcomes/satisfaction, unmet and under-served consumer needs.

Two (2) times yearly the agency will produce a summary report on activities implemented over the year.

Consumer Education

The agency will provide training with emphasis on self-expression, choice, person-centered services and elements of self-determination.

The agency will issue a participant survey to measure the progression of person directed approach to services.

Two (2) times per year the advocacy agency (ies) will participate in a DD system discussion session with DSD staff to review the progress of consumer education sessions, discuss service outcomes, and unmet consumer needs.

Two (2) times yearly the agency will produce a summary report on activities implemented over the year.

COMMUNITY LIVING SUPPORT

RESPITE CARE - ADULT #DSD012

Respite care is designed to provide for a substitute caregiver when an interval of rest or relief is needed by the primary care giver. Respite may be provided in the family's home, in a licensed foster home for children, or in a certified adult family home.

Agency Requirement-Respite Care

1) Semi-annually, the provider will produce a survey on un-met family/individual needs, in addition to, other service trends or needs identified.

2) Semi-annually, the provider will submit a report indicating service utilization and program participants' satisfaction.

3) Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

Unit of Service

A unit of service is one hour of direct service time.

Direct service time is staff time spent in providing service to the program participants which includes face-to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffings and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in service training, vacation, etc.)

Collateral contacts are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc.

Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

Documentation

Direct service time must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face. collateral, phone, etc.), (c) who the contact was with, (d) the content of

the contract, and (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

ASSERTIVE CASE INTERVENTION SERVICES #DSD014

Assertive Case Intervention Services for adults with developmental disabilities provides short and long term intervention services. Assertive Case Intervention is a component within the core group of Diversion Services. Support services are designed to address a wide range of behavioral challenges exhibited by consumers with DD and have a high range of support needs in the mental health area in order to function successfully in the community. Through a process of intervention and pro-active case involvement, this service is planned to guide consumers on a daily basis, and collaborate with other professionals through high-risk periods to reduce the loss of residential and /or day activity due to instability in social behavior. The goal is to foster manageability by the person in typical daily living experiences to reduce high-risk periods of emotional instability. Families and significant others to the client may also be assisted with education and support on an ongoing basis and especially in times of turmoil or crisis.
Adults in this service are developmentally disabled who also are dual diagnosed with a major mental health diagnosis, or who have problematic mental health or behavioral patterns. These characteristics present significant barriers to their successful community living status.

Assertive Case Intervention services provide the monitoring link with community providers and the home environment through direct community intervention and support to the individual. Communication among the intervention team members and with the client is paramount.

DSD staff serves as the fixed point of referral for all identified consumers. Referrals to the provider are directed by DD staff. DD staff holds regular case review meetings with the provider to monitor progress and provide technical assistance.

Individuals and families in Diversion Services are treated with dignity and respect. Although a variety of behavioral challenges exist, staff strives to provide reasonable assurances of personal safety and guide the person through opportunities to express interests, desires, and preferences. The consumer must have choice and flexibility in the services and supports they receive. All parties, the consumer, DSD and the provider staff work as partners in shaping the delivery of services and supports.

Assertive Case Intervention services offer four major service components;

1. Intervention/Functional Daily Living Component
2. Health and Wellness Monitoring
3. Guidance and Counseling

Social Supports

Through these service components the provider staff will:

1. Implement a service plan designed to address the consumers needs in daily living tasks.

This would include stable and safe housing, a daily activity, training program or job and free time structure. The plan should compare closely to the life values and culture of each individual. The focus is to assist the consumer to live in, learn, and cope with the community through functional tasks and social relationships.

2. Monitor health and safety in the living environment. The consumer's preferred health and personal habits should be accepted or their development guided. Interventions may be necessary to assist consumers with the maintenance of regular health care provider visits for physical health and mental/behavioral health visits, or with money management.

3. Offer an informal counseling and support service through individual contacts or in a group setting. The service should be offered according to the guidelines of the licensing and professional standards of the field. This service may be extended to family or other living environments to foster their ability to address crises. In accordance with the consumer's needs and wishes, referrals may be made to outside providers. Coverage from benefits should be taken into consideration.

4. Utilize a system of social supports to guide opportunities for meaningful and trusting relationships that is core to the measure of a functional life. Additionally, the provider will offer service that will feature a consumer run set of services. The provider functions as the facilitator of space, equipment, the structure of services and the variety of programs. This should include activities facilitating personal growth and opportunities that permit attendance at events and public resources.

Agency Requirements - Assertive Case Intervention Services

1. Assess and submit an initial plan within ten working days on all referrals. The final plan must be submitted within 30 days and include objectives. In this process each consumer should be given respect, their dignity a priority and their opinion included in the planning. The elements of self-determination must be implemented. This would include helping the person choose their own goals, choose what kind of help is needed to achieve them, and how to get that help.

2. Produce written reports every month and submit to DSD. The report should include a statement of progress and challenges toward the goals and any recommendations for changes in the service plan.

3. Attend regular meetings with DSD DD staff for the purpose of joint case review and to provide a time for administrative review and case processing.

4. Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

5. A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to the Contract Supervisor.

Expected Outcomes

Developmental Disabilities expects the following outcomes:

Decrease in the number of repeat inpatient psychiatric admissions of 3 or more days per calendar year. **Indicator:** Number of inpatient psychiatric admissions of 3 or more days during the year preceding the program evaluation.

Increase attendance of adults who are in structured day services or work options. Indicator: **Number and percent of adults who are in structured day services or work options at the time of the program evaluation.**

Decrease the number of adults with DD in crisis hospitalization during contract year. **Indicator:** Number of adults with DD who required crisis hospitalization during the year preceding the program evaluation.

Key supporting process and output measures include:

Number of repeat inpatient psychiatric admissions of 1 or 2 days for medication adjustment per calendar quarter for the consumers served that quarter.

Number of consumers receiving diversion services who participated in consumer run services.

Number of people maintained in or those assisted to move into stable housing.

Number of people participating in the development and implementation of their service plans.

Number of people referred and participating in a new service program.

Number of Families, Guardians and/or Significant others receiving education and support.

The agency must prepare a report on client outcomes acquired as a result of their participation in this service.

Unit of Service

A unit of service is one-quarter hour of direct service time.

Direct service time is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, vacation, etc.

Collateral contacts are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could

include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

Documentation

Direct service time must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face, collateral, phone, etc.), (c) who the contact is with, (d) the content of the contact, (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

COMMUNITY RESIDENTIAL PROGRAMS

Community living supports is a broad term that represents an array of supports or services to individuals with disabilities who are in the community. Participants or applicants reside independently, with family or significant others and need supports or intervention to enable their success, full participation or advance in skills for adult living.

SUPPORTIVE LIVING OPTIONS #DSD015

The Supportive Living Options Program provides individually tailored training, support and supervision to individual adults to promote, maintain, and maximize independence in community living. The premise of the program is that adults with disabilities can live independently or semi-independent in settings provided the appropriate support arrangements and home can be identified and acquired on behalf of the participant. Program participants are assessed for their abilities, needs, and family or significant other assistance in order to clarify the appropriate service components needed in the supportive living service structure. The goal of the program is to enable the participant to experience a safe, supported, and positive living experience while enhancing their understanding, access and utilization of community. Participants receive guidance with interpersonal relationships and supervision from various agency staff that fosters personal growth. The program model includes four service components: Case Management, Daily Living Skills Training, Daily Living – Maintenance Service, and Supportive Home Care Services.

Agencies interested in applying for this services in this program area must be able to provide the full array of services.

Case Management Services: Assessing, planning, monitoring, locating and linking an individual to supports and/or services. Supports needed generally reflect health care services, social services, benefits, or fundamental supports (e.g. housing). Case manager may assist with setting appointments, providing intervention with problems, documenting supports received and aiding through informal counseling or guidance with interpersonal problems or people relationships.

Daily Living Skills Training: Training or teaching an individual a skill to develop greater independence. Skill training is task-oriented and time-limited with pre- and post assessment. Areas of focus typically include: personal care, grooming, dressing, food preparation, money transactions, budgeting, home upkeep, use of community resources, community-travel training safety issues.

Daily Living Skills Maintenance: Assisting/accompanying an individual with typical day-to-

day functions that enable community living. This service typically includes functional training, general guidance and supervision of instrumental ADLs, informal intermittent, monitoring critical appointments to lessen vulnerability and increase or maintain success in community living. DL-Maintenance fosters the individual retaining their functional level and generally learning new tasks over time. It is likely that the individual in this category may always require the same level of support to maintain community living.

Supported Home Care: Instrumental ADL tasks performed by care workers, or care workers accompany an individual in functions related to personal care, grooming, shopping, medication set-up, mobility in the home and in community, home care and household chores, social activities, health care appointments and other daily living tasks. These tasks are actually hands-on activities performed by personal care workers.

SUPPORTED PARENTING #DSD016

Supported Parenting is a sub category of the supportive living program service or case monitoring service. This service provides training, counseling and intervention to adults with developmental disabilities who are also parents. The focus of this service is to offer guidance in community living and parenting. Participants are encouraged to identify their needs, routines, challenges, as well as family needs. Training and supports in personal skills and parenting skills vary. Guidance on how to support the family unit is provided on an individual and/or a group basis.

Persons receiving this service generally lack a natural support network or the extended family and friends are unable to assist at the level needed for successful family community living. Subsequently, staff seeks mentors and uses the mentoring approaches to foster learning. Staff provide practical and functional training in daily living skills, decision-making, social and community training, in addition to informal child rearing counseling, parenting skills and service coordination. The goal is to teach adult community living skills and promote stability in the family unit through guiding the parent to learn about and understand the parental role. Staff also functions as advocates for the parent on educational, medical and social service issues where the child is involved.

Agency Service Requirements - Supported Living: Supported Living and Parenting Programs

For Supported Parenting providers must produce a quarterly summary report including information on persons served, needs identified-addressed, progress made and unmet needs, and submit it to DD management staff.

Agency must submit a semi-annual update on the services provided, frequency and identify the general goals of the participants and progress made.

Agency must provide training in self-advocacy on elements of self-determination.

A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to the Contract Supervisor.

Representation at the Supported Living Service Meetings scheduled by Disabilities Services staff is required.

Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

Supportive Living Programs Service Requirements

All agencies seeking to provide Supportive Living Programs must comply with the following requirements:

1. Develop a comprehensive Living Plan (LP) with each SLP participant based on an assessment that addresses his/her needs and specifies responsibilities, methods to be used, and time frames for completion. Provide ongoing monitoring of progress towards attaining LP goals and recommend changes, including discharge planning as needed. Visit the program participant with frequency sufficient to insure progress in the LP. Coordinate semiannual staffing with appropriate parties to review status. The LP should provide or arrange for training or support in the following areas as determined by the initial assessment and progress:

    a. housekeeping and home maintenance skills
    b. mobility and community transportation skills
    c. interpersonal skills and relationships
    d. health maintenance
    e. safety practices
    f. financial management
    g. problem solving and decision-making
    h. self-advocacy and assertiveness training
    i. utilization of community resources and services
    j. recreational and leisure skills
    k. basic self-care skills
    l. menu planning and meal preparation
    m. communication skills
    n. time management
    o. coping with crises
    p. forming natural support systems

2. Maintain written documentation in case files of contacts, visits, and telephone conversations with program participants, service providers, and significant others.

3. Provide case management and informal counseling for individuals as needed. Case management services include but are not limited to:

    a. Ensure referral and follow-through to needed community services including vocational, educational, medical, psychological, alcohol and drug abuse and other specialized services, as appropriate. Maintain communication and coordination with other service providers.

    b. Provide prompt intervention to resolve interpersonal and community living problems.

    d. Encourage and support the individual's involvement in community life, activities, self-help, and advocacy programs.

    e. Assist individuals in applying for benefits as appropriate and securing needed documentation to resolve problems concerning those benefits.

e. Assist the individual in screening, hiring and training attendant and respite workers as required. Help the individual understand their responsibilities as employers.

f. Lead in the development of a support network for the individual which will include the resident and significant others who will contribute to the training, support and service plan of the individual.

g. Complete a community-based social/recreational Personal Planning Inventory (PPI) on all residents to enhance community integrative programming.

4. Maintain a 24-hour coverage plan to respond to residents when ill or in case of emergency. The agency must maintain a log of the emergency calls and the response time to an emergency call.

   Provide initial and ongoing training to program staff, including attendant and respite staff, regarding the concerns of residents.

   Notify Adult Services verbally and in writing of significant problems and submit discharge/termination summary.

   Provide consultation on community resources and service options in order to facilitate the development of consumer choice in service planning.

   Develop and review a “Safeguard Program Checklist” that identifies items/services or procedures critical for the care, stability or service need of the program participants, and review the list with participants/guardian, where appropriate.

The agency must prepare and submit a report indicating various client outcomes acquired as a result of their participation in this service (e.g. increase wages, acquire new job skill, individuals' goal achieved).

Unit of Service

A unit of service is one-quarter hour of direct service time.

Direct service time is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, and vacation.

Collateral contacts are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

PERSON-CENTERED PLANNING #DSD017

Person-Centered planning services provides a “skilled facilitator” to guide the parent, guardian and significant others, with the consumer through a process of identifying current and futures supports, in addition to planning future goals. The intent of the Person-Centered process is to identify the needs, interest and positive support elements to work collaboratively to accomplish desired consumer and family goals by engaging all parties in the planning and implementation process.

Disabilities Services staff interest in this method is to provide a vehicle that begins the “get-acquainted process” of individuals and their family with professionals in the field to recognize and utilize their strengths in navigating adult services and systems important to community living for the adult with a disability. Addressing needed supports through a family and significant other process provides the opportunity to capitalize on utilizing stable supports, who have a vested interest in the adult with the disability to assist in life planning and life services.

The trained staff providing person-centered services will be expected to possess the knowledge, and skill of person-centered planning approaches, upon contract award. In addition staff will need current understanding and familiarity of the adult systems to inform and guide family members. It is expected that staff will encourage and guide the person with family, primary caregiver and other interested parties to engage in functional skill building activities, social/peer relationship development, community activities, assistance with benefit counseling and develop future plans and goals that will aid the individual and their support network. The planning sessions are planned to occur, at minimum one to two times monthly, per person and as needed to accomplish the objectives.

Disabilities Services is the fixed point of referral and enrollment for this service.

Agency Service Requirements - Person-Centered Planning Programs

For Person-Centered Planning, providers must produce a quarterly summary report including information on persons served, needs identified-addressed, progress made and unmet needs, and submit it to DD management staff.

Agency must submit a semi-annual update on the services provided, frequency and identify the general goals of the participants and progress made.

Agency must provide training in self-advocacy on elements of self-determination.

A Consumer Satisfaction Survey must be issued and a written summary of the results forwarded to DSD management personnel.

Representation at the Person-Centered Providers Group Meetings scheduled by Disabilities Services staff is required, quarterly.

Agency must identify and submit three (3) personal stories identifying service outcome and client benefit.

Person-Centered Planning Services Requirements

All agencies seeking to provide Person-Centered Planning services must comply with the following requirements:

1. Develop a service/support plan with each participant based on assessing the individual. Provide monitoring of progress towards attaining the goals and recommend changes. Contact the program participant and family with frequency sufficient to insure progress. Coordinate semiannual staffing with appropriate parties to review status. Areas to focus on are::

    a. housekeeping and home maintenance skills
    b. mobility and community transportation skills
    c. interpersonal skills and relationships
    d. health maintenance
    e. safety practices
    f. financial management
    g. problem solving and decision-making
    h. self-advocacy and assertiveness training
    i. utilization of community resources and services
    j. recreational and leisure skills
    k. basic self-care skills
    l. menu planning and meal preparation
    m. communication skills
    n. time management
    o. coping with crises
    p. forming natural support systems

2. Maintain written documentation in case files of contacts, visits, and telephone conversations with program participants, service providers, and significant others.

3. Provide case management and informal counseling for individuals as needed. Case management services include but are not limited to:

    a. Insure referral and follow-through to needed community services including vocational, educational, medical, psychological, alcohol and drug abuse and other specialized services, as appropriate. Maintain communication and coordination with other service providers.

    b. Encourage and support the individual's involvement in community life, activities, self-help, and advocacy programs.

    c. Assist individuals in applying for benefits as appropriate and securing needed documentation to resolve problems concerning those benefits.

    d. Lead in the development of a support network for the individual that will include the resident and significant others who will contribute to the training, support and service plan of the individual.

e. Complete a community-based social/recreational Personal Planning Inventory (PPI) on all residents to enhance community integrative programming.

4. Provide consultation on community resources and service options in order to facilitate the development of consumer choice in service planning.

The agency must prepare and submit a report indicating various client outcomes acquired as a result of their participation in this service (e.g. increase wages, acquire new job skill, individuals' goal achieved

Unit of Service

A unit of service is one-quarter hour of direct service time.

Direct service time is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, and vacation.

Collateral contacts are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

TARGETED CASE MANAGEMENT (TCM) #DSD018

Targeted case management (TCM) is a service/practice which addresses the overall maintenance of a person including his / her physical, psychological and social environment with the goal of facilitating physical survival, personal health, community participation and recovery from or adaptation to mental illness. Targeted case management puts primary emphasis on a support professional- consumer therapeutic relationship and intervention to facilitate a continuity of care and promote successful community living experiences.

Target population

Persons served by TCM services have a diagnosis of a developmental disability and are typically at-risk for loss of stability in the community leading to an in-patience hospitalization or rehabilitation period and/or homelessness. This factor occurs due to the lack of family or significant adult instrumental in directing or guiding their care and support. Persons who are served by the program must:

- Be a Milwaukee county resident;
- Be at least 18 years of age up to 59;
- Active on Title 19; and
- Have demonstrated functional limitation in one or more of the following areas: housing, employment, medication or health care management, court mandated services, money management, community problem due to decision-making or symptom escalation to the point of requiring inpatient care

Targeted Case Management (DD target group) offers three major service components;

1. Health and Wellness Monitoring
2. Guidance and Informal counseling with daily functions
3. Social Supports/relationships

The service components the provider staff will:

1. Implement a service plan designed to address the consumers needs in daily living tasks. This would include stable and safe housing, productive and meaningful activity, and ideas for leisure or recreation time. The plan should identify and complement the life relationships, activities, values and culture of each individual. The focus is to assist the consumer to live in, learn, and participate in community.

2. Collaborate on health and safety in the community living. The consumer's preferred health and personal habits should be accepted or their development guided. Assistance may be necessary with the maintenance of regular health care provider visits for physical health and mental/behavioral health visits, or with money management.
3. Offer guidance and informal counseling/support through assistance with decision-making, individual contacts or in a group setting. This service may be extended to family or other

living environments to foster productive living experience. In accordance with the consumer's needs and wishes, referrals may be made to outside providers for formal counseling.

4. Provide guidance with social supports and build meaningful and trusting relationships that are core to a functional and productive life. This should include activities facilitating personal growth and opportunities that permit attendance at events and utilize public resources.

Agency Requirements – Targeted Case Management Services DD

1. Assess and submit an initial plan within twelve working days of all referrals. The final plan must be submitted within 30 days and include objectives. In this process each consumer should be given respect and priority to their views and opinion included in the planning. This would include helping the person choose their own goals, choose what kind of help is needed to achieve them, and how to get that help.

2. Agency must produce a semi-annual report on the services provided, frequency and identify the general goals of the participants and progress made. The document should be submitted to DSD staff. The report should include a statement of progress and challenges toward the goals for each participant and, any recommendations for changes in the service plan.

3. Agency must provide training in self-advocacy on elements of self-determination.

4. A Consumer Satisfaction Survey must be issued and a written summary of the results.

Unit of Service

A unit of service is one-quarter hour of direct service time.

Direct service time is staff time spent in providing service to the program participants which includes face to-face contacts (office or field), collateral contacts, travel time, telephone contacts, client staffing and time spent in documentation of service provision. (Direct service time does not include indirect time such as that spent at staff meetings, in-service training, vacation, etc.

Collateral contacts are face-to-face or telephone contacts with persons other than the program participants, who are directly related to providing service to the person and need to be involved by virtue of their relationship to the program participant. Collateral contacts could include contacts with family members, other service providers, physicians, school personnel, clergy, etc. Reimbursement for group services is based on one-hour units of direct service time. The total time must be equally divided between each group participant and recorded in the case record of the participant.

Documentation

Direct service time must be documented through an entry in the case notes or narrative for units billed. The narrative entry must include (a) the date of the contact, (b) the type of contact (face-to-face, collateral, phone, etc.), (c) who the contact is with, (d) the content of the contact, (e) the number of units (the length of the contact). The case narrative must be contained in the case record maintained by the agency.

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Section 5
Housing Division

YEAR 2009
PURCHASE OF SERVICE GUIDELINES
PROGRAM REQUIREMENTS

Issued July, 2008

TRANSITIONAL HOUSING PROGRAM (THP) MANAGEMENT
Program # H-001

The Transitional Housing Program (THP) is designed to assist the Milwaukee County Mental Health Complex inpatient units to discharge individuals who are psychiatrically stable and appropriate for independent community housing placement. There is a need to provide temporary housing for individuals ready for discharge as a plan is put together for a permanent housing location. This program will impact the inpatient census crisis by providing transitional housing to individuals who are SAIL eligible for case management services. The service provides single-room occupancy for seven individuals who have been discharged from the inpatient service. The program provides service coordination with Milwaukee County BHD case managers and provides 24/7 security through resident managers.

The goal of the program is to provide safe and temporary housing until permanent housing is found with assistance from case management. The outcomes are that the consumers have safe housing and that they remain connected to their case manager. Program outcomes are achieved by supporting the residents in their housing search and by assisting the consumers with obtaining income that would support them in permanent housing.

Staffing

The provider will have experience serving homeless individuals who have a serious and persistent mental illness. The program will provide a resident manager and a case coordinator to provide full coverage of the program.

Expected Outcomes

- All residents will be contacted daily to assure their safety
- Improvement in quality of life
- Residents will show improvement in their ability to perform activities of daily living
- Landlord will engage in positive interactions with residents and show an increased level of understanding behavioral health issues
- Residents will engage in health behaviors, e.g. reduced smoking, greater exercise
- Residents will engage in guided activities to express their creativity

SUPPORTED APARTMENT PROGRAM
Program # H-002

The Supported Apartment Program provides services to persons having a serious and persistent mental illness with a living environment that provides the support necessary for an individual to live as independently as possible in an apartment setting. The Supported Apartments are fully furnished including appliances. Services provided by the Supported Apartment Program will include collaborating with the Case Manager to encourage the consumer to work toward their treatment goals, provide prompts to complete Activities of Daily Living skills including cooking and attendance at day programs, social support including recreational activities and community meals, and medication education and symptom management. These services will be provided by the Supported Apartment Program facility staff in conjunction with other members of the consumer's support network. Consumers living at the Supported Apartment Program are expected to pay a monthly rent.

Supported Apartment Program – Other Requirements

Enrollment into a supported apartment program is implemented through a referral from the Behavioral Health Division's Service Access to Independent Living (SAIL) Unit. The SAIL Unit will assess the need for supported apartment and make referrals to contracted service providers. When a consumer is in an acute care setting, the supported apartment provider agency will do a face-to-face assessment within 72 hours after receipt of the referral packet from SAIL.

Supported Apartment Program Admission Policy

It is the policy of the BHD that individuals referred for Supported Apartment Program placement by SAIL will have an evaluation completed and a decision regarding admission will be reported to SAIL within seven business days of receipt of that referral.

Supported Apartment Program Inpatient Contact Policy

It is the policy of the BHD that, when a Supported Apartment Program resident is admitted to a psychiatric inpatient unit, the Supported Apartment Program Manager responsible for that client must contact the appropriate inpatient team within one business day of the admission in order to assist in the development of a plan of discharge.

Unit of Service

One day of care in a supported apartment program equals a unit of service.

Documentation

1 Resident case records maintained by the agency shall include daily attendance logs.

2 Client files must demonstrate coordination with the assigned case manager.

RESIDENT MANAGEMENT AT WEST SAMARIA
Program # H-006

The Resident Management program provides housing management services for persons living at West Samaria and with a serious and persistent mental illness. The residents of West Samaria are either involved in programming with Milwaukee County BHD or with Red Cross. The Resident Management program provides individuals with an increased level of service, assistance and supervision than what would normally be offered in this type of housing setting to enhance recovery. Many of the individuals in this program have extensive histories of homelessness as well as impaired daily living skills and Resident Management would assist these individuals in these areas. Integral to the program of resident management is a collaborative approach among three other partners: BHD, Red Cross and the landlord. Administrative staff from each entity will conduct staff meetings to ensure the quality of the program.

Resident Management Duties

- On-site supervision
  Duties include communicating with each resident daily to evaluate their safety and general well being as well as promoting positive behaviors and striving to create an environment which supports recovery
- Promotion of appropriate activities of daily living
  Duties include encouragement with personal hygiene, laundering of clothing and room cleanliness. Medication adherence will be encouraged and proper nutrition fostered. The staff will also support residents in keeping appointments and in engaging in appropriate activities outside of the building.
- Provision of linkages and communication with residents respective case managers
  Duties include participating in treatment planning with case managers as well as notifying case managers of changes in behavior of residents.

Expected Outcomes

- All residents will be contacted daily to assure their safety
- Improvement in quality of life
- Residents will show improvement in their ability to perform activities of daily living
- Landlord will engage in positive interactions with residents and show an increased level of understanding behavioral health issues
- Residents will engage in health behaviors, e.g. reduced smoking, greater exercise
- Residents will engage in guided activities to express their creativity