MILWAUKEE'S PROTECTIVE PAYEE PROGRAM:

Evaluating its performance and role in the larger case management system

Public Policy Forum

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June 2012

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INTRODUCTION

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

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

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

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

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

PROTECTIVE PAYEE PROGRAM

Program Overview

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

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

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

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

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

[3] Case Management Society of America: http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx

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

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

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

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

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

Program Participation

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

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

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

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

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

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

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

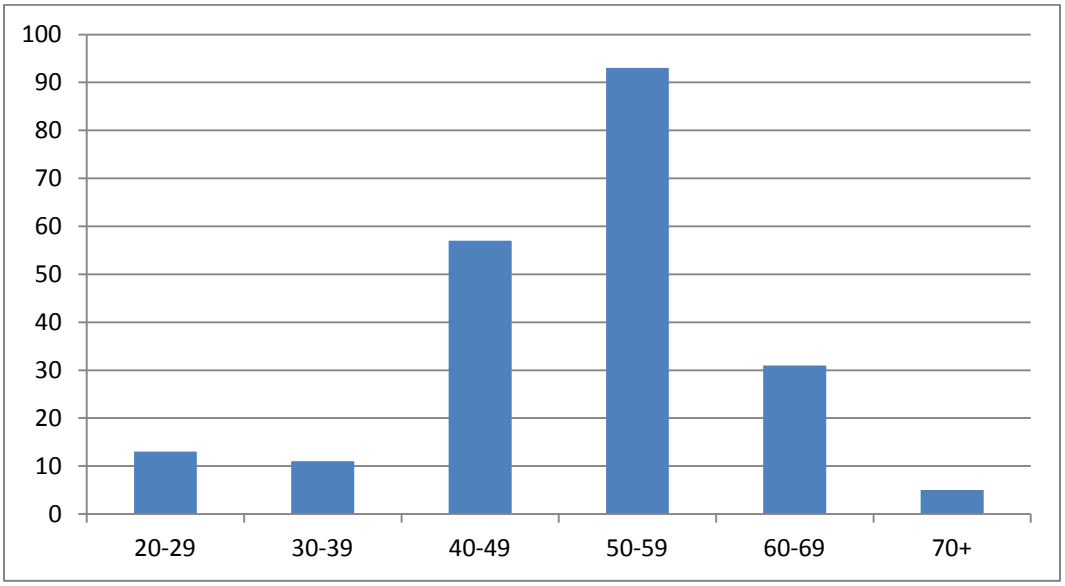
[6] HUD-eligible clients are those who meet HUD's definition of homelessness upon program entry. All three agencies serve additional clients who are not HUD-eligible through financial support from other sources.
[7] Excludes those with no information listed in the HMIS database.
[8] Safe haven programs offer temporary housing for homeless adults with mental illness.
[9] U.S. Department of Housing and Urban Development: http://www.hudhre.info/documents/HomelessAssistanceActAmendedbyHEARTH.pdf

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

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

Chart 1 shows the age breakdown of adult program participants. Approximately 61% of participants are over the age of 50, which means that program participants are significantly older than both Milwaukee's homeless and general populations. According to the U.S. Census Bureau's 2008-2010 estimates, approximately 29% of Milwaukee County residents are over the age of 50, while the Milwaukee Continuum of Care's 2011 Point in Time survey found that only 30% of Milwaukee's homeless population is over the age of 50.[12]

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



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

[10] National Alliance to End Homelessness: http://www.endhomelessness.org/content/article/detail/3006
[11] In 2011, the three agencies served a combined total of 205 cases, including 55 cases not funded by HUD.
[12] The Continuum of Care is a collaboration of public and nonprofit agencies in Milwaukee County that plans, organizes, and evaluates the continuum of services for homeless individuals and families and coordinates Milwaukee County's annual Supportive Housing Program application to HUD (http://milwaukeecoc.org). Additional details on the Milwaukee 2011 Point in Time Survey can be found at http://milwaukeecoc.org/MilwaukeePointinTime2011.pdf.

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

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

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

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

Table 3: Reason for leaving program

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

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

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

A majority of clients who leave the Protective Payee program continue to rent an apartment independently. Among the 81 clients who left the program between 2009 and 2011 and whose destination was captured in the HMIS database, 50 (62%) went on to rent an unsubsidized apartment.[14] **Table 4** breaks down the housing destinations of clients who left the program during that period.

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

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

Program Costs and Funding

As noted above, because of its focus on serving the homeless, the Protective Payee program qualifies for and receives most of its funding from HUD's Supportive Housing Program, which "is designed to develop supportive housing and services that will allow homeless persons to live as independently as possible."[15] As shown in **Table 5**, HUD funds 80% of the program's costs, while requiring each agency to provide a 20% match.

Table 5: Protective Payee program budgets by agency, 2011

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

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

[14] Excludes those recorded as "Don't Know/Refused" or "Information Missing."
[15] More information about HUD's Supportive Housing Program can be found at: http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/programs/shp

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

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

Table 6: Program expenditures per client, 2011

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

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

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

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

Table 7: Staffing and caseloads by agency

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

Program Outcomes

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

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

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

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

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

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

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

Payee program since the HMIS database was established in 1998.[16] Of those, 13% (53 clients) have returned to a homeless shelter after entering the program, while 87% (353 clients) have not. It is a positive indicator of the program's impact that the vast majority of clients have remained out of the shelter system since entering the program.

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

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

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

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

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

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

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

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

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

Summary

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

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

CASE MANAGEMENT SERVICES IN MILWAUKEE COUNTY

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

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

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

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

Projects for Assistance in the Transition from Homelessness (PATH)

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

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

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

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

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

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

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

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

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

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

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

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

Shelter Plus Care

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

[19] Service Access to Independent Living

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

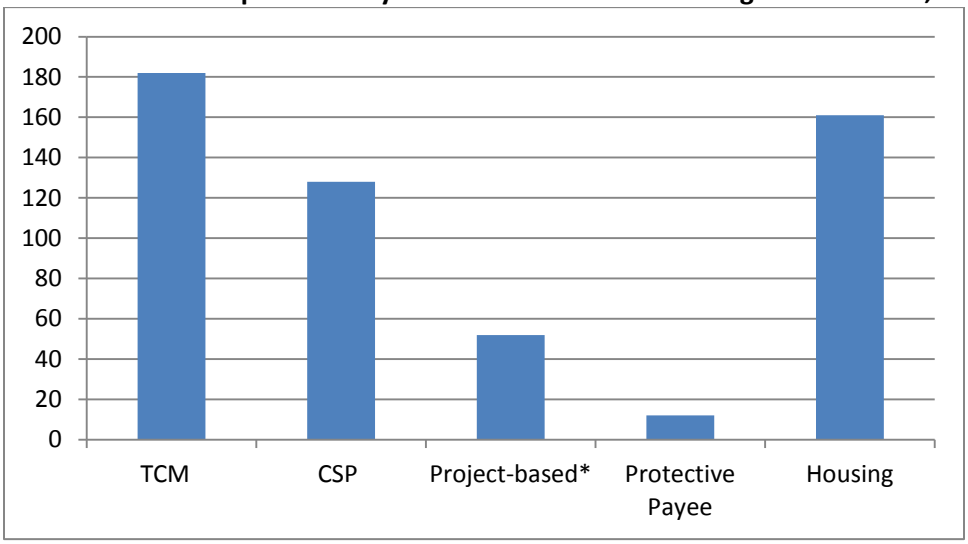
the Shelter Plus Care program and must suffer from serious mental illness, a chronic substance abuse problem, or HIV/AIDS. Through S+C, clients typically contribute approximately 30% of their income toward rent and receive a Housing Assistance Payment that covers the remainder. In 2011, a total of 535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

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

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

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

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



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

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

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

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

SHELTER PLUS CARE PROGRAM SNAPSHOT

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

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

Permanent Supportive Housing

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

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

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

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

[21] A few PSH residents receive a Shelter Plus Care (rather than Section 8) voucher. As with Shelter Plus Care vouchers, Section 8 vouchers allow clients to pay approximately 30% of their income toward rent and receive a subsidy that covers the remainder.
[22] Peer support services generally refer to services that provide social, emotional and other support to individuals with mental illness that are delivered by trained individuals who have suffered from mental illness themselves.
[23] U.S. Department of Housing and Urban Development: http://www.hudhre.info/documents/DefiningChronicHomeless.pdf
[24] Housing California Fact Sheet: http://www.housingca.org/site/DocServer/fact-sheet_homelessness_fed-definition.pdf?docID=1409

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

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

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

PERMANENT SUPPORTIVE HOUSING PROGRAM SNAPSHOT

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

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

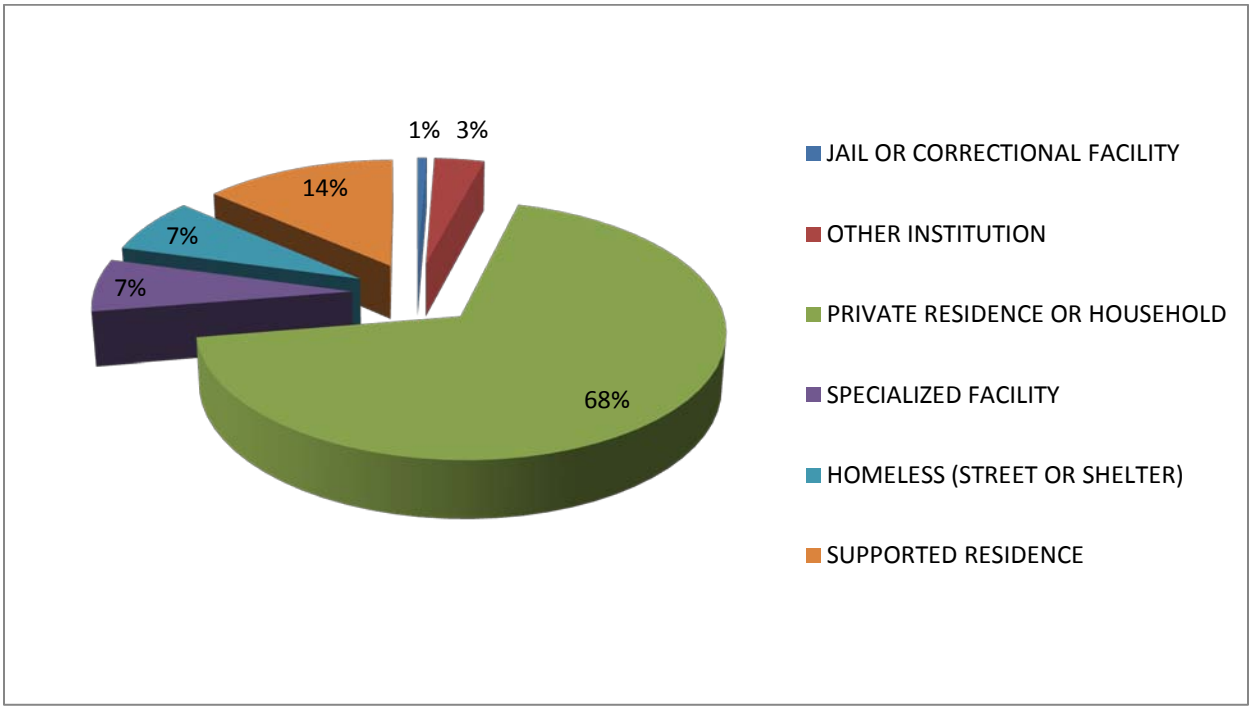
[25] Milwaukee Continuum of Care's 10-year plan to end homelessness: http://milwaukeecoc.org/10-Year-Plan.pdf

Targeted Case Management (TCM)

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

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

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



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

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

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

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

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

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

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

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

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

[28] HSRI: Transforming the Adult Mental Health Care Delivery System in Milwaukee County, October 2010: http://www.hsri.org/files/uploads/publications/Milwaukee_Mental_Health_System_Redesign_Final_Report.pdf
[29] 2011 BHD Request for Proposal document
[30] The overall staff to client ratio for the TCM Level 2 program is 1:23 when case managers, payees, RNs, and housing specialists are all included.

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

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

Community Support Program (CSP)

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

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

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

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

[31] Criteria for CSP qualification can be found in Wisconsin DHS Chapter 63.08: https://docs.legis.wisconsin.gov/code/admin_code/dhs/63/08
[32] Assertive Community Treatment Association: http://www.actassociation.org/actModel/
[33] HSRI: Transforming the Adult Mental Health Care Delivery System in Milwaukee County, October 2010: http://www.hsri.org/files/uploads/publications/Milwaukee_Mental_Health_System_Redesign_Final_Report.pdf

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

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

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

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

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

Table 9: Service Comparison

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

[35] Case management is not provided directly through Shelter Plus Care, but is a required component of the program. Most clients receive case management through TCM or CSP.
[36] This figure only includes costs associated with on-site peer support services and case management services not provided by TCM or CSP. Total program costs are greater.

Summary

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

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

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

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

OBSERVATIONS & CONCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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