COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: October 19, 2020

TO: Supervisor Marcelia Nicholson, Chairwoman, Milwaukee County Board of Supervisors

FROM: Shakita LaGrant-McClain, Director, Department of Health and Human Services

SUBJECT: **Report from the Director, Department of Health and Human Services, providing 2021 budget information requested by the Finance Committee**

Background

During the hearing on the 2021 County Executive's Recommended Budget for the Department of Health and Human Services (DHHS) on October 15, members of the Finance Committee requested additional information. This report has been submitted in response to this request.

Discussion

The following requests were made of DHHS:

1) **Supervisor Taylor requested the following information**:
   - Data collected relative to rates of recidivism for youth receiving services from DHHS
   - Outreach provided to the Aging and Disability Resource Centers and affected senior citizens regarding merging the Department of Aging into DHHS

Youth Recidivism Rates:

Comparison of Recidivism Rates for Youth in Secure Programs versus Community Programs
Please see a comparison of recidivism for Milwaukee County youth placed in secure settings (Lincoln Hills School, Copper Lake School, or Milwaukee County Accountability Program) versus youth who are served in community-based programming in the table below.

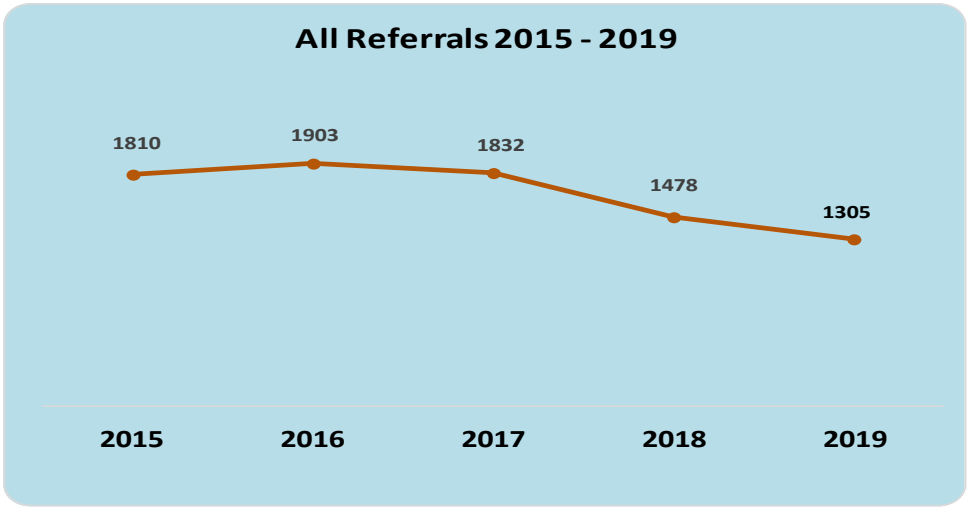
Understanding and constructing meaningful comparisons of recidivism rates across programs is a very complex challenge due to a number of variables. For example, it is important to understand that some programs are designed to serve high risk youth and, as a result are prone to producing higher recidivism rates. Since the state correctional programs (LHS and CLS) and MCAP are deigned to serve high risk youth, they demonstrate high recidivism rates:

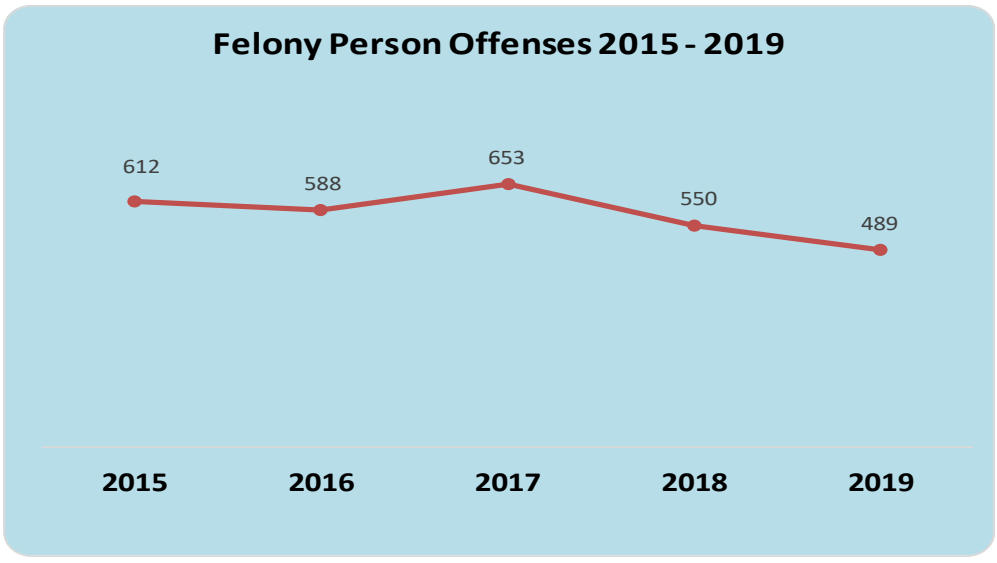
Rates of Program Recidivism for Youth Discharged in 2018:

Program	% with new offense during program	% with new offense w/in 1 yr. after order
LHS and CLS (non-Serious Juvenile Offender)	45%	29%
MCAP	36%	36%

By comparison, community-based programs contracted through DYFS and run by community-based organizations demonstrate overall lower rates of recidivism. However, these outcomes are also impacted by the population of youth who the program serves. Those serving higher risk youth reflect higher rates of recidivism. It's also important to note that the there is significant overlap in enrollment among the various community programs listed. A single youth could be enrolled simultaneously or consecutively in more than one program. For example, if a youth was placed at Shelter Care in 2018, was discharged to Level II Monitoring, and participated in the JETI program and that youth committed a new offense, it would be reported in the outcomes for each of the programs he was enrolled in.

Analysis:
The data above only reflects incidences of reoffending and does not provide information about the type of subsequent offenses committed. A more compelling data report would show whether the seriousness of re-offenses was increasing, declining, or staying the same. That level of reporting is currently unavailable to us. However, we can note that the overall number and seriousness of offenses committed by youth and referred to DYFS is declining over time:





It is also important to note that the usage of terms referring to risk levels of youth as "high", "moderate", or "low" is not a description of level of dangerousness but is used in an actuarial context to describe the likelihood that a youth may re-offend. A "high risk" youth may not be a danger to persons but might be a continued high risk for misdemeanor theft, for example. This is a critical distinction for this discussion.

Lastly, there is great reason for optimism for all youth who find their way into the youth justice system. As our recidivism numbers show, there is a small number of youth who persist in committing offenses even after receiving our most intensive and restrictive services. However even those who persist in the short term are likely to age out of committing criminal behavior as they enter their mid-twenties and beyond. Attached to this report is an executive summary of Pathways to Desistance, a large, comprehensive longitudinal study commissioned by the Office of Juvenile Justice and Delinquency Prevention that demonstrated dramatic long-term declines in criminal behavior for youth wo had committed serious offense and who were followed into their adulthood. The report also highlights the limited efficacy of longer stays in secure settings in spite of the challenges outlined here.

The Division of Youth and Family Services (DYFS) will continue to work with our judges and court stakeholders, youth and families, our provider partners and the broader community to continue to promote better outcomes and to help make Milwaukee County a more safe, just, and equitable place to live.

Outreach Conducted on the Integration of the Department on Aging: Please see the attached FAQ communication which identifies the outreach that has been completed. This was also sent out on Oct. 16 to the County Board.

2) **Supervisor Moore Omokunde requested the following information**:
   - Birth Outcomes Made Better (BOMB) Doula Program, relative to eligibility for participants enrolled in Badgercare, or other forms of government provided health services.

DHHS reached out to the Milwaukee Enrollment Services (MILES) Bureau operated by the State Department of Health Services to inquire about eligibility for doula services. While these services are not covered by BadgerCare or Medicaid, University of Wisconsin's School of Medicine and Public Health is working on a project to pilot coverage in Milwaukee and Dane Counties. DHHS is awaiting more information from the professor leading this pilot.

3) **DHHS Racial Equity Plan & Resource Center Staff Training**: In addition, DHHS has also attached its racial equity plan and the training plan for the Aging and Disability Resource Centers for more information for supervisors.

Recommendation

This report is informational and no action is required.

Respectfully Submitted:

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Shakita LaGrant-McClain, Director
Department of Health and Human Services

Attachments (4)

DYFS 2018 Recidivism Rates
Pathways to Desistance Report
DHHS MCDA Integration FAQ
DHHS Racial Equity Plan
Resource Centers Staff Training

cc: County Executive David Crowley
Mary Jo Meyers, County Executive's Office
County Supervisor Jason Haas, Finance Chair
Steve Cady, Research Director, Comptroller's Office
Pam Matthews, Fiscal & Management Analyst, DAS
Lottie Maxwell-Mitchell, Research & Policy Analyst, Comptroller's Office

DYFS Services/Programs Usage and Outcomes

Milwaukee County DHHS - Division of Youth and Family Services
Services/Program Outcomes
2018

Detention Alternative Programs	Admissions	Avg Age @ Adm	Served During Year	Discharged	Successful D/C	% Success D/C	Average LOS	# Reoffended During Programming	% Reoffended	Male	Female	Transgender/ Non-Binary	Black/ African Am	Asian	Native Am	Hispanic	White	Other/ Unknown
Shelter	249	15.3	260	246	162	66%	22.6	28	11%	204	56	0	233	0	0	13	14	0
Level II	191	15.5	908	764	459	60%	50.8	77	10%	704	204	0	768	3	1	75	61	0
Evening Report Center	50	15.1	55	53	27	51%	53.4	2	4%	36	19	0	49	0	0	3	3	0
Saturday Alternative Sanctions	46	15.6	56	54	27	50%	60.4	4	7%	46	10	0	104	1	0	10	8	0
Community Service & Restitution Coordination	111	15.9	123	108	80	74%	42.9	8	7%	104	19	0	36	1	0	0	5	0

Post Dispositional Programs	Admissions	Avg Age @ Adm	Served During Quarter	Discharged	Successful D/C	% Success D/C	Average LOS	# Reoffended During Program	% Reoffended	Male	Female	Transgender/ Non-Binary	Black/ African Am	Asian	Native Am	Hispanic	White	Other/ Unknown
Intensive Monitoring Program	110	159.0	207	122	95	78%	273.6	41	34%	181	26	0	183	1	0	15	8	0
Intensive Monitoring Program - Aftercare	30	16.6	37	25	12	48%	133.0	9	36%	33	4	0	32	0	0	2	3	0
Milwaukee County Accountability Program (MCAP) - Detention Phase	36	15.8	59	43	42	98%	176.1	1	2%	59	0	0	54	0	0	4	1	0
MCAP - Community Supervison	44	16.5	57	42	27	64%	133.0	15	36%	57	0	0	52	0	0	5	0	0
Juvenile Education Treatment Initiative (JETI)	66	15.4	95	58	40	69%	170.0	9	16%	79	16	0	75	0	0	10	10	0
Bakari - Type 2 RTC	1	16.2	1	0	0	0%	0.0	0	0%	1	0	0	1	0	0	0	0	0
Bakari - Community Supervision	0	0.0	0	0	0	0%	0.0	0	0%	0	0	0	0	0	0	0	0	0

Level II GPS	Admissions	Avg Age @ GPS	Served During Quarter	Discharged	Avg Days on GPS	Male	Female	Transgender/ Non-Binary	Black/ African Am	Asian	Native Am	Hispanic	White	Other/ Unknown
Level II GPS	632	632	715	619	42.3	552	163	0	614	2	0	54	45	0

DHHS-DYFS Report Definitions

Admissions:	Number of youth admitted to program/placement during quarter
Served During Quarter:	Number of youth who were active with program/placement at any time during quarter
Discharged	Number of youth who were discharged from program/placement during quarter
Successful Completion:	Youth that completed the program/placement and were not discharged because of new offense, AWOL or failure to comply or engage with program/placement
% Successful Discharge	Number of youth who were successfully from program/placement during quarter divided by the number of youth discharged from the program/placement
# Reoffended During Programming	# of Youth that reoffended between start date and discharge date of program/placement. A re-offense is a referral that rises to the level of a petition or Deferred Prosecution where the offense took place while the youth was in the program/placement
% Reoffend	# of youth that reoffended divided by the number of youth discharged during quarter
Days on GPS	Of the youth discharged from Level II/GPS during the quarter, what was the average length of time on GPS (in days)

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
Serving Children, Families, and Communities
JUVENILE JUSTICE
FACT SHEET

March 2011 *Jeff Slowikowski, Acting Administrator*

Highlights From Pathways to Desistance: A Longitudinal Study of Serious Adolescent Offenders

Edward P. Mulvey

The Pathways to Desistance Study is a large collaborative, multidisciplinary project that is following 1,354 serious juvenile offenders ages 14–18 (184 females and 1,170 males) for 7 years after their conviction (for more detailed information, see "Study Design").[1] This study has collected the most comprehensive data set currently available about serious adolescent offenders and their lives in late adolescence and early adulthood. It looks at the factors that lead youth who have committed serious offenses to continue or desist from offending, including individual maturation, life changes, and involvement with the criminal justice system.

Study Findings

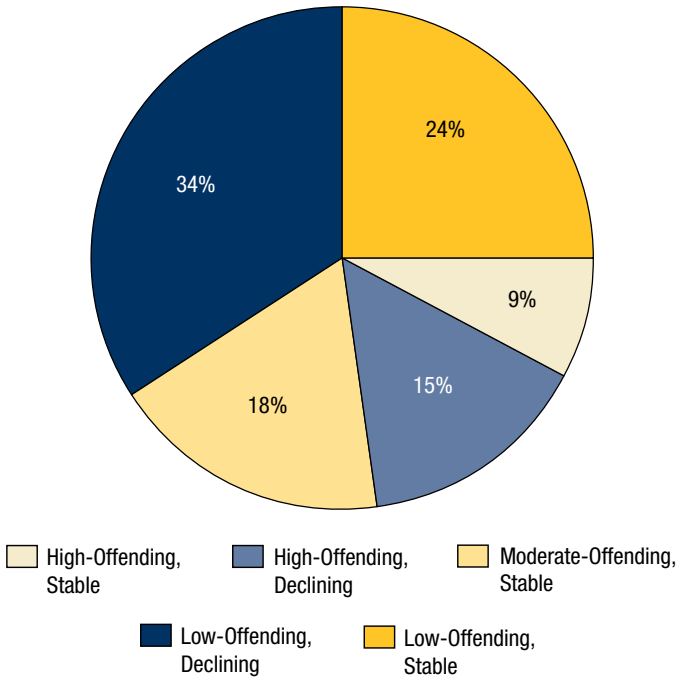
The primary findings of the study to date deal with the decrease in self-reported offending over time by most serious adolescent offenders, the relative inefficacy of longer juvenile incarcerations in decreasing recidivism, the effectiveness of community-based supervision as a component of aftercare for incarcerated youth, and the effectiveness of substance abuse treatment in reducing both substance use and offending by serious adolescent offenders.

Most youth who commit felonies greatly reduce their offending over time, regardless of the intervention. Approximately 91.5 percent of youth in the study reported decreased or limited illegal activity during the first 3 years following their court involvement. In particular, two groups of male offenders—those with high, stable offending rates, and those with high, but declining offending rates—had very different outcomes despite similar treatment by the juvenile justice system (see figure 1). For both groups, approximately 40 percent of offenders were in jail or prison across the 3-year followup period (see "Study Design"); each group also had similar percentages under detention or in a contracted residential placement (about 20 percent of each group was in each of these forms of supervision). Overall, approximately 50 percent of the youth in each group were under some form of supervision during the followup period, and about 20 percent were receiving community-based services.

Key Points

- Most youth who commit felonies greatly reduce their offending over time.
- Longer stays in juvenile institutions do not reduce recidivism.
- In the period after incarceration, community-based supervision is effective for youth who have committed serious offenses.
- Substance abuse treatment reduces both substance use and criminal offending for a limited time.

Figure 1: Groups of Male Offenders, Based on Self-Reports of Offending



Therefore, institutional placement and the type of setting appeared to have little effect on which high-end offenders persisted in offending and which reduced their offending (Mulvey et al., 2010).

Longer stays in juvenile institutions do not reduce recidivism, and some youth who had the lowest offending levels reported committing more crimes after being incarcerated. The researchers looked at two groups of cases that were adjudicated in juvenile court at both the Philadelphia and metropolitan Phoenix sites. Of 921 offenders who remained in the juvenile system, 502 received probation and 419 were placed in institutions. The researchers then matched the two groups based on 66 variables that would affect the probability that an individual offender would be placed in an institution to rule out those variables as potential causes of different outcomes between the placement and probation groups. After 64 of those 66 variables were ruled out, the two groups showed no significant differences in their rate either of rearrest or of self-reported offending. Also, when the researchers matched groups of offenders with similar backgrounds, they found that, for lengths of stay between 3 and 13 months, youth who stayed in institutions longer showed little or no decrease in their rates of rearrest compared with those with shorter stays (Loughran et al., 2009). Moreover, in another set of analyses, the study found that the group of offenders with the lowest levels of self-reported offending actually raised their levels of offending by a small but statistically significant amount following stays in institutions (Mulvey et al., 2010).

Community-based supervision as a component of aftercare is effective for youth who have committed serious offenses, and offenders who receive community-based services following incarceration are more likely to attend school, go to work, and reduce offending. Because the project collects monthly data about institutional placement, probation, and involvement in community-based services, investigators were able to examine the effects of aftercare services for 6 months after a court-ordered placement (the period when such services are presumably provided with greater intensity in most locales). Increasing the duration of community supervision reduced reported reoffending. In addition, although returning offenders generally received supervision only, rather than treatment, the research showed that in the 6 months after release, youth who were involved in community-based services were more likely to avoid further involvement with the juvenile justice system (Chung, Schubert, and Mulvey, 2007).

Substance abuse treatment reduces both substance use and criminal offending, at least in the short term. Research has consistently shown that substance use among adolescents is linked to serious juvenile offending. The adolescent offenders profiled in the Pathways to Desistance study reported very high levels of substance use and substance use problems.[2] Substance use was linked to other illegal activities engaged in by the study participants. It is a strong, prevalent predictor of offending. The presence of a drug or alcohol disorder and the level of substance use

Study Design

The study involved extensive interviews with young offenders at enrollment, followup interviews every 6 months for the first 3 years and annually thereafter, interviews following release from residential facilities, collateral interviews with family members and friends, data collection about significant life events recorded at the monthly level, and reviews of official records data. Enrollment took place between November 2000 and March 2003, and the research team concluded data collection in 2010.

The study followed young offenders in two metropolitan areas: Maricopa County (metropolitan Phoenix), AZ, and Philadelphia County, PA. Youth enrollees in the study were 14 to 17 years old and found guilty of at least one serious (almost exclusively felony-level) violent crime, property offense, or drug offense as the result of their current petition to court. The study limited the proportion of male drug offenders to 15 percent at each site to ensure a heterogeneous sample of serious offenders. Because investigators also wanted to ensure a large enough sample of female offenders—a group neglected in previous research—they did not apply this limit to female drug offenders. In addition, youth whose cases were considered for trial in the adult criminal justice system were still enrolled.

were both shown to be strongly and independently related to the level of self-reported offending and the number of arrests. This relationship held even when drug-related offenses and behaviors were removed from the offending measures, and characteristics including socioeconomic status, gender, and ethnicity were controlled statistically (Mulvey, Schubert, and Chassin, 2010). The good news, however, is that treatment appears to reduce both substance use and offending, at least in the short term. Youth whose treatment lasted for at least 90 days and included significant family involvement showed significant reductions in alcohol use, marijuana use, and offending over the following 6 months (Chassin et al., 2009).

Conclusions

The most important conclusion of the study is that even adolescents who have committed serious offenses are not necessarily on track for adult criminal careers. Only a small proportion of the offenders studied continued to offend at a high level throughout the followup period. The great majority reported low levels of offending after court involvement, and a significant portion of those with the highest levels of offending reduced their reoffending dramatically. Two factors that appear to distinguish high-end desisters from persisters are lower levels of substance use and greater stability in their daily routines, as measured by stability in living arrangements and work and school attendance.

The second conclusion is that incarceration may not be the most appropriate or effective option, even for many of the most serious adolescent offenders. Longer stays in juvenile facilities did not reduce reoffending; institutional placement even raised offending levels in those with the lowest level of offending. Youth who received community-based supervision and aftercare services were more likely to attend school, go to work, and avoid further offending during the 6 months after release, and longer supervision periods increased these benefits.

Finally, substance use is a major factor in continued criminal activity by serious adolescent offenders. Substance abuse treatment for young offenders reduces both substance use and non-drug-related offending in the short term, if the treatment period is long enough and if families take part in the treatment with the offender. Most young offenders who are diagnosed with substance abuse disorders, however, do receive treatment in institutions or community-based settings. Given that community-based supervision may reduce reoffending and promote prosocial attitudes and behaviors, and that continued substance abuse treatment may be needed to prevent longer term relapses, integrating substance abuse treatment into community-based services may realize greater benefits in

reducing serious adolescent offending while providing more efficient and effective delivery of services.

Notes

1. OJJDP is sponsoring the Pathways to Desistance study in partnership with the National Institute of Justice, the Centers for Disease Control and Prevention, the John D. and Catherine T. MacArthur Foundation, the William T. Grant Foundation, the Robert Wood Johnson Foundation, the William Penn Foundation, the National Institute on Drug Abuse (Grant Number R01DA019697), the Pennsylvania Commission on Crime and Delinquency, and the Arizona State Governor's Justice Commission. Investigators for this study are Edward P. Mulvey, Ph.D. (University of Pittsburgh), Robert Brame, Ph.D. (University of North Carolina–Charlotte), Elizabeth Cauffman, Ph.D. (University of California–Irvine), Laurie Chassin, Ph.D. (Arizona State University), Sonia Cota-Robles, Ph.D. (Temple University), Jeffrey Fagan, Ph.D. (Columbia University), George Knight, Ph.D. (Arizona State University), Sandra Losoya, Ph.D. (Arizona State University), Alex Piquero, Ph.D. (Florida State University), Carol A. Schubert, M.P.H. (University of Pittsburgh), and Laurence Steinberg, Ph.D. (Temple University). The rationale for the study may be found in Mulvey et al., 2004, and the details of operations can be found in Schubert et al., 2004.

2. During their baseline interviews, 57 percent of the respondents reported that they had smoked marijuana in the previous 6 months, 40 percent had drunk alcohol during that time, and 27 percent had used cocaine, hallucinogens, or other drugs. Approximately 48 percent of the study participants had used multiple substances during the 6 months before the baseline interviews and, in each followup interview, about 28 to 30 percent reported using multiple substances in the previous 6 months. In addition, at the time of the baseline interview, 37 percent of male study participants and 35 percent of female participants were diagnosed with a substance use disorder in the previous year, three to four times the rate in the general youth population (Mulvey, Schubert, and Chassin, 2010).

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References

Chassin, L., Knight, G., Vargas-Chanes, D., Losoya, S., and Naranjo, D. 2009. Substance use treatment outcomes in a sample of male serious juvenile offenders. *Journal of Substance Abuse Treatment* 36:183–194.

Chung, L., Schubert, C.A., and Mulvey, E.P. 2007. An empirical portrait of community reentry among serious juvenile offenders in two metropolitan cities. *Criminal Justice and Behavior* 34(11):1402–1426.

Loughran, T., Mulvey, E.P., Schubert, C.A., Fagan, J., Losoya, S.H., and Piquero, A.R. 2009. Estimating a dose-response relationship between length of stay and future recidivism in serious juvenile offenders. *Criminology* 47(3):699–740.

Mulvey, E.P., Schubert, C.A., and Chassin, L. 2010. *Substance Use and Offending in Serious Adolescent Offenders.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Mulvey, E.P., Steinberg, L., Fagan, J., Cauffman, E., Piquero, A., Chassin, L., Knight, G., Brame, R., Schubert, C., Hecker, T., and Losoya, S. 2004. Theory and research on desistance from antisocial activity in serious juvenile offenders. *Youth Violence and Juvenile Justice* 2(3):213–236.

Mulvey, E.P., Steinberg, L., Piquero, A.R., Besana, M., Fagan, J., Schubert, C.A., and Cauffman, E. 2010. Longitudinal offending trajectories among serious adolescent offenders. *Development & Psychopathology* 22:453–475.

Schubert, C., Mulvey, E., Cauffman, E., Steinberg, L., Losoya, S., Hecker, T., Chassin, L., and Knight, G. 2004. Operational lessons from the Pathways to Desistance Study. *Youth Violence and Juvenile Justice* 2(3):237–255.

Edward P. Mulvey, Director of the Law and Psychiatry Program at Western Psychiatric Institute and Clinic at the University of Pittsburgh School of Medicine and principal investigator for the Pathways to Desistance Study, prepared this document as a product of the Pathways to Desistance Project, which is supported by OJJDP grant 2007–MU–FX–0002 and National Institute of Justice grant 2008–IJ–CX–0023.

Frequently Asked Questions about the Integration of the Department of Health and Human Services, Department of Aging, and Veterans Services

Q: What are the benefits of integrating DHHS and the Department on Aging for residents?

- By integrating divisions, programs and services throughout DHHS, we can provide improved care to residents of all ages across their lifespan.
- The primary benefit of integration is that it allows for an improved level of service for residents of all Milwaukee County residents across their lifespan through the implementation of the No Wrong Door model. In alignment with the philosophy of the Older Americans Act (OAA), our goal is to achieve a coordinated, person-centered system of care.
- "No Wrong Door" means regardless of where you live, your age, ability or language you speak, you can contact Milwaukee County and we will take a holistic approach to serve your needs—instead of responding issue by issue. No Wrong Door will create easier access to quality care. The care and services will be driven by the person seeking help. So, no matter if you need housing or mental health or transportation services, there should be "no wrong door" to access the services you need.

Additionally, specific benefits for senior include:

- County veterans will have increased, direct access to wrap-around services offered by DHHS.
- Allows seniors to interact with the County without stigma or silos as the population over 60 years of age grows in Milwaukee
- Provides a more direct connection to services for seniors, which will increase health outcomes
- Adds staff on the frontlines to help those who need help the most
    - Adds two new Human Service Workers in the Aging Resource Center that will be located in our Access Units
    - Creates an Elder Benefit Specialist position to be the subject matter expert on Medicare programs/services as well as other Medicaid services/issues
- Provides direct access to eviction prevention, mental health and energy assistance—all services that are directly called out in the Older Americans Act
- Cushions programs for older adults and veterans from direct tax levy target reductions as they are part of a larger department
- Un-funds or eliminates management-level positions in order to protect senior center programming services
- Brings the County up to the same standard as the rest of the state and nation in terms of ensuring all people, regardless of age, have seamless access to services
- Enables extra funding to critical services such as transportation, neighborhood outreach, family caregiver support, and outreach to LGBT older adults.

Q: Why is now the time to integrate DHHS, MCDA and Veterans Services?

- Milwaukee County has been on a path toward breaking down silos among its services for many years. As shown by the integration of the Airport and MCTS into the Department of Transportation as well as the integration of various emergency services into the Office of Emergency Management, we know that we have to bridge the gap between County services into ensure all residents, including seniors and veterans, have seamless access to the services they need to thrive.

- The County Executive established a bold strategic plan in his first few months in office to become the healthiest county in Wisconsin by achieving racial equity. We are almost the least healthy county in the entire state, and we need to make dramatic changes as to how we provide services to our most vulnerable populations in order to achieve our vision.
- The County Executive decided to act swiftly and decisively in pursuing the integration of the Department on Aging, Veterans Services and the Department of Health and Human Services as one of several immediate actions that advanced all three strategic focus areas of creating intentional inclusion, bridge the gap in health disparities, and invest in equity.
- In addition to the urgency of advancing the County's bold strategic plan, the timing of integration is intended to ensure that the Department of Aging is at the table and meaningfully engaged in the work that DHHS is currently doing to implement its transformational No Wrong Door effort. For example, DHHS is currently establishing a new coordinated IT system, applying a customer-centric Practice Model, conducting the relocation planning for DHHS, and implementing the contract and QA/QI improvements. Integrating these departments at this critical juncture ensures that Aging will benefit from these changes and be at the table as these decisions are being made rather than afterwards.

Q: What will be the impact of integration on the Commission on Aging or the Aging and Disability Resource Center Governing Boards?

- None. Both the COA and ADRC Governing Boards will continue to carry out their important responsibilities, and they will have a critical role in working with staff to plan for the integration of the Aging Resource Center and Disability Resource Center. Next year will be a planning year for this integration, and both entities will be working collaboratively with staff to create an integrated ADRC model that is designed to best serve all of our customers.

Q: Is the Commission on Aging involved in the integration plan?

- Yes, County leaders have engaged the Commission on Aging (COA) since the decision was made to pursue an integration of the DHHS, MCDA and VS. The County Executive's Office and department leaders have presented the integration plan in several forums, including:
    - The COA meeting on September 25th, which included participants from the ADRC Governing Board and other senior advocates
    - The COA Advocacy Committee meeting on October 5th
    - The COA Executive Committee on October 5th
- The COA Advisory Council will be discussing the integration plan at its meeting on October 29th. All feedback on the County Executive's integration plan will be included in the amendment to Aging's current Area Plan that must be submitted to the state Department of Health Services by December 1st.

Q: How will the "voice" of older adults be impacted by integration?

- The full integration of DHHS and MCDA not only protects the quality of service for Milwaukee residents, it streamlines services to create faster turnaround times and an overall improved customer experience that continues to advance high quality service for Milwaukee's older adults and people with disabilities. In addition, staff is being trained to offer this high level of service for all residents looking for resources in order to increase access and advance the overall health of county residents.
- The statutory "voice" for older adults is the Commission on Aging, and nothing changes in terms of their role or responsibilities—especially their advocacy/public policy work with Aging Division staff as well as their role in developing the next Area Plan for the Aging Unit. The Aging Division Director and DHHS Director will work to elevate older adult issues to the County Executive and his staff, who will elevate them to federal officials.

Q: Have there been attempts to reach out to seniors about the integration plan, Commission on Aging outreach or otherwise?

Yes, absolutely. Meetings already completed:

- 9/25/2020-Commission on Aging meeting—The ADRC Governing Board members were also invited to attend this meeting, and most of them did.
- 10/5/2020-Commission on Aging Advocacy Committee meeting.
- 10/5/2020-Commission on Aging Executive Committee meeting

Upcoming meetings:

- 10/29/2020-Commission on Aging Advisory Council meeting.
- 11/13/2020-Regularly scheduled Commission on Aging meeting; there may be additional discussion on the County budget/integration plan.

Other notes:

- 10/30/2020-County Board public budget hearing; the public is encouraged to weigh in with their individual Supervisors at any time during the budget process.
- Individual County Supervisors are holding town hall budget meetings in October where constituents can weigh in on the budget and ask questions of County staff.

Q: How will the County measure success once the integration plan is fully implemented?

- Since June 2020, DHHS and Aging staff have been working on a pilot to create an integrated Adult Protective Services unit. Staff have created measures that track the effectiveness of the integrated unit, including percentage of individuals referred to services, reduction of risk factors for customers, and caseload volume.
- Milwaukee County will continue to track ADRC customer satisfaction as well as customer satisfaction with our contracted services such as meals, senior centers, wellness programs, etc. In addition, we will track Adult Protective Services/Elder Abuse metrics that have been developed by the Aging/DHHS team working on that pilot. Performance measures within our contracts will also be tracked, such as pre- and post-integration metrics for major programs when it comes to meals, transportation, and administrative overhead per FTE.

Q: What steps are being taken to address service delivery between Adult Protective Services and the Behavioral Health Division?

- The new case management software being implemented by DHHS, developed by RedMane, called MKE Cares, includes a notification system on an individual's record notifying the staff member as to whether they currently have an open case with another division. This was the catalyst for implementing new case management software, to streamline service delivery and create opportunity to collaborate with other divisions from the beginning.
- As part of the collaboration between the Disabilities Services Division, Department on Aging, and Behavioral Health Division, staff members take steps to include contacted parties from each division discussing details of the situation and creating a plan that is in the best interest of the client.

Q: What services will be reduced or eliminated?

- The integration does not reduce or eliminate any services.

Q: Where can someone access academic information or evidenced-based information for the No Wrong Door model?

- Milwaukee County's first strategic plan in over 20 years was unanimously approved by the County Executive and County Board of Supervisors. This is the primary resource for information around integration.
- The strategic plan outlines information regarding decisions to better deliver services to all populations in Milwaukee County, including older adults. Specifically, taking a No Wrong Door approach will help us:
    - Break down the silos between departments at Milwaukee County;
    - Create more direct access to an expanded array of services such as eviction prevention, mental health, and energy assistance; and
    - Provide a faster turnaround when connecting people to services.
- All of this will result in better customer outcomes.
- The following resources provide evidenced-based research supporting integration:
    - "Human Services Systems Integration" – Institute for Research on Poverty https://www.irp.wisc.edu/publications/dps/pdfs/dp133308.pdf
    - "Integrating Health and Human Services Programs and Reaching Eligible Individuals under the Affordable Care Act" -Urban Institute
    - The County Health Ranking recommends "social service integration" as an effective strategy for reducing health disparities in counties
    - "Implementing Services Integration and Interagency Collaboration: Experiences in Seven Counties" -Administration in Social Work

Q: Several areas of DHHS receive consumer calls, such as BHD/CARS, the Mobile Crisis Team, will those be integrated eventually?

- The Psychiatric Crisis Redesign expands our reach into the community by calling for a front door that gets people of all ages to where they can receive help as quickly as possible. There is some thought that this function should be tied to the intake process. Currently, the DRC has a Disability Benefits Specialist (DBS) and a Housing Specialist. When someone calls who needs assistance with private or public benefits or housing, we can connect them to someone right away or take a referral for that area. We could discuss having someone from BHD being available to our call center staff to assist with mental health concerns. This is an area we are still working through.

Q: Once integration occurs, will the one-on-one and community outreach provided by Aging staff be targeted to all age groups rather than older adults only?

- All of the outreach work currently coordinated by Aging staff is specifically designed to help the most underserved and impoverished older adults in our community. Aging staff have aligned their outreach work with the County's strategic vision. How, or to what extent, this outreach work is modified will be determined once the integration plan receives approval from Milwaukee County and state DHS decision-makers.

Q: Will there be reductions or changes in the MCDA workforce as a result of the integration?

- There will be no reductions to filled positions. Additionally:
    - The vacant Executive Director Aging position is eliminated and replaced by a full time Aging Unit-Administrator. This change has zero impact on senior services and follows state statutes that govern Aging operations.
    - The vacant Administrator-Finance Operations position is un-funded and job duties are absorbed within existing DHHS and Aging staff.
    - The vacant positions of Program Coordinator-Resource Center and Administrative Assistant are unfunded and job duties are absorbed within existing DHHS and Aging staff.

- One new in-house Elder Benefits Specialist is created to assist seniors calling the Aging Resource Center with Medicare-related services.
- Two new Human Service Worker positions are created in the Aging Resource Center to provide more comprehensive and robust services to older adults.
- A vacant Service Support Specialist position is eliminated.

Q: Will an integration of DHHS and the Department on Aging result in a reduced focus on the needs of older adults in Milwaukee County?

- No. In fact, we expect older adults to have access to more services with this integration. We are adding people and resources on the frontlines to preserve and expand services for older adults, including:

    - Extra funding for the transportation contract to make sure older adult residents can get to doctor appointments and grocery stores and have an opportunity to live full, independent lives no matter their age or ability;
    - Aging staff has also budgeted funding increases in 2021 for these older adult services: Neighborhood Outreach Program, outreach to LGBT older adults, family caregiving services, case management services for older adults with disabilities, and Meals on Wheels.

- By state and federal law, Aging funding streams can be used only for Aging services.
- Aging funds are segregated from other DHHS funding. Oversite of these funding streams will be kept by Aging staff, county auditors, and state and federal authorities.
- Resources freed up due to this integration through the removal of duplicative and redundant staffing are now re-directed to improve and expand services to seniors.
- Integration will make available to older adults faster and easier access to a multitude of services such as energy assistance, housing, and mental health, which are housed in DHHS and BHD.
- Aging staff will be able to draw from a wider network of vendors, procurement staff, and administrative resources previously not available to them

Q: Will this result in Aging services being offered in the same space as DHHS?

- The project to co-locate Aging and DHHS staff began over a year ago. The intent has always been to co-locate DHHS and Aging staff in a new building that is accessible for people of all ages and abilities, and to foster continued collaboration between Aging and DHHS staff. The integration plan formalizes that collaboration. An integrated ADRC means that all HSW's will be located in one spot together to implement the "No Wrong Door" approach.

Q: How does this integration advance Milwaukee County's vision of "By achieving racial equity, Milwaukee is the healthiest county in Wisconsin"?

- Create Intentional Inclusion: Ensures improved customer experience for all seniors through inclusion in No Wrong Door; as the population over 60 years of age grows in Milwaukee, seniors can interact with the County without stigma or silos.
- Bridge the Gap: Provides a more direct connection to services for seniors, which will increase health outcomes; adds staff on the frontlines to help those who need help the most; provides direct access to eviction prevention, mental health, energy assistance, etc.
- Invest in Equity: As part of a larger department, programs for older adults will be cushioned from direct tax levy target reductions; safeguards funds for five-day-a-week senior center social programming as a result of administrative cuts; brings the County up to the same standard as the rest of the state and nation in terms of ensuring all people, regardless of age, have seamless access

to services; enables extra funding to most wanted services such as transportation, family caregiver support, food delivery, case management, etc.

Additionally:

- Due to efficiencies gained with the integration, specifically through un-funding of managerial positions, freed up resources are re-invested back into services for older adults particularly those of color.
- A direct consequence is increased funding for high demand services that serve people in communities of color:
    - Transportation
    - National Family caregiver and Alzheimer's services
    - Neighborhood outreach services
    - Home Delivered meals
- A direct consequence of this integration is $120,000 of the $170,000 reduction in the Department on Aging's proposed budget for the senior center social programming contract is restored in the County Executive's Budget. Through this contract, approximately 44% of the older adult customers that are served are in communities of color.

What are the next steps in the integration process?

- The County Executive's 2021 Recommended Budget was submitted to the County Board of Supervisors on October 1, 2020. The County Board, via its Finance Committee, began its review of the County Executive's Recommended Budget during the week of October 12th. The Finance Committee reviewed and discussed the DHHS budget (which includes all Aging services) on Thursday, October 15th. Once the Finance Committee finishes its review of all Departmental budgets, the Finance Committee will review, discuss, and vote on any amendments to the Recommended Budget. On October 30th, the County Board will hold its annual public budget hearing (virtually this year). Also, in October, several County Supervisors will be holding town hall meetings at which budget issues and concerns can be shared by constituents and questions answered by County administrators. On November 9th, the County Board will review and vote on the final Adopted Budget.
- While the County Board is reviewing, discussing, and amending the County Executive's 2021 Recommended Budget, the Commission on Aging will also be reviewing and discussing the specific proposal to integrate Aging services with DHHS. The Commission on Aging was presented with the integration plan at its September 25th meeting, and next the Commission on Aging Advisory Council will be reviewing and discussing the integration plan at its October 29th meeting. The Commission on Aging is also planning to schedule a special meeting on November 6th to review and discuss the integration proposal.
- Per direction from the state Department of Health Services, the Aging Unit must submit an amendment to its existing Area Plan and answer a series of questions pertaining to the County Executive's integration proposal. This Area Plan amendment is due to DHS by December 1st. The questions and answers that are being drafted as part of this Area Plan amendment will also be reviewed by the Commission on Aging Advisory Council at its 10/29 meeting as well as by the full Commission on Aging at its 11/6 meeting. Once the Aging Unit submits its Area Plan amendment to the state DHS, DHS staff will review it and, ultimately, will provide direction to County staff on next steps.
- The second piece of the state DHS review and approval process involves an application that must be submitted by the County which focuses on the merger of the Aging Resource Center and Disability Resource Center. This application will be completed through a series of conversations in 2021 involving DHHS and Aging staff as well as community members, members of the Commission on Aging and ADRC Governing Board. The state's expectation is that all of these stakeholders, and others from the community who are interested in this issue, will work together to submit an application that provides detail on what an integrated ADRC looks like. The County expects to submit its application to the state DHS around July or August of 2021. The state DHS

will then review the County's application and likely ask follow-up questions. Ultimately, the state DHS must approve the County's application, at which point the County can move forward on implementation of a fully integrated ADRC. The 2022 Milwaukee County Budget process may also involve changes or policy direction that relate to the integrated ADRC operation. The County is hoping that this entire application and review process can be completed in 2021 so that a fully integrated ADRC an begin its work in January 2022.

Training for Staff in Aging Resource Center and Disability Resource Center

And Adult Protective Services and Elder Abuse

Call Center Staff Training:

All Call Center staff in ARC and DRC are AIRS certified. AIRS certification covers general information and referral (I&R) training, including best practice working with older adults and best practice working with people with disabilities. Call Center staff are certified after one year of experience and training in I&R and recertified every 2 years. It is the same training, test, and certification for the ARC and the DRC…CRS A/D (Community Resource Specialist – Aging/Disabilities). We would provide additional training to people not used to those populations on best practice when serving those customers.

We will cross train both the ARC and DRC staff on resources that are available specific to older adults, and vice versa. Many resources are not age specific. Some do have age or 'condition' eligibility. We are required by our contract to maintain an up-to-date resource database (currently online and accessible to staff and customers alike) that includes information on eligibility for different resources. Both the ARC and the DRC also maintain a 'common resources' document that staff also use as reference.

Human Service Workers-ARC and DRC (we also call them Options or enrollment counselors)

Per the DHS website https://www.dhs.wisconsin.gov/functionalscreen/ltcfs/instructions1.htm:

All people administering the LTCFS must meet the following four requirements:

1. Meet the **minimum criteria for education and experience**, which are:

- Bachelor of Arts or Science degree, preferably in a health or human services related field or have a license to practice as a registered nurse in Wisconsin pursuant to Wis. Stat. § 441.06, and at least one year of experience working with at least one of the target populations (frail elder, physical disability, or intellectual/developmental disability).

2. Meet all **training requirements** as specified by DHS:

- Completion of the web-based clinical certification course. This course is currently the primary way to meet the DHS training requirements.

3. Have at least one year of **experience working in a professional capacity with long-term care consumers**.

4. Successfully complete all mandatory certification courses, exams, refresher courses, and continuing skills testing as required by DHS

All DRC and ARC staff are required to meet these requirements and to take the CST (Continuing Skills Test) for the Long Term Care Functional screen every 2 years to remain certified. All DRC and ARC staff have been certified. Each of the Resource Center have dedicated screen liaisons who ensure:

1. LTCFS quality assurance efforts begin with each screener. **It is the screener's responsibility to be an objective screener, to be informed of the instructions, and to corroborate information gathered from the person and collateral contacts**. If a screener has questions, these should be addressed by the person designated as the screen liaison in each screening agency. The LTCFS results issue a determination of functional eligibility for Medicaid waiver programs. Therefore, screeners should be aware that unethical or fraudulent performance of screening activity will be referred to the DHS Office of the Inspector General for investigation.
2. **Part of the screen liaison's role is to oversee quality assurance activities related to the LTCFS**. At a minimum, each agency must include the following strategies:

· Ensure completion of continued skills testing by all certified screeners.

· Train, mentor, and monitor both new and experienced screeners.

· Perform random sampling for accuracy and consistency of screens performed by each screener at the agency.

· Complete reports as requested by DHS.

· Consult with the DHS LTCFS staff about complicated screens or to clarify policy and procedure.

· Discontinue access to FSIA for any screener whose job duties or employment status has changed.

· Respond to quality assurance findings of DHS.

There are new Options Counseling training requirements for both ARC and DRC Options Counselors.

All ADRC employees who do Options Counseling are required to complete 4 online modules (totaling about 6 hours) specific to Options Counseling, including passing a post test.

All other ADRC employees (non-Options Counselors) are required to complete 1 of those modules so they are familiar with what ADRCs do regarding Options Counseling.

Human Service Workers-APS and EA (Adult Protective Services and Elder Abuse staff)

Per DHS https://www.dhs.wisconsin.gov/aps/training.htm-

APS and EA staff members are responsible for assessing and evaluating the allegations of abuse, neglect, self-neglect, physical abuse, emotional abuse, and financial exploitation of individuals with intellectual, developmental, physical disabilities, dementia, mental health, etc. ages 18 and up. The assessment and evaluation period include determining risk factors, competency, assessing validity of allegations, determining whether allegations are substantiated per WI Administrative Code Chapter 55 and 46.90.

Trainings are provided by the Office of Corporation Counsel on guardianship, Watts Reviews, Court proceedings, removal of an individual from their primary residence, and court documentation.

APS and EA staff members attend various trainings sponsored by the National Adult Protective Services Association to receive the most current training content. Topics include;

- how to recognize abuse
- neglect
- self-neglect and
- financial exploitation of Adults At-Risk.

DHHS Department of Health & Human Services

Together, creating healthy communities.

Addressing Social Determinants of Health and Equity in the Behavioral Division of the Milwaukee County Department of Health and Human Services (DHHS)

Milwaukee County has committed to addressing racism, a public health crisis. In partnership with the Office of African American Affairs (OAAA), the Human Resources Department, and the Office of Performance, Strategy & Budget, DHHS is working to ensure our leaders and staff have knowledge, skills and resources to address inequities which impact many of the most vulnerable people. We aim to improve access to acceptable, high- quality and appropriate care, while addressing disparities in a way that improves the overall quality of life for all people who live in Milwaukee County.

In order for communities, families and individuals to thrive and reach maximum levels of health, sustainable investment in factors like community safety, family & social support, safe affordable housing, vocational training & economic development, and addressing policies that detract from people's ability to thrive is required. These factors, which are also called social determinants of health, are conditions in the environments in which people are "born, live, learn, work, play, worship, and age" that affect a wide range of health, functioning, and quality-of-life outcomes. DHHS is committed to tackling racial inequity, as well as injustice experienced by many because of age, gender, religion, incarceration history, developmental functionality, etc.

This approach will allow DHHS to move beyond treating symptoms, as in traditional medical and social service models, and contend with root cause (i.e. underlying needs). According to the American Public Health Association (2019),

> *Racism structures opportunity and assigns value based on how a person looks. The result: conditions that unfairly advantage some and unfairly disadvantage others. Racism hurts the health of our nation by preventing some people the opportunity to attain their highest level of health. Racism may be intentional or unintentional. It operates at various levels in society. Racism is a driving force of the social determinants of health (like housing, education and employment) and is a barrier to health equity*.

Since 2018, DHHS has made intentional efforts to address social determinants of health and racial equity across all divisions through the work it does within its organization, staff, and contracted staff, and externally with its participants, system and community partners. Through extensive research, partnership with experts, engagement of staff & stakeholders, and planning, ten areas of focus have been identified for DHHS to become healthier and more equitable.

- Hiring & Retention Practices
- Workplace Culture
- Contracting
- Technology & Communication
- Compensation & Pay Equity for Staff
- Research, Data & Quality
- Standards, Policies & Practices
- Community & Stakeholder Engagement
- Community Accessibility
- Budgeting and Reinvestment

Behavioral Health Division (BHD)

In addition to the department- wide strategies that are taking place across DHHS, the Behavioral Health Division has made progress on several of the focus areas: a) Hiring & Retention Practices; b) Research, Data

& Quality; and c) Workplace Culture. These areas were selected based on community and contracted vendor feedback,

results from a Racial Equity Readiness Assessment and best practices from the Government Alliance on Racial Equity (GARE). There are also efforts to respond to increased need for mental and behavioral health services because of COVID- 19. The following are examples of some of the activities that are in progress to advance racial and health equity related to these focus areas.

Hiring & Retention:

- BHD staff led- effort "Workforce Development for Diversity & Inclusion" established to respond to request from community members to have more diverse practitioners who reflect community
    - This effort provided training and support to new interns. It also assessed competencies of existing staff to improve culturally responsive practice.
    - Effort includes partnership with OAAA and other departments across MKE County
    - Key objective is to grow the local Mental Health Practitioner workforce through internships for people who live in Milwaukee by removing barriers and providing support to obtain licenses and certifications

Research, Data & Quality:

- Operationalized social determinants of health to include indicators in assessments with adult programs.
- Tracked local suicide- related data to develop culturally appropriate prevention and intervention strategies based on those who are most vulnerable. Strategies include engaging community stakeholders, people with lived experience, and experts from Substance Abuse and Mental Health Services Administration (SAMHSA) in processes.

Workplace Culture:

- Weekly townhalls for BHD staff have been hosted by the executive leadership team. This is an open platform for staff to ask questions and express concerns. Leaders provide transparent responses and provide updates on department and county-wide initiatives. When appropriate, guest speakers who are subject matter experts in pertinent topics are also invited to present information to staff.
- Coaching is available to BHD Leaders on leadership development. During quarter four of 2020, this will be expanded to include ways to support staff who have been impacted by COVID-19, how to work effectively with diverse staff and participants, and how to advance equity through policy audits and changes.

COVID- 19 Response:

- Staff have been deployed in the Milwaukee community to ensure those in greatest need of mental and behavioral health services receive care in the most accessible ways. Extensive efforts have been made to ensure the safety of staff and community members to mitigate the spread of COVID-19 through minimizing exposure through the use of PPE.
- A partnership has been established with the Milwaukee Mental Health Civic Response Team to implement a community participatory process that will allocate funds to community- based organizations that are currently providing mental and behavioral health related services to people who have been impacted by or are in areas of highest risk for COVID-19 infection.