COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: June 27, 2013

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

FROM: Héctor Colón, Director, Department of Health and Human Services
Kathleen Eilers, Interim Administrator, Behavioral Health Division
Prepared by: Geri L. Lyday, Administrator, Disabilities Services Division

SUBJECT: **From the Director Department of Health and Human Services, providing an informational report regarding the Department's plan to close the Behavioral Health Division Center for Independence and Development (formerly Hilltop) and Rehabilitation Center Central**

Introduction

Milwaukee County Department of Health and Human Services (DHHS) has made a commitment to transform the current outdated system of care at BHD to one focused on high-quality, individualized community-based care. Through several years of budget initiatives, DHHS has focused on downsizing the Behavioral Health Division's (BHD) Center for Independence and Development (CID) (formerly Hilltop) and relocating individuals with intellectual disabilities to the community. BHD and the Disabilities Services Division (DSD) have worked jointly to achieve several previous downsizing initiatives, including closing and relocating clients from at least two units previously operated by the CID. Most recently, in the 2013 Milwaukee County Adopted Budget, an additional 24-bed downsizing of the CID was included.

Over the past 15 to 20 years, a number of skilled nursing home downsizing and facility closure efforts have been completed in Milwaukee County as well as across the State of Wisconsin. Indeed, the long-term care bed capacity in Milwaukee County alone was hundreds of licensed beds greater than it is today due to this long-standing trend toward deinstitutionalization. This follows a nation-wide trend to reduce the reliance on institutional care that began in the late 1970s and has continued in the most recent decade through various initiatives by both local and state agencies. BHD has been downsizing and successfully moving clients to the community for many years beginning with a Master Plan completed in the 1990s by Kathleen Eilers.

This long-standing effort is a continuation of the commitment to complete the downsizing and support individuals in a community setting. Furthermore, it is consistent with the recommendations of:

- The Human Services Research Institute (HSRI) Report
- National and state trends
- The Resolution passed by the County Board from the Committee of the New Behavioral Health Facility Study (Please see Attachment 1)
- The goals and objectives of the Mental Health Redesign Taskforce
- Longitudinal research studies demonstrating the positive impact of deinstitutionalization

Most recently, this action has been followed up by the County Executive's February 2013 State of the County Address, wherein he highlighted his plan to close the long-term care programs operated at BHD and to develop community-based alternatives for individuals in Milwaukee County. This effort is to be completed within three years.

DHHS is currently working on a closure and relocation plan for the BHD long-term care programs. The programs currently serve approximately 121 individuals with co-occurring mental illness and intellectual disabilities. This is an exciting initiative that will provide the opportunity for individuals to live in more integrated community-based settings.

The decision to make this change in the service delivery model is not being done due to any incident that has occurred at BHD nor because of any expected tax levy savings. Changing the service delivery model away from institutional care and to shift services to more community-based alternatives is a fundamental statement about how the County is going to support individuals with intellectual disabilities and mental health conditions to live, work and play in this community and have an increased quality of life. This is the right thing to do and is also consistent with Federal Law including the Olmstead decision. Research has consistently shown that individuals have an increased quality of life in a community setting provided that setting has the environment and staffing to meet the individual's needs and that sufficient community support is available. The ultimate goal is to provide individuals with person-centered recovery oriented plans incorporating trauma informed care, that sets them up for success in true community integrated living.

The County Board affirmed their support for a deinstitutionalization and a community-based model of care in 2011 with resolution #11-516, stating:

"BE IT RESOLVED, that the County Board adopts the following as County policy:

- *The current BHD facility is too large and reflects an inpatient focused model of care that is financially unsustainable in both the short and long term; if Milwaukee County continues to utilize an inpatient centered approach to delivering mental health services, our ability to maintain current service levels will be eroded by rising health care costs and client outcomes will deteriorate even further*

- *Milwaukee County needs to reallocate how it spends its mental health dollars by transferring the majority of our system dollars into community-based services; these services can be provided by the private sector or a mix of private and publicly run options; the current inpatient focused system uses almost two-thirds of Milwaukee County's available system funds, leaving approximately one-third of the county's funds for community services; successful community-based care systems are most cost-effective and achieve better client outcomes than inpatient focused systems; in these systems, more than half to two-thirds of system funds are spent in the community; achieving this resource shift is more crucial to the future of mental health care in our community than the decision of whether Milwaukee County should build a new mental health facility on the County Grounds."*

The Board's policy passed unanimously and was signed by the County Executive. This initiative is responsive to County Board policy. It is the responsibility of DHHS to ensure that every relocation is successful and that consumers receive the services they need at a very high-quality level.

This report details background information including County Board policy that supports this initiative. Also included are details regarding the planning efforts and accomplishments that have occurred as well as initiatives currently being implemented.

Background

In March 2013, DHHS provided an informational report to the County Board regarding the intention to close both the CID and Rehabilitation Center Central. This report detailed the rationale for the decision to change the service delivery system and included considerable detail regarding previous downsizing and closures that have successfully occurred over the past 15 years in Milwaukee County and throughout the state. In addition, information was provided about numerous State of Wisconsin Department of Health Services (DHS) initiatives that resulted in the relocation of individuals living in institutional settings being relocated to community-based alternatives.

County Board Supervisors had questions regarding the March 2013 report and the project plan to close the long term care programs. In April 2013, the DHHS Director provided responses to questions raised by Supervisors (Please see Attachment 2) which included:

- Information about funding
- Timeline for closure
- Guardian issues
- The role of the County Board in the closure process
- The role of the Milwaukee Health Care Partnership (Hospital System)
- The DHHS emergency plan
- Workforce issues
- Fiscal issues
- Housing issues
- Community capacity questions
- Provider quality issues

In additional to the Department's response to questions raised by the County Board during the committee of the whole in April 2013, Chairperson Supervisor Peggy Romo West later introduced a resolution that established guidelines surrounding Milwaukee County's efforts to transition BHD's long-term care facilities to a community-based model of care (Please see Attachment 3). The full County Board adopted this resolution by a unanimous vote.

Long Term Care Closure Planning

DHHS is strongly committed to the closure initiative and takes very seriously its role in facilitating this change in the service delivery model for those individuals currently served by these programs which maintain safety and welfare for all consumers as the paramount goal. A number of strategies have been employed to support this change in services and detailed work plan has been developed. The administrative team is meeting on a weekly basis to monitor, implement and refine the work plan. The Department has also thoroughly reviewed the Resolution that was adopted in April, submitted by Supervisor Peggy Romo West - and adopted by the full County Board - and integrated the key points into the work plan. The following is a list of the key provisions and the Department's work plan activities that relate to each item:

1. Prior to the full closure of long-term care units operated by Milwaukee County, a more robust continuum of community services will be developed, including housing, specialized behavioral health services, and crisis services.

- BHD has been working with the Waisman Center in Dane County, a national best practice and model in serving individuals with intellectual disabilities and mental illness, to develop intensive crisis mobile team supports to provide enhanced services in the community for persons with both intellectual disabilities and mental illness. BHD has entered into an agreement with the Waisman Center for consultation services that will help develop the enhanced crisis capacity:
    - Development of a Community Consultation Team consisting of staff with expertise in working with individual who have co-occurring intellectual disabilities and mental health issues. This team will be available in 2013 to help support individuals in the community who experience periodic need for behavioral and crisis intervention (Please see Attachment 4).
    - The next step will then be for the Waisman Center consultants to complete an assessment and prepare recommendations for system improvements of the current service delivery system These recommendations may include the following:
        - Creating capacity to provide ongoing behavioral consultation, training, and support
        - Creating an outpatient clinic design that provides psychiatric services for individuals with developmental disabilities and potential direction for creation of such a clinic in Milwaukee
        - Establishing effective crisis capacity and needed service components
        - Expanding current service providers' confidence and capabilities to improve positive behavioral outcomes for individuals being served
        - Identifying future training needs and completing some identified trainings for service providers
- DSD is engaging a community-based provider to develop intensive crisis resource center beds to provide short-term alternatives to an emergency room for individuals with more significant needs in 2012.
- Increased community capacity is being developed to support individuals with serious and persistent mental illness who will relocate from Rehabilitation Center Central.
    - BHD Community Services Branch is funding additional beds that will provide intensive supports for clients who are not Family Care eligible. They will fund 10 beds in 2013 and an additional 14 beds in 2014.
    - BHD will be collaborating with the DHHS Housing Division to develop new housing options leveraging HUD funding - new scattered sites will be developed in 2013/2014.
    - New funding alternatives under the CCS and CRS programs are being explored to determine how to best leverage these new Medicaid benefits.
- DHHS is bringing nationally recognized experts in August 2013 to help develop new and specialized resources and supports for those with more challenging and significant behavioral support needs as well as issues around sexuality (Please see Attachment 5) in lieu of being admitted to BHD's Psychiatric Crisis Service (PCS). Experts will meet with BHD staff and providers interested in new specialized resource development
- DHHS is also appealing to other statewide provider agencies that have expertise in working with individuals with challenging and aggressive behaviors. Several of these providers are already

providing services in other parts of the State but are very interested in developing new specialized resources in the Milwaukee area.

- There are number of other recommended community investments identified in the 2014 Requested Budget totaling over $4 million (Please see Attachment 8).
- DHHS has met with representatives of DHS to discuss enhanced funding options that may be available to help support the closure activities. Those options include:
  - Enhanced funding availability for relocations from Money Follows the Person funding which uses the higher federal match rate of 100%. This could mean an estimated additional $50,000 annually.
  - Explore high cost COP funding options to assist with the project costs. COP funding is not limited to individuals with intellectual disabilities, but also can be used for mental health services. This may be used for a pilot project that supports relocating people with complex needs, training or technical assistance, (e.g., funding for consultants). It could also support costs associated with facilitating meetings and contracting with the Waismann Center.
  - DHS is seeking more details on increasing enhanced funding available to support the relocation efforts available through Medicaid.
  - DHS is investigating options to provide reimbursement for psychiatric hospital services when the length of stay is brief. It may be possible to characterize a short stay as something other than institutionalization.
  - DHS is also exploring the disenrollment requirement of an enrolled Family Care member when entering a psychiatric hospital (IMD) and examining language that exists in the Medicaid HMO contracts to see if there are alternatives to automatic disenrollment
  - DHHS is exploring the use of Medical Assistance Personal Care (MAPC) Medicaid funding to help support individuals residing in the community who have a mental illness. This program can potentially provide considerable supports to individuals who require assistance with personal care and could be a viable funding option to help support the community services provided by BHD.
- In June 2013, DHHS hosted a one-day strategic planning session with stakeholders from DHS, BHD, DHHS, advocates, MCOs and other key individuals to help plan for the service delivery system changes that will be needed to support the closure (Please see Attachment 6).

2. Given the reliance on the Family Care program, prior to successfully relocating individuals to community-based settings, the Department of Health and Human Services and BHD will work with the managed care organizations in Milwaukee County to ensure the development of resources and capacity to meet the specialized needs of the individuals relocating to the community.

- In March 2013, a meeting was held between DHS Secretary Kitty Rhoades along with key State staff and DHHS senior management to discuss the closure of long term care programs and to obtain feedback from the State regarding several questions related to:
  - MCO strategy regarding closure
  - Who is responsible for crisis services
  - Relocation dollars
  - Pilot opportunities regarding sustainability initiatives
  - Challenges around immediate disenrollment by the MCO's upon admission to the Behavioral Health Complex
  - Increase in the BHD Medicaid rate during the closure

    - Adequate capitated rates for MCO's when supporting persons with complex medical/mental health needs
- In June 2013, a joint meeting was convened including key State staff from the Office of Family Care Expansion, the Family Care Managed Care Organizations (MCO), the IRIS program and DHHS staff to discuss the closure of the CID and Rehabilitation Center Central and to elicit feedback from the MCOs about challenges and to review the closure plan, timelines and general information regarding those individuals who will be relocating. Future joint meetings are planned to provide updates and ensure that these critical stakeholders are aware of the project status and able to plan accordingly.

3. Careful planning, including individual planning with residents, guardians and families will precede the relocation of all long-term care residents.

- Over sight of the relocation process will also occur from the Chapter 50 relocation team which is responsible for the facility closure process and to ensure that adequate supports are provided to each individual who relocates. The team consists of:
    - DHS State Relocation Team Lead
    - DHS Office of Family Care Expansion
    - DHS Member Care Quality Specialist
    - County Facility Staff (Rehab. Hilltop and Rehab. Central staff)
    - County Human Services Departments/Waiver Programs
    - Aging and Disability Resource Center
    - Board on Aging and Long Term Care (Ombudsman)
    - Disability Rights Wisconsin Inc.
    - DHS Bureau of Long Term Support, Developmental Disabilities Services
    - Managed Care Organizations
    - IRIS (Include, Respect, I Self-Direct)
    - DHS Division of Quality Assurance
    - DHS Division of Mental Health and Substance Abuse Services
    - DHS Division of Enterprise Services
- In April 2013, guardian meetings were held with BHD leadership, the DHHS Director and DSD to discuss the plan for closure of both the CID and Rehabilitation Center Central and to receive feedback as well as answer questions that guardians may have about the initiative.
- As the closure process moves forward, communicating with patients, families and guardians and employees has been and will continue to be a top priority. BHD and DSD plan to organize an event that includes several different MCOs so families and guardians will be allowed to compare and contrast different options that are available. Over the past several months, small meetings with guardians have occurred and several guardians have gone on tours to view available community resources. The guardian meetings are very helpful in allowing families and guardians to be mutually supportive and to discuss positive things that are occurring that they can learn from one another.
- In July 2013, DSD is holding a resource fair for guardians and clients to learn about various MCO and other long-term care options. Guardians and clients will also be offered tours of available community resources.
- The Aging and Disability Resource Centers will conduct options counseling with all guardians and consumers prior to relocation.
- There have been several meetings held with guardians and additional efforts are being undertaken to provide opportunities for guardians to tour community-based living options and

to meet with the MCOs and have a chance to discuss the relocation process and learn more about community-based alternatives available

4. **Any housing consumers may be relocated to shall be compliant per current housing regulations and provide blended case management on site, on-site peer support, and best practice programming (examples of which may include: music therapy, financial literacy, and exposure to community enrichment activities/volunteer opportunities).**

    - All consumers that are relocated through the Family Care MCOs will have a Care Management Team which includes an RN and social worker that regularly monitor the individual's service plan as well as quality review teams as prescribed through individual contract standards of the Family Care program. The Partnership MCOs use an integrated model of care that includes acute and long term support services. They also utilize a nurse practitioner.
    - Family Care also has standards for housing and any housing option will have to meet these high standards. Further, CBRFs and adult family homes have to follow strict state standards.
    - Within the models of housing options being developed, best practice standards and evidenced based programming are being incorporated into the services such as on-site peer support and community integration activities which provide for volunteer opportunities and exposure to community enrichment.
    - For the non-Family Care eligible individuals, BHD has added 1.5 new positions in the quality assurance area to monitor community programs. Quality is of highest priority in developing services for clients.

5. **As part of the planning process, the department will organize local community meetings focusing on educating the community on the relocation of consumers, answering questions, and addressing concerns from community members and stakeholders.**

    - The Department is working with the Mental Health Redesign Committee to provide education to community members and stakeholders addressing stigma reduction and providing information regarding myths about persons with disabilities and mental health issues. We will be working closely with their efforts on educating the community on the relocation efforts currently under way.
    - DSD is conducting a gap analysis for persons with Intellectual Disabilities and this will include discussion with key community informants, stakeholders and advocates.

6. **Workshops will be organized for community-based long-term care providers who may be interested in accepting new clients from the facilities to ensure planning for adequate supports and quality of life programming are established.**

    - A meeting was held in June with BHD Crisis Services leadership, CID clinical staff, MCOs and community providers to share information about the Community Consultation Team being developed and to get feedback regarding supports they need to ensure that relocations are successful.
    - A strategy has been developed to reach out to community-based providers as well as advocates.
        - A meeting is being scheduled with community providers to discuss the closure project and to seek interested providers who would be able to support individuals who are being relocated from Rehabilitation Center Central who are not eligible for Family Care.

- A Community Consultation Team is being developed that will specifically help providers as they take on new clients who have challenges that a provider may have not worked with before.
- A meeting is being scheduled for July to meet with mental health providers that may be interested in providing supports to individuals who relocate from Rehabilitation Center Central.
- The Waisman Center is helping BHD/DSD develop a curriculum to train providers on working with the current long-term care population.

7 BHD will work with the Department of Human Resources to hold employee workgroups for discussion of the downsizing process, and the options available to employees who may be at a risk of layoff due to the closures

- In April 2013 and again in June 2013, BHD held town hall meetings for staff to share information about the closure and to answer questions. BHD plans to hold these meetings monthly to keep lines of communication open and to encourage employees to ask questions and voice any concerns they may have. Employees can also submit questions anonymously. Updates and changes are also distributed to staff electronically via the weekly BHD Newsbriefs.
- A comprehensive communication plan has been developed to effectively relay information to the staff at BHD as well as other stakeholders including guardians, MCOs and other community-based agencies (Please see Attachment 7).
- Managed Care Organizations have agreed to provide an opportunity for existing BHD staff to learn about options to start up a community based living program including developing CBRF, Adult Family Homes and other supportive living options. Staff that may wish to consider an entrepreneurial business opportunity will be provided with resources to begin the process.
- The Department is also exploring options to provide incentives to existing providers that may be interested in employing staff from BHD with experience in working with the clients.

The department has reviewed all of the individuals currently residing at Rehabilitation Center Central and CID and have estimated that approximately 70% will be able to receive services from Family Care which will mean that the department will not need to assume 100% of the funding for community services, but will augment the community services with crisis, training, consultation and other services. Of the remaining 30% that Milwaukee County will need to financially and clinically support, BHD and DHHS are developing community capacity through those services identified in the 2014 Requested Budget per the attachment as well as additional resource development will occur in 2015 as additional savings are realized through the continued downsizing efforts.

2014 Requested Budget and Financial Analysis

The 2014 Requested BHD and DHHS Budgets include over $4 million in various community investments to support the proposed long-term care closures as well as other initiatives within the BHD Requested Budget. These investments include expansion of existing successful programs, investments in evidence based services and partnerships with other County departments to offer expanded services to clients (Please see Attachment 8).

As part of the 2014 Requested Budget process, department fiscal staff worked diligently with clinical staff and others to prepare realistic cost estimates for each of the proposed closures. Meetings were held weekly with long-term care leadership, nursing leadership and budget staff. The team carefully reviewed staffing levels, patient revenues, State relocation funds, pharmacy, dietary, security and other

costs. The timing of the closures was also discussed extensively by the group. In the end, the 2014 Requested Budget includes proposals to close 24 beds of Rehab-Centers – Central as of July 1, 2014 and to close 24 beds on May 1, 2014 and the remaining 24 beds on November 1, 2014 in the CID. The total savings included in the 2014 budget related to these bed reductions and additional overhead reduction is just over $2.7 million (Please see Attachment 9).

BHD has reviewed the tax levy that is dedicated to each CID and Central bed based on the most common funding sources (Medicaid, SSI, Family Care, etc.). A CID bed costs upwards of $329 per day and a Central bed costs more than $405 per day in tax levy. As a comparison, BHD reviewed various community based services and their costs which vary significantly but are overall far less expensive than inpatient care. Most clients will receive multiple services in the community but by shifting the funding from the long term care units to the community, BHD will be able to provide sufficient services for successful outcomes for each client. It is important to note that legacy and crosscharges are included in the tax levy cost for inpatient care and they may impact the amount of funds available to purchase services in the community since those are typically fixed costs. Please see Attachment 10 for more detail.

The fiscal team will continue to review revenues, personnel costs and all other costs and return to the Board with any significant changes to the proposed 2014 Requested Budget.

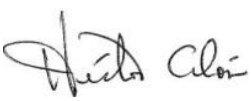
Next Steps

The next few months will focus on successfully relocating CID residents and closing the first 24 beds that were part of the downsizing initiative contained in the 2013 Adopted Budget. The timetable for implementation of the remaining beds at CID and RCC and will be finalized once the formal closure plan is approved by DHS. It is anticipated that the remaining two CID units will be closed by the end of 2014. Closure of the Rehabilitation Center Central will be completed in 2015 with the first unit being closed by mid-year 2014. These initiatives are further outlined in the 2014 Requested Budget and the Department will work with the County Executive on his budget over the summer and then work with the County Board in October.

Some County Board Supervisors have participated in tours of community-based living alternatives. Additional tours are to be scheduled during the summer and opportunities will be available for Supervisors to see a range of community-based living arrangements.

Recommendation

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board

Don Tyler, Director – DAS
Josh Fudge – Interim Fiscal & Budget Administrator – DAS
CJ Pahl, Assistant Fiscal & Budget Administrator
Matthew Fortman, Fiscal and Management Analyst – DAS
Martin Weddle, County Board Staff

Attachment 1

Supervisor Joseph Sanfelippo, Chairperson
From the Committee of the New Behavioral Health Facility Study, reporting on:

File No. RES 11-516

(ITEM) A resolution by Supervisors Sanfelippo, De Bruin, Schmitt, Dimitrijevic, and Romo West, endorsing a plan submitted by the Milwaukee County New Behavioral Health Facility Study Committee which states that the county's current inpatient model of providing mental health care is financially unsustainable and less cost effective than a community-based mental health system and urging county government to permanently and fundamentally shift its funding, staff, and programming into a community-based system of care and endorsing Milwaukee County's continued operation of an inpatient hospital facility with a 120 maximum number of county provided inpatient beds as part of the county's obligation to provide safety net services for persons with mental illness, by recommending adoption of the following:

AN AMENDED RESOLUTION

WHEREAS, the Milwaukee County Behavioral Health Division (BHD) is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders; and

WHEREAS, over 20,000 people who have, often severe, mental illness are treated by Milwaukee County's mental health system each year; and

WHEREAS, the current BHD Facility was constructed in the 1970s, and almost immediately upon completion of construction for Milwaukee County's current mental health hospital on the County Grounds, the preferred model for delivery of care drastically changed to a community-based treatment model less reliant on institutional care; and

WHEREAS, the 2010 Capital Budget included a $12,596,494 appropriation, for Capital Improvement Project WE033—Behavioral Health Facility, placed in the allocated contingency fund, for the planning, design, and construction of a new behavioral health facility and/or the renovation of the current facility; and

WHEREAS, on July 29, 2010, the County Board of Supervisors ("County Board") approved (File No. 10-284) the release of $1,825,890 from the 2010 BHD allocated contingency fund within capital funds (WE033) to address corrective actions related to a

Statement of Deficiency at the current facility, leaving a balance of $10,770,604 in the account; and

WHEREAS, the County Board adopted a resolution (File No. 10-322) in November, 2010, endorsing the concept of constructing a new behavioral health facility on the County Grounds and forming a Special Committee of Milwaukee County Supervisors, appointed by the Chairman of the Board, to obtain the information needed to assess the feasibility of constructing a new mental health facility on the County Grounds and to make recommendations on what a possible new facility might look like, including the financial, staffing, and programmatic components necessary to develop a facility; and

WHEREAS, the resolution called for the Special Committee to submit their final report no later than June 1, 2011; and

WHEREAS, a memorandum from the Milwaukee County Board Chairman, dated December 16, 2010, appointed the following supervisors to the aforementioned special committee:

- Supervisor Joe Sanfelippo, Chairman
- Supervisor Lynne De Bruin
- Supervisor James "Luigi" Schmitt
- Supervisor Marina Dimitrijevic
- Supervisor Peggy West

; and

WHEREAS, the Special Committee, named the New Behavioral Health Facility Study Committee ("Facility Committee"), met to discuss the charges laid out in the resolution (File No. 10-322) on a bimonthly basis beginning in January 2011; and

WHEREAS, the committee considered the following items during the aforementioned meetings:

- Programs and services currently provided by BHD, both outpatient and inpatient, and BHD's operational costs
- Chairman Holloway's Mental Health Initiative (File No. 11-81/11-49), which was adopted by the County Board on March 17, 2011
- Space usage and schematics at the current facility
- Presentations from current contracted community service providers regarding the services they provide as well as their capacity to expand

- Review of crisis operations, including the Crisis Resource Center Model and emergency detentions
- The Human Services Research Institute report (HSRI), *Transforming the Adult Mental Health Care Delivery System in Milwaukee County*
- A proposal from a consortium of providers proposing a public/private partnership for a cost-effective redesign of the mental health system
- A report from the Mixed Gender Unit Workgroup looking into the possible creation of single gender patient care units at BHD
- The Department of Audit Site Security Audit
- Possible land spaces available on the County Grounds for a new behavioral health facility
- Fiscal and square footage estimates for replacing the existing mental health complex
- Bonding issues entailed with building a new facility
- Estimated level of community supports/private sector beds needed to downsize the current inpatient facility
- An appraisal of the current BHD Facility land

WHEREAS, at the March 15, 2011, Facility Committee meeting, the committee approved a motion to adopt the HSRI Study as the committee's framework for an overall health care plan model; and

WHEREAS, at the May 10, 2011, Facility Committee meeting, the committee adopted a motion directing the Real Estate Services Manager to perform an updated appraisal of the BHD Facility land; and

WHEREAS, at the May 24, 2011, Facility Committee meeting, the committee approved a resolution by Supervisor Thomas in support of efforts to redesign and transform the Milwaukee County mental health delivery and financing system and directing the Facility Committee to submit an action-oriented plan to implement the HSRI Study findings and other recommendations, which the full Board later adopted (File No. 11-197/11-323); and

WHEREAS, the aforementioned resolution (File No. 11-197/11-323) extended the Facility Committee's report deadline to July 15, 2011, requested that the Committee provide an outline of items to be included in a Request for Proposal (RFP) process for the provision of behavioral health services and possible sites, and specified that the Facility Committee's recommendations shall be submitted to the Committees on Health and Human Needs and Finance and Audit for review and approval prior to consideration by the full Board of Supervisors; and

WHEREAS, the New Behavioral Health Facility Study Committee, at its meeting on September 9, 2011, recommended approval of an amended resolution (vote 5-0); now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors hereby adopts the policy recommendations included in the *New Behavioral Health Facility Study Committee's Final Report*, attached to this file; and

BE IT FURTHER RESOLVED, that the County Board adopts the following as County policy:

- The current BHD facility is too large and reflects an inpatient focused model of care that is financially unsustainable in both the short and long term; if Milwaukee County continues to utilize an inpatient centered approach to delivering mental health services, our ability to maintain current service levels will be eroded by rising health care costs and client outcomes will deteriorate even further

- Milwaukee County needs to reallocate how it spends its mental health dollars by transferring the majority of our system dollars into community-based services; these services can be provided by the private sector or a mix of private and publicly run options; the current inpatient focused system uses almost two-thirds of Milwaukee County's available system funds, leaving approximately one-third of the county's funds for community services; successful community-based care systems are most cost-effective and achieve better client outcomes than inpatient focused systems; in these systems, more than half to two-thirds of system funds are spent in the community; achieving this resource shift is more crucial to the future of mental health care in our community than the decision of whether Milwaukee County should build a new mental health facility on the County Grounds

- As part of a community based system, Milwaukee County will need to operate a smaller inpatient facility, with a maximum of 120 beds, in order to meet the need for inpatient treatment; capacity and interest in providing sufficient inpatient services does not exist in the private sector at this time thereby requiring the county's continued provision of inpatient care in order to meet the needs of clients with mental illness in our

community and to provide sufficient safety net oversight for this critical area of care

- Milwaukee County, which shall still be viewed as the payer of last resort, must commit to maintaining funding for mental health services as they are transitioned from being county-provided to community-provided

- No drawdown in county-provided services shall take place unless and until it is proven that capacity in the community exists to replace such services

- A clear public/private partnership between BHD and the community providers must be in place

- Stakeholders must be included in the mental health redesign process

- An internal finance team or "Workgroup" consisting of staff from BHD, Department of Administrative Services, County Board, and Department of Audit shall be convened, by the County Board Chairman and County Executive to assist in finance planning related to the redesign of the mental health system and the financing of a new BHD facility

- A further delay of system improvements cannot be tolerated

- The county must commit to continued funding of mental health care services at current levels with any savings produced as a result of the transition to a community-based service delivery model reinvested into the program to allow for expanded community services

- For budgeting purposes, the Facility Committee utilized a hypothetical model prepared by DHHS staff of constructing a 120 bed maximum facility on the county grounds; the committee recognizes that the ultimate size of the new facility may differ from this model and recommends that the following considerations be taken into account when making a final decision on the size a new facility:

  - The new facility should be based on the 120 bed maximum hypothetical model with the final size to be determined by the County Board upon review of the recommendations from the Redesign Task Force and the internal Finance Workgroup

- Because the new facility will have a major reduction in available inpatient beds, the county should not commit to building a new facility until it has already committed funding for the community expansion services needed to safely transition clients

- Any new facility shall be built utilizing "green design standards" to the maximum extent possible

- Proposals from providers to contractually provide behavioral health services, including inpatient beds in a privately run facility, shall be given serious consideration

- The land located at 92nd and Wisconsin Avenue is the best location for a new BHD facility

- If the county decides to move forward with constructing a new facility at the 92nd and Wisconsin site, negotiations with Children's Hospital must occur in order to obtain a release of the land

; and

BE IT FURTHER RESOLVED, the Interim Director, Department of Health and Human Services and the Administrator, Behavioral Health Division are authorized and directed to begin to effectuate the contents of this report by performing the following tasks:

1. Submit the Facility Committee's Final Report to the Mental Health Redesign and Implementation Task Force for consideration in system redesign implementation planning, per adopted resolution (File No. 11-173/11-284)

2. Ensure that the Mental Health Redesign and Implementation Task Force reviews all of the recommendations from the various reports presented over the past year to determine the best care practices available and then build a delivery of care model based on those practices in accordance with the aforementioned adopted resolution (File No. 11-173/11-284)

3. Return to the Milwaukee County Board of Supervisors, through the Committee on Health and Human Needs, with final recommendations during the January 2012, meeting cycle

; and

BE IT FURTHER RESOLVED, that the Interim Director, Department of Health and Human Services (DHHS), is authorized and directed to issue Request(s) for Proposals (RFP), renegotiate existing contracts, and/or realign county provided inpatient care as needed to make immediate improvements, including the reconfiguration of acute adult inpatient units, to create a 12-bed Intensive Treatment Unit (ITU), a combined Women's Option/Med-Psych Treatment Unit, and two remaining mixed gender units designated as General Acute Treatment Units, and the creation of a "children's suite" in the Psychiatric Crisis Service/Admission Center (PCS) with a separate outside entrance, consistent with adopted resolutions and county planning efforts, with submission of contracts to the Health and Human Needs and Finance and Audit Committees by the December 2011 cycle of the County Board at the latest; and

BE IT FURTHER RESOLVED, that the Interim Director, DHHS, is authorized and directed to issue a Request for Information (RFI) based on the goals contained within adopted resolution (File No. 11-197/11-323) and other County planning efforts to determine what capacity presently exists in the community and how it can be successfully incorporated into a new delivery model, and shall provide the information obtained through this process to the Mental Health Redesign and Implementation Task Force for the development of follow-up RFPs, contract revisions, and other system changes as recommended by the Mental Health Redesign and Implementation Task Force and approved by the County Board; and

BE IT FURTHER RESOLVED, that the Interim Director, DHHS, is authorized and directed to issue RFPs on behalf of the Mental Health Redesign and Implementation Task Force's work for the development of a community-based delivery model, and provide an update to the Health and Human Needs and Finance and Audit Committees by the January 2012 County Board committee meeting cycle regarding the outcomes of the RFP process, including consideration of any resulting contract changes as soon as possible; and

BE IT FURTHER RESOLVED, that the Interim Director, DHHS, is authorized and directed to report back to the Health and Human Needs and Finance and Audit Committees in the January 2012 County Board committee meeting cycle with recommendations related to the option of Milwaukee County constructing and operating an inpatient facility on the County Grounds (several potential funding sources for a new facility are listed in the Facility Committee's report) and how these options would tie into the broader system redesign of mental health services; this report shall include recommendations as to the preferred level of continued inpatient care to be

provided at a new facility, inpatient care services that are recommended for community-based inpatient or alternative community-based care, recommendations regarding the future use of the current BHD facility, and potential options for financing the recommended services; and

BE IT FURTHER RESOLVED, that the report(s) mentioned on lines 261 through 276 shall also explore and report on appropriate alternatives to Milwaukee County owning a mental health facility, including, but not limited to options of leasing, engaging a private developer to build a new hospital for Milwaukee County in exchange for long-term guaranteed lease payments (build-lease), or private/public partnerships developed through a Health Care Authority model, which would shift Milwaukee County's role from being mainly a direct provider of care to a placement agency, allowing for the flexibility of obtaining reimbursements for care given at fully integrated hospitals instead of a stand-alone mental health facility in which federal rules prohibit Medicaid reimbursements for patient care received in such facility; such report shall further explore the option of leveraging property owned at the County Grounds for private/public partnerships to realize the goal of providing the best care for mental health patients while also maximizing reimbursements for the county; and

BE IT FURTHER RESOLVED, that the Architectural, Engineering and Environmental Services Division is authorized and directed to issue an RFP for architectural design services for the new facility, the results of which shall be included in a report submitted to the Committees on Health and Human Needs and Finance and Audit in the March 2012 County Board committee cycle, and that a portion of the 2010 budgeted funds remaining in the allocated contingency fund within capital funds (WE033) shall be used to pay for these services.

Attachment 2

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: April 12, 2013

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

FROM: Héctor Colón, Director, Department of Health and Human Services

SUBJECT: **Follow up information about the informational report submitted to the March 2013 Committee of the Whole regarding the Department's intent to close the Behavioral Health Division Center for Independence and Development (formerly Hilltop) and Rehabilitation Center Central and to relocate residents to integrated community settings**

The following information is being submitted after questions were raised by the board during the Committee of The Whole meeting on March 12, 2013. I wanted to share our responses to the concerns expressed while assuring you that we are being thoughtful in our planning and responsive to the concerns raised.

In April 2011 the Milwaukee County Board passed a resolution supporting the movement of the adult mental health system to a more community-based model for the delivery of services. In the 2012 County Budget, Milwaukee County Executive Abele made a $3 Million investment to build on the existing capacity to jump-start the expansion of community-based services. In February 2013 he announced the intent to close the long-term care rehabilitation units at the Behavioral Health Division, which is a continuation of the trend to move the system to a more community-based model. This has been a consistent theme for the last ten years. The closure will mean that residents living at the Hilltop and Central Rehab units will be given the opportunity to live in more integrated community settings with the supports necessary to ensure success. Closure of the long-term care units was not a decision based on any incident, a quality of care issue at BHD, or an effort to save money. This move is the next natural progression in a series of downsizing phases over the past 25 years. There is also the Olmstead Law, which states that we should provide people with disabilities the opportunity to live in the most integrated setting possible in the community of their choice. Failure to meet the Olmstead standard has led to lawsuits across the country in the past. Moving away from institutional care is also a trend on both the state and national levels and Milwaukee County is behind the curve.

This is about doing the right thing by allowing people with mental illness to live in the least restrictive environment close to their loved ones and receive the care they deserve and need. Study after study shows that people thrive and recover much faster when they are in community, rather than institutional settings.

Individuals moving to community placements from our long-term care units will have the support to ensure the relocation plan is the right fit. The ultimate goal is to provide individuals with person-centered, recovery-oriented plans that set them up for success and true community integration. We will be working closely with our community partners to develop the resources needed to make the transition successful.

In an effort to provide some clarity, many of the inquiries by Supervisors have been arranged in themes to better support future discussion on these critical issues. I hope you find this information helpful and that it provides some clarity to the questions raised.

As always, if you have follow up questions or concerns, please don't hesitate to contact me at any time.

I. Funding

Several Supervisors expressed concerns regarding the sustainability of funding by the State Department of Health Services (DHS) for individuals who will be relocated to the community. There are two primary funding categories that have been identified. The first source of funding is to come from the Family Care program for those individuals who are eligible for this long term care support benefit. This funding is anticipated to cover 60 to 70 percent of all individuals who will relocate from either Hilltop or Rehabilitation Center Central. Also, Family Care is an entitlement benefit that is offered protection behind the Federal Government just as the Medicaid benefits covered by ForwardHealth. When the State attempted to cap Family Care in 2011, the Centers for Medicare and Medicaid Services ordered them to remove the cap because it was in violation of the Medicaid Waiver provisions. Therefore, by virtue of having an entitlement benefit, the protections are in place to ensure continued funding. It should also be noted that a recent article published in the Milwaukee Journal Sentinel reported that the State DHS has found the average cost of participants in the Family Care program has decreased resulting in the Governor considering further expansion in 15 additional counties of this valuable program.

The other primary funding source will be local funding within the Department of Health and Human Services (DHHS) Behavioral Health Division (BHD) budget, comprised primarily of State BCA and local tax levy. These funds will be needed to provide ongoing support to individuals who require residential options that meet their support needs. Funding for these locally-funded services will come from reinvested dollars currently budgeted to support the Rehabilitation Centers at BHD.

II. Timeline for Closure

During the Committee of The Whole meeting on March 12, 2013, DHHS indicated that closure of the BHD long-term care units would occur over a three-year period. The following factors support the rationale for this decision:

- It has been successfully demonstrated, through other downsizing, that this time frame is very reasonable given the number of people needing to be relocated. It should be noted that in the report presented to the Committee on the Whole on March 12, 2013, the following relocation examples were included:
    - 2002 – Jackson Center FDD (Milwaukee) – 79 residents relocated in 10 months
    - 2002 – Hearthside Rehab FDD (Milwaukee) – 183 residents relocated in 12 months
    - 2003 – Northern Wisconsin Center (Chippewa Falls) – 152 residents relocated in 24 months
    - 2005 – Horizons Unlimited FDD (Rhinelander) – 74 residents relocated in 12 months

- Due to the issue of staff attrition when these closures occur, it becomes difficult to maintain staffing levels needed to continue program operations. It is therefore advisable to move toward closing in a well-defined and limited time period to avoid loss of staff that could endanger patient safety.

- The closure time line is consistent with best practices as well as past practices employed in previous closures.
- We have had conversations with the State and the Family Care MCOs who expressed their support for the time line.

It is anticipated that the current Hilltop downsizing initiative, which included a reduction of 24 beds will be completed by July 2013 as indicated in the 2013 adopted County Budget. The resulting bed capacity after this project is completed will be 48 remaining beds for that program. The tentative plan is to continue the relocation of the 48 individuals from this program with an target completion date of July 2014.

For the residents of Rehabilitation Center Central, it is anticipated that relocations will begin to occur almost concurrently with approval of the Chapter 50 relocation plan by the State later this year. The average stay for individuals residing at Rehabilitation Center Central is not as long as those at Hilltop. As a result, there will be natural attrition of individuals as they become stable and ready for discharge. It should be noted that Chapter 50 rules require the facility to discontinue all admissions as soon as the closure plan is approved by DHS. In addition, assessments will be conducted to determine the community-based supports needed to provide living alternatives for all individuals. It is anticipated that all residents will be relocated within 24 months after the formal closure plan is approved by DHS.

III. Guardian Issues

Central to the planning process will be a substantial effort to work with guardians as the closure process is initiated. Meetings with guardians will be held and the relocation teams will work very closely with guardians to provide information, help to support decisions that will need to be made and ensure that staff members are available to provide guardians the necessary tools to make informed decisions about the relocation process. Indeed, the Chapter 50 process includes formal meetings with guardians that are required and are staffed by State representatives, as well as facility staff and advocates.

It should be noted that while all individuals residing at Hilltop have a legal guardian, individuals who reside at Rehabilitation Center Central often do not have a legal guardian. Many individuals may have a Chapter 51 commitment status, but are legally able to make their own decisions regarding relocation, support needs and other components of their lives. DHHS is also planning to arrange tours of residential options for guardians to help in their decision making to meet their loved ones needs. These will be offered based on guardian interest.

IV. Role of the County Board of Supervisors

The State of Wisconsin defines the roles of various entities that are to be involved in any licensed facility closure as described in Chapter 50 of Wisconsin Statutes and specified in the State of Wisconsin DHS publication "Resident Relocation Manual" November 2010 (See Attachment 1). The State establishes a relocation team responsible for the facility closure process and to ensure that adequate supports are provided to each individual who relocates. This State Relocation Team is comprised of:

- DHS State Relocation Team Lead

- DHS Office of Family Care Expansion
- DHS Member Care Quality Specialist
- County Facility Staff (Rehab. Hilltop and Rehab. Central staff)
- County Human Services Departments/Waiver Programs
- Aging and Disability Resource Center
- Board on Aging and Long Term Care (Ombudsman)
- Disability Rights Wisconsin Inc.
- DHS Bureau of Long Term Support, Developmental Disabilities Services
- Managed Care Organizations
- IRIS (Include, Respect, I Self-Direct)
- DHS Division of Quality Assurance
- DHS Division of Mental Health and Substance Abuse Services
- DHS Division of Enterprise Services

Per State statutes, the County Board does not have a direct role in the downsizing/closure process and the technical work planning that supports those activities. However, the Department intends to keep the Board informed with informational reports and updates on the progress of the closure. We also intend to return for a final endorsement of the closure plan. In addition, we will meet with the Chair of the Health and Human Needs Committee on a regular basis to provide updates.

The State takes a lead role in coordinating the relocation team and is directly responsible for monitoring the progress, time lines, work plans and specific case-by-case efforts to provide the best possible outcomes in a timely fashion for all individuals who leave the facility.

V. Role of the Milwaukee Health Care Partnership (Hospital System)

Meetings have been held with the Milwaukee Health Care Partnership and several of the hospital partners to notify them of the County's intent to pursue the closure of long term care facilities. The Partnership asked several questions which included:

- How many people came to Hilltop or Central from the Jackson Center and Hearthside Rehab closures?
  - The number of individuals who are residing at Hilltop and were living at either Jackson Center or Hearthside Rehab prior to those facilities closing is four, two from each facility. Given that the total number of individuals relocated from Jackson Center and Hearthside was 262, the total percentage of individuals at Hilltop from those two facilities is less than two percent (1.5%).
- What were our lessoned learned based on those experiences?
  - It is key to ensure that appropriate community-based resources are available to support the needs of individuals who are relocated. If adequate supports that focus on the individuals specific needs are not provided, the individual may not be as successful in the community.
  - The Department intends to conduct a one-day strategy planning event which will pull together key stakeholders and identify lessons learned from other closure/downsizing, identify challenges perceived by stakeholders as well as a plan that addresses concerns by all involved that supports a successful project outcome.

- What is our emergency plan?
    - There are a number of initiatives that will support emergency situations for individuals who relocated from Hilltop and Rehabilitation Center - Central including:
        - Expanded Crisis Respite Home beds available to individuals who experience an emergency and to be utilized as an alternative to Psychiatric Crisis Services (PCS). Currently, there are four additional beds for a total of eight beds available at the writing of this document.
        - Expanded crisis mobile team availability from Behavioral Health Division with expertise in serving individuals with dual diagnosed intellectual disabilities and mental health issues.
        - Add law enforcement officers to the Mobile Crisis Team with CIT training to help provide stabilization services in the community with the goal of decreasing the need for emergency detentions.
        - 24/7 available services to residential providers in the community to provide behavioral intervention and crisis services on site to address behavioral challenges and prevent out of home services when possible.

VI. Workforce Issues

The overall staff numbers at BHD will decrease as a result of these closures. We are working closely with the Human Resources Department to bring about the best options possible for all staff members. A workgroup has been put in place to create a workforce strategy that will include regular communications with staff. Employees will be notified about options for employment both within and outside Milwaukee County government. We are also working to provide informational workshops for employees who might be interested in starting their own community-based business, serving as providers to individuals who will be relocated. We have learned that in other similar facility closings, staff was able to successfully start their own businesses and continue to care for individuals when they moved into the community. We will host meetings with care management organizations that will provide information on possible business opportunities for employees. We will be also holding updates on this initiative; however, staff should feel free to talk to their managers and directors at any point when questions or concerns arise.

VII. Fiscal Issues – Anticipated Costs/Savings

The fiscal issues associated with the current downsizing initiative in the Adopted 2013 Budget include staff reductions and cost/revenue changes associated with the anticipated reduction of 24 beds by July 2013. The budget included fiscal allowances for anticipated temporary or one-time revenue enhancements that are negotiated with the State to help offset the loss of revenue during the downsizing/closure process. The fiscal model utilized to develop the budget for 2013 will also be utilized to include fiscal impact items in the 2014 requested DHHS budget. While the specific details are not final at this time, the overall reductions of tax levy expenditures will be reinvested in the community based service system to provide ongoing support for individuals who are relocated.

In addition, it is anticipated that negotiations will take place concurrently with the process of submitting a closure plan with DHS to provide temporary enhanced rates or one-time increased funding to help offset loss of revenue during the closure process. This is an expectation that is typically part of the

Chapter 50 process and is determined on a case-by-case basis with the County involved in a facility closure. There will be a comprehensive fiscal analysis of the revenue needs and costs associated to support the development of new residential and service options for those not eligible for Family Care.

It should also be noted that another key funding issue will be the availability of financial resources needed during the closure process to develop new residential and supportive services options for those who relocate and are not eligible for the Family Care program. This funding will be ultimately provided from cost reductions as long term care units are closed at BHD. However, it is imperative that services be made available as individuals leave to ensure successful community integration. More detailed cost estimates will be provided as details of the closure plan are completed. This will be accomplished before the closure plan is submitted to the State. The specific budget issues, including staff reductions and number of clients to be relocated, will be included in staggered County Budgets over the next three years.

VIII. Housing Issues

The DHHS Housing Division will play an important role in the development of housing alternatives for individuals who are relocating from long term care at BHD. There are a number of housing development alternatives that have been developed to incorporate supportive services options that may be alternatives for some individuals who relocate to community-based living.

While the specific needs and supports of individuals who relocate from BHD need to be carefully evaluated, we anticipate that housing alternatives may include Community Based Residential Facilities, (CBRF) three to four-bed Adult Family Homes (AFH) as well as supported apartment options. Currently, the Housing Division is working with community partner agencies to develop options that include supportive services that are affordable to individuals who have limited financial resources through social security. Using the experiences gained from previous housing development initiatives, the Housing Division will work closely with BHD to determine the needs of individuals who are relocating and to leverage funding mechanisms available through Housing to help provide affordable supportive housing that helps ensure the individual's successful transition to community living.

Other housing options will be developed by the Family Care Managed Care Organizations (MCO). The MCOs have a vast array of providers who have existing housing capacity as well as expertise at developing new capacity relatively quickly. New CBRF, AFH and supported apartment options can be developed within 60 days. This kind of development is happening routinely and has been done many times to support other downsizing/closure initiatives.

IX. Community Capacity Issues

As the residents are relocated to the community, several factors need to be considered to provide adequate service capacity to ensure that individuals are successful. For those residents residing at Hilltop, all will be eligible for Family Care and will receive services from this program. It is required of all Family Care Managed Care Organizations (MCO) including the Milwaukee County Department of Family Care, Community Care, Inc. and iCare to provide the supports needed for all eligible individuals in Milwaukee County, including those who relocated from Hilltop. The funding provided by DHS includes the expectation that services are available, that enough providers are included in the provider networks for the three Family Care providers and that those providers can support individuals who select the respective MCOs to provide services. Please see the attached maps showing the current number of residential providers currently contracted through each of the MCOs. (See Attachment 2).

While development of additional and new services may be required, it is anticipated that the Family Care agencies selected by the guardians will develop these services as individuals are identified to relocate from Hilltop. In addition, DHHS plans to provide certain supportive services to assist the provider networks with the transition. Included are those services discussed above such as expanded crisis mobile services, expanded crisis respite services and community-based consultation services to help develop and implement individualized behavioral treatment plans for community-based providers. Professional staff members from Hilltop who have supported individual residents will also be available to assist with transition issues and provide support to providers.

For individuals who do not meet the eligibility criteria for Family Care, BHD will be developing new community services including residential options for individuals relocating from Rehabilitation Center – Central. BHD will build on its existing programs to develop new supportive services that meet the individualized needs of those who relocate.

X. Provider Quality Issues

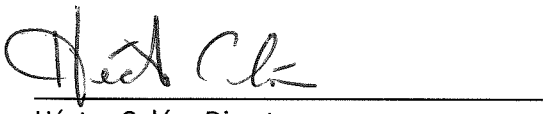
A question was raised as to the quality of Community Based Residential Facilities (CBRF) and how it is determined who can have a CBRF. The State DHS Bureau of Assisted Living licenses all CBRFs in Wisconsin. The process is governed by Wisconsin Statues Chapter 83 and includes applying to become a CBRF and following an application process. A few of the required qualifications include:

- A program statement, including administrator qualifications, availability of staff, facility capacity, class of CBRF, program goals, etc.
- Evidence of being "Fit and Qualified" including, financial history, criminal history, compliance history

Extensive information can be obtained about the process for becoming a CBRF including the qualifications from the State's website at the following link:

http://www.dhs.wisconsin.gov/rl_dsl/cbrf/CBRFinqResp.htm

We look forward to working in partnership with the County Board to complete this critical project.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Committee of The Whole Members
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board
Don Tyler, Director – DAS
Craig Kammholz – Fiscal & Budget Administrator - DAS
CJ Pahl, Assistant Fiscal and Budget Administrator – DAS
Antoinette Thomas-Bailey, Fiscal and Management Analyst – DAS
Jennifer Collins, County Board Staff
Jodi Mapp, County Board Staff

By Supervisor Romo West

File No. 13-363

A RESOLUTION

establishing guidelines surrounding Milwaukee County's efforts to transition the Behavioral Health Division's long-term care facilities to a community-based model of care

WHEREAS, the Milwaukee County Department of Health and Human Services Behavioral Health Division (BHD) operates two licensed nursing home facilities that provide long-term, non-acute care to patients who have complex medical, rehabilitative, psychosocial needs and developmental disabilities; and

WHEREAS, Rehabilitation Center-Central is a 70-bed, Title XIX certified, skilled-care licensed nursing home and the newly renamed Center for Independence and Development (formerly Hilltop) is a Title XIX certified facility for persons with developmental disabilities with 72-beds—though policy adopted in the 2013 Adopted Budget calls for a reduction of 24 beds by July 1, 2013; and

WHEREAS, in February 2013, the County Executive announced his intention to shift patients in BHD's long-term care units from BHD to integrated, community settings within the next three years in his State of the County address; and

WHEREAS, this action follows previous recommendations, and planning efforts, including 2011 Adopted Budget amendment 1A011, which stated the following:

> *The Behavioral Health Division will work with the Disabilities Services Division (DSD) to develop a plan to downsize the 72-bed Rehabilitation Center-Hilltop Title XIX certified facility for Persons with Developmental Disabilities. The Department of Health and Human Services-Disabilities Services Division will provide options counseling to current Hilltop clients, exploring, where appropriate, placements in the community. The Director, Department of Health and Human Services shall provide quarterly informational reports to the Committee on Health and Human Needs regarding the progress of this initiative.*

; and

WHEREAS, in March 2013, the Director, Department on Health and Human Services and BHD Administrator presented an informational report on the long-term care unit closure to the County Board's Committee of the Whole (File No. 13-199); and

WHEREAS, it is imperative that careful planning precedes the closure of units, and that the focus of such planning should be on ensuring the well-being of the residents and not on how quickly the facilities can be downsized; now, therefore;

BE IT RESOLVED, that the Milwaukee County Board of Supervisors hereby endorses the following guidelines for shifting persons from BHD's long-term care facilities to integrated, community settings:

1. Prior to the full closure of long-term care units operated by Milwaukee County, a more robust continuum of community services will be developed, including: housing, specialized behavioral health services, and crisis services

2. Given the reliance on the Family Care program, prior to successfully relocating individuals to community-based settings, the Department of Health and Human Services and BHD will work with the managed care organizations in Milwaukee County to ensure the development of resources and capacity to meet the specialized needs of the individuals relocating to the community

3. Careful planning, including individual planning with residents, guardians and families will precede the relocation of all long-term care residents

4. Any housing consumers may be relocated to shall be licensed, provide blended case management on site, on-site peer support, and best practice programming (examples of which may include: music therapy, financial literacy, and exposure to community enrichment activities/volunteer opportunities)

5. As part of the planning process, the department will organize local community meetings focusing on educating the community on the relocation of consumers, answering questions, and addressing concerns from community members and stakeholders

6. Workshops will be organized for community-based long-term care providers who may be interested in accepting new clients from the facilities to ensure planning for adequate supports and quality of life programming are established

7. BHD will work with the Department of Human Resources to hold employee workgroups to discuss the downsizing process, and the options available to employees who may be at a risk of layoff due to the closures

; and

BE IT FURTHER RESOLVED, that the Director, Department of Health and Human Services is authorized and directed to submit a report detailing the fiscal

analysis of this initiative to the County Board by the September 2013 Meeting Cycle so that the Board may review the report's findings prior to 2014 budget deliberations; and

BE IT FURTHER RESOLVED, the aforementioned report shall include a full analysis of the planned use of funding to support the relocation effort of individuals who are and are not eligible for Family Care, and the funding necessary to sustain and enhance the full continuum of needed community-based services.

BHD Community Consultation Team

for Individuals with Intellectual and Developmental Disabilities
June 7, 2013

Services Offered:

(1) Consultation to community providers

(2) Staff development services

(3) Crisis team

Description of Services

Consultation to community providers

The BHD Community Consultation Team (CCT) will be available to community-based providers of services to adults with intellectual and developmental disabilities. Potential service recipients include providers of residential services (group homes, adult family homes, etc.), providers of day program services, and Family Care MCO Interdisciplinary Teams (IDT's). The focus of this service is assisting in the development of individualized behavior support plans to address challenging behaviors presented by Family Care enrollees. Clinicians with extensive experience in behavior modification, as well as other CCT professionals, are available to work with case managers, residential staff, and others to try to problem solve around client behavioral as well as mental health issues.

Specific services available include functional behavioral assessments of clients, development of individualized behavior support plans, staff training on behavior plans, assessment of facility and staff needs, staff consultation and support, and serving as a liaison between stakeholders, providers, and potential providers. The CCT will maintain on-going involvement with clients in the community and increase or decrease this involvement as needed. Although behavioral challenges in the community can be expected, the focus of this service is on working in a preventative manner to diminish the likelihood of significant client behavioral and mental health crisis.

The CCT will be available to consult with other providers when clients are at least temporarily unable to remain in their community residence due to behavioral or mental health issues. This would include consultation with crisis or respite service providers in the community. If the client is brought to a local emergency room or crisis service, CCT staff can consult with them about the client's status. If the client is in need of acute psychiatric hospitalization at a local hospital, CCT staff would be available to consult with those staff and assist in transitioning the client back to the community.

Staff development services

The BHD Community Consultation Team (CCT) will offer a variety of educational and support services for community providers and their staff, as well as Family Care staff. One focus of this service will be a series of educational programs designed to increase staff job-related knowledge. This includes training aimed at new staff as well as "refresher" programs for more experienced staff. Specific topics covered include the nature of intellectual and developmental disabilities such as intellectual disability and

autistic disorders, understanding maladaptive behavior and mental illness, and basic behavior modification techniques. Other topics could be covered as needed. The focus is on providing community staff with more tools to successfully work with adults with intellectual and developmental disabilities.

A second focus of the staff development services is helping direct care providers in the community to better manage the demands associated with their jobs. While working with individuals with challenging behaviors can be quite rewarding, it can also be very demanding and stressful. This aspect of the service involves offering group support to providers as well as specific programming focused on stress management and personal well-being. The focus is on preventing staff burnout and turnover and facilitating staff morale and retention.

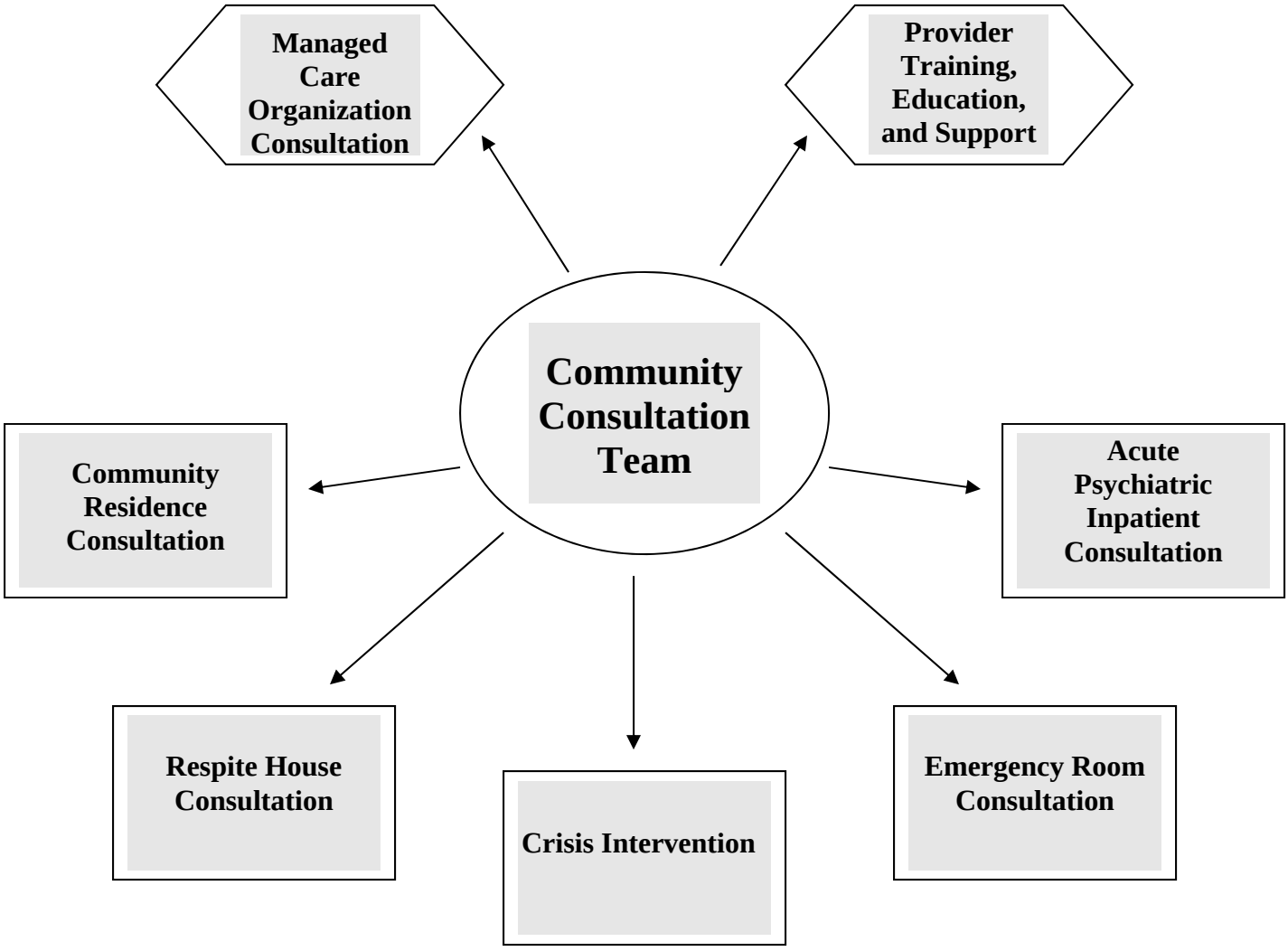
Crisis team

The BHD Community Consultation Team (CCT) will include a mobile crisis service that will be available to assist community care providers during client behavioral crises. The crisis team will be staffed with clinicians experienced in addressing behavioral issues and crisis intervention. The team will work with providers to try to diffuse the crisis or help arrange for temporary alternate services (for example, respite services), if available, based upon the current needs of the client.

The crisis team is just one component of an integrated crisis system available to help address the needs of adults with intellectual and developmental disabilities who are in behavioral or mental health crises. Others crisis services that may be utilized include crisis respite homes, a crisis line, BHD's Psychiatric Crisis Service (PCS) or other hospital emergency rooms, and BHD's Observation Unit. CCT staff will remain involved with the client as they transition through these various services and return to his or her community residence.

CCT staff will also be available to work with local law enforcement agencies. The focus of such involvement is on education regarding this population and helping officers to assist in a supportive manner when called for crisis situations in the community arising from a client's behavior.

Community Consultation Team
Service Model



Never Give Up

Assets Inc.'s Commitment to Community Life for People Seen as "Difficult to Serve"

John O'Brien

with

Kathryn Carssow

Matthew Jones

Maxwell Mercer

Laronsia Reynolds

Diana Strzok

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Contents

This report results from the desire of Assets' senior staff to more clearly articulate their approach to supporting people who are seen by most mental health and developmental disabilities service providers as difficult to serve. They wanted its preparation and dissemination to serve two purposes: to summarize their own learning and to share what they have learned with others. They invited John O'Brien to visit from 23-25 June 2003. He listened to their reflections on their work, conducted a focus group with staff, read documents, and wrote this report, which each of the other contributors reviewed and corrected.

Kathryn Carssow is Assets' Director of Mental Health Services. She came to Assets from the Alaska Division of Mental Health, where she was CMH/ARP Project Manager, in 2001.

Matt Jones is the Deputy Director of Assets, responsible for the Community Services Team. He has been personally involved with the people who are the focus of this report since he helped to found the supported living program as a direct support worker in 1986.

Maxwell Mercer was Assets' Director of Mental Health Services from 1996 to 2001. He initiated the effort to document Assets' approach to services and wrote a description of the foundations of Assets' practice that shows its connections to the literature of community services to people with developmental disabilities and the field of psychiatric rehabilitation.

Laronsia Reynolds is Co-Director of Assets' Community Services Team. She has worked with the people who are the focus of this report since she began as a direct support worker in 1995.

Diana Strzok has been Assets' Executive Director since 1995.

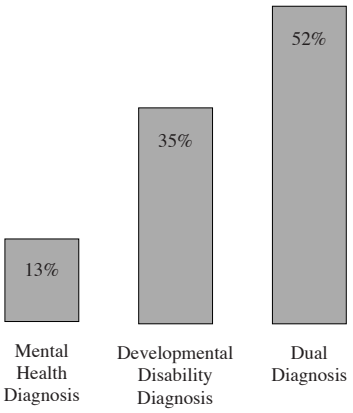
We act as if the practitioner's knowledge and technology are more important than the interpersonal relationship between the practitioner and person getting help. We know this is not the case from listening to what people tell us. When asked, a majority of people who are recovering from severe mental illnesses will mention that a critically important contributor to their recovery is other people –people who listened to them, believed in them, and supported them in numerous ways…

Today it is fashionable to argue for… the removal of choice with the phrase, "people are dying with their rights on". But I would also remind us that, "people are both living and dying with their dreams turned off". We cannot be seen as the field that walls people away from their hopes and dreams.

—William Anthony (2002)

Assets, Inc. supports people with developmental disabilities or psychiatric disabilities or both disabilities to live, work, and learn in Anchorage, Alaska. It serves about 250 people, offering each person one or more of these services: supported living, supported employment, and contract work. About 25% of the people Assets supports were referred by the Division of Vocational Rehabilitation (DVR) and about 75% were referred by the Division of Mental Health and Developmental Disabilities (DMHDD).* (For a brief description of Assets; organizational structure, see page 36.)

Supported Living	80
Supported Living for Children	19
Supported Employment	150
Commercial Contracts	150



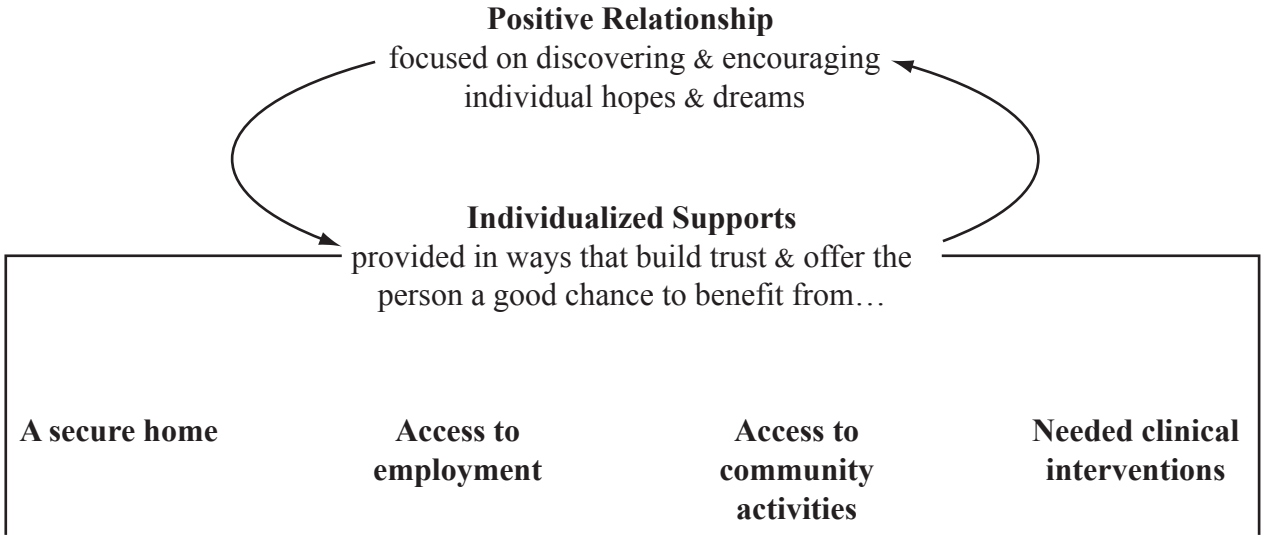
For nearly 20 years, Assets has systematically developed its staff's capacity to assist people that other community services were unwilling to include because they present challenges and risks that seem excessive to other providers. Assets' accumulating experience demonstrates the importance of an individualized approach to supports delivered within a positive personal relationship with staff. While some approaches to people who challenge services rely on separate and distinct facilities or service programs, Assets does not. The foundation of Assets' approach is a positive long-term relationship between the person and Assets' staff which allows the person to make the most possible use of the opportunities in their community. This relationship focuses on discovering and re-discovering each person's hopes and dreams and assisting each person to pursue those hopes and dreams in the context of a secure home and access to opportunities for employment and community participation. As need arises, staff develop and apply specialist knowledge and clinical skills so that people whose disabilities present unique barriers can benefit from

*On 1 July 2003, Alaska's human service system was reorganized. This report reflects the organizational structure in place before the reorganization.

Assets' Mission Commits Its Staff to People Who Need Substantial Supports

The Mission of Assets, Inc. is to consistently improve the employment opportunities, home environments, and community connection of individuals with developmental disabilities or mental illnesses who need substantial supports, so that their independence and self-worth are enhanced and the community in which they live and work realizes the benefits of their citizenship.

A Schematic View of Assets' Model for Support



the same variety of supported living and employment opportunities that Assets offers each person it supports.

Practitioners who are committed to community life for people who are difficult to serve sometimes describe people as having "severe reputations". This ironic label economically communicates three important ideas: 1) the way services have labeled and responded to this person has amplified their difficulties; 2) there is far more to the person than indicated by their diagnoses and negative stories about them; and 3) it is important to get to know the person by getting past frightening or pessimistic accounts before deciding on what supports will work best for the person.

Assets' experience shows the effectiveness of individualized supports created through a positive, long-term relationship with staff.

Assets' staff know the importance of these ideas. They also know that the people they assist are whole people with both light and shadow in their make up; whole people with both capacities to build on and dangers to safeguard against. They know that people's history often includes patterns of behavior that have, in some sense, earned them a severe reputation. They know that at least some of this difficult, dangerous, or frightening behavior may well endure into the new and positive relationships, opportunities, and individually tailored support that they are prepared to offer. They also know that the container for all of their efforts must be a relationship based on an appreciation of the person's hopes and dreams and a willingness to be on the person's side, offering encouragement, advice, and practical help as they take steps to pursue those hopes and dreams.

Over years, Assets has maintained most of its relationships with people who present significant challenges. Some who received supported living services as children or young people have moved on with their lives without Assets' support and some continue to receive assistance from Assets as adults. Most of the people who joined Assets as adults defined as "too difficult to serve" still receive support from Assets. While Assets has failed occasionally –over the years two people returned to prison after violating their parole and two people have left Assets services to return to a psychiatric facility– most people who came to Assets as "too difficult" have jobs, many are actively involved in some aspects of community life, and all have the support they need to live in their own homes.

Assets is not alone in its search for ways to dissolve the category of "too difficult to serve." The field of psychiatric rehabilitation (see Anthony,

1980 — Founded as *Employment Training Center of Alaska*
Sheltered workshop employs people in printing, bindery, & other contracts

1984 — Name changes to *ASETS: Alaska Specialized Education & Training Services*

Supported Living Services begin, including 8 people referred by the DD Division with dual diagnoses (primary diagnosis: developmental disability) turned down by or discharged by other providers

Contract Services (work crews) begin

1988 — Supported Living Services for Children begins; referrals of adolescents diagnosed as severely emotionally disturbed from Alaska Youth Initiative

1989 — Inappropriate Sexual Behavior Services initiated in response to one person's need; includes 8 people by 1992; 25 people by 2003

1991 — Include people referred by the Division of Mental Health with dual diagnoses (primary diagnosis; mental illness) and histories of assaultiveness and treatment resistance

1995 — Name changes to *Assets, Inc*

Include people referred from Corrections with psychiatric diagnoses in collaboration with DMHDD: 6 people by 2000

Collaboration with the recently formed Center for Human Development (UAP) to provide clinical services for people with inappropriate sexual behavior

1999 — Include people referred from the Katmai Unit (long stay) at Alaska Psychiatric Institute (API): 7 people by 2001 with diagnoses of chronic psychotic disorders with non-remitting symptoms and personality disorders

2001 — Include people participating in Recovery by Choice, a Mental Health initiative for the most frequent short stay users of API: 3 people by 2003 with multiple difficulties including substance abuse, involvement with the police and courts, and resistance to treatment as well as psychiatric diagnoses

Cohen, Farkas, & Gagne, 2002) is systematically expanding the options available within the mental health system by focusing on "processes such as collaborative goal setting, skills training, developing a person-centered plan, building the relationship between practitioner and service recipient, providing environmental accommodations, and coaching" (Anthony, 2003). Developmental disabilities services have invested substantially in creating positive approaches to behavioral support (see, for example, Koegel., Koegel, & Dunlap, 1996 and Lehr & Brown, 1996). Services to children and youth have created the teaching family model (Fixsen, Phillips, & Wolf, 1973) and wraparound services (Burchard, Burchard, Sewell, & VanDenBerg, 1993) to make institutional placement unnecessary. Assets draws from each of these streams of service innovation in developing individualized supports.

Assets' Evolving Role in Alaska's Service System

Assets has developed its competencies incrementally, over nearly 20 years, as the time line on the facing page shows. As one senior staff member, who began work as a direct support worker when Assets' supported living services began in 1986, put it, "Our niche has remained the same. We respond to the people others see as 'too hard to serve'. As other agencies become willing to accept more challenging people, we keep stretching ourselves to include new people who bring us new challenges."

"We keep stretching ourselves to include new people who bring us new challenges"

Alaska has chosen to redesign its developmental disability and mental health services to eliminate institutionalization and minimize the number of people who have long stays in psychiatric facilities. Harborview, the state's institution for people with developmental disabilities, closed in 1997 and by 2000 Alaska ranked first among the states in its focus on small (<6 person) residential settings. In 2000, 97% of Alaskans with developmental disabilities who receive residential supports lived with 5 or fewer others, 3% (25 people) lived with 6 to 15 others, and >1% (6 people) lived in nursing homes (Braddock, Hemp, Rizzolo, Parish, & Pomeranz, 2002). The Alaska Youth Initiative organizes wraparound services for children and young people at risk of out of state placement or placed in specialized facilities out of state with the aim of strengthening their families or re-unifying them with their families or offering stable foster care. Mental Health services are at work on strategically developing community supports across the state; downsizing the Alaska Psychiatric Institute, the state's single public mental health facility; and developing alternative services for people who would otherwise live for an extended

period of time in a psychiatric facility (Alaska Department of Health and Social Services, 2001).

Determining the quality of an effort to make public institutions unnecessary calls for answers, over time, to at least three questions:

- What opportunities and experiences are available to people who otherwise would have been institutionalized?
- Are financial savings invested in either increasing the numbers of people who benefit from services (e.g. by reducing the waiting list for residential supports among adults with developmental disabilities who live at home) or in improving the competence of services (e.g. by raising the wages of direct support workers)?
- Are people who challenge the competence of services exported from the restrictions of institutionalization into other very restrictive settings such as nursing homes, long stay psychiatric facilities, jails, homelessness, or community settings that control people through routine application of physical or chemical restraint?

One of Assets' contributions to the redesign of Alaska's service system –and the primary focus of this report– is its ability and willingness to create opportunities for people at risk of ending up living highly restricted lives to live in their own homes and hold jobs and pursue their personal hopes and dreams.

Assets supports its staff to make long term commitments to people avoided by other service providers as "too difficult to serve". This judgment has attached to some of the people Assets now supports because, in addition to diagnoses of developmental disability or mental illness, they have shown persistent patterns of difficult behavior, including: persistent non-compliance, violence to others, self-injury, property destruction, fire-setting, substance abuse, sexually inappropriate behavior (including pedophilia), probation and parole for criminal offenses (including homicide), persistent psychiatric symptoms that disrupt daily routines over long periods of time, and a history of poor response to or rejection of services and treatment interventions.

This daunting list of challenges indicates the scope of Assets' commitment and the possible applications of its learning to other agencies and service systems, but it is false to Assets' practice in three important ways. First, Assets sees and deals with whole people whose lives include

- See whole people and value their hopes and dreams
- Design and deliver support in an individualized way
- Focus on all people as an asset to their community

challenging or risky behavior rather than focusing first on symptoms or problems. Second, Assets sees and deals with people as individuals and not primarily as members of a problem or symptom identified group. Differences in referral sources do make a difference to the way public funds flow to Assets, but these differences affect only the way billing is done, not the practice of the staff who provide support according to a pattern tailored to fit each individual's whole life situation. Third, though the service system recognizes Assets' willingness to assist in complex situations, Assets does not publicly identify itself as a specialized service for people who are difficult to serve. Assets positions itself as a resource to the Anchorage community with a particular emphasis on the people it supports as workers contributing to the local economy. Publicity materials and annual reports emphasize individual accomplishments. Assets does not take public credit for responding to the complex difficulties faced by some of the people it supports (for examples, see www.assetsinc.org).

It can take years to establish the trusting relationships and individually tailored assistance necessary for people to achieve reasonable stability and security in their lives, reasonable productivity in their work, and reasonable levels of engagement in community life. However some notable results were apparent within three years to outside evaluators of one of Assets' recent efforts.

Quality of life can improve considerably even if clinical indicators of disability do not change much

> *The overall success of the Extended Care Services Project has been remarkable. The fact that eight individuals who had previously spent most of their adult life institutionalized were able to live outside an institutional setting is one predominant indicator of success. While overall clinical diagnostic indicators for measuring the success of these individuals remained relatively unchanged; quality of life, additional freedoms, and increased participation in social and community activities was achieved. Census at API was decreased from 25 beds to 20 beds on the Katmai Unit assisting API in the reduction of overall capacity from 79 to 74 beds. Furthermore, the cost of providing services to individuals in a community-based setting, as opposed to an institutional setting, was also decreased with substantial savings to the state.*[*] *(Alaska Comprehensive and Specialized Evaluation Services, 2003, p. 1).*

*The report computes a potential annual cost savings of about one million dollars for the group of eight people involved in this project (p. 30)

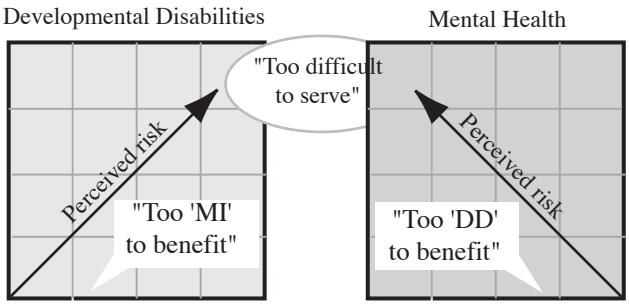
How people become "too difficult"

As Assets' staff see it, people become "too difficult to serve" when their real life situation generates lasting contradictions with ordinary service practices. Each field of human service shares some common assumptions about what falls within its boundaries and each agency has a distinct organizational culture. When policy and common assumptions that shape those service cultures don't encourage the creation of individually tailored supports that stretch familiar practices, people who challenge the ordinary become a threat to avoid.

Typical developmental disabilities services are most comfortable offering long term assistance to people's daily living and occupation and teaching everyday skills. These practices work acceptably well for most of the people who use developmental disabilities services, but people become difficult when behavioral problems or psychiatric symptoms can not be managed with easily implemented environmental controls or medications. Assignment of a psychiatric diagnosis in addition to developmental disability often decreases staff confidence that they are equipped to deal with the person and can invoke stereotypes about psychiatric disability. Developmental disabilities service providers can conclude that people fail to benefit from their services because of their mental illness.

Typical psychiatric services are most comfortable offering interventions that target symptom relief and specific skill development. Usually these services expect that intensive services will be of short duration. Except for some transitional housing and transitional employment services, people's work lives and home lives are mostly left to them to sort out. These practices work acceptably well for most of the people who use psychiatric services but people become difficult when symptoms persist and people require long-term assistance to maintain themselves. Assignment of a diagnosis of developmental disability often decreases staff confidence that they are equipped to deal with the person or leads to the judgement that the person lacks the ability to respond to anything other than medication and can invoke stereotypes about developmental disability. Mental health service providers can conclude that people fail to benefit from their services because of their developmental disability.

People who don't fit usual service practices become "too difficult" when perceived risk rises past a service provider's threshold of confidence. People who frequently assault staff, or have a strong desire to engage



in high risk behaviors, or are addicted to drugs or alcohol, or have a history of such dangerous behaviors as pedophilia or fire setting raise important questions about legal liability, threats to an agency's public reputation, and extra costs (such as extra clinical services, workers' compensation, liability insurance, and increased staff turnover). A history of offense against the law compounds the sense of difficulty and risk, in part because it engages the person with a third system, which also sees the person as a poor fit with its culture and competencies.

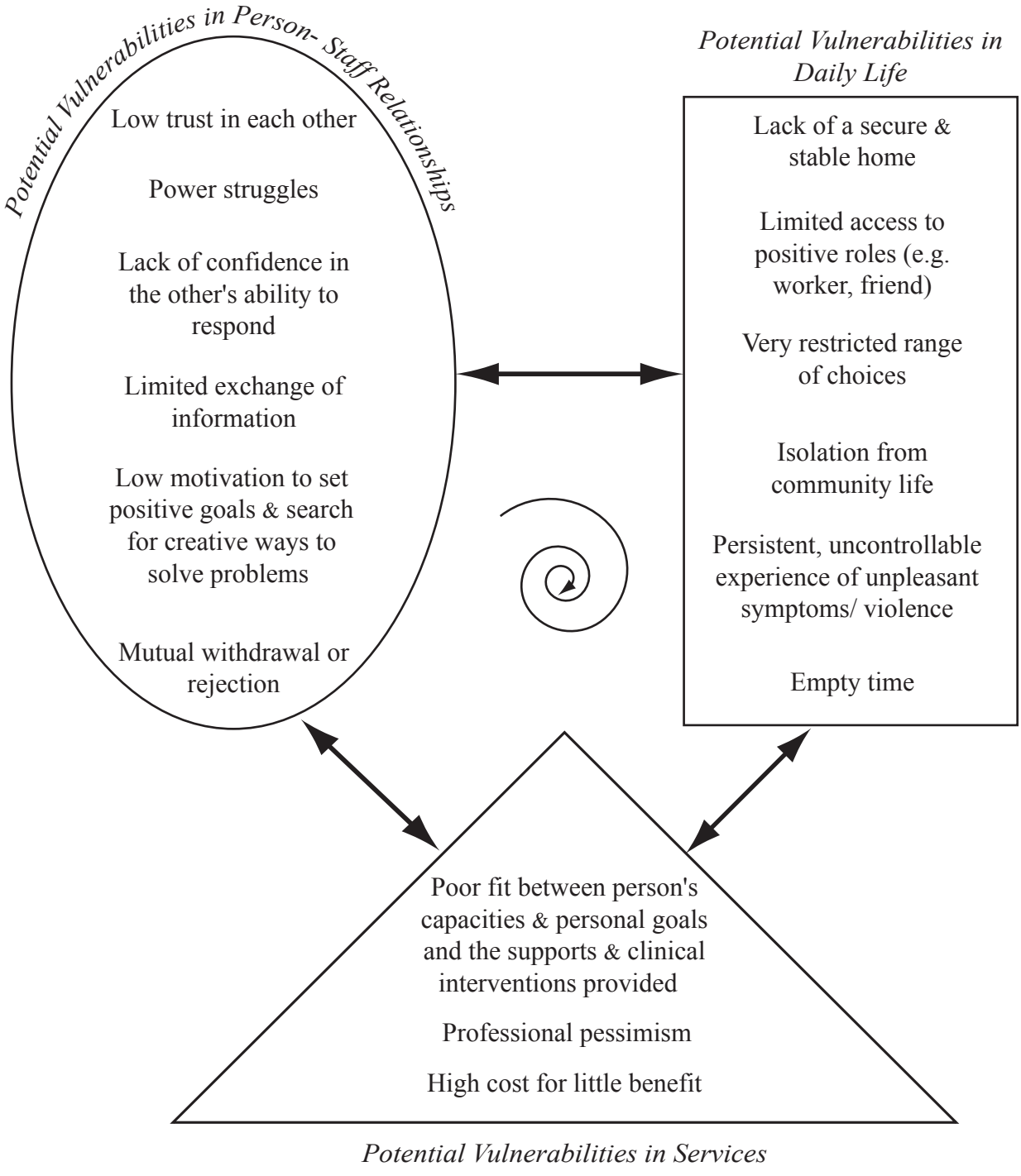
From this perspective, "too difficult" is a role created by the way a service system organizes its resources. The different grids of mission, definition, knowledge, technology, accountability for funds, methods of risk management, and policy that distinguish the organizational cultures of developmental disability services from mental health services and both systems from criminal justice services create a group of people who look anomalous from within all three perspectives. To the developmental disabilities system a person looks "too mentally ill" or "too much at risk of (re)offending" to benefit from what they can do. To the mental health system, a person looks "too mentally retarded" or "too much at risk of (re)offending" to benefit. To the criminal justice system a person looks "too mentally disabled" to manage effectively. When their perceived risk to an agency is high, people who don't fit neatly within the grid of an organizational culture become "too difficult".

People get locked into the "too difficult" role by interconnecting social processes which can create a trap for people with disabilities and those who serve them. Those currently responsible for serving the person can become emotionally engaged in…

…working to move responsibility for the person away from themselves and across the boundary of some other agency or system

…blaming the person for failure to respond to repeated applications of the approaches that usually work with most of the people they support (often blaming takes the form of multiplying diagnostic labels that do not so much shape more effective interventions as they express staff frustration and justify restrictive practices such as restraint, near sedative levels of medication, or aversive behavioral intervention)

The Negative Spiral That Can Trap People and The Staff They Rely On



…avoiding personal involvement with someone who seems threatening to staff's sense of confidence, if not their personal safety

This investment of emotional energy in banishing or shunning the person who doesn't fit in –which can be masked by clinical language, objective professional discussions, and formal procedures– communicates rejection and disrespect to the person. Such messages inhibit the development of trust, which in turn hinders the flow of information between the person and those providing services, and retards both the person's and the staff's motivation to set and seek meaningful goals. Combined with the consequences of continued exposure to poorly focused supports, the lack of a positive relationship makes the person even more difficult to serve.

Getting Out of the Trap

Over time, a poor fit between a person's life situation and available supports can result in a negative relationship between the person and professional and direct support staff. Mutually reinforcing difficulties in daily life accumulate, sometimes to the point that the person spends full time or nearly full time living an institutional life, whether in a large or a small facility. This increases the chances that the fit between the person and supports will grow even worse, sending the spiral through another cycle and further decreasing the person's opportunities. The diagram on the facing page summarizes the vulnerabilities risked by a person who occupies the "too difficult" role.

When they are caught in the trap created by this negative spiral, people can end up leading very restricted lives. While not every person identified as "too difficult" will have all of these negative experiences, it is likely that each person will have some of them and…

Vulnerabilities in daily life

…lack a secure and stable home of their own

…have limited access to the satisfactions and respect that attach to positive social roles such as being a worker or belonging to a community organization

…be subject to control of most of their daily routine by others

…be isolated from community life and unlikely to be seen as citizens

…frequently and persistently experience unpleasant symptoms or act violently and suffer the consequences with little or no sense of being able to exert control over these undesirable happenings

…face many hours and days of empty time

Vulnerabilities in services

…continue to receive services that are poorly matched to their situation

…be seen by most professionals as having little hope of a positive or productive future

…be seen as using large amounts of resources for little benefit

Vulnerabilities in relationships with staff

…distrust many of the staff they rely on and are not trusted by most staff

…frequently get entangled in power struggles with staff and often see no alternatives to attack or extreme passivity

…have little confidence that staff will be able to respond effectively to them and enjoy little confidence among staff that they will respond positively to staff efforts

…communicate guardedly about a limited range of topics

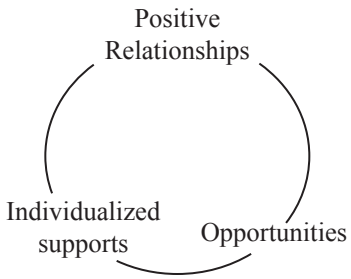
…rely on staff who have low motivation to set positive goals and engage in creative problem solving to deal with barriers to goal attainment

…withdraw from or reject staff and possibly experience withdrawal or rejection by staff

The longer people and staff are caught in this trap, the more its negative effects can become part of the person's sense of self. People's sense that they can make a positive difference to their own future decreases and they adjust their expectations for their life downward as they adapt to restricted circumstances. This makes the trap, and their place within it, seem familiar to people and this familiarity can make positive changes a source of anxiety. It can take some time and living through many ups and downs for people to build up a life outside the trap.

This metaphor of a trap does not suggest that people who are cast in the role of "too difficult" are not disabled. Many of the people Assets supports experience cognitive disabilities, many have psychiatric disabilities, some have neurological or physical disabilities, most people have a combination of these disabilities. In some form, these conditions are likely to endure throughout people's lives and continue to call for well organized, individualized assistance. The extent to which these disabilities negatively affect the quality of people's lives depends in important ways on three things that Assets can do to reverse the negative effects of the trap:

- Offer a positive relationship with staff that allows people to discover and take action to pursue their hopes, dreams, and personal meanings
- Provide sustained opportunities for a secure home and access to positive roles



- Offer individualized support that justifies people's trust and allows people as much autonomy and participation in community life as possible, consistent with their own safety and other's safety

Creating Opportunities

Assets holds the same aspirations for each person it serves. Young people who have chosen Assets as they grow out of their school years deserve individualized support to succeed as a worker and a community participant; so do people moving after many years of psychiatric hospitalization. People whose behavior poses no particular challenge deserve to enjoy a positive relationship with staff who are genuinely interested in being allies in pursuing their hopes and dreams; so do people with a history of inappropriate sexual behavior. People who are able to manage daily routines independently deserve a home of their own; so do people who require a high level of structure or assistance to deal with daily demands. All of the people Assets supports can make a valuable contribution to their communities (Review Assets Mission on page 4.)

These aspirations are encoded in Assets' statement of beliefs, reproduced on the next page. These beliefs commit Assets' staff to respectful relationships that honor people's choices, promote people's sense of themselves as powerful, recognize the importance of working for change in community prejudices, and serve people's participation in valued community roles as friend, family member, tribe member, contributor, employee, neighbor, association member, and advocate.

Some opportunities develop more slowly

Because Assets implements these beliefs by approaching each person as an individual, there is no need for programmatic distinctions based on a person's diagnosis or the amount of time and shared effort that might be necessary for a person to move into one or more valued social roles. For some people who were extracted from family and village life as children to receive services hundreds of miles away in Anchorage or even thousands of miles away in another state, recovering family and village roots may take years and include the time it may take to recover from disappointments or rejection. For some people who grew up in an institution, a sense of confidence and efficacy may grow slowly. For some people, it may take many trials to find ways to manage distressing emotions that overwhelm the desire for community involvement.

We Believe The Individuals We Support Should:

Have a stable home of their choice.

Be employed in rewarding jobs with benefits, growth opportunities, fair wages and flexible schedules.

Determine their service and define what improvement means for them.

Experience discreet, non-intrusive, individualized supports of their choice.

Be good neighbors who actively participate in their community and belong to community clubs, associations, leagues, etc.

Have access to affordable, accessible, flexible transportation.

Have opportunities to return to their roots (village, family).

Experience community acceptance on a day-to-day basis.

Be respected and heard.

Have a reputation and identify free from the human service system.

Make their own decisions based on informed decisions.

Be seen as givers/contributors to the community.

Be self advocates – network with each other for support.

Experience a sense of confidence and empowerment and control.

Have a variety of friends.

Understand the obligation of service providers and expect it to be fulfilled.

Get only the services they request.

Establishing a stable home and a job lays the foundation for success

It takes much less time for Assets to assist people to live in a stable home and have a job than it takes to support the developmental process that allows people to recover from all the negative effects of being placed in the "too difficult" role. Locating affordable housing that reflects a person's choice is not always easy in Anchorage, but Assets' staff have learned how to help people move into their own places. Finding a job that accommodates a person's need for structure and flexibility can be difficult, but Assets' staff have learned how to help people find jobs. Because Assets provides people with long term support, first homes and first jobs are just that. As staff earn people's trust by accompanying them through the ups and downs of first (and sometimes second and third and fourth or more) homes and jobs, they build the knowledge to find better and better matches with people's growing skill and confidence. A reasonable level of stability at home and at work can take months or even years to establish. But the opportunity to learn by being at home and at work is where Assets begins. There is no sense in continuing the failed practice of trying to get people ready for a stable home and a job, especially when coping with the disruptions that will almost certainly come when people begin to move from restriction into greater choice.

Meeting staff whose mission is to work with you to move into your own home and find a job, and who begin their relationship with you by listening to what you have to say about your hopes and dreams, and build their relationship by asking you about your preferences, and look for ways to help you realize those preferences creates a change for people who have been caught in the "too difficult" trap. When people move into their own place and collect their first paycheck they experience real benefits that strengthen their relationship with staff. When staff stick with them and look for positive ways through the inevitable difficulties and disruptions that threaten the benefits of living in one's own home and working a real job, the relationship grows stronger.

Assets' past investments provide some people with options. Assets was founded to provide contract work and still operates a successful printing and binding business in its building. Its early efforts in supported employment include a number of crews that work in community sites, including several well paid crews who work on contracts in federal facilities and military installations. Assets' contract services are

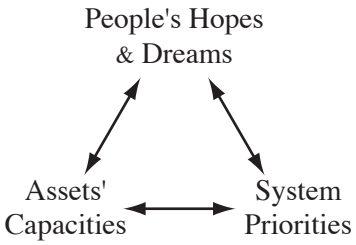
economically successful enough to employ both people with disabilities and some people without disabilities and offer a measure of flexibility and security that allows some people to make the quantum leap from full time patienthood in a psychiatric facility to at least part time employment more quickly than they might otherwise.

Assets acquired HUD funds to develop a nine unit apartment building in 1994 and a triplex in 2000. These apartments are not transitional housing: people can live in these properties until they choose to move to something better. And, people do find places that they like better and move. This occasional turnover provides places for people who may need an exceptionally accommodating landlord in order to establish themselves outside an institution.

Assets' staff and board are familiar with accepted principles of good practice. It would not be news to them if someone pointed out the disadvantages of congregating people with disabilities for work, or in an apartment building built for people with disabilities. They understand the dilemmas of offering individualized support while operating congregate service sites and they are clear that the future lies in the direction of expanding their capacity to offer individualized supports through individualized and community integrated service arrangements. However, they can point to positive outcomes consistent with their belief statement that balance the disadvantages for a number of people, especially people that other providers define as too difficult to serve.

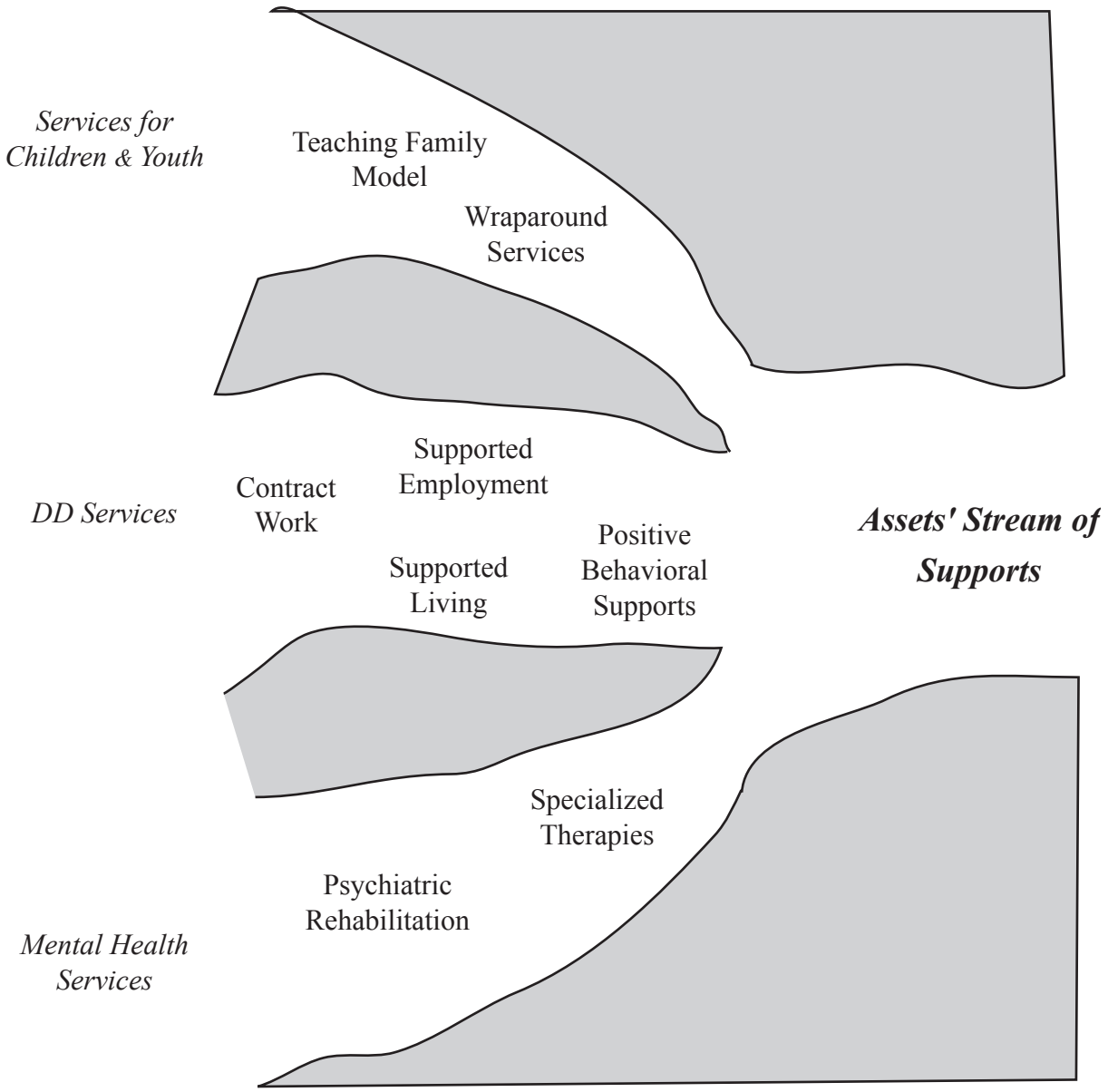
Assets creates lessons about effective processes, not replicable programs

Does Assets' experience suggest that an agency in another place needs congregate living and working sites in order to support people who are seen as "too difficult"? The incremental growth of Assets' engagement with challenging people over 20 years makes any answer to this question speculative. Assets has grown its capacity by committing whatever resources it has available to assist individual people to realize lives that reflect its mission and beliefs. What others can learn from their efforts is not in the form of a replicable program design. It is in the form of a learnable set of processes for offering opportunities, building relationships, and individualizing supports (for more on the idea of developing, evaluating, and transferring effective processes, see Anthony, Rogers, & Farkas, 2003).



Assets has been shaped by the interaction of its own beliefs and capacities with the emerging hopes and dreams of the people it supports and the demands of an evolving service system. Assets' efforts on behalf of people who have lived much of their adult life in psychiatric facilities were not, from Assets point of view, an exercise in adding a new program. From the point of view of participants, the project was an opportunity to live outside the institution, which initially may have seemed like a move into the unknown. From Assets' point of view it was a question of how to include eight new people, each with their individual hopes and dreams and challenges, into its ongoing search for effective ways to support people. From the point of view of the direct support workers involved, it was a matter of creating a positive relationship with the person who had helped select them as an assistant and finding ways to assist them to be secure at home and productive at work. From the service system's point of view, Assets was part of a project with a definite identity and location. The title of the state's evaluation study makes this clear: *Assets Enhanced Extended Care Services Katmai Project* (Alaska Comprehensive and Specialized Evaluation Services, 2003).

There are potential tensions in this interaction. People were selected by the state, based on their pattern of hospital use. Their increased opportunity to exercise choice began with their engagement with Assets. Until people found their feet in their new homes and got to know staff, they had to depend on hospital staff judgements about what was necessary for their safety and what meaningful goals for them might be. Change in state priorities or policies could affect Assets' ability to provide the type and intensity of support people need to keep developing. However, these different perspectives can be reconciled. The evaluation shows that the state is getting what it wants from the project. Direct support staff report satisfaction at helping people navigate their individual difficulties at making the move to community living despite some hard times and continuing challenges. Assets has begun to realize its mission for eight more people and strengthened its capacity to make a distinctive contribution to Alaska's human service system. Overall, the people involved report growing satisfaction with their new lives, despite the persistence of some troubling symptoms and periodic crises.


Services for Children & Youth
Teaching Family Model
Wraparound Services
DD Services
Contract Work
Supported Employment
Supported Living
Positive Behavioral Supports
Assets' Stream of Supports
Specialized Therapies
Psychiatric Rehabilitation
Mental Health Services

Providing Individualized Supports

Designers of some programs for people seen as difficult to serve begin their task by adopting a clinical technology that they believe will control the target group's difficult behavior or eliminate troubling symptoms. For example, programs have been designed around applied behavior analysis, or skill training based on social learning theory, or particular drug regimens or focused psychotherapies. The choice of technology sets criteria for admission and discharge, defines the sort of staff necessary, and strongly influences the program's schedule and physical environment.

"As far as clinical approaches go, we are masters of eclecticism."

To these program planners who start with technology, Assets might look like it was designed upside down. Rather than begin with a specific technology aimed at remediating what is deficient in a person, Assets begins by offering people opportunities and situation specific assistance to establish a home of their own and to go to work. Instead of admitting people into a specialized environment for a time limited course of treatment, Assets offers people long term relationships and flexible individualized supports aimed at assisting them to join and play an increasingly active part in Anchorage's communities. Instead of selecting staff based on the technology they are already qualified by their professional training to administer, Assets hires staff based on their willingness to build relationships and learn new ways to support people.

Many approaches inform Assets' individual supports

The diagram on the facing page uses the metaphor of a stream and its tributaries to suggest the approaches that shape the individualized supports that Assets offers. Each of the approaches that feed this stream have come from Assets' search for effective ways to implement its mission. The confluence of these ways of understanding people, teaching skills, adapting environments to improve the chances of safety and success, and assisting people to increase self-control gives Assets a growing repertoire of ways to tailor supports to an increasing variety of individual circumstances.

Assets values clinical interventions. Indeed, over the years senior staff have invested substantially in learning new approaches that have a chance to decrease the particular barriers people experience to their enjoyment of community life. They have developed strong connections with local universities through joint projects and graduate study. They have sought

training and case consultation from national experts in specific disabilities. They have applied what they have learned by incorporating a variety of clinical approaches into people's individualized supports, either through changes to people's routines and environments or by arranging or offering individual or group therapies. As one senior staff member puts it, "As far as clinical approaches go, we are masters of eclecticism."

Some decisions about clinical interventions can be made as Assets begins to work for a person. Assets' psychiatrist will decide to continue or modify a person's current medications. Participation in the university based clinical program for people with inappropriate sexual behavior may be a condition of a person's probation. Other decisions come later, when the effects of access to opportunities and positive relationships with staff allow a somewhat better understanding of who the person is and what works in assisting them. Sometimes Assets' repertoire already includes an effective response or a response that can be adapted to meet a new need. Sometimes staff will have to search for new approaches.

Assets' pattern for learning new ways to offer individual support

The development of Assets' capacity to support people with inappropriate sexual behaviors provides an example of the organization's learning process. It begins with a commitment to specific people who are excluded from their right to community life by a poor fit between their situation and available supports, as Karen Ward and her colleagues (1992) describe:

> *...In 1985, a group home resident exhibited inappropriate sexual behavior toward children, or pedophilia. Continued residence in the group home exposed the staff's small children who were living in the home, other residents, and the community to an unacceptable risk, since the home was located near an elementary school.*
>
> *At that time, because existing support service agencies for people with developmental disabilities were unprepared to manage inappropriate sexual behavior, the community offered no alternative living arrangement. The individual was placed at Alaska Psychiatric Institute (API), a state psychiatric hospital. While API offered sex offender treatment, their program made no provision for people with developmental disabilities. Yet, by law, people cannot be committed to psychiatric institutions*

indefinitely, without a treatment plan for improvement. The solution to this paradox arose from a change in ASETS [the agency's name in 1992] philosophy of residential service delivery… (pp. 3-4).

This commitment to creating an opportunity –initially by implementing stringent environmental controls and very close monitoring within Assets' supported living and employment for the person whose "too difficult" status caused his confinement without treatment– led staff to a more extensive search for knowledge and skill. As Assets' capacity grew, the service system and the courts acquired alternative ways to assess risk and respond. In 1995 the Center for Human Development (UAP) at the University of Alaska Anchorage assumed responsibility for delivering clinical services to people with inappropriate sexual behavior. (For a description of some of these services, see Ward, et al, 1992) Available to the whole community, their service now includes about 25 people that Assets supports.

Experience with people whose sexual behavior made them 'too difficult" validated and extended lessons staff were already learning from people whose violent behavior led other agencies to refuse to serve them.

- It's important not to let one threatening aspect of a person's life overwhelm the person's whole identity. Staff must be able to see a whole person with both the potential for dangerous behavior and the capacity for a productive life.
- Taking responsibility for making careful judgments about risk is a necessary part of supporting community life for people whose behavior threatens and repels others. Sexually inappropriate behavior that results from lack of information or lack of opportunities for appropriate sexual expression poses less threat than sexual arousal by children or by committing violent acts does. It is not enough for professional staff to know such things. They must also commit themselves, and their organization, to judgments that carry liability for the safety of others. That final decisions may be made by judges or authorities responsible for hospital discharge does not reduce this responsibility. Unwillingness to accept this responsibility (and the concurrent responsibility to seek consultation if necessary) leaves a person's future in the hands of whatever authority is willing to make a judgment.

- Prevention is essential and can be effective. To reduce the likelihood of hurting others, some people have to live with stringent controls that restrict some of their possessions, activities, and movements. These restraints need not take away the possibility of a person having a home and work life and pursuing some of his hopes and dreams as long as restrictions are consistently and rigorously enforced by staff who want to assist him to have a community life that makes sense.
- One limit to Assets' willingness to include people is this: Assets will not agree to imposed conditions that are so restrictive that they would be replicating a prison or a locked psychiatric ward in an apartment.
- Positive change is possible. Most if not all of the treatments that are effective with other people are also effective, or can be effectively adapted, for people with intellectual disabilities. People who display inappropriate sexual behavior have as much potential to respond to positive relationships with staff, opportunities to have their own home and a job, and effective clinical interventions as any other person does. Despite the possibility of positive change, some people require continuing assistance to control inappropriate arousal. Community safety and quality of life can improve even when some clinical conditions endure.

Assets' pattern for learning new ways to understand and assist people to deal effectively with behaviors and emotions that interfere with their pursuing a satisfying life can be summarized like this. First, **learn from** each person who they are, how best to communicate with them, and what matters to them. Then, **learn for** the person which clinical interventions offer the best chance of improving the quality of their life. This pattern for learning continues to increase Assets' repertoire of individualized supports.

Triggers for learning

Realization that staff are drifting from the kind of positive relationships that are fundamental to Assets' way of serving people frequently triggers new learning among staff. Signals of this drift include: losing sight of the whole person and focusing exclusively on the person's negatives; not making time for conversation about a person's hopes and dreams; not following-through in assisting the person to take positive steps forward; not being able to imagine a more hopeful future for the person; avoiding the person; feeling victimized or manipulated by the person; repeating

person-blaming explanations for poor outcomes; wanting the person to be punished; feeling unable to make any positive difference in the person's life; not being able to have productive problem-solving discussions with the team, with the person, with family members. A great strength of Assets' leaders is their ability to notice signs that staff are drifting into a trap and redirecting attention toward more positive possibilities.

Some people experience very frequent crises, impulsiveness that can include harming themselves or dramatically threatening to harm themselves, intense and uncontrollable emotions of anger and anxiety, very high sensitivity to abandonment, and great difficulty in forming and keeping stable and satisfying relationships. Life feels empty. Staff who get involved can feel a strong pull toward feelings of helplessness, victimization, anger, personal dislike and pessimism, if not in themselves then in others who deal with the person. When the person also shows signs of a disturbed sense of identity and dissociation and paranoid ideas when under stress, a diagnosis of "borderline personality disorder" summarizes these barriers to a meaningful community life. Dialectical Behavior Therapy (Linehan, 1993 and The Mental Health Center of Greater Manchester, 1998) gives Assets' staff both a hopeful and practical understanding of what the person struggles with and systematic ways to help the person learn to exert more effective self-control of their behavior, experience their emotions with less disruption, discover ordinary happiness, and find a measure of joy in living.

Awareness that a number of people have been victims of abuse or neglect and the possible effects that this can have has led staff to learning how to apply interventions that have proven effective in the treatment of post-traumatic stress disorders. For example, staff are developing their skills in applying EMDR (Eye Movement Desensitization and Reprocessing) (Maxfield, 1999) under the supervision of a local psychologist.

Persistent breakdowns in relationships between Assets' staff, a person, and the person's family and friends combined with a sense that more would be possible for the person if staff had more and better approaches to assisting people recovering from traumatic brain injury led Assets to seek an assessment and continuing consultation from an out of state specialist center. The success of this learning journey has led to further exploration of the fast growing field of applying neurological imaging techniques to

the design of accommodations and interventions.

Supporting Positive Relationships

One of Assets' senior staff has a gift for telling teaching stories. Here are three brief stories that capture some of the qualities Assets prizes in staff.

Our job isn't to grant people's wishes. It's to take a person's hopes and dreams seriously, however far away we may think they are. That means doing a lot of the kind of listening that is more likely to happen over coffee at Burger King than in an official meeting room. It also means helping the person identify some real step they can take that will move them at least a little bit closer to where they want to go.

S told us he wanted a driver's license. Over the years, he took the drivers test 77 times and failed it 76 times. In fact it took almost five months for him to get the process started because it took trying a lot of different strategies to help him overcome his social anxiety enough to go into the driver's license office and get one of the instruction books and an application for a learners permit. We worked on lots of things besides driving, but as long as he wanted to keep working on a license, we were right there with him.

———

It can take people a very long time to get control of their violence. And some people never completely achieve complete control, even after things have calmed down a lot in their lives and good things happen almost every day.

R loved to fish. I like to fish too. And I enjoyed fishing with him. Sometimes things would get difficult and we'd get re-acquainted with the old R. He'd trash his place and work on beating me up. Then he'd get back in control and we'd clean up his place and go fishing together.

———

A got in trouble for sexually inappropriate behavior. For him it was mostly about not having an appropriate partner. He decided he really wanted a girlfriend near his own age. We heard that. And we worked with him, starting with the idea that he'd have a better chance of getting a date if he didn't smell so bad and

if he practiced starting his conversations with something other than crude suggestions. He put in a lot of practice and had some success in creating a social life for himself. You can't let somebody fail just because they lack information. Sometimes what you need is the courage to tackle what's right in front of your nose. If you're not trying to punish people or put them down, they'll usually take honesty pretty well.

The qualities of positive relationships

Staff move toward people that others move away from

These stories communicate more than four important lessons about the positive relationships on which Assets builds its supports. First, staff go toward people that service workers in other agencies move away from. Second, staff work to discover what a person finds meaningful, what gives them a sense of mastery and satisfaction, what seems to them worth working toward getting. They expect people to have interests, hopes and dreams that are similar to their own: the freedom to drive; the enjoyment of fishing; the desire for friendship and intimacy that doesn't hurt. Third, staff are willing to help the person identify ways to take at least one concrete step in the direction of their dreams. If need be, they help the person rehearse or accompany the person as they take that step. They tell the person honestly about changes they will need to make to realize their dreams, in terms the person can understand. They find ways to make the way smoother without taking over the work the person needs to do to maintain their dream as their own. Fourth, staff have the courage and skill to be present to the violence or pain a person struggles with. They try to find ways to prevent violence; and if they cannot, they look for ways to protect the person from having to live with doing harm. They can avoid or deal with being hurt themselves. Their sense of a person's dignity and identity is not overwhelmed by the person's behavior. They have honest ways to reconcile with the person.

These enumerated lessons are far less powerful than the stories are. In part, this is because the stories send a crucial message in their form: each story is about a particular relationship with a specific person. Generalization can lead to missing this vital point. The storyteller did not go fishing with R after R trashed his home out of ignorance of the principles and practice of applied behavior analysis. The storyteller understands applied behavior analysis well and finds it a sometimes helpful perspective. The storyteller suggests catching fish in the context

of a long relationship with R, as a good thing for them to do together after they repair the damage to R's place.

There are people who want to do the work

"If a staff person stays long enough to play a part in one positive story in the life of a person they support, we have a good chance of keeping them"

It is not possible to provide the kind of support Assets has found effective and work at the distance from people with disabilities that is comfortable for many mental health professionals. This is both a source of dilemmas and source of great satisfaction.

Working at Assets demands a lot from staff. People who have lived in the trap created by the interaction of substantial disability with poorly fitting services can be difficult to get to know, may set difficult tests for people they begin to trust, and may continue to experience difficulties for a long time. There can be some risk of physical danger. A lot is at stake: some people can hurt themselves or other people, even with good support. Real positive change is very likely, but can come slowly and crisis may frequently interrupt progress. Because Assets individualizes supports, and because individual needs can change, it can be hard to learn the job by supporting one person and then smoothly transfer to work with another person. There are persistent demands to learn more, not only about new ways to think about people and new ways to do things but also to learn more about oneself. People need to enjoy accepting responsibility for figuring things out, often finding their way with a team through a process of trial and error. Someone who wants a well defined job, with clear boundaries, and predictable workdays would not find working with many of the people that Assets supports very satisfactory.

One of Assets' most important discoveries is that there are support workers whose diverse gifts match the diverse requirements of the jobs people need done. (One manager, made cautious by the time it can take to recruit suitable staff, says there are "almost enough" suitable people who want to work for Assets.) Staff discover meaning in their relationships and satisfaction in helping people claim their rightful place at home, at work, and in the community. Despite the availability of meaningful work, recruitment is a continuing issue, made more difficult by relatively low pay. However, many staff find the work rewarding enough to recommend Assets to their friends and referral from other staff is the single biggest source of new employees.

Assets invests in being a good employer, with high expectations, fair treatment, opportunities for promotion, a number of chances to participate in decision making, and a good work environment. Staff are not left alone without support. Teams, supervisors, and more experienced and skilled staff are available to help make sense of puzzling situations and share in problem solving. There are many opportunities for training. All of this helps to attract and retain good employees.

As important as good working conditions are, Assets has another advantage in retaining staff with a gift for the work. The people Assets supports are effective at recruiting staff into their lives. At root, what is required from staff is openness to the humanity they share with the people they assist. One senior staff member says this:

> *Staff need to be willing to identify with the people they support. This means that they recognize three things:*
>
> - *The people we support want the same kinds of things and have the same kinds of hopes and dreams that we have for ourselves and the people we love and care about in our own lives.*
> - *The people we support deserve a secure home and a job as much as we do.*
> - *The people we support should not be blamed for their disabilities.*

Another senior staff member observes:

> *We offer people the chance to work with integrity and make a real difference in the lives of people who have not had many of the advantages that come with people believing in them and supporting them. If a staff person stays long enough to play a part in one positive story in the life of a person they support, we have a good chance of keeping them.*

In addition to rewarding, if demanding, relationships with the people assets supports, relationships with co-workers are an important source of job satisfaction. The opportunity to play a part in a team with responsibility for identifying and making progress on genuinely difficult problems offers many rewards. But sometimes teams can compromise these satisfactions by trying to avoid responsibility for difficult decisions. Because people's safety is often on the line, teams can give away the chance for learning by delegating decisions up to more senior staff. This upward delegation is different from asking other people to join in the

Core Values

TREAT EACH PERSON WITH DIGNITY AND RESPECT.

This means: seeking first to understand the other person. Practicing active listening. Avoiding labels. Bringing out the best in each person. Making courtesies and kindness a part of all interactions. Practicing loyalty to those who are absent. Withholding criticism until you have "walked in the shoes" of the other person. Affirming each person's unique talents, interests and values.

MAKE A DIFFERENCE IN THE LIVES OF INDIVIDUALS WITH DISABILITIES.

This means: empowering, involving, encouraging, supporting, inspiring, recognizing each person. Being determined to make a positive impact on each person. Thoughtfully planning your actions. Thinking and communicating inclusion. Readily extending trust. Being partners. Managing risks. Increasing knowledge about possibilities and alternatives. Believing in each person. Providing assistance with integrity.

CONTINUALLY IMPROVE – FOREVER.

This means: always looking for ways to do better, be more efficient, be more effective, to make an even bigger difference. Honoring the creative process. Have a high tolerance for ambiguity. Being incessantly curious about the way things work. Encourage learning, diverse opinions and open disagreement. Actively work to decrease fear and anxiety. Be a learner. Share what you learn.

ADAPT, OVERCOME, IMPROVISE.

This means: finding a way when it doesn't seem possible. Practicing creative and patient persistence. Doing what it takes. Being smarter. Working smarter. Being a responsible risk taker. Creating an atmosphere that encourages risk and innovation. Having a sense of humor. Not taking yourself too seriously.

This Is the Assets Way!

problem solving effort or help a team get untangled from a process snarl that is holding up progress. It is also different from a team informing their supervisor of a decision and asking "Is there anything your experience tells you we should be thinking about before we implement this?" Upward delegation results in the team sitting back relieved, waiting to see what "they" are going to decide. This has at least four bad consequences: it moves decision making about important issues farther away from the person; it deprives the team and its members of the most important educational experience available to them; it reduces staff ownership of their work; and, it overloads the senior staff who accept the delegation. The art of senior management at Assets involves staying in close touch with each team's work and offering support for high quality problem-solving while avoiding upward delegation of responsibility.

Managing for Positive Relationships and Individualized Supports

Both good management and strong leadership are essential to Assets' ability to support people who are difficult to serve. Good management assures the resources necessary to do the work. Efficient structures and processes meet the many requirements of being a good employer and satisfying the state agencies that purchase services in ways that allow staff to act flexibly in response to the people they support. Strong leadership engages the organization in the continual personal and organizational development necessary to keep Assets delivering on its mission.

The statement of Core Values on the facing page encourages leadership. It telegraphs the results of staff reflections on how Assets' staff act when they are most effective. Core Values define expectations necessary for positive relationships and productive teamwork. They inform staff orientation and training and guide supervision. As staff practice these actions they strengthen a culture of service that can support people that other agencies see as too difficult to serve.

Assets' ability to support people well depends on continuing to develop five organizational capacities:

- Get to know and respond to each person as a whole individual with the right to a community life that makes sense rather than focusing on diagnostic labels
- Offer each person the same basic opportunities for a home, a job, and access to community life rather than treating people differently based on the source of their funding or their primary disability

- Expect all staff to form positive relationships based on people's hopes and dreams and competencies and sticking with people through bad times rather than understanding their role as treating symptoms or providing supervision and control
- Be inventive and flexible in individualizing supports rather than offering standardized services
- Keep looking for new ways to improve the quality of people's lives at home, at work, and in community life

Assets' ability to develop these capacities depends on the talent and commitment of Assets staff. It also depends on Assets' ability to manage its relationships with a changing human service system. The three paragraphs below each identify potential changes in the system that could require substantial adaptation if they are implemented. The fact that by the time this report reaches readers these issues may have dissolved and been replaced with concerns now unforeseen makes the point: Assets' functions in a shifting service environment. Monitoring and working to influence potential changes in two systems demands time and energy from Assets' leadership.

Financial stability makes it possible for Assets to innovate. Negotiating adequate rates for services, generating income from Commercial Contracts, and close attention to financial management has kept Assets financially strong for most of its recent history. The pressures of a bad economy on the state, combined with rapidly rising costs for insurance could thin the surplus that Assets has been able to invest in innovation and staff training. Assets' budget could face increasing pressure from the Mental Health system's practice of paying significantly less for services it defines as providing supervision than it pays for services it defines as treatment. Because this distinction does not make sense in terms of the way Assets provides services to people who have not been successful in typical mental health services, it could erode Assets' ability to get adequate reimbursement for the services that people who need substantial support require.

Being able to treat each person as an individual distinguishes Assets' approach. Each person Assets serves is assigned their own cost center, so budgets are individualized. From the point of view of the staff who provide services, it doesn't matter what the source of their service funding is. People who receive intensive services are not grouped by funding

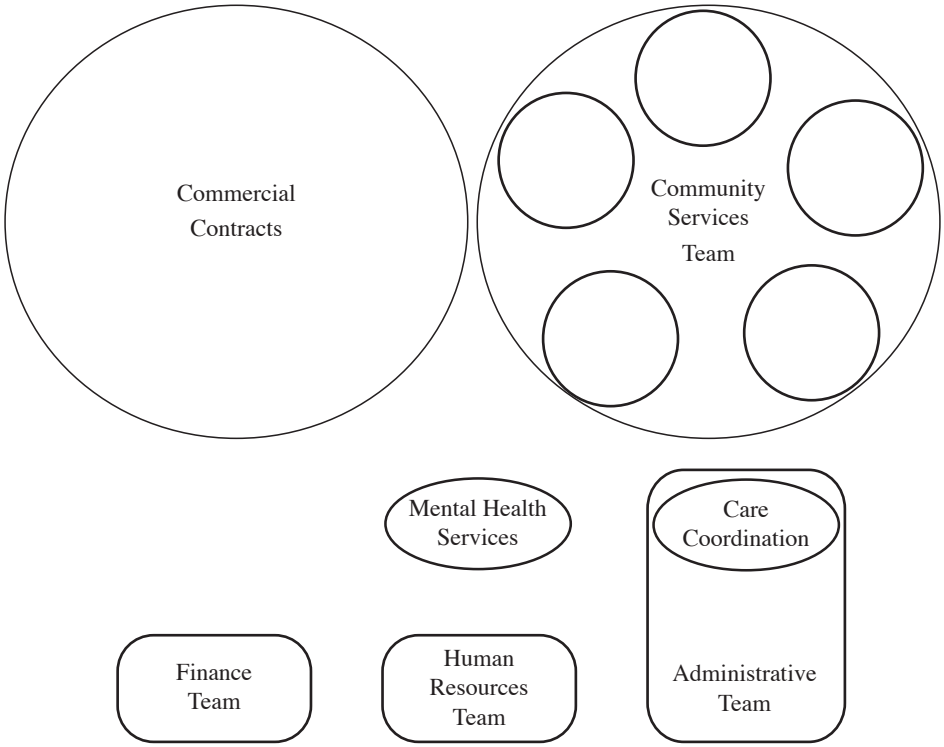
source. Whether a person's supports are funded by Developmental Disabilities or Mental Health dollars, staff keep the same records and follow the same plans. To make this work, records and plans are designed to conform to the requirements of both funding sources. Diverging requirements in both systems for planning, record keeping, and billing could make this unified approach increasingly difficult.

Keeping attention on improving quality of life encourages staff to hold high expectations for the people they support. Assets' Board has set an important strategic direction by directing the organization to grow by improving the quality of its services rather than seeking to substantially increase the quantity of people Assets serves. A rising trend among system administrators in several states favors managing costs by contracting with large lead agencies rather than a larger number of small and medium sized providers. If this trend becomes influential in Alaska it could reduce Asset's control over its own destiny.

Whatever adaptations Assets may need to make to stay on its course, its Mission and Beliefs point the direction and its Core Values identify the habits of action that make for resilience and creativity.

Appendix: Assets' Organizational Structure

Assets structure is partially summarized in the diagram below. The Contracts Team is responsible for the work life of employees who provide high quality services to Assets customers among local businesses. The Community Services Team provides supported living services to the people and families Assets assists in their own homes and supported employment services to people employed by local businesses. Mental Health Services provide consultation and training to staff teams, directly provide services to some individuals, and act as liaison to other community mental health service providers. Care Coordinators are responsible to people funded by HCB Waiver for service planning and assisting in access to appropriate services. Care Coordinators are part of the Administrative Team, which also manages records and provides a representative payee for people who cannot manage their own social security payments. The Human Resources Team recruits, trains, and supports staff. The Finance Team includes quality assurance.



Supported living and supported employment services for people who receive 24-hour assistance are delivered by one of four community services teams, called after precious metals and stones (Bronze, Diamond, Emerald, and Platinum). Each of these teams assists about 26 people and includes seven or eight Assets' staff. Individual supports are provided by a combination of team members and Personal Support Assistants. As much as possible, people have control of who assists them. A fifth team (Onyx) serves 88 people who only receive supported employment services from Assets, many of whom are funded by DVR.

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Highlights of 6/14/13 One-Day Brainstorm with Key Stakeholders re closings of Hilltop and Rehab Central

A. What would be the characteristics of a Successful Closing Process and Result?

1. Residents' voices are the most important
   - -residents get to decide what's important to them
   - -the person drives the plan
   - -services are built around the person's dreams and hopes
   - -people get to decide where to live and with whom
   - -people get to choose services/supports and providers
   - -consumers are the directors of their recovery

2. People have a rich, meaningful life with full involvement in the community
   - -people feel happy and safe in their new circumstances

3. Important personal relationships are preserved and new ones are created
   - -no actions are taken which would sever or harm existing important relationships
   - -support to create new relationships

4. Adequate funding
   - -in order to support people with complex/challenging needs
   - -to sustain appropriate levels of service over the long term

5. Strong Community Service Capacity
   - -adequate choice of providers, including providers willing and able to serve people with complex needs
   - -variety of service models and styles, so that finding a "good match" is possible
   - -good availability of recovery-oriented mental health services
   - -adequate availability of psychiatric services

6. High Quality Services and Supports
   - -truly individualized and person-centered
   - -An in depth individual plan developed before the person moves
   - -safety assured
   - -consistent and reliable support
   - -stability (person can stay in his/her home as along as she/he wants)
   - -high consumer and guardian satisfaction
   - -strong, independent quality assurance and oversight of services

7. Strong Collaboration among all parts of the system
   - -county government, MCOs, IRIS, providers, crisis services, advocates, law enforcement, CSPs, and hospitals

8. Strong Crisis Prevention and Response Capability
    -adequate capacity to support all people in crisis
    -availability of a variety of crisis responses
    -individual relocation plans include crisis plans
    -when a person experiences crisis, the first and preferred response is support in their own home

9. Community acceptance and integration
    -welcoming neighborhoods
    -multiple opportunities for people to meet and get to know a variety of non-disabled people
    -variety of real life social and community integration opportunities
    -effective strategies to reduce myths and stereotypes about people with disabilities

10. Support available to people moving out from other people with disabilities who have lived in institutions and successfully moved out

11. Low rate of people having to return to any institution

B. What has worked well in past institution closings?

1. Putting a lot of effort in supporting and working closely with guardians

2. Taking the time necessary to do good individual planning, and successfully resisting the "hurry it up" voices

3. Getting other former institution residents to meet with the people moving out to reassure and educate them

4. Making sure to address the relationship issues (i.e. preserve the important ones and help create new ones)

5. Giving people a chance to spend some time in the community (including prospective new homes) before they have to decide where they want to live

6. Showing respect for, and providing support to, the staff on the units in the institution

7. Creative housing strategies

8. Investing a lot of effort in finding the "right match" (i.e. of roommate, of provider, of provider staff)

9. Being flexible about the process and the timeline (finding a process that works for this resident and this guardian)
10. Focusing on the person's WHOLE LIFE

11. Good support and training, and good pay and benefits for direct service staff

12. Addressing people's sexuality issues

C. What has not worked well in past closings?

1. Allowing professionals to "veto" people's hopes and dreams

2. Forgetting about what the person will do during the day

3. New psychiatrist in the community changing psycho-active medications without consulting the previous physician

4. Being too cavalier about severing the person's ties with important people in his/her life

5. Putting people with complex behaviors in group settings

6. Viewing a group of institution residents as a "block of people" to place together in a group home

7. Lack of well-planned communication processes among the key players in the relocation

8. Assuming that "institution behaviors" will inevitably continue in the community

9. Relocation Team is not working well together

10. Not enough preparation for things going wrong

11. People with a dual diagnosis of developmental disability and mental illness being viewed as "one or the other"

D. What are our main opportunities?

1. Strong support from the County Executive and other key county officials, as well as from the advocates

2. Down housing market has increased availability of affordable housing

3. To involve more mental health consumers in the planning process and in the support of people moving out

4. To create a guardian support network

5. To have a bigger role for Movin' Out in Milwaukee

6. To involve IRIS

7. To deploy the very effective Hilltop Relocation (downsizing) Team for the closing

8. There's a reliable funding stream for most of these people (Family Care or IRIS)

9. CCS funding could possibly help

10. Some of the initiatives in the proposed budgets of county departments could help in the closing

11. There is strong momentum for the idea that the institution funding will be re-invested in the community

12. To show the community that "community services work"

13. To capitalize on the Mental Health Redesign process

14. To build on successes we've already had in the community

15. To provide training for provider staff

16. To possibly get some funding from Money Follows the Person for certain activities:
    -MCO work before enrollment
    -ARC options counseling
    -training

17. To get benefits counseling for these people through the DBS program

E. What could go wrong?

1. There may not be enough state and county funding to do this right.

2. There may not be enough adequately trained and stable direct services staff to do this right.

3. There may not be enough providers who really understand individualized services and who are committed to serve these people to do this right.

4. The support of the county board may not be solid enough, especially when some things go wrong.

5. The unions could try to block it.

6. There isn't enough safe, affordable, decent housing.

7. MCOs will be too preoccupied with cost, and will sacrifice quality.

8. The players will want to move too fast and the individual planning won't be done thoughtfully.

9. There won't be adequate capacity in the safety net and crisis response system, so law enforcement will be called too often.

10. There won't be adequate psychiatric care.

11. There are too many decision-makers and it's not likely they will agree on the key decisions.

12. A number of the guardians are wary of this, and some of them are pretty vocal.

13. The community in general, or specific neighborhoods, could push back.

14. There won't be an adequate effort to address substance abuse issues.

15. The system isn't very good at supporting people with a dual diagnosis of DD and mental illness.

6. There isn't much capacity in the community service system to serve people with violent behaviors.

F. Group Discussion Topic Recommendations

1. What would a really good guardian support strategy consist of?
    - Guardian education and support to help guardian enroll in LTC.
    - Liaison to connect with reluctant guardians; educate, support and serve as buffer for guardians with the various LTC systems.
    - Establish a guardian network; connect guardians to one-on-one support, guardian panel discussions.
    - Create video and printed stories about individual success stories from previous relocations.
    - Create opportunities for guardians to hear from individuals who have moved out of institutions.
    - Sponsor ongoing educational meetings for guardians that focus on particular subjects. For example: LTC, MCO system/IRIS/Disabilities Resource Center. Compile information on how to participate and advocate in the planning process, types of possible living situations and rights of guardians related to the relocation.
    - Resource table for guardians regarding employment programs, living arrangements and housing.

2. What concrete steps could we take to strengthen community capacity?
    - There is a need for in-network versus out-of-network information.
    - Psychiatric services, shortage of APNP's.

- Support BTLD staff and community positions.
- Shortage of the "right" housing cost-based reimbursement.
- There used to be special funding sources to ensure adequate funding for people coming out of institutions. Could DHS create that again?

3. How could we ensure that residents have input in their autonomy/choice/self-determination?
    - Include them in conversations.
    - Explain relocation.
    - Staff is supportive and understanding.
    - Have a plan for negativity or opposition from others.
    - Allow guided, compassionate discussions.
    - Be mindful of barriers, real or perceived.
    - Validate feelings of fear.
    - Have conversations with MA/DHS to remove barriers.
    - More physician and medical community education is needed to reduce use of prescriptions. (best practices)
    - Respect people as individuals.
    - Know the person.
    - Have physician/medical personnel on the team for discharge planning and overall assessment.
    - Empower people to know and understand how to take their medications.

4. How do we strengthen support for staff at Hilltop and Rehab Central?
    - Transparency.
    - Hold town hall meetings to explain the vision/direction.
    - Conduct focus groups (unit and team based). Allow staff to express thoughts, ideas and concerns. Encourage staff to become engaged. Help them understand their role.
    - Retention bonus.
    - Have staff tour community placements for better understanding.
    - BHD staff should partake in provider job fair; attain lead positions.
    - DQA – License, CBRF (or 1-2 people AFH) training to be provided to staff for possible independent ownership with safeguards to prevent staff from "shopping" for people.
    - Have proactive discussions with Nurses Union.

5. How can we better focus on the person's whole life?
    - Start with where they are.
    - Get a clear picture of who the person is.
    - Ask other people about the person's strengths, desires and wants.
    - A place for a person to expand their life.
    - Connect with life navigator, a peer for linkages.
    - MFP money for consultants.
    - Communicate the importance of relationships, dimensions of belonging.
    - Seek County Executive help to develop dialogue with businesses to explore job opportunities.
    - Involve supportive employment agencies in developing strategies.

- Link to IRIS/TMGs intensive employment initiative.
- Proactive effort to reach out to DVR.
- Explore opportunities with technical colleges, micro-enterprises and self-employment.

6. How can we prevent a revolving door back to the institution and strengthen the county's capacity to prevent and respond appropriately to crises?
    - Do not recreate the institution.
    - Bring crisis services to the person.
    - Improve communication and system collaborations.
    - Leverage federal and other sources of funding.
    - Consider new models for supporting the person in general and for crisis services.
    - Make it clear that county crisis/emergency services are available and utilized by MCO's. Clarify who pays for these services.
    - Empower community provider agencies to develop their own in-house crisis capacity.
    - Set up safeguards to ensure that higher levels of services are provided to the person in their first year. Unit reduced to a level that puts person at risk. Opposite extreme: implied "lifetime" promise of fixed level of support.
    - Install safeguards to prevent an MCO-provider dispute resulting in a person being forced to move out of their home or possibly experience a crisis.
    - "Community supported living" model separates provider from the person being able to stay in his/her home. Distinguish between "home and placement".
    - Develop strategies to safeguard against agencies profiteering (with a high rate) regarding people who are "challenging".

Attachment 7

Long-Term Unit Closures

BEHAVIORAL HEALTH DIVISION
Milwaukee County Department of Health & Human Services

OVERVIEW

In April 2011 the Milwaukee County Board passed a resolution supporting the movement of the adult mental health system to a more community-based model for the delivery of services. In the 2012 County Budget, Milwaukee County Executive Abele made a $3 Million investment to build on the existing capacity to jump start the expansion of community-based services. In February 2013 he announced the intent to close the long-term care rehabilitation units at the Behavioral Health Division which is a continuation of the trend to move the system to a more community-based model. This has been a consistent theme for the last ten years. The closure will mean that residents living at Rehab Hilltop and Rehab Central will be given the opportunity to live in the least restrictive environments and more integrated settings and be offered the chance to become more independent. This community-based model provides smaller settings that can facilitate better person-centered outcomes and success.

WHY WAS THIS DECISION MADE?

Closure of the long-term care units is not a sudden move and it was not a decision based on any incident, a quality of care issue at BHD, or an effort to save money. This move is the next natural progression in a series of downsizing phases over the past 25 years. There is also the Olmstead Law, which states that we should provide people with disabilities the opportunity to live in the most integrated setting possible in the community of their choice. Moving away from institutional care is also a trend on both the state and national levels and Milwaukee County is behind the curve. Discontinuing institutionalized long-term care treatment is also consistent with the goals and objectives of the Milwaukee County Mental Health Redesign. This decision is in the best interest of the people we serve and it is the right thing to do. In addition, new and specialized services will be developed to meet the unique need of many individuals being relocated. Our focus and paramount goal is on providing the healthiest and safest options for all people who will be relocated to community based settings.

WHAT ARE MY OPTIONS?

A team of clinical staff will be put in place and will assess each person to create a specific plan to meet his or her unique individual needs and goals. The individual plans include providing supported living options, treatment and other support services. Individuals and their families/guardians are involved in this process to ensure the best outcomes. Furthermore, individuals relocated to community living settings will be provided adequate support to ensure the plan is the right fit. The ultimate goal is to provide individuals with person-centered, recovery-oriented plans that set them up for success and true community integration.

WHAT SUPPORTS WILL BE IN PLACE TO ENSURE COMMUNITY PLACEMENT IS SUCCESSFUL?

Each individual's relocation plan will be based on a thorough needs assessment and will include a crisis plan. In addition to creating a plan, we are working to increase community capacity to ensure there are several safe options for individuals who might find themselves in a crisis situation. Evidence-based mobile crisis teams are already in place and we are working to bring on three new positions to staff these teams. Evaluations are underway to look into our area's current crisis capacity, including crisis respite sites available, to see if there is a need to ramp-up such programs. Staff is also working with local police to help improve protocols for people with mental illness who are in a crisis situation. Additionally, each individual will be regularly evaluated to make sure that his or her needs are met and services will be adjusted accordingly.

WHAT IS THE TIMEFRAME?

We will make sure to spend the necessary time and effort to ensure that everyone is safely relocated to the community with the proper supports needed for a successful transition. Based on previous closings, conversations with care management organizations and conversations with state officials, we believe this can be done within three years. The oversight that will be provided during the process will ensure that the units will not close if more time is needed.

HAS THIS BEEN DONE IN THE PAST?

BHD has been downsizing and successfully moving clients to the community since the 1990s. Several Hilltop units have been closed in favor of community-based options. A total of 30 large-scale facility closures have been completed across the state since 1999. As examples, closures include:

- Jackson Center (Milwaukee) - 79 individuals relocated in 10 months
- Hearthside Rehab (Milwaukee) - 183 individuals relocated in 24 months
- Northern Wisconsin Center (State Facility) – 152 individuals relocated in 24 months

Large relocations have been completed in a shorter time frame than we are proposing. With this initiative we plan to relocate 116 individuals within 36 months.

BHD will continue to provide for mental health services in Milwaukee County. We are simply changing the service delivery model so that individuals can be served in the community instead of an institutional setting.

Important Contacts

Interim BHD Administrator

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Héctor Colón

Director, Department of

Health & Human Services

TS 5/2013

MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION

Long-term Unit Closures: Communicating with Clients, Guardians & Others

Communication Is Key

As the long-term unit closure process moves forward, many of you will face questions from clients, guardians and each other. We encourage open and honest communication with everyone involved. We want to make sure that accurate information is being passed along and rumors are not offered as fact.

If at any time a client, staff person or guardian has a question and you do not have the answer, please avoid speculating or making a guess. If there are questions you do not feel comfortable answering, please refer them to Rehabilitation Centers Administrator Mike Spitzer or their treatment team.

Here are some common concerns clients and guardians might have and information you can provide:

All of the services available to clients at BHD will continue to be available but those services will be delivered in the community, rather than in an institutional setting.

Closures Timeline

- The plan is to close the long-term care units by 2015
- No one will be "kicked out" of BHD. Housing and supports will be in place before relocation
- Larger relocations have been completed in shorter times frames in Milwaukee County and around the state

Housing Options

- Each guardian will assist in selecting the setting that works best for the client and their needs
- Group homes are not the only option. People from our long-term care units may be placed in group homes, adult family homes, supportive apartments, and even independent apartments with the proper support to ensure success
- If supports needed do not currently exist in the community, they will be developed
- The safety of both the individual and the community will be priorities throughout this process

Backup Plans/Re-Admissions

- No one will be denied services at BHD
- By law, people cannot be readmitted to the long-term care units once the closure process begins
- Each client's relocation plan includes crisis strategies that detail treatment options and the steps that will be taken if an individual experiences a crisis
- Patients will be served through community-based options such as crisis mobile team, crisis respite, and outpatient clinics

Preparation

- Clients will begin the transition process while they are at BHD
- Resources such as the model apartment are being used to prepare individuals for relocation
- Individuals and their guardians will be able to visit and spend time at community housing options prior to discharge

Attachment 8

2014 Community Investments

January 1, 2014

Expand BHD's partnership with the Milwaukee Police Department for the **Crisis Mobile Team**, by adding one clinican to work directly with law enforcement in serving as first responders to ED calls with the goal of reducing involuntary Emergency Detentions	$	115,327
Start a **Peer Run Drop in Center** that would primarily operate in the evenings and on weekends and increase the existing peer services contracts	$	343,000
Add **quality assurance staff** - which includes one position dedicated to Crisis Services in January and another position starting in July.	$	121,832
Continue implementing the **Community Recovery Services (CRS)** program, which is a co-participation benefit for individuals with a severe and persistent mental illness that connects clients to necessary recovery services, such as supported employment and housing, to promote independence. This includes the creation of three positions.	$	275,000
Continue the **expanded case management**, including additional TCM slots.	$	125,000
Maintain funding for **Families Moving Forward**, focusing on the African American community	$	150,000
Invest in a new partnership with the **UCC/16th street clinic** to focus on the Latino community	$	45,000
Add resources specifically for clients moving out of **Rehab-Centers Central**, including 20 additional CSP slots, more group home beds and other additional supports such as adult family homes and other needed services.	$	597,162
Add **ACT/Integrated Dual Disorder Treatment (IDDT)** models, which are evidence based, to the existing CSP programs to improve and expand services for clients enrolled in that program. disorder.	$	389,200
Include a **cost of living adjustment** for all CSP providers that have been level funded since 2000. BHD will continue to review and consider COLA increases for other service areas in future years.	$	560,662

July 1, 2014

Open a **Southside Access Clinic** in July 2014 to help meet increased demand and also to address community needs by having a second location for services that individuals can more easily access	$	250,000
Apply for funds to implement **Comprehensive Community Services (CCS),** which is a Medicaid psychosocial rehabilitation benefit.	$	-

Phased in over 2014

In partnership with the Division of Housing, BHD plans to offer a new **housing pilot program** specifically aimed at AODA clients, to provide a safe living environment coupled with Targeted Case Management (TCM) services for individuals who are in the early stages of recovery from a substance use disorder.	$ 100,000
BHD, in coordination with the Department on Aging and the Disabilities Services Division, will work to create a **pilot program to address the County's responsibility under Chapter 55** of the Wisconsin Statutes in the Milwaukee community. The goal is to create a 24/7 crisis intervention team to assess the behavioral health, medical and cognitive needs of elderly individuals in Milwaukee County	$ 200,000
The Housing Division's **Pathways To Permanent Housing** program is funded on an annual basis and provides transitional housing including intensive care management and the presence of a robust level of peer specialist resources and expertise in 2014.In the 2014 Budget, $276,250 is transferred from BHD to Housing and an additional $70,000 in increased tax levy is invested.	$ 70,000
The Housing Division plans to implement a new initiative to create **20 permanent supportive housing scattered site units** to serve BHD consumers. The Housing Division will work with existing landlords to secure these units and the service model will include peer specialists to supplement the work of case managers.	$ 200,000
Establish a **Community Consultation Team** specifically for individuals dually diagnosed with both a developmental disability and mental health issue. This includes the creation/transfer of 5 positions throughout 2014.	$ 247,452
BHD and DSD will develop a **Crisis Resource Center** that will be available to individuals with Intellectual/Developmental Disabilities and a co-occurring mental illness. The primary goal of this program is to provide intensive support to assist an individual in acquiring the necessary skills to maintain or return to community living following	$ 250,000

TOTAL INVESTMENT IN 2014 **$ 4,039,635**

2014 Requested Budget Financial Plan

Units Closed Effective Dates	**Rehab Central One Unit - 24 Beds 7/1/2014**	**Rehab Center - Hilltop Two Units - 48 Beds 5/1/2014 & 11/1/2014**	**Operations Positions - BHD 1/1/2014**	**TOTAL**
Reductions [1]:				
Revenue	$ (437,722)	$ (1,786,576)		
Personnel	$ (721,914)	$ (1,844,438)		
Direct Costs [2]	$ (307,175)	$ (710,740)		
Overhead			$ (1,349,625)	
Total Reductions	$ (591,367)	$ (768,602)	$ (1,349,625)	**$ (2,709,594)**
Total FTE's (annual)	(20)	(67)	(19)	**(106)**
FTE Summary:				
Management	-	(1.0)	(5)	**(6)**
Professional	(10.5)	(20.5)	(5)	**(36)**
Staff	(9.5)	(45.5)	(9)	**(64)**

[1] Reductions are for a partial year depending on closure dates.

[2] Direct Costs include dietary, pharmacy, security and other expenditures

Revenue reduction is offset by a one time state payment of $12,000 per patient successfully placed.

Attachment 10

Financial Impact by Bed Type & Cost of Various Community Services **6/24/2013**

Center for Independence & Development (Hilltop)

	client type per DAY			
	T19	**SSI**	**Family Care**	**Private**
Funding	$ 257	$ 257	$ 257	$0
Cost per day	$ (586)	$ (586)	$ (586)	$ (586)
Net (Tax Levy)*	**$ (329)**	**$ (329)**	**$ (329)**	**$ (586)**

Rehab Central

	client type per DAY			
	T19	**SSI**	**Family Care**	**Private**
Funding	$ 113	$ 113	$ 113	$0
Cost per day	$ (518)	$ (518)	$ (518)	$ (518)
Net (Tax Levy)*	**$ (405)**	**$ (405)**	**$ (405)**	**$ (518)**

** Net (Tax Levy) includes legacy costs and crosscharges.*

Cost of Various Community Services

Array of Services		**Average Cost**		**Funding Available**
Housing				
	Independent Apartment	variable		
	Supervised Apartment	variable		CRS, CCS
	Residential Care Apartment Complexes	variable		CRS, CCS
	AFH (Care and Maintenance)	$ 101	/day	COP, CRS, CCS
	AFH (Room and Board)	$ 22	/day	SSI
	CBRF (Care and Maintenance)	$ 87	/day	COP, CRS, CCS
	CBRF (Room and Board)	$ 23	/day	SSI
Case Management				
	TCM	$ 2,797	/year	Medicaid 60/40
CRS				
	Community Living Supportive Services Per Diem	$ 125	/day	Medicaid carve out
	Community Living Supportive Services Hourly	$ 20	/hour	Medicaid carve out
	Supported Employment Hourly	$ 39	/hour	Medicaid carve out
	Peer Support Hourly	$ 46	/hour	Medicaid carve out
CCS		$ 17	/day	Medicaid carve out

Array of Services - Assessment, Recovery Planning, Service Facilitation, Communication and Interpersonal Skills, Community Skills, Diagnostic Evaluations and Specialized Assessments, Employment Related Skill Training, Medication Mgmt, Physical Health and Monitoring, Psychoeducation, Psychosocial Rehabilitative Residential Supports, Psychotherapy, Recovery Education and Illness Mgmt, Substance Abuse Treatment