Waukesha County Board of Supervisors

Minutes of the Health & Human Services Committee and Board
Thursday, November 10, 2022

Chair Wolff called the meeting to order at 1:00 p.m.

Committee Members Present: Supervisors Peter Wolff, Jeremy Walz, Jennifer Grant, Larry Bangs, Tom Schellinger and Matthew Weil.

Board Members Present: County Board Supervisors Larry Nelson, Christine Howard, Joel Gaughan and community members Mary Baer, Mary Berg, Mike Goldstone, Robert Menefee, Jr. **Absent:** Vicki Dallmann-Papke, Christine Beck

Also Present: Legislative Policy Advisor Sarah Fraley, Chief of Staff Sarah Spaeth, Administrative Specialist Barbara Hollander, Health & Human Services Director Elizabeth Aldred, Veterans Services Officer Dan Driscoll, ADRC Manager Mary Smith, Citizens Eric Holmes, Pat Craney and Fred VanderWal.

Public Comment
None

Executive Committee Report from October 24th
Fraley reported that the Executive Committee reviewed and approved two Sale Values for County-owned Foreclosure Properties. The Committee also conducted interviews for the District 22 Vacancy. The appointment of Gary Szpara will be voted on at the November 22nd Board meeting.

Legislative Updates
Fraley shared that post-election the leadership meetings are occurring in both parties, and later this year she will provide an overview of leadership, committees, and an overall landscape.

Annual Report of the Veterans Services Division
Driscoll provided an overview of the Veterans Services Division. The priorities of Veterans Services are VA health care access, veteran pension/survivor pension, veteran compensation for VA payments, education benefits (GI bill) and burial benefits and records.

Expenditures by the Veterans Service Commission in 2022 totaled $9,268.51 for Veterans Relief. The 2022 budget of $412,083 resulted in a return of $555,248,183 federal and state dollars to Waukesha County veterans and their dependents. These dollars were used for VA home loans, medical expenditures, compensation/pension, education benefits and insurance and indemnities.

Accomplishments this year include:
- Gained $300,000 retroactive payment for Waukesha surviving spouse
- Reopened cancer claim for Afghanistan veteran and successfully appealed

- Represented Menomonee Falls and Oconomowoc veterans to Board of Veteran Appeals in Washington, DC
- Appealed and gained waiver of $1800 VA hospital debt for Waukesha Korean war veteran

Projects for improvement include a Veterans Services Division restructure, Veteran Benefits 3.0, NACVSO training, VSO Outreach, burial records project and vet center enhancement.

Other accomplishments include purchasing a hospital bed, dental care, emergency housing, transportation to VA medical exams, payment of surviving spouse ambulance costs and VA debt. In summary, $1,347 was returned to Waukesha County for every $1 budgeted to run Veterans Services.

Transportation Program Updates

Smith presented on the challenges that the Department has been facing with providing cost-effective transportation for Waukesha County residents. The accessible van ridership contract, which assists people with rides to medical appointments, grocery shopping etc., went out for bid and the county only received one bid that came in double what was budgeted. The county is working with purchasing to re-issue the RFP and explore alternatives. Smith also shared that they had a consultant complete a study and provide a report that evaluates the transportation programs offered by the Aging and Disability Resource Center (ADRC) and provides alternatives for more effective service delivery.

Review of the Accomplishments during the 2020-2022 HHS Strategic Plan

Aldred presented an overview of the 2020-2022 Strategic Plan and highlighted HHS's accomplishments.

Customer Service:
Increased distribution of the Customer Service Satisfaction survey, created a standard process for survey data review and dissemination and offered customer service training for staff. Created a Diversity, Equity and Inclusion (DEI) checklist and provided training in its use to review HHS marketing materials.

Finance:
Created an informational Guide to Obtaining Benefits video displayed in outpatient clinic and economic support waiting areas, a pilot program to screen outpatient clinic admissions for insurance status and age/disability status, offered eligible clients an insurance resource packet that garnered success in enrolling individuals into Badger Care, developed standardized auditing processes regarding billing and coding that achieve meaningful increases in reimbursement.

Health and Safety:
Conducted a pilot program to screen outpatient clinic admissions for homelessness risk and offering a housing resource list as relevant, recommended to not implement the pilot program across HHS due to lack of available community resources. Defined trauma informed care as it relates to HHS, conducted environmental scan to establish baseline for existing trauma informed practices at HHS, required HHS workforce members to complete Trauma-Informed Care (TIC) training.

Quality:
Identified the rules, regulations and statutes each division/unit is bound by relative to interdepartmental sharing of participant information/PHI, mapped processes for sharing information, created guidebook for all divisions to explain how PHI can be shared across units.

Team:
Revised the formats of the "stay survey" and "exit survey" to gather data of employees who stayed/existed, developed structure for data collection and analysis of workforce, developed a DEI presentation protocol for departmental use when identifying trainers, recommended key components to support a DEI employee onboarding training.

Health and Human Services Committee Agenda Items

Approve Minutes of October 20th
MOTION: Walz moved, second by Bangs to approve the minutes of October 20th. Motion carried 6-0

Next Meeting Date
- December 8th

Future Agenda Item
Fentanyl and Opioid update

MOTION: Bangs moved, second by Walz to adjourn the committee meeting at 2:32 p.m. Motion carried 6-0

HHS Board Agenda Items

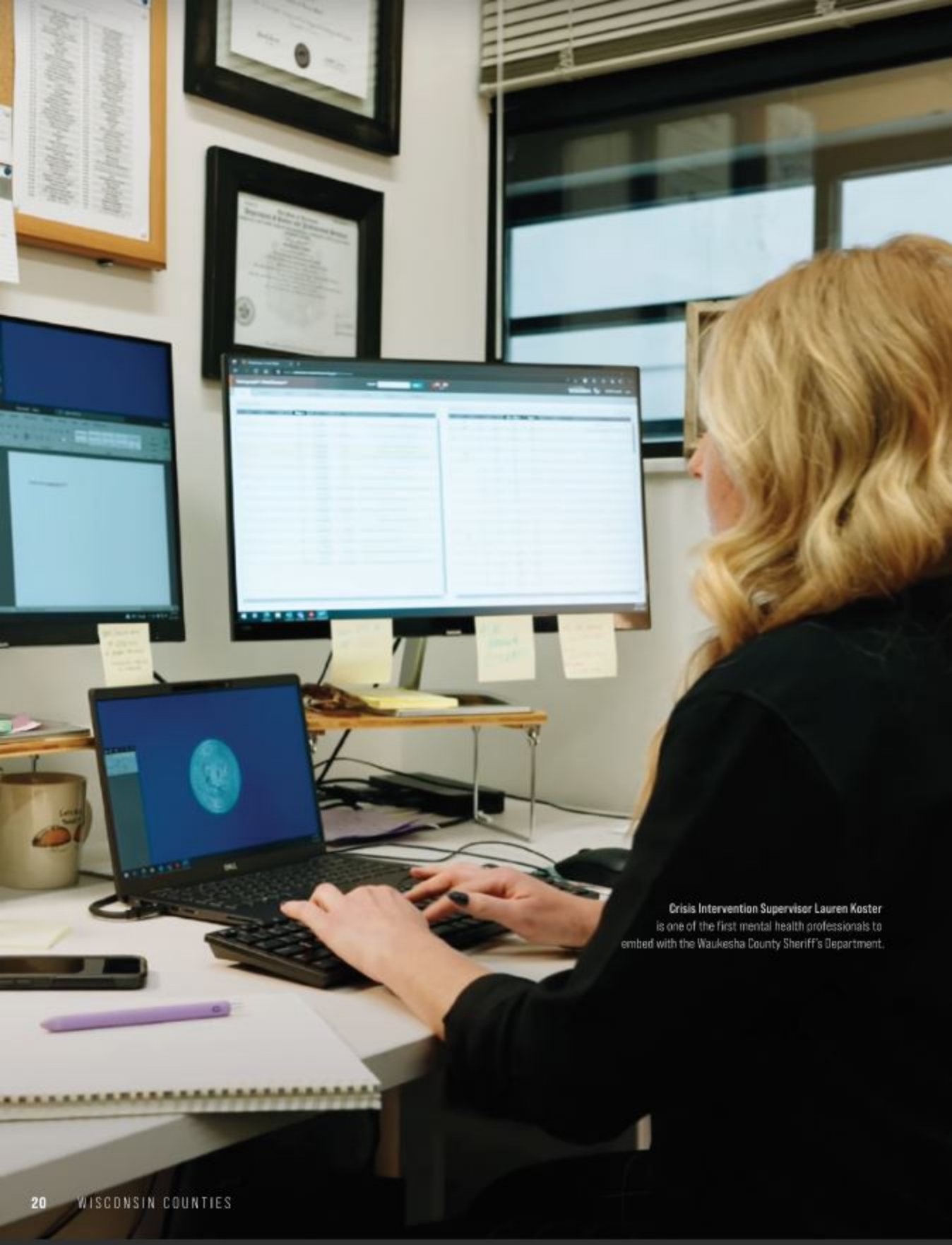
Approve Annual Report of the Veterans Services Division
MOTION: Howard moved, second by Baer to approve the Annual Report of the Veterans Services Division. Motion carried 7-0

Approve Minutes of October 13th
MOTION: Baer moved, second by Gaughan to approve the minutes of October 13th. Motion carried 7-0

MOTION: Menefee moved, second by Goldstone to adjourn the board meeting at 2:53 p.m. Motion carried 7-0

Respectfully submitted,

Matthew E. Weil
Secretary – Health and Human Services Committee



Crisis Intervention Supervisor Lauren Koster is one of the first mental health professionals to embed with the Waukesha County Sheriff's Department.

The Embedded Mental Health Professional

A Model for the County

by Jennifer Wrucke, Coordinator for Crisis Intervention Services, Waukesha County Department of Health and Human Services, Clinical Services

Over the past five years, the number of calls received by the Waukesha County Department of Health and Human Services Crisis Intervention Team increased by 50%, with the department projected to respond to nearly 7,000 calls in 2022.

Law enforcement frequently serves as first responders to individuals who are experiencing a mental health crisis. In 2021, the Waukesha County Sheriff's Department responded to almost 800 calls for service that required the assistance of a county crisis clinician.

Given the frequency of interactions between the crisis intervention team and the sheriff's department, they teamed up to create an embedded mental health professional program. The program addresses growing problems related to the significant amount of time law enforcement spends on mental health calls and the disproportionate involvement of the criminal justice system for persons with serious mental health issues.

Summary of the model

As masters-level clinicians based out of the sheriff's office, the two embedded mental health professionals hear 911 calls over the police radio, view calls for service on the dispatch system, and are available to assist deputies. They also self-dispatch when a call sounds like it may be appropriate for a mental health response. The mental health professionals travel separately from law enforcement and walk onto the scene once it has been deemed secure. If the situation does not require continued law enforcement presence after gathering initial information, they remain on the scene working with the person while the deputy is free to leave.

Jennifer Wrucke

How the program started

Funding for the pilot program came from a state Department of Health Services grant. The first embedded mental health professional began to take calls in November 2021. With data tracking practices in place, the program proved to be successful after only two months. As the grant period was concluding, the county reallocated resources to continue the program and, with the assistance of American Rescue Plan Act dollars, hired a second embedded mental health professional in September 2022.

Continued on page 22

Continued from page 21

Measurable successes

In addition to nearly 70 clinical interventions with individuals, the program produced several remarkable successes, including:

- An average response time of 22 minutes for an embedded professional, a more than 50% decrease compared to a non-embedded response.
- On 38% of calls, the embedded professional cleared deputies from the scene after the initial investigation revealed the situation no longer required a law enforcement presence.

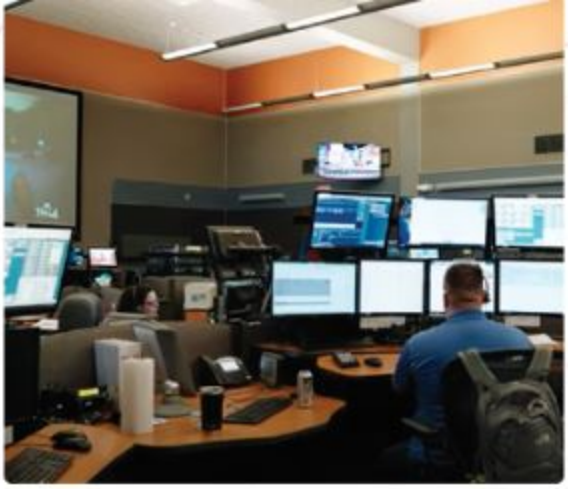
Impact to the larger mental health response system

The embedded program showed that a timelier response to a mental health crisis can have a significant impact on the outcome. The right person responding at the right time not only saves time, it means less use of high-cost emergency response systems such as continued police contact, jail admissions, emergency room admissions and involuntary psychiatric hospitalizations.

Building off the successes of the embedded program, a comparable collaboration is being initiated directly between the county crisis intervention team and the city of Waukesha Police Department, the second largest law enforcement agency in the county.

As county leadership recognized the importance of improving the mental health response for all members of the community, regardless of the size of municipality, they looked for ways to collaborate with more law enforcement agencies. Because the 911 Waukesha County Communications is the public safety dispatch center for most of the county's law enforcement agencies and the true "front door" of the emergency response system, it was an obvious partner.

The county is creating a model to embed a staff member at the 911 center, so the crisis team will have real-time knowledge about calls for service that may require a mental health response. Like the professional embedded with law enforcement, the embedded 911 crisis staff member will monitor calls to initiate and expedite a mobile response. This position has the potential to lead to a call-diversion model that would offer an option to dispatch a team of mental health professionals to low-risk, non-violent calls in place of a law enforcement response. The position is expected to be filled by January 2023.



The county is planning to embed a mental health professional at the **911 Waukesha County Communications Center** in the near future, ensuring real-time mental health response to appropriate calls.

Summary

While the embedded mental health professional program was not the first law enforcement/crisis program collaboration, it was the first of its kind in Waukesha County and is now leading the way for improved mental health response throughout the county.

The program has energized county leadership to consider cross-departmental and cross-organizational collaborations that were once unimagined. It has paved the way for increased partnerships that will have remarkable impact on the health and safety of the public and reduce high costs associated with emergency response systems. It is an exceptional example of how government agencies can seek creative solutions while taking the opportunity to utilize existing resources differently for maximum impact. ■

Jennifer Wrucke is the coordinator for crisis intervention services in the Waukesha County Department of Health and Human Services, Clinical Services. She has worked in crisis intervention programming since 2008. Wrucke currently oversees 24/7 crisis intervention, community-based crisis stabilization and Chapter 51 court services.

WATCH a short video about the Waukesha County Embedded Mental Health Program at: **bit.ly/Waukesha_Embedded**

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, *Executive Director*
c/o Badger Bay Management Company

WCHSA Budget Proposals for the 2023-25 State Budget Process

Budget Theme: Help People When They Need Help

Many Wisconsinites face threats to their safety and well being due to their low income, age or disability. These vulnerable populations depend on county human service departments to provide services and benefits to support them living independently in the community. When vulnerable persons need help, they need help quickly and in a manner that is respectful of their individual dignity. If services are not provided quickly when requests for help are made, it can have traumatic impacts on the well-being of vulnerable persons and sometimes tragic consequences for the community. Vulnerable persons deserve better. To act quickly, human service departments need resources to protect vulnerable persons, prevent tragedy and promote safety.

Protecting vulnerable persons by helping them when they need help is a vision that everyone can believe in.

Achieving that vision requires investments in human service programs services that will allow county human service departments to protect vulnerable populations and offer help when they need it. The Wisconsin County Human Services Association recommends the following investments for the 2023-25 state budget process. See the WCHSA budget paper for each of the proposals.

- Adult protective services – Provide $5 to $10 million of funds to expand county APS capacity to serve the growing population of elderly and persons with disabilities who need protective services. Ensure all counties have a minimum APS allocation. Create a statewide registry for long term care placements. Increase Department of Health Services capacity to provide APS training and technical assistance.

- Aging and disability resource centers (ADRCs) – Provide $5 to $10 million to support core operations of ADRCs to serve the growing population of elderly and persons with disabilities. Provide additional funds for specific ADRC services to ensure services are available at all ADRCs statewide. Expand the role of dementia specialist staff to give ADRCs more flexibility in how those staff can be used.

- Crisis intervention services – Provide $21 million for full state funding of Medicaid reimbursement to counties for crisis services. Eliminate the maintenance of effort requirement created by 2019 Wis. Act 9. Exempt crisis services from the WIMCR process. Create regional crisis stabilization facilities to provide more options for where persons in crisis can be taken for urgent care and observation.

- Community support program (CSP) – Provide at least $14 million for full state funding of Medicaid reimbursement to counties for CSP services. Exempt CSP services from the WIMCR process. Modify the CSP administrative rule DHS 63 to be more consistent with Assertive Community Treatment model.

- Human service workforce - Provide $5 million to support human service workforce grants to counties to recruit and retain human service workers. Establish additional federally-funded student stipend programs to support students getting human service degrees. Provide additional resources to the Department of Safety and Professional Services to improve licensing of human service occupations.

- Income maintenance administration – Provide up to $5 million GPR plus federal matching funds to cover county costs for current FoodShare and Medicaid caseloads. Provide additional funds if Medicaid expansion is approved. Provide $750,000 for income maintenance fraud prevention and investigation activities, as proposed by the Department of Health Services.

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Adult Protective Services

Program Area: Long Term Support

Budget Priority: Protect Vulnerable Populations.

Background:

County Adult Protective Services (APS) agencies are tasked with aiding Elder Adults and Adults-at-Risk who have been abused, neglected, or exploited. APS investigates allegations of neglect, abuse, sexual abuse or financial exploitation of vulnerable adults; a vulnerable adult is a person 18 and older who has physical or mental condition that substantially impairs his or her ability to care for their needs. Statutorily required protective services include but are not limited to, outreach, identification of individuals in need of services, counseling and referral for services, social services, case management, legal counseling, guardianship referral, and diagnostic evaluation. If vulnerable persons cannot remain safely in their own homes, counties are responsible for finding placements.

Wisconsin's counties and states across the U.S. continue to experience the effects of an increasing aging population, increased social isolation, lack of caregivers, and the need for additional resources such as additional health care, dementia care, and locations for aging seniors who can no longer care for themselves. County APS agencies and the Wisconsin Department of Health Services (DHS) have felt the strain of needing additional resources due to the lack of safe locations for dementia or disabled seniors, the lack of adequate funding to assist seniors and people with disabilities in need of protection, and the lack of caregivers for people with disabilities.

In 2010, the number of reported APS incidents for persons 60 and older was 5,799 and in 2021 the number of incidents rose 84% to 10,712. The top two categories for elder abuse are self-neglect and financial exploitation. In the same time frame, the number of APS incidents for adults with disabilities rose 38%.

Between 2015 and 2040, the population ages 65 and older will grow by 640,000 people, an increase of 72%. According to DHS in 2022, it is estimated that by 2040, 18 counties in Wisconsin are projected to have at least 33% of their total population ages 65 and older. Three of these counties are estimated to reach 40%.

In Wisconsin, the population is rapidly aging in rural areas and is most pronounced in the northern half of the state. Northern counties face tremendous challenges for their APS programs with greater than average growth in their aging population and tight labor markets creating workforce shortages of persons to provide care.

Along with population growth, there are projected increases in the prevalence of dementia. According to DHS, in 2015, it was estimated that 115,000 persons had dementia. By 2040, that number is expected to increase to 242,000 persons. In addition to the aging and dementia populations, APS also serves young adults with disabilities who have aged out of children's programs.

The increasing APS population has resulted in greater difficulty in finding placements for persons who need long term care. Often facilities, such as nursing homes, assisted living or Community Based Residential Facilities are unwilling to take persons with cognitive limitations if the persons also may act out with behavior issues. This has resulted in clients with cognition/dementia needs left waiting for a place to reside, creating ethical and dangerous situations for police officers, hospitals, health care facilities, and other care providers who are unable to safely care for these at-risk persons. Counties report in some instances contacting over 40 facilities that have stated they will not accept an elder at risk person.

Currently, in Wisconsin, 85% of individuals with disabilities who require direct care for some or all of their support cannot find paid help and 40% of the people are receiving care from unpaid caregivers. The lack of caregivers paid and unpaid results in additional calls of abuse and neglect for people with disabilities DHS-Adult Protective Services Division's annual report for 2021 showed 2,847 reports of abuse and neglect for people with disabilities which is 21% of all calls to county APS. The top two categories are self-neglect and neglect by others in reports for people with disabilities.

Counties currently receive an allocation of $4.9 million for APS services. Counties also receive approximately $2 million for elder abuse direct support (EADS) services, although those funds cannot be used for APS investigations. According to data DHS reports for the Social Services Block Grant, counties spent an estimated $30.6 million on APS in FFY 2021. Based on that estimate, counties provide over 75% of the funding for APS, using Community Aids or county levy funds. The state APS allocation to individual counties can be small, under $20,000 for many counties, that is not sufficient to support county APS staff. The state APS allocation to counties has not been increased since 2006.

Providing increased funding, support and resources, such as safe placement locations for elder at-risk persons, as well as continued and increased collaboration between DHS and counties related to these issues is imperative for the safety and well-being of some of our most vulnerable populations.

CURRENT STATUS

State GPR funding to counties to investigate reports of abuse and neglect for people with disabilities and older adults has remained static at under $5 million while the numbers of elders and adults at risk and in need of protection has risen across every county in Wisconsin.

REQUESTED ACTION

1. Provide increased GPR funding of $5 to $10 million GPR annually to counties for AP. While the increase is large in comparison with the amount of current state funding, counties would still bear the largest share of APS costs.
    - A $5 million increase would bring the state share to about 1/3 of total APS funding.
    - A $10 million increase would bring the state share to about 1/2 of total APS funding.

    If counties were provided a minimum allocation of $50,000, this option would affect 46 counties and require $1.16 million of additional funding. A minimum allocation could be included as part of an overall increase.

2. Develop a statewide central registry of long-term care placement resources that counties can use, rather than each county maintaining its own resource list. Funds could be provided to DHS to contract for a vendor to develop the statewide registry.

3. Provide additional funding to DHS to develop a statewide training program for county APS staff and provide additional technical assistance to county agencies.

References

- Legislative Fiscal Bureau 4/9/21 email to Rep. Rozar

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Aging and Disability Resource Center (ADRC) Funding

Program Area:

Budget Priority: Protect Vulnerable Populations

BACKGROUND

Aging and Disability Resource Centers (ADRCs) are one-stop shops designed to provide services to individuals who need, or expect to need, long-term care services, as well as their families. ADRC services include providing information and assistance, benefits counseling, coordinating short-term services, conducting functional screens, and enrollment processing and counseling. There are currently 34 single-county ADRCs, 12 multi-county/tribal ADRCs, and seven tribal Aging and Disability Resource Specialists (ADRS) that work with an ADRC.

ADRCs serve the fastest growing demographic of our state's population; yet the funding methodology for ADRCs has not been revised in more than a decade. The original funding methodology was based on several factors that were appropriate for the original ADRC pilots and the eventual expansion of ADRCs statewide. ADRCs were funded in three waves, with each wave funded differently and those funding differences have continued. It is now evident that the funding methodology needs revision in order to create a more equitable distribution of funds across the state. It is also clear that additional funding is required to allow ADRCs to effectively meet their mission.

The Office for Resource Center Development (ORCD) within the Department of Health Services (DHS) established a stakeholder advisory group to begin the work necessary to revise the funding methodology for ADRCs. Multiple issues were identified and addressed by the stakeholder advisory group to develop a reliable, accurate, equitable, and flexible funding formula for ADRCs. These issues include generational differences, health equity, projected population growth, and cost of living adjustments.

To implement the new ADRC allocation formula recommended by the stakeholder advisory group, an additional investment of $32.37 million state GPR funding is needed. This additional investment is needed to equalize the services provided by ADRCs throughout the state.

The stakeholder advisory group also recommended $25 million in additional funding to add critical services for required ADRC operations, including:

- Expand Dementia Care Specialist Funding Statewide: $3,320,000
- Fully Fund Elderly Benefit Specialists Statewide: $2,300,000
- Expand Caregiver Support and Programs: $3,600,000
- Expand Health Promotion Services: $6,240,000
- Expand Care Transition Services: $6,240,000
- Fund Aging and Disability Resources in Tribes: $1,180,000
- Fully Fund Aging and Disability Resource Support Systems: $2,650,000

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CURRENT STATUS

The current funding allocation results in an inconsistent approach to funding the state-contracted services every ADRC is required to perform. The allocations for individual ADRCs have not increased since 2006. The current funding allocation for ADRCs is based on cost estimates that are more than 10 years out of date and treats ADRCs differently depending on when they began operations

ADRC funding must be increased to keep pace with the state's increasing aging population – in 2010, Wisconsin had 777,314 residents aged 65 and over; in 2040, this population is expected to grow to 1,535,365

The funding allocation also does not account for all of the required and recommended services contained in the Scope of Services for the ADRC contract. For example, the state funds services for some ADRCs, such as dementia care specialists, but not for others.

REQUESTED ACTION:

1. Provide additional funding to support ADRC operations to keep pace with the ADRC caseload and equalize the funding for ADRCs. Full funding and equalization would require an additional $32.37 million GPR. WCHSA recommends that $5 to $10 million GPR be provided in the 2023-25 biennium toward the $32.37 million long term goal.

2. Seek additional GPR funding to expand specific ADRC services.

3. Expand the role of dementia specialist staff to give ADRCs more flexibility in how those staff can be used.

References

- ADRC Reinvestment Workgroup Funding Recommendations

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Mental Health – Crisis Intervention Services

Program Area: Behavioral Health

Budget Priority: Protect Vulnerable Populations

BACKGROUND

State law designates counties with the primary responsibility for the well-being, treatment, and care of persons with mental illness and substance use disorders. Counties must directly provide or contract with providers to deliver mental health and substance abuse services in the least restrictive environment appropriate for an individual's needs.

One of the required functions is every county must have an emergency mental health services program to serve persons in crisis situations. At a minimum, emergency programs must offer 24-hour crisis telephone service and 24-hour in-person response on an on-call basis. Programs may also operate crisis stabilization facilities to take persons to facilities where they can be observed and treated to resolve the crisis. If after providing crisis intervention services it is not safe for persons to return home, counties may do emergency detentions to have persons hospitalized.

Counties must serve all persons in crisis, regardless of whether the persons have Medicaid or private insurance coverage to pay for the cost of crisis intervention services. The percentage varies across counties, but in general about 75% of persons receiving crisis intervention services are Medicaid eligible. Counties can receive Medicaid reimbursement for persons who are Medicaid eligible, although counties have historically received only the federal portion (about 60%) of the Medicaid reimbursement. For the other 25% of persons served, counties must pay the full cost unless private insurance can be billed.

According to CY 2020 county expenditure data provided by the Department of Health Services (DHS), counties spent about $81 million on crisis intervention services with $60 million being Medicaid reimbursable. The county cost for crisis intervention services includes the $21 million spent on persons who are not Medicaid eligible along with the approximate 40% non-federal share or $24 million of the $60 million of Medicaid reimbursable services. Thus counties paid over half ($45 million) of the total cost of crisis intervention services in 2019 out of county tax levy funds.

In order to receive Medicaid reimbursement, county emergency mental health services programs must be certified under DHS Administrative Rule 34 and have additional features such as a mobile crisis team for on-site in person response, walk-in services, and short-term voluntary or involuntary hospital care (emergency detention). Sixty-five (65) of the 72 counties are DHS 34 certified. The seven non-certified counties receive no Medicaid reimbursement.

Certification is difficult for the seven counties, which are small rural counties. The counties must provide crisis intervention services and have the required minimum emergency service elements. The counties would have to invest additional tax levy to enhance their programs to meet the DHS 34 certification requirements before earning any Medicaid reimbursement. State tax levy limits make it impossible for these counties to make the upfront investment required to become DHS 34 certified.

For Medicaid eligible persons in certified counties, prior to 2020 counties paid the non-federal match share (about 40%) and received only the federal Medicaid reimbursement. 2019 Wis. Act 9 required the state to pay a portion of the non-federal share for certified counties, provided certified counties participate in shared regional services and meet a maintenance of effort (MOE) requirement. Depending on the local situation, certified counties may currently receive state GPR funding for some of their crisis intervention services.

The regional requirement was automatically met for counties that have multi-county community program (s.51.42) departments (currently Forest, Grant, Iowa, Langlade, Lincoln, Marathon, Oneida and Vilas) and counties with more than 350,000 residents (currently Dane, Milwaukee,and Waukesha). Other counties with a single-county human services or community program department can meet the regional requirement by participating in regional 24-hour crisis call centers and sharing services.

For counties that meet the regional requirement, Act 9 allows DHS to pay the full non-federal share of costs for Medicaid-eligible crisis intervention services after thecounty meets the MOE amount. The MOE amount requirement is fixed at 75% of the average annual amount (baseline) counties spent on crisis intervention services over calendar years 2016 through 2018.

> Example: A certified county has a baseline of $1.0 million of average annual crisis intervention expenses for Medicaid eligible persons. The county's MOE is $750,000. For the first $750,000 of crisis intervention services the county receives only the 60% federal portion of Medicaid reimbursement. For expenses above the MOE., the county receives 100% Medicaid reimbursement including both the 60% federal share and 40% state GPR share.

The Act 9 law change is slowing increasing the state GPR share of total crisis intervention costs. The impact varies widely by county however because crisis intervention spending can fluctuate from year to year. Counties with high baseline spending years have high MOE caps that limit how much GPR the county can receive. Counties with low baseline spending years have low MOE caps and may receive a lot of GPR. Due to local circumstances some counties find it difficult to enter into partnerships or have service providers expand their service territories to become part of a region. Act 9 had no impact on the seven non-certified counties, although should those counties become certified their Act 9 MOE would be zero so the counties would receive 100% Medicaid reimbursement for all of their Medicaid eligible crisis intervention services. The MOE requirement created by Act 9 has an inequitable impact on counties.

State funding sources available to counties that can be used as match for crisis intervention services include Community Aids Basic County Allocation and Community Mental Health Allocation. While counties also receive federal Mental Health Block Grant funds, those funds cannot be used as match for crisis intervention. The Community Aids funding has not kept pace over the years with increased county costs for services, resulting in counties bearing a disproportionate share of crisis intervention service costs from county tax levy.

Counties are limited in their capacity to use tax levy revenue due to state levy limits, so the lack of Community Aids increases combined with strict property tax controls makes it difficult for counties to maintain their crisis intervention services. While Act 9 law change providing partial state GPR funding for crisis intervention services was a step in the right direction, the additional state GPR funding has yet to have a substantial impact on reducing the disproportionate county share.

The reliance on county tax levy to fund crisis intervention services also results in variation across counties in the specific types of crisis services available. Counties must provide services within the constraints of their local budget and the landscape and population of their unique county or region. Service arrangements that make sense in large metropolitan areas may not work in rural or suburban communities. Full state Medicaid funding for crisis intervention services would make services available more consistently statewide and provide a greater incentive for the seven non-certified counties to become DHS 34 certified.

Compounding the Medicaid reimbursement complexities due to DHS 34 certification and Act 9 MOE requirement, an additional complication for counties is the WIMCR process used by DHS for Medicaid claiming of county costs. When counties bill Medicaid for crisis intervention services, counties get paid an initial claim for the service. The initial claim typically covers only part of the total cost of providing the service. The WIMCR process allows counties to submit additional costs to DHS for inclusion in the federal Medicaid claim through cost settlement reports. There is a long delay however because the costs settlement reports are done after the year closes and it is a lengthy process to collect the cost settlement information and DHS submit the additional federal Medicaid claim. DHS charges counties a 17% "tax" on cost settlement claims to cover the cost of the WIMCR vendor contract and generate revenue for the Medicaid trust fund. Between the long delay in reimbursement and the 17% tax, it is difficult for counties to build WIMCR revenue into their crisis intervention program budgets.

Implementing evidence-based practices is essential to providing effective crisis intervention services. Using evidence-based practices is a significant commitment for counties to invest staff time in training to become proficient in the new practice and maintain their fidelity to the practice over time. Providing full state funding for crisis intervention services will assist counties to invest in evidence-based practices and improve the skill level of their crisis staff.

In addition to the crisis intervention costs to county human service departments, counties and municipalities also incur law enforcement costs to transport and provide security for persons in a crisis. The limited state funding for crisis intervention services makes it difficult for counties to implement new evidence-based services, such as mobile crisis workers that could meet law enforcement officers in the field for crisis calls, that would reduce the need for law enforcement involvement and provide a more trauma-informed response to crisis situations.

Full state Medicaid funding of crisis intervention services will give county human service departments more capacity to implement crisis services that will support law enforcement officers in the field and reduce the traumatic impacts on persons to intervene in their crisis. When persons are in crisis, having their maddest or saddest day, they need more help than what law enforcement as first responders can provide. Building the capacity of county crisis intervention programs will give persons in crisis the right kind of help, at the critical moment when they need the most help.

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

CURRENT STATUS

The emergency mental health system in Wisconsin requires additional resources to respond appropriately to the needs of individuals experiencing a mental health crisis. Counties do not have the tax levy capacity to fund sufficient crisis intervention services to meet the need. The step made by Act 9 toward full state Medicaid funding of crisis intervention services was positive, but the remaining non-federal share should be covered by state GPR funds rather than relying on county tax levy to be the backbone of the emergency mental health system.

The Crisis Now model for emergency mental health services has three components – someone to call, someone to respond, and a safe place to go. Full state funding of Medicaid reimbursement for crisis intervention services will give counties the resources to improve all three components of the Wisconsin emergency mental health system.

REQUESTED ACTION

1. Provide additional state GPR be provided to fully fund crisis intervention services statewide. The Act 9 MOE requirement should be eliminated so 100% of county costs for Medicaid reimbursable services can be reimbursed. According to the Legislative Fiscal Bureau, full funding to eliminate the MOE would cost $20.8 million GPR. '

2. Make a statutory change to s.49.175 to exempt crisis intervention services from the WIMCR process. An exemption from WIMCR was done when full state funding was provided for the Comprehensive Community Services (CCS) program. The WIMCR exemption would not increase the GPR cost for full funding of crisis intervention services, but would reduce the amount of WIMCR revenue to the Medicaid trust fund.

3. WCHSA supports efforts to create regional crisis stabilization facilities that can provide observation and urgent care to persons in crisis. While urban counties may be able to create stabilization facilities, management and funding structures must be created to support stabilization facilities that can serve rural areas on a regional basis. Statutory changes are needed to authorize DHS to license the new facilities, create a Medicaid funding stream, and allow the facilities to perform emergency detentions when necessary.

<u>References</u>

- Legislative Fiscal Bureau 7/18/2022 memo to Rep. Rozar

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Mental Health - Community Support Program

Program Area: Behavioral Health

Budget Priority: Protect Vulnerable Populations

BACKGROUND

State law designates counties with the primary responsibility for the well-being, treatment, and care of persons with mental illness. If persons are diagnosed with mental health conditions that require treatment, counties are responsible for serving persons that do not have private insurance coverage. Counties must directly provide or contract with providers to deliver mental health services in the least restrictive environment appropriate for an individual's needs. The types of mental health services provided to persons varies depending on their mental health conditions and need for support services.

The Community Support Program (CSP) offers intensive community-based care for adults whose mental illness and functional limitations might otherwise require institutionalized care. Persons receiving CSP services have more acute and persistent mental illness and require support services for long periods of time. The CSP program uses assertive community treatment methods to avoid institutional care. Counties use CSP services to keep persons out of extended hospitalizations and support persons in the community following emergency detentions. CSP services are also used to assist persons who are homeless and as an alternative to incarceration for persons who commit criminal offenses.

CSP services are reimbursable under the Medicaid program, with counties responsible for the about 40% non-federal share of the reimbursement. Sixty-five (65) counties operate CSP programs certified under Department of Health Services (DHS) Administrative Rule 63. The non-certified counties receive no Medicaid reimbursement. Based on information from the Legislative Fiscal Bureau on the federal portion of CSP Medicaid reimbursement to counties, the non-federal share currently paid by counties is about $14 million.

State funding sources available to counties that can be used as match for CSP services include Community Aids Basic County Allocation and Community Mental Health Allocation. While counties also receive federal Mental Health Block Grant funds, those cannot be used as match for CSP. The Community Aids funding has not kept pace over the years with increased county costs for services, resulting in counties bearing a disproportionate share of CSP service costs.

Counties are limited in their capacity to use tax levy due to state levy limits, so the lack of Community Aids increases combined with strict property tax controls makes the overall funding for CSP stagnant with little capacity to serve more persons or cover increasing service costs.

Certification is difficult for the seven non-certified counties, which are small rural counties. The state tax levy limits make it impossible for these counties to make the upfront investment required to become DHS 63 certified. Full state funding of CSP services would give these counties an incentive to become certified.

In addition to being limited to only the 60% federal share of Medicaid reimbursement for CSP services, CSP services are subject to the WIMCR process. When counties bill Medicaid for CSP, counties get paid an initial claim for the service. The initial claim typically covers only part of the total cost of providing the service. The WIMCR process allows counties to submit additional costs to DHS for inclusion in the federal Medicaid claim through cost settlement reports. There is a long delay however because the costs settlement reports are done after the year closes and it is a lengthy process to collect the cost settlement information and DHS submit the additional federal Medicaid claim. DHS charges counties a 17% "tax" on cost settlement claims to cover the cost of the WIMCR vendor contract and generate revenue for the Medicaid trust fund. Between the long delay in reimbursement and the 17% tax, it is difficult for counties to build WIMCR revenue into their CSP program budgets.

CURRENT STATUS

The stagnant funding for CSP results in variations in the extent of services across counties, wait lists for services, and eligible persons receiving limited services. The public mental health system in Wisconsin is in need of additional resources to respond appropriately to the needs of individuals with persistent mental illnesses. Counties do not have the tax levy capacity to fund sufficient services to meet the need.

Providing full state funding for CSP services will allow counties to expand their CSP programs and offer more services to help keep persons with persistent mental illnesses out of hospital and jails. The state funding will allow counties to build capacity in their programs and implement evidence-based practices for mental health treatment.

REQUESTED ACTION

1. Provide state GPR to fund the non-federal share of Community Support Programs (CSP) services statewide so Medicaid reimbursement for CSP is fully funded. This would require approximately $14 million of GPR to cover the current county share of CSP Medicaid expenditures, plus future increases for caseload and service costs.

   Note: The $14 million amount could be higher to the extent that the portion of CSP services billed to Medicaid through the WIMCR cost settlement process was not reflected in the Legislative Fiscal Bureau estimate.

2. Make a statutory change to s.49.175 to exempt crisis intervention services from the WIMCR process. An exemption from WIMCR was done when full state funding was provided for the Comprehensive Community Services (CCS) program. The WIMCR exemption would not increase the GPR cost for full funding of crisis intervention services, but would reduce the amount of WIMCR revenue to the Medicaid trust fund.

3. WCHSA supports making modifications to the DHS 63 administrative rule to make CSP program requirements more consistent with the Assertive Community Treatment (ACT) model.

References

- Legislative Fiscal Bureau 7/18/2022 memo to Rep. Rozar

Date: 12/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Human Service Workforce

Program Area: Human Services (in General)

Budget Priority: Protect Vulnerable Populations:

BACKGROUND

County human service agencies routinely face workforce challenges to recruit and retain human services staff for children and family services, behavioral health, long term support and economic support. While county human service agencies offer good benefit packages and stable employment, it has always been a challenge to recruit and retain human service staff. County human service positions are often viewed as more stressful with lower wages and less public recognition than comparable positions in the private sector.

The current labor force shortage is driven by demographic patterns, the trend toward working remotely, and other factors that makes it more difficult than ever before to recruit and retain human service staff. Despite efforts to improve compensation and address other needs of employees, county human service agencies get few applicants for positions and vacancies can stay open for long periods. Contract human service providers face similar workforce challenges, with many service providers limiting their services and service areas based on the available staff.

New and expanded human service program initiatives are encountering more delays, not due to the lack for funding but because counties and contract service providers don't have employees to do the work. The workforce shortage is putting many vulnerable consumers of human services at risk of not receiving services that are essential to their health, safety and wellbeing.

For human service agencies to be more competitive in the tight labor market, Wisconsin needs statewide efforts to promote employment in human services. A partnership is needed with the state agencies DHS and DCF, county human service agencies and service providers to develop human service workforce strategies to increase the overall number of persons interested in work in human services. The state agencies face similar workforce challenges for their direct service operations. While both DHS and DCF have been supportive of workforce efforts, such as developing recruitment videos and the 2021 child welfare workload study, there is currently no overall plan to grow the human service workforce and no dedicated resources to assist counties and service providers with their workforce challenges.

The human service workforce challenges are compounded by the difficulties counties and service providers encounter with new hires being licensed and existing staff getting professional license renewals through the Department of Safety and Professional Services (DSPS). Staff frequently experience delays with the licenses due to the limited resources DSPS has to process licenses, resulting in staff not being able to perform functions that are required to be licensed.

CURRENT STATUS

County human service agencies and human service providers are experiencing unprecedented workforce challenges in hiring and retaining human services staff. Statewide strategies are needed to develop the human services workforce.

REQUESTED ACTION

1. Provide up to $5 million of funding to DHS and DCF for the following initiatives:
    - Statewide public awareness campaigns to promote the value of human service work and educate persons about the benefits of public sector work, such as federal forgiveness of student loan debt.
    - Human service workforce grants to counties. The workforce grants can be used by human service agencies to offer specialized compensation incentives, such as signing and retention bonuses, for difficult to recruit positions such as social workers or behavioral health counsellors.
    - Statewide human resources technical assistance contractor that can work with counties to support local recruitment efforts and do statewide recruitments to generate lists of applicants that multiple counties and community service providers can use.

2. Work with DHS to use federal funds to offer student stipend programs, similar to the Title IV-E stipend for child welfare workers, to subsidize the education of bachelors and masters degree students on the condition that they work in public human services. Similar stipend programs may be possible using federal Medicaid administrative funds for positions that do Medicaid reimbursable work such as behavioral health or children's long term care. This strategy may require amendments to state plans for federal funds or federal waivers.

3. WCHSA supports DSPS receiving additional budget authority and positions in their 2023-25 state budget request to fully utilize the existing licensing revenue to improve licensing of human service professionals.

References:
DCF child welfare workload study https://dcf.wisconsin.gov/cwportal/workload-study

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Income Maintenance Administration Allocation

Program Area: Economic Support

Budget Priority: Protect Vulnerable Populations

BACKGROUND

The Income Maintenance Administration Allocation (IMAA) is a combination of state and federal funds provided to county income maintenance (IM) consortia to perform the eligibility determination and management functions associated with federal benefit programs, including Medical Assistance and FoodShare. In 2012, DHS required counties to form regional IM consortia and there are currently 10 multi-county consortia that administer IM programs. DHS operates IM programs in Milwaukee County and tribes also operate IM programs.

The IMAA funding is a mix of state GPR, county levy and federal revenue. The federal government pays 50% for most FoodShare cases and different rates for Medicaid cases depending on the type of case, with either state or county funds used as match. When the regional IM consortia were formed in 2012, counties were required to continue investing the amount of county levy as a maintenance of effort. Counties were not required to invest additional county levy since 2012, although counties have done so to manage increased caseloads and maintain a high standard of services to benefit customers.

According to the Legislative Fiscal Bureau, the total funding for IM Administration in CY 2019 was $105.4 million, split as follows:

$13.6 million GPR + $22.5 million federal = $36.1 million state share
$26.0 million county levy + $43.2 million federal = $69.2 million county share

Since the regional IM consortia were formed and historically prior to 2012, the state share of IMAA funding has not kept pace with the workload to process and manage FoodShare and Medicaid cases. In recent years, counties have worked with the DHS and the Legislature to request additional IMAA funds to keep pace with caseload growth and administer new eligibility requirements.

Medicaid and FoodShare caseload grew substantially during the COVID-19 public health emergency without a corresponding increase in IMAA funding. From December 2019 to December 2021 the FoodShare caseload increased by 33.53%. From December 2019 to September 2021, the Medicaid caseload increased by 41.56%.

Along with the increased caseloads and a worker shortage, there is an increased cost for counties. The IMAA funding is used for staff and compensation costs for wage and benefit continue to rise.

IM consortia are required to conduct front end verification activities to verify that persons are eligible and receive the correct amount of benefits. IM consortia are also required to investigate benefit fraud and recover overpayments of benefits. The funding for verification and fraud investigation activities consists of a base fraud allocation of $2 million from DHS and incentives earned from collections of overpayments where IM consortia are allowed to retain part of the collection. The incentive funding can vary from year to year and is not a stable funding source for fraud activities.

Investment in fraud funding yields great returns in reducing benefit overpayments. The cost benefit ratio for IM fraud investment has historically been $15 to $20 of recovered benefits and preventing future overpayments for each dollar of fraud funding.

CURRENT STATUS

- Counties currently provide almost 2/3 of the total funding for IM administration. Counties lack the levy capacity to fund further increases in IM caseload costs.
- In the 2021-23 state budget, DHS requested increases in IMAA funding. The requested increases were $3.6 million ($1,45 mill GPR and $2,17 mill FED) in SFY 2021-22 and $5.3 million ($2.12 mill GPR and $3.18 mill FED) in SFY 2022-23 to fund projected workload increases. The requested increases were not approved by the Legislature.
- If the state chooses to adopt Medicaid expansion allowed under the Affordable Care Act, county IM consortia will need to manage an additional 100,000-plus Medicaid cases.
- DHS has made policy changes to reduce the number of overpayment cases pursued for collection, which will reduce collection incentive revenue and make funding for IM fraud activities even more unstable.

REQUESTED ACTION

1. Provide up to $5 million in additional GPR and related federal funds sufficient to cover the current FoodShare and Medicaid caseloads.

2. Provide additional IMAA funding if Medicaid expansion or other changes in program eligibility that would increase IM consortia workload are included in the state budget.

3. Provide additional stable base funding for IM fraud activities to offset reductions in incentive funding due to policy changes. DHS proposed a $750,000 increase in fraud funding in their 2023-35 budget request.

References:

- Legislative Fiscal Bureau 2021-23 budget paper 351 on Income Maintenance Workload

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, *Executive Director*
c/o Badger Bay Management Company

WCHSA Budget Proposals for the 2023-25 State Budget Process

Budget Theme: Keep Children at Home

Children do best when they are raised by their family in their own home. When children have needs requiring support services or face threats to their safety, Wisconsin county human service departments may become involved with the family. Agencies want to serve families on a voluntary basis in their own home, keeping children connected with the world that they know. When necessary to remove children from their home, children should be returned home as quickly as possible provided their safety can be assured. Programs to serve children in the home should be resourced to give all counties the capacity to offer in-home services. When out-of-home care is needed, providers need the capacity to serve children with complex needs.

Keeping children at home is a vision that everyone can believe in.

Achieving that vision requires investments in human service programs services that will allow county human service departments to support families in their homes. The Wisconsin County Human Services Association recommends the following investments for the 2023-25 state budget process. See the WCHSA budget paper for each of the proposals.

- Birth to Three Program – Provide $4 million to increase state GPR share of program funding to 20% and total state and federal share to 50%. Establish principle that state should fund future increases in program costs since the program is a state entitlement. Explore options to increase insurance and Medicaid funding.

- Child Welfare Prevention Services – Provide $5 to $8 million to support new evidence-based in-home prevention services to prevent removals of children. Increase state funding for home visiting services. Ensure that counties can receive new federal Title IV-E prevention revenue. Expand scope of eligible relations that can receive Kinship Care payments.

- Children and Families Allocation – Provide $5 to $10 million increase to cover higher county costs for child welfare services. Ensure all counties have a minimum child welfare allocation. Include funds to provide a foster care rate increase.

- Children's Long Term Support Program MOE – Provide up to $6.1 million to eliminate CLTS county maintenance of effort requirement. Can use part of current Children's COP program funds for the MOE buy-out, but need to ensure that all counties have adequate C-COP allocations to serve their caseload.

- Community Based Youth Justice Services – Provide $5 to $10 million in Youth Aids for counties to expand community services for youth. Consolidate small Youth Aids allocations as proposed by the Department of Children and Families. Modify Youth Aids allocation formula to reduce emphasis on youth arrests and youth corrections. Make Delinquent youth eligible for subsidized guardianship.

- Flexibility in Foster Care Licensing – Provide $950,000 for a pilot program to implement the professional foster parent model. Professional foster parents would receive a monthly stipend to be full-time caregivers for children with complex needs. Increase Kinship Care payments to support relative caregivers. Increase reimbursement rates for Children's Long Term Support program. Develop new foster parent liability insurance program.

- Human Service Workforce – Provide $5 million to support human service workforce grants to counties to recruit and retain human service workers. Establish additional federally-funded student stipend programs to support students getting human service degrees. Provide additional resources to the Department of Safety and Professional Services to improve licensing of human service occupations.

- Intensive Residential Care – Provide $6.2 million plus $600,000 for first-year start-up costs for an intensive residential care demonstration program. Program would pilot small residential care facilities to serve children with very complex needs and reduce use of out-of-state placements. Provide statutory authority and start-up funding to establish Psychiatric Residential Treatment Facilities (PRTFs).

WCHSA
Wisconsin County Human Service Association
Diane Cable, *President*
John Tuohy, Executive Director

Topic: Birth to Three Program

Program Area:

Budget Priority: Keep Children at Home

BACKGROUND

The Birth to 3 Program is a statewide early intervention program authorized under the federal Individuals with Disabilities Education Act (IDEA), Part C for Infants and Toddlers, and Wis. Admin. Code DHS 90. The U.S. Department of Education's Office of Special Education Programs (OSEP) is the federal administering agency.

The Birth to 3 Program serves children under the age of three with developmental delays and disabilities, as well as their families. The program works to enhance the child's development while supporting the family's knowledge, skills, and abilities as they interact with and raise their child. The goals of the Birth to 3 Program are to enhance the capacity of families to meet the special needs of their child, maximize the potential for independent living, and reduce long-term costs through remediating delays with early targeted intervention.

In Wisconsin, the Birth to 3 Program is administered by the Department of Health Services (DHS) and operated at the local level by counties. The Birth to 3 Program is frequently the first service system that children with disabilities encounter in Wisconsin. Part C of IDEA requires that all infants and toddlers with disabilities eligible for early intervention services be identified, located, and evaluated (34 C.F.R. § 303.302), so the program is effectively an entitlement.

Funding for the Birth to 3 Program includes a combination of federal, state, and local revenue. By rule, Birth to 3 service providers must access funding sources in the following order: private insurance, Medicaid, parental cost share (parent co-pays), local, state, and federal tax dollars.

State and federal funding for the program decreased from 2007 to 2016, going from $13,010,222 to $11,712,328, yet the cost to operate the program has continued to increase year after year. In addition, private insurance companies are increasingly denying coverage for Birth to 3 services. Counties fund the highest percentage of Birth to 3 program costs, over 40% with tax levy and Community Aids. Counties are responsible for covering most of the annual increase in program costs due to flat funding or limited growth in the other funding sources for the program. Please see attached table for the funding source percentages.

CURRENT STATUS

Counties currently bear the brunt of the increased costs associated with operating the Birth to Three program. While private insurance was once a major funding source for this program, denials of claims by insurance companies has reduced the revenue to being a small part of the total program funding.

The Birth to Three program must be operated as an entitlement under federal law. Since the Birth to 3 program is an entitlement, it is not appropriate for the program to depend primarily on county tax levy revenue which is constrained by state-imposed levy limits as compared with state GPR funds from income and sales taxes which are unrestricted in their growth.

Commercial insurance carriers are increasingly denying coverage of Birth to 3 services, indicating services in the "natural environment" are not covered. Parents can deny counties access to bill private insurance; however, federal law prohibits a delay or denial of Birth to Three services due to "inability to pay."

REQUESTED ACTION

1. Provide a $4 million dollar increase in the Birth to 3 state GPR allocation to bring the state share of the total program funding to approximately 20%.

   The additional GPR funding requested would bring state, federal and Medicaid funding to at least 50 percent of total program costs.

2. Provide annual GPR increases to cover the projected growth in caseload and service costs to relieve the burden on counties to cover annual increases in program costs.

3. Work with the Office of Insurance Commissioner to clarify the private insurance is the payor of first resort and enforce the requirement for insurance companies to reimburse counties for covered services.

4. Work with Department of Health Services to explore options for including certain types of Birth to Three services as Medicaid state plan options to increase the amount of Medicaid funding for the program.

References: Birth to Three funding table

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Birth to Three Funding Percentages

CY 2019 data

Number of children enrolled: 12,725

Funding Source	Amount	% of Total
County Funds	$ 14,781,466	32.88%
Medicaid	$ 6,961,636	15.48%
State GPR	$ 6,914,000	15.38%
Federal Grant	$ 5,836,046	12.98%
Community Aids	$ 4,692,521	10.44%
Private Insurance	$ 2,414,776	5.37%
Other Revenue	$ 1,807,952	4.02%
Parent Cost Share	$ 543,517	1.21%
Grand Total	$44,960,047	

Source: Legislative Fiscal Bureau 2021-23 Paper #360 *Birth to 3 Program (Health Service-Elder and Disability Services)*

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Child Welfare Prevention Services

Program Area: Children and Families

Budget Priority: Keep Children at Home

BACKGROUND

Counties are responsible for providing child welfare services, including the investigation of abuse and neglect and ongoing case management to families where there are safety threats to the children. Ongoing case management services can include in-home services provided under a safety plan and removal of children and placement in out-of-home care if their safety cannot be maintained in the family home.

The primary state funding source for child welfare services is the Children and Families Allocation (CFA), which is funded roughly equally with state GPR and federal IV-E foster care revenue. Other state funding sources include the Promoting Safe and Stable Families (PSSF) and Targeted Safety Supports Funds (TSSF), which are federally funded programs. DCF also provides funds to certain counties for Home Visiting services, with the Home Visiting allocations consisting primarily of federal funds.

While counties can provide prevention and early intervention services, CFA funds are generally needed to cover the costs of child protective services (CPS) which are mandated by statute whereas prevention services are optional. Due to levy limits, most counties do not have county funds to support prevention services. While PSSF funds can be used for family support prevention services, the PSSF allocations to counties are small. TSSF funds may be used only for families with identified safety threats and when children in out-of-home care are reunified. The lack of dedicated funding for prevention services results in many counties having very limited in-home services to avoid the removal of children.

The federal Family First Prevention Services Act (FFPSA) places a strong emphasis on in-home services to prevent removal of children. The FFPSA provisions include federal IV-E reimbursement for qualified in-home prevention services. To qualify for IV-E reimbursement, in-home services must be provided to families at risk of CPS intervention (e.g. candidates for foster care) and use evidence-based service models. The federal government publishes a list of evidenced-based services that states may select from. States can submit services to be included on the federal list, but services must be evaluated using rigorous methods to be considered evidence-based. States must conduct quality assurance to ensure fidelity to the evidence-based service models.

DCF submitted a FFPSA Prevention Services Plan in September 2021 that includes the three Home Visiting service models that DCF currently supports. Once the plan is federally approved, DCF can add additional services. If a service is included in the Prevention Services Plan, IV-E reimbursement can be claimed for 50% of the cost of qualified services. Services must be paid for with state GPR or county funds to be IV-E reimbursable.

DCF has not claimed any IV-E prevention services revenue to date while federal approval of the Prevention Services Plan is pending. Once the plan is approved, DCF can begin claiming IV-E prevention revenue for Home Visiting Services provided to candidates for foster care using Home Visiting and eWiSACWIS system data. Given that Home Visiting Services are primarily federally-funded, however, it is likely there will be very little IV-E prevention revenue claimed initially. Since there are no other evidence-based services that are currently operational statewide, DCF has not determined how IV-E prevention revenue will be claimed on services provided by counties using CFA or county funds.

Many of the evidence-based services included on the federal list are limited in their application, either to the type of family situation or the length of the service. County experience with the TSSF program has shown the important of having flexible funds that can be used to address the immediate concrete needs of families, in addition to other types of services to help to address safety issues present in families.

The FFPSA also emphasizes placement of children with relatives if removal is necessary as an alternative to foster care. While relatives can be licensed as foster parents to receive foster care payments, relatives caring for children typically receive payments from the Kinship Care program. Relatives can receive Kinship Care payments without the child being under a child welfare court order. A broad range of relatives are eligible for Kinship Care payments, however, depending on the lineage 1st and 2nd cousins may not be eligible for payments. Expanding the scope of eligible relatives would allow more children to be placed with relatives.

CURRENT STATUS

The Family First Act requires that child welfare agencies provide more early intervention services to prevent out-of-home placements, but there are limited funds available for prevention services. The limited funds that are available cannot be used to draw new federal IV-E prevention reimbursement. The Family First Act emphasizes use of relative for placements, but current eligibility for the Kinship Care program excludes some 1st and 2nd cousins.

REQUESTED ACTION

1. Provide $5 to $8 million of GPR funds to support statewide implementation of new evidence-based service models to build the availability of in-home prevention services. GPR funding is needed to allow claiming of IV-E prevention revenue.

   A portion of the funds would be used by DCF to contract with vendors to provide the sew service statewide, or train counties or existing service providers to provide the new service. Ongoing technical assistance should also be provided to maintain fidelity to the evidence-based model. Counties should also receive allocations designated for providing the new prevention services.

2. Provide additional GPR funds to expand the availability of Home Visiting services. GPR funds are needed to allow claiming of IV-E prevention revenue.

3. To the extent necessary, make statutory changes to clearly specify that IV-E prevention revenue can pass through to counties and is separate from IV-E foster care revenue used for the CFA. DCF should partner with WCHSA to determine what eWiSACWIS or DCF fiscal system enhancements are necessary to allow counties to claim IV-E prevention revenue on qualified services.

4. Modify the eligibility requirements for Kinship Care to include all 1st and 2nd cousins. Expanding eligibility would increase the amount of TANF funding needed for Kinship Care.

References: Wisconsin FFPSA Prevention Services Plan
https://dcf.wisconsin.gov/files/familyfirst/title-iv-e-5-year-prevention-plan.pdf

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Children and Families Allocation

Program Area: Children and Families

Budget Priority: Keep Children at Home

BACKGROUND

The Children and Families Allocation (CFA) is the primary state funding source for county child welfare services. County human and social service departments can use the CFA funds to provide prevention/early intervention, child protection and other services to children and families. Counties use the CFA funds for child welfare staff, contracts with children and family service providers, out-of-home placements, and other supports to children and families.

The CFA has existed as a separate allocation since 2009 when the Community Aids program was split following the creation of the Department of Children and Families (DCF) in 2008. Approximately 30% of the total Community Aids funds were transferred to DCF to become the CFA. The remaining Community Aids funds, known as the Basic County Allocation, are administered by the Department of Health Services and used by counties to provide other human services including behavioral health and long-term support.

The CFA has four funding sources including state GPR, federal IV-E, federal SSBG and federal IV-B funds. The IV-E funds are claimed by DCF based on out-of home care (aka foster care) placement and case management expenses incurred by counties, with the budget principle that IV-E funds claimed from foster care program expenses incurred by counties should be included in the CFA. The IV-E revenue is variable in that foster care placement and case management expenses and federal claiming rates can fluctuate, so the IV-E revenue available for the CFA must be re-estimated in each state biennial budget. The IV-B and SSBG funds are more fixed amounts from federal block grants. The SSBG amount includes funds transferred from the federal TANF block grant.

The CFA funding for CY 2022 is as follows:

GPR	$45.7 million
IV-E	$45.2 million
SSBG	$7.4 million
IV-B	$2.8 million
Total	$101.1 million

During the period prior to 2009 when child welfare funding was included in Community Aids, there were no general increases in child welfare funding from the early 1990s through 2008. Small increases were provided in biennia where foster care rates were increased, based on the budget principle that additional

funds be added to the CFA to cover the increased county costs from foster care rate increases. Since the CFA had been administered by DCF, there have been two general increases – a $5 million increase in CY 2018 and a $25 million increase in CY 2020. DCF has continued the budget principle of providing small increases when foster care rates are increased.

While the $30 million in recent general increases were helpful to counties to maintain child welfare services, the CFA increases have not covered the increased cost of child welfare services. Based on information from the Human Services Revenue Report, county spending on child welfare services increased by $40 million over the period of 2014 – 2019. Child welfare caseloads remain high and the complexity of individual cases has grown, with cases requiring more extensive intervention. Placement costs continue to increase, particularly for residential care where counties have to look for placements nationally due to limited capacity of Wisconsin residential care providers. The tight labor market is resulting in higher staff costs for counties that have to increase wages to hire and retain social workers. Community service providers are also experiencing higher costs, raising the cost to counties for contracted services.

DCF recently completed a comprehensive child welfare workload study that determined the average and optimal amount of worker time needed to manage child protective services investigations, ongoing case management and foster home licensing. The staffing in many counties is below the optimal level, showing the need for additional child welfare workers to adequately serve the current child welfare caseload. In addition, as a result of the federal Family First Prevention Services Act (FFPSA), DCF is directing counties to invest more effort into early intervention services to prevent the removal of children from families. While the early intervention goal of Family First is important and counties may eventually see reduction in out-of-home placement costs if successful, counties are currently lacking resources to build their early intervention services.

In addition to the need for additional overall funding for the CFA, there are inequities in how CFA funds are allocated to individual counties. The original allocation methodology for the Community Aids program was used only briefly in the early 1980s. Over the decades, funds have been added or taken out of Community Aids, such as the reduction when Family Care was implemented, so there is no logic to the Community Aids allocations to individual counties. Allocation amounts are not based on county population or other indicators of need. The lack of an allocation methodology continued when the CFA was split from Community Aids in 2009. The CFA allocations for small counties are as low as $250,000, which is not enough resources for those counties to operate effective child welfare programs. Due to the lack of an allocation methodology, the 2018 and 2020 increases were allocated as the same percentage across all counties, perpetuating the CFA allocation inequities. The 2020 increase included a minimum $50,000 increase amount, which recognized the need to provide small counties with additional funding.

In 2021, a DCF and WCHSA workgroup reviewed options for a CFA allocation methodology. The workgroup was supportive of using an allocation formula factor based on children in poverty. The child welfare program serves primarily low-income families, so children in poverty is a good indicator of the potential need for child welfare services, including early intervention services. The 2021 workgroup reviewed two possible factors including the total number of children in poverty based on Census data and the number of children receiving FoodShare (SNAP) benefits. The workgroup recommended that the allocation formula be applied only to increases and all counties be held harmless at their current CFA allocation amounts.

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

CURRENT STATUS

The CFA is the primary funding source for child welfare services, but the county allocations are not related to caseloads and rely heavily on federal IV-E foster care revenue. No funding increases were provided to counties or foster parents during the 2021-23 biennium. The CFA statutory language has provisions that are obsolete or should be updated.

REQUESTED ACTION

1. Provide a general CFA increase of $5 to $10 million to cover the increased cost of providing child welfare services.

   A minimum CFA allocation of $500,000 would ensure every county has sufficient resources to operate their child welfare program. Providing a minimum $500,000 allocation would affect 17 counties and require $1.9 million of additional funding. This could be incorporated into a general funding increase.

2. Continue the long standing budget principle of providing a CFA increase to cover the cost of foster care rate increases. Foster care rates were not increased in the 2021-23 biennium, so a foster care rate increase should be pursued in the 2023-25 biennium.

<u>References</u>

- Legislative Fiscal Bureau Information Paper 48 on Community Aids and Children and Family Aids

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Children's Long Term Support Program MOE

Program Area: Long Term Support

Budget Priority: Keep Children at Home

BACKGROUND

The Children's Long-Term Support (CLTS) program provides services and supports to children with significant physical disabilities, developmental disabilities, or severe emotional disturbances. Counties determine eligibility based on functional screens, authorize services and provide case management. The program is operated under a Medicaid waiver.

Prior to 2017, the CLTS program was funded with a mix of state-funded "slots" and county-matched slots. Due to limited state GPR funding and counties varying in the extent they invested in locally-matched slots, there were wait lists for service and families receiving services could go back on a wait list if they moved to another county. The 2017-19 state biennial budget made a significant state GPR investment in the CLTS program with the hope of eliminating the wait list for CLTS services. While the program is not an entitlement, the intent is to serve all eligible children.

Included in 2017 Wisconsin Act 59 was a provision requiring counties to maintain a specified level of local contribution for the CLTS program. Specifically, the Department of Health Services (DHS) was required to determine an equitable, locally controlled funding contribution mechanism for the CLTS program, also known as a maintenance of effort (MOE). The county MOE plus state GPR is used as match for federal Medicaid funding.

The MOE amounts for each county was determined using the CY 2016 CLTS cost reconciliation process. DHS reserves the right, in consultation with counties, to adjust the MOE methodology in the future to meet changing program needs. According to a DHS memo, the county MOE can come from the following sources:

- Children's COP (CCOP)
- Community Aids Basic County Allocation (BCA)
- County Tax Levy

The current county MOE amount is $6,105,940. There are currently 54 counties subject to the MOE requirements. Of the 54 counties subject to the MOE, amounts range from $1,347 to over $1 million. Five counties contribute over 50 percent of the total MOE.

While there was never disagreement on the need to eliminate the CLTS waitlist, counties objected to the MOE provision included in the proposal. Concerns included disproportionality (determining MOE based on a single year of expenses versus a multi-year average), counties being locked into an MOE amount when the number of children enrolled in the program could decrease in the future, and counties that invested in locally-matched slots prior to 2017 being penalized for their investment in serving children.

The CCOP program provides flexible GPR funds to counties to provide services that are not covered by the Medicaid waiver. The CCOP allocations vary by county depending on the county history with the former COP program, the predecessor to the current Family Care program. When the COP program was converted to Family Care, counties were allowed to keep the portion of COP funds spent on children which became the CCOP allocations. The current CCOP allocations are not based on the number of children with disabilities or other factors related to the current need for children's services.

Counties often use their CCOP funds to meet the CLTS MOE requirement, resulting in some counties not having viable CCOP programs. Of the $10.4 million in current CCOP allocations, $3.4 million is used for CLTS MOE. A few counties also use $1.4 million legacy COP funds for CLTS MOE.

CURRENT STATUS

There are 54 counties paying $6.1 million in CLTS MOE annually, with the MOE most affecting counties that made the biggest investment during the early years of the CLTS program. The counties that made investments to reduce waitlists prior to 2017 are penalized by having the largest MOE amounts. Much of the CCOP funds are used to meet the MOE requirement, resulting in limited CCOP services to meet the needs of families not covered by the CLTS waiver.

REQUESTED ACTION

1. Eliminate the MOE requirement in the CLTS program by providing additional GPR to buy out the county MOE portion of the CLTS funding. The buy-out could be done in in one of two ways:
    a. Provide $6.1 million in additional GPR and allow counties to keep the full amount of their current CCOP allocations.
    b. Work with DHS and counties to determine the amount of CCOP funds currently used as MOE that could be permanently transferred to the CLTS program budget. That would reduce the amount of GPR needed to buy out the MOE. The affected counties should be allowed to keep an amount of CCOP funds proportional to their population of children with disabilities.

2. Provide additional funding for the CCOP program based on the number of children with disabilities so that counties have an equitable amount of CCOP funds to use for services not covered by the CLTS waiver.

    Note: The request for additional CCOP funds is predicated on the CLTS MOE being eliminated. The equitable amounts by county should be determined after the MOE buy-out is complete, particularly if current CCOP funds are transferred as part of the buy-out.

References

- DHS fiscal data on CLTS MOE

Date: 11/2022

WCHSA
Wisconsin County Human Service Association
Diane Cable, *President*
John Tuohy, Executive Director

Topic: Community Based Youth Justice Services

Program Area: Children and Families

Budget Priority: Keep Children at Home

BACKGROUND

Counties are responsible for providing community-based youth justice services, including youth at risk of involvement in the youth justice system, juveniles in need of protection and services (JIPS) and youth adjudicated Delinquent for committing criminal offenses.

The primary state funding source for youth justice services is the Youth Aids program. Youth Aids includes a base allocation of $91.8 million for CY 2022, $3.7 million for Community Intervention Program (CIP), $1.3 million for an AODA allocation, and other small allocations for specific purposes. The base allocation consists of two parts – the historic base funding amount prior to 1999 that is not allocated by formula and the formula amount that applies to the increases since 1999. The Youth Aids allocation formula uses youth arrests and juvenile corrections placements as allocation factors. A $4.7 million Youth Aids increase was provided in the 2021-23 state budget starting in CY 2022 and was allocated using the Youth Aids formula.

Youth can be served in the youth justice system until they reach age 17. Youth age 17 are currently served in the adult justice system, which is no longer viewed as appropriate. Legislation to serve 17 year olds in the youth justice system has been considered for several legislative sessions, but the lack of additional funding to county human service departments to manage the increased youth justice caseload has been the major obstacle to approval of the legislation.

Youth justice case practice has evolved to divert youth from being arrested and prosecuted as delinquents, particularly for minor offenses. Research shows that involvement in the youth justice system for low-risk youth can lead to worse outcomes. Early intervention programs that are focused on strengthening families and restorative justice service models have shown better outcomes. Case practice has also evolved to limit the use of juvenile correctional placements except for youth that commit repeated or serious offenses.

Due to the decline in youth arrests and use of correctional placements, the Youth Aids allocation formula should be modified so that additional funding from increases is not tied to arrests and correctional placements. In 2021 DCF conducted input sessions with counties to identify alternative factors that could be used for the Youth Aids allocation formula.

Youth at risk of youth justice involvement often have challenges managing their behavior at home, school and other situations. Counties have been successful in serving youth with behavioral challenges through Coordinated Service Teams and behavioral health services such as CCS. While these strategies are still successful for many youth, counties struggle to provide early intervention services to families. Counties have generally not increased the number of youth justice staff in recent years due to expanding child welfare staff to cope with increased caseload and complexity of cases. As a result, youth justice workers often have high caseloads that do not allow for effective early intervention with families.

There is substantial overlap in family involvement in both the child welfare and youth justice service systems and the same types of services can often be used in both types of cases. However, some types of services are limited to only child welfare cases. Subsidized guardianship is available for CHIPS and JIPS cases but not for Delinquent cases. The Targeted Safety Support Fund (TSSF) program, which includes flexible funds that can be used to address concrete needs of families, requires families to be served under child protective services in-home safety plans. Flexible funds could be used with youth justice cases as well to help serve those families. The DCF Family First Prevention Services Plan designates youth at risk of youth justice involvement as candidates for foster care whose families can receive prevention services.

The eWiSACWIS system and the Wisconsin Child Welfare Professional Development System (WCWPDS) provide substantial system and training support to the child welfare program. While there are some system features and training specifically designed for youth justice services, additional system support and training are needed for youth justice workers.

CURRENT STATUS

The main component of Youth Aids funds is allocated largely based on arrests and correctional placements and smaller allocation have restricted uses. Counties do not have funds that can be used flexibly for early intervention services to youth and their families in the home to minimize out-of-home placements. Some of the child welfare funding resources and other program supports used to serve families are not available for the youth justice population.

REQUESTED ACTION

1. Provide $5 to $10 million of additional funds to counties through the Youth Aids program to support reduced youth justice caseloads and expand early intervention services.

2. Fold the current CIP and AODA allocations into the Youth Aids base allocation to give counties more flexibility with the funds and simplify fiscal reporting, as DCF proposed for the 2023-25 state budget.

3. Modify the Youth Aids allocation formula to no longer use youth arrests and correctional placements as allocation factors. Counties should be held harmless at their existing allocations, with the new formula applying to increases.

4. Pursue statutory changes to make Delinquent youth eligible for subsidized guardianship. This would increase state costs for the Subsidized Guardianship program by a small amount.

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

References: Legislative Fiscal Bureau Informational Paper 57 on Youth Justice and Youth Aids

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Flexibility in Foster Care Licensing

Program Area: Children and Families

Budget Priority: Keep Children at Home

BACKGROUND

When children are not safe to remain with their parents, child welfare agencies may have to place children in out-of-home care. The goal is to place children in a setting as close to family as possible, either with a relative or a licensed foster home. For children with complex behaviors, however, it can be difficult for the relative or foster parent to effectively care for the child in their home without extensive support. These high acuity children often wind up in higher levels of care, not because the higher level is better for the child but due to the higher level placement having staff with behavioral health practice skills to manage the child's behaviors.

Foster care has traditionally been viewed as a part-time activity for the caregiver, not as a profession. While some foster parents complete training to be licensed as a treatment level to care for high acuity children, the foster parents are paid only when they have child in their care. Foster care payments are intended to cover only the room and board costs for the foster child, not to compensate the foster parent for the investment of their time to develop and maintain the professional skills needed to care for high acuity children. The federal Title IV-E foster care reimbursement program is designed to only reimburse child-specific foster care payments. In addition, foster care licensing rules require that foster parents cannot depend on foster care payments as their primary income source.

There are foster parents with the skill and desire to be professional foster parents. Counties can supplement the child-specific foster care payments with purchase of service payments to the foster parent, but the mixed approach is cumbersome and can create income tax complications for the foster parents. A cleaner approach is to pay the foster parent a monthly stipend to compensate them for their professional skills and make child-specific foster care payments only for the room and board costs for the child.

While there are no legal barriers to the professional foster parent (PFP) model, the PFP model has not been widely used. Counties are unsure of how to convert any of their county-licensed foster parents to the PFP model. Paying the foster parent a monthly stipend could potentially create an employee-employer relationship that most counties want to avoid.

Private child placing agencies (CPAs) typically license foster parents at higher levels and provide training to build skills, so CPAs are more likely to have foster parents that would convert to the PFP model. Privately licensed foster parents can more easily serve as a regional resource as opposed to serving only one county.

Respite care is an important service for foster parents and other caregivers of high acuity children. Children with complex needs often require more attention from caregivers and typically require more medical and behavioral health treatment. Respite care is needed to allow caregivers time off to rest and maintain their households.

Other supports are available to relatives and foster parents to care for high acuity children. The Kinship Care program makes payments to relatives who cannot be licensed as foster parents or during the period while they are becoming licensed. The Kinship Care payments were increased to $300/month per child in 2022, but the payment amount still does not cover the room and board costs to care for a child. By comparison, foster care payments can be up to $2,000 per month.

The Children's Long Term Support (CLTS) Waiver can pay for services to children with disabilities, including behavioral conditions, to provide support services to keep children in a family setting. CLTS can also pay for respite care to give caregivers a break. While the CLTS program is a great resource for high acuity children, the CLTS Medicaid reimbursement rates have not been increased in recent years other than a temporary 5% increase paid for with one-time federal public health emergency pandemic funds. The lack of CLTS rate increases is making it more difficult to find providers to deliver the extensive support services necessary for children with complex needs. Similar to other human service programs, the tight labor market and historically low wages paid to service provider staff are eroding the capacity of the CLTS program. The lack of service providers results in families with eligible children being on wait lists for services or receiving less services than authorized in their CLTS individual service plan.

High acuity children can sometimes engage in destructive behaviors, which can make relatives and foster parents reluctant to take these children as placements. The Department of Children and Families (DCF) operates a foster parent liability insurance program that can reimburse foster parents for damages to their home, but the program only covers costs not reimbursed by the foster parent's personal homeowner liability coverage and there is a deductible. Foster parents must submit claims through their personal insurance policy and run the risk of being charged higher premiums. Unlicensed relative caregivers are not eligible for the DCF foster parent liability insurance program.

CURRENT STATUS

The PFP model should be tested as a demonstration project to determine how the model fits into the continuum of care options for high acuity children. Developing the PFP care model would help address the growing shortage of higher level residential care resources. The PFP model would help counties bring children currently placed with out-of-state residential care providers back to Wisconsin. PFP homes could also be used to provide short term care to prevent children from being placed in institutional settings or as step down resources to get children currently in institutions back into the community.

Other supports to relatives and foster parents, such as Kinship Care and CLTS, should be expanded to allow children with complex needs to be cared for by family and as close to their original home as possible. Supplemental insurance should be available to caregivers taking in high acuity children. Children generally do best when they can be kept at home. Children with complex needs deserve to be served close to home, the same as all other children.

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

REQUESTED ACTION

1. Provide $950,000 of GPR funding annually for a PFP demonstration program. The demonstration program would be operated by DCF under a competitive bid to one or more CPAs. The CPA would be responsible for recruiting parents, licensing the PFP foster homes, training the parents in the PFP model, and paying the PFP monthly stipend to the foster parent. Counties would make child-specific foster care payments for room and board when children are placed in the PFP foster homes. The PFP foster parents would also be available as respite care resources and mentors to work with relatives and other foster parents to help them care for high acuity children.

   The funding for the demonstration program includes the following elements:
   - $500,000 for PFP monthly stipends. The funding request is based on 10 PFP foster homes and a stipend of approximately $50,000 annually to each PFP foster parent. The goal is to have 2 PFP homes in each of the five human service regions to test the PFP model in all areas of the state, for a total of $500,000 for PFP stipends. The demonstration program would be bid by region, with CPAs being able to bid by region.
   - $100,000 or $10,000 per PFP foster parent for respite care.
   - $350,000 or $70,000 per region for the selected CPA(s) to recruit, license, train and case manage the PFP homes. The CPA grant would cover their administrative costs, so counties would not pay a CPA administrative payment on top of the child specific payment to the PFP foster parent.

   The selected CPA(s) would develop the PFP training curriculum and also serve as a consultant to counties that want to use the PFP model with county-licensed foster parents. DCF will be responsible for evaluating the effectiveness of the PFP model.

2. WCHSA supports increasing the Kinship Care monthly payment rate and expanding the scope of relatives that can be eligible for Kinship Care payments. The current Kinship Care eligibility rules limit the types of relatives that are eligible, particularly second cousins. The Kinship Care cost impact would be addressed as part of the TANF budget.

3. WCHSA supports provider rate increases for the CLTS program to make services more available. The CLTS program is an important resource to keep high acuity children in their family home by putting supports around the parents, but the program only works if the program reimbursement keeps up with the increasing cost of providing services. The CLTS cost impact would be addressed as part of the Medicaid budget.

4. WCHSA supports DCF working with the Wisconsin Office of Commissioner of Insurance to develop a proposal for a new foster parent liability insurance program that would allow foster parents taking high acuity placements to get insurance that would supplement their personal homeowner insurance and avoid making claims against their personal insurance. The new foster parent liability insurance program should be available to relative caregivers and include a state subsidy to make the insurance affordable for relatives and traditional part-time foster parents.

References:
DCF foster parent liability insurance program: https://dcf.wisconsin.gov/files/publications/pdf/2010.pdf

Date: 12/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Topic: Human Service Workforce

Program Area: Human Services (in General)

Budget Priority: Protect Vulnerable Populations:

BACKGROUND

County human service agencies routinely face workforce challenges to recruit and retain human services staff for children and family services, behavioral health, long term support and economic support. While county human service agencies offer good benefit packages and stable employment, it has always been a challenge to recruit and retain human service staff. County human service positions are often viewed as more stressful with lower wages and less public recognition than comparable positions in the private sector.

The current labor force shortage is driven by demographic patterns, the trend toward working remotely, and other factors that makes it more difficult than ever before to recruit and retain human service staff. Despite efforts to improve compensation and address other needs of employees, county human service agencies get few applicants for positions and vacancies can stay open for long periods. Contract human service providers face similar workforce challenges, with many service providers limiting their services and service areas based on the available staff.

New and expanded human service program initiatives are encountering more delays, not due to the lack for funding but because counties and contract service providers don't have employees to do the work. The workforce shortage is putting many vulnerable consumers of human services at risk of not receiving services that are essential to their health, safety and wellbeing.

For human service agencies to be more competitive in the tight labor market, Wisconsin needs statewide efforts to promote employment in human services. A partnership is needed with the state agencies DHS and DCF, county human service agencies and service providers to develop human service workforce strategies to increase the overall number of persons interested in work in human services. The state agencies face similar workforce challenges for their direct service operations. While both DHS and DCF have been supportive of workforce efforts, such as developing recruitment videos and the 2021 child welfare workload study, there is currently no overall plan to grow the human service workforce and no dedicated resources to assist counties and service providers with their workforce challenges.

The human service workforce challenges are compounded by the difficulties counties and service providers encounter with new hires being licensed and existing staff getting professional license renewals through the Department of Safety and Professional Services (DSPS). Staff frequently experience delays with the licenses due to the limited resources DSPS has to process licenses, resulting in staff not being able to perform functions that are required to be licensed.

CURRENT STATUS

County human service agencies and human service providers are experiencing unprecedented workforce challenges in hiring and retaining human services staff. Statewide strategies are needed to develop the human services workforce.

REQUESTED ACTION

1. Provide up to $5 million of funding to DHS and DCF for the following initiatives:
    - Statewide public awareness campaigns to promote the value of human service work and educate persons about the benefits of public sector work, such as federal forgiveness of student loan debt.
    - Human service workforce grants to counties. The workforce grants can be used by human service agencies to offer specialized compensation incentives, such as signing and retention bonuses, for difficult to recruit positions such as social workers or behavioral health counsellors.
    - Statewide human resources technical assistance contractor that can work with counties to support local recruitment efforts and do statewide recruitments to generate lists of applicants that multiple counties and community service providers can use.

2. Work with DHS to use federal funds to offer student stipend programs, similar to the Title IV-E stipend for child welfare workers, to subsidize the education of bachelors and masters degree students on the condition that they work in public human services. Similar stipend programs may be possible using federal Medicaid administrative funds for positions that do Medicaid reimbursable work such as behavioral health or children's long term care. This strategy may require amendments to state plans for federal funds or federal waivers.

3. WCHSA supports DSPS receiving additional budget authority and positions in their 2023-25 state budget request to fully utilize the existing licensing revenue to improve licensing of human service professionals.

References:
DCF child welfare workload study https://dcf.wisconsin.gov/cwportal/workload-study

Date: 11/2022

WCHSA
Wisconsin County Human Service Association
Diane Cable, *President*
John Tuohy, Executive Director

Topic: Intensive Residential Care Demonstration

Program Area: Children and Families

Budget Priority: Keep Children at Home

BACKGROUND

County human service departments are responsible for finding placements for children when they cannot be safely cared for by their parents at home. Some of the most challenging cases are children with complex behaviors due to developmental or intellectual disabilities such as autism, mental illness or behavioral disorders resulting from trauma they have experienced. When these high acuity children with complex needs require out-of-home placement, counties try to keep the children in foster care placements. For some children, however, counties need to use group residential care facilities on a short-term or long-term basis because the residential facilities can provide the more intensive treatment that high acuity children need.

The residential care industry is facing challenges in Wisconsin and nationally to offer quality care and meet the needs of high acuity children. Residential care providers struggle to staff their facilities and serve children who can be aggressive. Over the last 10 years the number of residential care beds available in Wisconsin has declined and counties are more frequently having to search nationally to find providers that can take high acuity children. Placing children out-of-state is very expensive for counties and traumatic for the child to stay connected with their family.

When seeking to place high acuity children, counties and providers may not be able to put an intensive service package in place to match the high acuity needs of the child. While counties can pay providers an exceptional rate on a case-by-case basis, the exceptional rate mechanism does not offer providers a steady revenue stream to sustain intensive residential services. When high acuity children need intensive residential care, the capacity is often not available at the time that children need it. Children may have to cycle through hospitals, detention centers or other inappropriate settings while the county is waiting for an appropriate residential bed to open up.

CURRENT STATUS

Wisconsin currently lacks the capacity to provide intensive residential care services for high acuity children, forcing counties to place children out-of-state. This problem sends Wisconsin taxpayer dollars to other states instead of those dollars staying in Wisconsin to build residential care capacity. The case-by-case exception rate process is not an effective approach to support intensive residential care. A new approach is needed to build and maintain intensive residential care capacity in Wisconsin.

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

REQUESTED ACTION

1. Request funding to pilot intensive residential care (IRC) facilities for high acuity children on a pilot basis. The pilot would support four, 4-bed IRC programs that would provide intensive services. The IRC programs would be fully supported with direct grant funding and not dependent on a daily rate to cover operating costs.

   The grant funds would be managed by the Department of Children and Families (DCF) with grants awarded on a competitive basis. Existing Wisconsin residential care providers would apply to participate in the pilot and could convert existing facilities to be IRC programs. DCF would be responsible for evaluating the IRC demonstration to determine if the direct grant funding approach is effective and could be expanded in future years.

   The funding needed for the demonstration project, as shown in the attached calculations, is:

   SFY 2023-24 $6.83 million including start-up costs
   SFY 2024-25 $6.23 million ongoing operating costs

   The funding will need to be 100% state GPR, at least initially. Federal Title IV-E funds can be claimed for placement costs for Title IV-E eligible children, but only when providers are paid on a per child rate basis. In addition, IV-E can only be claimed for residential facilities that are licensed as Qualified Residential Treatment Facilities (QRTPs). While the IRC programs may be licensable as QRTPs, a federal waiver would likely be required to claim IV-E for the direct grant funding approach.

2. WCHSA supports the creation of Psychiatric Residential Treatment Facilities (PRTFs) in Wisconsin. The Department of Health Services (DHS) is working on a PTRF proposal that will require statutory changes and funding in the 2023-25 state budget.

   If the DHS PRTF proposal is approved, it would take a few years to issue a licensing rule and get one or more PRTF programs operating. The PRTFs will serve a segment of the high acuity children as some of the Wisconsin children placed in other states are in PRTFs in those states. While new PRTF programs will help serve high acuity children, building intensive residential care capacity in Wisconsin is needed immediately.

References:

Date: 11/2022

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, Executive Director

Pilot Budget per 4-Bed Intensive Residential Care Program

Estimated program 1:1 Staffing using 2023 Max Rate		
Component	**Definition**	**RCC Per Diem Allowance**
Plant & Property	Mortgage Interest, Rent, Utilities, Property Tax, Insurance, Improvements, Maintenance & Repair	$33.07
Board & Incidentals	Food & Beverage, Children's Allowance, Laundry, Housekeeping	$36.05
Administrative Consumables	Office Supplies, Postage, Printing, Telephone, Internet, Cable, Background Checks, Staff Recruitment, Professional Subscriptions	$12.65
Programmatic Consumables	Program Supplies	$2.50
Insurance	Liability & Workman's Compensation Insurance	$8.54
Depreciation	Vehicles, Equipment & Property	$10.10
Direct Care Staffing		**$585.00**
	Hourly Average Cost Per Staff	**$32.50**
	* Direct Care Ratio: 1 Staff To X Children	**1.0**
	* Direct Care During School Hours Ratio: 1 Staff To X Children	**1.0**
	* Direct Care During Sleep Hours Ratio: 1 Staff To X Children	**4.0**
Supervisor Staffing	(Includes All Shifts In Calculation)	**$100.00**
	Hourly Average Cost Per Supervisor	**$35.43**
	* Supervisor Ratio: 1 Supervisor To X Children - Day	**6.0**
	* Supervisor Ratio: 1 Supervisor To X Children - School Hours	**6.0**
	* Supervisor Ratio: 1 Supervisor To X Children - Sleep Hours	**12.0**
Training	Staff Training	$7.16
Transportation	Vehicle Cost & Staff Mileage For Family Visits & Routine Care, Vehicle Expense Including Rentals & Insurance	$4.85
Recreation / Milieu	Activities / Outings For Children	$2.97
		$0.00
		$0.00
Therapy / Therapeutic Milieu	CPA: Purchased Clinical Services GH: Staffing To Ensure Therapeutic Environment For Youth RCC: Staffing For Therapy, Purchased Clinical Services	$37.01
Education	Educational / Vocational Supplies (Includes Staffing For RCCs)	$46.21
Medical	Medical Supplies (Includes Staffing For RCCs)	$13.50
Admin Overhead	Admin Allocation, Payroll Processing Fees, Self Funded Medical Costs	$75.64
	Subtotal	**$975.25**
COLA	COLA Dollar Adjustment	**$92.36**
	CPI Based On Two Twelve Month Cumulatives	**9.47%**
	Medical Care Group - CPI Based On Two Twelve Month Cumulatives	**4.56%**
Total Proposed Daily Rates Including COLA		**$1,067.61**

Annual cost 4 beds	**$1,558,705.96**
Start up capital improvement	**$150,000.00**
2023	$1,708,705.96
2024	$1,698,989.50

Note: This WAFCA estimate is built from the 2023 Max Rate Calculation for RCC as of Aug 13, 2022. The numbers in direct care staffing and supervisor staffing have been approximated based on the assumed ratios noted.

Funding Request for pilot project as recommended

Annual Estimated cost - one, 4 bed program		$1,558,705
Startup capital improvement		$150,000
2023	Four 4-bed programs and capital funding	$6,834,820
2024	Four 4-bed programs	$6,234,820

Source: WCHSA/WAFCA Intensive Residential Care workgroup, September 2022 recommendation

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, *Executive Director*
c/o Badger Bay Management Company

WCHSA Budget Proposals for the 2023-25 State Budget Process

Budget Theme: Keep Children at Home

Children do best when they are raised by their family in their own home. When children have needs requiring support services or face threats to their safety, Wisconsin county human service departments may become involved with the family. Agencies want to serve families on a voluntary basis in their own home, keeping children connected with the world that they know. When necessary to remove children from their home, children should be returned home as quickly as possible provided their safety can be assured. Programs to serve children in the home should be resourced to give all counties the capacity to offer in-home services. When out-of-home care is needed, providers need the capacity to serve children with complex needs.

Keeping children at home is a vision that everyone can believe in.

Achieving that vision requires investments in human service programs services that will allow county human service departments to support families in their homes. The Wisconsin County Human Services Association recommends the following investments for the 2023-25 state budget process. See the WCHSA budget paper for each of the proposals.

- Birth to Three Program – Provide $4 million to increase state GPR share of program funding to 20% and total state and federal share to 50%. Establish principle that state should fund future increases in program costs since the program is a state entitlement. Explore options to increase insurance and Medicaid funding.

- Child Welfare Prevention Services – Provide $5 to $8 million to support new evidence-based in-home prevention services to prevent removals of children. Increase state funding for home visiting services. Ensure that counties can receive new federal Title IV-E prevention revenue. Expand scope of eligible relations that can receive Kinship Care payments.

- Children and Families Allocation – Provide $5 to $10 million increase to cover higher county costs for child welfare services. Ensure all counties have a minimum child welfare allocation. Include funds to provide a foster care rate increase.

- Children's Long Term Support Program MOE – Provide up to $6.1 million to eliminate CLTS county maintenance of effort requirement. Can use part of current Children's COP program funds for the MOE buy-out, but need to ensure that all counties have adequate C-COP allocations to serve their caseload.

- Community Based Youth Justice Services – Provide $5 to $10 million in Youth Aids for counties to expand community services for youth. Consolidate small Youth Aids allocations as proposed by the Department of Children and Families. Modify Youth Aids allocation formula to reduce emphasis on youth arrests and youth corrections. Make Delinquent youth eligible for subsidized guardianship.

- Flexibility in Foster Care Licensing – Provide $950,000 for a pilot program to implement the professional foster parent model. Professional foster parents would receive a monthly stipend to be full-time caregivers for children with complex needs. Increase Kinship Care payments to support relative caregivers. Increase reimbursement rates for Children's Long Term Support program. Develop new foster parent liability insurance program.

- Human Service Workforce – Provide $5 million to support human service workforce grants to counties to recruit and retain human service workers. Establish additional federally-funded student stipend programs to support students getting human service degrees. Provide additional resources to the Department of Safety and Professional Services to improve licensing of human service occupations.

- Intensive Residential Care – Provide $6.2 million plus $600,000 for first-year start-up costs for an intensive residential care demonstration program. Program would pilot small residential care facilities to serve children with very complex needs and reduce use of out-of-state placements. Provide statutory authority and start-up funding to establish Psychiatric Residential Treatment Facilities (PRTFs).

WCHSA

Wisconsin County Human Service Association
Diane Cable, *President*

John Tuohy, *Executive Director*
c/o Badger Bay Management Company

WCHSA Budget Proposals for the 2023-25 State Budget Process

Budget Theme: Help People When They Need Help

Many Wisconsinites face threats to their safety and well being due to their low income, age or disability. These vulnerable populations depend on county human service departments to provide services and benefits to support them living independently in the community. When vulnerable persons need help, they need help quickly and in a manner that is respectful of their individual dignity. If services are not provided quickly when requests for help are made, it can have traumatic impacts on the well-being of vulnerable persons and sometimes tragic consequences for the community. Vulnerable persons deserve better. To act quickly, human service departments need resources to protect vulnerable persons, prevent tragedy and promote safety.

Protecting vulnerable persons by helping them when they need help is a vision that everyone can believe in.

Achieving that vision requires investments in human service programs services that will allow county human service departments to protect vulnerable populations and offer help when they need it. The Wisconsin County Human Services Association recommends the following investments for the 2023-25 state budget process. See the WCHSA budget paper for each of the proposals.

- Adult protective services – Provide $5 to $10 million of funds to expand county APS capacity to serve the growing population of elderly and persons with disabilities who need protective services. Ensure all counties have a minimum APS allocation. Create a statewide registry for long term care placements. Increase Department of Health Services capacity to provide APS training and technical assistance.

- Aging and disability resource centers (ADRCs) – Provide $5 to $10 million to support core operations of ADRCs to serve the growing population of elderly and persons with disabilities. Provide additional funds for specific ADRC services to ensure services are available at all ADRCs statewide. Expand the role of dementia specialist staff to give ADRCs more flexibility in how those staff can be used.

- Crisis intervention services – Provide $21 million for full state funding of Medicaid reimbursement to counties for crisis services. Eliminate the maintenance of effort requirement created by 2019 Wis. Act 9. Exempt crisis services from the WIMCR process. Create regional crisis stabilization facilities to provide more options for where persons in crisis can be taken for urgent care and observation.

- Community support program (CSP) – Provide at least $14 million for full state funding of Medicaid reimbursement to counties for CSP services. Exempt CSP services from the WIMCR process. Modify the CSP administrative rule DHS 63 to be more consistent with Assertive Community Treatment model.

- Human service workforce - Provide $5 million to support human service workforce grants to counties to recruit and retain human service workers. Establish additional federally-funded student stipend programs to support students getting human service degrees. Provide additional resources to the Department of Safety and Professional Services to improve licensing of human service occupations.

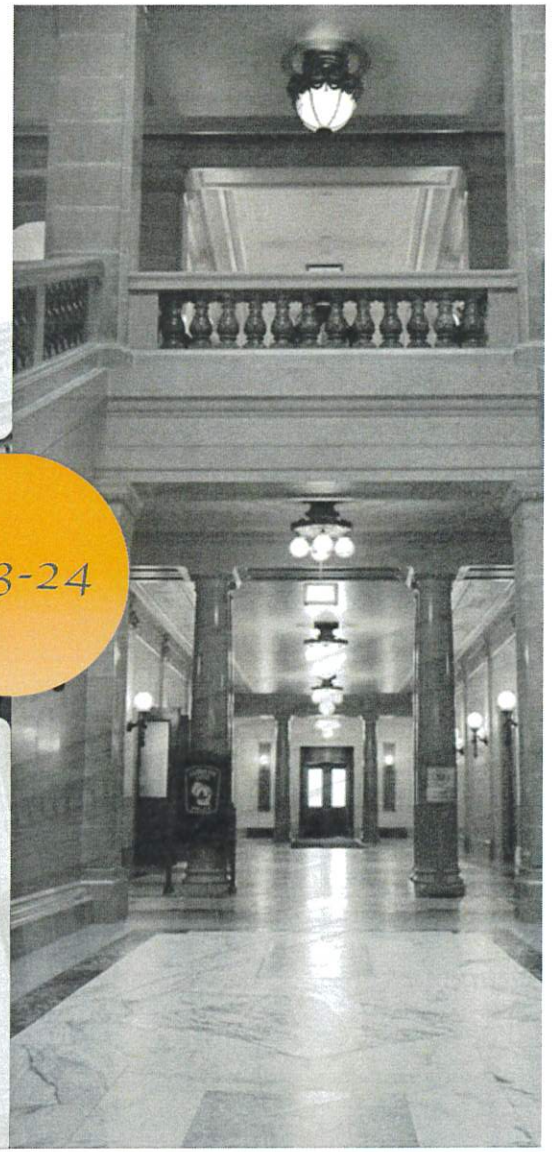
- Income maintenance administration – Provide up to $5 million GPR plus federal matching funds to cover county costs for current FoodShare and Medicaid caseloads. Provide additional funds if Medicaid expansion is approved. Provide $750,000 for income maintenance fraud prevention and investigation activities, as proposed by the Department of Health Services.

2023-24 Initiatives

Wisconsin Counties Association

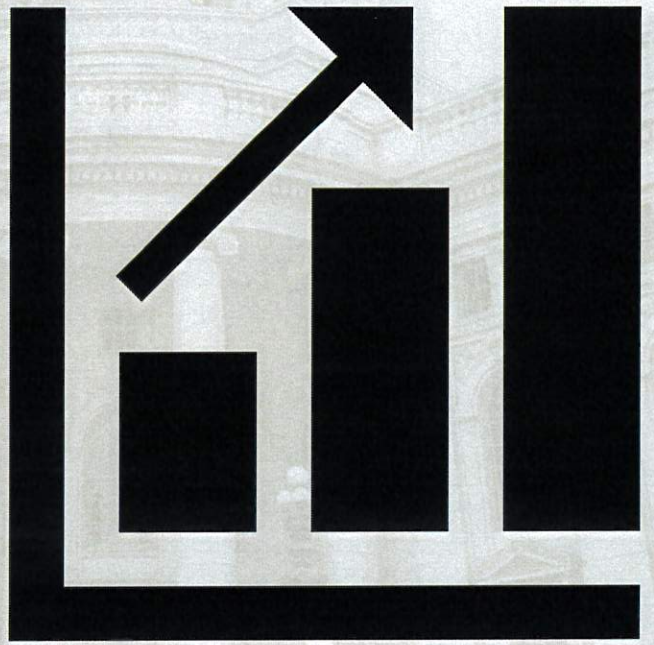
WHAT WE EXPECT

- Gov. Evers: K-12 funding and roads
- GOP: tax cuts and fighting crime
- There may be some compromise with schools and local governments (yay?)
- Other items on the horizon in Wisconsin:
  - the 173 year old abortion ban,
  - mental health in the state,
  - elections law changes,
  - marijuana legalization,
  - parole policies,
  - PFAS pollution



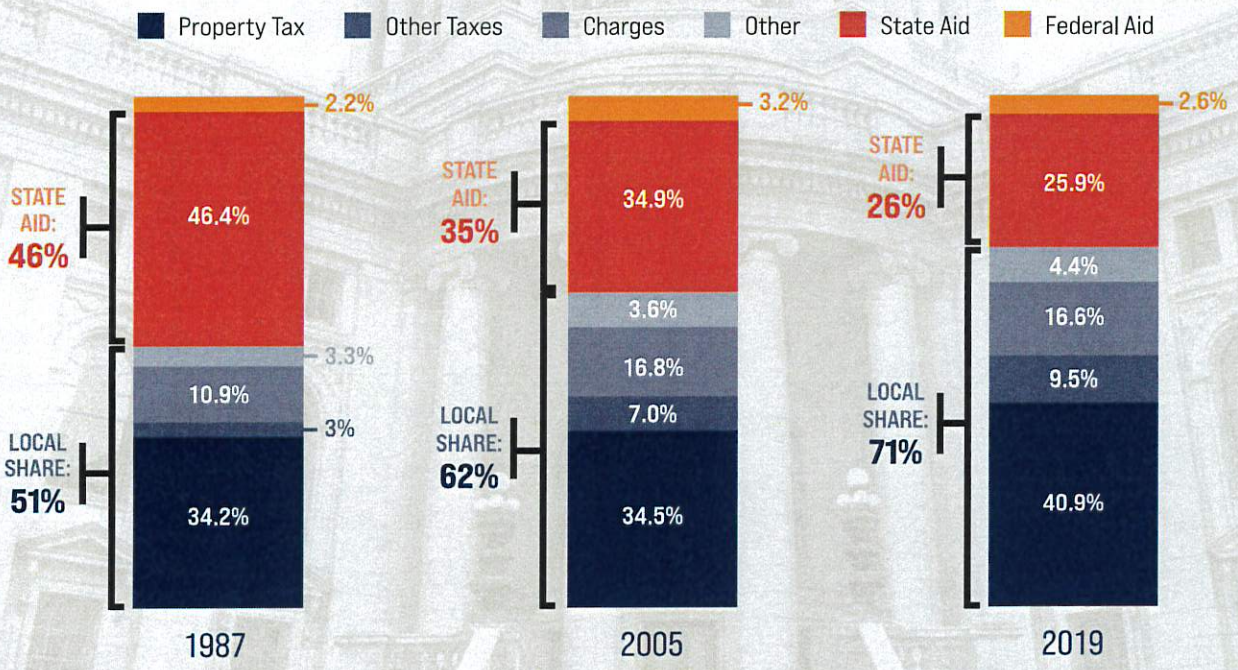
STATE FINANCES

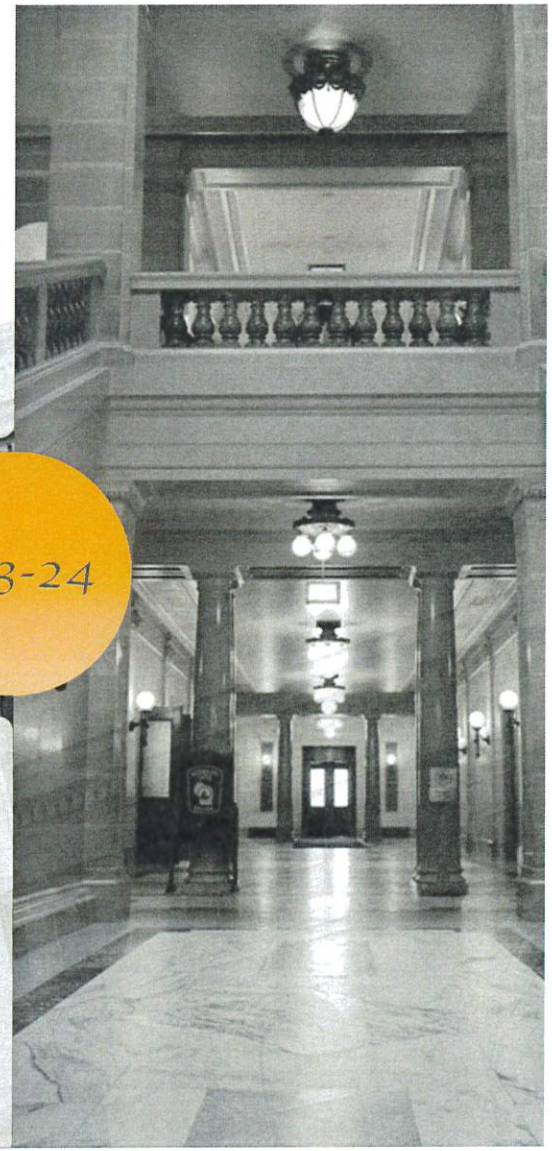
- State expected to end FY23 with **$6.6B** balance
- State rainy day fund = **$1.73B**



STATE-COUNTY FUNDING

DECLINE IN STATE SHARE OF COUNTY FUNDING **1987 - 2019**

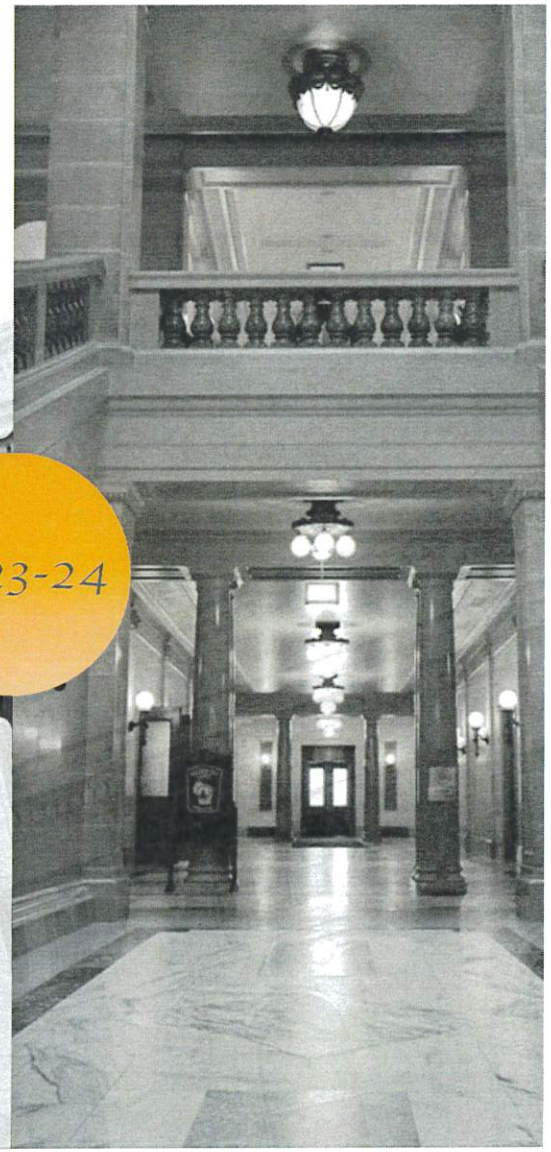




WCA TOP PRIORITIES

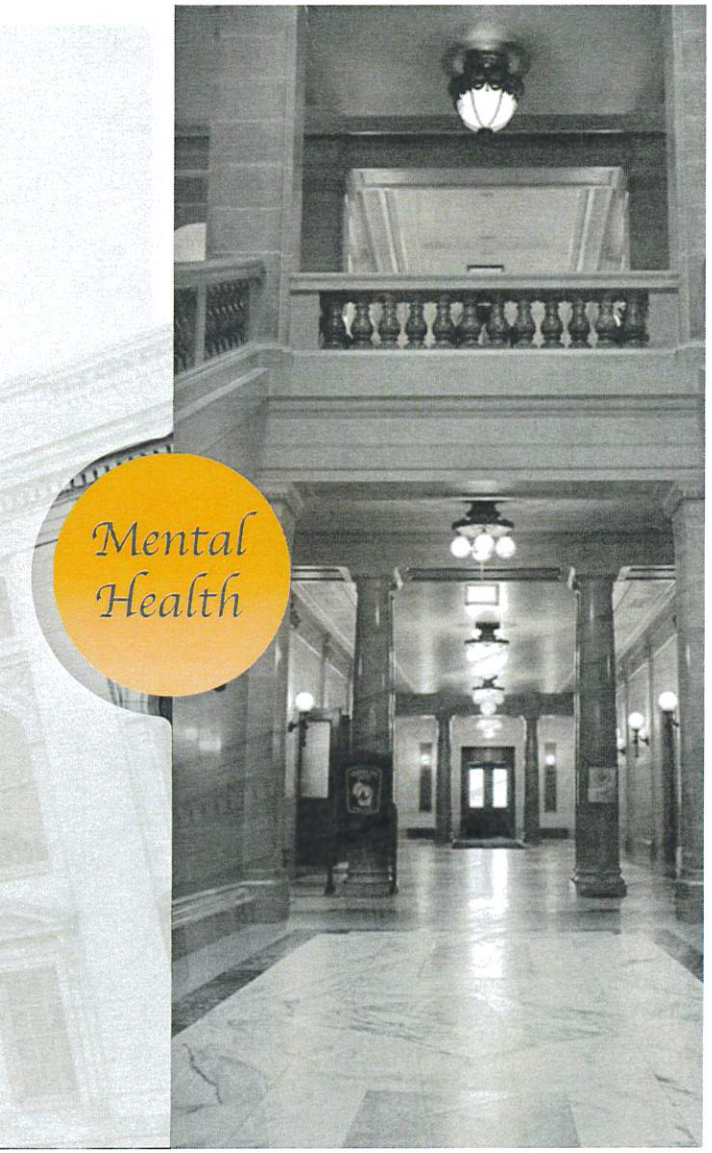
- New funding structure for local governments
- Add'l public safety funding
- Add'l funding for mental health services
- Sustainable transportation funding (+ EV $'s)

2023-24

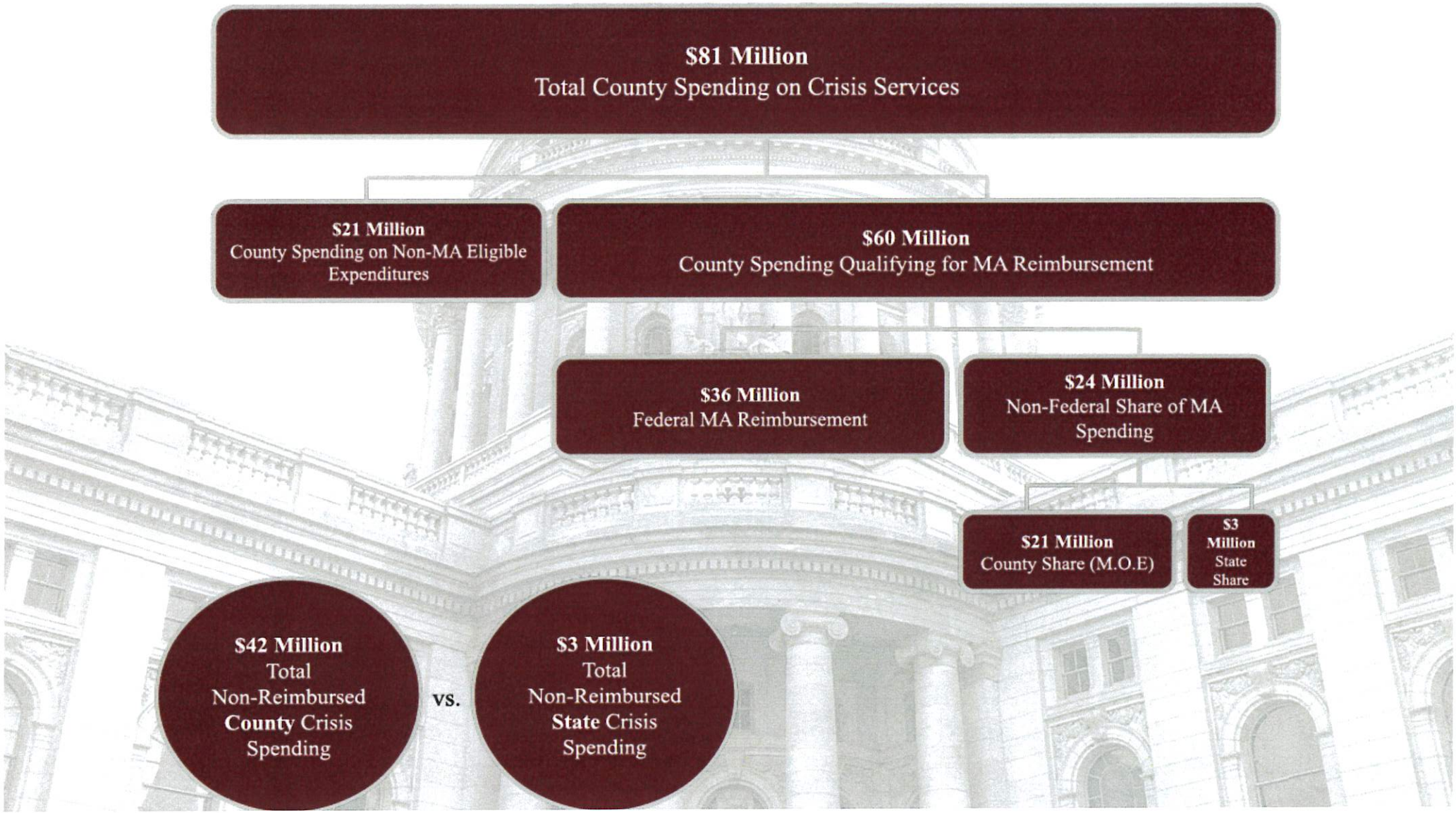


Mental Health Services

2. **WCA Budget Request:** Crisis Services & CSP
   - MH system in WI needs additional resources
   - WCA is requesting:
     - $21M annually for Medicaid reimbursable crisis services (Elimination of the MOE)
     - $14M annually for Community Support Programs

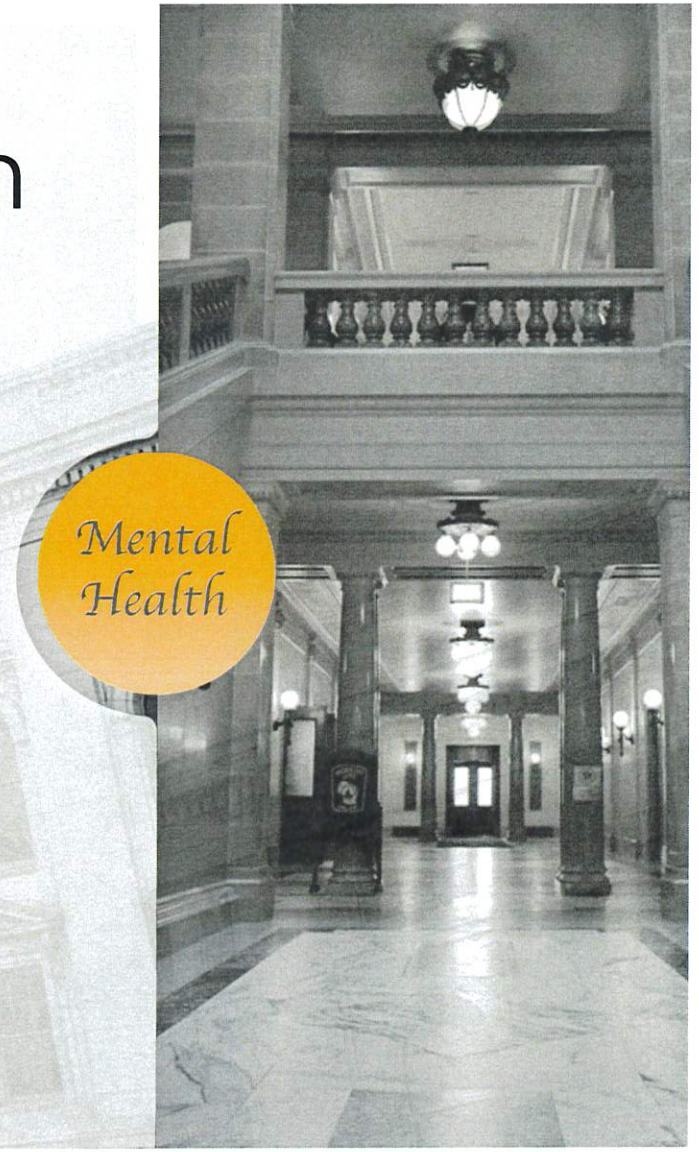


Strict Levy Limits + Lack of Community Aids Increases = Counties unable to provide needed services


$81 Million
Total County Spending on Crisis Services
$21 Million
County Spending on Non-MA Eligible Expenditures
$60 Million
County Spending Qualifying for MA Reimbursement
$36 Million
Federal MA Reimbursement
$24 Million
Non-Federal Share of MA Spending
$21 Million
County Share (M.O.E)
$3 Million
State Share
$42 Million
Total Non-Reimbursed County Crisis Spending
vs.
$3 Million
Total Non-Reimbursed State Crisis Spending

Mental Health Campaign

- Three Pieces to WCA MH Campaign:
  1. PSA Advertising through TV & Radio
     - ➢ MH awareness for all ages
  2. Digital Advocacy
  3. January 2023 *Wisconsin Counties*
     - ○ Mental Health Emergency Services
- Filming happened Tuesday- Thank you!!!!
- Time to start building relationships



2023 Meeting Schedule (updated 11/11/2022)
Health & Human Services Committee/Board Meeting Dates
(1:00 p.m. unless otherwise stated)

Committee Meetings DOA, Room AC130	Joint Meetings DOA, Room AC130	Board Meetings Human Services Center, Room 271
January 12, 2023		January 19, 2023
February 16, 2023		February 23, 2023
March 16, 2023 Annual Report & Fentanyl Community Health Initiative Report		
April 13, 2023		April 27, 2023 Community Needs Presentations (Advisory Committees) Substance Use Advisory, Mental Health Advisory, Public Health Advisory, CAFSAC Advisory, ADRC Advisory
May 11, 2023		May 18, 2023 (1:00-2:00pm) Preparation Meeting for County Executive
		May 18, 2023 (2:00-3:00pm) Meeting w/County Executive
June 15, 2023		June 22, 2023
July 13, 2023		July 27, 2023
August 10, 2023		August 17, 2023 (8:30am-4:00pm) HHS Annual Public Hearing & HHS Budget Review 8:30-10am: Public Hearing 10-10:05am: Board approval of Advisory Committees' Membership and Chairs 10:05am-4pm: HHS Budget Review
September 14, 2023 (Capital Project Review)		September 21, 2023
October 19, 2023 (Budget Review)		October 26, 2023 Clinical Division's Privileging of Medical Staff, Jeff Lewis
November 16, 2023 Veterans Annual Report		
December 7, 2023		No December meeting

Presentations by each HHS Division to the HHS Board, including state and federal mandates:
January 19, 2023 – Clinical Services Division (Kirk Yauchler)
February 23, 2023 – Child & Family Services Division (Penny Nevicosi)
March 16, 2023 – Annual Report (Joint Meeting)
April 27, 2023 – Community Needs Assessment (Advisory Committees)
May 18, 2023 – Board Needs Assessment Review / Presentation to County Executive
June 22, 2023 – Adolescent & Family Division (Ron Pupp)
Start of new rotation:
July 27, 2023 – Public Health Division (Ben Jones)
August 17, 2023 – Approve Committee Chairs and Membership
September 21, 2023 – Aging and Disability Resource Center (Mary Smith)
October 26, 2023 – Privileging, Admin Services Division (Randy Setzer)
November 16, 2023 – Veterans Services Division (Joint Meeting) (Dan Driscoll)

Clinical Services ARPA Projects

- Crisis Intervention/Law Enforcement
- MHC Redesign

WHY?

DATA-INFORMED DECISIONS
Data on crisis call volume, unmet needs, and current service provision supports these ARPA Projects.

FISCAL IMPACT
An efficient response saves time, money, and resources. These projects right-size our Crisis Response services and enhance stewardship of taxpayer dollars.

MANDATED SERVICES
County department is required to provide services to meet the needs of all eligible individuals suffering from mental illness, developmental disabilities, alcoholism, or other drug abuse. (Chapter 51.42)

EMERGENCY RESPONSE
Community agencies like law enforcement and hospital ERs expend incredible resources responding to people experiencing mental health crises.

CRISIS INTERVENTION TIMELINE

2010

Three full-time staff

2013

Mental Health Association contracts ends; Crisis service brought in-house 7 days/week

2016

Act 105 in effect, Unfunded Mandate; Crisis required to assess for Chapter 51.15 Emergency Detentions

2021

HHS and Waukesha Sheriff's Department collaborate on **Embedded Mental Health Professional Program**

Community-Based Crisis Stabilization launches

2022

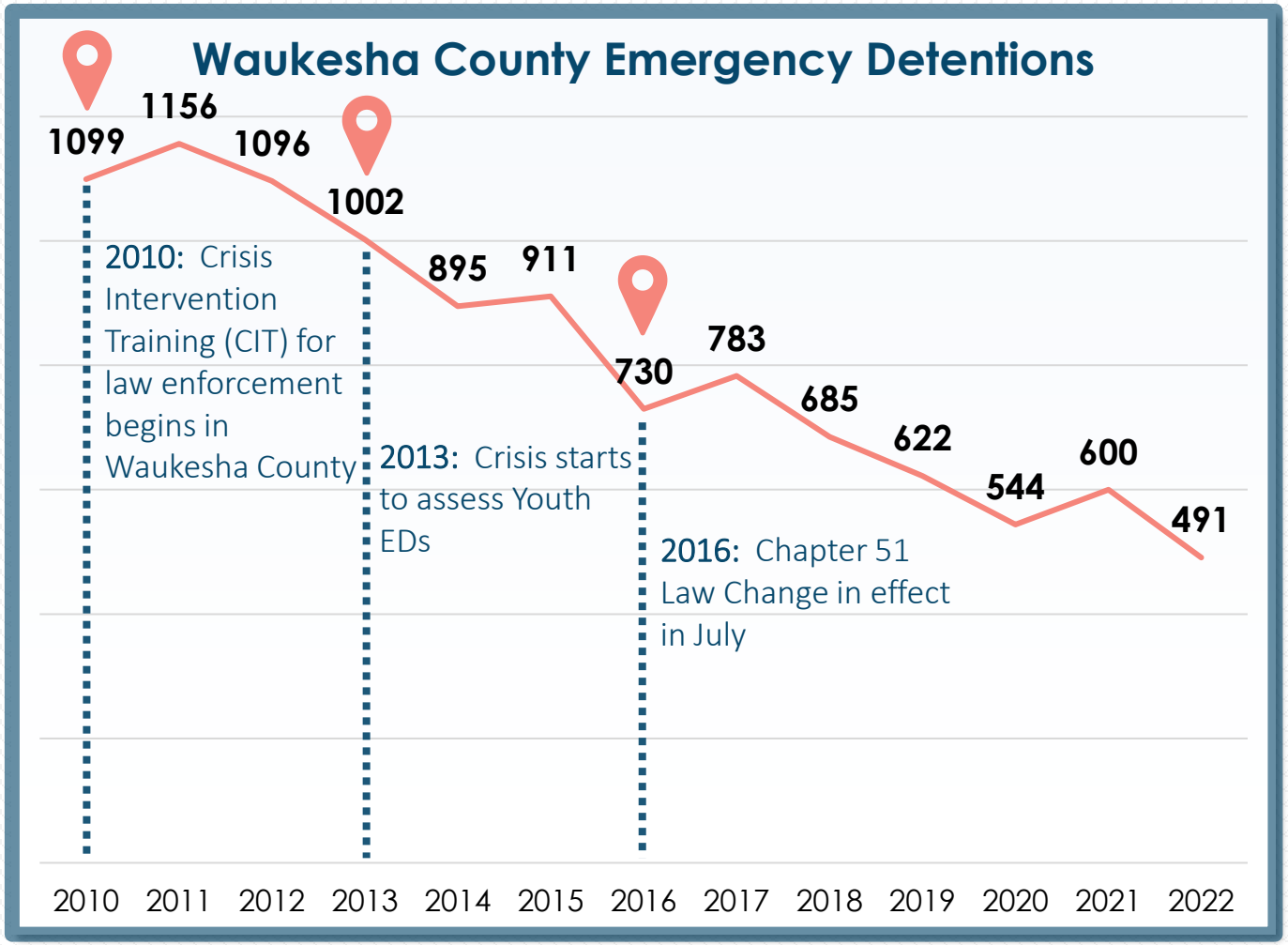
ARPA Project approved to add 3 positions for enhanced Crisis/Law Enforcement collaboration

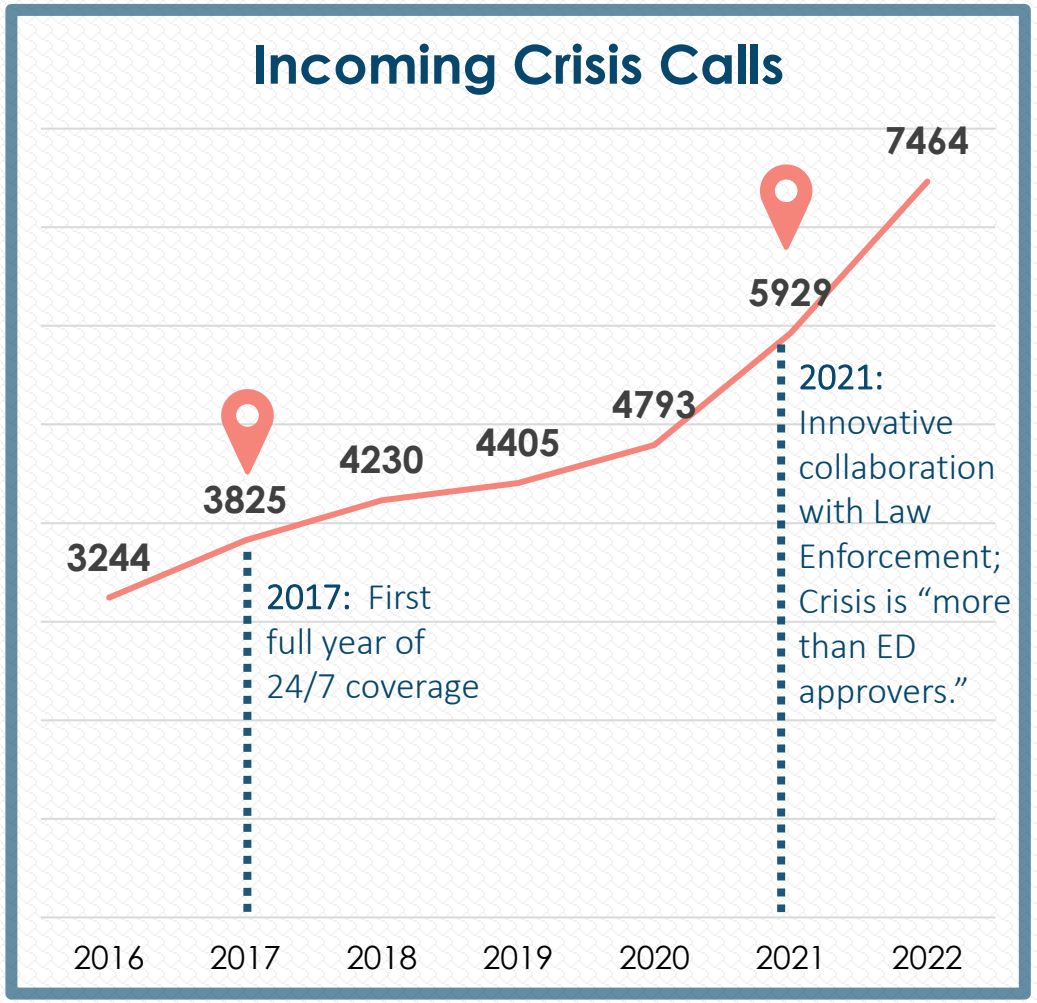
Awarded **Regional Crisis Stabilization Facility** DHS Grant

2024

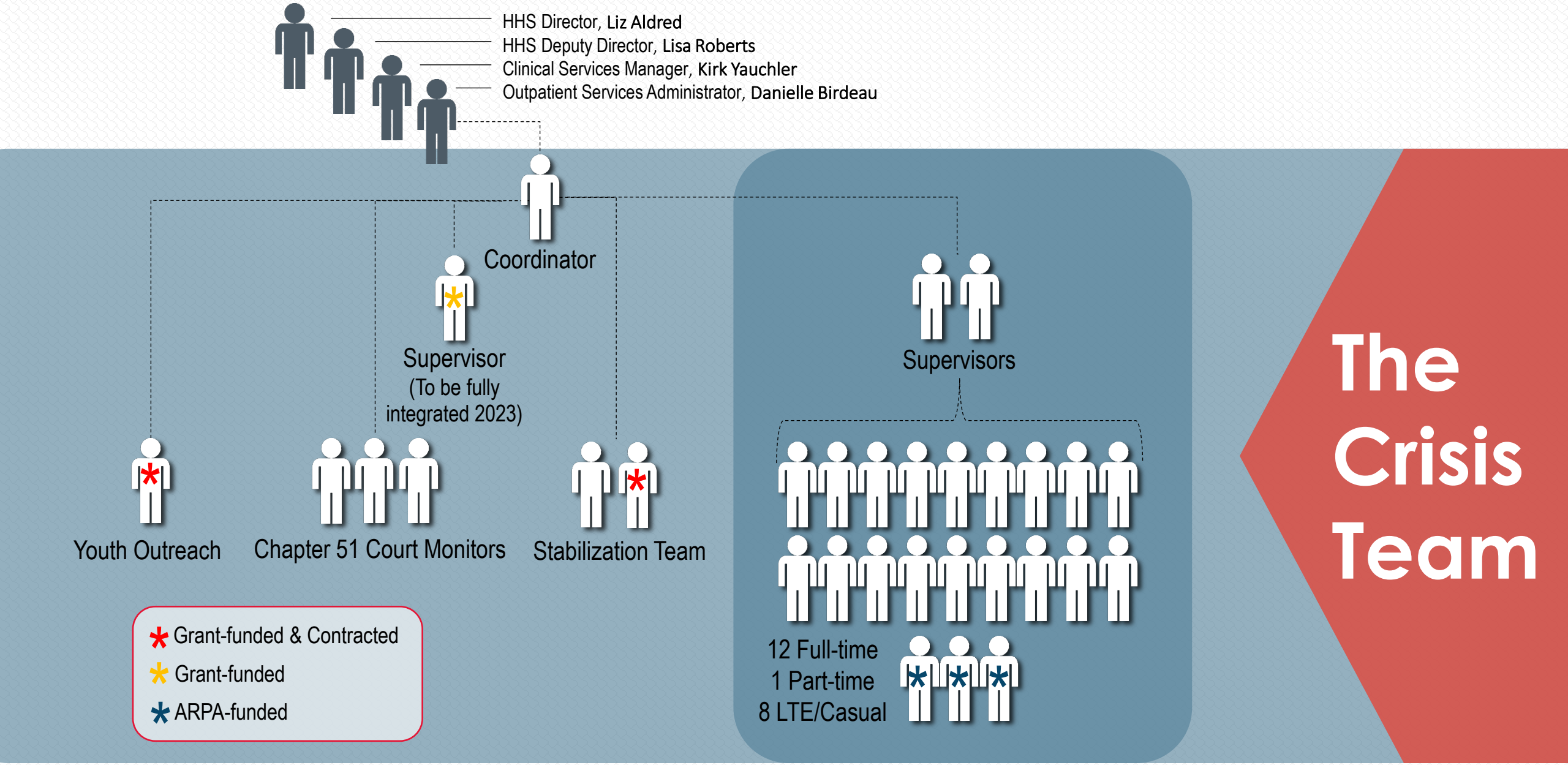
Crisis Stabilization Facility opens; To be called **Waukesha Crisis Resource Center**

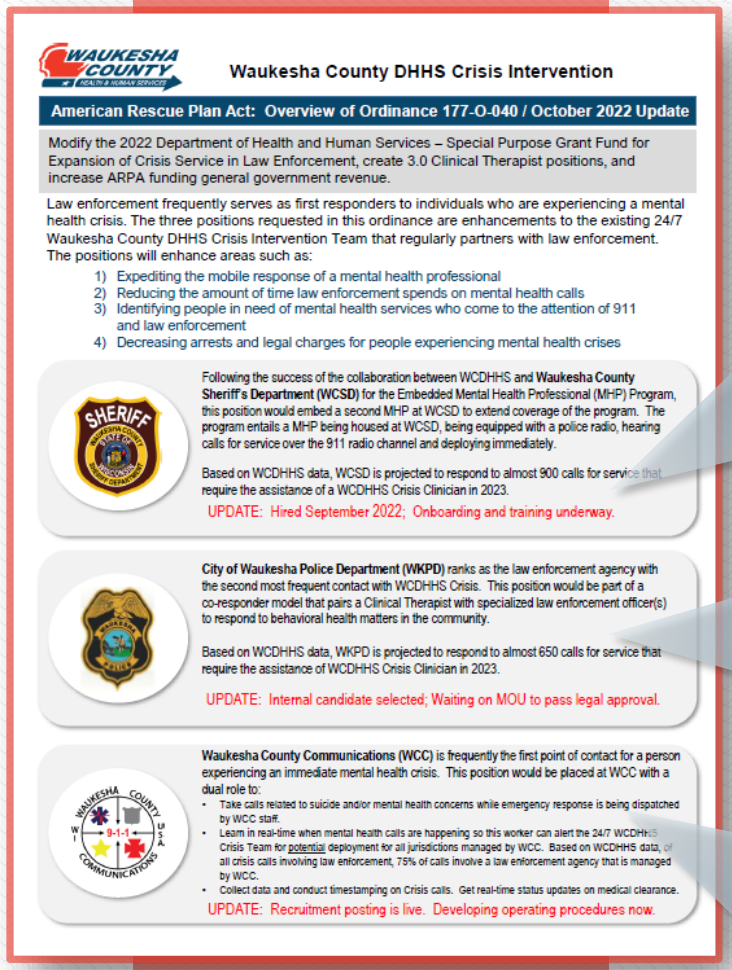
CRISIS INTERVENTION DATA





The Crisis Team





Waukesha County DHHS Crisis Intervention

American Rescue Plan Act: Overview of Ordinance 177-O-040 / October 2022 Update

Modify the 2022 Department of Health and Human Services – Special Purpose Grant Fund for Expansion of Crisis Service in Law Enforcement, create 3.0 Clinical Therapist positions, and increase ARPA funding general government revenue.

Law enforcement frequently serves as first responders to individuals who are experiencing a mental health crisis. The three positions requested in this ordinance are enhancements to the existing 24/7 Waukesha County DHHS Crisis Intervention Team that regularly partners with law enforcement. The positions will enhance areas such as:

1) Expediting the mobile response of a mental health professional
2) Reducing the amount of time law enforcement spends on mental health calls
3) Identifying people in need of mental health services who come to the attention of 911 and law enforcement
4) Decreasing arrests and legal charges for people experiencing mental health crises

Following the success of the collaboration between WCDHHS and **Waukesha County Sheriff's Department (WCSD)** for the Embedded Mental Health Professional (MHP) Program, this position would embed a second MHP at WCSD to extend coverage of the program. The program entails a MHP being housed at WCSD, being equipped with a police radio, hearing calls for service over the 911 radio channel and deploying immediately.

Based on WCDHHS data, WCSD is projected to respond to almost 900 calls for service that require the assistance of a WCDHHS Crisis Clinician in 2023.

UPDATE: Hired September 2022; Onboarding and training underway.

City of Waukesha Police Department (WKPD) ranks as the law enforcement agency with the second most frequent contact with WCDHHS Crisis. This position would be part of a co-responder model that pairs a Clinical Therapist with specialized law enforcement officer(s) to respond to behavioral health matters in the community.

Based on WCDHHS data, WKPD is projected to respond to almost 650 calls for service that require the assistance of WCDHHS Crisis Clinician in 2023.

UPDATE: Internal candidate selected; Waiting on MOU to pass legal approval.

Waukesha County Communications (WCC) is frequently the first point of contact for a person experiencing an immediate mental health crisis. This position would be placed at WCC with a dual role to:

- Take calls related to suicide and/or mental health concerns while emergency response is being dispatched by WCC staff.
- Learn in real-time when mental health calls are happening so this worker can alert the 24/7 WCDHHS Crisis Team for potential deployment for all jurisdictions managed by WCC. Based on WCDHHS data, of all crisis calls involving law enforcement, 75% of calls involve a law enforcement agency that is managed by WCC.
- Collect data and conduct timestamping on Crisis calls. Get real-time status updates on medical clearance.

UPDATE: Recruitment posting is live. Developing operating procedures now.

Summary of ARPA Project: Crisis/Law Enforcement Collaboration

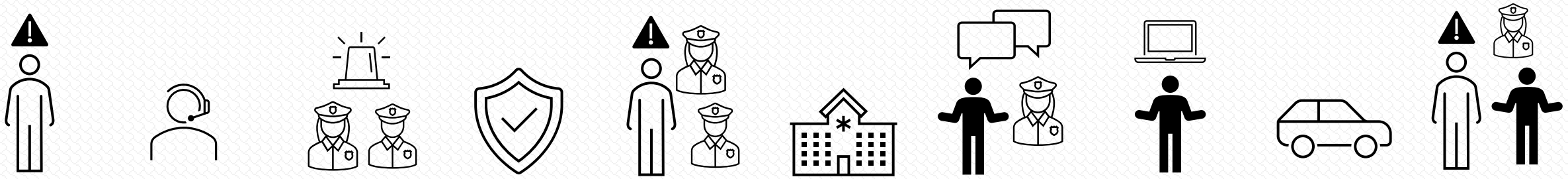
1 Crisis Clinician to expand Embedded Mental Health Professional Program (total of 2 MHPs), Hours M-F 0900-2300)
Fully operational as of November 2022

1 Crisis Clinician to co-respond with specialized officers (ride-along model), Hours M-F 1000-1800
Est. fully operational Feb 2023

1 Crisis Counselor to work alongside telecommunicators at WCC.
Hours M-F 1400-2200 Person started 1/3/23. Program under development.

Embedded Positions* Workflow for Crisis Intervention Calls

*Each crisis is unique and will vary depending on circumstances

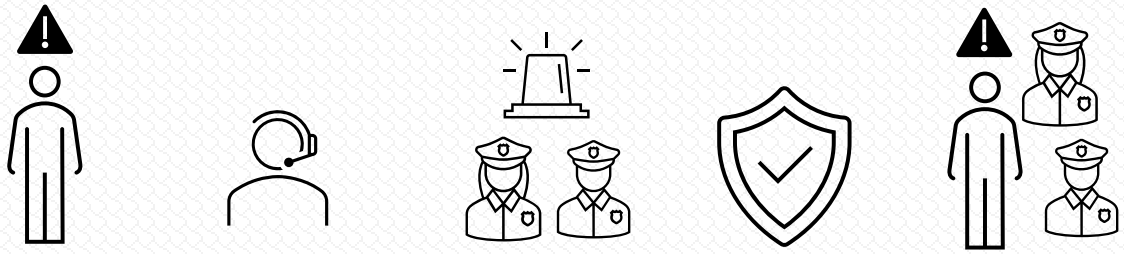


Person in Crisis	911 Call	911 Dispatches Police	Police arrive; Secure the scene	Police gather information	Police call MHC	Police and Crisis connect	Crisis staff reviews records	Crisis goes mobile	Assessment starts

Average: 47 Minutes

Embedded Positions* Workflow for Crisis Intervention Calls

*Each crisis is unique and will vary depending on circumstances



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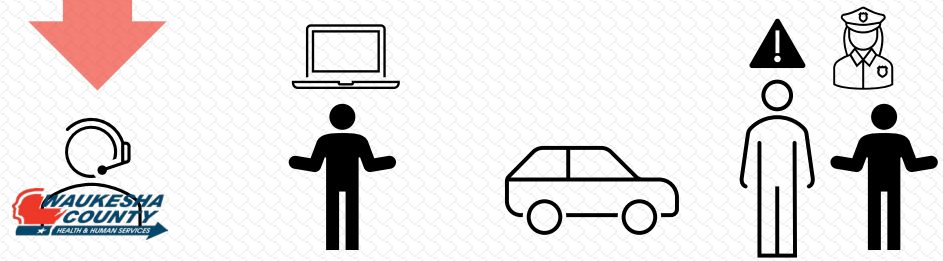


Embedded Staff learn of crisis call	Crisis reviews records	Crisis goes mobile/Rides with	Assessment Starts

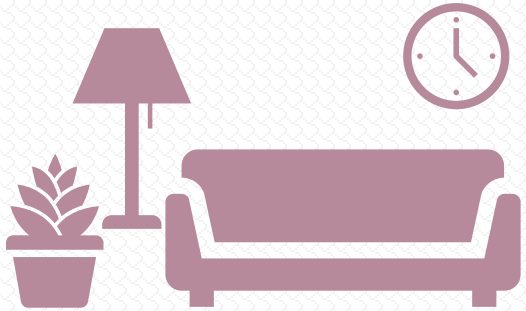
- **Expedite the response** of Crisis staff
- **Reduces time** Law Enforcement spend on mental health calls
- Helps to **identify people in need** of mental health response
- **Reduce arrests**/legal charges for people experiencing a mental health crisis

Intensity of Service

SERVICE CONTINUUM

Cost of Service

Variety of Outpatient Treatment Options



Facility-Based Crisis Stabilization

Inpatient Hospitalization

- Level of care missing from county services
- Home-like, person-centered environment
- Staffed 24/7 with trained professionals
- Cost-effective
- Alternative to hospitalization
- Best practice (Crisis Now – SAMHSA)

MENTAL HEALTH CENTER SUSTAINABILITY

Staffing »

Revenue

Census

- ⊗ Shortage of healthcare professionals since 2020
- ⊗ Recruitment challenges continued through 2021
- ⊗ Staffing impacted diversion rate

- ✓ Innovative recruitment efforts effective in 2022
- ✓ Hired security to allow for more admissions
- ✓ Right-sized staffing levels for reduced capacity

MENTAL HEALTH CENTER SUSTAINABILITY

Staffing

Revenue »»

Census

- ⊗ Operating expenses of two units was increasing ≈ $400,000/year
- ⊗ Diversions to State Institute increased due to staffing

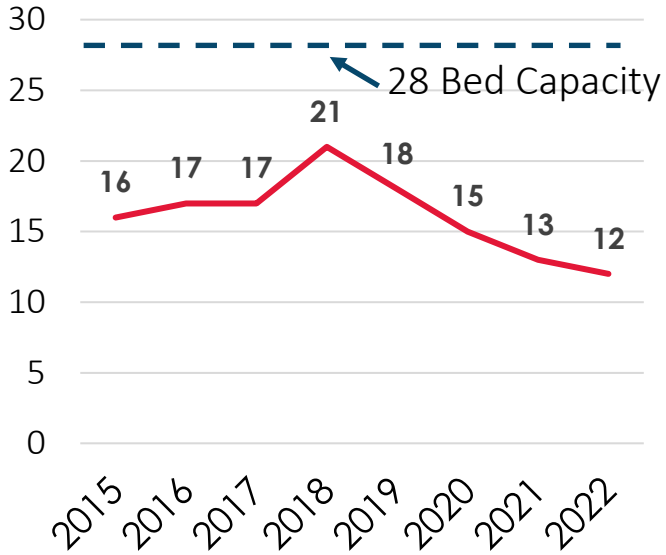
- ✓ Reducing bed size to 16 allowed to drop Institute of Mental Disease status
- ✓ Medicaid covers costs of services with no-IMD status ≈ $158,000/year

MENTAL HEALTH CENTER SUSTAINABILITY

Staffing

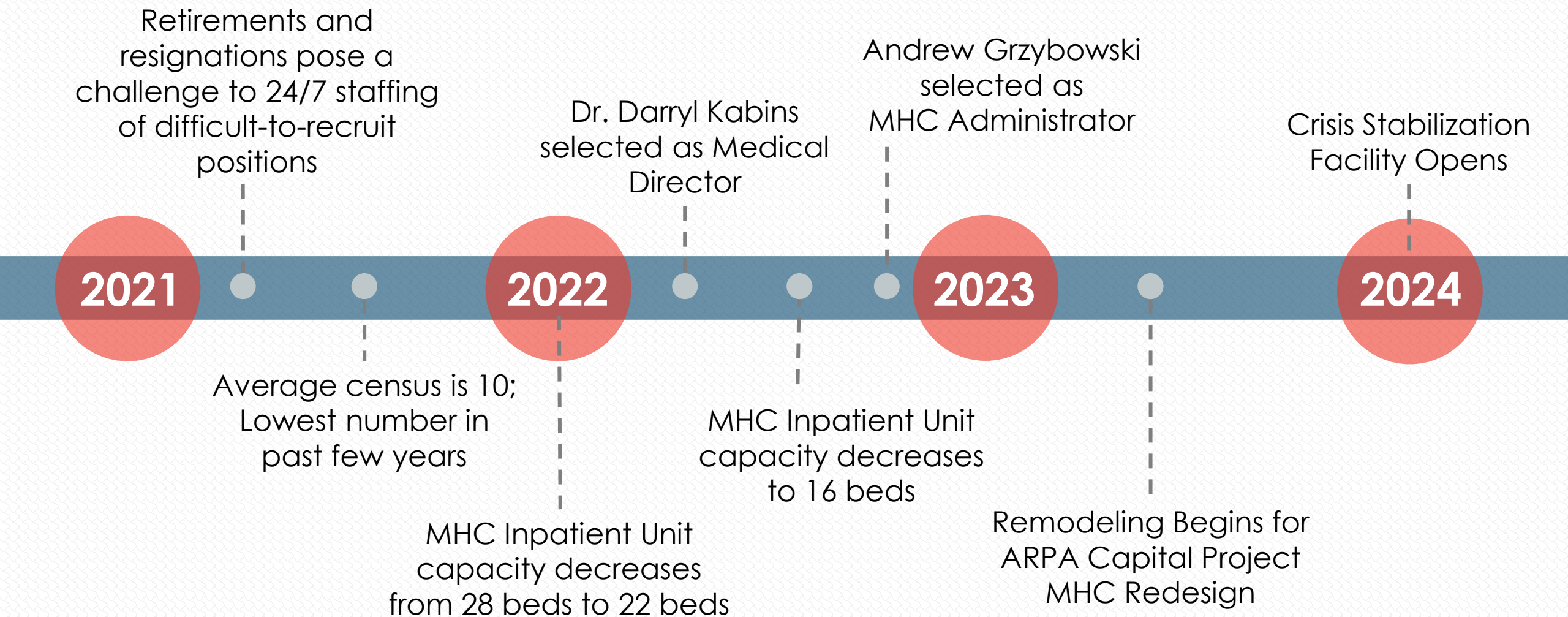
Revenue

Census »»



Average daily census decreasing

MENTAL HEALTH CENTER TIMELINE



Summary of ARPA Capital Project: MHC Redesign

Unit A: Crisis Stabilization

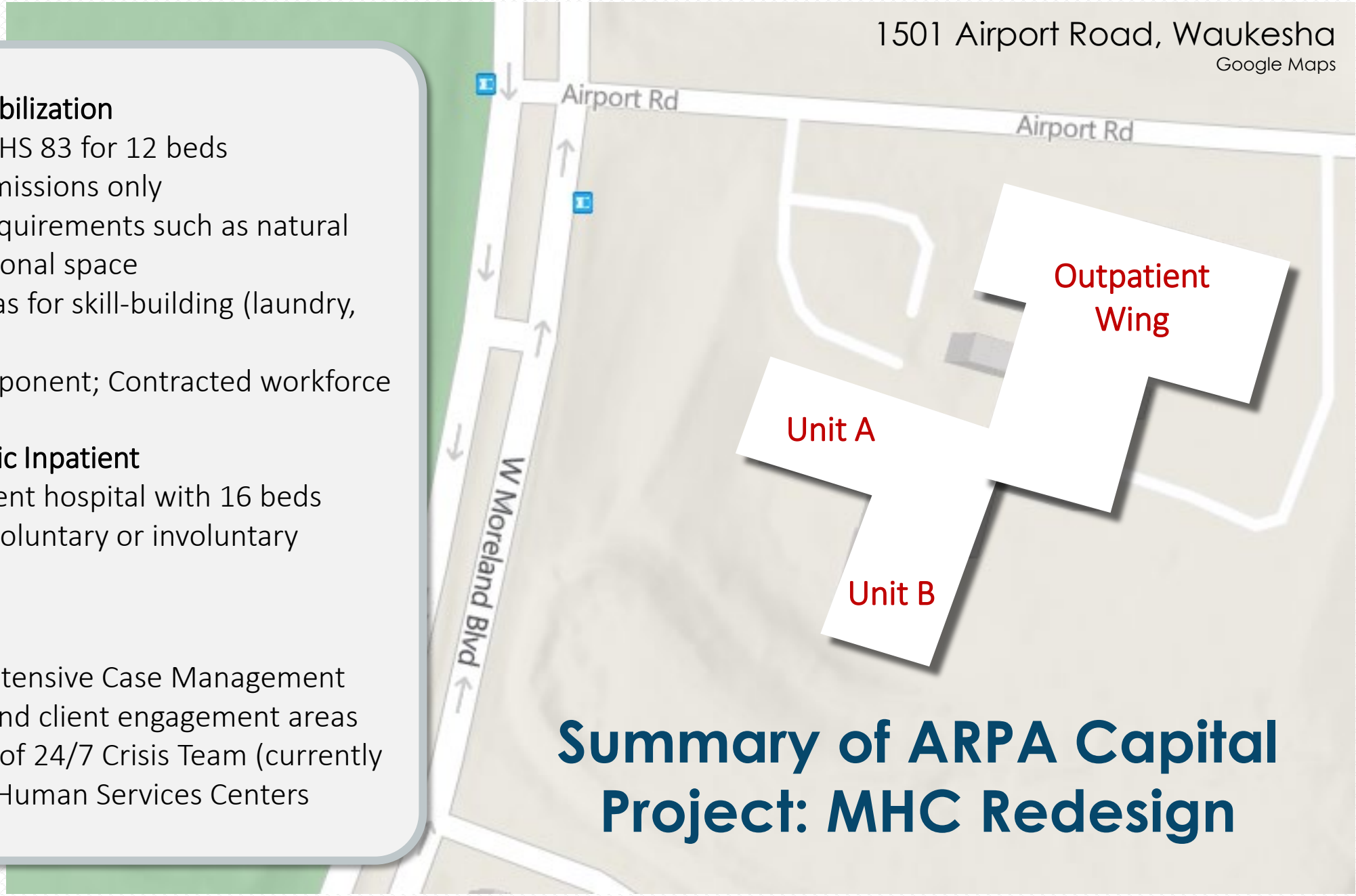
- Licensed as DHS 83 for 12 beds
- Voluntary admissions only
- Living area requirements such as natural light and personal space
- Common areas for skill-building (laundry, kitchen, etc.)
- Regional component; Contracted workforce

Unit B: Psychiatric Inpatient

- Locked inpatient hospital with 16 beds
- May receive voluntary or involuntary admissions

Outpatient Wing

- Upgrade to Intensive Case Management workspaces and client engagement areas
- Future home of 24/7 Crisis Team (currently based out of Human Services Centers




WAUKESHA COUNTY
HEALTH & HUMAN SERVICES
THANK YOU!