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1. Plan for and manage transitions in funding and programs.

#	Initiative Area	Current Status (Where are we now?)	Chosen Target (Where do we want to be?)	Tactics to Close the Gap (How do we get there?)	Measures of Success (How will we know we're there?)	Lead Staff Responsible (Who? By When?)	Progress December 2017
1.a.	Transition County administered MA Waiver services for adults with physical disabilities and frail elders to Family Care/IRIS	Currently there are approximately 450 Frail Elders and 275 Adults with Physical Disabilities served by the Legacy Waiver Programs. All of these consumers and those that are on our waiting list will be transferred to the FC/IRIS Model. Transition is scheduled to begin in 2018. There is a capacity strain on the existing POS agencies and the Long Term Support Unit due to case managers leaving the units to seek employment in areas that will not be impacted by the implementation of FC/IRIS.	▪ Develop strategies that will maximize case load capacity in order to open as many persons as possible on Medicaid Waiver to ensure they can access FC/IRIS Programs during initial transition process. ▪ Minimize disruption and negative impacts to consumers during the transition process. ▪ Maintain current LTS Unit case managers and/or staffing at POS agencies through the transition process.	▪ Aging/LTC Manager will work with POS agencies to creatively look at staffing, work flow systems and sharing of resources to maximize case management capacity. ▪ Aging/LTC Manager will work with DD Manager to explore option of utilizing UW Social Work students to help build case management capacity within the systems. ▪ Aging/LTC Manager will work with DD Manager and DCDHS management to assess ways in which displacement of staff is minimized through reassignment of duties. ▪ As transition progresses, LTS staff will be reassigned to duties that will remain in ACS post transition.	▪ Maximum number of persons are opened from the Long Term Care Services wait list (formerly COPW wait list). ▪ By 5-1-17 identify number of LTEs & student interns needed to preserve case management capacity through the end of the transition process. ▪ By 9-1-17 have student interns in place. Between 9-1-17 and 12-31-17 have additional LTEs identified and hired. ▪ By 9-1-17 identify ACS social work duties that will remain after FC/IRIS transition. Begin reassigning duties as able beginning 12-31-17.	Beth Freeman in coordination with DD Management, ADRC management and DCDHS management	▪ As of 12/31/17 there were 695 individuals open on COPW/CIPII Waivers as compared to 701 individuals at the end of 2016. ▪ Three LTEs and one student intern were hired within the identified timeframe to help with case management capacity and transition needs. ▪ By August 2017 remaining work duties had been identified ACS Case Management Staff impacted by Family Care Transition were surveyed to provide feedback as to their preferred positions post FC/IRIS based on available positions and were informed of their re-assigned duties. ▪ Staff did not begin reassigned duties until 2018.

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1.b.	Transition County administered Adult DD services to Family Care/IRIS.	WI-DHS has announced intention for Dane County operated long term care services to transition to Family Care/IRIS by early 2018.	Develop a systematic transition plan that minimizes disruption to approximately 1450 DD adults receiving services, their service providers and County staff.	▪ Identify unique features of Dane service delivery and work with WI-DHS staff to minimize gaps in future services. ▪ Meet with relevant policy makers to ensure continuity of outcomes. ▪ Create regular forums to share information with POS community, families and people who receive support. ▪ Collaborate with ADRC, LTS unit, POS community, future Managed Care Organizations (MCOs) and IRIS Consultant Agencies (ICAs) to develop information sharing process to communicate critical transition information.	▪ By 3-1-17 establish regular channels of communication with relevant Dane Co HSD staff, WI-DHS. ▪ By 12-31-17 have policy guidance on strategies to preserve outcomes. ▪ By 6-1-17 identify most vulnerable clients and work to ensure they have assistance and support from fellow citizens needed to navigate the FC/IRIS transition. ▪ By 12-31-17 be using agreed upon spreadsheet and process to relay data during FC/IRIS transition.	Monica Bear with assistance from Hunt/Miller/Radloff	▪ Created Dane County Difference Paper in Jan. 2017, presented to MCOs, ICAs, families, providers and DHS staff throughout first quarter. ▪ Participated in weekly call-ins with WI DHS beginning 6-2017. ▪ Hunt coordinated on-going monthly workgroup re: vocational outcomes and developed youth transition service package to sell to MCOs and IRIS participants beginning 2-2018. ▪ Bear developed DD crisis service array to sell beginning 2-2018; County managers and broker agencies collaborated to identify high risk individuals and communicate to MCOs and ICAs upon individual's enrollment selection. ▪ July to October 2017, identified citizen support to accompany individuals requesting additional assistance to ADRC for enrollment counselling. ▪ Collaborated with LTS Unit to establish standardized filing format and IT to ensure secure transmission of individual files beginning 10-2017. ▪ Collaborated with LTS to developed process to communicate individual enrollment decisions to POS providers beginning 10-2017.

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1.c.	Increase number of DD children on CLTS waiver	Currently serve 515 children on CLTS waiver; an additional 425 are on the waiting list. WI-DHS has announced intent to eliminate CLTS wait lists by the end of the 2018/19 biennium.	▪ Reduce wait list by 60 children by 6-1-17. ▪ Reduce wait list by an additional 60 (annual total 120) by 12-31-17.	Enlist DD-Adult case managers and POS providers to assist with intake, enrollment and on-going case management.	▪ 60 additional children will be receiving supports from the CLTS waiver by 6-30-17. ▪ 60 additional children will be receiving CLTS supports from 7-1-17 to 12-31-17.	Bear/Radloff December 2017	100 additional children added to CLTS waiver between 1-1-2017 and 12-31-2017. Decision to delay additional enrollments until 2018 was made due to Family Care transition and late passage of the State budget. Intent to eliminate current CLTS wait list in entirety by 12-31-2018.
1.d.	Family Care Model Transition planning	Family Care Model Transition planning	The ADRC will have a comprehensive plan to smoothly enroll approximately 2,300 people from the Legacy Waiver programs to Family Care/IRIS.	▪ Staff training will be developed. o The ADRC staff had training from ORCD staff and ADRC Management to help educate them on the transition and the process. ▪ Staff procedures will be developed and some existing procedures will be updated to match the Family Care/IRIS transition. o Procedures were developed for staff to follow and staff had cases assigned to them to work on during the transition along with target number to reach for enrollments into the new programs. ▪ Regular meetings will be held with County and State staff for planning. o Weekly calls are held between the ADRC and ORCD staff to work on the transition.	By the end of 2017 the ADRC will be ready to enroll customers into Family Care/IRIS.	Jennifer Fischer, ADRC Manager Joe Purcell, Lynn Riley, Bill Huisheere, I and A Supervisors Deb Solis, ADRC Program Specialist Dec 2017	By the end of December 2017, the ADRC had transitioned over 50% of customers from the legacy waiver program into the Family Care, Partnership or IRIS programs.

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2. Maintain successful regionalized services.

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2.a.	Mobility Services for All Americans Grant	Dane County Department of Human Services Transportation Unit along with ten other Southern Wisconsin counties agreed to partner with Greater Wisconsin Area on Aging Resources (GWAAR) on a planning grant to develop a regional Travel Management Coordination Center (TMCC) plan that coordinates human services transportation for older adults, Veterans, persons with disabilities, individuals with lower incomes and other transit-dependent user groups using technology solutions.	The plan for the TMCC and the cloud based information platform will be collaboratively developed with prospective participants: transportation users, providers, service agencies and health care providers, with the emphasis to connect the project to healthcare facilities, using the Design Thinking model.	▪ Reach out to partners in the community to explain the TMCC and its transportation benefits. ▪ 4 to 6 partners identified. ▪ Reach out to health care facilities to build a partnership. ▪ Health Care Facility selected. ▪ Organize a Project Advisory Committee of transportation users to evaluate each phase of the plan. ▪ Participate in the Design Thinking Sessions.	A TMCC plan is developed.	DCDHS Transportation Coordinator Jane Betzig December 2017	• Stakeholder kick off in February 2017. Partners include County Human Service Departments, ADRCs, healthcare clinics, transportation providers, SMV services, case managers and city councils. • Stakeholder research survey interviews were completed in Mar. and Jul. 2017. • Stakeholder needs assessment and current practice surveys completed in Sep. 2017. • Stakeholder/Advisory Panel Design Thinking session 11/7/17 based on surveys. Four transportation areas: Agreements, Outreach and Recruitment, Data Collection and Software. • Design Thinking Session led to three potential prototypes: Mobility Management Suite, transportation provider suite, transportation driver module.

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4. Assess and implement evidence-based service delivery models.

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4.a.	Increase the number of individuals continuing in alcohol and drug treatment	In 2015 Hope Haven referred 21 successfully discharged County funded or standard BadgerCare clients to outpatient treatment at Journey Mental Health Center. Of those, 11 (52%) followed through with some treatment at JMHC. The average number of hours of treatment at JMHC was 7.27 hours, representing slightly less than four weeks of outpatient treatment for those who followed through.	75% of Hope Haven's County-funded successfully discharged clients follow-up with outpatient or intensive outpatient (IOP) treatment for a minimum of 8-9 weeks following discharge; goal is 90 consecutive treatment days.	▪ Change verbiage from "aftercare" to "continuing care". ▪ Establish a weekly continuing care orientation/education group introducing the concept that substance use disorders are chronic conditions that require ongoing treatment. ▪ Make referral and intake appointment for continuing care within first seven days of admission. ▪ Begin continuing care while in last week of residential or transitional residential treatment: Warm Handoff approach. ▪ Follow-up at 7, 30, and 60 days after discharge with individual and continuing care agency.	Data to reflect successfully discharged participants continued in treatment up to 90 consecutive days.	DCDHS AODA Manager Todd Campbell and AODA Specialist Debra Natzke December 2017	▪ Increased continuing care connections from residential to IOP from 50% in 2015 to 71% in 2017. ▪ 82% of Dane County funded clients discharged from Hope Haven had continuing care appointment set up before discharge from residential treatment.
4.b.	Integrate Mental Health, Substance Use, and Alternative Sanction Services into one system of care	Currently, mental health, substance use, and alternative sanction are in both the CYF and ACS Divisions.	One system of care, Behavioral Health, that incorporates services for mental health, substance use, and alternative sanctions	▪ Explore known evidence based practices used by systems that have previously integrated. ▪ Organize services into service areas for integrated mental health and substance use and align budget accordingly. ▪ Develop a management structure that oversees the service areas. ▪ Engage POS providers to provide input into the transition, including the development of a vision/values statement. ▪ Incorporate integrated care expectations in POS contracts and RFPs.	▪ POS providers will endorse a vision statement for behavioral health integration. ▪ The County's contracts and budget will reflect integration of mental health and substance use services. ▪ An integrated management structure will be in place.	Todd Campbell, Mary Grabot, Carrie Simon, Debra Natzke, Jennifer Hendrickson December 2017	▪ With input from POS providers, advocates and consumers, a vision statement was created: Collaborating for Recovery. ▪ Integration was discussed with the mental health system and Recovery Coalition to gather more information and support. ▪ Management and budgetary structures were discussed, including draft models. ▪ Targeted Case Management RFP was issued which asked the same thing for mental health as it did for substance use services. ▪ Retitled AODA Manager to Behavioral Health Manager and recruited to fill that position.

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5. Assess and enhance the Department's service outcomes.

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5.a.	Adult Protective Services	▪ In 2015, 6.6% of the elder abuse and neglect (EAN) reports were referred by law enforcement. It is believed that law enforcement comes into daily contact with elders where there is an EAN concern. ▪ There are approximately 30 financial institutions in Dane County and Adult Protective Services has Memorandum of Understandings with less than 25% of them. Financial exploitation is the second largest area of concern for Adult/Elders at Risk.	▪ Law enforcement is aware of APS resources for elders. ▪ Dane County financial institutions are aware of APS resources to individuals over the age of 18. ▪ Dane County financial institutions are aware that they can report financial concerns to APS.	▪ Provide two trainings to law enforcement and EMS staff: one training will be with NESCO focusing on North/East Madison emergency responders; the second training will be with Colonial Club staff to focus on Sun Prairie emergency responders. ▪ Memorandum of Understandings will be sent to all of the financial institutions in Dane County.	▪ The number of referrals from law enforcement will increase in comparison to referrals received in 2016. ▪ APS will have MOU's from 75% or more of Dane County's financial institutions.	Shari Gray-Dorn, APS Supervisor, EAN staff, NESCO and Colonial Club staff. December 2017 Shari Gray-Dorn, APS Supervisor December 2017	• In 2016, 7.10% of EAN reports came from Law Enforcement. Presentations were held on 6/28/17 at the Colonial Club and on 12/4/17 with NESCO. • APS completed MOU's with 74% of Dane County's financial institutions.
5.b.	Supportive Home Care (SHC) funding is intended to provide limited assistance with personal cares and household chores to support Frail Elders staying in their homes.	▪ At this time, SHC program funding is not equitably distributed to persons served by the 15 Focal Points in Dane County. Currently there are 60 frail elders receiving services through SHC – approximately 6 hours of service per month. However, these 60 consumers are only from 6-8 of the 15 Focal Points. ▪ With the upcoming transition in Dane County to FC/IRIS the SHC funding will be an important piece of supporting frail elders in their home until they become eligible for Medicaid funded long term care.	▪ Frail elders across the County eligible for SHC funding have access to it. ▪ There are consistent and equitable formulas developed to determine how much SHC funding may be made available to each Focal Point.	▪ Aging/LTC Manager will assess spending of SHC monies across Focal Points in 2016. ▪ Aging/LTC Manager will work with program analyst and accounting to develop a formula by which SHC funding may be allocated to Focal Point agencies based on: o Population of older adults in a community; o Number of older adults who fall below 225% of the Federal Poverty guidelines; o Number of clients and units of service provided in 2016 to existing Focal Points – if any. ▪ Development of policy guidelines under which each Focal Point agency will administer their SHC funding allocation. ▪ Meet with providers and Focal Points about the proposed changes.	▪ Systems are in place for equitable distribution of SHC monies among the Focal Points. ▪ Focal Points and contracted SHC providers are informed about changes to the SHC program administration.	Beth Freeman	▪ SHC Work Group established – Work Group consensus to utilize AAA Case Management Formula to determine allocation of SHC services/funding to 15 Focal Points. Additional work to be completed on updating policy guidelines and forms related to SHC program. ▪ Update on overall status of SHC program re-design was not able to be shared in 2017 but email update to Focal Point system on 2/12/18 was done. ▪ Focal Points that would see a decrease or elimination of SHC funds were directly notified prior to system update. This included West Madison Senior Coalition, East Madison Monona Coalition and North/Eastside Senior Coalitions.

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5.c.	Evaluate the transportation funding distribution for the Rural Senior Group Access Program	The Rural Senior Group Access Program assists 60+ seniors and persons with disabilities, who live outside the Metro Transit boundaries, with transportation to shopping and nutrition. Group rides are coordinated through the Focal Point closest to where riders live. Each rural community has unique transportation criteria that affect the cost of transportation.	To distribute transportation funds to Focal Points equitably	▪ Reach out to rural Focal Points to discuss transportation funding distribution. ▪ Discover transportation barriers in rural communities. ▪ Discover economic data that effects transportation in rural communities. ▪ Decide what criteria affects transportation in different rural communities. ▪ Obtain and read the nutrition site equitable study. ▪ Meet with staff that developed the nutrition study for discussion.	Identify criteria using transportation barriers and population data for each Dane County Focal Point and distribute funds accordingly	DCDHS Transportation Coordinator Jane Betzig December 2017	• The Focal Points with high attendance received increased funds due to extra bus seat needs. • Rural communities requiring greater driving miles and time received funding to account for this. • Funding was available to offer transportation to monthly activities outside of the community, to lengthen the time at the nutrition sites and to increase number of shopping days per week.

6. Improve alternatives to inpatient care for children and adults.

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6.a.	Ensure the smooth transition from two Care Centers to one in 2017	The County is contracting with one Care Center for 3,650 units. In 2016, we contracted for 3,729 service units, which was an all time high. Inpatient costs are well over budget and have been historically as well. Four individuals have remained in long term care Institute for Mental Disease (IMD) settings out of county and one individual was in Mendota all of 2016.	▪ Increase the use of diversion options, including the care center, Recovery House, contracted group homes and support services. ▪ Ensure the community is aware of the change to one care center and how to access it. ▪ Ensure that the Care Center provider makes appropriate decisions regarding admissions and prioritization.	▪ Explore shared risk and different service approaches for high need individuals. ▪ Monitor the use of the Care Center and other crisis stabilization supports. ▪ County and Crisis staff review decisions regarding hospitalization. ▪ Centralize residential referrals and decision making regarding prioritization and funding. ▪ Consult with care center provider weekly regarding admission and prioritization decisions. ▪ Maximize use of Recovery House, contracted group homes and support services.	▪ Care Center utilization meets or exceeds 3,650 units. ▪ Inpatient Adult MH costs fall within budget. ▪ 3000 or fewer WMHI/MMHI days. ▪ Discharge clients from out-of-County placements and return them to community services. ▪ Fewer individuals are returned to inpatient settings.	Mary Grabot, Carrie Simon, Todd Campbell, County Administration December 2017	▪ Care Center utilization was 3,350 units. Bayside provided 38 days in January until all admits went to Tellurian's Care Center. Intake changed due to using only one facility, making it easier to make decisions, admit or make alternate plans. ▪ Inpatient utilization exceeded budget by $319,565. ▪ 3,859 days at W/MMHI exceeded goal of 3000. ▪ One client left Trempeleau County Health Care Center and another one is being planned for discharge in 2018. ▪ Dane County still has a high return rate. Dane was the highest in the State in 2015 and 2016. JMHC and County met several times in 2017 to discuss this issue.

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8. Diversify and maximize revenue streams.

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8.a.	Ensure that appropriate funding streams are used for contracted service units and that POS providers earn budgeted contingent revenues	Many programs are under a contingent earning basis in 2017. Revenue targets are adjusted annually in an effort to have reasonable, accurate budgetary targets.	▪ Revenues are maximized, risk to County is minimized, and POS providers have incentives for increasing revenues earned. ▪ Programs have sufficient match for earned MA revenue.	▪ Ensure that budgets and contracts have reasonable and accurate revenue targets; ▪ County staff to closely track service units and revenues, and adjustments are made annually. ▪ Unit and revenue data is shared with POS programs monthly. ▪ Payments to programs are based on revenues earned. ▪ DCDHS makes policy decisions regarding netting and risk-sharing and communicates those policies to POS partners. ▪ Improve methods of securing patient consent to bill insurance for inpatient care. ▪ Define contract terms that improve transparency of services purchased and clients served.	▪ Programs are producing service units as contracted and earning budgeted third party revenue. ▪ Inpatient Adult MH costs fall within budget and collections are maximized.	Mary Grabot, Carrie Simon, DCDHS fiscal and management staff December 2017	• Many programs produced fewer service units and therefore less third party revenue in 2017. In part, this was due to the quick expansion of the Comprehensive Community Services (CCS) Program. Many programs did not adequately staff their programs in order to meet contract expectations along with CCS services. • Inpatient costs exceeded budget by $319,565. Getting insurance forms signed so that insurers can be billed for services still remains problematic as we don't often know where the person is after discharge or have no means to mandate that the person signs the release forms.
8.b.	Continue to enhance the Comprehensive Community Service (CCS) infrastructure to better meet the needs of the program	The CCS Module is not fully developed which makes workflow more challenging. At this time we still need to develop the Eligibility (Intake/Discharge), Assessment, Desktop, and scanning capabilities in the CCS Module. Progress has been made on automating billing processes, but this is not complete. Reports have been added to allow providers to track revenue cycle. Over 400 consumers are enrolled in CCS. Twenty agencies are providing service facilitation. Quality of progress notes and recovery plans is extremely variable and sometimes substandard.	▪ A user friendly IT system that allows providers easy access, confidentiality, ability to complete workflow, and accurate billing for CCS services provided; ▪ Improved quality of documentation; ▪ Ensure ongoing availability of sufficient service facilitation capacity to meet consumer demand.	▪ Weekly meeting with IT staff to track progress and work towards goals; ▪ Provider re-training in progress note and Recovery Plan documentation; ▪ Ongoing IT development and training of staff in new CCS Module functionality; ▪ Market to service providers to expand service options and maintain network capacity. ▪ Complete billing automation.	▪ Further development and launch of Eligibility, Desktop, and Assessment functions in CCS Module; ▪ Development and completion of advanced re-training in recovery plan development to service facilitators; ▪ Accurate reimbursement that coincides with the billing that was entered into the CCS Module and ability of providers to run necessary reports to verify revenue cycle.	Julie Meister, Carrie Simon and Mary Grabot December 2017	▪ Eligibility, Desktop, and Assessment functions in CCS Module did not launch in 2017. ▪ Completed re-training on Assessment and Recovery Plan in April 2017. Began work on Mental Health Professionals Bootcamp training for 2018. ▪ Reimbursement has been accurate within 1% error. Reports have been added, however will be further enhanced once more billing info is in CCS Module in 2018. ▪ Added 21 agencies with 228 staff in 2017. ▪ Have 689 participants in CCS as of December 2017. ▪ Hired Data Analyst and Admin Asst. ▪ Provided training for facilitators and MHPs.