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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 2016
1a.	Mental Health Community Options Program (COP), OBRA, MH Matching and MH Block Grant funding of $1,076,985 ended December 31, 2015. Community Mental Health Allocation (CMHA) replaced this funding with new criteria for its use.	Mental Health staff are defining the use of the CMHA to meet State requirements while at the same time, continuing to fund COP enrolled individuals' services. Not all of the COP approved services are CMHA approved.	Individuals who were enrolled in COP as of December 31, 2015 will transition out of COP-funded services by securing other resources or enrolling in Community Recovery Services (CRS).	▪ Define the use of funds for each service area; ▪ Create a structure to fund services not approved within CMHA; ▪ Expand the Community Recovery Services (CRS) and the Comprehensive Community Services Programs' (CCS) enrollment; ▪ Inform system individuals and staff regarding the changes; ▪ Hire a Behavioral Health Resource Specialist to assist individuals with accessing services covered under their insurance provider.	▪ Individuals continue to get needed services necessary to maintain their ability to live in the community using the appropriate funding. ▪ There is a smooth transition to the new system. ▪ Maximize use of CMHA funds to draw down federal MA revenue.	Mary Grabot December 2016	▪ The State defined what services could be funded by CMHA. A structure was developed for use of the CMHA funds. Worked with Case Managers and clients to assess each client need and made decisions about what could be funded. Most services were funded thru June and some were funded thru Dec. ▪ There was one appeal file, which resulted in a hearing. Otherwise, a very smooth transition. ▪ All CMHA funds were used.
1b.	Expand Jail Re-Entry Services to provide case management for Dane County Jail inmates who have substance use concerns.	The 2016 budget included funding for Genesis Social Services to provide case management to Dane County residents re-entering the community following incarceration at the Dane County Jail.	Participants will reduce their frequency of use of alcohol and other drugs at the time of discharge when compared to the time of admission. (The frequency of use at admission and at discharge shall be based on non-incarcerated time only.)	▪ Case management service to begin prior to release from Dane County Jail. ▪ Assure half of the program's participants will participate in an AODA assessment following release from Dane County Jail.	Frequency of use has reduced among participants at the conclusion of their involvement in the program.	Todd Campbell December 2016	In 2016 Genesis Social Services started up this service. They opened eight current and former jail inmates and made contact with several more. Three individuals were discharged in 2016. Two of the three individuals (67%) reduced the frequency of their substance use.

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1c.	Intellectual/Developmental Disabilities (I/DD) children's case managers will be qualified to provide services to dually eligible CLTS/CCS children and young adults.	I/DD case managers are trained and credentialed to provide case management to participants of the CLTS and other DD home and community based waivers.	All I/DD children's case managers and community services manager will be trained and credentialed to provide CCS service navigation to children dually eligible for CLTS and CCS waiver services.	All case managers, case manager supervisor and community services manager will attend trainings required to bill for CCS service navigation.	By December 2016 all impacted staff will have completed required training and submitted necessary documentation to CCS program specialist for credentialing.	Angela Radloff/Monica Bear December 2016	All I/DD Children's case managers completed CCS certification in 2016. The number of dually eligible CLTS/CCS children was lower than anticipated due to State changes in eligibility criteria. One dually enrolled child is being served in the ACS Division.
1d.	With the State of Wisconsin deciding to implement Family Care statewide in January 2017 or as soon thereafter as the Wis. Dept. of Health Services deems reasonable, DCDHS's adult service system needs to plan for the eventual transition from Medicaid waivers to Family Care/IRIS 2.0.	▪ There are about 2,200 adult consumers receiving Medicaid Waiver services. ▪ Many local agencies and businesses provide MA Waiver funded services. These agencies and businesses and their employees will be impacted by the transition to Family Care. ▪ MA Waiver funding helps to cover administrative, facilities and infrastructure costs in DCDHS and the Adult Community Services Division. ▪ Dane County has unique services and exemplary outcomes that could be compromised or lost in the transition to FC 2.0.	DCDHS identifies steps to take to minimize disruption and negative impacts to consumers, families, POS agencies, DCDHS staff and future DCDHS operations.	▪ Engage DCDHS staff, consumers, family members, guardians, POS providers, elected officials and other stakeholders in conversations regarding the upcoming transition; ▪ Use this information to develop first draft of a transition blueprint; ▪ The draft document attempts to identify roles of County staff during the transition, what County staff positions will endure beyond the 2.0 transition; how County can partner with POS partners to best serve participants during transition; a fiscal plan for DCDHS during and post transition and what if any role Dane County will maintain in a redesigned long term care system.	By December 2016 we will have the first draft of a transition blueprint.	Fran Genter, Lynn Green, Jean Kuehn & Edjuana Ogden, with support from DCDHS program and fiscal management staff December 2016	▪ The Wis. Dept of Health Services (DHS) intends to transition Dane County to Family Care in 2018. Dane will be the last county to move to Family Care. ▪ County staff have met with State of WI DHS staff for broad overview of transition timeline and activities as well as small group meetings to discuss specific questions/issues. ▪ DHS has issued an RFP for MCOs in Dane County. The RFP is due mid-May. ▪ Fiscal models have been developed and shared with Department of Administration. ▪ Transition planning continues in 2017. The communication plan includes meetings with interested Department staff and specific units as requested. Intermittent meetings with oversight committees (H&HN, HSB, LTS, AAA, ADRC and P&F) are planned as more information becomes available.

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1e.	Maximize caseload capacity while enhancing the timely processing of new COPW / CIPII pending applications	Current wait list time for frail elderly participants is one year and wait list time for adults with physical disabilities is nearly two years. Any persons on the COPW or CIPII waiting list 90 days prior to transition to Family Care 2.0 could wait up to 3 years to be enrolled into Family Care 2.0. It is incumbent upon DCDHS to maximize caseload size, shorten wait list times and process new applications in a timely manner. This will ensure the maximum number of COPW/CIPII participants can be transitioned to Family Care 2.0 when it arrives in Dane County	▪ Monthly monitoring of caseload capacity, attrition and waitlist; ▪ Caseload capacity within the Aging/PD system will be increased prior to Family Care 2.0 implementation.	▪ The Aging/PD LTC Program Manager will work with IT to develop a report that measures the following each month: number of clients open on COPW/CIPII, number of clients closed on COPW/CIPII, number of new clients opened onto COPW/CIPII, CM units reported by POS agency and LTS case manager. ▪ The Aging/PD LTC Program Manager will request start up monies from the State to expand case management capacity with POS agencies.	▪ At a minimum, all LTC case managers will serve 30 clients by the end of 2016. ▪ Each POS agency and LTS will open an average of 3 new COPW/CIPII clients per month. ▪ By the end of 2016 the Frail Elder wait list will be under 1 year. ▪ By the end of 2016 the PD waiting list will be under 1 year. ▪ Case Management capacity will be expanded at CLA and SMCE by one case manager.	Beth Freeman December 2016	▪ Due to significant turnover of case management staff across the 3 units serving older adults and adults with physical disabilities in 2016 the goal of case management capacity of 30 individuals for each case manager has not been fully met. This issue has been further compounded by difficulty in finding staff to fill open positions due to the Legacy Waiver programs sun setting in 2018. ▪ Waiting lists remain at 12-14 months for older adults and nearly 36 months for adults with physical disabilities. ▪ Start up monies for a new case management position at CLA were secured in July 2016, however, the new position was not filled until late 2016. As a result, capacity was not expanded as fully as anticipated. Funds were focused on CLA since the PD wait list has the longest wait time.

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3. Improve outcomes for people of color and other cultures.

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3a.	United Family Caregivers Grant	▪ The ADRC of Dane County along with the ADRC of Milwaukee County agreed to partner with the Wisconsin Department of Health Services on a research grant to provide support to African American caregivers of people with dementia. Other grant partners include the Wisconsin Alzheimer Institute, Alzheimer Association, Alzheimer and Dementia Alliance, and United Community Center. ▪ The ADRC is in the process of hiring a Caregiver Coach to participate in this research study and do outreach to the African American population in Dane County.	In 2016 the Caregiver Coach will enroll 10 families into the United Family Caregivers program and also do at least 10 outreach events specifically targeting African American caregivers.	▪ Reach out to partners in the community to explain the program and benefits for caregivers of the program; ▪ Advertise the United Family Caregivers program during ADRC outreach; ▪ Reach out to local dementia organizations and memory clinics to let them know about the program and how to refer customers to the program.	▪ The Caregiver Coach will receive referrals from the ADRC staff and other community partners. ▪ The Caregiver Coach will enroll 10 caregivers into the United Family Caregivers Program.	TBD Caregiver Coach Jennifer Fischer, ADRC Manager December 2016	▪ The Caregiver Coach was hired for the position on March 4, 2016. ▪ The Caregiver Coach has completed a series of outreach events in the community regarding the United Family Caregivers (UFC) Program. ▪ The Caregiver Coach has received referrals from the ADRC and community partners for the UFC Program. ▪ The Caregiver Coach has worked with 9 families interested in the program but none of them officially enrolled in the research project.
3b.	I/DD managers and intake staff will improve their ability to communicate the process for enrolling Spanish speaking participants in adult waiver services.	I/DD adult staff rely on bilingual children's case managers or ADRC staff to communicate high school transition information to between 3-5 families per year. No sharable, Spanish language, written materials exist.	Have written, Spanish language, transition materials to share with young adults, their families, support teams, ADRC staff and high school transition teachers	▪ Obtain translator to develop Spanish language transition materials; ▪ Print materials for dissemination during 2016 high school transition process.	All students, families and interested parties will have Spanish language transition materials available upon request.	Monica Bear February 2016	▪ DD high school transition materials were translated into Spanish in time for 2016 high school vocational transition. ▪ Materials were shared with all Spanish speaking families, ADRC and relevant high school transition teachers.

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

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4a.	Healthy Living with Diabetes Evidence-Based Class	The ADRC has partnered with Access Community Health to offer the evidence-based Healthy Living with Diabetes to interested participants at the Access clinic.	Introduce evidence-based programs at the ADRC that may improve the health of Dane County residents	▪ The ADRC will send two staff Mindy Russel and Anna McCabe to become trained in the Healthy Living with Diabetes evidence-based class. ▪ The ADRC and Access will advertise these classes to obtain customers interested in participating in the class.	▪ Hold one Healthy Living with Diabetes class at Access Community Health Center this spring; ▪ Hold one Healthy Living with Diabetes class at the ADRC this fall.	Trained Healthy Living with Diabetes staff – Rich Zietko, Stephanie Hendrix, Michelle Hahn, Mindy Russel and Anna McCabe Lynn Riley, ADRC Supervisor December 2016	▪ The ADRC held the Healthy Living with Diabetes class at the Access Community Health Center. Fifteen people registered for the class. ▪ The ADRC also held a class at the Mount Horeb Focal Point that had 10 people register for the program.
4b.	Adopt redesigned Operating While Intoxicated (OWI) Court admission process that assigns individuals to the program based on their assessed risk to commit additional crimes.	▪ The OWI Court accepts all individuals who meet criteria, which does not take into account the individual's risk to commit additional crimes. ▪ In 2015 the average time from arrest to OWI Court admission was 287 days.	▪ Eligible participants are identified early and admitted to the OWI Court program (Key Component #3 of Problem Solving Courts). ▪ Eligible participants are admitted to the OWI Court program by factoring in their assessed risk to recidivate.	▪ Adopt the use of a risk assessment instrument with individuals meeting other admission criteria of the OWI Court program; ▪ Continue discussions with partners in the criminal justice system about a revised referral and intake procedure; ▪ Other programmatic adjustments will be reviewed to enable participants' more prompt admission to the OWI Court program.	Eligible participants will be admitted to the OWI Court within an average of 215 days from the time of an individual's arrest (25% reduction).	Todd Campbell, Journey Mental Health Center, Circuit Courts, Court Commissioners, District Attorney's Office, State Public Defenders Office, State Department of Corrections December 2016	▪ The use of a risk assessment geared specifically to intoxicated drivers is being piloted with new Dane County OWI Court participants. ▪ Revising the referral and intake procedure is on hold pending review of risk assessment pilot. ▪ Time from charge to 2016 admission increased to 356 days.

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

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5a.	Increase utilization of the Bus Buddy and Mobility Training Programs, which train individuals to independently use fixed-route public transit, local shared-ride taxis and county-funded group transportation services	▪ In 2013, Dane County funded these two travel training programs at a maintenance level, after losing New Freedom (Sec. 5317) funding for them. ▪ In 2014 a new funding source (expanded Sec 5310) was identified and it was anticipated the programs would receive increased referrals, due to a newly-funded Metro Transit In-Person Assessment (IPA) project. There were some referrals, but the program was still under-utilized. In 2014 a successful small pilot providing group transit-familiarization excursions was cited to secure 2015 funding. ▪ In 2015 group transit excursion programs were well received, and 81persons received training. Since all four excursions were fully attended, seniors requested continuation of the excursions program for 2016.	▪ Increase the number of persons trained to use fixed-route public transportation through the Bus Buddy and Mobility Training Programs	▪ Continue to work with Metro Transit's IPA project to increase referrals of appropriate individuals; ▪ Continue to receive referrals from ADRC and Focal Point staff to the Mobility Training and the Bus Buddy program; ▪ Increase the number of referrals from teachers and case managers of high school students with disabilities to mobility training; ▪ Continue to host group transit-familiarization excursions to familiarize seniors with Metro; ▪ Graduates who migrate rides from Metro paratransit to accessible fixed-routes will receive free commuter bus passes from Metro Transit.	▪ Increase the number of group transit excursions (4 excursions in 2015); ▪ Increase utilization of the Mobility Training program (MTILP) by 20% (13 people served in 2015); ▪ Increase utilization of the Bus Buddy (BB) program by 50% (91 people served in 2015).	Transportation Manager; Mobility Program Specialist December 2016	▪ Four excursions in 2015; six excursions in 2016. ▪ 13 people were served by MTILP in 2015. 19 people were served by MTILP in 2016. This is a 45% increase. ▪ 91 people were served by BB in 2015. 125 people served by BB in 2016. This is a 37% increase.
5b.	Update Supported Living Guidelines so that all I/DD supported living providers share a common definition of and framework for delivering services	Supported Living Guidelines were last updated in 2001.	A current, Supported Living Guidelines co-created by County staff and POS agencies is shared at Supported Living Coalition, posted on the County website and widely disseminated to interested parties.	▪ County staff will work with Supported Living Coalition to review and revise existing guidelines. ▪ Consultant will synthesize, solicit feedback and edits then produce a final document. ▪ Document will be disseminated to stakeholders and posted on the County website.	2016 Supported Living Guidelines will be shared at April 2016 Supported Living Summit, e-mailed to I/DD stakeholders and posted on County website by May 2016.	Sue Werner June 1, 2016	Supported Living Guidelines were updated and distributed by April 2016. All supported living providers received a copy. Over 100 supported living staff attended the summit/training event where guidelines were introduced and reviewed. This was posted to the County website.

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5c.	Continue the successful TimeBank Transportation Project (formerly Rural Renal Dialysis Transportation Project); Expand trip purposes to include rides for outpatient therapies, for example, chemotherapy, radiation, and physical therapy.	▪ In 2012 DHS received a small grant from the National Center for Senior Transportation to pilot TimeBanking as a solution to providing transportation assistance to non-Medicaid dialysis patients. The pilot was successful and the funding was extended by the County. ▪ In 2014 the program expanded rides to include slightly-sedated outpatient procedures. ▪ In 2015 the Transportation Call Center received numerous ride requests for individuals requiring transportation to outpatient therapies (chemotherapy, radiation). The client is often exhausted after therapy sessions making it difficult to drive.	Provide transportation to/from outpatient therapies	▪ Extend the approved trip purposes for rides provided by Dane County TimeBank to include out patient therapies. ▪ Although there is demand for this service, it is difficult to estimate the number of patient and TimeBank driver connections that will take place.	The Dane County TimeBank transportation program will track the number of one-way trips provided to/from outpatient therapies.	Transportation Manager; Mobility Program Specialist December 2016	There were 34 one-way rides to outpatient therapies.

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5d.	Continue the successful transportation options for low-income and unemployed workers in urban and rural areas	▪ In 2014 we created a revolving auto loan program. Three loans were processed. In 2015, 5 loans were processed. All payments are current. In 2016, we plan to process 4 loans. ▪ In 2014 we created a low-income job seekers program. Eligible recipients received a bus pass to job search and a second pass was given to those who successfully found employment. The program was extremely popular and funds from the approved employment transportation line were designated specifically for this program. In 2015, 274 bus passes were distributed to job seekers. Follow up contact (successful with 85% of clients) demonstrated that 72% secured employment. In 2016 we will distribute 275 bus passes to job seekers.	▪ Continue the revolving auto loan program which is tied to fiscal literacy classes and ride-sharing programs; Loans will provide transportation to low-income families and improve their credit ratings upon complete repayment of their loans. ▪ Continue the low-income job seekers program.	▪ Provide zero interest car loans to low-income working families in 2016; Ridesharing and fiscal literacy classes will be a requirement of the program. ▪ Distribute one monthly bus pass each to unemployed job seekers and an additional pass to those who successfully find employment.	▪ Provide at least four additional loans in 2016, for a total of 12 outstanding loans; ▪ Loan repayment will be current on 83% of outstanding loans. ▪ 100% of the loan recipients will be registered with a state or federal ridesharing database. ▪ Provide bus passes to 275 job seekers. Provide a second bus pass to those who find employment. ▪ At least 80% of persons receiving bus passes will be successfully contacted for follow up, and at least 65% of contacted individuals will have secured employment.	Transportation Manager; Mobility Program Specialist December 2016	▪ There were 12 car loans in 2016. ▪ Loan repayment is current on 82% of the outstanding loans. ▪ 100% of the loan recipients signed a statement agreeing to rideshare. ▪ 186 bus passes were distributed to job seekers. ▪ 83% of persons receiving bus passes were successfully contacted and 78% of the contacted individuals secured employment.
5e.	Continue to enhance the Comprehensive Community Service (CCS) infrastructure to better meet the needs of the program	▪ CCS Providers have reported major concerns and issues with the CCS Module for several months. There are episodic difficulties with access. Parts of the system are still under construction, making staff work flow more challenging. The billing processes are not yet automated and providers lack the ability to generate meaningful reports to track revenue cycle. ▪ Many individuals are enrolled, but we are limited in our ability to enroll the number of clients interested and in need of services due to limited service facilitation agency capacity. Wait times for services are increasing.	▪ A user friendly IT system that allows providers easy access, confidentiality and accurate billing for CCS services provided; ▪ Increased availability of service facilitation and substance abuse service providers.	▪ Meet with IT staff informing them of the gaps and issues related to the module; ▪ Train and fully implement an improved IT system to track data, case notes, billing and payments; ▪ Market to service providers to expand service options; ▪ Provider training; ▪ Outreach to individuals; ▪ Reach out to providers to increase the amount of substance abuse and service facilitation services.	▪ Ability to reliably open the module on the first attempt; ▪ Ability to enter case notes and billing codes without problems; ▪ Accurate reimbursement that coincides with the billing that was entered and ability of providers to run necessary reports to verify revenue cycle. ▪ Expand service facilitation and substance abuse service providers by 25%.	Julie Meister Carrie Simon Mary Grabot December 2016	▪ CCS Module has shown improvement in 2016 in terms of reliability. ▪ CCS staff can reliably enter progress notes, including billing codes. ▪ Report was created for providers to more easily verify revenue cycle. ▪ CCS has nearly doubled the number of service facilitation agencies in 2016. ▪ CCS continues to be interested in increasing number of substance abuse service providers in the Network.

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5f.	Adult Protective Services	▪ In 2014, 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. ▪ When a person agrees to serve as guardian she receives 1 – 2 pamphlets defining her ongoing responsibilities. These pamphlets contain a minimal amount of information regarding the roles and responsibilities of a guardian.	▪ Law enforcement is aware of APS and EAN resources for elders. ▪ Guardians have resources and are knowledgeable about their responsibilities.	▪ Provide two trainings to law enforcement and EMS staff; one training will be with EMMCA focusing on East Madison and Monona emergency responders. The second training will be with Fitchburg Senior Center staff to focus on Fitchburg emergency responders. ▪ A folder will be created for guardians outlining what a guardian needs to know in their new role.	▪ The number of referrals from law enforcement will increase in comparison to referrals received in 2015. ▪ By 12/15/16 a folder with information on responsibilities (Orders, WATTS, how to seek assistance, etc.) for guardians will be created.	Shari Gray-Dorn, APS Supervisor, EAN staff, EMMCA and Fitchburg Senior Center focal point staff. December 2016 Shari Gray-Dorn, APS Supervisor and AGP staff December 2016	▪ Presentations occurred on 4/18/16 and 6/24/16. Statistics on the number of Law Enforcement referrals are not available until April 2017. ▪ A 55 page guardianship folder was created and shared with Probate staff. The folder includes the following information: guardianship court process, frequently used terms, duties and powers, inventory instructions and examples, protective placement and WATTS information, helpful telephone numbers and websites. The folder will be given to guardians in 2017.

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

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6a.	Revisit the potential for creating ways to divert older adults and adults with physical disabilities at risk for an institutional admission	In Dane County there is no facility that provides short-term crisis care for elders with dementia and severe behaviors or adults with physical disabilities. The purpose of a crisis home would be to divert admissions from MMHI and/or be a step-down facility. The Department should research whether there is a potential target population and the cost and resources required to develop the resource. Additionally, the County should explore ways to provide in place stabilization supports to facilities / caregivers using existing county and community resources.	▪ Feasibility assessment for crisis home is completed; ▪ Increased communication with BPHCC, ESU, Community TIES APS and Focal Points to identify persons at risk of institutionalization and a more comprehensive way in which to offer resources and support to those situations.	▪ Aging/PD LTC Program Manager will form a work group to assess viability of a crisis home. ▪ If a facility appears viable, work with 1 or 2 assisted living providers to develop and design the special features of a home for elders with dementia and behavior issues. ▪ Aging/PD LTC Program Manager will work with the Division Administrator to facilitate a system by which LTC manager is made aware of at-risk individuals so they can try to connect them to resources that will minimize risk of institutionalization.	▪ Feasibility/viability determined; ▪ If feasible, program model and cost structure is determined; ▪ If feasible, RFP or outline for an RFP is prepared; ▪ Dementia specific trainings will be developed for Focal Point Case Managers to increase their knowledge and skills in supporting individuals with dementia and their caregivers. Training will be offered summer of 2016. ▪ By end of 2016 there will be a system in place by which ESU, BPHCC, APS, Focal Points and Community TIES are in communication on a regular basis about at-risk adults with behavioral challenges.	Beth Freeman December 2016	▪ The work group met in April 2016 including Alzheimer's & Dementia Alliance, South Madison Coalition of the Elderly and CBRF providers to discuss the possibility of a crisis home. It was determined that it was not fiscally feasible to pursue this option. Concern was also expressed regarding the impact of multiple transitions and the negative impact that could have on persons with physical disabilities. ▪ Focal Point trainings were not developed in year 2016. Additional work can be done in this area by utilizing existing community resources that specialize in supporting persons with dementia. ▪ Relationships have been further established with ESU. Journey ESU supervisor, Hannah Flannigan, will bring to the attention of LTC/PD manager those situations for which they are getting repeated calls about persons with dementia and related behaviors. ▪ BPHCC, APS, Mental Health and LTC/PD Manager now meet monthly to discuss situations and clients that may overlap systems. Strategies and information is shared to develop appropriate placement plans either in the community or at BPHCC.

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6b.	Explore additional funding/resources that could expand the current services provided by the Dementia Support Team	Currently the Dementia Support Team (DST) is limited in its support to persons with dementia who have been admitted to an institution and those with dementia eligible for CIPII / COPW funding. Increased capacity for support may help reduce inpatient stays at an institution and reduce County costs.	DST capacity is expanded to serve individuals with dementia at risk of institutionalization in the community who may not be connected to the Department or funding sources.	Aging/PD LTC Program Manager explores any additional funding options within the County and grant opportunities that may be available to expand the capacity of the DST.	▪ Aging/PD LTC Manager will analyze the 2016 budget by 4/30/16 to determine if any monies within current budget could be moved to support expanded DST. ▪ Ongoing monitoring of Dementia Capable communications to identify any other funding / grant opportunities for which the Department could apply.	Beth Freeman Ongoing	▪ A new program line within the SMCE budget was established to reflect the specific activity of the DST. This new program line will allow for further analysis of the fiscal savings that are achieved in 2017 by diverting and/or relocating persons with dementia out of an institution efficiently. ▪ At the time of this work plan update there have not been other grant/funding opportunities for which application could be submitted. LTC/PD manager will continue to monitor for such opportunities.
6c.	Develop alternative treatment and placement options for people with challenging behaviors	▪ There are several people who stay in inpatient settings for long periods of time because we have no other alternative for them. This applies to those with serious and persistent mental illness as well as those dropped by the Department of Corrections and converted to 51 commitments and people with complex needs due to overlapping disabilities and severe trauma histories. ▪ Often, we rely on Dodge and Trempealeau Counties for high need placements as Dane does not have alternatives. ▪ Having Winnebago Mental Health Institute (WMHI) as the primary Institute creates problems for case managers, law enforcement and support agencies due to distance.	▪ Reduce placing people with challenging behaviors out of County; ▪ Have additional treatment facility options in Dane County; ▪ Improve cross-system collaboration to meet the needs of those with multiple disabilities.	▪ Define needs that require alternative placement options; ▪ Work with Providers to expand placement options; ▪ Collaborate with law enforcement seeking funding for alternative treatment options; ▪ Issue an RFP for the Care Center model and residential supports, including serving those with challenging behaviors; ▪ Explore enhancements to the Transitional Housing Program; ▪ Participate in system conversations including stakeholders from throughout the community; ▪ Reduce use of WMHI, Trempealeau Co. Health Care Center, and Dodge County's Clearview facility.	▪ People who no longer clinically need hospitalization do not remain in inpatient settings for lack of a less restrictive placement. ▪ People receive care in Dane County rather than at facilities far from their home, family, and support system. ▪ Use of WMHI decreases. ▪ Individuals with multiple disabilities will receive cross-system supports to address their complex needs and help them remain in the community.	Mary Grabot, Carrie Simon, Administration December 2016	▪ RFP for Care Center model was issued and Tellurian was awarded the 2017 contract. County worked with JMHC to make the transition to one Care Center in 2017. ▪ Little movement was made in impacting out-of-County placements. ▪ Fewer people were admitted to MMHI/WMHI in 2016 (244) than were in 2015 (257). Length of stay was lower in 2016 (16.1 days) than it was in 2015 (18.5 days). ▪ Developmental Disability and Mental Health staff met quarterly to ensure multi-system supports were in place as needed.

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7. Measure and communicate system performance for each division.

#	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 2016
7a.	Define measurable outcomes and use for program evaluation	▪ Program outcomes identified in contracts are inconsistent and at times difficult to measure. ▪ Limited use of the MH/AODA Functional Screen. ▪ Data gathered is often incomplete and not readily accessible for use in program evaluation.	▪ Outcomes identified in contracts are measurable, meaningful, and consistent across services. ▪ POS produces reports that are complete and are in compliance with State and County expectations.	▪ Work with IT to improve data collection and accessibility; ▪ Work with Planning and Evaluation to define meaningful outcome measures; ▪ Increase the use of the MH/AODA Functional Screen and fully complete the MH Supplemental Information; ▪ Keep abreast of Program Participation System (PPS) changes at the State and pass on to POS system; ▪ Hold stakeholder groups to inform about the data needed and seek input on identifying outcomes.	▪ We will begin to routinely administer the MH Functional Screen to CSP clients. ▪ POS Agreements will include improved performance requirements. ▪ MH Supplemental Information is fully completed for at least 75% of consumers served in 2016. ▪ Online portal available to POS agencies for entering MH Supplemental data.	Mary Grabot, Carrie Simon, Administration December 2016	▪ MH/AODA Functional Screen was done on CSP waitlist only and decisions made re: service needs. ▪ County staff worked together with IT and Planning and Evaluation staff on outcome measures in contracts and PPS reporting. ▪ Lori Bastean presented to MH providers regarding outcome measurements and PPS to increase awareness and compliance by POS.

2016 WORK PLAN - ACS

8. **Diversify and maximize revenue streams**.

#	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 2016
8a.	Ensure that contracted service units and contingent revenues are achieved by the POS programs	▪ Many programs were placed under a contingent earning basis in 2016. ▪ Revenue targets are adjusted annually in an effort to have reasonable, accurate budgetary targets. ▪ Inpatient costs are well over budget and have been historically as well. One problem is patients refuse to sign insurance forms, which results in lower offsetting insurance revenue.	▪ Revenues are maximized, risk to county is minimized, and POS agencies have incentives for increasing revenues earned. ▪ Maximize number of people who are insured.	▪ County staff to closely track service units and revenues. 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. ▪ Increase budgetary allocation for inpatient hospital costs. ▪ Establish process to get people insured, to get insurance forms signed for inpatient care and to hold people accountable for payments. ▪ Ensure that budgets and contracts have reasonable and accurate revenue targets. ▪ Hire a consultant on an LTE basis to explore possible methods to increase reimbursement for inpatient services. ▪ 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. ▪ Budgets are adjusted based on actual cost of service units. ▪ Inpatient costs fall within budget. ▪ POS contracts clearly define eligibility requirements and reporting expectations. POS agencies adhere to these expectations.	Mary Grabot, Carrie Simon, DCDHS fiscal and management staff December 2016	▪ County staff and providers met regularly in 2016 to adjust contracts and revenue expectations. Many programs had contingent funding. Some contracts were adjusted to better manage risk. An LTE consultant was hired to study reimbursement methods for hospitalizations. ▪ Inpatient costs including out-of-County placements exceeded the adopted budget by $78,165. ▪ Providers and County staff worked to better define contract terms and transparency. Many programs were contracted based on contingency earning reimbursement.