F-00944 Narrative Response:

1. ***Describe the Governance structure for your CCS Regional Service Model. Include a description of the administration of the CCS Regional Service Model, the lead agency and/or lead staff , and a description of the design, membership and functions of the CCS Coordinating Committee(s). Attach a copy of the legal agreement established by counties/tribes for the operation of CCS (such as a Wis. Stat § 66.0301 Intergovernmental Cooperation Agreement, a contract, or a memorandum of*** **understanding).**

The regional CCS administrative structure begins with our vision: *The Central Wisconsin Health Partnership (CWHP) strives to improve health outcomes in Central Wisconsin by expanding access to behavioral health services.*

And mission: *To serve as a consortium structure assuring equitable access to quality behavioral health services. Across disciplines, this partnership brings together the best of integrated medicine, integrated human services and integrated public health initiatives. By sharing best practices, innovative contracting, and prevention services, the CWHP promotes quality services to all residents across the region.*

The continuum of community-based psychosocial services, assured by the counties for recovering clients, is an important part of the infrastructure on which all other services depend. Psychosocial rehabilitation services are recognized by the partnership as an essential approach to enabling and empowering consumers into self-directed care. Our partnership is committed to sustaining and expanding psychosocial rehabilitation services (HFS 36) to all eligible residents of the region.

To best fulfil this vision, The Central Wisconsin Health Partnership will operate our regional CCS as a Shared Services model. This approach builds upon the foundation of core services already in place. In addition, our shared services will promote a balance of autonomy among interdependent programs. This balanced approach will occur through the application of person-centered values.

Recovery occurs where people live and requires self-determination within a milieu of locally accessible resources. The infrastructure that supports recovery should hold the same balance between the individual and community, county and region. At the same time, each county has an investment in their resident consumers along with the programs and resources cultivated on the consumer's behalf. Recovering consumers will contribute through their own growth, and to the growth of resources close to home and beyond to the region. We are building on strengths in place while assuring voice, access and ownership at every level.

Oversight of this initiative is assured by a Regional Coordinating Committee (per DHS 36.09) that has full support of the CWHP. As an oversight committee, the Regional Coordinating Committee will include members of the CWHP (County DHS Directors, Public Health Officers, Federally Qualified Health Center), along with CCS Service Directors, Consumers and community stakeholders. Under the direction of this group will be a regional CCS Program Administrator (per DHS 36.10 (2) (e) 4) who serves as a link to each county's lead program staff in order to assist with cultivation of each program, developing new resources and assuring program compliance. In addition, this administrator will link the regional initiative with key staff from State DHS

Our counties represent a range of stages of development for their programs. Three counties; Adams, Waushara and Green Lake have established programs. A fourth, Juneau County, is starting its CCS with initial certification just days away. Finally, Marquette and Waupaca Counties are very interested in starting CCS. They both have strong collaborative systems of care, especially through CST programs. Our shared services application will consist of the four counties with certified programs. Within the first year (2014-15) our development plan is to include Marquette and Waupaca as they become certified.

Each county program will maintain and expand current standard positions and functions per HFS 36. As funding allows, increased services will be enabled through the hiring or contracting for service facilitation and other clinical services within appropriate consumer-provider ratios to sustain optimal services. Through our expansion, annual cost per consumer will hold steady while the numbers being served will increase. (Average case rate and numbers to be served are depicted on attached Spreadsheet: CWHP CCS Projections 2012-2018.)

In the interest of promoting efficiencies, direct service providers will have the largest increases based on function while management/administrative positions will show the least possible growth across the region. Any practical consolidations of functions will be considered as the programs evolve with greater uniformity around best practices.

A unique strength of the region is the long history of collaborative practices across counties. The CWHP is only one of many initiatives that bring counties and providers together to better assist our high needs and medically underserved populations. Comparable demographics and earned trust relationships across our 6 counties have set the stage for strong partnerships where calculated risks may be taken to alter and improve systems of care.

Important to the balance of shared services across the region is the multidisciplinary vision of CWHP. As a subset of the CWHP, our Regional CCS Coordinating Committee (RCC) will serve as a venue for sharing best practices, lessons learned and where new multidisciplinary resources can be developed to enhance the opportunity for psychosocial rehabilitation. The RCC will parallel the coordinating committees at the county level maintaining proportionate 1/3 provider and 1/3 consumer representation. Local coordinating and regional oversight

committees will both adhere to HFS 36.09. We are in discussion with Grassroots Empowerment Project (GEP) regarding strategies for consumer participation in program development.

2. ***Describe how consumers will access CCS. How will individuals enroll in CCS, and how will services be made available to CCS recipients across the region? Describe access for children and adults, addressing both mental health and substance abuse services.***

Consumers will access CCS in two ways; the first is through standard enrollment accessible in each county of residence. The second is upon completion of formal services, when the individual may continue recovery through lifelong learning, advocacy, including participation in local or regional coordinating committees to help shape this program for future recipients. The ongoing participation of consumers in program development is essential for growing the therapeutic milieu and eliminating the glass ceiling that exists when an individual's recovery is tied to being a program "recipient."

Each certified county will offer the standard array (March 2014) of psychosocial rehabilitation services which includes mental health and substance abuse services to all ages. Variations within each service array will occur across counties based on local need and availability of resources. These differences are largely contained within the array #s 14 & 15 and when a service is contracted or provided by DHS staff.

The county of residence will take responsibility for the enrollment and administration of services to their consumers. Each county will operate under its own certification and assure the highest quality of care at the most efficient cost. Accountability for best practices will be assured locally with each coordinating committee and through the addition of regional certification with oversight by the regional coordinating committee.

All of the counties in our partnership provide a full continuum of behavioral health services. Most of these services are provided by employees of the human services departments. Where outpatient services are contracted by the county, such as Waushara and Marquette Counties, there are also strong psychosocial services such as CSP and CST that demonstrate a commitment to wrap around and integrated services.

Across the region, we have uniformity in our commitment to collaborative systems of care and variation that reflects local flair. The robust CCS program in Waushara County is a model for the region with many services directed toward children and families. An investment in mentors for families in CCS is a good example of the regional customization that can occur as a coordinating committee looks for the best ways to serve the needs of their consumers.

Other unique features in the region include the drop-in center, Friendship Connection, in Adams County. In this setting, consumers host educational events and recovery focused socialization. In Adams County, the CCS Coordinating Committee is integrated into the Collaborative Systems Advisory Committee which advises on developments for the county HHSD Clinic and the independent CST Coordinating Committee. Waupaca County recently initiated community-wide

focus groups aimed at developing more effective alternatives to meet the needs of youthful offenders with serious mental illness and/or substance abuse concerns. As we learn from success, each variation enriches options for the region.

Piloting new and innovative approaches to care is possible when the essential services are assured through the county DHS. Across the region, counties provide an anchor for formal programs and services. Contractual relationships are developed primarily to procure select services that could not easily be provided in-house.

A snapshot of our wish list for expansion includes; gender-specific service facilitation, peer and parent mentoring, respite, personal trainer/life coach, vocational rehab specialist/job coach, in-vivo desensitization specialist, AODA recovery support workers, equine therapies, etc. Any of these services could also share with other counties, and in some cases, the partnerships will incentivize services to come into the area.

Through regional certification we will also explore opportunities to contract county staff to other parts of the region as specializations in one area rise as the best practice option for a neighboring county. For instance, a Wellness & Recovery Management Group in Adams County could be open to consumers from neighboring Juneau and Marquette Counties, or parent mentors in Waushara County could be contracted to serve consumers in Marquette County. Green Lake County DHS has all of their clinicians dually certified to provide mental health and substance abuse treatment. Contractual arrangements across counties will evolve organically as need and opportunities come together. Our guidepost will be the fidelity to the values and practices of CCS.

Beyond the standard CCS service array our CWHP offers a unique opportunity for innovation due to the participating interests. Through Human Services we have core services and a safety net. Through Public Health we have wellness & recovery outreach and education. And through our Federally Qualified Healthcare Center we have the benefit of integrated medicine. Thus, we are well positioned to pilot or enhance psychosocial rehabilitation through a range of complementary partnerships. These partnerships include; (1) Christine Anne domestic violence shelter, (2) Brief Intervention Screening (BIS) through Family Health LaClinica, (3) interfacing with the new Child Psychiatry Access Line, (4) a multi-county crisis stabilization network, (5) adapting the closed Neshkoro School as a wellness & recovery center (including drop-in center and "living room" stabilization site), (6) cultivating CCS Health Educators though Public Health Departments, (7) Grassroots Empowerment Project's SAMHSA grant promoting participatory decision making, and last but not least, (8) the management of chronic disease and co-morbid conditions through regional grants and Family Health LaClinica's new medical home initiative.

The Regional Coordinating Committee will steward the expansion of psychosocial rehabilitation services and assure the counties are meeting the needs of residents across the region. With each county certification for CCS, there is a commitment to serve individuals across the lifespan and to deliver both mental health and substance abuse services. Each county program has strengths and growing edges. The RCC will partner with the county leading quality assurance to approve development plans for each program that assure gaps in service are closed and unique needs are being addressed.

3. ***For CCS programs using the Shared Services regional model, identify and describe the services and/or functions of CCS that will be shared by county/tribal partners. DHS' CCS Advisory Committee recommends a minimum of two major components of CCS be shared by partners. DHS has identified the following examples of major components of CCS.***

    - ***Administration of program***
    - ***Staff or Providers***
    - ***Clinical Supervision***
    - ***Training***
    - ***Electronic health records or program documentation***
    - ***Billing/Claims***
    - ***Quality Improvement Plan***
    - ***Facilities***

Our Regional Administrator position will be funded equally across the 6 counties and will free up 1/6th of each current program administrator's time. (Or, 4 currently certified counties each sharing 1/4th of the cost.) This position is intended to be budget neutral. Benefits of this position will be demonstrated over 1-3 years as efficiencies are developed and more consumers are served across the region. First year priority for this administrator is to assist in the application and initial certification of Marquette and Waupaca Counties.

Other combined regional roles will include:

(1) Administrative Employer; furnishing office, salary and benefits of the Regional Administrator. This function is comparable to the hiring and supervision of the ADRC Director for our region. Currently provided by Green Lake County DHS but the function can rotate to other counties per the residence of a particular employee.

(2) Fiscal Agent; streamlining regional budget, harmonizing rate setting and furnishing audit reports. Again referring to the ADRC, this function is currently provided by Waushara County DHS but the function can rotate, as needed, to other counties.

(3) Training Lead; facilitating regional training and stewarding the expansion core competencies of providers, and of recovery practices for consumers and community members. One area that will further enhance uniformity around best practices is through shared training. Our first regional training (CCS-101) was held on February 27th. We targeted 80 staff from certified and yet to be certified counties. These staff included behavioral health clinicians, service facilitators, public health (including health educators) and representatives from referring agencies such as school counselors, hospital staff and even law enforcement. This was an overview of CCS presented by experienced providers and consumers. Future trainings will focus on core competencies for serving rural populations and numerous other subjects tailored to improve recovery practices in the region.

(4) Quality Improvement; assuring fidelity to the CCS model, including individual program compliance around regionally established benchmarks for performance and coordination of program surveys for DQA recertification. Programs that have taken initiative to advance QI measures will take a lead role in disseminating toolkits and practices that, when adopted by each program, will bring services up to regionally agreed upon standards. We will incorporate the Mental Health Statistics Improvement Program (MHSIP) and/or Recovery Oriented Systems Inventory (ROSI) consumer surveys into our QI plan, though we prefer the recovery oriented survey as this tool best reflects our program values. The centralized efforts around QI will dovetail with coordination of site surveys for purposes of certification by DQA.

(5) Provider Development: Closing the service gaps by expanding the pool of innovative CCS service providers available to each county. These providers could cover a wide range of services from intake workers that screen for functional eligibility to parent mentors and respite providers. Any particular specialty can be assumed by the county of best fit, similar to the ADRC model already in place regionally.

(6) Multi-purpose facility: at this time we are exploring the use of a central facility that will host numerous psychosocial rehabilitation services as well as administrative functions. The old Neshkoro Grade School is under a promissory purchase agreement between the School District of Westfield and the Neshkoro Area Community Center. This multi-purpose facility will house services such as the local library, enrichment classes including art, yoga, athletics and cooking. Regional trainings of mixed sizes will also be hosted at this school/community center. The Northeast Regional Training Partnership is already planning to hold crisis trainings at this site this summer. This facility also includes a unique space, to be staffed and used on an as-need basis, for crisis diversion along the lines of a "living room" model. Furnishings for this space will come from donations. Staff to facilitate stabilization services will come from the counties participating in a regional crisis stabilization network, all certified under HFS 34 III.

Wellness and recovery programs are a central interest for the Community Center and our regional CCS. Thus, this facility will also house a consumer driven drop-in center, including Illness and Recovery Management classes, and other recovery oriented groups as needed. This facility will also house offices for our Regional Administrator, Fiscal Agent, and staff dedicated to quality improvement (QI).

The Community Center is also interested in hosting outpatient services such as primary care, dental and behavioral health services. Potential partners include Family Health LaClinica, FQHC, Community Health Network, and The Medical College of Wisconsin. This last group is interested in partnering with our CWHP for rural psychiatric residencies.

The Neshkoro Area Community Center will administer any lease arrangements for this cooperative. Our CWHP-CCS will hold a lease for at least ¼ of the facility and use of its amenities. The vision of wellness and recovery is shared by all partners and the benefits of this continuum of care will extend to all.

(#3 Continued)

Identify efficiencies and/or estimate savings to be achieved through the shared service model.

A number of measures can be used to reflect the fiscal impact of this program. These approaches include: (A) Savings to the counties receiving match. (B) Conservative estimates of the demonstrated influence of CCS. (C) Comparison of overall match contribution vs. the gross liability of out of home services, and (D) The cost of inaction.

First, we must outline our methodology for overall program estimates. A pragmatic look forward uses past performance of a balanced and integrated program to determine a reasonable rate of growth for our model. In essence, by 2017 we anticipate the expansion of our program to levels of implementation similar to that currently demonstrated by Marathon County. We chose Marathon as a standard due to their commitment to service integration which includes medical services through their affiliation with North Central Healthcare.

Beginning with the Medicaid population of each county in our region, we estimate the number of consumers who will be served at the Marathon County rate of penetration of CCS cases among Medicaid recipients at .0088. (Please refer to the Attached Excel spreadsheet Tab #1) By calculating back to the current CWHP County's rate of penetration we can estimate the reasonable rate of growth across the region each year from 2014 to 2017.

Now, with the implementation of the Affordable Care Act, it appears that counties in our region will have comparable numbers of dis-enrolled as newly enrolled Medicaid recipients. In addition, when we account for the growth of the Medicaid population in each county over the past 14 years we see a trajectory of growth of these populations at 4% per year. Due to the durability of this growth over time we believe it is appropriate (meaning safer) to recognize this increase in our estimates. (Please refer to the Attached Excel spreadsheet Tab #2)

Next, considering the numbers of consumers served and the average rate of CCS billable services annually among our established programs, we can estimate overall costs per person per year. This case rate averages to $5,568 at 60% and $9,280 at 100% funding. The match estimate of 40% comes to $3,712 per consumer. In the first year, 2014, we should have 115 consumers served in our region, up from 70 currently. Cost of the match for 115 consumers in 2014 is $426,880 and $1,187, 840 in year 2017.

(A) Savings to the counties receiving match:
Therefore, savings to the counties in the first year considering only the match is $426,880. (The uncertainty of what the counties might receive through WIMCR are not factored into this figure.)

(B) Conservative estimates of the demonstrated influence of CCS: Savings from service efficiencies, using DHS one-year data, indicate a potential decrease in cost for the following services:

- Emergency Detention; $48,300
  [14% (State Ave.) of 115 (cases) = 16.1 (cons.) x 3 days (typical Inpt stay) x $1,000 (cost per day)]
- Voluntary Inpatient; $69, 000
  [20% (State Ave.) of 115 (cases) = 23 (cons.) x 3 days (typical Inpt stay) x $1000 (cost per day)]
- Crisis Stabilization; $14,352
  [8% (State Ave.) of 115 (cases) = 9.2 (cons) x 13 (hours/yr) = 119.6 (total hrs) x ($120)]

Total Annual Savings from Services: $131,652

If savings are applied to the cost of the CCS program, the annual case rate per consumer decreases to $8,135; a 12% reduction in overall cost of care. We believe this savings figure will shift significantly upward as the impact of CCS on stabilization services are shown over 3 and 5 year periods. There are many other measures of program efficiencies if we look for impact beyond only one year. Complex systems take longer to impact but have greater return on investment when considering the number of lives impacted among families. Children's out of home care is one measure that will show savings when measured over time.
(C.) Comparison: The population served through CCS has a higher than average use of stabilization and out of home treatment. Treatment out of the homes where people live and recover is a costly substitute for community-based supports. When this population is served adequately in the community, the costs of out of home care decrease. Thus, one ideal target population for CCS is this population ending up in out of home care. For consumers who could be CCS eligible, the fiscal liability of out of home services for residents among the 6 counties of our CWHP is considerable:

Annual Mental Health Inpatient costs for 93 individuals on Medicaid comes to;	$672,138.
Annual out of home care for 141 children on Medicaid comes to;	$2,003,558.
Together this gross cost of out of home care is;	$2,675,694.

The comparison of $426,880 (in CCS match) vs $2,675,694 (out of home care) is striking. Taxpayers will pay for one or the other. While these are not equivalent datasets, we believe it is important to recognize the gross differential to illuminate the level of risk management assumed by the counties. According to a report by the Agency for Healthcare Research and Quality, of Medicaid recipients, Mood Disorders are among the top four most expensive inpatient conditions. This is only one condition. As it is easy to take success for granted, we must remember that without an adequate continuum of supports, the entire annual clinical services budget for most of our CWHP counties (each serving 500 to 900 individuals) could be consumed by the psychiatric inpatient costs of only 4 or 5 individuals from each county hospitalized for one year. The counties' role in providing risk management is enhanced by programs such as CCS where stabilization and recovery work hand-in-glove to restore consumers and their communities.

Again, a conservative estimate indicates that we could save just 12% or $131,652 of these gross stabilization and inpatient treatment costs for 115 consumers through the more efficient use of CCS. Potentially, if we could serve each of our 234 at-risk Medicaid recipients in CCS, the program could save taxpayers at least $321,083 per year at the rate of 12% on $2,675,694. We request that 3 and 5 year impact of CCS on stabilization services be evaluated to include a longitudinal measure of inpatient psychiatric services and children's out of home care where mental health needs are present. Within our projected CCS population we believe the savings will be significantly higher than 12%. Meanwhile, we know that early and effective use of recovery based psychosocial services will go a long way toward preventing the need for the out of home care all together.

Further implications: Across the region, greater savings may also be shown on high users with complex medical needs. Integration of care is a strength of CCS which parallels nicely with medical home models. This is a promising area of development for our region with partnership that includes our FQHC for primary care and dental and Public Health Departments.

In addition, Community Health Improvement Plans across our region identify the need for mental health & substance abuse services and chronic disease management. Acting on these concerns, Adams County has secured a WPP grant which funds a community based nurse navigator to help manage chronic disease and promote health management independence amongst her clients. Long term sustainability of the model could be to have some of her position funded by CCS. Estimates of cost savings must take into consideration the multiplier effect of collaborative grants that can be pulled in to creatively assist the management of chronic conditions where mental health issues drive up cost and exacerbate medical problems.

(D) The cost of inaction is most apparent when considering complex and chronic disease conditions. According to the Kaiser Family Foundation Commission on Medicaid and the uninsured, Medicaid and Medicare per capita spending is substantially higher for dual eligible consumers with multiple chronic conditions, particularly when mental/cognitive conditions are present. "Annual mean per person spending for all dual eligible was $19,400, with Medicaid covering more than half (56%) of spending. Spending for persons with more than one mental/cognitive condition rose to $38,500, and reached $31,000 for those with both physical and mental/cognitive conditions." A large percentage of CCS consumers fall within these profiles. And back to our concern regarding out of home care, "Half of persons with multiple mental/cognitive conditions and close to two-fifths of those with multiple physical or both physical and mental/cognitive conditions were hospitalized during the year." These profiles represent a clear public health issue that we cannot afford to ignore.

There is a silver lining; we have the awareness of how chronic physical and mental conditions are mutually reinforcing. Understanding and coordinating care for both unlocks the cycle of pathology. We now have an opportunity for innovative partnerships that build on the recovery practices of CCS. We look to models such as Marathon County's partnership with North Central Healthcare. When adequately supported, these practices can yield dramatic outcomes and fiscal savings. We look forward to partnering with DHS to implement and demonstrate the potency of this program.

Please refer to Attached:

A. CWHP Regional CCS Memorandum of Understanding.

B. CWHP CCS Organizational Chart.

C. Spreadsheet: CWHP CCS Projections 2012-2018.