Questions / Answers from 2/5/08 Consumer / Stakeholder Advisory Council Meeting
Milwaukee County Long-Term Care Planning

1. In the current Family Care system in Milwaukee County, how many consumers utilize mental health and/or Alcohol and Other Drug Abuse (AODA) services? How are those needs identified, and how are services determined? I have heard this is an area of concern and I want to make sure that if Family Care is expanded here, that these issues aren't replicated. Does the functional screen used by Family Care adequately evaluate these needs?

The Managed Care Organization (MCO) has data on the number of members who have a diagnosis of chronic mental illness (CMI), but it is difficult to sort out what services they receive specific to their CMI. For example, we know that 66 members receive outpatient therapy (either group or individual) for mental health treatment. But it is more difficult to say, for example, who is in a residential / skilled nursing facility (SNF) due to CMI vs. other diagnoses. Also, many members receive treatment from their medical doctor (MD) (in the form of medication) for their CMI and this is not something we track. There are 662 members who are currently assigned to our specialty mental health teams and receiving "specialized care management" related to their mental illness.

Looking at diagnoses, 52% of Family Care members have a diagnosis of mental illness, and 12% have a diagnosis of a severe and persistent mental illness.

The Family Care statewide experience has been less a matter of needs identification than a matter of service utilization. That is, the functional screen identifies evidence of mental health and AODA service needs for a larger percentage of members than the number of members actually receiving mental health services.

Member's needs are determined via the assessment process with the social work assessment asking specific questions regarding cognition and behavior. We also have a mandatory specialty assessment whereby those who score in the moderate to high risk area of the Geriatric Depression Scale are referred to their physician / geriatrician for further assessment. Using this data, and relying on "Member choice" we would use the Resource Allocation Decision-Making (RAD) tool to determine actual needs.

It might also be said that the 662 members who are currently assigned to our specialty mental health teams are receiving "specialized care management" related to their mental illness.

2. What will be the relationship between the Aging and Disability Resource Center (ADRC) and Service Access to Independent Living (SAIL)?

The ADRC refers to SAIL all individuals who request a Functional Screen AND are in the Mental Health Target group AND NOT in any of these target groups:

-Frail Elderly
-Physically Disabled
-Developmentally Disabled

3. What are the County's plans to ensure that the ADRC and care management staff understands not only mental illness, but recovery?

The ADRC performs eligibility determinations. As such screening and identification are the issues. Mental Illness is a screening and identification issue which we understand. Recovery is a treatment issue. We provide no services or treatment. Thus, we only make a referral to those who DO deal with this issue.

The functional screen asks if diagnoses of mental illness are present, but it does not specify whether activities of daily living (ADL) or instrumental activities of daily living (IADL) issues are related to the CMI or the members other health conditions. There is a functional screen specific to folks with a diagnosis of CMI - which we don't use.

Family Care Care Managers receive training and education on all services they are expected to coordinate and/or authorize. The Education and Training Steering Committee will be working with the Behavioral Health Division (BHD) and local advocates to provide training in Behavioral Health and recovery issues in 2008.

4. Family Care is "authorized" under a waiver the state receives from the feds. Part of the value of the waiver is the ability to provide services that may be different from what is required under card services, correct? How much flexibility is there? The easiest example I can give is that personal care under fee-for-service requires that a personal care worker be supervised by a Registered Nurse, even though personal care workers don't do medical care. In Family Care, could that be waived? What parameters are there for how differently services can be done? In other words, how creative can the services be? Or how restrictive?

Centers for Medicare & Medicaid Services (CMS) grants various types of waivers. The type of waiver granted for Family Care is the same type of waiver the state has received for Community Integration Program (CIP) and Community Options Program (COP), a "c waiver." People eligible for services under this waiver must pass a screen, in this case the functional screen, at a nursing home level of care. CMS waives the requirement of the Medicaid (MA) program that requires institutional care for those individuals at an institutional level of care. The services available in this waiver are those services identified in the waiver application submitted by the state. The services that are available as waiver services are defined in the Health and Community Supports Contract (see attachment 1).

Certain personal care services can be provided by a supportive home care agency (see attachment 1).

5. Of the Family Care members who receive a "Notice of Action," (NOA) how many go on to appeal those?

The MCO sent 1,428 NOAs to members in 2007. 12% of those notices of actions resulted in the filing of grievances/appeals/complaints.

6. Can I get a list of the members on the MCO committee that reviews complaints?

State contract provides at Article V.F.2.c. "The governing board of the MCO shall review and resolve appeals and grievances. This function may be delegated in writing to a grievance committee." Technically, specific case review by the Board or subcommittee is not required if they have delegated to the grievance committee.

Becker	Donna	MCFI-DD	**SM**
Bissonnette	Theresa	BP Team	**A**
Ceranski	Sandy	BP Team	**A**
Flemal	Jennifer	BP Team	**A**
Harms	Katherine	Goodwill	**SM**
Johnson	Trudie	MCDA-Placement team	**SM**
Kimble	James	Community	**SM**
Matson	Sandy	BP Team	**SM**
Richardson	Tamara	MCDA-Placement Team	**A**
Verduyn	Virginia	Community	**SM**
Walker	Ann	BP Team	**A**
Wells	Mary	Community	**SM**

SM = Standing Member

A = Alternate