COUNTY OF MILWAUKEE

Inter-Office Communication

DATE: July 20, 2011

TO: Supervisor Lee Holloway, Chairman, Milwaukee County Board of Supervisors

FROM: Community Advisory Board for Mental Health
Prepared by Co-Chairs: Barbara Beckert and Paula Lucey, RN

SUBJECT: **REPORT FROM THE COMMUNITY ADVISORY BOARD ON THE CONTINUED ACTIVITIES OF THE BOARD AND ADDITIONAL RECOMMENDATIONS RELATED TO FILE NO. 10-213**

Issue

The Milwaukee County Board created the Community Advisory Board (CAB) with Resolution No. 10-213. The resolution includes a requirement for the committee to submit a report to the Milwaukee County Board of Supervisors quarterly.

Action Requested

It is requested that the Milwaukee County Board of Supervisors refer the Community Advisory Board's recommendations to the Interim Behavioral Health Division (BHD) Administrator. The Interim BHD Administrator shall include these recommendations in the work and implementation activities of the Mental Redesign Task Force developed by resolution in April. It is further requested that the County Board of Supervisors accept the report as meeting the requirements set forth in File No. 10-213.

Background

This is the fourth report from the Community Advisory Board which was established in May 2010 by the Milwaukee County Board of Supervisors**,** following an investigation by the state and federal government of safety and quality of care concerns on the Acute Care unit at the Milwaukee County Mental Health Complex.

The CAB was established to provide oversight and additional recommendations for positive change – and go beyond the narrow regulatory focus of state and federal monitors. The board has included a dedicated group of community members including mental health consumers, family members, sexual assault advocates, community providers, attorneys, advocates, law enforcement, County Supervisor Joe Sanfelippo, and others who worked together and in collaboration with BHD staff over the past year.

The September report to the County Board included recommendations for the 2011 budget which were included in the County Executive's proposed budget, and adopted by the County Board;

additional recommendations regarding safety, patient centered care, and linkages to the community were included in the January and May reports.

This final report includes reflections on the work of the CAB and next steps, as well as a report from each work group.

REFLECTIONS AND NEXT STEPS

Over the past year, the CAB members have worked very hard to identify opportunities for improvements in safety, patient centered care, and linkages to community services and provided recommendations to BHD and the County Board. The CAB has brought in experts to share successful models including Community Ties which provides a continuum of support in the community for complex people with developmental disabilities and mental illness; Peerlink which provides support in the critical time following discharge from the hospital and beyond with a 46% decrease in hospitalization for participants, the Bridges Clinic which provides consumers with holistic treatment and choice including alternative and traditional treatment options, and the Sanctuary model which promotes trauma informed care for both staff and patients, as well as reducing use of Seclusion and Restraints.

However, recommendations are just a first step and the work is far from done. To ensure that the urgent work of system change advances and that we improve access, quality, and outcomes for people with mental illness, the CAB urges the following:

- We strongly endorse the mental health redesign initiative as defined in County Board Resolution 11-284. Members of the CAB are eager to take part in the Redesign Task Force and Action teams. We believe that the Redesign Task Force should take immediate steps to begin its work, including planning for implementation of the CAB recommendations.
- The CAB also endorses the proposed 2012 budget initiatives which will move forward with system change including the community-based Crisis Stabilization program which will utilize Peer Specialists to provide support to clients as they transition from inpatient hospitalization back into their communities; Developmental Disabilities-Mental Health Pilot Respite Program pilot program which will incorporate the ACT model, and development of additional community crisis options. We urge County Executive Abele to include these proposals in his 2012 budget and to also consider other options which may come from the Redesign Task Force.
- We urge continued action on implementing initiatives in the 2011 budget including development of a plan to incorporate peer specialists in the Community Services Branch; hiring of additional staff at the mental health complex including staff to support the zone model in Acute Care; continued implementation of an education and mentoring initiative for all BHD staff with a focus on Recovery, Person Centered Planning, and Trauma Informed Care; contracting with a nationally recognized consultant to provide technical assistance and review efforts to date to address safety issues; and fee for service basis for psychotherapy services and trauma counseling sessions by a licensed therapist for an additional 250 patients.

- We urge the board to authorize the CAB for an additional year, with a focus on an oversight and monitoring role for the current system - specifically, patient safety, patient centered care, and linkages to community services on the Acute Care Unit. This monitoring and oversight role is not in the scope of redesign.

  We propose that the CAB would meet on a quarterly basis to receive updates and reports from BHD staff on progress and implementation and in turn provide quarterly updates to BHD and the Health and Human Needs regarding the CAB's assessment of progress and implementation. This will limit the time commitment needed from BHD staff.

  The Community Advisory Board provides a unique and vitally important perspective by bringing together mental health consumers including peer specialists, family members, advocates, experts from the sexual assault community, front line workers including nursing, the public defender, and community clinicians. There are similar oversight boards for Family Care and people with mental illness deserve this same level of community oversight. Patients and families will benefit from and deserve a strong and independent community oversight group to monitor these important quality and safety concerns.

In moving forward with redesign and system change, we propose the following principles:

- **We must invest in community resources prior to downsizing inpatient services**. If we downsize without building community capacity, the result will be disastrous and will not result in better outcomes for people with mental illness. Instead, we will see dramatic increases at PCS as well as an increase in people with mental illness being inappropriately and tragically placed in the criminal justice system.
- Commitment to consumer inclusion – nothing about us without us. Redesign will not be successful without strong consumer representation, as well as participation from families and advocates.
- Public private partnership. Redesign should look at the provision of mental health services in the county – and not be limited to the services actually funded by Milwaukee County. The county is part of a larger system and broad community ownership and partnership is essential to success.
- Built on recovery principles which SAMHSA lists as: Self Direction, Individualized & Person Centered, Empowerment, Holistic, Non-Linear, Strengths-based, Peer Support, Respect, Responsibility, Hope. SAMHSA defines recovery as "A journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or full potential. "
- The right of people with mental illness and other disabilities to live in the most integrated setting that provides opportunities to live, work, and receive services in the greater community, like individuals without disabilities. This is mandated by the American with Disabilities Act and affirmed by the Supreme Court's decision in Olmstead v. L.C.
- Reflective of the diversity of our community, and committed to providing culturally proficient care.

- Moves beyond the medical model to include the services and supports that enable people to maintain their independence, including housing, employment, education, and benefits counseling.

We have a historic opportunity and responsibility to achieve system transformation – and the challenges are great. As compared to other communities, we spend far more on costly and traumatizing crisis and inpatient services – and much less on the community based services that can help people maintain their health and limit the need for expensive inpatient and crisis care. Our system has a shockingly high rate of emergency detentions and of consumer refusal of services, suggesting that the services now available may not be reflective of the needs and preferences of those served, as well as the need to promote voluntary treatment, person centered planning, and more consumer education.

This redesign initiative has the potential to develop new models and partnerships – to stop the tragic revolving door where people cycle through the Milwaukee County Mental Health Complex again and again, without being adequately connected with community services, at ultimately great human and fiscal cost.

Together, we can help lead the way to righting the balance of resources between inpatient/crisis services and community based services. In a time of record fiscal challenges, an increased emphasis on community supports will maximize the number of people able to receive services from a system with limited resources. And finally this shift will support better outcomes for our community members who rely on these services, expanding use of peer operated and peer support services, supportive housing, supported employment, and other evidence based practices such as ACT – the hospital without walls.

Finally, we are deeply grateful to all who contributed to the work of the Community Advisory Board including the following:

- The Milwaukee County Board and Chairman Lee Holloway who authorized this initiative, and especially the Health and Human Needs Committee and Supervisor Peggy West for leadership in proposing the CAB and serving as an ongoing partner in our work. We look to you for continuing support for these recommendations and for the redesign task force.
- BHD staff who were active partners in the work of the CAB and provided professional and timely response to our requests. Special thanks to Jim Kubicek, Jennifer Begerson, Amy Lorenz, Walter Laux, and Jen Wittwer who were primary staff for the work groups. Thank you for your partnership and all you do every day to provide hope and help for people with mental illness.
- Our dedicated CAB members who took time from their tremendously busy schedules to give back to the community and share their expertise, including County Supervisor Joe Sanfelippo who was an active and valued contributor. Special thanks to the outstanding individuals who provided leadership for the work groups – Sue Eckhart, Colleen Dublinski, Karen Avery, Shirin Cabraal, and Beth Burazin provided dedicated and energetic leadership.

The remainder of this document includes final reports provided by each of the three CAB work groups, in their own words.

Safety Work Group Update and Recommendations

The Safety Workgroup met on Wednesday, June 29th for our final meeting. We reviewed all of the recommendations we have submitted to the CAB previously and received a verbal update from BHD staff on the status of the recommendations. Below is s summary of those recommendations, along with the status and any additional comments we have for members of Health & Human Needs.

A. MAINTAINING A SAFE AND HEALING THERAPEUTIC ENVIRONMENT

The members of the Safety Workgroup felt that the highest priority for the department is to approach safety from a broad context – it's not just about keeping patients safe from assaults; for people to recover, the environment must be healing and therapeutic.

Recommendations

1. We support the BHD Trauma-Informed Care (TIC) initiative and Comprehensive, Continuous, Integrated System of Care (CCISC) initiatives to support culture change, and the need to allocate funds for staff training time.

STATUS: These initiatives have been started by BHD and we hope they will continue their commitment to them.

2. We strongly supported the allocation of funds for a safety consultant in the 2011 budget and we were pleased to see that was been approved with support of the County Board.

STATUS: Moving forward with this initiative should be a high priority. We recommend that criteria for the safety consultant should include experience with successful models for serving patients with challenging behaviors, including patients with both a mental illness and developmental disability.

3. We recommended exploring "therapeutic communities" as a possible model for Acute Care. Therapeutic community is a term applied to a participative, group-based approach to long-term mental illness, personality disorders and drug addiction. The approach is usually residential with the clients and therapists living together, is based on milieu therapy principles wherein patients join a group of around 30, for between 9 and 18 months. During their stay, patients are encouraged to take responsibility for themselves and the others within the unit. Milieu therapy is thought to be of value in treating personality disorders and behavioral problems. Another model that reduces violence and increases patient outcomes is the Sanctuary Model. The Sanctuary Model® represents a theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organizational

culture. Other in-patient units have utilized this model to successfully reduce the use of seclusion & restraints and to decrease the incidence of violence.

STATUS: As BHD moves forward with the Vulnerable population unit, they will be utilizing the Sanctuary model. The current intent is that development of programming on this unit will be a model for other units. BHD has made significant enhancement to the programming of the current units in terms of groups and engagement of the clients in unit activities.

B. STAFFING & TRAINING

Having the right staff and sufficient staffing is essential to maintaining safety and quality of care. Quality training and mentoring are also essential to maintaining safety and quality of care.

Recommendations

1. It is absolutely critical to overall safety to provide additional staff at BHD and we commend the fact that dollars were put in the 2011 budget for that purpose.

STATUS: BHD reports that adequate staffing without overtime has been challenging; however numerous new CNAs and RNs have been hired and all Psychiatrist positions have been filled. This will be an on-going challenge.

2. We recommend that there should be an increase in the use of Peer Support Specialists throughout BHD's services, both at the Mental Health Complex and in the community. Peer specialists can be used to help empower patients to be partners in their own recovery, by supporting them in development of WRAP plans – Wellness Recovery Action Plans.

STATUS: BHD staff report that they are exploring additional ways of utilizing Peer Specialists, including a 2012 budget initiative which looks very promising.

3. We have recommended that staff training time be budgeted for, to enable staff to have paid time to participate in training, as is the practice at other hospitals. Members of the Community Advisory Board and other community experts are willing to partner with BHD to provide training for free or minimal costs in areas where we have expertise, but the barrier is the labor cost of having staff attend.

STATUS: BHD staff report that new training has been developed.

4. At our last meeting, we identified the importance of BHD implementing an Electronic Records System to reduce medication errors and other safety-related issues.

STATUS: BHD reported that they are in the process of evaluating several software systems to address this issue and will move forward with EMR. This is included in the 2012 budget initiatives.

C. RESPONSE TO SEXUAL ASSAULTS

Recommendations

1. When an alleged assault occurs, the patient should immediately be offered the option to go to the Sexual Assault Treatment Clinic (SATC) and the exam should be done by experts at SATC. BHD staff should review their protocol regarding the response when an allegation of sexual assault occurs, including communication with family member or guardian, and see if changes are needed.
STATUS: BHD reports that this procedure has been implemented.

2. We recommended that additional training be provided for BHD staff regarding the response when a sexual assault occurs, and SATC staff is a resource for training as well.

STATUS: BHD staff concurs with this recommendation. BHD staff report that physicians have been told to not do any physical exam in any potential cases of sexual contact unless the patient refuses to be transported. Then an assessment is offered for any immediate medical needs.

3. We heard concerns that some law enforcement personnel who respond to allegations of sexual assaults at BHD react with skepticism to the patients concerns and seem to not believe the patients. There was also discussion of the benefits of having more female deputies respond to these complaints as many victims are more comfortable speaking to a woman.

STATUS: This needs to be followed up on. No actions have occurred regarding this recommendation so we encourage BHD and HHN to ensure that this issue be addressed. Deb Donovan, from the Sexual Assault Treatment Center (SATC) at Aurora, offered to do a presentation to the leadership at the Sheriff's Department. CAB members are willing to work with BHD staff to discuss with Sheriff Clark the benefits of having more female deputies available to respond and of honoring the victim's choice if they have a preference for a female (or male) deputy.

D. SECLUSION & RESTRAINTS (S&R)
Recommendations

1. Initially, BHD staff reported that in 2010, the use of S&R in the in-patient units increased. They speculated that this was in response to staff concerns about violence and assaults. As a result, we recommended that BHD move forward with implementation of their new initiative for responding to escalating behaviors and reducing use of seclusion and restraint. Workgroup members were very enthusiastic about the new tools, particularly the advance planning for crises which includes the patient. It is also important that all staff have training and knowledge about trauma-informed care and understand how the use of S&R can trigger traumatic memories in residents and exacerbate their behaviors.

STATUS: BHD has been doing intensive training to address this and recently developed new initiatives that are aimed at dealing with escalating behaviors, with minimal use of restraint and

seclusion. A new component is the use of the Broset Violence checklist, which is completed by an RN and then updated throughout the patients stay at the acute unit at BHD. A positive and unique part of the new initiative was the inclusion of a personal safety plan for advance crisis planning. This planning tool is done collaboratively with patients to reflect their preferences in what helps them de-escalate and also the particular use of restraint and seclusion if it becomes necessary. Staff reported that these new initiatives reduced S&R by 23% in the first quarter of 2011. BHD should continue carefully reviewing and monitoring its use of chemicals for purposes of S&R as there are strict federal rules regarding their use.

E. EVALUATING PROGRESS OF SAFETY INITIATIVES

Recommendations

1. Members of the Workgroup have had several discussions with BHD staff on how to best evaluate progress regarding safety at BHD. There was some agreement that it would be helpful to develop a "Dashboard" of indicators in which progress (or lack thereof) could be easily identified without exposing anything that would breach patient confidentiality.

STATUS: BHD has not yet developed this criteria for external review. We highly recommend that this be done and that the Community Advisory Board or a similar external body be responsible for reviewing the quality indicators on a regular basis.

F. MIXED GENDER REPORT

Recommendations

CAB members reviewed the Report on Mixed Gender Patient Care Units and submitted a memo to the board on 3/2/11 commenting on the report and generally supporting the recommendations. There are some promising recommendations; however, the manner in which they are implemented is critically important, therefore, we recommended:

- We strongly encourage BHD to include stakeholder input as they move forward.
- The new units should have a focus on treatment that is appropriate for these specialized populations – people with challenging and aggressive behavior and people with additional vulnerability.
- BHD should also consider how to incorporate "therapeutic milieus" within any new models of care (described in our recommendations in the last report).
- It is very important that the Intensive Treatment Unit have a higher staff to patient ratio including staff with specialized training and skills to work with patients with challenging behaviors.
- We must continue to explore other models for serving complex people with challenging behaviors who cycle through the system and are not appropriately placed at Acute Care. To support this, additional data collection and analysis may be needed.

STATUS: BHD Administrative staff has begun to plan for implementation of the recommendation

Patient Centered Care (PCP) Work Group Update and Recommendations

What a difference a year makes! The PCP committee set forth to build bridges over many a moat, dividing "us" and "them" on many levels. From the media, we heard words like "perpetrators", "victims", "insubordination", "dangerous mental patients" and "neglectful staff." Misunderstanding flowed rampantly, within the bureaucracy, the community, and within the organization itself.

We learned early on, that the concept of "Recovery" applies to every layer – and it occurs through the "uncovering" of barriers, and the "discovery" of meaningful collaboration.

Essential in this effort was the awareness that Trauma Informed Care applies to everyone – as members of humanity. We became aware that those with challenging behavior come in all forms, regardless whether a patient, caregiver, politician, observer, or reporter, and we owe it to one another to honor one another's views with appreciation and respectful consideration.

To gain understanding, our committee welcomed and accepted the diverse experience and perceptions of all who came to the table.

We needed to recognize our commonality. The things that people want and need are similar to that of organizations. Within a person centered framework, we acknowledge that people and systems need confidence within themselves that they have the tools they need to face challenges on a daily basis. They need a supportive community, working in tandem with others toward common goals; and finally, they need the knowledge of an extended network of people who "speak the same language", and are willing to partner with them in pursuit of the best possible outcomes for all.
We were fortunate to bring strong, talented leaders from our community, who were interested in serving as guides rather than critics – to work in collaboration with equally dedicated and committed BHD and County staff to work as partners in system transformation.

We recognized early on, that resistance to change is a strength – for each member represented an expert perspective on a shared challenge. The staff were the aware of what it's "really like" to work at BHD; the patients were aware of what it "feels like" to receive that care, and how it translates to what they really need. We found ways in which well meaning community organizations both helped and hindered the process.

We searched for and provided ways to empower BHD staff and the community with resources to help them help themselves, to brainstorm and enact ways to improve the system, providing inspiration and support to them as they engaged in this effort. Education and awareness was emphasized on partnership, collaboration, person centered, trauma informed care. To this end,

the TIC committee for BHD, the promotion of CCISC, and the CAB have all made significant strides.

The PCP Committee considered many areas.

Grievances:
Emphasized need for understanding & awareness of the grievance process, reviewed the current system, and devised ways to improve access to the process.
Status: The Patient Rights Committee implemented this recommendation. BHD now provides a user-friendly version as a quick reference within the admission packets provided people upon admission, and there was agreement to add a grievance form on the reverse side. Brochures for DRW are also included, and have been made available in other languages.

Access to Interpreters
Adequately trained interpreters, accessible in a timely manner, is an ongoing concern, and across the board for both spoken languages and for those who use sign language.
Status: A member of the PCP-CAB committee will work with BHD to develop a list of qualified persons. It is recommended that BHD include interpreters in their training related to TIC and PCP – and to also ensure proficiency to interpret complex mental health concerns accurately.

CCISC
The committee endorsed the CCISC initiative to address co-occurring issues, though emphasizes that Trauma is an aspect of this, and that specific training be offered in TIC. CCISC also endorses a person centered model. We also recommended the appointment of a coordinator to oversee the implementation of these initiatives.
Status: CCISC is moving forward and has been expanded from an original community focus to also include inpatient.

Culture Change
The PCP Committee was invited to Aurora Psychiatric Hospital – to learn about the Plane Tree model which has provided a framework for culture change – moving from a strict medical model, to one that is patient centered. We recognized that the philosophy of this program is basic, and "free." The requirement is a "buy-in" from the uppermost levels of administration, through all levels of employees and volunteers. This teamwork has resulted in improved outcomes, and job satisfaction.
Status: BHD is looking at other models for culture change which may incorporate many components of the Plane Tree model.

Developmental Disabilities
The CAB heard a presentation from the Waisman Center at UW-Madison highlighting the Community Ties model for serving people with developmental disabilities and complex needs in the community, including providing a continuum of care and support for frontline workers. The CAB strongly endorses the Community Ties model.

Status: BHD is looking at new models for serving this population, including the ACT model, and consulting with staff from the Waisman Center.

Cultural Competency
Although cultural competency was defined as a priority area for the PCP work group, we did not adequately address this topic due to resource and time constraints.
Recommendation: The Milwaukee Mental Health Task Force held a summit on Mental Health: Race, ethnicity and Culture and is working on a post summit action plan. We recommend that the task force meet with BHD staff to discuss concerns and best practices regarding cultural proficiency and opportunities for improvement.

The PCP work group thanks Milwaukee County for honoring the community by appointing the CAB. We all need mental health, and designing ways to effectively streamline the funds supporting this will lead to positive outcomes and a more productive community. What a difference a year has made - the moat is not a moat any more.

Community Linkages Work Group and Recommendations

The Community Linkages Work Group has developed the recommendations listed below related to alternatives to hospitalization and resource material. We also met with BHD staff to update on the status of previous recommendations.

Recommendations to Decrease Hospitalization:

1) Pilot use of the PeerLink model for patients discharged from the Acute Care Unit at BHD. Partner with NAMI Greater Milwaukee and Grassroots Empowerment who have been local partners in this project.
   Status: This is included in the 2012 budget as mentioned earlier.
2) Support the county's efforts to work with the private sector and federal funding to develop additional supportive housing and independent living options, across the county, including in suburban locations. A Housing First model will ultimately be a good investment.
   Status: This is an on-going focus of the Housing Division.
3) We recommend that advocacy and provider groups partner with BHD to explore the ACT model, including hosting an educational session. ACT, the "hospital without walls" is seen nationally as an evidence based model and best practice for people with serious and persistent mental illness, and the HSRI study recommended that Milwaukee add ACT to our community services. Although some Milwaukee CSPs incorporate many aspects of the ACT model, there is a need for better understanding of the ACT standards and the support needed for true fidelity to the model. Speakers are available from the state PACT program which provides training to ACT teams throughout the country and is nationally recognized as experts.
   Status: This approach has been proposed related to a project to look at individuals who are seen frequently in PCS. This has been presented to the board in April.

4) Support the efforts of Warmline to expand their hours in order to serve more people. Warmline provides non-crisis peer supported listening and referral to people with mental illness. They serve over 700 people a month in a very cost effective manner and help people maintain their independence and mental health, and are in the process of establishing a new Spanish Warmline in partnership with the Latino Health Coalition.
5) Expand Mobile Crisis Team – staff in mobile crisis team spread too thin for current responsibilities: mobile crises/emergency detentions, evaluations at the hospitals, walk-in clinic, evaluations for crisis respite, observation unit and psychiatric crisis services. Additional staff would help the police resolve situations before they result in an emergency detention thereby reducing the number of ED's. Additional staff can be trained to provide respite to families with a family member having a crisis due to MH and/or DD issues. Staff would also be available to provide assistance for problem situations in group homes. Madison has implemented these services and they have seen a reduction in hospitalizations.

Resource Material

The initial charge to the Community Advisory Board included development of a resource guide. The Community Linkages Work Group reviewed available materials, and the materials currently on hand at BHD. We determined that a wide range of guides are available online and in hard copy and that development of an additional guide in unnecessary. Instead, we recommend that BHD partner with community agencies to ensure that staff, patients, and families have access to the most current resource materials.

1) Develop a collaboration with community groups to create a Resource Center at BHD
2) Resource information available online
3) 211, Mental Health America and Community Advocates all have comprehensive resource manuals and/or online databases and should be key partners.

Previous recommendations from the work group are listed below. BHD has provided updates on some of the recommendations, as noted in status.

September 1, 2010 report:

1) SAIL (Service Access to Independent Living)
   a) Enhance the referral process and make decisions in a more timely fashion especially for individuals who are currently hospitalized. Get inpatient consumers connected to a TCM (targeted case management) or CSP (Community Support Program) before they are discharged. Move to integrate the AODA & MH Functional screen to create a seamless mechanism to assess people and determine the level of care necessary.
2) Inpatient discharge planning process
   a) Need for follow up with consumers after discharge making sure people are connected to services and help trouble shoot any other problems.
      Status: Planned in the 2012 budget, with a Peer Support model.
   b) A better connection with family members, guardians, and individual support systems that includes participation in the discharge process is critical.
      Status: This should be an outcome of the program proposed in the 2012 budget.

c) Improve access to computers on the units that would allow for e-mail and sending of information to medical staff and for looking up resources.
d) Reduce the time it takes for Family Care staff to evaluate and connect someone to services.
Status: Refer to the Family Care and Partnership MCOs and work with them on improving the process.
e) Concern that there is not adequate staff support to provide the level of discharge planning needed.
f) Move to de-emphasize the hospital and look more at the community. The period of time right after discharge is critical. Need robust community services. The new medical record system will be in place next year although staff will still share computers. New Family Care cap states that if someone is hospitalized or incarcerated for more than a week, they lose their Family Care spot. This guideline is being addressed. Challenges need to be addressed by getting current partners to come together. Connect individuals discharged from the hospital with peer support to help with ongoing planning.
Status: This is consistent with the mission and vision of the Redesign Task Force.

January 12, 2011 report:

1) Expand Quality Assurance staff at BHD and add a Peer Support Specialist to this team. Require that the RFP process should include as input to the reviewers the QA team's evaluations of current or past providers who have submitted proposals. County's TCM and CSP programs must go through the RFP process as well.
Status: BHD has included two additional QA position s in the 2012 budget. Community (private) TCM and CSP are required to go through the RFP basis annually, and are open for competitive bid every third year. BHD-operated programs do not go through the competitive bid process, and this may not be feasible given the County budgeting process and required County Board approval to outsource operated programs. However, operated programs could be subjected to the QA audit identified in the above bullet for the community review panel to identify quality improvement opportunities.
2) Consumers have the ability to choose which CSP or TCM program they want to join. Easier process for consumers to transfer to a different CSP or TCM.
Status: BHD supports this recommendation, and can use a similar policy within the AODA network as a template. However, in order to proceed with this recommendation, CSP and TCM should be moved to a fee-for-service arrangement that can more readily adapt to demands for services and rewards quality agencies. In a purchase-of-service environment, choice is limited to provider capacity identified within the Milwaukee County contract.
3) Adequate IT support must be a component in the integration of programs. Explore Electronic Support grant money for electronic records development. Federal grants are available to change/enhance the health care system using electronic records.
Status: BHD is moving forward with an EMR initiative.
4) Develop a SAIL appeal process for denial decisions for entrance into a CSP or TCM program, as required by state law.

Status: additional information that is required to process the application for services, or basis for denial with the opportunity to provide further relevant information upon notification from SAIL. SAIL will codify this process in policy by the end of the third quarter, and mirror an escalating appeal process utilized by the State for client grievances that would include additional County review by the clinical program director and, if necessary, the BHD medical director.

5) Expand range of community services and supports by moving forward with 1915(i). 1915(i) may no longer be an option. Additional discussion is needed with the State officials. Feedback from the State indicates that they are now looking into 1937 which is not statewide and has no entitlement piece and enrollment can be capped.
   Status: Milwaukee County continues to explore the viability of implementing 1915(i) with the State, as well as implementing other possible MA programs.
6) Evaluate the high volume of ED's at PCS so we can assess whether ED's are being used appropriately and identify opportunities for diversion.
   a) Work with private hospitals and CIT/CIP trainers to develop better training of staff in private hospital's emergency rooms.
   b) Move to support commitment to CIT and CIP. Have lost ground with both CIP &CIT. Chief Flynn has stated CIT will continue. Brenda Wesley is working on this issue with MPD and the Sheriffs Dept. She is also working with the private hospitals to incorporate CIP training; cost is an issue.

   Status: It should be noted that the Chief Judge recently submitted a grant application for Evidence-Based Decision Making (Phase 2), and this grant would also address CIT.
7) Establish a work group to plan for inclusion of peer support in CSP and TCM programs. Status: This will be part of the work for one of the Action Teams within the Redesign Task Force framework.

May 4, 2011 report:

1) Explore the development of community access points which would be open 24 hours a day 7 days a week to help link people to services and provide diversion from PCS. Provide collaboration and coordination of services. Staff would assist with appointments to outpatient clinics or other referrals and follow-up with individuals to insure access to services, provide appointment reminders, and identify barriers to treatment and resolutions. Other services would include benefits counseling, and assistance with securing housing.
   Need to evaluate what would be in place if PCS wasn't there.
2) Develop a Crisis Resource Center (CRC), including peer support, on the north side of town. Also recommend that Milwaukee County support efforts of the CRC leadership and advocacy groups, to urge the states to change Medicaid reimbursement rates to maintain adequate funding.
   Status: Expansion of this model requires a resolution of payment from the Medicaid HMO's .
3) Expand outpatient services:
   a) Geographic diversity to improve access

b) Provide some Walk In Clinic hours
c) Have a holistic model of services including access to mental health and substance abuse services, benefits counseling, connections to resources such as housing and peer support.
d) Culturally and linguistically appropriate care.
e) Partner with Federal Quality Health Clinics (FQHC) to develop outpatient capacity as they receive a better federal reimbursement rate.
f) Work with DHS and other stakeholders in the states to hold MCO's accountable for providing access to mental health services in their networks.
BHD has $350K in this year's budget to provide trauma informed care. Need more details about how that money will be utilized.
Status: BHD is exploring different opportunities to leverage outpatient services that would increase capacity. These values are consistent with the Redesign Task Force charge.

Fiscal Impact

At this point, the fiscal impact of these recommendations has not been determined. We request the Administrator of the Behavioral Health Division work with appropriate staff to determine costs of implementation.

SPECIAL NOTE: Paula Lucey has been the co-chair of this board. As Paula Lucey has become the BHD Administrator, she has continued to work with the Community Advisory Board but her participation should not be taken as official endorsement of any of the recommendations. Ms Lucey, as Administrator, will review the referred recommendations for appropriate action.

Respectfully submitted:

_____	_____
Barbara Beckert	Paula Lucey
Milwaukee Office Director	Administrator
Disability Rights Wisconsin	Milwaukee County Behavioral Health Division

cc: County Executive Chris Abele
Pat Farley, DAS Director
Antionette Bailey-Thomas, Analyst - DAS
Jennifer Collins, Analyst - County Board
Jodi Mapp, Committee Clerk - County Board