HHN

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COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

Referred
JAN 2011
County Board
Chairman

DATE : January 20, 2011

TO : Michael Mayo, Sr., Chairman, Milwaukee County Board of Supervisors
Supervisor Peggy West, Chairwoman, Health and Human Needs Committee

FROM : Lee Holloway, Milwaukee County Executive

SUBJECT : Mental Health Initiative

Attached to this communication is a document that outlines my mental health vision and initiative. This is basically, a proposal to improve care to patients with mental illness by collaborating with the community, establishing partnerships with area health care providers, focusing on community-based services, and establishing mechanisms that will bring more funding (and therefore more support for services) into the mental health system.

The document is presented as a seven-page report, accompanied by two attachments which visually present the plan, plus a resolution and fiscal note to initiate the initial phase and direct reports back.

This is an issue I feel very passionate about, as I know the members of the County Board do. I hope Board members review it closely and approve it on February 3, so that we can begin the process of establishing the criteria for a managed care model for mental health and related services in Milwaukee County.

Lee Holloway
Milwaukee County Executive

Attachment

Cc: Milwaukee County Supervisors

Milwaukee County Executive's Mental Health Vision and Initiative

Introduction

Over 20,000 people who have, often severe, mental illness are treated by Milwaukee County's mental health system each year. It is no secret, however, that the system has faced challenges. Some of these problems are patient care related, some relate to the physical plant, and still others are financial in nature.

There has been much community involvement in seeking sustainable approaches to the care of this vulnerable population and identifying these problems and trying to find effective solutions. Community groups have included: the Milwaukee Mental Health Task Force, Behavioral Health Advisory Council, Community Advisory Board and, recently, New BHD Facility Study Committee. In addition, the Public Policy Forum, in collaboration with the Milwaukee Health Care Partnership and the Medical Society of Milwaukee County, worked with a consultant, Human Services Research Institute (HSRI), to look at the improvements in the mental health system. Of course, the Milwaukee County Board Committee on Health and Human Needs has reviewed numerous issues relating to the Behavioral Health Division on a monthly basis, including ideas for improvement. And the Milwaukee County Long Range Strategic Plan Steering Committee has taken up the issue from an overall planning perspective. Most recently, the Milwaukee County Transition Committee I appointed has been briefed on mental health issues and may be weighing in soon.

All of these groups and these efforts are to be commended and used as a basis for moving forward. In addition, the management and clinical staff at the Behavioral Health Division should be recognized and thanked for their ongoing efforts to deliver patient care in an extremely challenging environment, and for their contributions to try to improve the mental health system.

Building off these efforts, I am presenting what is, basically, a proposal to improve care to patients with mental illness by collaborating with the community, establishing partnerships with area health care providers, focusing on community-based services, and establishing mechanisms that will bring more funding (and therefore more support for services) into the mental health system.

Background

The proposed initiative for mental health services in Milwaukee County has as its foundation the results of several years of intensive analysis and community input. It synthesizes the recommendations and ideas of multiple studies and feedback from advisory groups, as indicated above, including the Public Policy Forum/HSRI study. It also incorporates mental health proposals included in the 2011 Milwaukee County adopted budget since several support infrastructure needed for the proposed redesign. These ideas are also consistent with national trends and research.

In December of 2007, the Behavioral Health Advisory Council was created by the Milwaukee County Department of Health and Services and its Behavioral Health Division (BHD) in response to high demand for mental health services in Milwaukee County. From this effort, a relationship was established with the BHD, Milwaukee Health Care Partnership, Public Policy Forum and the Medical Society of Milwaukee County. This public-private partnership commissioned the HSRI study in 2008, which resulted in the report: *Transforming the Adult Mental Health Care Delivery System in Milwaukee County*, completed October 2010.

While this comprehensive study was being undertaken, a series of other informative assessments of the Milwaukee County Mental Health System were taking place. The State of Wisconsin Department of Health Services, Division of Quality Assurance (DQA) surveyed the Behavioral Health Division and in response BHD submitted plans of correction, which were approved by the necessary state and federal regulatory agencies and implemented.

In April 2010 as Chairman of the County Board, I directed the Milwaukee County Department of Audit to conduct an audit of BHD to address patient safety. The report released October 2010, *System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health*, concurred with BHD patient safety initiatives already in progress and recommended further enhancements which are in the process of being implemented.

The County Board and I also requested a review of the safety of BHD facilities by the Milwaukee County Sheriff's Department. That report released in June 2010, also concurred with safety initiatives being implemented by BHD and made recommendations for further improvements, which are in the process of being implemented.

In April 2010, the Milwaukee County Health and Human Needs (HHN) Committee requested a report from BHD on mixed gender units for acute inpatient. An initial report developed by BHD medical staff, discussed at the HHN Committee at their June 2010 meeting, concluded that there was insufficient research from the literature review and BHD medical staff would need to develop their own study. This study was undertaken and the follow-up report is being reported to the HHN Committee in January 2011.

The Milwaukee Mental Health Task Force, a forum with over 45 organizations committed to implementing mental health services, has also offered ideas for mental health system improvements over the years.

Disability Rights Wisconsin (DRW), as part of their protection and advocacy role, reviewed BHD patient records and developed a report in May 2010 with a series of recommendations for improvements needed within the behavioral health system, including substantially increasing community based alternatives to hospitalization.

Based on the results of the then available assessments, the County Board adopted a Resolution to establish the Community Advisory Board of numerous mental health stakeholders in May 2010. This Council was formed to provide input on policies regarding patient safety and mental health treatment.

In October 2010, the County Board formed a Special Committee of members of the Board of Supervisors to examine the merits of locating some BHD functions at sites other than the County Grounds, BHD space needs and possible locations on the County Grounds for a new facility. Although this Committee is newly formed, its task is consistent with aspects of my proposed initiatives.

During the Milwaukee County 2011 Budget process, several amendments were adopted which also are incorporated into and support this mental health initiative:

- The Department of Health and Human Services (DHHS) will be developing a plan to downsize the 72-bed Hilltop Center, a certified facility for persons with developmental disabilities and mental health issues.
- The Behavioral Health Division is to continue to work with the State to address eligibility criteria for 1915(i) Community Recovery Services and develop an implementation plan for County Board approval, prior to moving forward with this initiative which could expand community based services and bring in federal resources.
- The Behavioral Health Division is to survey the need for crisis beds to alleviate the strain on the Psychiatric Crisis Service Admission Center (PCS) including researching the development of a Crisis Resource Center in the northern part of the city.

Mental Health Initiative: The Time to ACT is Now

Multiple evaluations of BHD have been completed by local and national experts and community stakeholders. It is time to take the information available and the understanding from our years of experience being responsible for the operation of a major mental health care and hospital system and develop a strategic initiative. This initiative prioritizes mental health system improvements, lays out action steps and presents a view of the proposed redesigned system.

Attached are two schematics, which outline my mental health initiative and ultimate redesign.

- Attachment 1 presents the overall initiative. At its center is recovery-oriented patient care. It includes guiding concepts and specific actions that can begin immediately, which will eventually lead to mental health system redesign. It is, in essence, a road map for improving our mental health system. Five key concepts are addressed, all of which inter-relate and support each other:

    1. Strengthen Public/ Private Partnerships
    2. Pursue alternatives to institutionalization
    3. Increase access to crisis services
    4. Enhance community-based services, and
    5. Leverage federal funds to increase services.

- Attachment 2 presents a view of the redesigned mental health system once the initiative would be implemented.

First: The Ultimate Vision for a Redesigned Mental Health System

My vision is of a Milwaukee County mental health system with community-based small-scale facilities, where services could be provided through a managed care program of capitated payments and patient care management. A schematic of this vision is outlined in the diagram in Attachment 2.

The redesign presents a community-based, pay-for-performance model for the delivery of mental health services to individuals in Milwaukee County. The service model could be roughly based on the General Assistance Medical Program (GAMP) previously operated by Milwaukee County until replaced with a State medical program. Patients would have their mental health care managed in the community by interdisciplinary teams through capitated payments and incentives for recovery. It is expected that by taking this type of approach with an emphasis on wellness and community support that hospitalizations, visits to crisis services and emergency detentions would decrease. This should be an enhanced way of life for the clients while, freeing up resources to reinvest back into community-based services.

Working with the federal and state government to ensure compliance with all regulations, it is envisioned that patient care would be provided throughout Milwaukee County in 16-bed (or smaller) mental health facilities (including at the County mental health complex), which would be part of, and overseen by, the Milwaukee County mental health system but could be privately developed and operated. (The exact number of such facilities needed would be determined following implementation of the pilot program and other components of the initiative.) These community-based facilities would be eligible for Title 19 (Medicaid) funding. Patient care would be provided by interdisciplinary team(s) that could include nurse practitioners, nurses, psychiatrists, psychologists, social workers, rehab services, physical medicine and peer specialists, under the pay-for-performance managed care model. The initiative would begin with the proposed pilot program implemented through a request for proposals (RFP) process.

By developing a managed care system for patient care in the community in small facilities, and through implementation of the other initiatives proposed, such as increasing crisis services and downsizing Hilltop, Milwaukee County could downsize its current mental health facility and develop a smaller one located on a site on the County Grounds. The specific roles of the County's smaller facility in the mental health system would be identified through implementation of the initiatives, which would determine the appropriate role for the facility, but could include programs for short-term mental health treatment and for controlling medications of patients in the mental health system.

To Get to the Envisioned Mental Health System Redesign: the Initiative

My broader mental health initiative, which leads to the ultimate redesign, is outlined in Attachment 1. It describes the initiative's guiding concepts and, within each concept, specific objectives. These proposed action steps support the broader initiative and, if implemented as

envisioned, could lead to the eventual redesign of the mental health system as described above. These are necessary beginning steps, which are laid out in broad terms here with the expectation that details, strategies and implementation plans would be developed and presented to the County Executive and County Board.

1. **Strengthen Public/ Private partnerships**

   A. Meet with universities, medical colleges, nursing schools and technical schools to increase and enhance interdisciplinary teams, specifically focusing on strategies for recruitment, retention and education of licensed professionals. This could assist in addressing shortages of nurse practitioners (APNP) providing psychiatric care and certified nursing assistants (CNA).

   B. Partner with hospitals to develop strategies to prioritize and expand necessary capacity in the mental health services continuum.

2. **Pursue alternatives to institutionalization**

   C. Develop a plan to downsize the 72-bed Hilltop Center, a certified facility for persons with developmental disabilities and mental health issues, and provide community-based services. This would include enhancing partnerships with Family Care – Care Management Organizations. These partnerships would augment the development of the specialized resources necessary to meet the needs of the current residents at Hilltop.

3. **Increase access to crisis and community mental health outpatient services**

   D. Research the development of an additional Crisis Resource Center in the northern part of the city that would include expansion of Crisis Respite beds.

   E. Develop strategies for additional crisis prevention, intervention and stabilization services (such as mobile crisis). This effort would support the concept of pursuing alternatives to institutionalization.

   F. Pursue partnerships with existing Federally Qualified Health Centers (FQHCs) to expand opportunities to increase federal funding and increase access to community mental health outpatient services.

4. **Enhance community-based services through a managed care system of service delivery (pilot program)**

   G. Develop a Request for Proposal (RFP) to initiate a pilot program to establish a pay-for-performance, managed care model for a mental health delivery system in the community. The managed care pilot would include:

   - A capitated payment system based on patient levels of care
   - Incentives for recovery
   - Opportunities to assess different staffing models
   - Quality oversight
   - Monitoring of hospitalization, crisis and emergency detention rates
   - Monitoring of service costs and cost effectiveness

The pilot would initially be limited in scope to accommodate evaluation and assessment before any expansion. It would be designed to begin to move patient care into the envisioned small-scale, community-based mental health facilities.

Work could begin immediately on the design of the pilot and a report describing its programmatic and fiscal details that would be included in an RFP. **This pilot would offer a test-run of the managed care component of the mental health redesign and a first step toward the development of smaller-scale community mental health facilities as reported by *The Milwaukee Journal Sentinel* in an article on January 13, 2011, "Mental Health Redesign Proposed" and supported in an editorial on January 14, 2011, "Mental Health: The Holloway Plan."**

5. **Leverage federal funds to increase services**

   H. Develop a written implementation plan for getting additional federal funds for Community Recovery Services 1915(i) once issues related to eligibility are addressed. This would add additional services to the system including Community Living Supportive services, Supported Employment and Peer Support. It also could provide resources for the managed care model for services in the community, helping to reduce hospitalizations and therefore reduce pressure on the demand for acute inpatient beds.

   I. Develop a strategy to create mental health facilities with 16 beds or fewer throughout the community, and at a County's mental health facility on County Grounds, to enable Medicaid reimbursement for services. This network of small-scale facilities throughout the community was broadly outlined in the articles mentioned above.

Need for Fiscal Analysis

The 2011 County Budget already requires follow-up reports to the County Board for several components of the initiative (1915(i), Hilltop downsizing, Crisis Resource Center). As these individual budget items are further addressed, their fiscal impact will be identified.

A detailed fiscal analysis will be needed to identify both expenditures and revenues associated with the pilot program to be RFP'd.

The Behavioral Health Division, working with the Department of Administrative Services-Fiscal Affairs Division and County Board staff, should develop a detailed fiscal analysis of the components of an RFP, by March 30, 2011.

Recommendations

It is recommended that the County Board approve the attached resolution, which supports the concepts and objectives outlined in this mental health initiative.

The resolution also directs that a report describing the details for a pilot project to establish a managed care model for a mental health delivery system with small facilities located in the community to be included in a Request for Proposal (RFP).

The report is to be submitted to the County Board for review and approval by March 30, 2011.

It is also recommended that the Behavioral Health Division, working with the Department of Administrative Services-Fiscal Affairs Division and County Board staff, develop a detailed fiscal analysis of the mental health pilot program to be RFP'd, to accompany the report describing the details of the pilot project, by March 30, 2011.

Finally, it is recommended that the groups that are focusing on issues relating to the Behavioral Health Division, including, the Community Advisory Board, the New Behavioral Health Facility Study Committee and the Behavioral Health Advisory Council, be encouraged to direct their efforts on implementing the mental health initiative outlined in this report and in the attached documents.

Attachments: 1 and 2 Schematics of Mental Health Initiative
Resolution and fiscal note

Attachment 1

County Executive's Mental Health Initiative

Patient-centered Recovery Oriented Continuum of Care

Strengthen Public/Private Partnerships

A. Meet with University/Tech-Nursing Schools to increase and enhance interdisciplinary teams, specifically Nurse Practitioners (APNP) providing psychiatric care and enhanced training to Certified Nursing Assistants (CNA).

B. Partner with hospitals to expand capacity in the mental health services continuum.

Pursue Alternatives to Institutionalization

C. Develop a plan to downsize Hilltop and provide community-based alternatives.

Enhance Community Based Services Through a Managed Care System of Service Delivery

G. Develop an RFP to initiate a pilot program to establish a pay-for-performance managed care model for a mental health delivery system in the community. The pilot would include:

- Capitated payment system based on patient levels of care
- Incentives for recovery
- Opportunities to assess different staffing models
- Quality oversight
- Monitoring of hospitalization, crisis and emergency detention rates
- Monitoring service costs and cost effectiveness

The pilot would initially be limited in scope to accommodate evaluation before expansion.

Increase Access to Crisis & Community Mental Health Outpatient Services

D. Research the development of an additional Crisis Resource Center.

E. Develop a strategy for additional crisis prevention, intervention, and stabilization services (such as mobile crisis).

F. Pursue partnerships with existing Federally Qualified Health Centers (FQHCs) to expand opportunities to increase federal funding and increase access to community mental health outpatient services.

Leverage Federal Funds to Increase Services

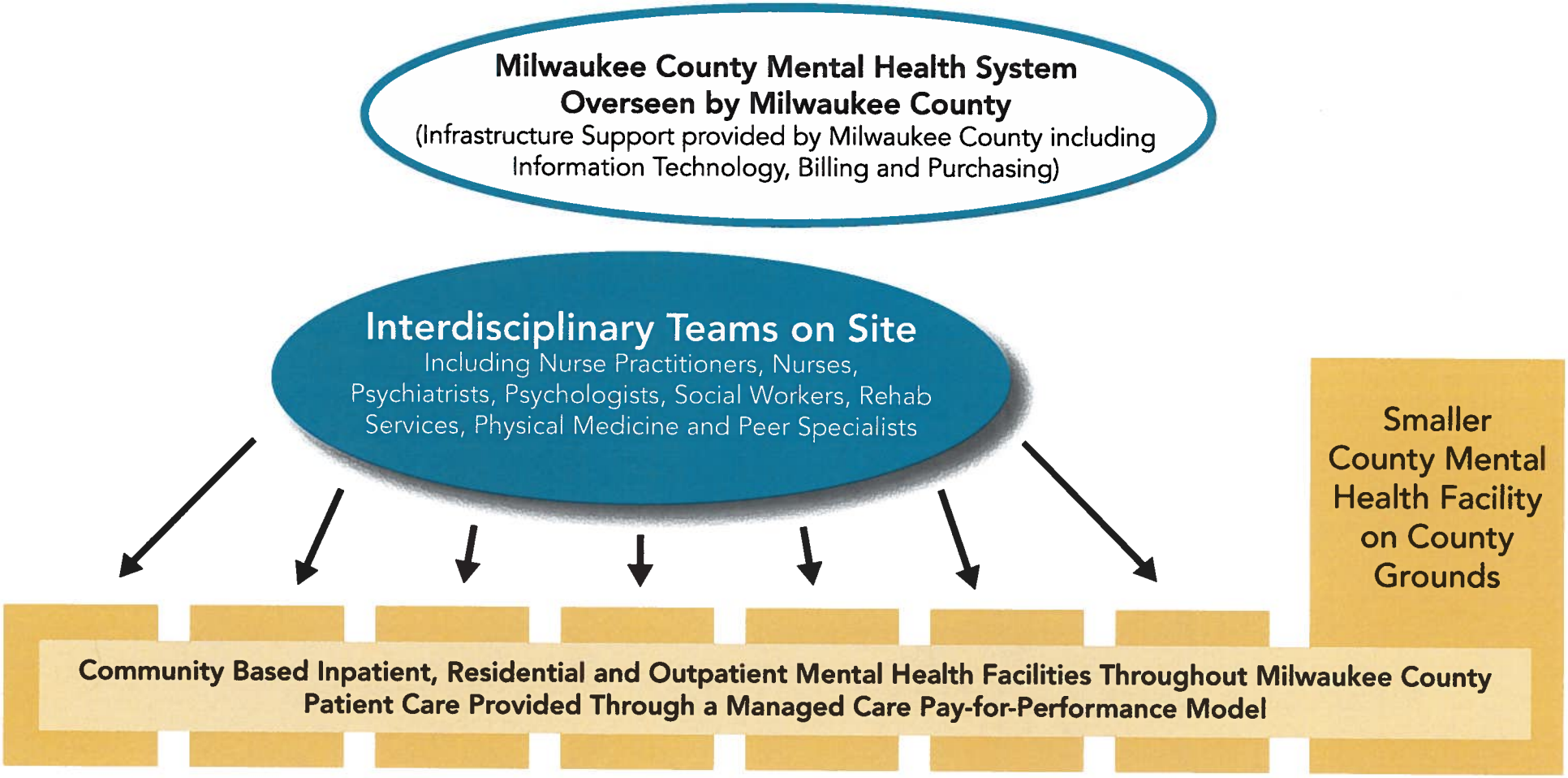
H. Develop an implementation plan for 1915(i) Community Recovery Services. Includes Community Supportive Services, Supported Employment and Peer Support.

I. Develop strategy to create mental health facilities throughout the community, and at the County's mental health facility, with less than 16 beds to enable Medicaid reimbursement.

View of Proposed Redesigned System, Attachment 2

County Executive's Mental Health Initiative

View of Redesigned Mental Health System After Initiative is Fully Implemented



▪ 16 beds or fewer - Title 19 (Medicaid) funding eligible ▪ Privately developed and privately operated ▪ Based on GAMP type service model

First Step: RFP a pilot program to develop a model for managed care and smaller community based mental health facilities

Submitted by County Executive Lee Holloway, January 2011

(Item 1) From the County Executive requesting support of the concepts and objectives outlined in the mental health initiative and directing the Interim Director, Department of Health and Human Services, to develop a report describing the details of a pilot project creating a model for a managed care system with small facilities located in the community.

A RESOLUTION

WHEREAS, the Milwaukee County Behavioral Health Division (BHD) is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders; and

WHEREAS, over 20,000 people who have, often severe, mental illness are treated by Milwaukee County's mental health system each year; and

WHEREAS, various entities have conducted studies recently, illustrating the challenges facing the mental health care delivery system in Milwaukee County; and

WHEREAS, included in the aforementioned entities is the Milwaukee County Department of Audit, which issued an audit titled, *"System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division," in October 2010;* and

WHEREAS, another group, Human Services Research Institute worked with the Public Policy Forum as a local consultant to issue "*Transforming the Adult Mental Health Care Delivery System in Milwaukee County,"* also in October 2010; and

WHEREAS, over the past year, the Milwaukee County Health and Human Needs Committee has reviewed multiple reports, including those mentioned above, a report from the Milwaukee County Sheriff's Department assessing the safety of BHD facilities, and reports from BHD evaluating whether mixed gender units are appropriate for adult acute inpatient stays; and

WHEREAS, the County Board passed a resolution (File. No. 10-213) creating the Community Advisory Board, which consists of numerous mental health stakeholders who provide input on safety, linkages to the community, and patient-centered care at BHD; and

WHEREAS, the County Board also adopted a resolution (File. No. 10-322) forming a New Behavioral Health Facility Study Committee of appointed Milwaukee County Supervisors to examine the merits of locating some BHD functions at sites other than the County Grounds, BHD space needs, and possible locations on the County Grounds for a new facility; and

WHEREAS, the efforts initiated by the Community Advisory Board, the New Behavioral Health Facility Study Committee, additional community stakeholders, and the key principles mentioned in the various studies are critical, and will be integrated as the county moves forward to enhance the delivery of behavioral health services; and

WHEREAS, in the 2011 Adopted Budget more than $59 million in tax levy support is included for BHD, a number which has increased annually over the last decade, and is expected to continue to grow unless the service model changes; and

WHEREAS, Milwaukee County as a whole is faced with significant fiscal challenges; and

WHEREAS, changes to the mental health system delivery model have the ability to enhance the services that are provided and also leverage additional funding; and

WHEREAS, in order to be successful, the entire Milwaukee County community must come together and embrace change, whereby responsibility for individuals with mental health needs are coordinated between the public and private sectors, and any risks are shared; now, therefore,

BE IT RESOLVED, that Milwaukee County supports the concepts and objectives outlined in the attached mental health initiative; and

BE IT FURTHER RESOLVED, that the Interim Director, Milwaukee County Department of Health and Human Services, is directed to develop a report describing the details of a pilot project creating a model for the managed care system with small facilities located in the community to be included in a Request for Proposal (RFP); and

BE IT FURTHER RESOLVED, that the Interim Director, Milwaukee County Department of Health and Human Services shall submit a report to the Board of Supervisors for review and approval by March 30, 2011; and

BE IT FURTHER RESOLVED, that the Behavioral Health Division, working with the Department of Administrative Services-Fiscal Affairs Division and County Board staff are directed to develop a detailed fiscal analysis of the mental health pilot program, which shall be attached to the aforementioned report; and

BE IT FURTHER RESOLVED, that the groups that are focusing on issues related to the Behavioral Health Division, including, the Community Advisory Board, the New Behavioral Health Facility Study Committee and the Behavioral Health Advisory Council, are encouraged to direct their efforts on implementing the mental health initiative outlined in the attached documents.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 1/19/11

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: A resolution supporting the concepts and objectives outlined in the mental health initiative and directing the Interim Director, Department of Health and Human Services, to develop a report describing the details of a pilot project creating a model for a managed care system with small facilities located in the community.

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☒ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

This resolution has no direct fiscal effect, although staff time will be required to develop a Request for Proposal (RFP) creating a model for the community-based managed care system, to perform a detailed fiscal analysis of the mental health pilot program to be RFP'd, and to prepare a report to be submitted to the Milwaukee County Board of Supervisors by March 30, 2011.

Department/Prepared By

Authorized Signature

Did DAS-Fiscal Staff Review? ☒ Yes ☐ No

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

HHN

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Milwaukee County

County Courthouse
901 N. 9th Street, Rm. 105
Milwaukee, WI 53233

Text File FILE NO. 11-74

File Number: RES 11-25

19 (4)

Referred
JAN 2011
County Board
Chairman

Introduced: 1/13/2011 **Current Status:** ATS Review

Version: 1 **Matter Type:** Resolution

Title

A Resolution requesting Wisconsin's State and Federal representatives to work to establish a "fast-track" exception process for determining and presenting military related honors for deserving World War II or other aging veterans and authorizing and directing the County Clerk to convey such message to the Wisconsin representative delegation.

Body

A RESOLUTION

WHEREAS, according to the United States Department of Veteran Affairs, as of September 2009 there were more than 2 million surviving veterans of World War II, and

WHEREAS, as WWII veterans advance to the later stages of life, the families of many veterans have come to realize that their loved ones may have an Armed Forces service history that warrants appropriate military awards, such as service medals or Purple Hearts - recognition that many men and women never sought during their armed forces service; and

WHEREAS, when veterans or their families seek information that could result in an appropriate military award or recognition, they are often confounded by an unimaginably complex bureaucracy that produces only dead ends and SNAFUs, resulting in delays of months or, often, years in simply retrieving service records; and

WHEREAS, the Department of Veteran Affairs has estimated that the median age of World War II veterans is 86, and that nearly 900 veterans of World War II die each day, evidence that, simply put veterans cannot afford bureaucratic; and

WHEREAS, the need for expedited awards determinations was highlighted recently when the family of Orville Lemke - injured during service as a Communications Specialist in Germany during World War II and deserving of a Purple Heart - was effectively stymied for more than seven years while pursuing his deserved recognition; and

WHEREAS, despite pursuing the records that could lead to his Purple Heart since 2003 and receiving significant assistance in that regard from Milwaukee County's Office of Veteran's Services, Orville Lemke passed away on December 24, 2010 without receiving any final resolution to his family's request; and

WHEREAS, the Heroes of the Greatest Generation and all of our veterans deserve a better process and more timely determination of their US Military honors and awards; now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors hereby requests our state and federal representatives to work to establish a "fast-track" exception process to prevent the delays in determining military recognition for veterans of World War II and other veterans of advanced age or declining health, so that the awards may be presented directly to the Honored Recipient rather than posthumously; and

BE IT FURTHER RESOLVED, that the Milwaukee County Clerk shall forward a copy of this resolution to the Governor of the State of Wisconsin, and other State and Federal Legislative Representatives from Milwaukee County.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: January 18, 2010

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: A Resolution requesting Wisconsin's State and Federal representatives to work to establish a "fast-track" exception process for determining and presenting military related honors for deserving World War II or other aging veterans and authorizing and directing the County Clerk to convey such message to the Wisconsin representative delegation.

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

- ☒ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

- ☐ Absorbed Within Agency's Budget
- ☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.[1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

Adoption of this resolution will have no direct fiscal effect, although an expediture of staff time in the County Clerk's Office will be required.

Department/Prepared By County Board/Ceschin

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

RECEIVED
2011 JAN 18 PM 4:00
COUNTY BOARD
CHAIRMAN

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

MEMORANDUM

Date: January 14, 2011

To: Supervisor Peggy West, Chair, Committee on Health and Human Needs

From: Maria Ledger, Interim Executive Director, Department of Family Care

Subject: Update on the current parking availability and meeting space for visitors to the Department of Family Care

This memorandum is a status report on current parking availability and meeting space for visitors to the Department of Family Care.

All Department of Family Care staff that wished to park at MacArthur Square have been able to purchase parking there.

There are two conference rooms available in the Family Care Office Suites. In addition, the Department has been fortunate to be able to reserve other rooms located throughout the courthouse. The Department is validating parking for Family Care members, their families and members of the community who serve on Department Committees.

15 Department staff are now located at the Underwood Recreation Center. This space is leased from the Office for Persons with Disabilities. As a Managed Care Organization serving both frail elders and people with disabilities, we are honored to partner with the Office for Persons with Disabilities as well as Easter Seals Inc, who provides a very popular day camp at the site in the summer for people with disabilities.

The Underwood site has free surface parking and offers a large training space that will be available for our use when renovations are completed.

If you have any questions, please call me at 287-7610.

Maria Ledger, Interim Executive Director
Milwaukee County Department of Family Care

cc: County Executive Lee Holloway
Terrance Cooley
E. Marie Broussard
Jodi Mapp
Don Natzke
Jim Hodson
Linda Murphy
Eva Williams

MEMORANDUM

Date: January 20, 2011

To: Supervisor Peggy West, Chair, Committee on Health and Human Needs

From: Maria Ledger, Interim Executive Director, Department of Family Care

Subject: Status of Second Managed Care Organization in Milwaukee County

Program Descriptions

The Family Care program integrates home and community-based services, institutional care services (i.e., nursing homes), Medicaid personal care, home health, and other services that were previously funded separately. Family Care does not provide acute/primary health care services such as hospital stays, emergency room visits, medications, and doctor visits. Family Care members use Medicare and Medicaid to purchase the health care services they need.

In November 2009, the Milwaukee County Department of Family Care (MCDFC) was certified by the Wisconsin Department of Health Services (DHS) to provide Family Care to persons with physical and developmental disabilities age 18 to 59 in addition to the members age 60 or older already in Family Care and served by the MCDFC.

Community Care, Inc. (CCI) was also certified in November 2009 to provide Family Care in Milwaukee County to the same target groups in need of long-term care services. Community Care also participates in the Partnership program, as does Icare, Inc.

The Partnership and PACE (Program of All Inclusive Care for the Elderly) programs integrate long-term care services and primary and acute health care services, and prescription medications. Therefore, all home and community based services, institutional care services, physician services, hospital stays, prescription medications, and all other medical care is integrated into the Partnership or PACE benefit.

Risk Sharing Arrangement

In late December 2010, the State Department of Health Services (DHS) notified the MCDFC, that DHS is entering into another "risk sharing arrangement" with CCI. With this arrangement, CCI is only responsible for the first 1% of its losses. For everything beyond the first 1%, the State will share equally in the loss.

While we have no first hand knowledge of the financial challenges faced by CCI, the MCDFC has communicated numerous times to the Milwaukee County Board of Supervisors and to DHS Office of Family Care Expansion (OFCE) that CCI is, in many instances, paying higher rates to Family Care service providers than is the MCDFC.

Supervisors and to DHS Office of Family Care Expansion (OFCE) that CCI is, in many instances, paying higher rates to Family Care service providers than is the MCDFC.

By paying more for services, CCI has been able to grow their provider network at the expense of Milwaukee County's more cost effective option, the MCDFC. In turn, some of these providers have encouraged members to disenroll from MCDFC and to enroll in CCI's program so that they (the providers) can be paid at a higher rate.

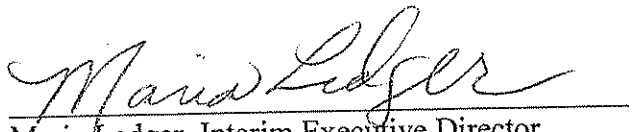
On December 31, 1020, CCI has sent a letter to its providers (see attached) stating, "Since 2007, in an effort to reduce the impact to our providers, Community Care has lost over $13 million operating this program. Without dramatic actions, given the reduced funding in 2011, Community care would lose $14 million. Community Care is no longer able to absorb losses."

The letter goes on to state, "To ensure a sustainable program for 2011 and beyond, we are left with no alternative but to reduce the rates we pay to providers."

The MCDFC wants to reassure the Milwaukee County Board of Supervisors that we are not implementing across the board rate reductions for our providers. We have worked diligently over that past 10 years to establish cost effective rates and to be good stewards of public dollars.

The Milwaukee County Department of Family Care has, according to DHS, "achieved operating stability while managing the expansion of services to individuals with disabilities." The quality in this program is excellent and the management team has established a positive and collaborative working relationship with DHS. The Milwaukee County Department of Family Care is the only MCO in Wisconsin that has been solvent through an expansion of Family Care services and we have done so while maintaining extremely high quality standards.

As the Board is aware, the Department submitted its expansion proposal to DHS in 2008 with the expectation that Milwaukee County would be the only MCO awarded a contract in Milwaukee County. In 2011, although the State DHS has stated they will not suspend referrals to CCI during this period of financial difficulty, MCDFC continues to have sufficient administrative and service capacity to serve any and all members who choose to enroll in Milwaukee County's MCO.



Maria Ledger, Interim Executive Director
Milwaukee County Department of Family Care

Attachment

Cc: County Executive Lee Holloway
Terrence Cooley
E. Marie Broussard
Renee Booker
John Ruggini
Antionette Thomas-Bailey
Stephen Cady
Jennifer Collins
Jodi Mapp
Jim Hodson
Linda Murphy
Eva Williams

Familiar places. Caring faces.

December 31, 2010

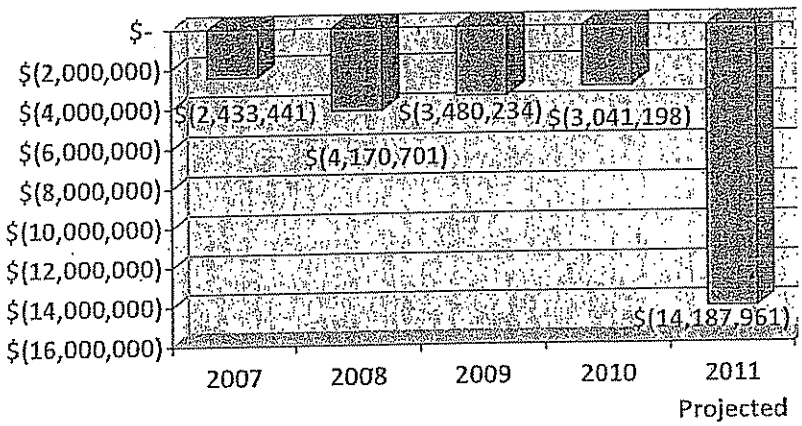
Dear Provider:

The purpose of this letter is to share the actions that Community Care is implementing in 2011 to achieve sustainability in our Family Care and Family Care Partnership Programs given the challenging economic realities we are facing. On December 20th we received confirmation of our 2011 funding for Family Care and Family Care Partnership from the State of Wisconsin, Department of Health Services. Our funding reflects the State's need to fund all Managed Care Organizations (MCOs) equitably with the dollars that are available. The impact to Community Care will be a decrease of approximately $10 million from our 2010 funding.

Community Care began operating Family Care in Racine and Kenosha Counties in 2007 and now offers the program in 11 counties serving approximately 7,000 members. Since 2007, in an effort to reduce the impact to our providers, Community Care has lost over $13 million operating this program. Without dramatic action, given the reduced funding in 2011, Community Care would lose an additional $14 million (see chart below).

Community Care is no longer able to absorb losses. Since 2007, we have worked diligently to reduce our internal costs. Currently, we have the lowest administrative rate of any MCO and our care management costs are the third lowest of the nine MCOs. While we are continually working to reduce these costs further, we are not able to reduce them enough to cover the projected loss of State funding for these programs:

Community Care Operating Losses



To ensure a sustainable program for 2011 and beyond, we are left with no alternative but to reduce the rates we pay to our providers. This decision was not made lightly since we truly value the partnerships we have built with our providers.

Community Care Inc Community Care Health Plan Inc 1555 S Layton Blvd Milwaukee, WI 53215 414-385-6600 communitycareinc.org
Calumet Kenosha Milwaukee Ontagamie Ozaukee Racine Sheboygan Walworth Washington Waukesha Waupaca

Rate reductions may be based on a percentage decrease or may be targeted at providers who have current rates that are higher than we typically pay for the same service. Our goals are to achieve sufficient rate reductions to ensure sustainability and to improve the equity between the rates paid to providers for the same type of service.

Building a sustainable Family Care Program has not been and will not be easy but we owe it to our members to find a way to make the program work so that the services that enable them to achieve their outcomes are maintained.

We are living in very difficult economic times. Family Care is funded 100% with Medicaid funds and as the economy continues to struggle, the projected shortfall in these funds grows larger. Community Care is a nonprofit organization dependent on Medicaid funding, a source of funds that can no longer support the current level of spending. We understand that most of our providers are in the same situation and we encourage you to respond to rate reductions by finding ways to reinvent your organizations so that we can all continue to serve those who are dependent upon us.

The enclosed documents will provide you with detailed information, including effective dates, for services provided by your organization. It is imperative that we implement these changes immediately as any delay will reduce the amount of savings and require us to implement deeper cuts. All rate adjustments will become effective on February 1, 2011 for services authorized for Family Care, Family Care Partnership and PACE.

If you need additional information or would like to request technical assistance, a list of contact names with email addresses and phone numbers is enclosed. Thank you for your ongoing commitment to those we serve.

Sincerely,

Edward T. Kohl
Family Care Program Officer

County of Milwaukee
INTEROFFICE COMMUNICATION

DATE: January 17, 2011

TO: Sup. Michael Mayo, Sr., Chairman, Milwaukee County Board of Supervisors
Sup. Peggy West, Chairperson, Committee on Health and Human Needs

FROM: Stephanie Sue Stein, Director, Department on Aging

RE: Request for authorization to award additional funds to calendar year 2010 contracts with Bethesda Community Senior Citizens' Center, Inc., Project Focal Point, Inc., Asian American Community Center, Inc., Indian Council of the Elderly, Inc., Hmong/American Friendship Association, Milwaukee Christian Center, Inc., Goodwill Industries of Southeastern Wisconsin, Inc., and Interfaith Older Adult Programs, Inc., for program and service contracts originally authorized under File No. 10-34 (a)(a)

I respectfully request that the attached resolution be scheduled for consideration by the Committee on Health and Human Needs at its meeting on January 26, 2011.

The attached resolution authorizes the Director, Department on Aging, to award additional funds to calendar year 2010 contracts with Bethesda Community Senior Citizens' Center, Inc., Project Focal Point, Inc., Asian American Community Center, Inc., Indian Council of the Elderly, Inc., Hmong/American Friendship Association, Milwaukee Christian Center, Inc., Goodwill Industries of Southeastern Wisconsin, Inc., and Interfaith Older Adult Programs, Inc., for program and service contracts originally authorized under File No. 10-34 (a)(a) and listed below:

1. Increase by $5,000, from $85,000 to $90,000, the contract with Bethesda Community Senior Citizens' Center, Inc., to provide Programs in Minority Senior Centers, and

2. Increase by $5,000, from $61,317 to $66,317, with Project Focal Point, Inc., to provide Programs in Minority Senior Centers, and

3. Increase by $5,000, from $39,300 to $44,300, the contract with Asian American Community Center, Inc., to provide Services to Asian American Elderly, and

4. Increase by $5,000, from $84,572 to $89,572, the contract with Indian Council of the Elderly, Inc., to provide Services to Native American Elderly, and

5. Increase by $5,000, from $32,850 to $37,850, the contract with Hmong/American Friendship Association, Inc., to provide Community Outreach and Access Services to Southeast Asian American Elderly: Translation and Interpretation, and

6. Increase by $2,030, from $40,000 to $42,030, the contract with Milwaukee Christian Center, Inc., to provide Nutrition Site Supervision at Milwaukee Christian Center, and

7. Increase by $3,500, from $254,106 to $257,606, the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Nutrition Site Supervision Services (Multiple Sites);
   and

8. Increase by $1,500, from $829,000 to $830,500 the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Case Management and Home Delivered Meals, and

9. Increase by $2,000, from $304,017,232 to $306,017, the contract with Interfaith Adult Programs, Inc., to provide Coordination of Neighborhood Services.

The Department awards funds to provider agencies based on the availability of federal, state, and local funds, usage by older persons of programs and services, anticipated changes in service demand, and allowable costs. When additional funds become available, the Department seeks to use those funds to fully reimburse vendors for the services they provide and for one-time only expenditures designed to maintain or enhance the quality of programs and services provided.

Funds for proposed increases in awards to the contracts within this resolution reflects deferred revenue from prior years and carryover of 2009 revenue from supplements to the State/County contract. The increases in awards fund (1) one-time only purchases for various supplies, equipment, furniture, and facility improvements, and (2) expenses related to the Senior Ambassador program.

If you have any questions, please contact me at 2-6876.

Stephanie Sue Stein, Director
Milwaukee County Department on Aging

cc: County Executive Lee Holloway
E. Marie Broussard
Jennifer Collins
Antionette Thomas-Bailey
Renee Booker
John Ruggini
Jonette Arms
Nubia Serrano
Mary Proctor Brown
Jill Knight
Beth Monrial Zatarski
Brad Peele
Gary Portenier
Pat Rogers

Attachments

RESOLUTION

WHEREAS, on December 16, 2009, the Milwaukee County Board of Supervisors authorized the Director, Department on Aging, to execute contracts to provide programs and services for the period January 1, through December 31, 2010 [File No. 10-34 (a)(a)]; and

WHEREAS, the Department awards funds to provider agencies based on the availability of federal, state, and local funds, usage by older persons of the programs and services provided, anticipated changes in service demand, and allowable costs; and

WHEREAS, when additional funds become available, the Department seeks to use such funds to fully reimburse vendors for the services they provide and for one-time only expenditures designed to maintain or enhance the quality of programs and services provided; and

WHEREAS, the Department has identified nine programs in need of various supplies, equipment, vehicles, facility improvements, and other expenses eligible for reimbursement under Wisconsin's allowable cost policy; and

WHEREAS, to cover those costs under annual awards would reduce the capability of vendors to provide needed services to Milwaukee County seniors; and

WHEREAS, the Department has identified sufficient funds available to award increases to nine contracts for calendar year 2010; and

WHEREAS, the Department recommends increases in awards for the following contractual services based on actual or anticipated costs and to expend the awards as follows:

1. Increase by $5,000, from $85,000 to $90,000, the contract with Bethesda Community Senior Citizens' Center, Inc., to provide Programs in Minority Senior Centers, and

2. Increase by $5,000, from $61,317 to $66,317, with Project Focal Point, Inc., to provide Programs in Minority Senior Centers, and

3. Increase by $5,000, from $39,300 to $44,300, the contract with Asian American Community Center, Inc., to provide Services to Asian American Elderly, and

4. Increase by $5,000, from $84,572 to $89,572, the contract with Indian Council of the Elderly, Inc., to provide Services to Native American Elderly, and

5. Increase by $5,000, from $32,850 to $37,850, the contract with Hmong/American Friendship Association, Inc., to provide Community Outreach and Access Services to Southeast Asian American Elderly: Translation and Interpretation, and

6. Increase by $2,030, from $40,000 to $42,030, the contract with Milwaukee Christian Center, Inc., to provide Nutrition Site Supervision at Milwaukee Christian Center, and

7. Increase by $3,500, from $254,106 to $257,606, the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Nutrition Site Supervision Services (Multiple Sites); and

8. Increase by $1,500, from $829,000 to $830,500 the contract with Goodwill Industries of Southeastern Wisconsin, Inc., to provide Case Management and Home Delivered Meals, and

9. Increase by $2,000, from $304,017,232 to $306,017, the contract with Interfaith Adult Programs, Inc., to provide Coordination of Neighborhood Services.

BE IT RESOLVED, that the Director, Department on Aging, is hereby authorized to adjust awards in the 2010 program and service contracts listed above, and in the amounts recommended, to (1) reimburse vendors for the actual costs of providing services and (2) enhance the quality of programs and services provided to Milwaukee County seniors.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: January 14, 2011

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Request for authorization to award additional funds to calendar year 2010 contracts with Bethesda Community Senior Citizens' Center, Inc., Project Focal Point, Inc., Asian American Community Center, Inc., Indian Council of the Elderly, Inc., Hmong/American Friendship Association, Milwaukee Christian Center, Inc., Goodwill Industries of Southeastern Wisconsin, Inc., and Interfaith Older Adult Programs, Inc., for program and service contracts originally authorized under File No. 10-34 (a)(a)

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☒ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	
	Revenue	0	
	Net Cost	0	
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

The attached resolution authorizes the Director, Department on Aging, to award additional funds to calendar year 2010 contracts with Bethesda Community Senior Citizens' Center, Inc., Project Focal Point, Inc., Asian American Community Center, Inc., Indian Council of the Elderly, Inc., Hmong/American Friendship Association, Milwaukee Christian Center, Inc., Goodwill Industries of Southeastern Wisconsin, Inc., and Interfaith Older Adult Programs, Inc., for program and service contracts originally authorized under File No. 10-34 (a)(a).

The Department awards funds to provider agencies based on the availability of federal, state, and local funds, usage by older persons of programs and services, anticipated changes in service demand, and allowable costs. When additional funds become available, the Department seeks to use those funds to fully reimburse vendors for the services they provide and for one-time only expenditures designed to maintain or enhance the quality of programs and services provided.

Funds for proposed increases in awards to the contracts within this resolution reflects deferred revenue from prior years and carryover of 2009 revenue from supplements to the State/County contract. The increases in awards fund (1) one-time only purchases for various supplies, equipment, furniture, and facility improvements, and (2) expenses related to the Senior Ambassador program. The nine awards total $34,030.

The proposed resolution has no direct fiscal impact on Milwaukee County other than the allocation of staff time required to prepare the accompanying report and resolution.

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Coordinator: Department on Aging / Gary W. Portenier, Program Planning

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

MILWAUKEE COUNTY
Inter-Office Memorandum

DATE: January 11, 2011

TO: Supervisor Michael Mayo, Chairman – Milwaukee Co. Board of Supervisors

FROM: Geri L. Lyday, Interim Director, Department of Health and Human Services

SUBJECT: REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES PROVIDING AN UPDATE ON THE CHILDREN'S LONG TERM SUPPORT WAIVER PROGRAM EXPANSION IN THE DISABILITIES SERVICES DIVISION

Introduction

This report provides an update on the expansion of the Children's Long Term Support (CLTS) Waiver Program within the Department of Health and Human Services Disabilities Services Division (DSD) and an overview of the State of Wisconsin's Third-Party Administrator Payment pilot project currently under development.

Background

2009 Wisconsin Act 28 provided funding for the CLTS waiver program to permit counties to serve additional eligible children and families with disabilities. Over the past six years, DHS has funded new slots for the CLTS Waiver program on a limited basis and DSD has added a few children and families each year from the children's waitlist. However, this has not been sufficient to address the waitlist of over 500 families. Prior to the start of this expansion, DSD had been funding approximately 65 children and families through this program. With the expanded funding available during the current biennium, it is anticipated that over 130 additional children will receive funding for services. In addition, DHS will fund CLTS Youth Transition slots for eligible young adults who are making the transition to Family Care. It is anticipated that over 100 new additional slots will be available to children for up to 12 months to provide transition services to Family Care. The accumulated expansion of new resources is over 200 new slots available to children with disabilities and their families. It should be noted that the number of slots available will be determined by the average cost per child.

Children's Long Term Support Waiver Services

With the expansion of available slots, DSD has begun opening cases and will continue this process until summer of 2011. Approximately ten new cases are being opened per month during this period of expansion for CLTS Waiver services and about 15 cases per month for the CLTS youth transition funding.

As a result of this additional caseload expansion, DSD has included three human services worker positions in its 2011 budget. The expanded positions provide ongoing service coordination, which is required under the CLTS Waiver guidelines. The timing of these expanded service coordination functions also reduced the number of staff that were budgeted to be transferred to the Department of Family Care as included in the 2010 adopted budget.

In 2010, DSD earned approximately $790,818 in new revenue to reflect the expansion of the CLTS Waiver and CLTS Youth Transition programs.

In 2011, the first full year of the CLTS and Youth Transition expansion, DSD anticipates $4,646,777 in new revenue and $4,182,765 in expenditures. The difference of $464,000 is administrative funding which will be used to offset the cost of the three human service workers. DSD will reduce the children's waitlist for services with the new additional funded slots. In order to best facilitate this process, DSD has established several program modifications that will enhance and maximize its ability to effectively fund services. DSD has worked with both stakeholders and DHS to develop the following guidelines:

1. DSD will focus on a child's needs first and then address providing needed services through all appropriate funding options. Children will not be put on multiple waiting lists for different funding sources.

2. DSD will maintain one Children's Services waitlist (except for CLTS Autism services that are managed by the state). This list will include the names of children waiting for services, whether the child's service need is short-term or long-term. Once a child is removed from the waiting list and receives services, his or her name will be removed from the wait list. If the child/family who receives short-term or one-time funds (via the Family Support Program) has new significant needs in the future, he or she could be referred back on the wait list at that time.

   DSD will continue the practice of considering hardship and crisis situations.

3. If a child is being served through the CLTS Waivers (including Autism), Family Support Program funds might be able to be used if the child's needs exceed what is allowable under the CLTS Waiver. Families would contact their service coordinator if the child has additional service needs.

4. DHS currently requires that a child be eligible for services based on his or her level of functioning before the child's name can be placed on DSD's Children's Services waiting list. Once a family sends a completed application to DSD and the child is considered eligible to be considered for Children's Services, the child must have a Children's Long Term Care Functional Screen (CLTS-FS). DSD staff would contact the family to arrange a home visit, perform the screen and if functional eligibility is determined, the child's name would be placed on the waiting list. When the child is removed from the waiting list, another functional screen may be needed as part of the assessment process.

5. DHS has provided some resources to Milwaukee County to focus on youth ages 17 to 21, transitioning into adult services. These resources will allow DSD to provide services earlier by helping them ease into the adult publicly funded long-term care service system. Youth will come off the Children's Services wait list based on their age, "hardship" to wait criteria, date the youth was added to the Children's wait list and/or the Adult wait list. In addition to the enhancements developed for the additional CLTS Waiver funding, DSD is also working to develop specific referral protocols for the CLTS youth transition slots. These protocols will support a smooth transition for young adults and families who will be making the transition from children's funded services to adult funded services under the Family Care program.

6. Beginning 2010, DSD established a new, dedicated phone number for children's services, including services funded through CLTS Waivers, Autism, Family Support Program and Birth to Three Services. The new contact/referral line is answered by staff trained in children's services and referral linkages.

DSD is also working in partnership with DHS and the University of Wisconsin-Milwaukee on a Medicaid infrastructure grant project to develop protocols and long range planning practices for families with school age children who have disabilities to transition to adult services including vocational and employment options.

Current Expansion Progress

As of December 2010, DSD has made significant progress in the expansion effort by adding over 100 children in new CLTS Waiver slots and approximately 100 children in new youth transition slots. In addition, the waitlist for children's services has been reduced allowing children and families to be contacted within three months. This is a significant reduction from earlier in 2010 when the waitlist time was about two and one-half years. Further, the waitlist that was comprised of over 500 children and families at the start of 2010 has been reduced to 75. The changes in the waitlist time have been attributed not only to the additional slots available, but also to the changes noted above in managing the waiting list more effectively. It is anticipated that this waitlist will be reduced further and potentially eliminated.

Third Party Administrator Payment Pilot Project

In February 2010, DHS requested Milwaukee County's participation in a new children's Third Party Administrator (TPA) Payment pilot project in which the State wanted DSD and several other counties to participate. This project was being driven by the State's requirement to collect and provide to the Center's for Medicare and Medicaid (CMS) certain information about services provided under the home and community based waiver programs, which includes the CLTS program. Beginning in April 2010, DSD began working with three other pilot counties to roll out the new payment system.

The TPA system requires that counties no longer make payments directly to the agencies who provide services under the CLTS waiver benefit. Rather, the counties will provide prior authorization to a third party payment agency who will process the payments on behalf of the

county. A similar system of payment is utilized by the Family Care program in Milwaukee County. DHS has entered into a contract with WPS to provide the payment function also known as claims processing.

This pilot project has resulted in the need to make numerous changes to DSD procedures and business practices.

Summary

The expansion of Children's Long Term Support Waiver funding is providing a unique opportunity for DSD to reduce waitlist for services and to enhance the availability of services to children with disabilities and their families. The 2011 DSD budget reflects this expansion initiative and will help to retain staff positions required to support this program.

DHS has initiated a new Third Party Administrator Payment system for the children's programs that will require new procedures and information technology to implement. As a result of this new system, certain functions performed by DSD will no longer be required resulting in a decreased need for support staff. It is anticipated that this new system will be implemented late in 2010 and fully implemented in 2011.

Recommendation

This report is for informational purposes only. No action is recommended unless otherwise directed by the Board.

Respectfully submitted:

Geri L. Lyday

Geri L. Lyday, Interim Director
Department of Health and Human Services

cc: County Executive Lee Holloway
Renee Booker, DAS Director
Antionette Thomas-Bailey, Analyst - DAS
Jennifer Collins, Analyst - County Board
Jodi Mapp, Committee Clerk - County Board

COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION

Date: January 12, 2011

To: Supervisor Michael Mayo, Sr., County Board Chairman

From: John Barrett - Clerk of Circuit Court/Director of Court Services

Subject: Permanency Plan Reviews

Request
The Clerk of Circuit Court is requesting authorization to enter into a contract with the Wisconsin Department of Health and Family Services in the amount of $320,537 for the period of January 1, 2011 through June 30, 2011 to conduct permanency plan reviews for all Milwaukee County children in out-of-home care. The $320,537 shall offset the cost of 4.8 positions and all related operating costs for six months.

The County continues calendaring permanency plan reviews for cases that meet the requirements set forth in sec. 48.38(2) when the dispositional order for CHIPS extensions expired on or after Monday, February 26, 2001.

The State will fund the 4.8 County positions needed to staff the case processing of the permanency plan reviews at Children's Court in Milwaukee County. These 4.8 positions consist of one full-time Court Commissioner, one .4 Court Commissioner, one Administrative Assistant III, one Clerical Assistant I position, one full-time and one .4 Deputy Court Clerk/Judicial Assistant.

Fiscal
Approval of this contract will have no tax levy effect, as the State will fully fund all related expenditures.

John Barrett

JB/smg

cc: Supervisor Peggy West, Chairperson, Health & Human Needs Committee
Jodi Mapp

File No.

(ITEM *) From the Clerk of Circuit Court requesting authorization to enter into a contract with the Wisconsin Department of Children and Families for the period of January 1, 2011 through June 30, 2011 to conduct permanency plan reviews for all Milwaukee County youth in out-of-home care.

A RESOLUTION

WHEREAS, Milwaukee County schedules plan reviews for all cases that meet the requirements set forth in Section 48.38(2) of the Wisconsin Statutes when the dispositional order for CHIPS extensions expired on or after Monday, February 26, 2001; and

WHEREAS, the Clerk of Circuit Court is requesting authorization to enter into a contract with the Wisconsin Department of Children and Families in the amount of $320,537 for the period of January 1, 2011 through June 30, 2011 to conduct permanency plan reviews for all Milwaukee County children in out-of-home care; and

WHEREAS, this is a continuation of a six-month contract that the Courts and the Wisconsin Department of Children and Families have entered into; and

WHEREAS, the existing County positions needed to staff the case processing of the permanency plan reviews at Children's Court in Milwaukee County consist of:

- 1.0 FTE Court Commissioner
- 0.4 FTE Court Commissioner
- 1.0 FTE Administrative Assistant III
- 1.0 FTE Clerical Assistant I position
- 1.0 FTE Deputy Court Clerk/Judicial Assistant
- 0.4 FTE Deputy Court Clerk/Judicial Assistant

; and

WHEREAS, the $320,537 in State funding shall offset the cost of the existing positions and permanency plan reviews operating costs for six months; and

WHEREAS, this is a six month contract whereby the Courts and the Wisconsin Department of Children and Families have negotiated terms for the first six months of the year; now, therefore,

BE IT RESOLVED, that the County Board of Supervisors hereby authorizes the Clerk of Circuit Court to enter into a contract with the Wisconsin Department of Children and Families in the amount of $320,537 for the period of January 1, 2011 through June 30, 2011 to cover the necessary positions and operating costs associated with conducting permanency plan reviews for all Milwaukee County children in out-of-home care.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: January 12, 2011

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Execution of Contract

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	320,537	0
	Revenue	320,537	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A) The proposed contract will allow Milwaukee County Clerk of Circuit Court, Children's Division the ability to continue conducting Permanency Plan Reviews for all Milwaukee County children in out-of-home care for the period January 1, 2011 through June 30, 2011.

B) The dollar cost to Milwaukee County to perform these services will be $320,537. The State of Wisconsin has agreed to reimburse Milwaukee County for these costs. There will be no tax levy impact for Milwaukee County.

C) There are sufficient funds to cover the cost of the contract in org. 2864. Although uncertain of the dollar costs in subsequent years, it is anticipated the State of Wisconsin will continue to fund the program.

D) The State of Wisconsin has agreed to fund expenditures of $320,537 for this program for the first six months of 2011.

Department/Prepared by: Deborah Bachun

Authorized Signature: _____

Did DAS Fiscal Staff Review? Yes No

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By _

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☐ No

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: January 3, 2011

TO: Supervisor Michael Mayo, Chairman, Milwaukee County Board of Supervisors

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Prepared by: Eric Meaux, DHHS Delinquency & Court Services Division Administrator

SUBJECT: REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REQUESTING AUTHORIZATION TO ENTER INTO A STATE/COUNTY CONTRACT FOR COMMUNITY YOUTH AND FAMILY AIDS FOR 2011 AND TO ACCEPT $38,003,499 FOR STATE CORRECTIONS CHARGES AND COMMUNITY BASED SERVICES

Issue

Section 301.031 of the Wisconsin Statutes requires counties to execute an annual contract with the state Department of Corrections (DOC) for the "Community Youth and Family Aids Program." This program provides state funding for county services to juvenile offenders as mandated by state and/or federal law.

County ordinances require that departments obtain authorization from the County Board in order to execute contracts. The Interim Director, Department of Health and Human Services (DHHS), is therefore requesting authorization to sign the 2011 contract with the state DOC for the provision of juvenile justice services mandated by state law. The county cannot receive 2011 revenue from the state until this contract is signed.

Background

The Community Youth and Family Aids Program, commonly referred to as "Youth Aids," is the state's primary means of providing counties with direct assistance to fund the cost of services to juvenile delinquents. This revenue is used exclusively to fund costs in the DHHS Delinquency and Court Services Division. Counties supplement their juvenile justice funding needs with Basic Community Aids, property tax levy and various grant revenues to fund the overall costs of the juvenile justice system.

On December 27, 2010, DHHS received the actual 2011 contract from DOC for Youth Aids. The state's 2011 contract will provide Milwaukee County with $38,003,499 of Youth Aids funding (excluding our estimate of Corrective Sanctions funding - see Attachment 1, pg. 1 of 1).

Youth Aids Revenue

The state contract allocation consists of three components: 1) the annual state budget amount allocated by formula; 2) any surplus amount from "over-charging" counties during the prior state fiscal year for the cost of state Juvenile Institutions compared to DOC's actual costs; and 3) an allocation for the Corrective Sanctions program. The actual 2011 state funding for Corrective Sanctions will not be determined until January 2011, based on actual usage of the program by each county during 2010.

The attached exhibit lists the Youth Aids funding based on the seven (7) separate allocations contained in s. 301.26, Wis. Stats. However, DOC has not provided the same level of funding detail for 2011 as was available through 2008. This department's fiscal staff has requested that detail from DOC so it can be determined if Youth Aids have been allocated appropriately.

The separate allocations are as follows:

1) The Original Base Allocation which is based on the initial formula for allocations to counties when Youth Aids was created in 1979;

2) Prior Year Refund revenue. Statutes require that DOC provide a refund to counties if the amount paid by counties under the statutory daily rates is greater than DOC's actual costs in the preceding state fiscal year. The refund would be based on each county's proportionate share of the days of care provided by DOC.

3) The 1999 Act 9 supplemental funding is allocated based on three factors: a) a county's proportion of the statewide juvenile population for the most recent year available; b) a county's proportion of statewide Part 1 juvenile arrests under the uniform crime reporting system of the Office of Justice Assistance for the most recent three year period available; and c) a county's proportion of statewide juveniles placed in a juvenile correctional institution, a secure child caring institution or secure group home for the most recent three-year period available;

4) The 2001 Act 16 supplemental funding is allocated based on the same three factors above, but with an "override" provision that no county receives less than 93% nor more than 115% of the amount it would have received if the juvenile placement factor (item "c" above) were the sole factor used to determine county allocations;

5) The 2007 Act 20 supplemental funding is allocated based on each county's proportion of the number of juveniles statewide who are placed in a juvenile correctional facility during the most recent three-year period for which that information is available;

6) Alcohol & Other Drug Abuse (AODA) funding is allocated based on each county's Youth Aids spending on community services (defined as the amount of Youth Aids left after state charges); and

7) Corrective Sanctions funding is allocated following the close of the calendar year, based on each county's usage of the 136 total slots authorized by statute.

The DOC 2011 allocation for Milwaukee County of $38,003,499 (excluding Corrective Sanctions) represents a revenue increase for DHHS of $373,884, compared to the 2011 Budget of $37,629,615.

Recommendation

It is recommended that the County Board of Supervisors authorize the Interim Director of DHHS, or her designee, to execute the 2011 State/County contract following Department review for Community Youth and Family Aids, and any addenda to that contract.

Fiscal Impact

The 2011 state contract provides $373,884 more revenue than was anticipated in the in the 2011 Budget (excluding Corrective Sanctions). A fiscal note form is attached and a fund transfer will be completed later in 2011 if necessary.

Respectfully Submitted,

Geri Lyday, Interim Director
Department of Health and Human Services

Attachments

Cc: County Executive Lee Holloway
Renee Booker, DAS Director
Allison Rozek, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

1/3/2011

Community Youth and Family Aids 2011 State Funding Notice vs 2010 Adopted Budget

State Contract Revenue Source	2009 State Contract	2010 State Contract	2011 Adopted Budget	2011 State Notice	Difference State Notice vs 2011 Budget	Comments About State Amount
Original Base Funding (1979 formula)	$30,096,407	$27,201,413	$37,319,022	$37,723,226	$404,204	Constant Original Base funding (1979 formula)
Alternate Care Prior Year Refund (if any)	$41,208	$76,753	$0		$0	If prior year revenue charged counties exceeds DOC costs
1999 Supplement - Rate Adjustment	Not Provided	$1,739,546	$0		$0	
1999 Supplement - 3 Factor Formula	Not Provided	$1,180,474	$0		$0	Updated for 3 most recent Calender years data
2001 Supplement - 3 Factor with Over-ride	$916,798	$985,515	$0		$0	Updated for 3 most recent Calender years data
Sub-Total 1999 and 2001 Supplements	$916,798	$3,905,535	$0		$0	
2007-09 Supplement - Placements Formula						
2008 Supplement	$5,694,909	$6,135,321	$0		$0	Most recent 3 Calender years placements
2009 Supplement	$0	$0	$0		$0	Most recent 3 Calender years placements
Sub-Total for State & Local Services	$36,749,322	$37,319,022	$37,319,022	$37,723,226	$404,204	
Youth Aids AODA	$356,749	$310,593	$310,593	$280,273	($30,320)	County Community spending % of Statewide - last 3 years
Sub-Total Youth Aids Revenue excl CS	**$37,106,071**	**$37,629,615**	**$37,629,615**	**$38,003,499**	**$373,884**	Final State Allocation; Corr Sanctions added year-end
YA Corrective Sanctions (CS)-Budget	$1,158,551	$1,142,701	$1,142,701	$1,142,701	$0	Estimated 2010; actual funds received Jan 2011 for 2010
Total Youth Aids Revenue incl CS	**$38,264,622**	**$38,772,316**	**$38,772,316**	**$39,146,200**	**$373,884**	**Youth Aids for State Charges & Community Programs**

File No.
(Journal,)

(ITEM) From the Interim Director, Department of Health and Human Services, requesting authorization to enter into a State/County contract for Community Youth and Family Aids for 2011, by recommending adoption of the following:

A RESOLUTION

WHEREAS, Section 301.031 of the Wisconsin Statutes requires counties to execute an annual contract with the state Department of Corrections (DOC) for the "Community Youth and Family Aids Program," and county ordinances require that departments obtain authorization from the County Board in order to execute contracts; and

WHEREAS, the Interim Director, Department of Health and Human Services (DHHS), is requesting authorization to sign the 2011 contract with the State DOC for the provision of juvenile justice services mandated by State law, and the county cannot receive 2011 revenue from the State until this contract is signed; and

WHEREAS, the state's 2011 contract will provide Milwaukee County with $38,003,499 of Youth Aids funding (excluding Corrective Sanctions); now, therefore,

BE IT RESOLVED, that the Interim Director, Department of Health and Human Services, or her designee, is hereby authorized to enter into a contract with the State Department of Corrections covering Community Youth and Family Aids for the period of January 1 through December 31, 2011, and any addendum thereto.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 1/3/11

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Interim Director, Department of Health and Human Services, requesting authorization to enter into a State/County Contract for Community Youth and Family Aids for 2011 and to accept $38,003,499 for State Corrections Charges and Community Based Services

FISCAL EFFECT:

☐ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☒ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure		373,884
	Revenue		373,884
	Net Cost		0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. Section 301.031 of the Wisconsin Statutes requires counties to execute an annual contract with the State Department of Corrections (DOC) for the "Community Youth and Family Aids Program." This program provides state funding for county services to juvenile offenders as mandated by state and/or federal law. County ordinances require that departments obtain authorization from the County Board in order to execute contracts. The Interim Director, Department of Health and Human Services (DHHS), is therefore requesting authorization to sign the 2011 contract with the State DOC for the provision of juvenile justice services mandated by state law.

B. The 2011 Contract provides $38,003,499, which is $373,884 more revenue than budgeted in 2011 for Youth Aids revenue for State Charges and County community-based programs. DHHS will continue to update projections based on monthly State Juvenile Corrections Charges and complete a fund transfer later in 2011 if necessary.

C. See Section B above

D. No assumptions. Data based on State contract.

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Thomas F. Lewandowski

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: January 11, 2011

TO: Supervisor Michael Mayo, Chairman - Milwaukee County Board of Supervisors

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Prepared by: Eric Meaux, Administrator, Delinquency and Court Services Division

SUBJECT: REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REQUESTING AUTHORIZATION TO WAIVE THE DHHS REQUEST FOR PROPOSAL REQUIREMENT AND ENTER INTO PROFESSIONAL SERVICE CONTRACT WITH JEWISH FAMILY SERVICES FOR ADMINISTRATIVE AND FISCAL AGENT FOR THE YOUTH SPORTS AUTHORITY PROGRAM

Issue

Section 56.30 of the Milwaukee County Code of General Ordinances requires County Board approval for professional service contracts of $50,000 or greater. Per Section 56.30, the Interim Director of the Department of Health and Human Services (DHHS) is requesting authorization to waive the solicitation for proposals requirement and enter into a professional service contract with Jewish Family Services.

Background

In November 1999, the Milwaukee County Board of Supervisors adopted a provision as part of the 2000 county budget that provided $200,000 for establishment of the Milwaukee County Youth Sports Authority. The Sports Authority was to be governed by a seven-member Board that would review requests for funding of youth sports programs from community organizations. The program, which was housed in the County Health Programs Division (CHP), was aimed at promoting activities for at-risk youth that would encourage healthier lifestyles and positive interpersonal behavior.

In February 2000, the County Board approved a recommendation from CHP to execute a contract with the Milwaukee Foundation to serve as administrator and fiscal agent for the Sports Authority. Later that year, the County Board also approved operational policies to govern the distribution of Sports Authority funds. In 2002, a resolution was adopted that limited board members terms to 2 years and calls for a seven (7) to thirteen (13) member Board that would be appointed by the County Executive and Chair of the County Board alternately. [1]

The Sports Authority Board received an appropriation of $200,000 in the 2001, 2002, and 2003 adopted budgets. The 2003 Adopted Budget also directed CHP to initiate a process to potentially

[1] File No. 02-576, December 2002.

secure a new entity to administer the program in 2003. In August 2003, the Planning Council for Health and Human Services, Inc. was awarded a six-month contract to serve as the new fiscal agent and administrator of the Sports Authority. The 2004, 2005, 2006 Adopted Budgets contained an appropriation of $150,000 for the Sports Authority Board and transferred funding from CHP to the Delinquency and Court Services Division. An appropriation of $145,000 was contained in the 2007 Adopted Budget. An appropriation of $200,000 was contained in the 2008 and 2009 Adopted Budgets. With County Board approval, that contract was extended each year through February 2009. In January 2009, the Planning Council informed Milwaukee County that it would not seek to renew the Sports Authority contract. In March 2009, with County Board approval, Fighting Back Inc. was awarded a twelve-month contract to serve as the new fiscal agent and administrator for the Sports Authority. The 2010 budget did not contain a Sports Authority appropriation however some funds balances remained. In January 2010, Fighting Back merged with Jewish Family Services and became a division of that organization. The Sports Authority Board last presented allocation recommendations to the County Board in April 2010 for Spring 2010 activities. The 2011 Adopted Budget includes a budget allocation of $100,000 to support the Sports Authority for Youth program.

Given the reduction in funds available; Jewish Family Services' prior experience administering the solicitation; fund dispersment and tracking processes; and the agency's agreement to perform the administrative services for a reduced amount not to exceed $8,000, the Department is recommending that the County Board consider waiving the solicitation for proposals requirement.

It should also be noted that the Department and JFS will need to work with both the County Executive and County Board offices to ensure that the necessary appointments are made to the Sports Authority Board to allow for the selection of grant awards.

Recommendation

It is recommended that the County Board of Supervisors waive the DHHS Request for Proposal requirement and authorize the Interim Director of DHHS, or his designee, to execute a one-year contract for the Youth Sports Authority administrative and fiscal agent contract with Jewish Family Services, Inc., for the period of February 1, 2011 through January 31, 2012. Under the administrative and fiscal agent contract, the full Sports Authority appropriation of $100,000 is transferred to Jewish Family Services, Inc., which would retain a maximum of $8,000 as an administrative fee. The balance of the appropriation, $92,000, is to be distributed to eligible organizations, based on recommendations by the Sports Authority Board and approval by the County Board of Supervisors.

Fiscal Effect

Approval of this request will have no tax levy impact in 2011 since the 2011 Adopted Budget contains sufficient funds. A fiscal note form is attached.

Geri Lyday, Interim Director
Department of Health & Human Services

Cc: County Executive Lee Holloway
Renee Booker, DAS Director
Allison Rozek, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

File No.
(Journal,)

(ITEM) From the Interim Director, Department of Health and Human Services, requesting authorization to waive the DHHS request for proposal requirement and enter into a professional service contract with Jewish Family Services for administrative and fiscal agent for the Youth Sports Authority program, by recommending adoption of the following:

A RESOLUTION

WHEREAS, per Section 56.30 of the Milwaukee County Code of General Ordinances, the Director of the Department of Health and Human Services (DHHS) has requested authorization to waive the DHHS Request for Proposal requirement and enter into a 2011 professional service contract; and

WHEREAS, the 2011 Adopted Budget contains $100,000 for the Youth Sports Authority program that provides funding to selected organizations to support positive recreational activities for youth; and

WHEREAS, since 2000, the County Board has allowed the Department to contract for the provision of administrative and fiscal agent services that support the program and the Youth Sports Authority Board; and

WHEREAS, Jewish Family Services has performed the administrative and fiscal agent services including the solicitation, fund dispersment and tracking processes, for the Youth Sports Authority; and

WHEREAS, a reduction in the funds has not resulted in a reduction in administrative services, and Jewish Family Services has agreed to perform said services for a reduced amount not to exceed $8,000 and likely to be less; now, therefore,

BE IT RESOLVED, that the Interim Director, Department of Health and Human Services, or designee, is hereby authorized to waive the DHHS Request for Proposal process and enter into professional service contract with Jewish Family services for the period February 1, 2011 through January 31, 2010 in the amount of $100,000, with administrative fees not to exceed $8,000, for the provision of administrative and fiscal agent services associated with the Youth Sports Authority program.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 1/3/11

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REQUESTING AUTHORIZATION TO WAIVE THE DHHS REQUEST FOR PROPOSAL REQUIREMENT AND ENTER INTO PROFESSIONAL SERVICE CONTRACT WITH JEWISH FAMILY SERVICES

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	100,000	0
	Revenue	100,000	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue		

	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.[2] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. The Interim Director of DHHS has requested authorization to execute a Professional Service Contract with the Jewish Family Services to perform administrative and fiscal functions associated with the Youth Sports Authority program for the period beginning February 1, 2011 theought January 31, 2012.

B. Total planned expenditures in 2011 are $100,000.

C. Approval of this request will have no tax levy impact in 2011 since the 2011 Adopted Budget contains sufficient funds.

D. No assumptions are made.

[2] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Thomas F. Lewandowski, Fiscal & Management Analyst

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

MILWAUKEE COUNTY
INTEROFFICE MEMORANDUM

DATE: January 18, 2011

TO: Chairman Michael Mayo, County Board of Supervisors

FROM: Geri Lyday, Interim Director - Department of Health and Human Services
(Prepared by: Jim Tietjen, Administrator - DHHS Operations)

RE: **FROM THE INTERIM DIRECTOR, DHHS, SUBMITTING AN INFORMATIONAL REPORT REGARDING THE EXAMINATION OF CURRENT PARKING AVAILABILITY AT THE COGGS CENTER AND OPTIONS AVAILABLE FOR UTILIZING ADDITIONAL PARKING, INCLUDING THE POSSIBILITY OF USING OR ACQUIRING NEARBY PUBLIC AND PRIVATE LOTS, AND RETROFITTING THE ENTRYWAY ON 13TH STREET TO BE USED FOR CLIENTS WANTING SPECIAL ACCESS TO THE AGING AND DISABILITIES RESOURCE CENTERS**

Background

The Marcia P. Coggs Human Services Center located at 1220 West Vliet Street houses three floors of Milwaukee County and State of Wisconsin Social Services staff. The building, built in 1924, is 208,494 square feet and was renovated in 2004 for a cost of up to 14 million dollars. Adjacent to the building, the County owns three parking lots containing a total of 476 parking spaces. Included in that total are eleven handicapped spaces in Lot A, plus 36 special use disabled spots plus six handicapped spaces on 13th Street. The lots have a minimum of 70 vacant spaces for employees and vendors at any given time during the day.

Summary of Plan

The Operations Bureau of the Department of Health and Human Services is working with Dave Gulgowski of Milwaukee County DTPW - Architecture and Engineering on the acquisition and development of the four vacant lots on 13th Street between Vliet and Cherry Streets. The lots are 1301 West Cherry Street (City-owned), 1304 West Kneeland (City-owned), 1423 North 13th Street (City-owned) and 1306 West Vliet Street. The lot at 1306 West Vliet Street is privately owned, but the owner has indicated he would be interested in the sale of the parcel for the "right price".

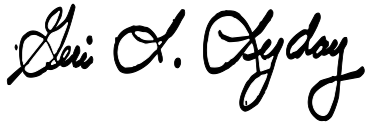
The Operations Bureau has been in discussions with Alderman Willie Hines' office and they have given us their support, but recommended meeting with the neighbors to lay out our proposal. Mr. Gulgowski of DTPW has been in contact with the City of Milwaukee Department of Neighborhood Services and they have requested a plan to evaluate the request.

We are moving forward with the plan and design development and will be working up a budget and time line for proposal. The work group of DHHS Operations and DTPW - Architecture and Engineering will be developing a progress report and will return to these Committees with the results.

Recommendation

This is an informational report. No action is necessary.

Respectfully Submitted:



_____

Geri Lyday, Interim Director
Department of Health and Human Services

cc: County Executive Lee Holloway
Renee Booker, Director, DAS
Antionette Bailey-Thomas, Analyst - DAS
Jennifer Collins, Analyst - County Board
Jodi Mapp, Committee Clerk - County Board

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: January 11, 2011

TO: Supervisor Michael Mayo, Chairman – Milwaukee Co. Board of Supervisors

FROM: Geri Lyday, Interim Director, Department of Health and Human Services

SUBJECT: REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, PROVIDING AN INFORMATIONAL REPORT ON THE 2011 CONTRACTS FOR THE INCOME MAINTENANCE AND CHILD CARE PROGRAMS

Background

In 2009, Wisconsin Act 15 authorized the State Department of Health Services (DHS) to assume responsibility for managing the administration of the State's Income Maintenance (IM) program in Milwaukee County. This involved the establishment of a Milwaukee County Enrollment Services unit (MILES) to determine eligibility and administer the Food Share and BadgerCare public assistance programs. Section 49.825 (2)(d)(1) provides for the reimbursement to the County of all approved, allowable costs related to the County staff assigned to this unit in excess of the county's minimum required contribution of $2.7 million. In addition, subsection (2)(c) authorizes DHS to enter into a contract with the County that provides for the performance by the County of any administrative functions under this subsection.

Similarly, Wisconsin Act 28 created section 49.826 of the statutes authorizing the Department of Children and Families (DCF) to establish a child care provider services unit (Milwaukee Early Care Administration - MECA) to support the Wisconsin Shares child care subsidy program. Section 49.826 (2)(c) provides that DCF shall reimburse the county for all approved, allowable costs that are incurred by the county.

The first State/County contracts for Income Maintenance (IM) and Child Care authorized by these statutory changes were executed in early 2010 and covered calendar year 2010. As of January 2011, the 2011 contracts with DHS and DCF have not been finalized. DHHS has met internally to review the contracts and is negotiating with the State on the specific terms. The purpose of this report is to update the County Board on the changes included in the draft contracts.

DHS IM Contract Changes

The DHS proposed contract is identified as Appendix AL – 2 to the 2011 State County Contract Covering Social Services, Community Programs and Income Maintenance. The appendix has two major sections: 1) Shared Services and Staff and 2) State/County Lease Agreement. The contract also includes a document describing the operational procedures between IMSD and State DHS.

The major changes to the Shared Services and State/County Lease sections in 2011 compared to 2010 are as follows:

1) **Shared Services and Staff**

Per Wisconsin Statute 49.825, the county will provide shared services and staff to assist the State in its administration of the public assistance programs. Shared services involve payroll and benefits services, record center and staffing and contract management billed using an hourly rate and charged based on monthly time reporting.

New language is included in this section requiring the county to reconcile quarterly based on actual costs and units of service for each shared service provided. If the amounts paid are above the actual rates, the county will refund the difference to the State. The scope of the specific shared service is the same as 2010 unless otherwise noted.

a) **Record Center and Staffing:** DHHS will continue to maintain its existing Records Center located at 3700 W. Michigan Ave. for inactive IM and Child Care case files. The contract provides for reimbursement for one staff person and space rental. As part of the 2011 contract, the space rental charge of $115,121 will now also include transportation costs related to moving records as well as supplies such as boxes.

b) **Information Technology (IT) Services:** The IT services provided by the Information Management Services Division (IMSD) to the State are now identified as part of an attachment to the contract. In 2010, the cost for IMSD services was included in the monthly Coggs space rental charge. For 2011, the contract reimburses these costs based on a flat fee charged per active computer device. IMSD is currently negotiating the fee and services with the State.

c) **Wisconsin Medicaid Transportation:** For 2010, the county processed and paid invoices related to common carrier transportation services for the Wisconsin Medicaid and BadgerCare Plus Standard Plan. Beginning in July, the State plans to use a transportation broker to arrange for these Medicaid transports. The State is seeking to continue county services until June 30, 2011. However, if this initiative is not implemented by then, the State could amend the contract beyond this date to continue county services. The State fully reimburses the County for all transportation provider costs as well as administrative costs related to this service.

d) **General Assistance Burials:** The county pays for a portion of a county staff person responsible for conducting the eligibility review on individuals applying to the county's General Assistance Burials program. In 2010, the county reimbursed the State $24,000 or approximately 25 percent of the cost of the individual. In 2011, the contract reflects an increased charge of $40,000 to the county.

e) **Interim Disability Assistance Program (IDAP):** In 2010, the State provided eligibility services to the county for IDAP at no cost with one dedicated FTE. The cost to the county for 2011 is $100,000 for two FTEs.

2) **State/County Lease Agreement**

This proposed lease reflects approximately 75,850 square feet of space in the Marcia P. Coggs Human Services Center from January 1, 2011 through December 31, 2011. This reflects an increase in square footage of 1,350 feet compared to 2010. All references to a long-term lease have been removed. The 2010 contract included a statement indicating that the State and county would discuss the terms of continued space needs and occupancy including a space design plan and any capital investment that would be needed. The State has indicated that if the county and state agree to longer term changes to the Coggs Center, the contract can be amended at that time.

The 2011 contract also includes new language allowing the State to end the space use agreement by providing at least 30 days written notice to the county.

Finally, the 2011 contract requires that DHHS provide a monthly report to the State identifying incidents that occur at the Coggs Center involving the physical structure or security as well as plans to remedy the situation.

The lease reflects a monthly payment from the State of $132,356 for building operations. This compares to $131,917 per month negotiated in 2010 for building operations only. For 2010, the State's total lease payment was $241,356 which included Coggs building operations for $131,917 and IMSD phone and IT services for $109,439. As mentioned previously, IT services are covered under the shared services section of the contract and are no longer part of the State's lease payment.

DCF Child Care Contract Changes

The DCF proposed contract is a separate contract. There are no major changes to this contract for 2011 compared to 2010. However, hourly rates for all of the shared services are still being negotiated.

Fiscal Effect

The County is reimbursed based on monthly invoices submitted to the State for personnel costs for County employees, shared services and space rental. Specific payroll information must be submitted for the reimbursement of County employees assigned to Income Maintenance and Child Care. The shared services portion of the invoice is reimbursed based on 100 percent time reporting by DHHS payroll, DAS fiscal services, records center and contract management staff and the agreed upon hourly rate. As mentioned previously, the 2011 hourly rates for these services are still being negotiated.

Wisconsin Statute 49.825 provides for the reimbursement of costs for county Income Maintenance staff assigned to the Milwaukee Enrollment Services (MILES) unit less the minimum county contribution of $2.7 million. This contribution is included in the 2011 Adopted Budget. The salary and fringe costs for county Child Care program staff are 100 percent reimbursed by DCF.

The space rental revenue included in the contract is $132,356 monthly or $1,588,272 annually. The 2011 Adopted Budget assumes $1,565,606 in State rental revenue.

The new charge for IDAP of $100,000 and $16,000 increase for eligibility services for the GA Burials program were not included in the 2011 Adopted Budget.

Recommendation

This is an informational report only. Once the 2011 contracts with DCF and DHS are finalized, DHHS will provide a report to the County Board seeking authorization to execute 2011 contracts with the Department of Health Services (DHS) and Department of Children and Families (DCF).

Geri Lyday, Interim Director
Department of Health and Human Services

cc: County Executive Lee Holloway
Renee Booker, DAS Director
Antionette Thomas-Bailey, Fiscal and Management Analyst, DAS
Jennifer Collins, County Board Staff
Jodi Mapp, County Board Staff

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: January 11, 2011

TO: Supervisor Michael Mayo, Chairman – Milwaukee County Board of Supervisors

FROM: Geri Lyday, Interim Director, Department of Health and Human Services

SUBJECT: **REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REQUESTING AUTHORIZATION TO TERMINATE THE 2011 PURCHASE OF SERVICE CONTRACT WITH SOCIAL REHABILITATION & RESIDENTIAL RESOURCES INC AND ENTER INTO A 2011 PURCHASE OF SERVICE CONTRACT WITH ARO BEHAVIORAL HEALTHCARE INC. FOR TARGETED CASE MANAMGEMENT (TCM) SERVICES FOR THE BEHAVIORAL HEALTH DIVISION**

Policy Issue

Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. Due to recent changes for the 2011 Targeted Case Management (TCM) purchase of service contracts (POS), the Interim Director of the Department of Health and Human Services (DHHS) is requesting authorization to terminate the 2011 BHD purchase of service contract with Social Rehabilitation & Residential Resources, Inc. and enter into a 2011 POS contract with ARO Behavioral Healthcare Inc. for the Behavioral Health Division (BHD).

Background

For the past several years, BHD has maintained a purchase of service contract with Social Rehabilitation & Residential Resources, Inc. (SRRR) to provide Targeted Case Management (TCM) services to BHD clients. In December 2010, the Health and Human Needs Committee authorized DHHS to enter into a 2011 purchase of service contract with SRRR to provide TCM services. In the 2011 BHD TCM contract allocation, SRRR received an allocation of $224,112. The recommended provider has performed the relevant services for BHD for multiple years, and has met expectations and contract requirements in providing quality services to BHD clients enrolled in the TCM program.

Discussion

In early November, BHD received written notification dated October 22, 2010 from SRRR that a change in agency CEO leadership had occurred effective October 11, 2010 and the Board of Directors was pursuing a number of viable alternatives relative to the CEO position. On October 28, 2010, BHD received email notification that ARO Behavioral Healthcare Inc. (ARO) signed a Memorandum of Understand (MOU) with SRRR "to liquidate SRRR and wind up its affairs in an orderly fashion." The email also inquired about how to proceed with respect to various Milwaukee County contracts and agreements for human services. BHD immediately referred the matter to Contract Administration within DHHS for assistance.

According to a Memorandum of Understanding executed between the SRRR Board of Directors and ARO on October 27, sometime in late September 2010, the Board of SRRR discovered that its Executive Director had

allegedly misappropriated funds being held in trust by SRRR for various chronically-ill clients under the care of SRRR. The Board terminated the employment of the Executive Director, and the matter is now the subject of further investigation. As a result, SRRR has been experiencing severe financial problems, including cash flow problems. The Board entered into an MOU with ARO to assist in achieving an orderly wind-up of SRRR, with emphasis on protecting and preserving the health, welfare and interests of SRRR's clients and patients. Subsequently, SRRR's Board passed a resolution authorizing the liquidation (including bankruptcy filing) of SRRR and transfer of the operation of some of its health and human services programs to ARO.

Pursuant to the foregoing, ARO (with the cooperation of the SRRR Board) has been managing SRRR, keeping it viable (paying only the bills necessary to "keep the lights on", take care of clients, and pay employees), and concluding in an orderly fashion. Clients served by SRRR have retained their SRRR case managers and all clinical services have been seamless so client care has been unaffected. ARO anticipates filing Chapter 7 bankruptcy for SRRR or placing SRRR into receivership on or about February 1, 2011, but all contracts and agreements must first be assigned to ARO before this can be completed.

BHD has been in contact with ARO and is confident they will continue to provide quality services to BHD clients enrolled in the former SRRR TCM program. Therefore, BHD is requesting that $224,112 of funding originally allocated to SRRR in the December 2010 Purchase of Service Report to the County Board, now be allocated to ARO. BHD will keep the Board informed regarding any additional changes to this service line as the transition moves forward.

Recommendation

It is recommended that the County Board of Supervisors authorize the Interim Director, DHHS, or her designee, to terminate the 2011 BHD purchase of service contract with Social Rehabilitation & Residential Resources, Inc. and enter into a new 2011 purchase of service contract with ARO Behavioral Healthcare Inc. to reflect the organization's assumption of the SRRR purchase of service contract for the period of January 1, 2011 through December 31, 2011 in order to maintain continuity of care for individuals receiving care funded through BHD. This action will allow ARO Behavioral Healthcare Inc. to receive $224,112 previously authorized for SRRR for Targeted Case Management services for the same period. The total amount allocated to ARO would be $224,112.

Fiscal Effect

There is no fiscal impact associated with this recommendation, since the allocation of funds is contained in the 2011 BHD Adopted Budget. A fiscal note is attached.

Respectfully Submitted:

Geri A. Lyday

Geri Lyday, Interim Director
Department of Health and Human Services

cc: County Executive Lee Holloway
Renee Booker, DAS Director
Allison Rozek, Fiscal & Management Analyst - DAS
Steve Cady, Fiscal & Budget Analyst – County Board
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

File No.
(Journal,)

(ITEM *) Report from the Interim Director, Department of Health and Human Services, requesting authorization to terminate the 2011 BHD purchase of service contract with Social Rehabilitation & Residential Resources, Inc. enter into 2011 purchase of service contract with ARO Behavioral Healthcare Inc for Targeted Case Management (TCM) services for the Behavioral Health Division, by recommending adoption of the following:

A RESOLUTION

WHEREAS, per Section 46.09 of the Milwaukee County Code of General Ordinances, the Interim Director of the Department of Health and Human Services (DHHS) is requesting authorization to enter into a 2011 purchase of service contract with ARO Behavioral Healthcare Inc for the Behavioral Health Division (BHD); and

WHEREAS, For the past several years, the Behavioral Health Division (BHD) of DHHS has maintained a purchase of service contract with Social Rehabilitation & Residential Resources, Inc. (SRRR) to provide Targeted Case Management (TCM) services to BHD clients; and

WHEREAS, in December 2010, the Health and Human Needs Committee authorized DHHS to enter into a 2011 purchase of service contract with Social Rehabilitation & Residential Resources to provide TCM services; and

WHEREAS, in the 2011 BHD TCM contract allocation, SRRR received an allocation of $224,112; and

WHEREAS, on October 28, 2010, BHD received email notification that ARO Behavioral Healthcare Inc. signed an agreement with SRRR to assist in the liquidation of SRRR and orderly winding up of its affairs as a result of SRRR's "dire financial situation"; and

WHEREAS, subsequently, SRRR's Board passed a resolution authorizing the liquidation (including bankruptcy filing) of SRRR and transfer of the operation of some of its health and human services programs to ARO; and

WHEREAS, BHD is requesting that $224,112 of funding originally allocated to SRRR in the December 2010 Purchase of Service Report to the County Board, now be allocated to ARO; and

WHEREAS, BHD will keep the Board informed about any additional changes to this service line as the transition moves forward;

WHEREAS, this contract assignment will ensure that all Targeted Case Management services provided to consumers previously served by Social Rehabilitation & Residential Resources, Inc. will continue under the management of ARO Behavioral Healthcare Inc., now, therefore,

BE IT RESOLVED, that the County Board of Supervisors hereby authorizes the Interim Director, DHHS, or her designee, to terminate the 2011 BHD purchase of service contract with Social Rehabilitation & Residential Resources, Inc.

BE IT FURTHER RESOLVED, that the Interim Director of the Department of Health and Human Services, or her designee, is authorized to enter into a new 2011 purchase of service contract with ARO Behavioral Healthcare Inc. for Targeted Case Management services in an amount not to exceed $224,112 to reflect the organization's assumption of Social Rehabilitation & Residential Resource's purchase of service contract for the period of January 1, 2011 through December 31, 2011, as specified below:

Adult Agencies - Mental Health	**Service**	**2011 Contract**
ARO Behavioral Healthcare, Inc.	Targeted Case Management	$ 224,112

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 1/3/2011

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Request from the Interim Director, Department of Health and Human Services (DHHS), to terminate the 2011 BHD purchase of service contract with Social Rehabilitation & Residential Resources, Inc. and enter into a 2011 Purchase of Service contract with ARO Behavioral Healthcare Inc for the Behavioral Health Division (BHD).

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure		
	Revenue		
	Net Cost		
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.[1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A) Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. Due to recent changes for the 2011 Targeted Case Management (TCM) purchase of service contracts (POS), the Interim Director of the Department of Health and Human Services (DHHS) is requesting authorization to terminate the 2011 BHD purchase of service contract with Social Rehabilitation & Residential Resources, Inc. and enter into a 2011 POS contract with ARO Behavioral Healthcare Inc for the Behavioral Health Division (BHD).

B) In the December 2010 Purchase of Service Report from BHD, $224,112 was alloocated to SRRR for TCM services. Since that time, BHD received email notification that ARO Behavioral Healthcare Inc. (ARO) signed an agreement with SRRR to transfer the operation of some of its health and human services programs to ARO BHD is now requesting that the $224,112 originally allocated to SRRR, be allocated to ARO.

C) Sufficient funds are included in the 2011 BHD Budget. No net tax levy change results from this recommendation.

D. No assumptions/interpretations.

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Alexandra Kotze, BHD

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

13

Date : January 4, 2011

To : Supervisor Willie Johnson Jr., Chair, Judiciary Committee
Supervisor Peggy West, Chair, Health and Human Needs Committee

From : Laurie Panella, Interim Chief Information Officer, IMSD

Subject: Informational Report: Capital Project WO444 – Electronic Medical Records System

BACKGROUND
The 2010 Budget included an appropriation for capital improvement project WO444 Electronic Medical Records System to replace the current system in place at the Office of the Sheriff (MCSO) and to implement a new Electronic Medical Records (EMR) System for the Behavioral Health Division (BHD).

This report is intended to provide an informational update on the progress of the EMR project and the anticipated phases to complete the project.

ANTICIPATED PROJECT PHASES
The EMR project is broken down into the following four (4) phases:
Phase 1 - Planning and Design
Phase 2 - RFP Process and Vendor Selection
Phase 3 - Implementation
Phase 4 - Closeout and Audit

CURRENT PROJECT STATUS
The EMR project began in August of 2010 with the selection of the Joxel Group, LLC, (TJG) for project management services. Approval was granted by the Finance and Audit Committee to execute a contract for Phase 1 (Planning and Design) with the option of amending the contract to include subsequent phases.

Phase 1 (Planning and Design)
Phase 1 – Planning and Design for the EMR project has been completed at this time. Phase 1 included extensive interviews with BHD and MCSO resources and staff across functional areas of both departments. The interviews for both the departments included management, Medical Directors, Nursing Supervisors and staff, Social Workers, and resources from functional areas such as intake, outpatient, crisis services acute services, long-term care, day treatment, dietary, pharmacy, lab, radiology, rehab, medical records, quality improvement, IT, and Fiscal. The interviews resulted in a list of business and technical requirements, identification of the critical success factors for the project, and the documentation of business processes for both BHD and MCSO that are relevant to an EMR solution. The requirements and process flows were then validated with various stakeholders at BHD and MCSO to ensure that a comprehensive and accurate list of requirements was detailed for the creation of the Request for Proposal (RFP). Meetings were also scheduled with Accenture, the current IT/data processing contractor for BHD, to ensure that the system requirements were integrated into the RFP for seamless integration of BHD operations from an

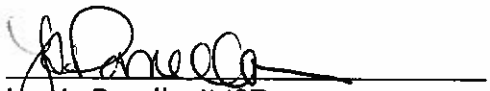
ongoing standpoint. In December 2011, BHD signed a 2-month contract extension with Accenture (January 1, 2011 – February 28, 2011). BHD is currently working with Corporation Counsel and Cambridge Advisory Group to negotiate a future contract extension with Accenture for 2011. If an extension is granted, enhanced language will be included to further ensure smooth transition of data and prioritize work services for the implementation of an EMR system.

Phase 2 (RFP and Vendor Selection)
Phase 2 is currently in process and will incorporate the specifications gathered during the Planning and Design phase and will ultimately result in an RFP to consider potential EMR solutions.

Upon receiving responses to the RFP, a panel will be convened consisting of representatives from MCSO, BHD, Information Management Services Division, and TJG to review responses, conduct vendor interviews, vendor selection, and negotiate a contract for the EMR solution. The final product of Phase 2 will be contract consideration and approval by the County Board of Supervisors for the implementation of the proposed EMR system(s).

As Phase 2 of this capital improvement project continues for EMR selection, it is anticipated the outcome of this phase will govern and significantly impact the remaining phases and project milestones for successful completion. As we progress from Phase 2 to subsequent phases, we will provide informational updates to this Committee to keep your appraised on our progress.

RECOMMENDATION
The Interim Chief Information Officer respectfully requests this report to be received and placed on file.



Laurie Panella, IMSD
Interim Chief Information Officer

cc: County Executive Lee Holloway
Chairman Michael Mayo Sr., County Board of Supervisors
Terrance Cooley, Chief of Staff, County Executive Office
Lynne DeBruin, Vice Chair, Judiciary Committee
Marina Dimitrijevic, Vice Chair, Health and Human Services
Sheriff David Clark
Renee Booker, Director, Department of Administrative Services
Geri Lyday, Director, Health and Human Services
Linda Durham, Judiciary Committee Clerk

Rick Ceschin, Judiciary Research Analyst
Jodi Mapp, Health and Human Services Committee Clerk
Jennifer Collins, Health and Human Services Research Analyst
Alexandra Kotze, Fiscal and Management Analyst, Behavioral Health Department
Allison Rozek, Fiscal and Management Analyst, Department of Administrative Services
Sushil Pillai, The Joxel Group

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: January 3, 2011

TO: Supervisor Michael Mayo, Chairman – Milwaukee Co. Board of Supervisors

FROM: Geri Lyday, Interim Director, Department of Health and Human Services

SUBJECT: INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REGARDING THE 2010 BEHAVIORAL HEALTH DIVISION CAPITAL BUDGET PROJECT AND ISSUES REGARDING THE RECENT STATEMENT OF DEFICIENCY

BACKGROUND

On June 3, 2010 BHD received a Statement of Deficiency (SOD) from the State of Wisconsin as a result of a recent State Centers for Medicaid and Medicare Services (CMS) survey. This was BHD's routine four-year survey that encompasses a comprehensive review of the physical plant and its operations. The majority of the citations BHD received were regarding the physical building. BHD was required to respond with an initial plan for corrective action by June 14, 2010 and an immediate corrective action on specified citations by June 25, 2010.

At the July 2010 meetings of the Committees on Health and Human Needs and the Finance and Audit, approved the expenditure authority for $1,825,890 in 2010 BHD Capital Funds to address all SOD related capital conditions by the final deadline of April 1, 2011. BHD has been providing monthly updates to the County Board since that time.

DISCUSSION

The first requirement of the SOD was to respond to the Conditions, or immediate citations, listed below in Table A, by June 25, 2010. All Conditions were completed by BHD and reviewed by state surveyors during the week of June 28, 2010. At this time, BHD has no outstanding Conditions regarding the initial list for June 25, 2010. It was necessary for BHD to take immediate action to address the SOD citations requiring correction by the June 25, 2010 deadline. The risk of not demonstrating immediate and continuing efforts to respond to the citations would have resulted in sanctions by the State, with the possibility of losing Medicaid certification. Without such certification, the County would have lost significant revenue, similar to the recent occurrence at the State's mental health facility – Mendota Mental Health Institute. The Plan of Correction is a work-in-progress and the expectation by BHD and State surveyors is that continuous progress be made in correcting all cited conditions by April 1, 2011. The State

has at least five opportunities to review citations and conduct site visits/inspections before the final inspection April 1, 2011.

The following is a list of Conditions that were met by the initial June 25, 2010 deadline:

TABLE A	
Conditions/Citations	**Status**
Maintain clear access to exits by removing storage	Completed
Remove various shelving	Completed
Clean and dust various office closets, storage spaces and ventilation grills	Completed
Flush floor and shower drains	Completed
Lock unused rooms and maintain log	Completed
Adjust waste storage per guidelines	Completed
Seal all holes, penetrations throughout BHD	Completed
Replace metal plate in Crisis	Completed
Replace tissue dispenser	Completed
Remove bed rails	Completed
Replace missing heat guards	Completed
Remove dust/lint in laundry room	Completed
Change various locks	Completed
Replace various dietary equipment	Completed
Replace insulation on some water pipes	Completed
Caulk various locations throughout BHD	Completed
General adjustments and fixes for doors including install of push/pull door releases, replacement of door hardware, removal of some doors, adjustments of door guides etc	Completed
Seal various walls for smoke barrier	Completed
Replace lighting in various closets/storage areas, replace aluminum plates and adjust other burnt out lighting	Completed
Remove storage from various areas and adjust to meet fire code	Completed
Replace damaged escutcheon sprinkler rings	Completed
Seal ceiling holes due to misaligned tiles	Completed
Electrical clearance issues	Completed
Replace damaged astragal	Completed
Adjust doors to have positive latches, repair self-closure mechanisms and change fire plan accordingly	Completed
Repair damaged floor areas in bathrooms	Completed
Replace gate in stairwell	Completed
Replace cover on heater	Completed

Replace refrigerator on CAIS	Completed
Replace door on fire hose container	Completed

Due to the extremely short timeframe mandated by the State for responding to the Conditions, BHD Administration determined that applicable purchases and maintenance staff overtime were emergency costs that needed to be incurred immediately. This action was taken to ensure compliance with State regulations and avoid risk of decertification that could result in the loss of State Medicaid reimbursement to BHD. The cost estimate for year-to-date supplies/commodities and additional contract work (such as deep cleaning, moving vans, and dumpsters etc.) is $552,885 through December 15, 2010. The BHD maintenance overtime to date related to the SOD is $96,775. Additional Department of Transportation and Public Works (DTPW) skilled trades costs for labor and overtime is estimated at $210,368 YTD- bringing the total spent on corrective actions for SOD issues out of BHD operating funds to $860,028.

In addition to the immediate (conditional) items that have been completed, there are a number of citations requiring a longer timeframe for completion. These citations are displayed below and grouped as bond-eligible projects, Table B, and cash-financed projects, Table C. While some projects are complete and have final costs reported below, the cost estimates should be considered preliminary for projects that have yet to be completed, as plans are still being finalized and some bids have not yet been received. BHD continues to work with the Department of Administrative Services (DAS); the DTPW – Architectural, Engineering and Environmental Services (A&E); and Zimmerman Architectural Studios Inc, to obtain refined quotes. BHD is required to have all work, which addresses the citations completed by April 1, 2011 as documented in the SOD report.

TABLE B
Bondable Items (based on information available December 27, 2010)

Issue	**Cost Estimate***	**Due Date Per Plan of Correction**
Remove and replace Library Halon System	$35,000	Completed on 10-25-10
Door Replacement	$54,000	Completed on 11-18-10
Additional Sprinkler Heads	$13,750	Completed on 9-30-10
Construct 100,000 sq ft of seamless ceilings	$575,000	April 1, 2011
Repair 300 feet of foundation	$26,500	Completed on 10-1-10
Replace damaged window sills	$125,000	Completed on 10-1-10 (BHD will complete other damaged sills in 2011)
Determine hazardous storage rooms and create smoke barriers	$324,000	Completed on 11-1-10 (Additional work being done to prevent future citations)
Replace milk cooler and installation	$25,000	April 1, 2011 – Equipment ordered in November 2010
Dish Room, Tray Line Tiles and Laundry Repairs	$200,000**	April 1, 2011

Materials and labor (DTPW, BHD and Time and Materials Contractors)	$281,650	On-going
Contingency (10%)	$165,990	
Total	**$1,825,890**	

**Items above represent initial quotes and have preliminarily been determined to be bond eligible. DAS- capital staff will continue to review and work with BHD staff to solidify actual costs and ensure all items are bond-eligible. If the scope of a project changes, it may be determined that cash financing needs to fund certain portions of the above listed projects. A 10% contingency has been included in the cost sub-total to account for any fluctuations that may occur as hard costs are obtained.*

***The Dish Room and Laundry facility repairs are a significant project within the SOD citations and are based on conceptual plan only. BHD is working on a plan and is considering consolidating space within the complex to streamline operations. This cost estimation will likely fluctuate based on the final plan and has been included in this request as a place holder to ensure all compliance costs were included in this request for County Board consideration.*

TABLE C
Cash Items (based on information available December 27, 2010)

Issue	**Cost Estimate***	**Time Frame**
Seal bathrooms to be water tight	$75,000	March 1, 2011
Replace sidewalks	$28,200	Completed on 10-1-10
Exit Lighting	$4,550	Completed on 9-13-10
Roof repair at Food Service Building and Hospital	Included in YTD purchases	Completed on 8-1-10
Electrical Upgrades	Included in DTPW OT estimates and YTD purchases	Completed on 7-1-10
Install Door Closers	Included in YTD purchases	Completed on 7-15-10
Ventilation Addition	$53,250	Completed on 12-1-10
Medical Records Room fire walls and ventilation	$12,000	March 1, 2011
Materials and labor (DTPW, BHD and Time and Materials Contractors)	$38,144 (Preliminary estimate)	On-going
Contingency (10%)	$22,887	
Total	**$234,031**	

**All estimates are based on the best information available as of December 27, 2010 and are subject to change based on scope of the project and information gained from more detailed reviews. DAS staff will continue to review and work with BHD staff to solidify actual costs based on additional quotes. A 10% contingency has been included in the cost sub-total to account for any fluctuations that may occur as hard costs are obtained.*

Since the last report, BHD Operations and DAS have met to review all expenditures to determine what items (including staff time) are allowable under the capital budget. BHD is working with DAS to itemize each project for allowable costs for capital and cash funding streams. Once all the detail is complete, the DAS Capital Finance Manager will complete a fund

transfer to move costs from the BHD budget to the capital project. DAS and BHD hope to have this complete by the end of January 2011.

In addition, BHD has been working over the last several months for a solution to the issues in the SOD regarding the Dish Room, Tray Line and Laundry facilities. It has been determined by BHD, DAS and DTPW that the best approach is to change the use of the Dish room at BHD to avoid costly reconstruction and instead move food and tray line operations from the main BHD facility to the Food Service Building. This will require BHD to purchase some new equipment for food service and change some processes for food delivery but will also help streamline food service delivery and avoid significant construction costs within BHD. Currently, bids are being solicited and a new plan is being put together in conjunction with BHD, DTPW, DAS, A'viands and the State. BHD plans to return to the Board in the March cycle with final estimates for the change and any necessary fund transfers.

BHD has worked diligently to address immediate SOD Conditions and continues to move forward with the long-term projects to ensure all corrections are completed by the State deadline of April 1, 2011. The items included in Tables A, B, and C include all current citations noted in the SOD. BHD and DAS will provide the Board with informational reports as work progresses.

RECOMMEDNATION

This is an informational report. No action is necessary.

Respectfully Submitted:

Geri L. Lyday

Geri Lyday, Interim Director
Department of Health and Human Services

Cc: County Executive Lee Holloway
Renee Booker, DAS Director
Allison Rozek, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board
Steve Cady, Analyst – County Board
Carol Mueller, Committee Clerk – County Board

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: January 11, 2011

TO: Supervisor Michael Mayo, Chairman - Milwaukee County Board of Supervisors

FROM: Geri Lyday, Interim Director, Department of Health and Human Services

SUBJECT: **INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES REGARDING A FOLLOW-UP REPORT REGARDING MIXED-GENDER PATIENT CARE UNITS AT THE BEHAVIORAL HEALTH DIVISION**

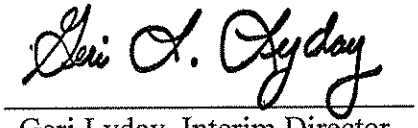
Issue
On April 14, 2010, the department received a referral from Supervisor Peggy West, Chairperson for the Health & Human Needs Committee, requesting a report from the Behavioral Health Division (BHD) on mixed-gender units for the acute psychiatric inpatient unit. The BHD Administrator assigned medical staff the responsibility to conduct a study and literature review, consistent with Joint Commission expectation that the medical staff have a leadership role in enhancing the quality of care, treatment and service, and patient safety.

On June 16, 2010, a preliminary report from the BHD Gender Unit Work Group was presented to the committee. The conclusion was that the mixed-gender acute inpatient units utilized by BHD are the norm among public psychiatric hospital systems in Wisconsin and have been the standard model for inpatient psychiatric treatment for decades. Any revision to the existing practice at BHD of mixed-gender units must look carefully at implications for safety, patient satisfaction and choice and therapeutic benefit. For these reasons, the Gender Unit Work Group recommended that BHD do a detailed study to more thoroughly evaluate the various options to ensure a safe inpatient unit environment. The work group presented an update to the committee in September and is now returning with a follow-up report that specifically addresses the current practice of mixed-gender units at BHD.

Discussion
The follow-up report from the BHD medical staff makes several recommendations important to the discussion of mixed-gender units. Specifically, the Gender Unit Work Group recommends a configuration of the four Acute Adult Inpatient units that would create a 12-bed Intensive Treatment Unit (ITU) that is expected to be predominantly male; a combined Women's-Option/Med-Psych Treatment Unit; and two mixed-gender General Treatment Units. More information about these recommended units, the rationale, and supporting documentation is included in the attached *Milwaukee County BHD follow-up report to the BHD Administrator: Mixed-Gender Units*, submitted by the Gender Unit Work Group.

Recommendation
This is an informational report. No action is necessary.

Respectfully submitted:



Geri Lyday, Interim Director
Department of Health & Human Services

Attachment

cc: County Executive Lee Holloway
Renee Booker, Director – DAS
Allison Rozek, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

FOLLOW-UP REPORT TO BHD ADMINISTRATOR:

MIXED - GENDER UNITS

Submitted by the

GENDER UNIT WORK GROUP

December 1, 2010

EXECUTIVE SUMMARY

Introduction

On June 16, 2010, the *Preliminary Report to BHD Administrator: Mixed-Gender Units (May 22, 2010)* was presented to the Milwaukee County Committee on Health and Human Needs. The Committee had requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. A Gender Unit Work Group conducted a comprehensive international literature review on mixed and single-gender units, obtained information from Wisconsin public psychiatric hospitals, reviewed BHD incident and inpatient consumer satisfaction data and explored the history of mixed-gender units, prevalence, patient perceptions and staff attitudes. The report concluded that the mixed-gender Acute Adult Inpatient units utilized by BHD are the norm and have been the standard model for inpatient psychiatric treatment for many decades. The Work Group recommended before there is any revision to the existing practice of mixed-gender units at BHD that a more detailed evaluation be done of the various gender unit options, while continuing the current practices in place to minimize risk and ensure a safe, therapeutic unit environment. This Follow-Up Report details the comprehensive study conducted by the Gender Unit Work Group of the current practice of mixed-gender acute units at BHD, specifically in the context of patient sexual safety.

Methods

To this aim, the study involved four phases. We administered semi-structured questionnaires to BHD Acute Adult inpatients to assess their perceptions of safety on the current mixed units as well as preferences for single-gender units. We surveyed BHD staff working on the Acute Adult inpatient units on their perceptions of patient sexual safety on the units, effectiveness of current safety practices and attitudes toward gender unit options. We communicated with other public psychiatric hospitals regarding the gender configuration of their acute adult units. We obtained input from community stakeholders on male and female patients residing on the same and single-gender units and on recommendations to improve quality of care in the acute hospital.

Results

BHD Patient Perceptions. Most of the 130 patient respondents reported feeling somewhat or very safe on a mixed-gender unit. More than 90% of male patient respondents and nearly 84% of female respondents felt somewhat or very safe with men and women on the same unit. The majority of them explained that their feeling safe related to positive interpersonal interactions and denial of concerns about aggression. The small percentage of men and women patients who felt unsafe on a mixed-gender unit was concerned about safety from aggression. Respondents indicated that they would feel safer on a mixed-gender unit with improved interpersonal interactions and with unit and security staff presence, behavior and monitoring. Almost 50% of male and female patient respondents did not prefer to be on a same-gender unit. The primary reason cited for this finding was the perceived value of interpersonal interactions between patients and the negative impact a single gender unit would have on these interactions. A secondary, less predominant, reason was the potential for more aggression on an all-male or all-female unit. Only 15% of male patient and 29% of female patient respondents indicated that they would prefer a same-gender unit if it were available. The women who did prefer an all-female unit cited the positive impact of female-to-female interpersonal interactions, and did cite concerns about male aggression on a mixed-gender unit. Thirty percent of both male and female respondents were unsure of their preference for a same-gender unit. but commented on the mainly positive features of interpersonal interactions with both men and women on a unit.

Only one-quarter of the total of male and female patient respondents indicated that they would feel safer on a same-gender unit. A higher percentage of men would feel less safe (38%) than more safe (23%) on an all-male unit. The men who said they would feel less safe on a same-gender unit were mostly focused on the potential for aggression. Male respondents who gave reasons for feeling safer on a same-gender unit cited interpersonal benefits. A slightly higher percentage of women responded that they would feel less safe (32%) than more safe (29%) on an all-female unit. Women who said they would feel less safe on a same-gender unit were mostly focused on the potential for interpersonal conflict between women. Those who responded that they would feel safer on a same-gender unit cited safety from aggression and expected improvements in interpersonal interactions.

Women did not express a definitive preference for a women's-only lounge to be made available on the unit. Of the women who were opposed (39%) to a women's-only lounge, the majority of their reasons cited an expected negative impact on interpersonal interactions. The remainder of their comments cited expected verbal and physical aggression between women. Of the women who would prefer (32%) that there be a women's-only lounge on the unit, most reasons centered on an expected benefit in their interpersonal interactions and shared communication with other women. Only a few comments referenced a vague feeling that they would feel safer.

BHD Inpatient Staff Perceptions. More than 60% of the 82 staff respondents thought that men and women patients are somewhat or very sexually safe residing on the same unit. Nearly 40% of staff respondents think men and women patients are somewhat or very sexual unsafe residing on the same unit. Staff respondents' sexual safety concerns for both men and women on the same unit were related to the individual's vulnerability to sexual harassment, intimidation, exploitation and/or abuse, and also to the unit configuration, staffing pattern and patient mix. Staff respondents identified that both men and women raised sexual safety concerns about vulnerability to sexual harassment and intimidation; being concerned about personal boundary violations; and general (nonsexual) safety concerns. Nearly half of staff respondents said that men usually expressed no sexual safety concerns, and nearly one-quarter said women did not raise any sexual safety concerns.

Current practices were predominantly rated by staff respondents as being somewhat effective for ensuring the sexual safety of patients on the unit. Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective. In regard to other suggestions to improve sexual safety on the mixed-gender units, the largest percentage (32%) of staff respondents suggested an improved staffing pattern. Additional suggestions included better supervision and training of staff, better teamwork and hospital configuration of patient mix.

Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. This group of respondents thought that this would reduce or eliminate sexual harassment and contact and could better serve the subset of women with sexual abuse and trauma issues. Unsure or neutral respondents cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units and were concerned about not being able to control or prevent all sexual contact, including same-gender activity. Those not viewing the unit as being helpful were also concerned about same-gender sexual activity and felt that patients need to function in a normalizing environment similar to the community. Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could particularly help high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those respondents that were unsure or not in favor of an all-men's unit cited concerns about the unit being more violent than a mixed-gender unit, that vulnerable males may be abused, and same-gender sexual behavior.

Only about one-quarter of staff respondents were in favor of a women-only lounge, citing it as a safe and secure place for women to go to when feeling threatened. Those staff respondents not in favor or unsure indicated that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Most staff respondents were unsure or did not think that having a men-only lounge on a mixed-gender unit would improve sexual safety. They indicated that inappropriate sexual behavior occurs in places other than lounge areas, and the area would require close monitoring by staff. Only one-fifth of staff respondents were in favor of a men-only lounge.

As for staff preference for type of unit work assignment, nearly half of staff respondents would not prefer to work on an all-women's unit. Primarily this was due to their concerns about having to deal with stressful demands, and secondarily their viewing the benefits of a mixed-gender recovery environment that reflects the community to which patients will return. Similarly, most staff respondents did not prefer or were neutral or unsure about working on an all-men's unit due to the potential for aggression and violence. Most staff respondents preferred to work on a mixed-gender unit due to the variety of patient needs and personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community

Public Psychiatric Hospital Practices. Information from 9 Midwest public psychiatric hospitals with civil acute units revealed that none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Practices some hospitals use for patients identified at increased risk for dangerous behaviors include heightened levels of observation and monitoring to reduce opportunity for acting out, as well as a psychiatric intensive care unit to manage particularly violent or high-risk patients.

Community Stakeholder Input. A total of 216 community stakeholders shared a variety of responses about having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. Nearly half of respondents offered comments citing advantages of mixed-gender units, and slightly more than a half cited reasons against such an arrangements. Consumers and families tended to be more favorable in their opinions of men and women on the same units, whereas advocates and "other" type respondents were more skewed in their focus on disadvantages as compared to advantages. The advantages of mixed-gender units fell into the two main content categories of *Therapeutic Recovery Environment* (beneficial effect on interpersonal interactions and treatment milieu, and practice standards) and *Quality of Care & Patient-Centered Treatment* (core issues of quality of care, staffing/supervision and screening/treating of most dangerous/vulnerable). Disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* (negative impact on interpersonal interactions and treatment milieu) and *Vulnerability, Trauma and Patient Mix* (impact on safety, potential for harassment, abuse and re-traumatization of women and patient mix of vulnerable and dangerous).

With respect to having patients reside on all-male or all-female units, approximately two-thirds of respondents shared benefits of gender segregation and one-third focused predominantly on disadvantages. The advantages of single-gender units fell into the same two main categories as did the disadvantages of mixed units: *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. Likewise, responses focusing on disadvantages of single-gender units fell into the same two main categories as did the advantages of mixed units: *Therapeutic Recovery Environment* and *Patient-Centered Treatment.*

Conclusions

The results of the study indicate that when it comes to the issue of mixed and single-gender units, it is not about one answer but rather it is a process. There are reasons for and reasons against each option. BHD inpatients, hospital staff and community stakeholders, including consumers, are all of varying opinions and preferences. Of interest among all respondent types, regardless of their opinion about unit gender mix, is the recurrent theme that gender should not be the primary factor in determining best placement, and that quality of care and recovery focus will not be adequately addressed by resort to single-sex segregation. Other factors, such as severity of illness and risk of violence and vulnerability, are equally important, if not more so, in creating a safe and therapeutic inpatient environment. The Gender Unit Work Group concludes that segregation by gender of all BHD Acute Adult Inpatient units is too indiscriminate and compartmentalized an approach. We propose a configuration of the adult units that offers a blended model that is more thoughtful, flexible and pragmatic.

Recommendations

The Gender Unit Work Group recommends a configuration of the four Acute Adult Inpatient units that would create a 12-bed ***Intensive Treatment Unit (ITU)*** that is expected to be predominantly male, a combined ***Women's-Option/Med-Psych Treatment Unit*** and two mixed-gender ***General Treatment Units***. The ***Intensive Treatment Unit*** would be designated for patients with high risk for aggression and violence, including sexual acting out. The ITU can be presumed to be predominantly, if not always, all male. Most women with aggression can usually be managed in the general population with enhanced monitoring. The ITU concept will need to be further developed, but the Work Group is united in its stand that the intention is not that the unit be a "secure" unit (all BHD acute units are secure and locked), a "forensic" unit (BHD has no such formally designated forensic services or specialty) or a "detention" unit (BHD is not a correctional facility). The ITU <u>must</u> have reduced beds. We recommend the ITU have a capacity of 12 beds. The implication is that BHD would have to reduce

its overall Acute Adult Inpatient bed capacity by 12 to a total of 84 beds. The benefit of the ITU is that it achieves separation, from the general patients, of predominantly those male patients with higher violence potential. Such separation addresses the main safety concerns of staff and patients, especially vulnerable male patients and many female patients. The concerns of women patients, however, are more complex due to higher rates of trauma and may not be fully resolved by segregation of high-risk men. For this reason, the Work Group recommends that one unit be designated as a combined ***Women's-Option/Med-Psych Treatment Unit.*** The unit would consist of the small number of vulnerable geriatric and complicated medical-psychiatric patients whom BHD serves, with the majority remainder of beds prioritized for female patients at heightened risk of vulnerability to inappropriate sexual behavior, abuse and violence. Assignment would be per medical staff assessment and/or patient choice, depending on clinical safety needs and bed availability. With a new overall Acute Adult Inpatient bed capacity of 84 beds, the female beds on this unit (Women's-Option and Med-Psych) could conceivably accommodate more than half of the total estimated adult female patients at any given time. The remaining two units would be mixed-gender ***General Adult Treatment Units*** with separate bedroom hallways as is currently the case. The separation of those patients with highest violence and vulnerability potential would, hopefully, allow these units to better serve the general population in a therapeutically-focused milieu.

The Work Group believes that the proposed configuration offers a more individualized, needs-based and trauma informed care approach than simple division by gender. The model addresses many of the concerns of BHD staff, inpatients, community consumers and other stakeholders as well as coheres with accepted practices of public psychiatric hospitals. Aside from requiring a 12-bed reduction in Acute Adult capacity, the recommendation is feasible and offers flexibility with census management. It addresses gender-based safety concerns while affirming the current improvement practices in place. This recommendation of the Gender Unit Work Group is advisory to the BHD Administrator. Should it receive endorsement, a detailed planning process will need to be undertaken, addressing considerations in three areas of: Human Resources, Program Development and Physical Environment Audit. The estimated timeline for implementation of this unit configuration recommendation is during Quarter 3 of 2011 (July to September). Regardless of the final decision, BHD shall continue its current practices, policies and guidelines in place to maintain a safe, therapeutic unit environment.

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

FOLLOW-UP REPORT TO BHD ADMINISTRATOR:

MIXED - GENDER UNITS

December 1, 2010

Submitted By The

GENDER UNIT WORK GROUP

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INTRODUCTION

On June 16, 2010, the *Preliminary Report to BHD Administrator: Mixed-Gender Units (May 22, 2010)* was presented to the Milwaukee Committee on Health and Human Needs. The Committee had requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. A Gender Unit Work Group was formed, under Medical Staff leadership, to examine the issue of mixed-gender units. The Work Group conducted a comprehensive international literature review on mixed and single-gender units, obtained information on units in Wisconsin public psychiatric hospitals and reviewed BHD incident and inpatient consumer satisfaction data. The report explored the history of mixed-gender units, their prevalence, patient perceptions and staff attitudes.

The report concluded that the mixed-gender Acute Adult Inpatient units utilized by BHD are the norm among public psychiatric hospitals in Wisconsin and have been the standard model for inpatient psychiatric treatment for many decades. An extensive literature search failed to identify any published articles in the United States (U.S.) on the issue of mixed and single-gender units. Similarly, there is little research in the U.S. on whether female inpatients consider gender segregation to be either desirable or likely to contribute to their sense of safety. In the United Kingdom where the topic of single-sex accommodation has received much attention, there is little empirical research comparing single-sex and mixed-sex units. Available studies are small in size, the settings variable and generalizability limited across other systems and cultures. The views of their female patients and staff are more complex and reflect concern about overall safety that may not be wholly resolved by the introduction of single-sex units. An informed, aware and safe unit milieu depends on many factors beyond patient gender mix – among them, staff sensitivity and training, monitoring and environmental design. There are different ways that psychiatric hospitals here and across the country protect patient safety, including sexual safety.

Any revision to the existing practice of mixed-gender units at BHD must look carefully at assumptions regarding safety, choice, patient satisfaction and therapeutic benefit. For these reasons, the Work Group recommended a more detailed evaluation by BHD of the various gender unit options, while in the interim continuing the current practices put in place to minimize risk and ensure a safe, therapeutic unit environment. The Committee on Health and Human Needs endorsed this recommendation for further study by BHD of mixed-gender units.

This Follow-Up Report details the study conducted by the Gender Unit Work Group. The aims of the study were to: assess BHD inpatient perceptions of safety on the current units and preferences for gender composition; assess BHD staff perceptions of patient sexual safety on current units, effectiveness of current safety practices and attitudes towards gender unit options; attempt to identify public psychiatric inpatient facilities who have single-gender units and communicate with them regarding their experience; and obtain input from community stakeholders on recommendations to improve quality of care on acute inpatient units, including thoughts about gender composition.

The original Gender Unit Work Group reconvened on July 21, 2010 and members re-evaluated their continued participation in the next phase of the study. Additional members were nominated to represent consumers, direct care acute unit nursing staff, acute inpatient management, rehabilitative services and program evaluation and research. The Gender Unit Work Group met for 14 sessions (approximately 3 times a month) between July 28 and December 1, 2010 for over

28 hours, in addition to numerous times outside of meetings to design measures and procedures, compile results and analyze findings. A note about language: the terms single-gender and mixed-gender are used in this report to describe the types of units, though respondents may have used similar interchangeable terms of same-sex or mixed-sex. A number of terms are often used to refer to consumers of mental health services. This report uses the term *patient* to refer to a person receiving treatment in an acute inpatient unit, consistent with language for persons admitted to a general hospital and understandable to the public.

METHODS

Participants and Procedures

BHD Acute Inpatient Survey. A semi-structured questionnaire was administered to patients hospitalized on the Acute Adult psychiatric units between August 16 and September 10, 2010. The sample was drawn from the four Acute Adult inpatient units with a total patient capacity of 96 and approximately 184 admissions per month. All patients consecutively admitted to these units over this four-week period were eligible to participate in the survey after having been in the hospital for a minimum of one day. Patients considered by the primary unit RN to be too ill or acutely dangerous that day to participate were approached at a later date when more stable. Patients were limited to one survey per episode of hospital stay; if a patient was re-hospitalized during the survey period, they were eligible to do the survey again. Patients were interviewed on the unit using a semi-structured questionnaire. The two interviewers were independent of the patient's clinical treatment team and BHD management. One interviewer was the BHD Client Rights Specialist. The other interviewer was a part-time staff member from Vital Voices, a mental health advocacy organization with extensive experience conducting interviews of consumers of mental health services. Both interviewers had years of experiences working with persons with serious mental illness and conducting patient interviews and surveys. Each interviewer assumed primary responsibility for two units.

A semi-structured questionnaire was developed specifically for this study to obtain the opinion of BHD Acute Adult inpatients about men and women being on the same unit here (see Appendix A for copy of the survey tool). The questionnaire consisted of three main questions with objective ratings asked of both male and female patients, and then a fourth question for female patients only. Each objective question was followed by an open-ended question asking the patient to explain more in a narrative response. One question had an additional open-ended follow-up item. The questions were developed by the Work Group with careful attention to non-leading language and avoidance of intrusive questions about personal experiences that could provoke emotional distress. The three main questions asked whether patients: (1) preferred to be on an [*same gender as pt.*] all-men's/all-women's unit if it were available ("No" "Unsure/Doesn't Matter" "Yes") and then to explain why; (2) how they feel with men and women patients on the same unit ("Very Unsafe" "Somewhat Unsafe" "Somewhat Safe" "Very Safe") and to explain why and say what would make them feel safer; and (3) how they would feel if there were [*same gender as pt.*] all men/women patients on the unit ("Less Safe" "No Difference" "More Safe") and to explain why. The fourth question for women only asked whether they (4) would prefer there to be a <u>women-only</u> patient lounge available on the unit ("No" "Unsure/Doesn't Matter" "Yes") and to explain why.

Interviewers were trained on the patient questionnaire by the Work Group Chair. Interviewers approached eligible patients individually, explained the purpose of the survey and that participation was voluntary and would not influence the services they receive. The questionnaire was administered in a semi-private location on the unit. The interviewer entered the date of the survey, patient's date of admission, age, gender, race/ethnicity and acute unit. The Interviewer read each objective question and response choices to the patient, and then circled the patient's response. The interviewer asked the follow-up open-ended questions and recorded the patient's narrative answer verbatim.

BHD Acute Adult Inpatient Staff Survey. *An Acute Adult Inpatient Staff Survey: Patient Sexual Safety* was distributed to all clinical staff working in the Acute Adult Inpatient program, either as their regular assignment or as pool/float staff. The purpose of the survey was to obtain staff's opinions specifically about the sexual safety of men and women patients residing on the same acute units here, as this was the main charge of the Work Group. For the purposes of the survey, *sexual safety* was defined as referring to preventing and managing sexual behavior between patients – including sexual contact, harassment, exploitation, intimidation and assault. The survey was printed on special paper to prevent photocopying and individuals submitting more than one survey. Surveys were delivered to staff mailboxes in sealed blue envelopes with staff name on envelope label but no staff-identifying information on the survey tool itself. Staff was assured that their answers were confidential. Work Group members briefed unit clinical treatment teams on the purpose of the survey and encouraged their participation. The surveys were distributed to 236 Acute Adult Inpatient staff, consisting of approximately 24 Medical Staff (MD- psychiatrists and physical care doctors, PhD-psychologists, APNP-advanced practice nurse prescribers), 22 Social Work/Rehabilitative Services (social workers, occupational therapists, music therapists), 104 Registered Nurses (unit, float, pool, nursing program coordinators, administrative resources), 76 Certified Nursing Assistants (unit, float, pool), 7 Peer Specialists, 3 Dieticians and 1 Chaplain. Of the RN and CNA staff, approximately 76 were pool or float. Surveys were disseminated on September 16 with due date of September 30, 2010.

The Acute Adult Inpatient Staff survey consisted of ten main items, nine of them questions with objective ratings followed by one or more open-ended follow-up questions requiring a narrative response. The remaining one item was solely an open-ended question giving staff an opportunity to make other suggestions to improve the sexual safety of men and women patients residing on the units (see Appendix B for copy of survey tool). The first item asked staff their opinion as to how sexually safe men and women patients are residing on the same unit in our hospital, followed by a series of items about what sexual safety concerns they have for patients and what concerns patients themselves have raised. Next, staff was asked to rate the effectiveness of 11 current practices for ensuring the sexual safety of patients on the unit, then followed by recommendations to improve them as well as any other suggestions to improve the sexual safety of men and women residing on the same units. Lastly, staff opinions were obtained on possible future strategies to improve unit safety for men and women, specifically developing plans for an all-women's unit, all-men's unit, and women-only and men-only lounges on the mixed-gender units. Staff was also asked to rate their preferences for working on all-women's, all-men's and mixed-gender units. Demographic/descriptive data recorded included gender, position, years of employment at BHD and years of employment in Acute Adult Inpatient.

Public Psychiatric Hospital Information. An attempt was made to locate other public psychiatric facilities with single-gender acute units and communicate with them regarding their experience. The search was narrowed to facilities in states from the Midwest geographic region

and close to a major metropolitan area. The only state included outside of the Midwest was Pennsylvania. Names of public psychiatric hospitals were obtained from the web sites of the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health and Developmental Disability Directors and state departments of mental health. An effort was made to select those hospitals that appeared to have or might reasonably have a civil acute unit (versus medium/long-term stay civil units or forensic units). An email letter was developed describing the BHD Acute Adult Inpatient Service (# of beds, median and mean lengths of stay), the study we had undertaken of whether to continue to use mixed-gender units and a desire to communicate with public adult psychiatric hospitals that currently have, or had within the last 5 years, single-gender units. The hospital was asked to contact the Chair of the Work Group if they had relevant experiences they were willing to share with us about the gender configuration of their acute adult units. The email letter was sent to the hospital's chief clinical officer, chief operating officer, or administrator as identified by the site or by phone contact with the facility. The email letter was sent to a total of 24 public psychiatric facilities in the states of Illinois, Minnesota, Missouri, Michigan, Ohio and Pennsylvania. Except for one county-operated hospital, all other facilities were state-operated psychiatric hospitals and regional treatment centers.

Community Stakeholder Input. Community stakeholders (i.e., consumers, family members, behavioral health providers, advocates and other interested parties) were invited to provide input relevant to BHD's evaluation of the current practice of mixed-gender acute adult inpatient units and recommendations to enhance the quality of care in the acute hospital. Thoughts and opinions were requested specifically about men and women patients residing on the same acute inpatient units at BHD and having patients reside on all-male and all-female acute inpatient units at BHD. Respondents were asked to identify themselves as either a consumer/patient, family member, provider, advocate or other. They were asked to answer the two questions on the attached form and send their response by postal or email address to the BHD Manager of Community and Employee Outreach. The request for input was distributed on November 9 with deadline of November 17 (subsequently extended to November 19) and sent to relevant community stakeholders via organizational network lists of BHD as well as Disability Rights Wisconsin.

Data Analysis

Quantitative data from the inpatient and staff surveys were analyzed using SPSS (Statistical Package for the Social Sciences). Narrative answers from BHD inpatients, BHD staff and community stakeholders to the open-ended questionnaire items were analyzed using a content analysis descriptive approach. The content analysis was conducted by hand and involved grouping responses into categories and, for some items, counting the responses. The most formal content analysis was applied to the BHD inpatient survey and BHD inpatient staff survey question #3 because of the relevant and direct experience of these participants to the study questions at hand. The content analysis began with one judge sorting the verbatim responses into main content categories that occurred to her and writing a brief definition of the category. The preliminary categories and definitions were then presented to several members of the Work Group or the entire Work Group for them to sort the same set of responses without seeing the judge's results. They compared notes, discussed responses on which they disagreed and resolved differences. Based on this process, categories were added or deleted/combined and clearer definitions formulated.

RESULTS

BHD Acute Adult Patient Survey

Characteristics of Participants. One hundred thirty patients participated in the study. Of those 130, 74 (56.9%) were men and 56 (43.1%) were women. This gender breakdown very closely mirrors the latest BHD figures for Acute Adult Inpatient admissions of 59.8% men and 40.2% women (data from 01/01/2009 through 10/31/2010), slightly over-representing women. Fifty-nine were African American (45.4%), 58 White/Caucasian (44.6%), 5 Hispanic/Latino (3.8%), 1 Native American (0.8%) and 7 Other (5.4%). Average age was 40.9 years (median 41.5, range 18 -81 years). Median length of stay in the hospital at time of survey was 6.0 days (overall BHD Acute Adult Inpatient median LOS = 7.0 days). Thus, patients were surveyed after having been reasonably exposed to the inpatient unit and sufficiently stable in their treatment to provide informed opinions to the survey questions. Participation was representative of all 4 units and reflected slight differences in their admissions (43A – 26.2%; 43B - 18.5%; 43C – 25.4% and 43D – 30.0%).

Content Analysis and Main Patient Themes. A summary of all main patient content themes of responses to the open-ended follow-up items is contained in Appendix A. The main content theme categories and definitions are presented in Table 1.

Table 1. *Main Patient Content Themes*

SAFETY FROM AGGRESSION	***INTERPERSONAL INTERACTION***
❖ Concern about or experience of: o Verbal aggression o Physical Aggression o Sexual behavior o *Safety* issues ❖ Includes either *presence* or *denial* of concern about any safety issues	❖ Quality and mix of opportunities for patient interpersonal interactions, including: o Communication, sharing o Cooperation, respect o Socialization o Emotional or social attributes ❖ Includes either *positive* or *negative* interpersonal effects and expectations
UNIT AND SECURITY STAFF	***SELF ADVOCACY***
❖ Unit or security staff presence and behavior	❖ Feeling of confidence or ability to manage, advocate for or protect self
OTHER	
❖ Irrelevant to question ❖ Does not belong to available theme categories	

Perceptions of Safety on Mixed-Gender Units. Patient perceptions of how safe they feel with men and women patients on the same unit are reflected in their responses to Question 2a. of the survey (see Table 2).

Table 2. *Patient Feelings of Safety with Men and Women Patients on Same Unit*

2. How do you feel with men and women patients on the same unit?						
	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
Very Unsafe	5	6.8	6	10.7	11	8.5
Somewhat Unsafe	2	2.7	3	5.4	5	3.8
Somewhat Safe	15	20.3	14	25.0	29	22.3
Very Safe	52	70.3	33	58.9	85	65.4
2a. Respondents' explanation of 'why'						
	MALES		FEMALES		TOTAL	
Somewhat / Very Unsafe	N	%	N	%	N	%
Safety from aggression	6	100.0	6	85.7	12	92.3
Interpersonal interaction	0	0.0	1	14.3	1	7.7
Unit & security staff	0	0.0	0	0.0	0	0.0
Self advocacy	0	0.0	0	0.0	0	0.0
Somewhat / Very Safe						
Safety from aggression	9	21.4	18	39.1	27	30.7
Interpersonal interaction	20	47.6	19	41.3	39	44.3
Unit & security staff	8	19.0	6	13.0	14	15.9
Self advocacy	5	11.9	3	6.5	8	9.1

- Over 90% of the men felt somewhat or very safe with men and women patients on the same unit. For these men, their comments centered primarily (48%) on potentially beneficial interpersonal interactions, and additionally (21%) on denial of aggression as a concern, with a few fearing there would be more fights with all men. Almost a fifth of the comments (19%) focused on how unit and security staff contributed to their feelings of safety. Another 12% of the men who felt safe gave as the reason their confidence in their ability to advocate for their own safety.

- Slightly less than 10% of men felt somewhat or very unsafe with men and women on the same unit. All of their explanations were concerned with the potential for aggression.

- Nearly 84% of women felt somewhat or very safe with men and women patients on the same unit. For these women, 41% of the reasons had to do with the positive interpersonal experience of having men on the unit. An additional 39% of the reasons why women felt safe centered primarily on feelings of safety from aggression. Another 20% gave reasons for their feeling of safety having to do with unit and security staff and confidence in their own self-advocacy skills.

- Approximately 16% of women felt somewhat or very unsafe with men and women patients on the same unit. Their reasons were primarily (86%) concerns about safety from aggression.

- Almost 88% of all patients said they felt somewhat or very safe with men and women on the same unit. The majority of them mentioned reasons related to positive interpersonal interactions and denial of concerns about aggression. Among these patients who reported feeling safe, a few mentioned unpleasant interpersonal experiences or safety concerns involving the opposite gender. The small percentage (12%) of patients who felt somewhat or very unsafe with men and women patients on the same unit cited primarily concern about potential for aggression.

As for what would make patients feel safer on the mixed-gender units, their suggestions fell into three main themes centering on improved interpersonal interactions, unit and security staff and reliance on self advocacy (see Table 3).

Table 3. *Patient Suggestions to Increase Feeling of Safety*

2b. How do you feel with men and women patients on the same unit? What would make you feel safer?						
	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
Very Unsafe	5	6.8	6	10.7	11	8.5
Somewhat Unsafe	2	2.7	3	5.4	5	3.8
Somewhat Safe	15	20.3	14	25.0	29	22.3
Very Safe	52	70.3	33	58.9	85	65.4
Respondents' explanation of 'What would make you feel safer?'						
	MALES		FEMALES		TOTAL	
Somewhat / Very Unsafe	N	%	N	%	N	%
Interpersonal interaction	2	28.6	6	66.7	8	50.0
Unit and security staff	2	28.6	2	22.2	4	25.0
Self advocacy	1	14.3	0	0.0	1	6.3
Other	2	28.6	1	11.1	3	18.8
Somewhat / Very Safe						
Interpersonal interaction	7	11.3	8	14.3	15	12.7
Unit and security staff	41	66.1	32	57.1	73	61.9
Self advocacy	7	11.3	6	10.7	13	11.0
Other	7	11.3	10	17.9	17	14.4

- For the 10% of men who felt unsafe on a mixed-gender unit, no single factor stood out that would make them feel safer, with the few comments offered spanning interpersonal interactions, unit and security staff and self advocacy.

- For the more than 90% of men who felt safe on a mixed-gender unit, 66% of their suggestions for what would make them feel safer centered on unit and security staff presence, behavior and monitoring. Other factors identified that would make them feel safer were evenly split between improved interpersonal relations (11.3%) and reliance on self-advocacy and protection (11.3%).

- For the approximately 16% of women who felt unsafe on a mixed-gender unit, suggestions as to what would make them feel safer clustered mostly (67%) around improvements in overall interpersonal interactions, with just a few suggestions about unit and security staff.

- For the almost 84% of women who felt safe on a mixed-gender unit, their suggestions for what would make them feel even safer centered primarily (57%) on unit and security staff presence, behavior and monitoring. Other factors identified that would make them feel safer included a mixture of comments regarding interpersonal interaction (14.3%) and reliance on self-advocacy and management (10.7%).

- For the 12% of patients overall who felt unsafe on a mixed-gender unit, factors they identified that would make them feel safer included improved interpersonal interactions (50%) and, to a lesser extent, unit and security staff (25%). For the 88% of patients who reported feeling safe on a mixed-gender unit, nearly 62% of their suggestions as to what would make them feel safer focused on unit and security staff presence. This pattern was consistent for both men and women patients.

Preferences For and Attitudes About Single-Gender Units. On the question of preference to be on an all-men's/all-women's unit if it were available, almost 50% of male and female respondents did not prefer to be on a single-gender unit and about 30% were unsure of their preference. Results are presented in Table 4.

Table 4. *Patient Preferences for Single-Gender Units*

1. Would you prefer to be on an all-men's / all-women's unit if it were available? Explain why.

	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
No	41	55.4	23	41.1	64	49.2
Unsure / Doesn't Matter	22	29.7	17	30.4	39	30.0
Yes	11	14.9	16	28.6	27	20.8

	MALES		FEMALES		TOTAL	
No	N	%	N	%	N	%
Safety from aggression	6	14.6	3	9.7	9	12.5
Interpersonal interaction	35	85.4	28	90.3	63	87.5
Unsure / Doesn't Matter						
Safety from aggression	5	38.5	1	7.7	6	23.1
Interpersonal interaction	8	61.5	12	92.3	20	76.9
Yes						
Safety from aggression	0	0.0	7	38.9	7	35.0
Interpersonal interaction	2	100.0	11	61.1	13	65.0

- More than half of the men (55%) did not prefer to be on an all-men's unit. More than 85% of the explanations for this preference cited the negative impact it would have on interpersonal interactions with other patients. Less than 15% of the reasons related to safety from aggression.

- Almost 30% of men were unsure or felt it did not matter but cited mainly positive features of interpersonal interactions when a unit has both men and women.

- Less than 15% of men preferred to be on an all-men's unit and only two explanations were given related to interpersonal interactions.

- More than 40% of women did not prefer to be on an all-women's unit. Over 90% of the reasons related to positive interpersonal interactions with men and women on the same unit and expectation of negative interactions if there were only women. The remaining reasons why women do not prefer to be on an all-women's unit had to do with concerns about potential aggression with other women on the unit.

- Approximately 30% of women were unsure or felt it did not matter. However, their comments mentioned mostly positive expectations for interpersonal interactions and minimized concerns and problems with men on the unit.

- Almost 29% of women preferred to be on an all-women's unit. More than 60% of their explanations cited an expected positive impact all women would have on interpersonal interactions. Almost 39% of explanations for why these women preferred an all-women's unit centered on concerns about male aggression.

- Almost 50 % of men and women did not prefer to be on a same-gender unit. Another 30% were unsure or said it did not matter, whereas 20% said they would prefer to be on a unit with same-gender patients. All three groups cited reasons that overwhelmingly (>81%) had to do with the effect they thought a same-gender unit would have on the quality of interpersonal interactions with each other. The remaining reasons were related to safety from aggression.

As for how safe patients thought they would feel if there were all single-gender patients on the same unit, only about 25% of both male and female patients indicated they would feel safer. Complete results are in Table 5.

Table 5. *Patient Expectations of Safety on Single-Gender Units*

3. How would you feel if there were all men / all women patients on the same unit? Explain why.						
	MALES (n=74)		FEMALES (n=56)		TOTAL (n=130)	
	N	%	N	%	N	%
Less Safe	28	37.8	18	32.1	46	35.4
No Difference	29	39.2	22	39.3	51	39.2
More Safe	17	23.0	16	28.6	33	25.4
3a. Respondents' explanation of "why"						
	MALES		FEMALES		TOTAL	
Less Safe	N	%	N	%	N	%
Safety from aggression	22	78.6	7	33.3	29	59.2
Interpersonal interaction	6	21.4	14	66.7	20	40.8
No Difference						
Safety from aggression	4	26.7	8	44.4	12	36.4
Interpersonal interaction	11	73.3	10	55.6	21	63.6
More Safe						
Safety from aggression	3	33.3	7	53.8	10	45.5
Interpersonal interaction	6	66.7	6	46.2	12	54.5

- Slightly less than 40% of men said they would feel less safe if there were all men on the unit. Just fewer than 80% of their reasons focused on concerns about safety from aggression, including serious fights.

- Approximately 40% of men felt there would be no difference for them being on a unit with all men patients because they recognize the potential for people to get along.

- More than 20% of men felt they would be safer on a unit with all men due to the expected quality of the interpersonal interactions.

- Slightly less than a third of the women said they would feel less safe on an all-women's unit. Approximately two-thirds of their reasons cited concern about increased interpersonal conflict with all women and one-third of the reasons related to the potential for physical aggression.

- Slightly less than 40% of women said there would be no difference for them being on a unit with all women patients. The majority of comments cited positive effects on interpersonal interactions with men and women together and a minimization of concerns about potential for aggression.

- Slightly less than 30% of women said they would feel safer being on a unit with all women patients. The two main reasons were safety from aggression and expected improvement in interpersonal interactions.

- Overall, about 40% of men and women felt that being on a same-gender unit would make no difference to them in terms of safety. Slightly more than a third said that they would feel less safe, whereas a fourth of all patients said they would feel safer. {This response pattern held true for both men and women pts. However, a slightly higher % of men than women expected to feel less safe on a same-gender unit, and a slightly higher % of women than men expected to feel more safe on a same-gender unit.}

Women's Preferences for Women-Only Lounge. Women were split in their preference for a women-only lounge on the unit and the majority of reasons for and against focused on the expected effect on interpersonal interactions rather than safety (see Table 6 for results).

Table 6. *Women Patient Preferences for Women-Only Lounge*

4. Women only: Would you prefer there to be a women-only patient lounge available on the unit? Explain why.		
	N	*%*
No	22	*39.3*
Unsure / Doesn't Matter	16	28.6
Yes	18	32.1
4a. Women respondents' explanation of 'why'		
	N	*%*
No		
Safety from aggression	5	20.0
Interpersonal interaction	20	80.0
Unsure / Doesn't Matter		
Safety from aggression	1	14.3
Interpersonal interaction	6	85.7
Yes		
Safety from aggression	4	22.2
Interpersonal interaction	14	77.8

- Women were split in their preference for a women-only lounge on the unit, with 39% saying no, 32% saying yes and 29% being unsure or neutral.

- Of women who were opposed to a women-only lounge, 80% of their reasons cited an expected negative impact on interpersonal interactions and 20% of the comments cited expected verbal and physical aggression between women.

- Of women who said they would prefer a women-only lounge, the vast majority (77.8%) of their reasons centered on an expected benefit in their interpersonal interactions and shared

communication with other women. Only a few comments referenced a vague feeling that they would feel safer.

- Of interest, all of the comments by the unsure or neutral group of women emphasized no problems with the current arrangement of a shared lounge with men on the unit.

BHD Acute Adult Inpatient Staff Survey

Characteristics of Participants. A total of 82 staff participated in the survey, a 34.6% return rate. Though lower than hoped for, this response rate is not unusual for this type of survey and is a more than adequate sample size for analysis. Of those staff who responded, 22 (27.2%) were male and 59 (72.8%) female. Breakdown of response by position and (% of total sample) was medical staff 11 (13.9%), social work/rehab services 8 (10.1%), registered nurse 38 (48.1%), certified nursing assistant 15 (19.0%), peer specialists 4 (5.1%) and other 3 (3.8%). Mean years of employment at BHD was 9.7 years with mean years of employment in Acute Adult Inpatient 7.8 years.

Content Analysis and Main Themes. A summary of main content themes of responses to the open-ended items is contained in Appendix B.

Staff Perceptions of Patient Sexual Safety on Mixed-Gender Units. More than half of staff respondents think that men and women patients are somewhat sexually safe residing on the same unit. An additional 9 % think they are very safe (total for somewhat and very sexually safe = 60.5%). Almost 40% of staff respondents think that men and women patients are somewhat (27%) or very (12%) unsafe residing on the same unit. Please see Table 7.

Table 7. *Staff Perceptions of Patient Sexual Safety*

1. HOW SEXUALLY SAFE DO YOU THINK MEN AND WOMEN PATIENTS ARE RESIDING ON THE SAME UNIT IN OUR HOSPITAL?		
	N	%
Very Unsafe	10	12.3
Somewhat Unsafe	22	27.2
Somewhat Safe	42	51.9
Very Safe	7	8.6
Total	81	100.0

Asked about specific safety concerns they have for women patients on the unit, staff respondents indicated that most (53%) of their concerns for women patients' sexual safety were related to the women's vulnerability to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for women on the unit. Additionally, staff respondents identified concerns about women initiating or provoking sexual activity. As for sexual safety concerns they have for men patients on the unit, staff respondents indicated that most (46%) of their concerns for men patients' sexual safety also were related to some men being vulnerable to sexual harassment, intimidation, exploitation and/or abuse. Of note, 14% of staff responses indicated they had no sexual safety concerns for men patients. Staff respondents identified concerns about men initiating or provoking sexual activity. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for men on the unit.

With respect to sexual safety concerns that women patients have raised with them, of staff who responded, 33% reported women raising concerns about vulnerability to sexual harassment and intimidation. Almost 29% cited women being concerned about personal boundary violations, with another 12% of comments saying that women have raised general (nonsexual) safety concerns. Almost 22% of staff respondents reported women not having raised any sexual safety concerns. As for sexual safety concerns raised by men patients, of staff who responded, 30% reported men raising concerns about vulnerability to sexual harassment and intimidation. Almost 12% cited men being concerned about personal boundary violations, with another 9% of comments saying that men have raised general (nonsexual) safety concerns. Another 46% of staff said that men usually expressed no sexual safety concerns.

Effectiveness of Current Sexual Safety Practices. Current practices were predominantly rated by staff respondents as being somewhat effective (approximately 3.0) for ensuring the sexual safety of patients on the unit (see Table 8) Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective.

Table 8. *Staff Rating of Effectiveness of Current Practices*

2. HOW WOULD YOU RATE THE EFFECTIVENESS OF THESE CURRENT PRACTICES FOR ENSURING THE SEXUAL SAFETY OF PATIENTS ON THE UNIT? *									
CURRENT PRACTICES	Scale Avg.** Rank Ordered	Very Ineffective		Somewhat Ineffective		Somewhat Effective		Very Effective	
		N	%	N	%	N	%	N	%
Locked Community Bathrooms	3.2	3	4.1	9	12.3	30	41.1	31	42.5
Unit Zone Surveillance system	3.1	7	10.1	9	13.0	21	30.4	32	46.4
Cross Shift communication of special risk patients	3.1	4	6.0	7	10.4	35	52.2	21	31.3
Bedroom Hallways separate for M & W; no bed assignment beyond fire doors for W	3.0	6	8.3	10	13.9	32	44.4	24	33.3
Behavior Observation monitoring for special risks	2.9	7	9.3	12	16.0	32	42.7	24	32.0
Therapeutic Groups	2.9	4	6.0	13	19.4	31	46.3	19	28.4
Overall Effectiveness of current practices	2.9	7	9.5	11	14.9	40	54.1	16	21.6
Recovery Planning special risks, treatment obj., interventions	2.9	4	5.8	15	21.7	37	53.6	13	18.8
Morning Report with both treatment teams represented	2.8	9	14.5	5	8.1	36	58.1	12	19.4

Assessments by PCS and Inpatient MD/PhD of special risks	2.8	8	11.4	12	17.1	35	50.0	15	21.4
Patient Education on sexual contact policy	2.8	4	5.7	15	21.4	42	60.0	9	12.9
Electronic Video Monitoring of unit	2.7	10	18.9	10	18.9	20	37.7	13	24.5

*Instructions for this survey question directed respondents to leave blank any items for which they did not have experience. Total number of respondents for each item was between 53 and 75 (total surveys received = 82).

** Response Scale: 1 = very ineffective / 2 = somewhat ineffective
3 = somewhat effective / 4 = very effective

For current practices rated as ineffective, staff was asked for recommendations to improve them (see Appendix B for complete list). Staff suggested that the unit zone surveillance was a very good idea and would work even better if staffed adequately and with better monitoring of CNA performance. Patient education on the no sexual contact policy, though well intended, was often inconsistent and of little benefit for patients with impulse control issues. Some staff commented that higher risk patients seem to get around unit safety nets.

In addition to the current safety practices, staff was asked for any other suggestions to improve the sexual safety of men and women residing on the same unit (see Table 9).

Table 9. *Staff Suggestions to Improve Sexual Safety*

3. WHAT OTHER SUGGESTIONS DO YOU HAVE TO IMPROVE THE *SEXUAL SAFETY* OF MEN AND WOMEN RESIDING ON THE SAME UNIT?		
Suggestion Category	**N**	**%**
Staffing pattern (e.g. adequacy & composition of staff for monitoring & duties)	26	31.7
Staff performance (e.g. staff supervision, training, and teamwork)	20	24.4
Hospital configuration for patient mix (e.g. based on gender, risk, acuity, etc.)	15	18.3
Clinical interventions (i.e. clinical strategies for intervening with patients)	11	13.4
Unit environment modification (i.e. modifications to existing unit physical environment and practices)	10	12.2
Total	82	100.0

Nearly one-third (32%) of suggestions from staff indicated that an improved staffing pattern (e.g. adequacy and composition of staff for monitoring duties) would contribute to the sexual safety of men and women residing on the same unit. Nearly another quarter (24%) suggested better supervision and training of staff and better teamwork would improve the sexual safety of men and women residing on the same unit. Additional staff respondent suggestions for improving sexual safety included the hospital configuration for the mix of patients; increasing the use of clinical intervention strategies regarding sexual issues and behavior; and modifying the existing unit physical environment.

Attitudes and Preferences for Single-Gender Units. Table 10 presents staff opinions on the helpfulness for managing sexual safety for BHD to develop plans for an all-women's unit.

Table 10. *Staff Opinions about an All-Women's Unit*

4. HOW HELPFUL DO YOU THINK IT WOULD BE FOR MANAGING SEXUAL SAFETY ON THE UNITS FOR BHD TO DEVELOP PLANS FOR AN ALL-WOMEN'S UNIT?		
	N	%
Not at all helpful	10	12.5
Not very helpful	10	12.5
Neutral / Unsure	22	27.5
Somewhat helpful	15	18.8
Very helpful	23	28.8
Total	80	100.0

Nearly half (48%) of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. These respondents thought that this would promote the women on the unit feeling safer and reduce or eliminate sexual harassment and contact. Staff also thought an all-women unit could better serve the subset of women with sexual abuse and trauma issues. Slightly more than a quarter (28%) of staff were neutral or unsure whether an all-women's unit would be helpful primarily due to not being able to control or prevent all sexual contact, including same-gender activity. Additionally, staff cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units. Another quarter of staff respondents thought that an all-women's unit would be not very or not at all helpful due to the possibility of same-gender sexual activity and that patients need to function in a normalizing environment similar to the community.

Table 11 presents staff opinions on the helpfulness of BHD developing plans for an all-men's unit. Nearly half (49%) of staff respondents thought it would be somewhat or very helpful for

Table 11. *Staff Opinions about an All-Men's Unit*

5. HOW HELPFUL DO YOU THINK IT WOULD BE FOR MANAGING SEXUAL SAFETY ON THE UNITS FOR BHD TO DEVELOP PLANS FOR AN ALL-MEN'S UNIT?		
	N	%
Not at all helpful	12	15.2
Not very helpful	8	10.1
Neutral / Unsure	20	25.3
Somewhat helpful	14	17.7
Very helpful	25	31.6
Total	79	100.0

managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could help particularly high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those staff respondents who were unsure (25%) cited concerns that this might shift the risk of sexual behavior toward vulnerable male patients, and that an all-male unit may be more violent than a mixed-gender unit. Another quarter of respondents thought that an all-men's unit would not be very or at all helpful, and also cited concerns about same-gender sexual behavior and the abuse of vulnerable males.

Preference for Unit Work Assignment. Most staff respondents would not prefer or were neutral or unsure about working on a single-gender unit if BHD had one, with more staff respondents preferring to work on an all-men's unit rather than an all-women's unit See Tables 12 and 13). Nearly half (48%) of staff respondents would not prefer to work on an all-women's

Table 12. *Staff Preferences to Work on All-Women's Unit*

6. WOULD YOU PREFER TO WORK ON AN ALL-WOMEN'S UNIT, IF BHD HAD ONE?		
	N	%
No	37	48.1
Neutral / Unsure	29	37.7
Yes	11	14.3
Total	77	100.0

unit if BHD developed one. Their reasons were primarily concerned with the stressful demands and problems they would have to deal with from hostile, moody, and threatening women. They also cited the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Male staff respondents were also concerned about the potential for false accusations of sexual advances. Almost 38% of staff respondents were neutral or unsure about working on an all-women's unit. The few reasons provided by the 14% of staff respondents who preferred to work on an all women's unit referenced wanting to feel safe and to be there for all patients.

Table 13. *Staff Preferences to Work on an All-Men's Unit*

7. WOULD YOU PREFER TO WORK ON AN ALL-MEN'S UNIT, IF BHD HAD ONE?		
	N	%
No	33	42.9
Neutral / Unsure	26	33.8
Yes	18	23.4
Total	77	100.0

Most staff respondents did not prefer (43%) or were neutral or unsure (34%) about working on an all-men's unit. The primary reasons cited were concerns about anger and the potential for aggression and violence. They also cited the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Nearly a quarter (23%) of staff respondents would prefer to work on an all-men's unit due to either their personal preference or their belief that men are easier to handle and deal with.

Table 14. *Staff Preferences to Work on Mixed-Gender Unit*

8. WOULD YOU PREFER TO WORK ON A MIXED-GENDER UNIT (MEN & WOMEN), LIKE BHD HAS NOW?		
	N	%
No	5	6.6
Neutral / Unsure	28	36.8
Yes	43	56.6
Total	76	100.0

Most (57%) staff respondents preferred to work on a mixed-gender unit like BHD has now (see Table 14). Most reasons for this preference had to do with the variety of patient needs and

personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Approximately 37% of respondents were neutral or unsure but cited the benefits of the current mixed-gender recovery environment for interpersonal interactions.

Attitude on Single-Gender Lounges. Most staff respondents were unsure or did not think that having single-gender lounges on mixed-gender units would improve sexual safety (Tables 15, 16). Approximately 40% of staff respondents did not think that having a women-only patient

Table 15. *Staff Attitude about Women-Only Patient Lounge*

9. DO YOU THINK THAT HAVING A WOMEN-ONLY PATIENT LOUNGE ON A MIXED-GENDER UNIT WOULD IMPROVE SEXUAL SAFETY?		
	N	%
No	31	39.7
Neutral / Unsure	26	33.3
Yes	21	26.9
Total	78	100.0

lounge on a mixed-gender unit would improve sexual safety. Another third of respondents were neutral or unsure. The primary reasons why these two groups of respondents did not think it would improve sexual safety were focused on their observation that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Slightly more than a quarter of staff respondents were in favor of a women-only lounge as a safe and secure place for women to go to when feeling threatened.

With respect to a men-only patient lounge, approximately 45% of staff respondents did not think

Table 16. *Staff Attitude about Men-Only Lounge*

10. DO YOU THINK THAT HAVING A MEN-ONLY PATIENT LOUNGE ON A MIXED-GENDER UNIT WOULD IMPROVE SEXUAL SAFETY?		
	N	%
No	35	44.9
Neutral / Unsure	27	34.6
Yes	16	20.5
Total	78	100.0

that having a men-only patient lounge on a mixed-gender unit would improve sexual safety. Approximately another third of respondents were neutral or unsure. The primary reasons why these two groups of respondents did not think it would improve sexual safety were focused on their observation that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Only 20% of respondents were in favor of a men-only lounge and provided few reasons.

Public Psychiatric Hospital Findings.

Ten of the 24 public psychiatric hospitals that were contacted responded to the email inquiry. Of the 10 replies, all but 1 have civil acute units at their facility; the civil units at the 1 other facility that replied has an average length of stay of 5 years and, therefore, cannot be considered to be

acute. Of the 9 public hospital respondents, none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Some of the hospitals shared that patients identified at increased risk for dangerous behaviors are on a heightened level of observation and monitoring to reduce opportunity for acting out. Some of the hospitals operate a psychiatric intensive care unit to manage particularly violent or high-risk patients that, though not intended or designated as such, tends to be predominantly male.

Community Stakeholder Input

Characteristics of Respondents. Input was obtained from community stakeholders regarding the practice of having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. Input was received from 216 respondents. The self-identified breakdown was: Consumer 112 (51.9%), Family 8 (3.7%), Provider 35 (16.2%), Advocate 37 (17.1%) and Other (e.g., human service, corrections, law enforcement) 24 (11.1%). Some individuals checked more than 1 box. The reply was counted in the order of respondent type above to try to reflect those respondent types more likely to have had direct experience with acute psychiatric inpatient services and operations. Because this respondent classification is approximate, findings are summarized for the total group of respondents, with any trend differences between respondent types informally noted.

Content Analysis and Main Categories. The responses to each of the two questions posed were sorted into those citing primarily advantages of mixed and single-gender unit arrangements, and those citing primarily disadvantages. The advantage and disadvantage groups of comments were then further divided into major content categories based on the main ideas expressed in those comments. Included in the content tables are responses illustrating those main ideas. The questions asked for respondents' thoughts about, not necessarily mutually exclusive preference for, the two types of gender-unit accommodations. Indeed, a number of respondents who offered positive comments about single-gender accommodation also offered positive comments about mixed-gender accommodation. It is important to interpret the summary of opinions with caution due to limitations associated with the collecting of this input. The information was obtained through an open invitation for input, not based on systematic sampling procedures.

Opinions about Mixed-Gender Units. With respect to the first question on men and women patients residing on the same acute inpatient units, approximately 47% of respondents cited predominantly advantages, and approximately 53% cited predominantly disadvantages. The respondents who were noted to emphasize more advantages over disadvantages of mixed-gender units tended to be consumers and families. Advocates and other respondents were more skewed in their focus on disadvantages as compared to advantages.

Comments citing advantages of mixed-gender units fell into the two main categories of *Therapeutic Recovery Environment* and *Quality of Care & Patient-Centered Treatment*. A third category was comprised of *Nonspecific* positive comments. The categories and illustrative responses are summarized in Table 17 below.

Table 17. *Community Input on Advantages of Mixed-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ Quality of interpersonal interactions ❖ Impact on overall treatment milieu ❖ Practice standards and availability	QUALITY OF CARE & PATIENT-CENTERED TREATMENT ❖ Focus on safety and quality of care ❖ Role of staff, supervision and training ❖ Screening and treatment for vulnerability/risk
• Healthy environment realistic to everyday interaction; should be reflective of society; hospital experiences should mimic the community and help patients cope with the real world they will return to • Should have opportunity to learn from men and women, share experiences; healthier and promotes recovery • Adults who are not a threat should have access to the least restrictive and most integrated treatment environment; been on coed inpatient units before and had no problems as long as there is supervision • Better to be in a natural setting, not prison-like, when in a crisis • Standard of care for most hospitals as long as adequate supervision; realistic approach with screening and monitoring processes; refer to best practices for guidance and determining beds for inpatient facilities	• Question whether mixed gender is really the core cause of problems vs. interrelated issues of adequate staffing, skills and prevention of violence in general; violence is usually related to staffing, observation of and interaction with patients and absence of a recovery focus; main concern is safety and gender mix doesn't matter – people can be violent against their same sex, too • Segregation by gender doesn't fix the problem or promote resilience – the problem is staffing, supervision, programming; better and easier as long as enough trained staff to oversee the unit; with proper supervision, the practice is quite acceptable as long as potential for violence is not high – anyone displaying questionable behavior toward others is removed or closely supervised • If use trauma-informed care as a standard, it won't matter how we house patients – needs of patients should be indicators of units to be placed on, no one size fits all in recovery; appropriately assign patients to units for benefit of treatment, not just restriction of freedom • Issue is not gender but protecting people who are vulnerable or have aggressive behavior that hampers safety or recovery; need better screening and keeping more vulnerable or potentially dangerous patients under closer care; more appropriate to place by acuity; patients should be housed by severity of behavior – men assault men and women, women; put people who are scaring others in their own unit and help them get better • Don't base decisions on people's opinions but on research, site data and careful analysis – treatment of people with mental illness is not any less worthy
NONSPECIFIC ❖ Brief, general comments	
• Good idea, nothing wrong with it	

Comments citing disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. A third category was comprised of *Nonspecific* negative comments. These categories and illustrative responses are summarized in Table 18 below.

Table 18. *Community Input on Disadvantages of Mixed-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ **Quality of interpersonal interactions** ❖ **Impact on overall treatment milieu** ❖ **Practice standards and availability**	**VULNERABILITY, TRAUMA & PATIENT MIX** ❖ **Impact on overall experience of safety** ❖ **Potential for harassment, abuse and victimization of women** ❖ **Patient mix of vulnerable and dangerous**
• Can focus on recovery more; coed atmosphere counterproductive due to distractions of the opposite sex ; focus should be on behavioral issues not socialization during hospital stay; causes problems relationship-wise • Opposite sex can add stress to a difficult situation; people need to be away from opposite sex to heal • Possible fears of opposite sex that would affect rehabilitation, competition for attention and detract from treatment; would reduce further anxiety at a time of crisis and limit potential for manipulation; puts patients in uncomfortable position not conducive to recovery • Taking individuals with mental illness and putting them with dangerous people creates tension and hostility; interferes with sense of privacy, security and therapeutic outcomes • Behavior may be improved on mixed-wards but staff needs to help individuals make competent choices among treatment alternatives	• Too much risk of inappropriate behavior; patients of opposite sex may lack appropriate boundaries or are not supervised closely enough and adds to stress and possible sexual contact or abuse; patients will feel safer; dangerous situation; so no one gets hurt; potential for manipulation and intimidation by opposite sex; bad idea safety-wise • Experiencing mental illness is difficult enough, why add element of sexuality to the mix, tempt individuals with little impulse control over behavior and make work of staff more difficult; too much access to inappropriate behavior regardless of how well supervised • Unsafe/uncalming environment for those already in vulnerable state, especially females; women more vulnerable and at increased risk of harm from harassment, discomfort, abuse, assault; men give the women reason to feel unsafe • Patients are very sick and many women are already traumatized; higher proportion of females who have been physically or sexually assaulted by men and they should feel secure to facilitate treatment; could be possible with enough staff to supervise but reservation mixing vulnerable people and women with issues of past abuse who could be victimized by men on the same unit • Shouldn't put dangerous patients together with vulnerable of both genders – creates environment likely to result in sexual and physical assaults; females and vulnerable males feel safer in less triggering environment – separate hypersexual males from both sexes; women may be victims of sexual abuse or domestic violence and can be uncomfortable - men with histories of these crimes need to be separated
NONSPECIFIC ❖ **Brief, general comments**	
• Bad idea, oppose/no; should be separate; trouble waiting to happen	

Opinions about Single-Gender Units. With respect to the second question on having patients reside on all-male or all-female units, approximately 66% of respondents cited predominantly advantages, and approximately 34% cited predominantly disadvantages. Comments citing advantages of single-gender units fell into the two main categories of *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. A third category was comprised of *Nonspecific positive* comments. The categories and illustrative responses are summarized in Table 19 below.

Table 19. *Community Input on Advantages of Single-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ **Quality of interpersonal interactions** ❖ **Impact on overall treatment milieu** ❖ **Practice standards and availability**	**VULNERABILITY, TRAUMA & PATIENT MIX** ❖ **Impact on overall experience of safety** ❖ **Potential for harassment, abuse and victimization of women** **Patient mix of vulnerable and dangerous**
• Though isn't normal to segregate sexes during the recovery process, seems safe and smart; fine, if helps individuals focus on their recovery; less distraction; less stressful for healing; men and women will feel more comfortable and the recovery process more successful; should be working on their issues, getting well; less interference with therapy • May find it easier to relate to same sex; so women won't have their therapy interrupted by men; decreased anxiety and some women may not be comfortable residing with the opposite sex due to privacy and space • Could be beneficial and offered as an option based on patient preference and staff to create sense of security and patient-centered care; wouldn't have an issue with them but should be based on consumer preference then staff; some patients do fine on mixed units and some better on single-gender – ideally hospital could maybe have both types to give patients and caregivers options; mixed gender not an issue but some clients are easily manipulated or intimidated by opposite sex and may have better therapeutic stay on separate units	• Much safer; safest situation for women; protects patients and staff more effectively; female clients will feel safer with all women and have less paranoia about men • Avoids vulnerable people being taken advantage of; decreases potential for victimization between residents; segregation eliminates possibility of male on female sexual assaults • Some have been abused by opposite sex and have triggers; men won't be tempted; would make men and women who have been harassed by opposite sex feel safer; because of trauma, important for women who feel safer on all-female unit • Fine if facility can't have good screening system; first choice but problem is with severity and sufficient staff; may be circumstances that warrant mixed units though at times same-sex facilities must be mandated by staff for good of patient; hopefully, safer treatment option for men and women who are vulnerable and limited in judgment and impulse control • For particular patients whose history makes it unsafe for them to be in an environment with the opposite sex, placement on a same-gender unit may be indicated based on professional evaluation; violent patients should be kept as separate as possible from all other patients
NONSPECIFIC ❖ **Brief, general comments**	
• Makes sense; if feasible, better option; would be fine, too; would be a good change	

Comments citing disadvantages of single-gender units fell into two main categories of *Therapeutic Recovery Environment* and *Patient-Centered Treatment*. A third category was comprised of *Nonspecific* negative comments. These categories and illustrative responses are summarized in Table 20 below.

Table 20. *Community Input on Disadvantages of Single-Gender Units*

THERAPEUTIC RECOVERY ENVIRONMENT ❖ **Quality of interpersonal interactions** ❖ **Impact on overall treatment milieu** ❖ **Practice standards and availability**	**QUALITY OF CARE & PATIENT-CENTERED TREATMENT** ❖ **Focus on safety and quality of care** ❖ **Role of staff, supervision and training** ❖ **Screening and treatment for vulnerability/risk**
• Provides degree of safety while under care but doesn't reflect society and may create false security; limits experiences to share with each other and should only be by choice; can be therapeutic for men and women to be with each other; makes little sense to restrict sexes from learning from one another if goal is to reintegrate back into society; we're grown adults and should be with other people, male or female; while such units may put people at ease over safety concerns, they will tend to increase tension and hostility less prevalent on mixed units and can be counterproductive • Makes mental health recovery place more like a jail, prison-like setting; can be viewed as a move to corrections approach versus focusing more on person-centered, trauma-informed care • Archaic, based on other hospitals familiar with and where coed works out fine • Not conducive to reducing stigma; should be based on competent research and data informed judgments, not on what's popular with the public or press; problems are likely not related to gender issue – though makes for great media and political scrutiny • Not necessary for the general population – violence can occur on same-sex units as well and having a recovery focus would contribute more to a healing, safe environment in the long run than segregation	• Wouldn't focus on gender segregation – create a respectful environment, segregate troublemakers; problem isn't mixing patients of different gender but quality of care- that should come first • Issue isn't keeping people separate but supervision, trained staff and better screening to keep vulnerable/potentially dangerous people under closer care; staff need to care more and walk around to see what's going on • Treat people for their problems, not demographics, and if people can't behave acceptably among peers, they should be treated on separate units with staff to meet their special needs; no segregation of men and women – find a place for people who are most destructive instead; important to do what's best for individualized patients – one may be comfortable on mixed unit and would be nice if another with trauma had a choice • More appropriate response is to isolate high risk male patients from women rather than remove women to separate unit – conveys that sexual aggression is related to individual high-risk men and reduces stigma of being on a women-only unit; gender mix doesn't matter, male to male and female to female can be just as unsafe or violent • This approach can be used for setting up units with increased supervision of patients at greater risk for violence; better to segregate patients by degree of potential for violence with increased supervision; segregation of all patients is not needed; don't see this as an issue of male-female but rather as predatory and vulnerable, regardless of sex
NONSPECIFIC ❖ **Brief, general comments**	
• Not good idea; like coed better but would be fine; not much benefit; fine but not necessary	

DISCUSSION

The purpose of this study was to conduct a detailed evaluation of the current practice of mixed-gender units at BHD, specifically in the context of patient sexual safety. To this aim, the study assessed BHD inpatient perceptions of safety on the current mixed units as well as preferences for single-gender units; examined BHD staff perceptions of patient sexual safety on the inpatient units, effectiveness of current safety practices and attitudes toward gender unit options; communicated with other public psychiatric hospitals regarding the gender configuration of their acute adult units; and obtained input from community stakeholders on male and female patients residing on the same and single-gender units, and recommendations to improve quality of care in the acute hospital.

BHD Patient Perceptions

Most of both male and female patient respondents reported feeling somewhat or very safe on a mixed-gender unit. The majority of them explained that their feeling safe related to positive interpersonal interactions and denial of concerns about aggression. Almost 88% of all patient respondents reported that they felt somewhat or very safe with men and women patients on the same unit. More than 90% of male patient respondents felt somewhat or very safe with males and females on the same unit. Nearly 84% of women felt somewhat or very safe with male and female patients on the same unit. The predominant explanation provided by male respondents for feeling safe centered on potentially beneficial interpersonal interactions and denying aggression was a concern, although some respondents did fear there would be more fights on an all-male unit. They also cited that unit and security staff and their own self-advocacy contributed to their feeling safe. The predominant explanation provided by female respondents feeling safe focused on the positive interpersonal interactions of having male patients on the unit and feelings of being safe from aggression. These women also cited that unit and security staff and their own self-advocacy contributed to their feeling of being safe on the unit. The small percentage of men and women patients who felt unsafe on a mixed-gender unit was concerned about safety from aggression.

Respondents indicated that they would feel safer on a mixed-gender unit with improved interpersonal interactions and with unit and security staff presence, behavior and monitoring. For male patient respondents, most indicated that what would make them feel safer was concerned with unit and security staff presence, behavior and monitoring. For women patient respondents, most indicated what would make them feel safer were improvements in overall interpersonal interactions and unit and security staff presence, behavior and monitoring.

Almost 50% of male and female patient respondents did not prefer to be on a same-gender unit. The primary reason cited for this finding was the perceived value of interpersonal interactions between patients and the negative impact a single gender unit would have on these interactions. A secondary, less predominant, reason was the potential for more aggression on an all-male or all-female unit. Only 15% of male patient and 29% of female patient respondents indicated that they would prefer a same-gender unit if it were available. The women who did prefer an all-female unit cited the positive impact of female-to-female interpersonal interactions, and did cite concerns about male aggression on a mixed-gender unit. Thirty percent of both male and female respondents were unsure of their preference for a same-gender unit. Of note, however, were

their explanatory comments that cited mainly positive features of interpersonal interactions with both men and women on a unit.

Only one-quarter of the total of male and female patient respondents indicated that they would feel safer on a same-gender unit. A higher percentage of men would feel less safe (38%) than more safe (23%) on an all-male unit. The men who said they would feel less safe on a same-gender unit were mostly focused on the potential for aggression. Male respondents who gave reasons for feeling safer on a same-gender unit cited interpersonal benefits. A slightly higher percentage of women responded that they would feel less safe (32%) than more safe (29%) on an all-female unit. Women who said they would feel less safe on a same-gender unit were mostly focused on the potential for interpersonal conflict between women. Those who responded that they would feel safer on a same-gender unit cited safety from aggression and expected improvements in interpersonal interactions.

Women did not express a definitive preference for a women's-only lounge to be made available on the unit. Of the women who were opposed (39%) to a women's-only lounge, the majority of their reasons cited an expected negative impact on interpersonal interactions. The remainder of their comments cited expected verbal and physical aggression between women. Of the women who would prefer (32%) that there be a women's-only lounge on the unit, most reasons centered on an expected benefit in their interpersonal interactions and shared communication with other women. Only a few comments referenced a vague feeling that they would feel safer. The comments by the unsure or neutral group (29%) of women emphasized no problems with the current arrangement of a shared lounge with men on the unit.

BHD Inpatient Staff Perceptions

Most staff respondents thought that men and women patients are somewhat or very sexually safe residing on the same unit. More than 60% of staff responding to the survey thinks that men and women patients are somewhat (52%) or very (9%) sexually safe residing on the same unit. Nearly 40% of staff respondents think that men and women patients are somewhat (27%) or very (12%) sexually unsafe residing on the same unit. Staff respondents' sexual safety concerns for both men and women residing on the same unit were related to the individual's vulnerability to sexual harassment, intimidation, exploitation and/or abuse, and the unit configuration, staffing pattern, and patient mix. Staff respondents indicated that most (53%) of their concerns for women patients' sexual safety were related to the women's vulnerability to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for women on the unit, and identified concerns about women initiating or provoking sexual activity. Staff respondents indicated that most (46%) of their concerns for men patients' sexual safety were related to some men being vulnerable to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for men on the unit, and identified concerns about men initiating or provoking sexual activity. Staff respondents identified that both men and women raised sexual safety concerns about vulnerability to sexual harassment and intimidation; being concerned about personal boundary violations; and general (nonsexual) safety concerns. Nearly half of staff respondents said that men usually expressed no sexual safety concerns, and nearly one-quarter said women did not raise any sexual safety concerns.

Current practices were predominantly rated by staff respondents as being somewhat effective for ensuring the sexual safety of patients on the unit. Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective. In regard to other suggestions to improve sexual safety on the mixed-gender units, the largest percentage (32%) of staff respondents suggested an improved staffing pattern. Additional suggestions included better supervision and training of staff, better teamwork and hospital configuration of patient mix.

Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. This group of respondents thought that this would reduce or eliminate sexual harassment and contact and could better serve the subset of women with sexual abuse and trauma issues. Unsure or neutral respondents cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units and were concerned about not being able to control or prevent all sexual contact, including same-gender activity. Those not viewing the unit as being helpful were also concerned about same-gender sexual activity and felt that patients need to function in a normalizing environment similar to the community. Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could particularly help high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those respondents that were unsure or not in favor of an all-men's unit cited concerns about the unit being more violent than a mixed-gender unit, that vulnerable males may be abused, and same-gender sexual behavior.

Only about one-quarter of staff respondents were in favor of a women-only lounge, citing it as a safe and secure place for women to go to when feeling threatened. Those staff respondents not in favor or unsure indicated that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Most staff respondents were unsure or did not think that having a men-only lounge on a mixed-gender unit would improve sexual safety. They indicated that inappropriate sexual behavior occurs in places other than lounge areas, and the area would require close monitoring by staff. Only one-fifth of staff respondents were in favor of a men-only lounge.

As for staff preference for type of unit work assignment, nearly half of staff respondents would not prefer to work on an all-women's unit. Primarily this was due to their concerns about having to deal with stressful demands, and secondarily their viewing the benefits of a mixed-gender recovery environment that reflects the community to which patients will return. Similarly, most staff respondents did not prefer or were neutral or unsure about working on an all-men's unit due to the potential for aggression and violence. Most staff respondents preferred to work on a mixed-gender unit due to the variety of patient needs and personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community.

Public Psychiatric Hospital Practices

Information from 9 Midwest public psychiatric hospitals with civil acute units revealed that none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Practices some hospitals use for patients identified at increased risk for dangerous behaviors include heightened levels of observation and monitoring to reduce opportunity for acting out, as well as a psychiatric intensive care unit to manage particularly violent or high-risk patients.

Community Stakeholder Input

Community stakeholders shared a variety of responses about having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. This wide range of opinions is to be expected as some respondents are more likely to have direct experience with BHD acute inpatient services and/or acute hospital operations, whereas those groups of respondents extending further into the community have more a indirect and varied information base. Nearly half of respondents offered comments citing advantages of mixed-gender units, and slightly more than a half cited reasons against such an arrangements. Consumers and families tended to be more favorable in their opinions of men and women on the same units, whereas advocates and "other" type respondents were more skewed in their focus on disadvantages as compared to advantages. The advantages of mixed-gender units fell into the two main content categories of *Therapeutic Recovery Environment* (beneficial effect on interpersonal interactions and treatment milieu, and practice standards) and *Quality of Care & Patient-Centered Treatment* (core issues of quality of care, staffing/supervision and screening/treating of most dangerous/vulnerable). Disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* (negative impact on interpersonal interactions and treatment milieu) and *Vulnerability, Trauma and Patient Mix* (impact on safety, potential for harassment, abuse and re-traumatization of women and patient mix of vulnerable and dangerous).

With respect to having patients reside on all-male or all-female units, approximately two-thirds of respondents shared benefits of gender segregation and one-third focused predominantly on disadvantages. The advantages of single-gender units fell into the same two main categories, described above, as did the disadvantages of mixed units: *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. Likewise, responses focusing on disadvantages of single-gender units fell into the same two main categories, described above, as did the advantages of mixed units: *Therapeutic Recovery Environment* and *Patient-Centered Treatment*. Of interest is that a number of respondents, including consumers, regardless of their opinions about unit gender mix, argued that gender should not be the primary factor taken into consideration in determining placement, and that quality of care and recovery focus will not be adequately addressed by resort to single-sex segregation. Other factors, such as severity of illness and risk of violence, are equally if not more important in creating a safe and therapeutic environment.

LIMITATIONS

This study is limited by the sample of respondents who participated in the various phases. BHD inpatients were sampled over a restricted period of one month and were self-selected. Their opinions may not be necessarily representative of all BHD acute inpatients. Participants may have felt unwilling to appear critical of care while in the hospital. BHD staff respondents were self-selecting and the generalizability of their opinions is limited by the overall response rate. In addition, participants might have had particular concerns around issues of patient sexual safety and gender configuration of acute units. The findings on single-gender units at public psychiatric hospitals represent the practices of those facilities that responded. It is unknown if those who did not respond failed to do so because they had no experience with single-gender units to share, or due to other customary reasons. The process of obtaining input from community stakeholders was an open request for opinions and was not based on systematic sampling procedures. As such, the opinions only represent those individuals who chose to respond and may not be representative of community stakeholders in Milwaukee County as a whole. Additionally, it is unknown to what extent those who provided opinions have knowledge of the operation of the BHD acute inpatient units, or psychiatric inpatient units in general, and whether they have more or less favorable perceptions of the services provided on these units. For example, some comments indicated that the respondent had erroneous assumptions about the acute inpatient units (e.g., units could be single-gender and patients meet in a coed TV room and dining room; male and female patients shouldn't live together but have opportunity to interact at coed social and recreational activities).

RECOMMENDATIONS

Based on this extensive study, The Gender Unit Work Group recommends a configuration of the 4 Acute Adult Inpatient Units that would create a 12-bed ***Intensive Treatment Unit (ITU)*** that is expected to be predominantly male, a combined ***Women's-Option/Med-Psych Treatment Unit***, and 2 remaining mixed-gender units designated as ***General Acute Treatment Units***. The new configuration of the Acute Adult Inpatient units and bed capacity would be as follows:

ACUTE ADULT UNIT CONFIGURATION	
• Intensive Treatment Unit (ITU)	12 beds
• Women's-Option/Med-Psych Treatment Unit	24 beds
• General Acute Treatment Unit	24 beds
• General Acute Treatment Unit	24 beds
NEW CAPACITY	84 beds

Unit Configuration Model

The ***Intensive Treatment Unit*** would be designated for patients with high risk for aggression and violence, including sexual acting out. The ITU can be presumed to be predominantly, if not

always, all male. Most women with elevated risk of violence can usually be managed in the general population with enhanced monitoring. Though the ITU concept will need to be further developed, the Work Group is firm in its stand that the unit not be considered nor referred to as a "secure" unit [all BHD acute units are secure and locked], a "forensic" unit [BHD has no formally designated forensic services or specialty nor is it in a position to add such] or a "detention" unit [BHD is not a correctional facility]. The ITU must have reduced beds, as is the practice in other hospitals with such units. We recommend the ITU have a capacity of 12 beds. The implication is that BHD would have to be prepared to reduce its overall Acute Adult Inpatient bed capacity by 12 beds to a total of 84 beds. The benefit of the ITU is that it achieves separation, from the general acute patients, of predominantly those male patients with higher violence potential. This separation addresses the main safety concerns of staff and patients, especially vulnerable male patients and most female patients.

The needs of women patients, however, are more complex due to higher rates of trauma and may not be fully resolved by segregation of high-risk men. For this reason, the Work Group recommends that one unit be designated as a combined ***Women's-Option/Med-Psych Treatment Unit.*** One of the current adult units has historically been partly dedicated to treating geropsychiatric patients and younger patients with complex medical-psychiatric disorders. BHD Acute Adult Inpatient admission data from 2009 – 2010 YTD were reviewed using an age cut-off of 60 and older (though not "geriatric" it errs on side of caution to allow for younger med-psych patients). At any given time, there are approximately 9 "geriatric/med-psych" patients on this unit. Per BHD current acute inpatient gender breakdown (59.8% male and 40.2% female), this equates to 5-6 men and 3-4 women. With a unit capacity of 24, this leaves 15 beds that are anticipated to be available as Women's-Option beds. These beds would be prioritized for female patients at heightened risk of vulnerability to inappropriate sexual behavior, abuse and violence. Assignment would be based on medical staff assessment or patient choice, depending on clinical safety needs and bed availability. Though there will be a minority of generally older male patients on this unit, the anticipated risk is lower and can be planned for. With a new overall bed capacity of 84 beds, the female beds on this unit (Women's-Option plus Med-Psych beds) would equate to more than half of the total estimated adult female inpatient beds.

The remaining two units would be mixed-gender ***General Adult Treatment Units***, with separate bedroom hallways for male and female patients as is currently the case. The separation of those patients with highest potential risks of both violence and vulnerability would, hopefully, allow these units to better serve the general patient population in a normalizing, therapeutically focused milieu which many patients value.

Rationale

Segregation and mixing of genders is not an all or nothing approach. It is not about one answer. It is a process. There are reasons for and reasons against each option. To some, segregation by gender of all of the units seems to be the obvious choice. However, the Work Group was unanimous in its conclusion that, though appearing progressive on the face of it, this approach is compartmentalized and rigid. The proposed configuration offers a blended model that covers the main bases in a thoughtful, flexible and pragmatic way. It is not one-size-fits-all. It offers a more individualized, needs-based, trauma informed care approach than simple division by gender. A strong impression was given by a number of patients and consumers that a recovery focused, de-stigmatizing and normalizing treatment environment is desirable to them. The model addresses many of the concerns of BHD staff, patients, community consumers, and stakeholders and

coheres with accepted practices of public psychiatric hospitals. Other than requiring a 12-bed reduction in overall Acute Adult Inpatient capacity, the recommendation is feasible and offers flexibility with census management. It acknowledges gender-based safety concerns while affirming the current improvement practices already being implemented.

Next Steps and Implications

The recommendation of the Gender Unit Work Group is advisory to the BHD Administrator. Should it receive endorsement, the proposal will need to be presented to the full BHD clinical and administrative-finance leadership teams. Then a detailed planning process will need to be undertaken, addressing considerations in three main domains:

1. Human Resource – Determination of staffing composition and pattern of the ITU; staff selection (preference is for selection by skill versus seniority) and labor union issues; Medical Staff recruitment to fill vacant acute inpatient positions
2. Program Development – Development of model for ITU and Women's-Option units, admission/transfer criteria, programming needs, staff training
3. Physical Environment/Operations – Plans for reduction in bed capacity and census management, physical environment audit of proposed ITU unit location and completion of any necessary environmental modifications

To allow for the planning required, the estimated timeline for implementation of the unit configuration recommendation is during the Quarter 3 of 2011 (July to September). Regardless of the final decision, BHD shall continue the current practices, policies and guidelines in place to maintain a safe, therapeutic unit environment. Patient risk assessment, interdisciplinary treatment planning and effective patient monitoring processes are essential components. Staff supervision and active patient intervention are recognized as factors that can contribute to reduction of violence of all types. Peer specialists and client rights specialists provide essential advocacy services to help represent patient interests and support dignity, respect and autonomy.

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APPENDIX A

Contents

I. BHD Acute Inpatient Questionnaire – *Acute Adult Inpatient Gender Unit Preference Survey*

II. Content Analysis of Male and Female Patient Responses to Open-Ended Items

ACUTE ADULT INPATIENT
GENDER UNIT PREFERENCE SURVEY

We would like to know your opinion about men and women being on the same unit here. Your answers are confidential and will not influence the services you receive.

Date of Survey: _____/_____/2010 **Date of Admission:** _____/_____/2010

Gender: _____ **Male** _____ **Female** **Race/Ethnicity (check one):**

Age: _____ **years** ____ **African American** ____ **White/Caucasian**

Acute Unit ____ **43A** ____ **43B** ____ **Hispanic/Latino** ____ **Native American**

____ **43C** ____ **43D** ____ **Asian/Pacific Islander** ____ **Other**

		NO	UNSURE/ DOESN'T MATTER	YES
1.	Would you prefer to be on an [*say same gender as pt.*] all-men's/all-women's unit if it were available?	1	2	3

➢ 1a. Explain why.

		VERY UNSAFE	SOMEWHAT UNSAFE	SOMEWHAT SAFE	VERY SAFE
2.	How do you feel with men and women patients on the same unit?	1	2	3	4

➢ 2a. Explain why.

➢ 2b. What would make you feel safer?

		LESS SAFE	NO DIFFERENCE	MORE SAFE
3.	How would you feel if there were all [*say same gender as pt.*] men/women patients on the unit?	1	2	3

➢ 3 a. Explain why.

THE NEXT QUESTION IS FOR WOMEN ONLY:

		NO	UNSURE/ DOESN'T MATTER	YES
4.	Would you prefer there to be a women-only patient lounge available on the unit?	1	2	3

➢ 4a. Explain why.

THANK YOU FOR COMPLETING THIS SURVEY!

Question 1. Would you prefer to be on an all-men's unit if it were available? (1a.) Explain why.		
NO	**UNSURE/DOESN'T MATTER**	**YES**
SAFETY FROM AGGRESSION		
• Less fights if mixed – 2 • M would kill and fight each other – 2 • Some M are homosexual so would not make us safe • Don't feel comfortable around a lot of guys	• W touching other people too much • Could be sedated and clothes half off and lead to charges of indecent exposure • M trying to mess with the girls • Because what's going on in the media, pt had sex with a W and had a baby • Staff should be watching what's going on so pts are safe	
INTERPERSONAL INTERACTION		
• Want to be around M and W – 7 • W give a different point of view, can learn from them – 3 • In real world, have to deal with multiple genders – 2 • Integration of M and W facilitates healing • Meet new people, socialization – 5 • Different people to talk to – 5 • Like to see variety of people on unit – 3 • W have soft touch, more understanding • Like to see a smiling face • Get along better with W • Pts need help • Keep to myself • M are rude • Pick up bad habits • Don't want to look at all M all day • Boring	• Nice to have a mix of cultures • Like to be around different people • Nice to see a pretty face – 2 • People need to get along – 2 • W are trouble - 2	• Everyone would have their own space • Don't feel appreciated
OTHER		
		• Get mixed emotions • Poison in food

Question 1. Would you prefer to be on an all-women's unit if it were available? (1a.) Explain why.		
NO	**UNSURE/DOESN'T MATTER**	**YES**
SAFETY FROM AGGRESSION		
• There haven't been any problems sexually with M and W on the unit • W would just fight • Because W are always arguing over hair products	• M are not going into W's rooms, so I don't have fears about my safety	• Men try to intimidate W • Sometime I feel safer when I'm around all W • Because you have to watch what you're wearing with all M around • M act out more – I was called a derogatory name this morning by a M • M might swear at us or hurt us • Because M might want to have sex, sometimes it makes me nervous to be around M • Lot of interactions between the sexes, at times disruptive to safety and treatment
INTERPERSONAL INTERACTION		
• Good to meet new, different people, I like a variety of people – 5 • Would like to meet M and W, prefer M and W, been with M and W all my life – 7 • Like having input/talking to both genders, hearing M talk and interacting with them – 4 • You need to talk to M and give each other feedback, can teach each other lessons - 2 • Don't get along with W very often, W can't get along with each other – 3 • W are catty, get into "he said she said" kind of talk, are too bitchy when they get together as a group, are not as nice to each other as they should be, would nag at each other and try to control – 5 • They think they know everything and talk too much • W like to form cliques	• I like to see different people very day, like to see a mixture of people – 2 • We're all human and should be around each other and get along, as along as we all get along – 2 • We're all treated the same and here for the same reason • I can get along with anybody, I'm flexible – 2 • I don't let M bother me most of the time • I haven't had any problem with anyone here • Doesn't matter, I'm a little old lady • W are louder than M • All the hospitals I've been in have M and W on the same unit so I can't compare to anything else	• Feels better with all W, personally like W better than M – 2 • Get along better with W than M – 3 • W are easier going, fun – 2 • W have a lot in common, could talk about our children and women's issues • More privacy with just W • Lot of interaction between the sexes, at times it's healthy • M are devils
OTHER		
• Cause M and W wouldn't get along		• Because I can change without M being around • Neither, I'd like to go home

Question 2. How do you feel with men and women patients on the same unit? (2a.) Explain why.	
VERY UNSAFE/SOMEWHAT UNSAFE	**SOMEWHAT SAFE/VERY SAFE**
SAFETY FROM AGGRESSION	
• Would be a fight – 3 • Some W touching people all the time • Other people can get into arguments • Pts sometimes pour coffee on another pt	• Some M make me feel safe • No one gets hurt, no fighting or killing • W usually not violent, though some can be • Never know when someone's going to snap – 2 • Would be lots of fights with all M, More M will be trouble other pts try to start fights – 3 • Pt threw coffee on me
INTERPERSONAL INTERACTION	
	• M and W get along, communicate – 6 • We can talk it out – 3 • + Here to get help, focus • W tell what they see • Depends on people on the unit and attitudes • Both M and W can be moody • W over-exaggerate more than M, like to fuss – 2 • Some W approach you • Some W have a bad attitude
UNIT AND SECURITY STAFF	
	• Because of social worker and nurses • Staff watch people • Feel protected by CNAs • Security on unit • Staff and security act fast if pts get aggressive and loud; staff able to handle any problems – 2 • Staff are busy and sometimes can't get to us right away • Staff tease pts too much
SELF ADVOCACY	
	• I walk away, don't argue with people • I know how to separate myself from people - 2 • I'm a huge guy

Question 2. How do you feel with men and women patients on the same unit? (2a.) Explain why.	
VERY UNSAFE/SOMEWHAT UNSAFE	**SOMEWHAT SAFE/VERY SAFE**
SAFETY FROM AGGRESSION	
• When it's all girls, I feel safer • M and W like to fight each other • M are devils • Besides being called a name this morning, some of the M try to go down the W's hallway • Because people are yelling for help at night and I don't know what's happening to them • There's people here doing things to me that make me feel like they don't want to be around me – both pts and staff	• M don't try to do anything to the W on the unit; don't have problems with the M, haven't shown themselves to be predators towards me; no one tried to come in my room and there's a no-touch policy – 3 • No one would touch me, no pt would touch each other • I haven't seen any violence since I've been here; no one has tried to do anything bad - 2 • M would take notice if a W was being mistreated and would do something about it; the M will defend us W, being around M makes me feel safe – 3 • Because when W try to get in a fight, the M pts will try to help break it up • A W could punch me for no reason as could a M • I feel threatened by some of the M – 2 • Sometime, depending on the person there's been sexual contact in the past • Some of the W make me feel unsafe also, if they are aggressive or intimidating • I get scared sometime • Depending on their illness, all W on the unit would make me feel safe • The W would protect me
INTERPERSONAL INTERACTION	
• Because of different age groups; young people should be together and old people with each other because young try to get you caught up in their issues or to do things for them	• M and W need to get along with each other – 2 • M and W get along better • Used to being around M and W – 2 • We should have different kind of people from all over, never know how they will respond to you – 2 • The M don't bother me, they are not mean, I don't have any problems, M are nicer to W here than on the street – 5 • M will watch over W, we have each other's back – 2 • M always like to talk to the W, we can work together – 2 • Don't know the other people very well, matter of meeting them, talking and making friends • I get along with anyone but need younger pts on unit • Sometime think people are my friend but they're not, so feel somewhat safe
UNIT AND SECURITY STAFF	
	• If you have a problem, you can tell the nurse and they take of it • Staff manages behavior by redirecting people as needed • Staff have everything under control and there's security staff to help if necessary • It's improved since CNAs are sitting in different areas of the • Pts who need to be watched are supervised more carefully • People are always walking around
SELF ADVOCACY	
	• I feel safe with anyone – 2 • I will stand up for my rights
OTHER	
• I don't like being here - 2	

Question 2. How do you feel with men and women patients on the same unit? (2b.) What would make you feel safer?	
VERY UNSAFE/SOMEWHAT UNSAFE	**SOMEWHAT SAFE/VERY SAFE**
UNIT AND SECURITY STAFF	
• Security • Nobody make me feel safer	• Security – 19 • Staff – 11 • The Zone – 3 • Staff need to get their act together, do their jobs – 6 • Don't trust security – 2
INTERPERSONAL INTERACTION	
• More M - 2	• Respect and boundaries, caring, if patients could get along – 2 • Family and friends - 3 • No threats • If people wouldn't steal
SELF ADVOCACY	
• I will make myself feel safe	• I know how to protect myself – 3 • Myself - 2 • I feel safe already – 2
OTHER	
• Sheriff • No poison	• In my own house, not in hospital with strangers – 2 • Access to personal belongings, music • Good environment • Sheriff • God • Contact with Social Security Office because of concern about my benefits

Question 2. How do you feel with men and women patients on the same unit? (2b.) What would make you feel safer?	
VERY UNSAFE/SOMEWHAT UNSAFE	**SOMEWHAT SAFE/VERY SAFE**
UNIT AND SECURITY STAFF	
• Security • Staff could help people get along	• Staff, my nurse, doctors – 12 • Security – 12 • CNA • Should have more than 1 CNA on each unit per shift to take care of the M • Make certain staff give me the right medication so I can get well • Staff should pay more attention to the pts, people who are more sick – 2 • I'd feel better if they'd control the noise; I feel threatened when people yell, staff should have them in their room • If staff would treat us the way they want to be treated, with more respect • Sometime staff makes us feel invisible when we go to the desk, they ignore us when we have important questions
INTERPERSONAL INTERACTION	
• If people wouldn't get angry and swear • People respecting their elders • If M and W have separate units; that M are out of my life – 2 • More people who are here to get professional help • Curtains dividing the rooms so no one is watching you and you have some privacy to heal • I couldn't get out of my room this morning and that makes me uncomfortable	• No issue with the M • I need to get to know people better • Family - 2 • W friends • Mixing of genders is an issue at times • The M, not staff; Feel the pts will help me instead of staff - 2
SELF ADVOCACY	
	• Myself – 2 • Take my medications on time – 2 • They can talk to me but not touch me, touching my hand would be OK • Mind my own business
OTHER	
• Sheriff and police	• Cops - 2 • I feel safe now - 3 • A cleaner environment • God • Nothing – 3

Question 3. How would you feel if there were all men patients on the unit? (3a.) Explain why.		
LESS SAFE	**NO DIFFERENCE**	**MORE SAFE**
SAFETY FROM AGGRESSION		
• Fights, someone will get killed – 18 • Sexual assaults, M get "funny" ideas– 3 • M like to start trouble	• I wouldn't feel threatened - 3 • Mixed feeling – men carry weapons	• No one would touch you • I can defend myself • M don't start arguments like W
INTERPERSONAL INTERACTION		
• Enjoy W's company; wouldn't have emotional help from W, more compassionate – 2 • M have hidden agendas, don't trust them • I have nothing to offer a M • Would feel like prison • Would need more activities to keep M calm	• I get along with everyone – 4 • Both M and W can get along – 2 • I walk away from drama - 2 • Everyone's docile • What matters is if someone cares • All are strangers anyway	• More comfortable • Could get to know each other and do things together • M are more reliable • M are more protective • Women are nosy, they watch everything that goes on • Prefer M and W
OTHER		
		• No poison

Question 3. How would you feel if there were all women patients on the unit? (3a.) Explain why.		
LESS SAFE	**NO DIFFERENCE**	**MORE SAFE**
SAFETY FROM AGGRESSION		
• They like to fight and scream at each other; lot of W get into cat brawls; there'd be a lot of bruises on me – 6 • When I get around a lot of W, they threaten to hurt me	• M on this unit have not been harmful in any way; I don't feel threatened – 2 • We all need help and unit staff or security will intervene if needed – 2 • Anyone can have an acting out behavior problem • If a W attacked me, I could handle her • I don't argue with people • Staff knows what they're doing; if anyone acts out they intervene	• W don't fight; not as aggressive as the M; may form cliques but usually don't get violent – 3 • No M could hurt me; don't want any M making advances toward me – 2 • Don't feel afraid but feels like all W unit would be safer • W protect each other
INTERPERSONAL INTERACTION		
• Need mixed gender, need the openness of both M and W, all our peers – 2 • More tension with all W, too many W get on my nerves, W don't get along very well, they talk about each other or gossip, too many young women get upset about too many things, like doing things better than them – 5 • Don't like to be around all W, don't get along with W like I do M – 2 • W get bitchy when they get their period – 2 • W can be loud and domineering; having M around keeps them somewhat under control – 2 • Have less privacy with W around and boundary issues, they think they have the right to invade your personal space	• Wouldn't mind, I like W also – 5 • W should participate more, we should stick together but we don't • I don't have to worry about them • M and W are good together; both friendly with me – 2 • Some of the M are enjoyable	• All W stick together, we can watch one another – 2 • I can try to trust W, it's harder to trust M • Has to do with wearing appropriate clothing when M are around • I keep to myself • Depends on type of illness W has, some are more serious
OTHER		
• Men are like animals • I will not like it on unit if we share with M		

Question 4. Would you prefer there to be a women-only patient lounge available on the unit? (4a.) Explain why.		
NO	**UNSURE/DOESN'T MATTER**	**YES**
SAFETY FROM AGGRESSION		
• W like to argue and M don't • W like to fight; catty girls would get in a fight and staff couldn't get to us to intervene – 2 • W are jealous of each other an they want what you've got and they'll try to get it • M might try to protect us from others who try to hurt us	• Don't want to go in any room with someone alone, M or F	• Feel safer with all W in the room; would make me feel more safe; safer if I could go in a room without M and watch TV – 4
INTERPERSONAL INTERACTION		
• Need a mixture of M and W; still want to have a conversation with both M and W pts; like to meet different people – 5 • Don't like all W; not all W like other W; W don't get along well - 5 • Both genders are people; M and W should like each other and be together; OK the way it is – 4 • Feels more normal to have M and W around – keep it real, like in the community; healthier environment, like the rest of society and the world; M like to watch TV with us – 3 • Most of the M mind their own business • Stupid idea, only so much room on the unit, we should just all get along • If staff is watching the pts, there shouldn't be need for a separate lounge	• I will talk to all W • Works fine the way it is, don't care if M and W are in the same room – I'll talk to either; extra lounge would be a waste of money – 3 • Haven't had a problem with any of the M, people have been respectful; There are some nice and interesting M we like to talk to - 2	• W have more in common and could talk about things that don't concern M; we could talk about different issues, problems with just W; can talk about things that I can not tell M; can talk about personal business - 6 • I get along better with W, like to hang out with W better, W are friends – 4 • W might want to be alone with no M around – 2 • I trust W more than M • Good idea, by trying it they could observe if W liked it
OTHER		

APPENDIX B

Contents

I. *BHD Acute Adult Inpatient Staff Survey: Patient Sexual Safety*

II. Content Analysis of Staff Responses to Open-Ended Items

ACUTE ADULT INPATIENT STAFF SURVEY: *PATIENT SEXUAL SAFETY*

The BHD Gender Unit Work Group would like to know your opinions about the ***sexual safety*** of men and women patients residing on the same Acute Inpatient Units here. **For the purposes of this survey, SEXUAL SAFETY refers to preventing and managing sexual behavior between patients – including sexual contact, harassment, exploitation, intimidation and assault.**

PLEASE RETURN SURVEY TO DR. MARY KAY LUZI -CENTRAL ADMINISTRATION BY SEPTEMBER 30, 2010 via Inter-Office Mail or Placement in Locked Mail Box Outside Administration Suite 1046. *Your answers are confidential. Only original printed surveys are to be used. Thank you for your time and participation. We value your input.*

Gender: _____ **Male** _____ **Female**

Years of Employment at BHD: _____ **Years**

Years of Employment in Acute Adult Inpatient: _____ **Years**

Position :
- ____ **Medical Staff (MD/PhD/APNP)**
- ____ **Social Work/Rehab Services**
- ____ **Registered Nurse**
- ____ **Certified Nursing Assistant**
- ____ **Peer Specialists**
- ____ **Other (e.g., Dietician, Chaplain)**

CIRCLE THE NUMBER IN THE BOX THAT BEST DESCRIBES YOUR ANSWER

		VERY UNSAFE	SOMEWHAT UNSAFE	SOMEWHAT SAFE	VERY SAFE
1.	How sexually safe do you think men and women patients are residing on the same unit in our hospital?	1	2	3	4

- 1a. What sexual safety concerns do you have for women patients on the unit?

- 1b. What sexual safety concerns do you have for men patients on the unit?

- 1c. What sexual safety concerns have women patients raised?

- 1d. What sexual safety concerns have men patients raised?

**** IF YOU HAVE NO EXPERIENCE WITH AN ITEM, LEAVE IT BLANK.**

2.	How would you rate the effectiveness of these current practices for ensuring the sexual safety of patients on the unit?	VERY INEFFECTIVE	SOMEWHAT INEFFECTIVE	SOMEWHAT EFFECTIVE	VERY EFFECTIVE
2a.	Assessments by PCS & Inpatient MD/PhD of special risks	1	2	3	4
2b.	Recovery Planning special risks treatment objectives & interventions	1	2	3	4
2c.	Patient Education on sexual contact policy	1	2	3	4
2d.	Unit Zone Surveillance system	1	2	3	4
2e.	Morning Report with both treatment teams represented	1	2	3	4
2f.	Cross Shift communication of special risk patients	1	2	3	4
2g.	Behavior Observation monitoring for special risks	1	2	3	4
2h.	Bedroom Hallways separate for men & women; no bed assignment beyond fire doors for women	1	2	3	4
2i.	Locked Community Bathroom	1	2	3	4
2j.	Therapeutic Groups	1	2	3	4
2k.	Electronic Video Monitoring of unit	1	2	3	4
2l.	OVERALL EFFECTIVENESS of current practices	1	2	3	4

- 2 m. For any current practice you rated as ineffective (1 or 2), explain why and your recommendation for improving it. (please list by item #)

3.	What other suggestions do you have to improve the **sexual safety** of men and women residing on the same units?

		NOT AT ALL HELPFUL	NOT VERY HELPFUL	NEUTRAL/ UNSURE	SOMEWHAT HELPFUL	VERY HELPFUL
4.	How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an All-Women's Unit?	1	2	3	4	5

- 4a. Explain why.

		NOT AT ALL HELPFUL	NOT VERY HELPFUL	NEUTRAL/ UNSURE	SOMEWHAT HELPFUL	VERY HELPFUL
5.	How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an All-Men's Unit?	1	2	3	4	5

- 5a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
6.	Would you prefer to work on an All-Women's Unit, if BHD had one?	1	2	3

- 6a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
7.	Would you prefer to work on an All-Men's Unit, if BHD had one?	1	2	3

- 7a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
8.	Would you prefer to work on a Mixed-Gender Unit (men & women), like BHD has now?	1	2	3

- 8a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
9.	Do you think that having a Women-Only Patient Lounge on a Mixed-Gender Unit would improve sexual safety?	1	2	3

- 9a. Explain why.

		NO	NEUTRAL/ UNSURE	YES
10.	Do you think that having a Men-Only Patient Lounge on a Mixed-Gender Unit would improve sexual safety?	1	2	3

- 10a. Explain why.

PLEASE RETURN SURVEY TO: DR. MARY KAY LUZI – CENTRAL ADMINISTRATION BY SEPTEMBER 30, 2010. THANK YOU AGAIN FOR YOUR PARTICIPATION!

1a. What sexual safety concerns do you have for women patients on the unit? ***(92 comments)***

Vulnerability to Sexual Harassment, Intimidation, Exploitation, Abuse *(53.3%)*
• Being approached by others making sexual advances, being propositioned, verbally harassed, intimidated (7) • W who are mentally retarded/cognitive impaired are vulnerable, lack capacity to say no (6) – (e.g., slower functioning W taken advantage of for cigarettes, food, provisions; vulnerable to sexually aggressive M) • MI/psychotic state who otherwise wouldn't consent in normal state of mind (8) – (e.g., acute psychiatric pts, esp. manic, can be very unpredictable and impulsive and harassment esp. is difficult to prevent; due to mental illness, sexually preoccupied; afraid of the M and might consent to sex from fear of harm) • W with trauma histories are very vulnerable to sexual predators and those sexually inappropriate due to power issues with M (3) • Potential for sexual assault (5) • Potential for sexual abuse (2) • Being inappropriately touched (3) (e.g. unwanted touching difficult to stop in common areas of unit) • Sexually inappropriate behavior (4) • Sexually explicit comments • Being victimized • Inability to effectively manage hypersexual males with history of violence • Exploitation by some M • Violent M seducing W for sex, preying on the vulnerable ones (2) • Sexually aggressive M pursuing pt on unit and trying to get contact information after discharge • Being trapped in room with sexually aggressive M • Not being assertive or able to advocate for self • STDs, pregnancy, birth control • Age and physical limitations (e.g., elderly, dementia)
Propensity to Initiate or Provoke Sexual Behavior *(8.7%)*
• Due to decompensation, sexually provocative behaviors themselves, can be sly in hiding actions (2) • They get too close to the M and incidences do occur • Not always the M – some W tell me he looks so fine, I can just grab him and hold him forever • Roommates with bisexual W • W who prey on both sexes • W sought out by M pts more often than not are active willing participants and will take steps to set up meetings together • When M and W are hypersexual, they look for partners and find many willing ones; rape is one thing but keeping people from being sexual when they're impulsive and sexually charged is different
Hospital Unit Configuration and Patient Mix *(18.5%)*
• M sexual predators routinely housed on same unit in close proximity to vulnerable F pts (6) • When sexual predator/violent pt on unit, need extra milieu management to keep genders separate; though q 15 beh checks, takes only 1 minute to abuse someone (3) • Keeping W on their side of the unit (2) • Putting W in the M hall unless on 1:1 (2) • Pts being placed in M hallway due to no female hall beds (2) • M pts wandering into W room to use bathroom and W are exposed, vulnerable • In rooms by self at night

Staffing Pattern *(9.8%)* (Adequacy and composition of staff for monitoring & duties)
• Inadequate staffing – short staffing, decreased ability to monitor all pts (8) • Units are safe with the zones, but only if there is staff to do it
Staff Performance *(3.3%)* (Team work, staff supervision and training)
• Verbally redirecting W pt who's sexually inappropriate and ask for help from RN and nothing's done • Staff not paying attention or believing it's happening • Knowing pt's history and potential to engage in sexual behaviors
Minimal to No Problems *(6.5%)*
• None to little (4) • I feel W are now safe on the unit • OK with proper supervision & security

1b. What sexual safety concerns do you have for <u>men</u> patients on the unit? *(84 comments)*

Vulnerability to Sexual Harassment, Intimidation, Exploitation, Abuse *(46.4%)*
• Sexual predator s may focus on vulnerable M, psychotic M (4) • Mixing developmentally disabled with general population (4) (e.g., cognitive or emotionally impaired M with sexually aggressive M) • M & W can be abused the same way because of mental illness (3) • Vulnerable M being targeted for physical abuse by aggressive M (4) • Being approached by M & F making sexual advances, propositioning, harassing (4) • Exploitation by some M & F (2) • Sexual assault (4) • Being sexually touched by M pts (2) • Being sexually touched by F pts • Being victimized • M with trauma histories who will not receive care they need if there are sexual predators on the unit (2) • At disadvantage because often neglected fact that they may fall victim to other M and are unlikely to report or protect self (2) • Acute psychiatric pts, esp. manic can be very unpredictable and impulsive, and harassment difficult to prevent • If put in room with M who's sexually active that could cause problems even with 15 min checks (2) • Often accused of sexual advances that may or may not be true due to manipulative W • Age and physical limitation differences • STDs

Propensity to Initiate or Provoke Sexual Behavior *(11.9%)*
• Sexually enticing W (3) • Due to decompensation, engaging in sexually provocative behaviors themselves • M who prey on both sexes (2) – (e.g., many M have potential for soliciting sex from other M as well as W • Sexually inappropriate behaviors (2) • Some talk sexual and I tell them this is a hospital and is not tolerated here • M get too close to the W and incidents occur
Hospital Unit Configuration and Patient Mix *(11.9%)*
• Keep M on one side of the unit (2) • When M are in the F hall unless on 1:1 • If they are roommates with bisexual M or sexually aggressive M (2) • W wandering in M's rooms • Even large M complain of safety concerns when violent pts on the unit – assaultive/repeat antisocial pts shouldn't mix with regular population (2) • Predatory clients can be identified and should be segregated on a special unit • Prison separation causes same sex sex
Staffing Pattern *(13.1%)* **(Adequacy and composition of staff for monitoring & duties)**
• Inadequate staff, short staffing for monitoring (6) • Less need for monitoring because no risk of pregnancy • Residents are monitored much much more and units are truly safer – if had staff for zones, will work perfect (2) • Need more security on units • Psych techs
Staff Performance *(2.4%)* **(Team work, staff supervision and training)**
• Assessment of M behaviors/indicators during peer contacts so not "lost in crowd" • That rounds are done
Minimal to No Problems *(14.3%)*
• None (12)

1c. What sexual safety concerns have women patients raised? *(87 comments)*

General Safety Concerns *(11.5%)*

- Personal safety, keeping them safe (3)
- Feeling unsafe with M pts on unit (2)
- Feeling unsafe at night in their rooms
- Some concerned with loud, chaotic ward (2)
- Asking to have door locked at night
- General safety concerns by vulnerable F

Personal Boundary Violations *(28.7%)*

- Room intrusions (9) – (e.g., M coming into their bedrooms when they are asleep or in shower)
- Inappropriate, unwanted touching (4)
- They flirt (2)
- M following them (3) (e.g., talking, smiling, asking for phone numbers)
- Personal space violations (4) (e.g., M getting too close to them and brushing up against them)
- "stalking" on unit – no private space to go, don't feel safe in room (2)
- Not liking the way M or W talk or look at them

Sexual Harassment, Intimidation, Exploitation, Behavior, Contact *(33.3%)*

- M harassing them, intimidating (6)
- Trying to solicit sex (5)
- Sexual remarks from M (3) (e.g., take your shirt off)
- Alleging sexual assault (rarely) or nonconsensual sex (3)
- M showing unwanted sexual interest in them (2)
- Hypersexual roommates (2)
- Being vulnerable to abuse and sexual behavior
- M flashing genitals and suggestive language (2)
- Fear of hypersexual M who are also violent
- Concerns come up after the fact is done
- Some W tell me how they've been sexually molested by family and when a M comes up and starts talking, the F freaks out and says he wants to have sex and I have to explain that he does not want to harm you
- Fear or rape concerns – all have been product of psychosis
- Propositioning by W

Hospital Unit Configuration and Patient Mix *(4.6%)*

- Keep W on one side of unit
- Wandering to M's side when not watched closely
- Don't want to be in M hallway when no bed in F hall
- Some don't care and some want to be on F side only and their own room

Minimal to No Problems *(21.8%)*

- None (18)
- They don't talk about it

1d. What sexual safety concerns have men patients raised? *(76 comments)*

General Safety Concerns *(9.2%)*
• Fear of peer, reported threats (2) • Fear of violent M (2) • Don't feel safe on unit • Noise on the unit • Not liking the way M or W look at them or talk to them
Personal Boundary Violations *(11.8%)*
• Afraid of certain M peers coming in their room (3) • W wandering in their room (2) • W following them around the unit • Intrusiveness of other pts • They flirt • On 3rd shift, some say this W came into my room and I couldn't get her out, she wouldn't leave
Sexual Harassment, Intimidation, Exploitation, Behavior, Contact *(30.3%)*
• Complaints about M peer making sexual comments or advances to them (5) • Extremely rarely have M made allegation of sexual assault by another M (3) • Sexually preoccupied with aggressive M peers • Unwanted touching by M (2) • Propositioned by F peers (2) • Being harassed, targeted (2) • Afraid of peers they perceive as gay, bisexual (2) • Being touched by W • Being recipient unwanted sexual advances and feeling unsafe • When they have sexual behavior issues • They sometimes expose self • Being accused • Concerns come up after the fact is done
Hospital Unit Configuration and Patient Mix *(2.6%)*
• Wander to F side when not watched closely • Keep M on one side of the unit
Minimal to No Problems *(46.0%)*
• None, usually no complaint (34) • They don't talk about it

2m. For any current practice you rated as ineffective, explain why and your recommendation for improving it.

2a. Assessments by PCS & Inpatient MD/PhD of special risks	2b. Recovery Planning special risks treatment objectives & interventions
• PCS MDs go overboard in initial monitoring orders; assessment of sexual risks done improperly and not relevant per pt (2) • Unit Drs go a little overboard with monitoring ½ pts on unit without any history • PCS not aware of case mix on unit • Don't think Drs listen enough to RN/CNA and try to appease pt without taking violence risk into account • CNAs not notified immediately of behavior risks of pts • Screen out criminals that belong in jail (Pers. D.O. & malingerers vs. true MI) • Background checks should be done on pts to identify sexual offenders	• Interventions not always followed (2) • CNAs don't read the charts • Team doesn't seem to meet with pts as they should • Useless, record not pt-oriented • Need to implement Trauma Informed Care
2c. Patient Education on sexual contact policy	**2d. Unit Zone Surveillance system**
• Inconsistent and of questionable benefit (10) – e.g., inconsistent, pts are very impulsive and not sure RN really goes over orientation material; only few pts are capable of benefiting; don't believe has any effect with main perpetrators (manic pts); doesn't mean pts will listen if they have sexual issues; pts will still do what they want if not monitored; pts don't retain the unit policy info given them. • Better sexual education & consequences of sexual attachment	• Would work/be very effective if staffed (5) – e.g., zones will work if each unit has enough staff; frequently understaffed and CNAs pulled; RNs have to fill in and it's a lot of work; if short-staffed, RNs won't help CNAs • Very good idea but issues with staff performance (7) – e.g., staff is reading, texting, listening to ipods; staff sit at beginning of hallway not halfway down so can see rooms better; staff sit in chairs, sit together and talk; staff not always in zone areas & don't know where pts actually are; with increased CNA expectation could be very effective; if short, RNs won't help CNAs with some duties so they have to leave zones • Very positive step
2e. Morning Report with both treatment teams represented	**2f. Cross Shift communication of special risk patients**
• Don't follow through, both teams are never together (2) • CNAs not involved in morning report; were told at least 1 CNA would be but never happened (2) • Different on each unit – touch & go	

2m. For any current practice you rated as ineffective, explain why and your recommendation for improving it.

2g. Behavior Observation monitoring for special risks	2h. Bedroom Hallways separate for M&W; no bed assignment beyond fire doors for W
• So many pts on behavior checks the importance is diminished, so go to 15 minute rounds (6) – e.g., every pt should be on Q 15 minute checks; not done consistently because not taken seriously – everyone's on them; almost everyone's on 15 min checks for vulnerability and difficult to manage, cumbersome • Staff don't always know where pts are so can't monitor; CNAs sitting & talking, need to walk more (4) • Useless, double CNAs and put security in place	• Halls should be single sex only (3) • If beds are tight, have to go beyond fire doors – 3/room is too crowded • Pts find ways to engage in sexual contact despite
2i. Locked Community Bathroom	**2j. Therapeutic Groups**
• Shouldn't be necessary with the Zone • CNAs don't always lock or pts shut the door • A pt found a way to unlock it • Lack of privacy and M peeing on the toilet would make me crazy	• Many pts don't attend • No groups on evenings & weekends • Nursing groups ineffective • No groups to teach pts how to change their behavior • Other hospitals have good groups, like coping skills, not "coloring" • More training for groups from Education Dept
2k. Electronic Video Monitoring of unit	**2l. Overall Effectiveness of current practices**
• Who does this and how is it implemented? (2) • 1 security officer w/o knowledge of pts and risks monitoring multiple units not as effective as staff stationed in various places on unit who know pts and risks • Not noticed effective use or communication with staff; never seen security guard come during emergency situation that could have been seen on camera – we always call for help (2) • Physical appearance of security would be money better spent • Not in every place – limited space • Electronic ankle monitor for high risk pts from entering designated areas (2)	• Wards frequently understaffed to put these practices in use, incl. Lunch coverage for CNAs (5) • Need correct staff- 4 RNS and psych techs who constantly rove/monitor, not just sit • Many CNAs don't watch – chat on cell phones & travel the building • "Secure unit" for violent/sexually predatory pts (3) • Pts with sexual abuse hx may be predatory and find ways to get around safety nets • Present mix of pts on a given unit can be scary • Focus on very effective practices – separate M&F units (2) • If everyone on all 3 shifts would be on their watch, could prevent most • Staff remains in nursing station for lengthy periods of time

3. What other suggestions do you have to improve the sexual safety of men and women residing on the same units? ***(82 comments)***

STAFFING PATTERN *(31.7%)*
- **Adequacy of staff**
- **Composition of staff for monitoring & duties**

- Units fully staffed & consistent monitoring (9)
- Unit Zone Surveillance is adequate for monitoring sex (2)
- Properly man the zones and will be most effective tool for sexual safety (2)
- More CNAs (2)
- Better way to measure acuity & ensure correct coverage (2)
- More RNs (4) – e.g., 4 RNs for 6 pts each more manageable esp. to cover Zone 2 and CNA breaks, RNs doing CNA work, not job hired to do so they could talk to pts more
- More security visible (4) - e.g., to deal with behavior issues therapeutic staff can't monitor while doing other cares
- Manager has to be on the unit to make sure CNAs are rounding, not sitting

STAFF PERFORMANCE *(24.4%)*
- **Team Work**
- **Staff Supervision**
- **Training**

- Better CNA supervision and training on Zones (5) – e.g., enforce zone supervision; make sure CNAs are doing job and roving, not talking on phone, doing word searches; not allowing CNAs on break to visit other units
- Increase RN involvement with CNAs (2) – e.g., help CNA when pts need redirecting
- Increased supervision of staff (3) – e.g., each staff person doing their job
- Close proximity of staff to pts (close monitoring) (2)
- Enhance execution of current safeguards (2)
- Give all staff immediate report of pt sexual behavior issues
- More team work
- MDs need to listen to RNs (too permissive and prescribed Viagra in past)
- Increase training of staff (2) – e.g., rights of pts to a recovery environment; sexual safety policies
- Welcoming attitude and take seriously pts bringing sexual safety concerns to staff

CLINICAL INTERVENTIONS *(13.4%)*
- **Clinical strategies for intervening with patients**

- Increase unit groups & activities (3) – e.g., to decrease boredom; better teaching groups geared to unit population; group and individual therapy to discuss sexual abuse and vulnerability
- 1:1s at least until meds in system (2)
- RNs to intervene when pts are being sexually inappropriate
- Ensure pts know to inform staff if they feel threatened
- Remind pts each shift about no sexual contact
- Pass restrictions for those with sexual assault histories
- Give something to lower libido
- Discharge sooner

UNIT ENVIRONMENT MODIFICATION *(12.2%)* • **Modification to existing unit physical environment and practices**
• Separate M-only & F-only hallways (3) – e.g., no exceptions, no 3/room • Door/wall to separate M & F on same unit, with coed groups, meals and supervised social areas (3) • Allowing bedroom door to be locked upon request (2) • Separate lounges • Separate M & F bathrooms
HOSPITAL RECONFIGURATION OF PATIENT MIX *(18.3%)* • **Reconfiguration of patient mix on units based on such variables as gender, risk, acuity, etc.**
• All M and all F units (5) • Separate unit for high risk males • Segregate pts with sexual, criminal, antisocial history, violent behavior • "Forensic" unit (2) – e.g., dangerous pts found incompetent to stand trial; should be a hospital & prison • Special unit for dangerous pts (more than average) (3) – e.g., esp. physical assault, but ending coed units not the answer; don't put predators on mixed gender unit • Acute mixed unit for decompensated pts at higher risk • Separate by acuity: MI vs. personality disorder • Segregating sexes not the answer – can still assault same sex

4. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an <u>All-Women's Unit</u>?

NOT AT ALL HELPFUL/NOT VERY HELPFUL
• Can still have W to W sex (6) • Pts. Need to function in a normal setting, community environment (3) • W are hypersexual (when noncompliant with meds) and separating units won't help (2) • Anything can happen no matter what and if employees don't do their job • Staff need to carry out plans • More violent environment for pts and staff • Only need all M unit for criminals, sexual offenders, history of assaultive behavior • Opposite sex caregiver could be falsely accused of inappropriate behavior at increased rate
NEUTRAL/UNSURE
• Sexual acts can occur between same sexes (5) • Would prevent some, not all, contact • Life interactions involve M&W; won't give pts chance to interact and learn from opposite sex (2) • Don't believe sexual contact can be controlled in any setting • If aggressive M are on all M unit, can monitor W more easily & not have availability of highly sexualized M • Hypersexuality is dangerous, whether M or F • Fully staffed • Increased security time on units • Trauma informed care is the solution
SOMEWHAT HELPFUL/VERY HELPFUL
• W to W sex still possible, but W would feel safer (5) • Answer to many problems coming up – vulnerable W mixed with M, limits exposure of W to predatory aggressive M (4) • Would reduce/remove M-F contact, assault, harassment (3) • Potential for harassment from those who prefer same sex (2) • Some W have fear of M due to past trauma • W with trauma history are retraumatized as solicited by M for sex • Still sexual issues but no pregnancies • Allow for stabilization in a manic state until less sexually preoccupied • Remove temptation with no M around • Prevents M from undetected access to W • Subset of population (gender identity, sexual abuse) better served by same-sex unit • Effective, easier fewer incidents • Caring staff can better understand and care for gender • Potential problem of W vying for attention, getting restless with each other (2) • But staff can become inattentive in monitoring • Won't need zones but zones are working well • But best to address safety in general

5. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an All-Men's Unit? Explain why.

NOT AT ALL HELPFUL/NOT VERY HELPFUL
• M to M sex can still be a problem; vulnerable M can still be abused by M (12) • Concern about increased fighting, safety concerns, violence potential (2) • Need a community environment (2) • Many nurses are small W and may be at increased risk for victimization • Only if staffed with all M • Anything can happen if employees don't do their jobs • Need to monitor all pts. • Not enough CNAs to cover zones
NEUTRAL/UNSURE
• M could sexually assault each other unsure if would shift risk to same sex behavior, vulnerable M could be a target (9) • May be more violent/aggressive than on a coed unit (2) • All pts who are hypersexual are dangerous • Life interactions involve M & F • Staff may be less willing to work there, if mixed with violent pts, could be safety issue for staff (2) • Some M pts. Would still be on units with F pts. • Don't believe sexual contact can be entirely controlled in any setting
SOMEWHAT HELPFUL/VERY HELPFUL
• To separate perpetrators from general pop, from predatory/violent men from preying on vulnerable (5) • Eliminates M-F assault, W would be safer, protects most vulnerable W (3) • Eliminates pregnancy concern (2) • Some M like M, can have sex with each other (2) • Stop the sexual tension between the genders; reduces temptation (2) • But need to focus on overall safety – violence and sexual safety (2) • Zone & monitoring makes M to M sexual contact unlikely • With caring team could better understand needs of that gender • Would require significant staff engagement and use of therapeutic technique • Secure unit for violent high risk men would be safer environment for rest of population • High risk unit with strict behavioral guidelines to protect other pts • Forensic unit for chronic offender • Especially antisocial and sexual predator • Only for violent pts with criminal records and history of violence of any kind • But need to separate violent M and W from general population • Must be highly secure for violence as well as sexual contact – security on unit all times, adequate RN/CNA staff • Send criminals to jail, prosecute when they attack staff and pts.

6. Would you prefer to work on an All-Women's Unit, if BHD had one? Explain why.

NO
• Don't believe in its principles – to a pt's mental health benefit to be on a mixed unit, current recovery environment more accurately reflects community to which pts will return (4) • Concern about false accusation of sexual advances toward me and other M staff (3) • W can be just as loud, hostile aggressive, threaten other W; worse than M; W can be nasty, lie; cattier and sneakier; too moody (8) • More personality disorders without enough staff to meet needs; too demanding (2) • Not a fan of too many manic W • More problems, too stressful (2) • Array of problems – what if % M vs. F is skewed and single gender units are full? • I enjoy M & F mix and different issues
NEUTRAL/UNSURE
• As M RN would rather not, but would if had to • I have concerns about being falsely accused of abuse • Only if a F older population • Cat fights, more discord between pts per staff who have worked on all F units
Yes
• Because I'm a W, and want to feel safe (2) • I'm here for all pts. • Won't be concerns about sexually inappropriate behavior, though it's not happening now because zones are in place

7. Would you prefer to work on an All-Men's Unit, if BHD had one? Explain why.

NO
• Don't believe in its principles, to a pt's mental health benefit to be on a mixed unit, more accurately reflects the community to which pts return (4) • I'm a W – too dangerous, I'm too small to protect myself (3) • Too much anger/aggression potential, too violent, danger of violence to staff would be higher (4) • Too little variety (2) • Not if a young M population • Because of my own trauma history • Not much tolerance for sexual comments toward me • Nice way BHD is set up, just need more supervision and training
NEUTRAL/UNSURE
• M might try sexual behavior on F staff • I'm a M RN • They can be mean • Many M pts are protective of F staff • Will have a wide array of problems
Yes
• M are easier to handle and control (3) • Personal preference (2) • Less manic behavior and M seem more respectful to F • Less moody, demanding • Less drama and likelihood of allegation if someone touched me • Better control of unit population to focus on treatment and not policing • As a F, I can talk better to M, reason with them and have them tell me their problems • With the correct staffing and security presence, it would be improved • I'm here for all pts • If you start a high risk unit, I'll work on it

8. Would you prefer to work on a Mixed-Gender Unit, like BHD has now? Explain why.

NO
• Unsafe
NEUTRAL/UNSURE
• Flexible, I'll work anywhere (2) • System has worked for a long time though has some flaws • Think pts communicate better with mixed genders • Do value interactions between M & W as reflection of "real life" • OK for me, not as safe for pts • Only if trauma informed care is implemented • If predators are separated from the general population
Yes
• Variety (personalities, needs, issues) (7) • Current recovery environment more accurately reflects the environment to which pts will return (4) • Never worked on an inpatient unit with sex segregation – will be like jail, it's about how you monitor • I'm here for all pts • I'm a people person and understand both M & W • Only if properly staffed • To pts mental health benefit to be on mixed unit • Was working until secure M unit closed and violent sociopathic M were integrated onto general units • Would get burned out on all-M or all-F unit • Zones are working • Believe staff is able to manage/separate/protect pts, need to enforce our policies • Easier to work with • Less pt discord • Would work with elderly pts • I like where I am now • OK other than some comments, hand kissing, butt grabbing

9. Do you think having a Women-Only Lounge on a Mixed-Gender Unit would improve sexual safety? Explain why.

NO
• Most inappropriate sexual behavior occurs in places other than lounge areas, day and night, not just leisure time (4) • If they want to have sex, they'll find a way to do it – they watch staff to find opportunity (3) • M would be jealous, angry and see it as unfair (3) • Sounds discriminating (3) • Lack of space (3) • W have sex with W (2) • Would only increase sexual curiosity toward one another, been seen as another challenge by M pts (2) • Modulating, moderating effect on behavior & emotions with mingling genders • Sexual safety not determined because you have a same sex group • When they decide to get to the other sex, they can be very dangerous • Would still need to monitor • Adequate staff to monitor pts based on acuity • W many times won't use it – sexually preoccupied and want to be near M • Problem is sexual interaction (willing/unwilling) on a mixed unit and it won't solve that • Would help tiny bit but not big difference • Don't need a lounge to hold a gender-specific group • Living quarters separate, common areas mixed • Feel strongly about F-only unit
NEUTRAL/UNSURE
• Would be difficult to keep people separated, would have to closely monitor (3) • Most sexual contact without consent occurs away from lounge • Another thing staff would have to police • Would increase need for more staff • May increase stalking • Not sure if pts would find a way to get away with things • Space concerns • Staff address harassment when it occurs, lounge may help with prevention • Not sure what goal would be • Too isolating for some pts • Not sure would increase safety but would give W sense of comfort and place to relax • Would be a therapeutic benefit • If aggressive M are on their own unit; lounges are in view of staff & pts need to learn to interact in healthy ways
Yes
• Offer W safe place to be on unit when feel threatened (3) • Improve sense of safety, security, place to go and sit (2) • Supplement with a women's group and different trauma topics (2) • Limits sexual contact, innuendo. Flirting between opposite sex pts (2) • Lot of inappropriate behavior happens in the community room • Unstructured time on second shift is higher risk • Zones are working good • May be hard to enforce • May decrease temptations

10. Do you think having a Men-Only Lounge on a Mixed-Gender Unit would improve sexual safety? Explain why.

NO
• If they want to have sex, they'll find a way to do it, they watch staff to look for opportunity, can be very dangerous (5) • Lack of space (4) • Most inappropriate sexual behavior occurs in places other than lounge areas (2) • Potential sexual predators could bond/plan offenses without W present, and see which peers are weaker (2) • Sounds discriminating (2) • Have M that have sex with M, can prey on other M as well (3) • When you restrict something, they work harder to obtain it; Prefer staff to monitor mixed=gender lounge and be alert to developing relationships • Would only increase sexual curiosity toward one another • Moderating, modulating effect on behavior, emotions with mingling of genders • Adequate staff to monitor pts based on acuity. • Sexual safety is not determined because you have a same sex group • Our job is to monitor changes in inappropriate behavior to return pt to community • Help a tiny bit but not make a big difference • Don't need a lounge to hold a gender-specific group • Would cause anger and hostility with M • Important for pts to interact with both genders as must do in community • Feel strongly about F only unit • Living quarters separate; common areas mixed
NEUTRAL/UNSURE
• Staff addresses harrassment when it occurs; lounge may help with prevention • Another thing staff will have to police • M seem prone to take other means because they're insecure in their sexual identity • Not sure would increase safety but would give M a sense of comfort and place to relax • Need better staff training to improve safety • Not sure if pts would be determined to find a way to get away with things • Would have to monitor closely so W wouldn't enter M lounge (2) • Most sexual contact without consent occurs away from lounge • Too isolating for some pts • If aggressive M are on their own unit; lounges are more in view of staff & pts need to learn to interact in healthy ways
Yes
• Limits sexual contact, innuendoes, flirting between pts of opposite sex (2) • May be hard to enforce • Unstructured time on second shift is higher risk • Zones are working good

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: January 11, 2011

TO: Supervisor Michael Mayo, Chairman – Milwaukee Co. Board of Supervisors

FROM: Geri Lyday, Interim Director, Department of Health and Human Services

SUBJECT: INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REGARDING THE USE OF FEE FOR SERVICE AGREEMENTS BY THE BEHAVIORAL HEALTH DIVISION

Background

At the December 8, 2010 meeting of the Health and Human Needs Committee, an informational report was requested regarding the use of fee for service agreements by the Behavioral Health Division (BHD). The BHD has been utilizing fee for service agreements for several years, particularly for programs in the Community Services Branch and Wraparound Milwaukee, and continues to transition some of its purchase of services contracts to fee for service agreements.

Discussion

The Community Services areas within BHD, for children and adults, have traditionally used both purchase of service and fee for service systems to pay vendors for providing services to BHD clients. In recent years, the trend in Wisconsin and the US for the provision of community services is to transition more services to fee for service networks. This allows greater monitoring of the allocation of service units instead of using a not-to-exceed contract approach. BHD has followed this trend and is using more fee for service agreements to pay vendors.

In a fee for service network, a group of providers is identified and authorized to supply prescribed services to enrolled clients. This is a different approach to the provision of services because it puts the client in charge of where to "spend" their service vouchers since often there is more than one provider offering a specific service. In behavioral health settings, this can encourage ownership on the part of the client, as they are taking an active role in determining the provider for their treatment and recovery services. Providers are paid at a pre-established rate based on the service provided and the number of clients served. In the fee for service system, providers do not have fixed amount contracts; rather, they are reimbursed as services are rendered. BHD then monitors service credits approved for clients rather than contracts to project and monitor spending for the year. The move from contracts to a fee for service network has resulted in a change in the reports given to the Board regarding purchase of service contracts, but has not caused a reduction in expenditures for service areas or in the number of clients served under the programs.

Below is a summary of each area within BHD that has fee for service networks including specific services and actual expenditures.

Adult Community Services – Alcohol and Other Drug Abuse Services (AODA)

WIser Choice is the adult public sector community-based substance abuse system for Milwaukee County. The WIser Choice system serves Milwaukee County residents ages 18-59, and pregnant women of all ages, with an emphasis on both the general and corrections substance abuse populations. Functioning much like a managed care entity, the WIser Choice system is currently funded by 11 different funding streams and uses a mechanism of behind the scenes "braided funding" to leverage the various forms of funding with one another to achieve maximum fiscal efficiency and a seamless provision of service to the clients as well as payment to the providers. The system has functioned as a fee for service network since its inception.

In Milwaukee County, WIser Choice is the central access point for Milwaukee County residents requiring substance abuse services. Services are accessed at any number of Central Intake Units (CIU) in the community. When a client arrives at a CIU, they receive a comprehensive screen, which helps to identify the severity of the substance abuse issue and in turn determine an appropriate level of care for treatment. Immediately, while still at the CIU, the client chooses an agency/team who will provide their Recovery Support Coordination or Case Management, and also chooses a treatment provider who provides the level of care for which they have been determined eligible. The goal is that the client will be reviewing a menu of agencies complete with accurate descriptors, so that the choices they are making are adequately informed.

The WIser Choice network has 80 agencies, at more than 100 site locations, to provide a broad array of services. WIser Choice has annual written agreements with all providers in the network, developed in conjunction with the Milwaukee County DHHS Contract Administration. WIser Choice has a team of Quality Assurance professionals who work to develop service descriptions in accordance with any applicable state statutes and laws and establish unit rates for services. The Quality Assurance team conducts regular audits of providers and also verifies the credentials of all new providers entering the system. Service authorizations are tracked and monitored by BHD staff.

Below is a summary of the fee for service agreements in the Adult Community Services – AODA area.

Fee for Service Agreements – Adult Community Services (AODA)

Service Area	**Actual Spent (January – December 27, 2010)**
Primary Treatment Services	$ 7,437,424
Recovery Support Coordination	$ 1,899,738
Ancillary Recovery Support Srvs	$ 738,697
TOTAL	**$ 10,075,859**

Adult Community Services – Mental Health

Adult Community Services is composed of community-based services for persons having a serious and persistent mental illness and for persons having substance abuse problems or a substance dependency. The majority of services in the mental health program area are provided through contracts with community agencies. In 2009 and 2010, BHD began transitioning all direct service community contracts to fee for service and will continue this conversion in 2011. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) provides Wisconsin with $7 million in block grants for mental health services, which ensures a base for community services and fosters system transformation. There are reporting requirements under the federal block grant programs and the federal government is encouraging states to develop systems that collect claim-like, encounter-level data. A two-year phase-in period is being planned by the State to comply with these changes. Fee for service agreements support the collection of encounter level detail that will be required under block grant reporting.

Mental health residential treatment programs were the first to be converted from purchase of service contracts to fee for service agreements beginning September 1, 2009. BHD is preparing to convert Target Case Management (TCM) contracts to fee for service by the end of 2011. At the same time, BHD will be developing the infrastructure and provider network identified in the 2011 Budget for additional outpatient capacity to purchase up to $360,000 of psychotherapy services for trauma counseling and the related medication costs annually. All Outpatient and Community Support Program contracts will be converted to fee for service within the two year phase in period.

Another significant benefit of implementing fee for service agreements on the mental health side is that the community mental health and substance abuse delivery systems will be much more closely aligned in terms of infrastructure and business processes. Historically, individuals with co-occurring mental health and substance use disorders received sequential or parallel treatment from the separate mental health and substance abuse treatment systems, resulting in fragmented and duplicative care. Establishing the same management information platform for both systems sets the stage to pursue co-occurring integrated care, and create clinical, operational, and cost efficiencies within one system.

Below is a summary of the fee for service agreements in the Adult Community Services – Mental Health area.

Fee for Service Agreements – Adult Community Services (Mental Health)

Service Area	**Actual Spent (January – December 31, 2010)**
Residential	$ 4,921,256
TOTAL	**$ 4,921,256**

Wraparound Milwaukee

Wraparound Milwaukee is a special Medicaid Managed Care entity under a 1915 federal waiver that provides mental health and supportive services to children with serious emotional and mental health needs. As a type of HMO, responsible for the provision of mental health, social and out-of-home services, it must have a very comprehensive service array available to individualize care for seriously emotionally disturbed children and their families. Community providers are brought together in an organized network of over 200 agencies that provide everything from outpatient and substance abuse treatment to mentors, job coaches, and crisis 1:1 stabilizers, to treatment foster care, group home and residential care centers.

Wraparound Milwaukee develops service descriptions, establishes unit rates for services, and authorizes the provision of these services on a child-by-child basis. There are no guaranteed contracts or volume of business to any of the network providers as families chose the services and providers that best align with their child's and family's needs.

There are currently 70 different services, 200 agencies and several thousand individual providers of care. Wraparound Milwaukee has annual written agreements with all providers in the network, developed in conjunction with Milwaukee County DHHS Contract Administration. Wraparound Milwaukee and Contract Administration conduct regular audits of providers. BHD-Wraparound Milwaukee credentials all new providers based on state/federal certification standards and has a credentialing committee chaired by the Medical Director for licensed clinical providers.

Below is a summary of the fee for service agreements in the Wraparound Milwaukee area.

Fee for Service Agreements – Wraparound Milwaukee

Service Area	**Actual Spent (January – October 2010)**
AODA	$ 76,536
Crisis	$ 2,486,760
Day Treatment	$ 112,033
Foster	$ 3,268,788
Group Home	$ 3,789,255
Independent Living	$ 309,474
Mental Health	$ 2,888,115
Residential	$ 9,816,947
Supportive Services	$ 1,542,256
TOTAL	**$ 24,290,164**

<u>Recommendation</u>

This is an informational report. No action is necessary.

Respectfully Submitted:

Geri Lyday, Interim Director
Department of Health and Human Services

cc: County Executive Lee Holloway
Renee Booker, DAS Director
Allison Rozek, Fiscal & Management Analyst - DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

COUNTY OF MILWAUKEE

Inter-Office Communication

DATE: January 12, 2011

TO: Supervisor Michael Mayo, 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 INITIAL ACTIVITIES OF THE BOARD AND INITIAL RECOMMENDATIONS RELATED TO FILE NO. 10-213**

Issue

The Milwaukee County Board created the Community Advisory Board 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 return with a report outlining steps to implement the recommendations, 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 second report from the Community Advisory Board which was established in May 2010 by the Milwaukee County Board of Supervisors. 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. Since the September report, the Community Advisory Board has continued its efforts to address concerns related to safety, patient centered care, and community linkages. Work group activities are summarized below. We value the support and partnership of BHD in moving forward with these recommendations, as well as the support of the County Board. We also wish to acknowledge and express appreciation for the active participation of County Board Supervisor Joe Sanfelioppo.

Work GroupUpdates

Patient Centered Care Work Group:

As outlined in the resolution, this group is focused on service delivery and the culture of care. The PCC work group has met 3 times since the last report on the following topics:

- September: *Consumer Grievance Rights Under Wisconsin Law.* Speakers were Shirin Cabraal, Disability Rights Wisconsin and Desirene Vann, BHD Client Rights Specialist.
- October: An *Overview of the Planetree Model* was provided by Jamie Lewiston and Pete Carlson, both of Aurora Health Care and Community Advisory board members.
- December: *People with Developmental Disabilities Served at the Mental Health Complex.* Speakers were Dr. Justin Kuehl and Claudia Meyer. OT, both on the staff of the BHD Observation Unit, and Jim Kubicek, PCS Director, and Disability Services Staff Mark Stein and Sandra Butts.

Key insights and recommendations are as follows:

Consumer Grievances
BHD has an appropriate grievance policy which is in compliance with the law. However, there are opportunities to strengthen awareness of the policy among staff, patients, and families and to enhance the way in which it is implemented. The Work Group is submitting the following recommendation to BHD's Patient Rights Committee for their consideration and hopes to work with BHD on implementation.

- Patients receive a brochure with information about the grievance process. The information is fairly complex and comprehensive as required by the law and may be difficult reading for many patients and family members. Although the current brochure should be provided, as legally required, work group members recommend development of a more user friendly "quick reference" that explains the grievance process in a very short and simple format, understandable by those with low literacy level. This should be available to both patients and families.
- It is important to monitor that staff are accountable for using other approaches to explain the grievance process to individuals who do not read or are non-English speakers **(confirm that brochure is available in Spanish**), or those who may need accommodations due to disability.
- The work group discussed options for increasing awareness of the right to file a grievance such as including a grievance form in the admission packet or having them available on each unit without the need to request from staff. We recommend that the Patients Rights Committee pilot such an option for 30 – 60 days and report back to the PCC work group on the impact.
- During the past year, it's our understanding that no grievances went through the appeals process which seems surprising. We request that staff analyze the process and the reason for this. Is there sufficient awareness of the appeals process? Is the process timely enough to respond to patient needs given shorter stays?

- Patients and families should also have the right to an external advocate, if needed. Posters with Disability Rights Wisconsin's contact information are now posted on all units and that practice should continue. In addition, we recommend that new admissions and family members receive a copy of DRW's brochure along with the grievance policy. Given the number of mental health consumers in Milwaukee, and the challenges with access to service and quality, we recommend that DRW pursue funding for an additional advocate to focus on the needs of mental health consumers in Milwaukee County.

Culture Change
Aurora completed a presentation to this work group regarding the implementation of the Planetree Model within their hospital system. Planetree is the model Aurora used to move forward with culture change and enhance patient centered care and staff engagement and empowerment. The work done by Aurora illustrates the need for staff at all levels to be involved with a culture change that supports best practice and quality patient-centered care. To achieve this implementation, Aurora trained all staff (clinical, administrative staff, maintenance staff, etc.), completed comprehensive planning with treatment teams, and had staff devoted solely to the implementation. The Aurora efforts also affirmed the importance of nurturing staff and providing appreciation for staff to maintain morale and build a sense of teamwork and common purpose: that being the care and respect of the patients.

Recommendations

- BHD is moving forward with culture change using the models of Trauma-Informed Care (TIC) initiative and Comprehensive, Continuous, Integrated System of Care (CCISC) initiative which this work group strongly supports and affirms.
- We recommend that BHD use a similar approach to Aurora for the implementation of the TIC CCISC initiatives. BHD has been making efforts to increase staff knowledge about TIC but has not been able to formally train the staff. Specifically, **we recommend that the funding allocated for TIC in the 2011 budget be utilized to fund an initial half-day training on TIC for all staff at BHD and any other initial training needs for expansion of this initiative**.
- A full-time position dedicated to the implementation and sustainability of this initiative is required at BHD. Having a staff member dedicated to this role is common practice in all hospital systems and no less should be expected for the success of this initiative at BHD. We recommend that funds in the 2011 budget for TIC be used to underwrite staff time.
- Aurora is making extensive use of volunteers on their units, which provides support for both staff and patients. This includes friendly visitors, use of the arts, pet therapy, and staff appreciation efforts. We recommend exploring opportunities to expand the BHD volunteer program and staff appreciation efforts.

People with Developmental Disabilities Served at the Mental Health Complex
A very informative presentation was provided by BHD and Disability Services (DSD) staff regarding people served by Milwaukee County with a dual diagnosis of a developmental disability and mental illness. Good work has been done at OBS to develop expertise and skilled staff for serving people with developmental disabilities and mental illness. There appears to be a

clear lack of these specialized skills on Acute Care, in community settings, and in the Family Care Managed Care Organizations. Consumers are often sent to PCS because of challenging behaviors which community providers are struggling to address, and they may remain at the Mental Health Complex because of the lack of appropriate community placements. There is currently limited support to help community providers address these concerns on site.

Recommendations

- Advocates, providers, and Milwaukee County staff should work together to develop a new model for serving people with developmental disabilities and mental illness in the community. There is a need for more skilled community providers with expertise in challenging behaviors. This expertise is also needed at the Mental Health Complex on Acute Care, although the availability of better community in the community will ultimately reduce the census of patients w/developmental disabilities and mental illness on Acute Care. We recommend that BHD explore the feasibility having an Acute Care unit that specializes in serving patients with a dual diagnosis, and recruiting specialized staff to support this unit.
- We recommend that BHD explore the model used in Dane County, Family Ties. This program is a collaboration with the Waisman University Center for Excellence in Developmental Disabilities at University of Wisconsin-Madison, and with other community providers. It provides a multi-disciplinary approach to address the needs of individuals with developmental disabilities and mental illness who live in the community. This includes development of person centered behavior support plans, development of intensive supports including training providers on crisis response strategies, use of Environmental adaptations and modifications, a mobile team, and a Safe House. The Community Advisory Board will bring in a speakers from the Waisman Center in 2011.
- Given the need to develop a work force with the skills to work with consumers with a developmental disability and mental illness, we recommend that BHD explore closer ties to higher education institutions for staff training resources. The Waisman Center has expertise in providing this type of training and could be a resource for both community providers and BHD staff.
- Although BHD staff often recognize that patients with developmental disabilities are not appropriately placed on the Acute Care unit, they may remain on Acute Care because of difficulties in securing a community placement. At times, these delays are due to the interface with the Family Care Managed Care Organizations (MCOs), their limited experience with this population, and their failure to development needed community capacity. Advocates and BHD staff should work with the Family Care MCOs to address these concerns. Strategies should include urging the MCOs to hire staff with expertise in serving people with developmental disabilities and mental illness, and include them on the care team, as well as having MCO leadership with expertise in disability services.

Access to Interpreters

The work group discussed concerns about timely access to appropriately trained interpreters for deaf and hard of hearing patients and family members. BHD staff shared the challenges

regarding access as they must go through the County procedure to secure interpreters and availability is sometimes problematic.

Recommendations

- A work group member with expertise in this area will work with BHD on developing a more comprehensive list of interpreters.

Community Linkages Work Group

As outlined in the resolution, this group is focused on developing strategies to better connect patients to community supports that are alternatives to hospitalization, as well as the process of accessing SAIL community programs. The work group has met seven times since the first report to the County Board. Meetings have been held at community locations including, the Crisis Resource Center (CRC), Autumn West, Pathfinders, DRW, & Wisconsin Community Services (WCS). The next meeting is Tuesday, January 18, 2011 and will focus on strategies for expanding access to outpatient services and the role of federally qualified health care clinics (FQHCs). We will also move forward with review of current resource guides and develop a strategy for availability of resource materials at BHD.

The following recommendations have emerged from work group meetings and will be shared with BHD, as well as the Board:

Quality of Service

As the focus of care move to the community, it is essential that quality oversight be in place to ensure that clients are receiving the best level of care and that tax dollars are being spent with care. One of the strongest indicators of quality is consumer satisfaction which can be enhanced by giving choice.

Recommendations

The work group sees opportunities for improvements in quality of community services overseen by SAIL:

- Currently BHD has only 2 Quality Assurance (QA) staff to evaluate approximately 20 mental health providers and 80 AODA providers, which is not adequate for such a large provider network. We recommend:
  - Expand the QA staff and add a Peer Support Specialist to this team, to allow for a greater degree of oversight and accountability.
  - Require that the Request for Proposal (RFP) process should include as input to the reviewers the QA team's evaluations of current or past providers who have submitted proposals. This will help maintain the quality of contracted Targeted Case Management (TCM) and Community Support Program (CSP) services.
  - At this time Milwaukee County's TCM and CSP programs do not have to go through the RFP process. We recommend that they must go through this process as well.
- Provide consumers with the ability to choose which CSP or TCM program they want to join. It is also recommended that there be an easier process for consumers to transfer to a different CSP or TCM program.

- Develop a SAIL appeal process for denial decisions for entrance into a CSP or TCM program, as required by state law. There is currently no formal appeal process.
- Expand the range of community services and supports by moving forward with 1915(i) which will draw down federal funds to support new recovery oriented community services such as peer support and supported employment.

Access to Services
There is currently a crisis with access to outpatient mental health services for uninsured and people on Medicaid. Because of inability to access outpatient services, people often end up at PCS using costly crisis services and in some cases are admitted to Acute Care. Improving access to outpatient services should be a priority and will ultimately save money by decreasing reliance on crisis and inpatient services.
Recommendations

- Increase access to outpatient services. The Crisis Walk-In Clinic (CWIC) can only serve 4 – 5 new patients a day and the need far exceeds this. Consumers arrive at 6:30 AM to wait for these precious slots. In addition, CWIC cannot make timely referrals to other outpatient clinic because of lack of capacity in the community. It may be possible to streamline the process to make it easier for individuals needing access to medication only.
- Explore partnerships to create additional service location in other areas of the community where the need is greatest; a south side outpatient clinic is a high priority. Loss of the south side outpatient clinic left a big gap in services, especially for Spanish speakers.
- Explore options for adding walk-in slots to existing community clinics.

Emergency Detentions
Work group members are concerned about the high rate of emergency detentions in Milwaukee County and the need to provide more options for voluntary treatment.
Recommendations
Evaluate the current high volume of Emergency Detentions (EDs)at PCS so we can assess whether EDs are being used appropriately and identify opportunities for diversion.

- Work with private hospitals and CIT/CIP trainers to develop better training of staff in the private hospital's emergency rooms. Currently when police bring patients who are voluntary to the ERs, some staff are insisting that an emergency detention must be done.
    - Need accountability and commitment to change from private hospitals.
    - Prioritize efforts to provide CIP training to staff at private hospitals. This is skill building training that requires willingness of hospital staff to attend.
    - The Emergency Medical Treatment and Active Labor Act (EMTALA) should be incorporated into the CIP training. It provides protections to ensure that patients needing emergency treatment can be discharged only under their own informed consent or when their condition requires transfer to a hospital better equipped to administer the treatment
    - Consider developing quick reference card or job aid.
    - Internal training at BHD is necessary as well

- To reduce emergency detentions, we recommend the expansion of alternative models to support diversion. The Crisis Resource Center model which provides peer support and is an alternative to PCS or inpatient services is strongly supported by the work group and we recommend expansion of this model. Expansion should prioritize development of funding for a north side location. In addition, the current CRC would benefit from additional psychiatrist hours.

Discharge Planning
The work group heard about delays in discharging patients from Acute Care because of the delays in options counseling for Family Care.
Recommendation

- We recommend exploring options to streamline this process such as requiring that the Disability and Aging Resource Centers to evaluate consumers within a week from the date of the referral, as there are people waiting in hospitals or nursing homes that cannot be released until this evaluation is completed and a placement is made.

Peer Support
The September report recommended establishment of a work group to plan for inclusion of peer support in CSP and TCM programs. This was approved in the 2011 budget. This plan should address development of the peer support role, training providers about the role of peer support, strategies for recruitment of peer specialists, and options for offering more training. Currently only one provider offers training and it is offered infrequently. We recommend moving away from that model so that one group does not have a monopoly on providing training.
Recommendations:

- Members of CAB remain ready to assist the implementation of this approach.
- Develop a broader panel of providers to assist with training

Safety Work Group
As outlined in the resolution, this group is focused addressing safety concerns and providing oversight for policy changes made by BHD to address safety. Since the last report, the Safety Workgroup has met four times.

September: Candice Owley, WI Federation of Nurses & Health Professionals and CAB member, presented outcomes of a survey of nurses and therapists from PCS and acute care. It provided a vivid picture of challenges faced by staff. In particular, 80% of respondents indicated that their work area was short staffed, with 59% stating they didn't usually have enough RNs, 62% stating they didn't have enough clerical support and an even bigger problem is a lack of Certified Nursing Assistants (CNAs 80% of the time. When asked how safety could be increased, many recommended increasing staffing, including need for back-up workers. Staff training was also a concern for many: 61% stated that when they were "pulled" to work for another work area, they did not receive adequate orientation.

October: Captain Meverden, Sheriff's Department, presented on the BHD Security Survey. Overall, the changes and recommendations seemed to be appropriate although some workgroup members had concerns that we remember this is a hospital – a place for people who need healing, recovery-oriented services – and not a jail.. Work group members also expressed concerns that efforts on safety issues would more directly address the concerns regarding sexual assault. Joy Mead-Meucci, a workgroup member and clinician in the private hospital setting, presented about the need for adequate & trained staff and having a culture in the environment which is therapeutic and supports recovery.

November: Glenn Krasker, from Critical Management Solutions, spoke about the services his organization is providing to assist BHD in regaining their Joint Commission, to resolve existing CMS deficiencies, and to design practices aimed at creating a safe environment for patient care. It was reported that 50% of the Joint Commission standards are directly related to safety in the hospital setting. Krasker presented data from studies that showed that a small number of patients are responsible for a majority of aggressive episodes and spoke about general and personal safety procedures, aggression predicting factors, obtaining patient histories from patients with violent behaviors, techniques to de-escalate violent acts and strategies to avoid physical harm.

December:Beth Burazin, peer specialist and social worker, presented information from interviews with consumers who had been in the BHD acute unit within the past year. She reported that many consumers felt the Certified Nursing Assistants (CNAs) on the units don't care and are not helpful. Those interviewed seemed to like the RNs but felt they were usually too busy to help them. Some consumers didn't seem to know about Peer Support Specialists but indicated they felt they would like to use those services if they were available. Peer specialists can present consumers with hope for recovery, by interacting with someone who has "been there, done that" and has managed to succeed.

Key Points and Recommendations:

Staffing
Having the right staff and sufficient staffing is essential to maintaining safety and quality of care.
Recommendations

- 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. We urge that these dollars be used as planned to hire additional CNAs, Lead RNs, and training staff. There is a currently a lack of Lead RNs, who are needed to ensure accountability, provide mentoring, to address morale issues, and provide leadership for frontline staff. Additional CNAs are needed to staff the new Zone model developed to address safety concerns.
- BHD currently faces many challenges in recruiting experienced staff. We encourage BHD to explore partnerships to cultivate and recruit staff who are more likely to be successful. For example, partnerships with higher education institutions should be explored to see if CNA students can have the opportunity to train at BHD, developing a pool for future recruitment; this model has worked well for Aurora. There may also be opportunities to review and

streamline the hiring process which is currently very slow and cumbersome, and not responsive enough to the pressing need to fill frontline positions.

- We believe that the new Administrator must be well-versed in recovery concepts, trauma-informed care and empowerment, providing strong leadership on creating this type of culture. We recommend that the Community Advisory Board have an opportunity to provide input to the administrator's job description and to have a CAB representative play a role in the hiring process to ensure a strong community perspective.
- 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.

Training
Quality training and mentoring are also essential to maintaining safety and quality of care.
Recommendations

- It's critically important that direct care staff receive training, both initially and on-going. We recommend 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.
- CNAs have the greatest amount of patient contact. We have heard feedback from patients that some CNAS do not engage with patients and are not helpful. Most CNAs begin their work at BHD without experience working with mental health consumers and with little knowledge about mental illness. BHD staff will be updating the CNA training in 2011. Members of the Community Advisory Board are eager to work collaboratively with BHD staff to enhance the training to include a consumer perspective, the importance of empathy and respect, and updated information about mental illness and developmental disability. CAB members are involved with the CIT training which may offer some good models to adapt for use in the CNA training.

Maintaining Safety and a Healing Therapeutic Environment
Safety must be considered in 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

- 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.
- We strongly support allocation of funds for a safety consultant in the 2011 budget and are pleased to see that has been approved with support of the County Board. Moving forward with this initiative should be a high priority. The County Department of Audit Report highlights the challenge of finding a better model for serving a small number of aggressive patients who tend to cycle through system without finding an appropriate placement. 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.

- .Work groups members agree with BHD staff that "wanding" should not be implemented at the walk-in clinic. This not the practice at other community clinics, would be stigmatizing and not warranted based on the past history.
- We recommend 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. This is another area we plan to explore in 2011.

Fiscal Impact

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

Respectfully submitted:

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