

County of Milwaukee
INTEROFFICE COMMUNICATION

DATE: May 4, 2011

TO: Sup. Lee Holloway, 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 increase by \$42,879, from \$406,209 to \$449,088, the 2011 contract with Legal Action of Wisconsin, Inc., to provide Benefit Specialist/Legal Services authorized under File No. 11-34 (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 May 18, 2011

The resolution authorizes the Director, Department on Aging, to increase by \$42,879, from \$406,209 to \$449,088, the 2011 contract with Legal Action of Wisconsin, Inc., to provide Benefit Specialist/Legal Services authorized under File No. 11-34 (a)(a).

The Benefit Specialist/Legal Services program assists about 1,000 Milwaukee County seniors annually to work through the complex maze of state and federal benefit programs and how they compare to private benefit plans. The program provides seniors, their family, and caregivers with health benefit information, counseling services, and assistance in understanding their public and private health insurance options. The program helps seniors to determine which health insurance plan, prescription drug program, or other benefit plans would service them best and how to apply for such benefits.

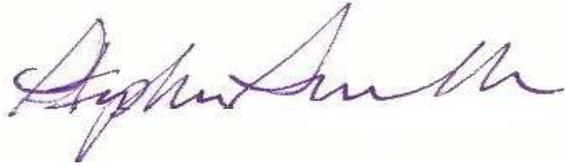
The 2011 contract award to Legal Action of Wisconsin, Inc., provides for both benefit specialist services and legal services to seniors age 60 or older. Offering such services is a priority of the Older Americans Act and is part of the Milwaukee County Area Plan for Older People. In addition to Older Americans Act dollars, the program receives funding from several state sources including State Benefit Specialist Program, State Health Insurance Assistance Program (SHIP), and a grant from the Office of the Commissioner of Insurance (OCI).

The awards from both the State Health Insurance Assistance Program (SHIP) and the Office of the Commissioner of Insurance (OCI) are for periods other than a calendar year. The SHIP award covers the period April through March and the OCI award covers the period July through June. The attached resolution, if approved, amends the 2011 Benefit Specialist/Legal Services contract to add SHIP and OCI funds not included in the original resolution.

The attached resolution authorizes the Director, Department on Aging, to increase by \$42,879, from \$406,209 to \$449,088, the 2011 contract with Legal Action of Wisconsin, Inc., to provide Benefit Specialist/Legal Services. It reflects additional funds available for the contract year. The \$42,879 increase includes \$15,070 from SHIP and \$27,809 from OCI.

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

A handwritten signature in purple ink, appearing to read "Stephanie Sue Stein", is centered on a light yellow rectangular background.

Stephanie Sue Stein, Director
Milwaukee County Department on Aging

Attachments

cc: County Executive Chris Abele
George Aldrich
Antionette Thomas-Bailey
Jennifer Collins
Jonette Arms
Nubia Serrano
Mary Proctor Brown
Brad Peele
Gary Portenier
Pat Rogers

1 RESOLUTION

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3 WHEREAS, on December 16, 2010, the Milwaukee County Board of Supervisors
4 authorized the Director, Department on Aging, to execute contracts to provide programs
5 and services for the period January 1, through December 31, 2011 [File No. 11-34 (a)(a)];
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9 and

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11 WHEREAS, the Department awards funds to provider agencies based on the
12 availability of federal, state, and local funds, usage by older persons of the programs and
13 services provided, anticipated changes in service demand, and allowable costs; and
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17 WHEREAS, one of the programs and services funded under File No. 11-34 (a)(a)
18 is the Benefit Specialist/Legal Services program; and
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21 WHEREAS, both the State Health Insurance Assistance Program (SHIP) and the
22 the Office of the Commissioner of Insurance (OCI) are funding sources utilized by the
23 Department to support the Benefit Specialist/Legal Services program; and
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27 WHEREAS, both programs operate on a fiscal year other than a calendar year,
28 resulting in a reallocation of funds between the two calendar years, and
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31 WHEREAS, since \$15,070 remains available from SHIP and \$27,809 remains
32 available from OCI, for a combined total of \$42,879, the Departments recommends
33 increasing 2011 funding for the Benefit Specialist/Legal Services program by \$42,879,
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35 from \$406,209 to \$449,088; now, therefore
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37

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39 BE IT RESOLVED, that the Director, Department on Aging, is hereby authorized
40 to increase by \$42,879, from \$406,209 to \$449,088, the 2011 contract with Legal Action
41 of Wisconsin, Inc., to provide Benefit Specialist/Legal Services originally authorized
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43 under File No 11-34 (a)(a).
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MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: May 4, 2011

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: Request for authorization to increase by \$42,879, from 406,209 to 449,088, the 2011 contract with Legal Action of Wisconsin, Inc., to provide Benefit Specialist/Legal Services originally authorized under File No. 11-34 (a)(a).

FISCAL EFFECT:

- | | |
|--|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact
<input checked="" type="checkbox"/> Existing Staff Time Required
<input type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below)
<input type="checkbox"/> Absorbed Within Agency's Budget
<input type="checkbox"/> Not Absorbed Within Agency's Budget
<input type="checkbox"/> Decrease Operating Expenditures
<input type="checkbox"/> Increase Operating Revenues
<input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures
<input type="checkbox"/> Decrease Capital Expenditures
<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> 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.

This resolution authorizes the Director, Department on Aging, to increase by \$42,879, from \$406,209 to \$449,088, the 2011 contract with Legal Action of Wisconsin, Inc., to provide Benefit Specialist/Legal Services originally authorized under File No. 11-34 (a)(a). Funds required to execute this contract amendment come from the State Health Insurance Assistance Program (SHIP) and the Office of the Commissioner of Insurance (OCI). The increase includes \$15,070 from SHIP and \$27,809 from OCI.

This resolution has no other fiscal impact on 2011 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 Department on Aging / Gary W. Portenier, Program Planning
Coordinator



Authorized Signature _____

Did DAS-Fiscal Staff Review? Yes No

COUNTY OF MILWAUKEE
Inter-Office Communication

Date: May 2, 2011

To: Johnny Thomas, Vice Chair, Committee on Finance and Audit
Peggy West, Chair, Committee on Health and Human Needs

From: Jerome J. Heer, Director of Audits

Subject: Status Report – BHD Food Service Privatization Audit (File No. 10-290)

At its meeting on September 23, 2010, the Committee on Finance and Audit passed a motion to receive and place on file our audit report entitled "Savings from BHD Food Service Privatization Fall Short of Expectations but Remain Substantial," with a status report due back to the Committee. At the Committee on Health and Human Needs meeting on October 27, 2010, the Committee chair also requested the status report.

Attached for your review is the requested status report. Please note Behavioral Health Division management comments regarding its progress toward implementing our two audit report recommendations, along with the draft checklist to be used for future privatization initiatives.

As noted in the status report, the recommendations are being adequately addressed, with completion of the first recommendation expected in July and continued efforts to adhere to the State's corrective action plan.

The status report is informational and no further action is required.


Jerome J. Heer

JJH/PAG/cah

Attachments

cc: Finance and Audit Committee Members
Health and Human Needs Committee Members
Chris Abele, Milwaukee County Executive
Geri Lyday, Interim Director, Department of Health and Human Services
Paula Lucey, Director, DHHS – Behavioral Health Division
Terrence Cooley, Chief of Staff, County Board Staff
Steve Cady, Research Analyst, County Board Staff
Jennifer Collins, Research Analyst, County Board Staff
Carol Mueller, Chief Committee Clerk
Jodi Mapp, Committee Clerk, County Board Staff

STATUS OF IMPLEMENTING DEPARTMENT OF AUDIT REPORT RECOMMENDATIONS

Audit Title: Savings from BHD Food Service Privatization Fall Short of Expectations but Remain Substantial

File Number: 10-290

Audit Date: August 2010

Status Report Date: April 29, 2011

Department: DHHS - Behavioral Health Division

Number & Recommendation	Deadlines Established		Deadlines Achieved		Implementation Status		Comments
	Yes	No	Yes	No	Completed	Further Action Required	
1. Work with the Department of Administrative Services to develop a comprehensive standardized checklist of elements for consideration in calculating savings from privatization initiatives. The checklist should include, but not be limited to, all personnel costs, including active fringe benefit costs, overtime, unemployment compensation, and employee displacement services, as well as outside revenue offsets and other costs. The calculations should be made for both the initial year of implementation and for subsequent years, if materially different.		X		X	No	Yes	Auditee: BHD has been working with DAS to develop a checklist for future privatization initiatives. A DRAFT checklist is attached to this report. DAS And BHD will continue this initiative by asking Audit, County Board Staff and the new Director of DAS and Fiscal and Budget Administrator to review the document and make suggestions and comments. BHD and DAS staff will revise it and submit a final checklist to the Department of Audit in July 2011.

STATUS OF IMPLEMENTING DEPARTMENT OF AUDIT REPORT RECOMMENDATIONS

Audit Title: Savings from BHD Food Service Privatization Fall Short of Expectations but Remain Substantial

File Number: 10-290

Audit Date: August 2010

Status Report Date: April 29, 2011

Department: DHHS - Behavioral Health Division

Number & Recommendation	Deadlines Established		Deadlines Achieved		Implementation Status		Comments
	Yes	No	Yes	No	Completed	Further Action Required	
2. Adhere to the corrective action plan related to oversight of contracted dietary services, outlined to the State of Wisconsin in its response to the Statement of Deficiencies and Plan of Correction report for the survey completed on May 11, 2010.		X		X	Yes	No	Auditee: BHD has continued to abide by all elements included in the Plan of Correction regarding contracted dietary services including: <ul style="list-style-type: none"> ✓ The Infection Control Practitioner completes rounds of all food service areas at minimum on a quarterly basis. ✓ A viands representatives attend the BHD Infection Control and Environment of Care meetings monthly. ✓ BHD Maintenance staff has completed a significant amount of work on the food service building including re-building coolers, re-surfacing many areas with stainless steel and increasing maintenance of equipment. BHD Operations managers conduct regular rounds of the building. ✓ BHD established an annual deep cleaning scheduled for all on-site and off-site kitchen operations with the BHD cleaning vendor. ✓ A viands cleaning schedule is monitored regularly by BHD operations staff. ✓ A new Dietary Supervisor has been hired by BHD to oversee food services including quality control and adherence to dietary needs of clients. She works closely with BHD staff and the food service vendor to improve food service and address any issues that arise. ✓ A new Quality Assurance Coordinator was hired by BHD to monitor contracts, including food service.

DRAFT

Privatization Initiatives Checklist

If a department is considering a new privatization initiative, DAS requests that the following spreadsheet be used when calculating savings. A calculation must be done for the initial year of implementation and the subsequent year on a budget and an actual basis.

	Current Year Budget	Initial Year Budget	Subsequent Year Budget		Current Year Actual	Initial Year Actual	Subsequent Year Actual	NOTES
Fiscal Considerations								
Salary (5199)								
Social Security (5312)								
Overtime (5201)								
FTE (include detail of all abolished and created positions on a separate form with title code, salary etc)								
Active Fringe Benefits (5420 and 5421)*								
Support Services Analysis (i.e. reduction or increase in maintenance, fiscal, HR, administration, contracts, QA outside of service area)								
Unemployment Compensation (Use Federal UE compensation rates and work with DAS to determine a % of employees likely to collect UE)								
Displacement Services (Work with Central HR to consider costs per employee depending on field)								
Revenue Adjustment - include explanation of loss of revenue if any								
Crosscharge Adjustments (include Ceridian, IMSD, Central Service etc)								
Sick Pay Balance Payout								
Payout for vacation (depends on timing)								
Miscellaneous and Other fiscal issues								
Cost of contract (Include an explanation of how this was calculated - i.e. using RFP bids, industry standards etc)								
Other increased costs related to implementation of the contract such as oversight, supplies etc								
Other Considerations	Narrative							
Program Changes - include benefits to the program and potential issues from a programmatic point of view. This should be reviewed after one year and reassessed.								
Performance Measures - Establish performance measures before privatization and track them for at least one quarter prior to and after implementation of privatization.								
Assess if the contract should be Purchase of Service or Professional Service (refer to Audit for more information and detail)								

*if doing as a budget initiative, please use the budgeted fringe rate. If doing mid-year, use memos from DAS- Accounting regarding the actual fringe rate for the year.

COUNTY OF MILWAUKEE

Inter-Office Communication

DATE: May 4, 2011

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

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

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

Issue

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

Action Requested

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

Background

This is the third 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; additional recommendations regarding safety, patient centered care, and linkages to the community were included in the January report.

The Community Advisory Board has continued its efforts to address concerns related to safety, patient centered care, and community linkages and this report contains additional updates and recommendations for policy makers. A list of related meetings is provided as an attachment. We appreciate the support and partnership of Behavioral Health Division staff in moving forward with these recommendations, as well as the support of the County Board, and the active participation of County Board Supervisor Joe Sanfelioppo as a valued member of the CAB.

MILWAUKEE COUNTY AUDIT DEPARTMENT BHD REPORT

ISSUE: The October 2010 report from the County Audit Department indicated that different options are needed to support a small number of aggressive patients who are not appropriately placed at the Adult Acute Inpatient Hospital. The Audit Report suggested that Community Advisory Board could be a resource for identifying long term strategies and resources to address this model.

RECOMMENDATION: The CAB is committed to working collaboratively with BHD to identify potential strategies. One component of such a strategy should include developing other models for serving people with developmental disabilities and mental illness. Although the audit report does **not** provide any data regarding the disability of the individuals with a pattern of aggressive behavior, we note that when the federal and state governments conducted their investigation of the Milwaukee Mental Health Complex Acute Care Unit in January 2010, the hospital was cited for failing to maintain the safety of 11 of the 17 patients reviewed. Five of these patients had a cognitive disability, including the patient who became pregnant and another patient who had a long history of sexual aggression and was alleged to be the father of the baby. This report includes recommendations for another model for serving people with developmental disabilities which includes a continuum of community based resources. We will continue to work on identifying other strategies and resources. We also recommend that BHD gather additional data about the small number of patients with aggressive behavior so strategies can be targeted to address their disability.

MODELS FOR SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES

ISSUE: Among the 14,000 people seen at PCS annually, a significant number are people with developmental disabilities – many but not all of these individuals also have a mental illness. Some are enrolled in Family Care. Many are at PCS because of challenging behaviors which some community providers do not have the expertise or support to address, and they may unnecessarily remain at the Mental Health Complex because of difficulty securing appropriate community placements. There is currently limited support to help providers and families address these concerns in the community. Additional supports are needed to ensure that people with developmental disabilities and mental illness are successful living in the community, and to reduce reliance on costly institutional care including Hilltop.

A potential model was presented to the CAB by Paul White, from the University of Wisconsin Waisman Center for Excellence in Developmental Disabilities. Mr. White shared the Dane County Community Ties program, a promising model for serving people with developmental disabilities and complex needs in the community, including people currently served at the Mental Health Complex. Disability Rights Wisconsin (DRW) also hosted a meeting with Mr. White and the three Family Care/Partnership Managed Care Organizations.

QUARTERLY REPORT FROM THE COMMUNITY ADVISORY BOARD ON BOARD ACTIVITIES AND RECOMMENDATIONS RELATED TO FILE NO. 10-213

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RECOMMENDATIONS: The CAB strongly endorses and recommends the following:

- BHD, Disability Services, and community partners to work with the Waisman Center to develop a continuum of services similar to Community Ties for serving people with developmental disabilities and mental illness, and other people with developmental disabilities and complex needs.
- This should include 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. (see attachment for information about Community Ties)
- BHD, Disability Services, the three Family Care/Partnership MCOs, and Disability Rights Wisconsin (the Family Care Ombudsman) should meet to explore how to work together to promote successful life in the community for Family Care members with developmental disabilities and complex needs, reduce admissions to the Mental Health Complex, and accelerate discharge to the community when admissions occur. This will be critically important if the proposed cap on Family Care in the state budget moves forward. If people are not discharged quickly, they will lose their slot in Family Care.
- BHD should track and analyze admissions and discharge of people with developmental disabilities at the Mental Health Complex to better understand why people are being admitted and the areas which need to be addressed to reduce admissions.

MENTAL HEALTH REDESIGN

ISSUE: A number of proposals are under consideration to redesign the adult mental health system in Milwaukee County. The CAB work groups have reviewed the HSRI Public Policy Forum recommendations and also had the opportunity to hear from Chairman Holloway about his proposal. Some CAB members have had the opportunity to speak to the County Board's Special Committee.

RECOMMENDATIONS: There are positive components in all of the proposals and we encourage policy makers to move forward with redesign. The CAB work groups have supported and recommend that the following principles guide the Redesign:

- Efforts to redesign adult mental health in our county should include the overall system – the Milwaukee County system, private hospitals, FQHCs, advocacy organizations, consumer run organizations, and physicians and therapists. A public private partnership, as proposed by the HSRI plan, is needed to move forward with redesign.
- Our current system has an overreliance on costly and traumatizing crisis and inpatient services. We need to shift resources – not decrease them – to increase availability of the community based services and supports that can help people maintain their health and independence, and avoid expensive inpatient and crisis care.
- There is support for expanding partnerships with the private hospitals to serve more people and reduce the number served at the Mental Health Complex. The HSRI report indicated that our number of hospital beds is probably about right – but that there were opportunities to reduce inpatient costs by expanding partnerships with the private

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hospitals. In addition, the private hospitals already have Joint Commission certification and less difficulty recruiting staff.

- As noted in our January report, Milwaukee County has an extremely high level of emergency detentions - of the 14,000 visits to PCS last year, approximately 8000 were emergency detentions – people brought to PCS in handcuffs by the police. The second largest county in our state, Dane County, had only 400 EDs. We continue to support the recommendations in the January report including the need for a focused quality improvement effort including data gathering and analysis; training of staff at BHD, private hospitals, and law enforcement; and expansions of alternatives for diversion such as the Crisis Resource Center..
- Redesign must address the culture of care with a commitment to provide person centered, recovery oriented, culturally competent, trauma informed, and integrated delivery model and culture.
- To be successful, any efforts to improve the mental health system must include consumers – meaning people who have experienced mental illness - and advocates, as full partners. The HSRI study indicated that our system has a shockingly high rate of consumer refusal of services. By including consumers and advocates as full partners, we can move towards a system that is more reflective of the needs and preference of those served and that promotes voluntary treatment.

SAFETY WORKGROUP

Listed below are some of the issues discussed by the Safety Work Group and recommendations for addressing them.

RESPONSE TO SEXUAL ASSAULTS

ISSUE: One staff member from the Sexual Assault Treatment Center(SATC) reported anecdotally that they had reports of one client with potential sexual contact/assault who was examined by BHD staff before referral to SATC, and this staff member was concerned that this might be occurring in other cases. BHD staff agreed this is not appropriate as it may destroy evidence. BHD staff indicated they have some conflicts in duty related to regulations that require assessment of any complaint prior to any transfers. Concerns were also discussed regarding the timeliness of communicating with family members or guardians

RECOMMENDATION: When an alleged assault occurs, the patient should immediately be offered the option to go to the SATC and the exam should be done by experts at SATC. BHD staff should review their protocol regarding the response when an allegation of sexual assault occurs, including communication with family member or guardian, and see if changes are needed. SATC staff are available as a resource to discuss protocols. In addition, the CAB recommends that additional training be provided for BHD staff regarding the response when a sexual assault occurs, and SATC staff is a resource for training as well. BHD staff concurs with these recommendations and many have already been implemented. BHD staff report that physicians have been told to not do any physical exam in any potential cases of sexual

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contact unless the patient refuses to be transported. Then an assessment is offered for any immediate medical needs.

ISSUE: The group heard perspectives from Community Advisory Board members regarding opportunities to improve the response to allegations of sexual assault at BHD. The CAB includes a number of members with experience in this area including staff from the Sexual Assault Treatment Center and the Healing Center, an attorney from DRW, and county staff including a representative from the Sheriff, an RN, and peer specialists. Concerns were expressed that some law enforcement personnel who respond to allegations of sexual assaults at BHD do not believe the patients. There was also discussion of the benefits of having more female deputies respond to these complaints as many victims are more comfortable speaking to a woman.

RECOMMENDATION: Have training provided to law enforcement. Deb Donovan, from the Sexual Assault Treatment Center (SATC) at Aurora, offered to do a presentation to the leadership at the Sheriff's Department. Discuss with Sheriff Clark the possibility of having more female deputies available to respond and try to honor the victim's choice if they have a preference for a female (or male) deputy.

SECLUSION & RESTRAINTS (S&R)

ISSUE: BHD continues to work on reducing use of seclusions and restraints. However, staff reported that in 2010, the use of S&R in the in-patient units increased. They speculated that this was in response to staff concerns about violence and assaults. BHD has been doing intensive training to address this and recently developed new initiatives that are aimed at dealing with escalating behaviors, with minimal use of restraint and seclusion. A new component is the use of the Broset Violence checklist, which is completed by an RN and then updated throughout the patients stay at the acute unit at BHD. A positive and unique part of the new initiative was the inclusion of a personal safety plan for advance crisis planning. This planning tool is done collaboratively with patients to reflect their preferences in what helps them de-escalate and also the particular use of restraint and seclusion if it becomes necessary. There was also discussion about concerns regarding the use, and possible overuse of chemical restraints.

RECOMMENDATION: Move forward with implementation of the new BHD initiative for responding to escalating behaviors and reducing use of seclusion and restraint. Workgroup members were very enthusiastic about the new tools, particularly the advance planning for crises which includes the patient. It is also important that all staff have training and knowledge about trauma-informed care and understand how the use of S&R can trigger traumatic memories in residents and exacerbate their behaviors. BHD should consult with organizations such as St. Ameliens, who have successfully implemented trauma-informed care concepts in S&R reduction initiatives. BHD should continue carefully reviewing and monitoring its use of chemicals for purposes of S&R as there are strict federal rules regarding their use.

EVALUATING PROGRESS OF SAFETY INITIATIVES

ISSUE: Members of the Workgroup have had several discussions with BHD staff on how to best evaluate progress regarding safety at BHD. There was some agreement that it would be helpful to develop a “Dashboard” of indicators in which progress (or lack thereof) could be easily identified without exposing anything that would breach patient confidentiality. Although these indicators have not yet been defined, there seemed to be agreement that “trending data” might be useful.

RECOMMENDATION: BHD should work with the CAB to agree on a list of indicators that they are willing to routinely report on as a way to evaluate the efficiency of the changes being made to address safety concerns.

MIXED GENDER REPORT

ISSUE: CAB members reviewed the Report on Mixed Gender Patient Care Units and submitted a memo to the board on 3/2/11 commenting on the report and generally supporting the recommendations.

RECOMMENDATION: There are some promising recommendations; however, the manner in which they are implemented is critically important:

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

PATIENT CENTERED CARE WORK GROUP

The following issues and recommendations are from the Patient Centered Care work group.

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE

ISSUE: Milwaukee County is moving forward with CCISC – Comprehensive, Continuous, Integrated System of Care. This evidence based model has as its goal an integrated service

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system that can provide high quality, recovery oriented services that are co-occurring capable, person-centered, culturally competent, trauma informed, family involved and include peer to peer services.

RECOMMENDATION: The CAB strongly supports and endorses the CCISC initiative and its focus on person centered recovery oriented care, and increased commitment to finding more effective ways to support and engage complex people. We recommend implementation of CCISC system wide – in the community, acute care, and long term care systems and anticipate significant positive impact from a welcoming, acceptance of people with co-occurring issues on consumers, providers, and the system.

ACCESS TO INTERPRETERS

ISSUE: The CAB had previously expressed concern about the availability of appropriately trained interpreters for deaf and hard of hearing patients and family members. A work group member had offered to assist with identifying additional resources.

UPDATE: A member of the workgroup has been collecting a list of interpreters with specialized credentials to provide to the County, as well as to identify which interpreters meet the new state credentialing law which went into effect in December 2010. As soon as all of the information is updated, this information will be shared with county staff.

GRIEVANCE POLICY UPDATE

ISSUE: As noted in the January report, the grievance policy document is in compliance with the law but complex. The CAB recommended development of an additional “quick reference version” that is very simple and understandable for those with low literacy levels.

UPDATE: The document has been developed by BHD Patients Rights Committee with input from CAB members and is now part of the admissions packet. The Disability Rights Wisconsin brochure is also included in the packet as previously recommended.

COMMUNITY LINKAGES WORK GROUP

The following issues and recommendations are from the Community Linkages work group.

ESTABLISH COMMUNITY ACCESS POINTS

ISSUE: Our mental health and human services system can be confusing and difficult to navigate. People in need of mental health services and supports often face many barriers to accessing help, and as a result may end up relying on expensive crisis care.

RECOMMENDATION: Explore the development of community access points which would be open 24 hours a day and 7 days a week to help link people to services and provide

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diversion from PCS. This would provide collaboration and coordination of services. These community access points could be located at sites already operating 24/7, such as the Crisis Resource Center. The CRC could be an ideal site for an initial pilot.

Staff would have the expertise and the computer resources to provide information and referrals. These sites could also be utilized by the police or PCS for assessment and linkage to community resources, reducing the number of folks going to the PCS emergency room.

Staff would assist with appointments to outpatient clinics or other referrals and follow-up with individuals to insure access to services, provide appointment reminders, and identify barriers to treatment and resolutions. Other services would include benefits counseling, and assistance with securing housing.

EXPAND THE CRISIS RESOURCE CENTER MODEL

ISSUE: The Milwaukee Crisis Resource Center (CRC) is a community based, recovery oriented alternative to inpatient hospitalization and emergency department visits, that is not only cost effective, but a better service option for individuals experiencing a psychiatric crisis that does not require medical treatment. In 2010, there were 340 individual admissions to the CRC, and 54% were diverted from a hospital ER or inpatient hospitalization. However, the CRC has very limited capacity with 7 beds and is located on the south side, so can only serve a very small number of those who may benefit from this cost effective diversion. Over 120 people have been turned away this year due to limited space. In addition, the CRC is facing fiscal sustainability challenges due to the low Medicaid reimbursement rate.

RECOMENDATION: The CAB strongly supports the County Board's recommendation to develop a Crisis Resource Center (CRC), including peer support, on the north side of town. We also recommend that Milwaukee County support efforts of the CRC leadership, and advocacy groups, to urge the state to change Medicaid reimbursement rates to maintain adequate funding.

Proposals to DHS for Supporting the CRC:

- Increase the Medicaid rate for the crisis stabilization per diem code S9485 to a level capable of sustaining residential care in an environment that is less restrictive than inpatient care and inappropriate emergency room care.
- Identify a new Medicaid code for acute residential care that would allow the T19 HMOs to include clients served under this code in the T19 HMO contract encounter data.

EXPAND OUTPATIENT SERVICES

ISSUE: We are experiencing a crisis in access to outpatient mental health services. This is due in part to limited number of psychiatrists in the state, and the very limited number who

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serve Medicaid patients. In addition, the number of outpatient slots funded by Milwaukee County for uninsured has declined and there is no longer an outpatient mental health clinic on the south side for those receiving outpatient services through Milwaukee County. People literally end up at our county emergency room, because they cannot access outpatient services – this has a very high fiscal cost, as well as a tragic human cost.

RECOMMENDATION: It should be a top priority to maintain and expand our network of outpatient mental health services. As recommended by HSRI, the CAB supports development of a plan to reallocate resources so we can provide more outpatient and community based services and fewer people will be forced to access costly crisis and inpatient care.

We propose these principles for expansion of outpatient care:

- Geographic diversity to improve access.
- Some Walk In Clinic hours to provide access to new clients and to those with an urgent need for assistance.
- A holistic model of services including access to both mental health and substance abuse services, benefits counseling, connections to resources such as housing, peer support. The Bridge Health Clinic (<http://www.thebridgehealthclinics.com>) is an excellent example of this model.
- Culturally and linguistically appropriate care.
- Partner with Federal Quality Health Clinics (FQHC) to develop outpatient capacity as they receive a better federal reimbursement rate.
- Work with DHS and other stakeholders in the states to hold MCO's accountable for providing adequate access to mental health services in their networks.

DECREASING HOSPITALIZATION

ISSUE: After a psychiatric hospitalizations, people are at risk for readmission if there is not adequate support in the community. In an effort to decrease hospitalization, Optum Health (United Health), in partnership with Grassroots Empowerment and NAMI Greater Milwaukee, has piloted the PeerLink Project. The program matches a Certified Peer Specialist who is successfully managing his or her own recovery with peers in Optum Health who are currently receiving services in inpatient facilities or recently discharged. The goal is to ease the transition of individuals being discharged from hospital settings back into community life and to significantly decrease the need for readmission to the hospital by engaging people prior to the potential need for entry into the inpatient facilities. Results to date have shown a 46% decrease in hospitalization for members involved with the program.

RECOMMENDATION: Pilot use of the PeerLink model for patients discharged from the Acute Care Unit at BHD. Partner with NAMI Greater Milwaukee and Grassroots Empowerment who have been local partners in this project. In addition the above

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recommendation about expansion of the community resources and out-patient services will make a significant difference in the number and length of hospitalizations.

HOUSING FIRST

ISSUE: Homelessness or housing insecurity is a large contributor for many people experiencing a mental health crisis. Milwaukee County has made some very positive strides with a public private partnership to develop affordable, accessible housing with supportive services for people with mental illness; however the need still greatly exceeds the supply. The lack of housing also delays discharge from expensive inpatient care, or, when housing is not secured, contributes to costly readmission to the hospital and the “revolving door”. The January 26th Point in Time survey of homeless people in Milwaukee County found that in the past six months, 6 – 9% of those discharged from mental health treatment did **not** have a place to stay upon discharge and ended up in shelters or on the street.

RECOMMENDATIONS: The CAB strongly supports the county’s efforts to work with the private sector and federal funding to develop additional supportive housing and independent living options, across the county, including in suburban locations. The HSRI report included a recommendation to enhance and emphasize housing supports to offer a greater continuum of housing resources; we support those recommendations as well. A Housing First model will ultimately be a good investment and reduce the overreliance on crisis and inpatient care. The homeless service system should be included as a partner.

Fiscal Impact

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

Special Note

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

Respectfully submitted:

Barbara Beckert
Milwaukee Office Director
Disability Rights Wisconsin

Paula Lucey
Administrator
Milwaukee County Behavioral Health Division

QUARTERLY REPORT FROM THE COMMUNITY ADVISORY BOARD ON BOARD
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cc: County Executive Chris Abele
Antionette Bailey-Thomas, Analyst - DAS
Jennifer Collins, Analyst - County Board
Jodi Mapp, Committee Clerk - County Board

Meetings for Community Advisory Board and Work Groups -January – April 2011

Community Advisory Board Meetings

1/19/11

- Douglas Jenkins, Deputy Director of Audits spoke about the County Audit Department's report on BHD, and discussion of CAB feedback
- Update on Special County Board Committee to Study Construction of a New Behavioral Health Facility, County Supervisor Joe Sanfelippo – CAB member and committee chair
- County Executive Lee Holloway spoke about his vision for the mental health system

2/23/11

- Presentation of Mixed Gender Report by Dr. Mary Kay Luzi and work group members
- Discussion of CAB feedback on the report recommendations

3/21/11

- Presentation by Paul White, University of Wisconsin Waisman Center for Excellence in Developmental Disabilities about models for serving people with developmental disabilities and mental illness or with developmental disabilities and complex needs.
- A meeting was also hosted by DRW with Mr. White and representatives of the three MCOs serving residents of Milwaukee County in Family Care/Partnership programs.

Safety Work Group Meetings

1/26/11

- Presentation by Deb Donovan, of the Sexual Assault Treatment Center at Aurora Sinai Medical Center
- Workgroup members learned about services and statistics regarding sexual assault in Milwaukee, as well as the referral procedures between BHD and SATC.
- Discussed the type of indicators staff could share with workgroup to “measure” improvements in safety at BHD.

2/23/11 Hosted CAB meeting on Mixed Gender Unit report- noted above

3/23/11

- BHD Staff did a presentation on Seclusion & Restraints, as well discussing two new tools being developed to address S&R
- Further discussion on how BHD might develop some sort of “dashboard” of indicators related to tracking safety improvements

4/27/11

- Michelle Cohen, from St. Amelian, did a presentation on their strategies to reduce seclusion & restraint (S&R) with youth.
- Shirin Cabraal, Co-Chair of the Workgroup and an attorney with Disability Rights Wisconsin, did a presentation on the laws regarding S&R.

Community Linkages Work Group Meetings

1/18/11

- Use of Emergency Detentions including overview by Public Defender Dennis Purtell and input from CIT officer
- Lack of outpatient clinics – consumers going to ER departments for med refills
- Concerns re new Managed Care Organization initiative: consumers must be dropped off at clinics 90 minutes before appointment – leads to crowded waiting rooms and unhappy customers

2/25/11

- Outpatient clinic capacity in Milwaukee County
- Disability Benefit Specialists at the Disability Resource Center and elsewhere– too few given the needs in Milwaukee County and financial impact of uninsured
- Medicaid reimbursement for Psychiatrists

3/9/11

- Todd Campbell from the Bridge Health Clinic and Research Center. Provides mental health and substance abuse services. Serves people on Medicaid and uninsured.
- Peter Hoeffel and Serge Blasberg from the Peer Link Program - Overview of the program which is being studied by Yale. Results show a significant decrease in readmission to the hospital for participants.

3/25/11

- Mental Health resources in Milwaukee and current capacity
- Resources utilized by Community Resource Center
- Lack of access to community services are people leave jail – and lack of access to treatment contributes to many ending up in jail

4/3/11 and 4/29/11

- Discussion about recommendation for community services and prioritizing recommendations into 3 tiers:

Patient Centered Care Work Group

1/6/11

- Review and endorsement of HSRI recommendations
- Overview of need for adequate, appropriately trained interpreters for both spoken language and signing. Examples illustrated deficits related to inadequate service provided to Spanish and Hmong speaking individuals, and deaf, leading to suboptimal care.
- Need for expanded list for deaf/hearing impaired interpreters. Denise Johnson will assist them in developing this.
- Recommend interpreters have adequate credentials (mental health specific) and actively participate in the CCISC, PCP, TIC, and Recovery trainings.

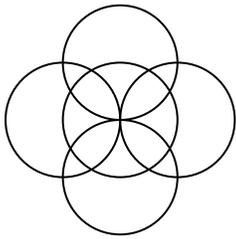
2/9/11

- Person Centered Planning and Creating a Recovery Culture
Speakers: Front line workers including RN, peer specialists. (have had difficulty getting participation from CNA or unit clerk speaker)
Lalena Lampe, Recovery Coordinator for the State of Wisconsin.
 - update on State training initiatives - Person Centered Planning, Recovery, TIC
 - webcasts = free training

3/21/11 – hosted program with Paul White noted above

4/13/11

- CCISC – Comprehensive, Continuous, Integrated System of Care
- Speaker: CHRISTIE A. CLINE, MD, MBA, PC. Dr. Cline partners with Kenneth Minkoff, M.D..
- Systems Change initiative - co-occurring disorder program enhancement, curriculum development, and staff training.



Waisman Center

University of Wisconsin – Madison
1500 Highland Avenue, Room A109
Phone: 608-263-0271
Fax: 608-265-4101

Community TIES UW – Waisman Center

A Community Model for Supporting People with Developmental Disabilities and Challenging Behaviors.

Mission

To support behavioral, psychological and emotional needs of persons with developmental disabilities using approaches that assure continued full participation in supported community life.

Discussion

Supported life for persons with developmental disabilities is most effective when it promotes Full Community Membership and assures individual choice (Self Determination). Within this lifestyle most people lead overall meaningful, productive and healthy lifestyles.

Support to some people includes added attention to emotional, behavioral or psychological needs. Such needs, if unmet, are commonly termed “challenging behaviors”. The community team is challenged to, on behalf of the individual, understand and meet these needs. This can sometime present a daunting task. Any “typically developing” individual striving to sustain his/her own emotional health knows this to be difficult enough. Understanding and meeting such needs on behalf of someone else and in this case a person with cognitive and/or communication challenge is most often quite complex.

Challenging behaviors can be expressed overtly (tension, emotional or physical distress) or covertly (withdrawal or isolation). The cause or life situation that may be stimulating the challenging behavior can be wide and varied. Included here is a list of common “stress triggers” for people with developmental disabilities. These stress triggers can occur individually but are often presented in combination.

For some individuals challenging behaviors occur more often or with sufficient intensity to include aggression, destruction or self injury. It is not uncommon for community support teams to consider moving individuals to lifestyles where safety for the individual and others is better assured. This often results in more restrictive locations where community membership and choice is limited. Examples include ICFMRs, Mendota or Winnebago Mental Health Centers. While the immediate safety for the community is met, the more restrictive setting often only serves to increase the number of stress triggers that can result in challenging behaviors. In fact, the challenging behaviors may have been occurring because the supported living program was not the best fit for the individual in the first place. This is, unfortunately, a common life dilemma for people with developmental disabilities.

A suggested blueprint for supporting people with developmental disabilities and challenging behaviors in the community is offered by Community TIES and Dane County Human Services.

- I. Develop a supported living model within the County that subscribes to “best practice” standards for Full Community Membership and Self Determination. Apply these standards to all persons with developmental disabilities, including people who present challenging

behaviors. Continue to apply resources and training to this end. Practices that are essential to this model include:

- a. Person Centered Planning and a team approach
- b. Meaningful relationships
- c. Self Directed Services
- d. Living, working and recreating in the community
- e. Living with only a few house mates
- f. Meaningful work and recreational activities
- g. Opportunities to explore spirituality

II. When challenging behaviors are of concern look first and foremost to the community support program to assure that it is truly “best practice” as described above. Continually resist pressures to move individuals to, or create, more restrictive settings. Develop a program within the County where additional supports can be added to the existing community lifestyle and only as much as is required. Included here are examples of gradually adding behavioral supports in an effort to assure continued supported community life:

- a. Provide a consultant to the existing community team who can offer insights and direction on supporting persons with challenging behaviors
- b. Use the Personal Futures Planning style to develop a written plan to support challenging behaviors (behavior support plan). Assure that the wording is straightforward and that the plan is accessible to all direct providers.
- c. Offer training and support to direct providers on sensibilities in developing relationships with people who present challenging behaviors.
- d. Build in more intensive supports that assure safety within the existing community support program. This effort sometimes includes the judicious use of Restrictive Measures. Reduce the need for these supports as the individual learns adaptive alternatives to the challenging behaviors.
- e. Provide learning opportunities to direct providers on positive behavioral supports and dealing with potentially dangerous challenging behaviors.
- f. Assure that psychiatric consultation with expertise in disability issues is available to people when needed.
- g. Develop a crisis response that offers an alternative to unnecessary stays in psychiatric hospitals, mental health centers or jail. Crisis response includes:
 - Accelerated access to a behavioral consultant
 - Emergency psychiatry
 - Crisis response staff providing support in the community setting
 - Short term stay “crisis home” in the community

The response should assure either continued participation in community life or a quick return to the supported living program.

The Community TIES model can also be a cost effective approach. While providing supports as described above will require additional funding, it can be less costly than extended stays in more restrictive settings where the per diem rates if often quite high. Additionally the pro-active orientation of the approach offered here will lessen the need of more restrictive and expensive supports over time.

Written by Paul White, Administrator
Community TIES
UW-Waisman Center
April 18, 2011

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: April 29, 2011

TO: Supervisor Peggy West, Chairperson - Health & Human Needs Committee
Supervisor John Thomas, Vice – Chairperson - Finance & Audit

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Prepared by Paula Lucey, Administrator, Behavioral Health Division

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

Since the last report in March 2011, a final Statement of Deficiency (SOD) survey was conducted by the State on April 1, 2011. At that time, the State surveyor inspected all of the original citations and requested one additional piece of information from BHD. BHD sent the final documentation, as requested, to the State. On May 3, 2011, we received a final closing letter from the State stating compliance with the Conditions of Participation. A copy is attached.

To date, \$1,173,939, including personnel, equipment, and materials costs has been spent on the SOD repairs. BHD Operations and DAS met in early 2011 to review all \$858,000 of 2010 expenditures to determine what items (including staff time) were allowable under the capital budget. The DAS Capital Finance Manager completed a 2010 fund transfer for \$258,361, which moved all allowable costs from the BHD operating budget to the capital project. The majority of the items were determined NOT to be allowable capital expenses due to the nature of the repairs. Therefore approximately \$600,000 was spent out of the 2010 BHD operating budget. BHD and DAS have not met to review the \$315,000 in 2011 SOD expenses yet. Due to the shift of spending from the Capital project to the BHD operating budget, a minimum of \$1.25 million remains from the original Board approved allocation. BHD recommends using the remaining SOD funds to address the one major outstanding SOD issue.

Although BHD has addressed all of the physical plant citations, there is one initiative related to the original SOD that BHD has only submitted a final plan but has not yet fully implemented. This is sufficient for the State because in the Plan of Correction, BHD had indicated they would submit the plan but complete the project after that time, therefore only significant planning was required. The project is the Dish Room area.

Dish Room, Tray Line and Laundry Facilities

As noted in prior reports, the Dish Room and Laundry facility repairs are a significant project within the SOD citations and the original cost projections of \$200,000 were based on a conceptual plan only. BHD has worked on a plan and is now proposing to consolidate space within the complex to streamline operations. 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. Specifically, the current Dish Room and Tray Line area will change to storage areas thus avoiding the costly renovations and instead meals will be prepared, refrigerated and rethermed at the Food Service Building, and then brought over to the BHD Facility prior to each mealtime.

BHD has worked with our food service professionals and decided to move toward a new way of food delivery within the long-term care units at BHD. To accomplish this, BHD plans to renovate one of the long-term care kitchens as a pilot project by installing a steam table and dishwasher in the unit kitchenette, as well as new cabinets and a small refrigerator for resident use outside of the kitchen. Required additional equipment also includes new dietary carts for transporting the food between buildings and new trays and smallwares. If the pilot project goes well and the State approves of the changes, BHD will move forward with changing all of the long term care units, and possibly the acute care units, to this meal service style. The staff on the pilot unit has met with the dietician and welcomes the proposal. We will have a community meeting to include the clients in the discussion and let them make some selections about the plan. This will be received well by the state surveyors looking for client involvement in the unit decisions.

Preparing and serving food directly on the units offers many advantages. First, in-unit food preparation will help to create a more home-like environment on the long-term care units and could also serve as an occupational therapy tool for clients involved in the setting and cleaning up of the dining areas. Additionally, clients will have some limited choices about their food selection, which is again important for client satisfaction and a home-like environment. Avoiding the use of retherm carts will improve the quality of the food served. This will help address some of the food service complaints received in the past. Moreover, the dietary carts needed to implement the new system are substantially less expensive than the dietary carts and other attendant equipment that are currently being used. There is also cost avoidance as the potential new carts draw more electricity and would require some redesign of the food preparation building.

This change will require BHD to purchase new equipment for food service including steam tables, dish washers, small refrigerators, cabinets, dietary carts, and new trays and smallwares. It will also change some processes for food delivery but will help manage food production, improve the home-like environment, increase food quality, streamline food service delivery and avoid significant construction costs within BHD. It is estimated that the cost of the necessary equipment and installation by County staff will be about \$150,000 or about \$25,000 per kitchen on each of the six long-term care units. In addition, some changes and equipment will be needed for the Acute care units but that plan will depend on the success of the pilot steam-table project. BHD estimates that regardless of meal service type, the five Acute units will cost no more than \$150,000 for the necessary Dietary changes. Therefore the total cost for this change would be approximately \$300,000, which would be significantly less than repairing the Dish Room.

BHD has already discussed these changes with the State and gotten tentative, verbal approval. BHD plans to move forward with this initiative by continuing to work with the State to ensure that the move out of the Dish Room will satisfy the citation, installing the pilot steam-table and kitchen modification by June 6, 2011 on one long-term care unit, and continuing to work with DTPW, DAS, BHD clinical staff and A'viands to revise the plans as necessary. If the pilot is successful BHD will move forward on the remaining units.

RECOMMENDATION

BHD plans to move ahead with the \$300,000 in Dietary changes to address the SOD plans submitted and avoid any further citations in the future. BHD will work with DAS capital staff to ensure that the purchases are allowable costs under bond rules. BHD will return to the Board in September 2011 with an updated report regarding this project.

This is an informational report. No action is necessary.



Gerri Lyday, Interim Director
Department of Health and Human Services

cc: County Executive Chris Abele
Terrence Cooley, County Board Chief of Staff
CJ Pahl, Interim Fiscal & Budget Administrator - DAS
Toni Thomas-Bailey, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board
Steve Cady, Analyst – County Board
Carol Mueller, Committee Clerk – County Board

CMS Certification Number (CCN): 52-4001

RECEIVED

April 29, 2011
(Via Certified Mail)

MAY - 3 2011

MCBHD
ADMINISTRATOR'S OFFICE

John Chianelli
Administrator
Milwaukee County Behavioral Health Division
9455 West Watertown Plank Road
Milwaukee, WI 53226

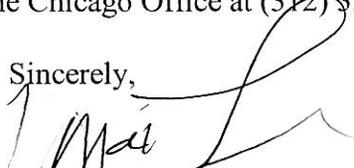
Dear Mr. Chianelli:

In our September 9, 2010 letter, we informed you of Milwaukee County Behavioral Health Division's non-compliance with the Condition of Participation of Physical Environment and issued a termination date of May 1, 2011. The termination date was based on your August 24, 2010 plan of correction which indicated that your hospital would be in compliance by March 11, 2011. The Wisconsin Department of Health Services, Division of Quality Assurance (DQA) conducted surveys to monitor your corrective actions. The April 4, 2011 monitoring survey revealed that your hospital is now in compliance with the Conditions of Participation. Therefore, we are rescinding our proposed termination action.

The DQA will no longer conduct monitoring surveys of your hospital. You should continue your corrective actions for any deficiencies that remain uncorrected.

We appreciate your cooperation. If you have questions regarding this matter, please contact Stephanie Ysrael, Certification Specialist, in the Chicago Office at (312) 353-2908.

Sincerely,


Mai Le-Yuen
Principal Program Representative
Non-Long Term Care Certification & Enforcement Branch

cc: Wisconsin Department of Health Services
Division of Quality Assurance
Division of Health Care Financing
National Government Services - 00450

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: May 1, 2011

TO: Chairman Lee Holloway, County Board of Supervisors

FROM: Geri Lyday, Interim Director - Department of Health and Human Services
Paula Lucey, Administrator - Behavioral Health Division

SUBJECT: INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, PRESENTING A PROPOSAL FOR A PILOT PROJECT IN THE COMMUNITY TO PROVIDE SPECIALIZED SERVICES FOR A SPECIFIC POPULATION OF BEHAVIORAL HEALTH DIVISION CLIENTS

BACKGROUND

On February 3, 2011 the County Board Adopted a Resolution (File No. 11-81/11-49) directing the Interim Director, Department of Health and Human Services (DHHS), 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 Proposals. Since that time, DHHS and the Behavioral Health Division (BHD) convened a work group to discuss and develop a plan to move forward on this initiative. This report presents the recommendations of the work group.

DISCUSSION

The BHD staff welcomed an opportunity to create an innovative addition to our current community support programs. After looking at data and discussing various options with clinical experts at BHD, the workgroup decided to pursue a pilot project for a specific target population and approach this design in two phases.

The first phase proposes to develop an in-home intensive treatment model called ACT. The second phase establishes a 15-20 bed specialized residential treatment program utilizing managed care principles. This approach is being recommended because the goal is not only to pilot the 16-bed facility, but also provide stabilization services and crisis intervention to a small

group of individuals currently living in their own home. These individuals are frequent users of the Mental Health Complex whom we are currently not receiving any reimbursement for.

Below is a detailed summary of each aspect that was discussed at the work group and information for review.

Identification of Target Patient Population

BHD conducted a review of the Psychiatric Crisis Service (PCS) data, which revealed that there are 40 individuals with a Developmental Disability (DD)/Mental Illness (MI) diagnosis who each had four or more PCS encounters in 2010. Further review of these individuals revealed that they have a total of 294 or almost 3% of the total PCS admissions. Additional relevant information was collected related to this group of clients to help BHD determine if it was an appropriate group to consider for this initiative. This opportunity to focus on a specific group of high users is also a way to pilot craft an original solution.

After further review, BHD determined that 54% of this population lived in a structured living or home situation. This is exactly the group that BHD hopes to find ways to maintain in their environment and out of higher cost care. It is also interesting to note that only 10.5 percent of the visits resulted in actual admission to the hospital indicating that their PCS encounter was more of a crisis or short-term destabilization.

From a purely fiscal perspective, these consumers are the heaviest users of the most expensive resources. More importantly, they personally experience the most extreme and devastating consequences of having a serious mental illness. Traditionally, the mental health system has not been successful in engaging these consumers in effective treatment. However, some teams, specifically ACT which is discussed later, can successfully help consumers who have extensive needs to live safely and autonomously in the community.

Managed Care Approach

Managed care is a term utilized in health care financing to describe an approach of shifting risk. Managed care works best when the managed care organization focuses on assisting the client towards wellness with a focus on prevention and primary care and avoiding high cost "illness" care, which occurs in hospitals. At this point, most managed care organizations do not utilize their fundamental approach towards wellness to mental health care. Instead, most seek to limit their risk by limiting out-patient visits and hospital stay days.

By targeting the above-mentioned population, the proposed program seeks to shift the paradigm of mental health to a wellness model of care. BHD proposes to engage in a newly

defined level of community support for clients with co-occurring Mental Health and Development Disabilities diagnoses.

Co-Occurring Disorders: Core Values

Since the specific population that BHD plans to serve is a specialized group with a co-occurring disorder, the workgroup looked at the best practices for this specific group. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are six guiding principles that serve as fundamental building blocks for programs in treating clients with co-occurring disorders:

1. Employ a recovery perspective
 - a) Develop a treatment plan that provides for continuity of care over time
 - b) Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment
4. Address specific real-life problems early in treatment
5. Plan for the client's cognitive and functional impairments
6. Use support systems to maintain and extend treatment effectiveness
 - a) Building community
 - b) Reintegration with family and community

Treatment and Support in the Community

Utilizing the concepts of managed care with a focus on prevention and primary care, BHD would like to plan care based on the Assertive Community Treatment (ACT) model that would work towards keeping this high PCS utilization group in the community and out of BHD. This is not an approach we currently have in place.

ACT is for a relatively small group of consumers who are diagnosed with serious mental illness, experience the most intractable symptoms, and, consequently, have the most serious problems living independently in the community. Because of the severe and recalcitrant nature of their symptoms, these consumers are more likely to frequently use emergency and inpatient medical and psychiatric services.

ACT is a way of delivering comprehensive and effective services to consumers who have needs that have not been well met by traditional approaches to delivering services. ACT teams directly deliver services to consumers instead of brokering services from other agencies or providers. For the most part, to ensure that services are highly integrated, team members are cross-trained in one another's areas of expertise. ACT team members collaborate on

assessments, treatment planning, and day-to-day interventions. Instead of practitioners having individual caseloads, team members are jointly responsible for making sure that each consumer receives the services needed to support recovery from mental illness.

ACT is characterized by:

- A team approach — Practitioners with various professional training and general life skills work closely together to blend their knowledge and skills
- In vivo services — Services are delivered in the places and contexts where they are needed
- A small caseload — An ACT team consists of a staff-to-consumer ratio of approximately 1 to 10
- Time-unlimited services — A service is provided as long as needed
- A shared caseload — Practitioners do not have individual caseloads; rather, the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals
- A flexible service delivery — The ACT team meets daily to discuss how each consumer is doing and the team members can quickly adjust their services to respond to changes in consumers' needs
- A fixed point of responsibility — Rather than sending consumers to various providers for services, the ACT team provides the services that consumers need and if using another provider cannot be avoided (e.g., medical care), the team makes certain that consumers receive the services they need
- 24/7 crisis availability — Services are available 24 hours a day, 7 days a week. However, team members often find that they can anticipate and avoid crises

Core ACT services include:

- Crisis assessment and intervention;
- Comprehensive assessment;
- Illness management and recovery skills;
- Individual supportive therapy;
- Substance-abuse treatment;
- Employment-support services;
- Side-by-side assistance with activities of daily living;
- Intervention with support networks (family, friends, landlords, neighbors, etc);
- Support services, such as medical care, housing, benefits, transportation;
- Case management; and
- Medication prescription, administration, and monitoring.

In addition to this level of care management, we would propose to work with the Disability Services Division and the Department of Family Care to develop a facility that would provide crisis and respite care to these clients and others like them. In looking at models in Madison, this type of facility is designed for a short stay with intensive stabilization. It remains the goal

of returning the client to the community as soon as possible in a stabilized state with a plan for the future. We also have antidotal information that families do not have reasonable access to respite and resort to the emergency department to provide that care.

We would initially have discussions, in partnership with the Disability Services Division and Family Care, with community providers to develop the challenges and opportunities and then release a RFP for a community agency to create and manage this advance in our network of care.

Proposal

As a pilot, BHD proposes to first plan for an approach to care in the community for:

- An ACT approach to care treatment in the community for the target population
- Development of a quality monitoring plan to evaluate the pilot approach
- Document savings in unreimbursed care
- Identify challenges and opportunities in working with focused population that represents a high utilization of resources

Second, based on our current experience and learning from the pilot:

- Development of crisis/respite facility, specifically for the Developmentally Disabled population with mental illness or behavioral issues. For the second phase, we would work with DSD and Family Care to develop a model DD crisis/respite facility for 15-20 clients.
- The facility would provide short stay support for those in crises and for those families who need a respite occasionally.
- Care of the clients related to medical records and development of safety, respite and behavioral plans will be key to ensure a smooth continuity of care within the overall network.

Fiscal

In order to make this a sustainable component of the BHD system, funding needs to be reviewed especially in light of the shifting state and federal budget decisions. BHD is currently getting more data and information to help define and clarify funding sources for these clients.

BHD has reviewed the fiscal information for these clients from prior years. During 2010, across all clients, there were 2,254 acute inpatient admissions and 31,087 inpatient bed days. This patient group accounted for 31(1%) of these admissions and 682 (2%) of the bed days. BHD charges are based on cost. The inpatient per diem cost/charges in 2010 for this group of clients was \$688,675 for which payments of \$194,892 were received.

On the Observation Unit, there was a total of 2,143 admissions that accounted for 3,596 bed days. This group had 124 (6%) of the Observation Unit admissions and 557 (15%) of the bed days. Per diem rates for Observation are generally not reimbursed, although we do receive some payment for professional services. In 2010, the cost/charges for the Observation Unit for this client group were \$800,662 for which we were paid \$130,313.

In total, for the Emergency Room, the Observation Unit and inpatient care, BHD provided \$1,164,132 in non-reimbursed care and unrecognized revenue for this group of clients during 2010. This revenue gap only stands to increase as costs/charges have risen. The BHD cost of an emergency room visit in 2011 is \$604 and the cost of an acute inpatient day for an adult age 21-64 is \$1364, yet Medicaid pays only \$323 per visit/day.

The fiscal effect of such a change for BHD is difficult to quantify. Although these clients represent a significant number of visits to PCS each year, they would likely be replaced with other clients. It is almost impossible to know what type of clients with what payer source these additional clients would have.

BHD will continue to look at fiscal data to try to quantify the avoidance of PCS encounters and determine funding sources for these clients, the amount BHD could pay per client per month for this level of support and what agencies would be charged for any PCS visit.

NEXT STEPS AND RECOMMENDATION

BHD hopes to move forward with this initiative by:

1. Conducting a survey of families to better define the need and determine if they would be likely to utilize such a facility/resource. It is possible that other families would also utilize such a facility and that might allow them to care for their loved one in their home for a longer period of time.

2. Obtain more financial data, including working with Family Care and the Disability Services Division, to help determine the available funding sources for these clients and an appropriate per member rate.
3. Develop an approach to ACT in the community.
4. Draft a Request for Proposals to solicit bids for this population and return to the Board for approval.
5. Work with the Disability Services Division to develop the model that encompasses principles for both persons with developmental disability and mental illness.

This is an informational report so no action is necessary. BHD and DSD will return to the Board with a draft RFP and an updated report by the July board meeting.



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