

September 22, 2010

To: County Executive Scott Walker
County Board Chairman Lee Holloway
Supervisor Peggy West, Chairwoman, Committee on Health and Human Needs

RE: Mental Health Community Advisory Board

Introduction

The initial meeting of the Mental Health Community Advisory Board (CAB) was held June 29, 2010. Co-Chairs Barbara Beckert and Paula Lucey gave opening remarks and, after introductions by all attendees, laid out the workgroup structures and the process to be followed based upon the directives and goals laid out in the May 27, 2010 resolution that created the Board.

- Steering Committee
- Community Linkages Workgroup
- Patient Centered Care Workgroup
- Patient Safety Workgroup

John Chianelli, Behavioral Health Division (BHD) Administrator at that time, and Dr. Tom Harding, BHD Medical Director, gave an overview of the Behavioral Health Structure. Below, I have included a few interesting facts pointed out during this presentation.

- the BHD psychiatric emergency room (PCS) is the second busiest in the country with 12,000 visits annually
- 2,800 inpatient admissions annually
 - 30% increase since 2000
 - 80% admitted involuntarily
 - 70% have a payer source
- Average patient ratio is 60% male and 40% female
- Acute adult inpatient median length of stay was 9 days in 2003, 7 days in 2009
- Acute adult inpatient readmission rate was 15.2% in 2003, 21.6% in 2007

A training session was held on July 20, 2010 for all members. Talk was given on the importance of practicing Trauma Informed Care in order to most effectively treat persons with mental illness.

- 56% of adults surveyed reported at least one traumatic event
- 90% of mental health clients have had a traumatic event-most have had multiple

For someone outside of the mental health field like me, this training session was very helpful in explaining the intricacies and challenges of successfully treating individuals with mental health issues.

Workgroups

To date, all workgroups have had at least two meetings and some three. Most of these meetings have reviewed current practices, policies and procedures at BHD. A lot of information has been covered thus far, and I expect that we will soon transition from the “fact finding” stage into researching current/best industry practices and discussing various options and ideas for improvements to our own program.

Examples of topics that have been discussed in each workgroup:

Community Linkages

- Need to get family members involved in patient care
- Improvements to discharge process needed to prevent readmission
 - Connect patients with Targeted Case Management (TCM) prior to discharge
 - Link patients to community-based resources for post-discharge help
 - Improve communication from provider to social worker to patient
 - More follow up after discharge
- Free flow of information critical to treatment and recovery
- Limited computer access hampers workflow
- Need to develop a Health Information Technology (HIT) Plan
 - Federal incentives/payments based on HIT Plan beginning in 2015

Patient Centered Care

- Need to increase use of Peer Specialists
- Continued training of all staff on Trauma Informed Care
- Consumer Grievance Rights under WI Law
- Improve communication between patients and families
- Review process for reporting grievances and complaints

- Between provider and patient
 - Between patient and patient
- Review resolution process for client grievances.
- Training of staff on patients rights.
- Making sure patients and their families understand their rights.

Patient Safety

- Facility safety report from Sheriff
- More control of building access both in and out
- Stricter monitoring of visitors
- Improved communication for faster responses to behavioral emergencies
- Enhanced care planning, behavior monitoring and team communication
- Treatment plans revised to assess/address risks of sexual behavior/vulnerabilities
- History and physical assessment form updated to include comprehensive sexual history
- Daily Noon Safety Report assures immediate reporting of and response to all areas of risk
- Mandatory staff training on BHD policies and procedures followed up by post-training audits to monitor adherence.
- Increased environmental surveillance
 - Zone surveillance process for staff
 - Video monitoring process-conforming to law
- Improved patient communication
 - Daily “community meetings” with staff/patients
 - Written notices including posters w/patient rules/rights
 - Educate on how to report harassment and other complaints
- Post incident and follow-up procedures

Steering Committee

The Steering Committee reviews the work of each workgroup and will ensure that the outcomes of each as directed by the resolution will be achieved. The Steering Committee is also charged with making quarterly reports to the County Board via the Health and Human Needs Committee and will prepare and present a final report as directed by the resolution.

Examples of topics that have been discussed by the Steering Committee:

- Need to communicate services available after discharge to reduce readmissions
- Milwaukee County relies too highly on costly emergency services and falls way short of providing continuum of care in the community

- Emergency Detentions (ED) are dropping statewide but dramatically increasing in Milwaukee County
- Local hospitals/emergency rooms do not view mental illness as in their purview
- Supportive housing, while improved, still is short
- Too much focus on hospitalization and not enough reliance on community based services
- Very few counties operate public psychiatric hospitals
- Need to explore community based service options
- Review the transformation of mental health care practices since the existing facility was built and forecast what the delivery service model will look like in the future

Conclusion

During this initial phase, the CAB has focused attention primarily on gathering information and facts relative to the current policies and operating procedures of the BHD. I have been impressed with the caliber of representatives on the Board and the seriousness and dedication with which they are all conducting their respective work. The wide range and diverse experience of the members has thus far contributed positively to the investigative process.

Each workgroup, while charged with specific responsibilities, seems to be focused on two main objectives: what is the best way to successfully treat mental health patients and how do we tread the delicate line between providing a safe environment and one that promotes healing and recovery.

Two areas that I found to require more in-depth analysis are the practice of gathering background information on patients upon admittance and the reporting process for alleged sexual contact/abuse between patients.

Hospital staff seems to be somewhat reluctant to conducting criminal background checks on patients admitted to the acute care units. Their contention is that operating too much in a “prison-like” atmosphere could adversely effect patient treatment, as well as make some individuals reluctant to seek treatment for fear of possible legal troubles. I believe that some form of background check for past criminal activity is necessary for the safety of patients and staff.

While all complaints of alleged sexual contact/abuse between patients are investigated by staff, only those that are determined to be non-consensual are reported to upper BHD administration. I believe there should be a strict policy of documenting and reporting every allegation to BHD management.

Joe Sanfelippo, 17th District Milwaukee County Supervisor
Mental Health Community Advisory Board Appointee