Attachment A

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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