Action Team: Person-Centered Care

Mental Health Redesign and Implementation Task Force

All people, programs, and systems providing and supporting mental health care in Milwaukee County should commit to multiple pathways to improve person-centered, welcoming, recovery-oriented, trauma-informed, and co-occurring-capable service. Community-based services and supports must be expanded to ensure that individuals experience recovery in the least restrictive setting. A culture of person-centered care strives to inspire the hopes of all individuals and families with complex needs and appreciates the value of life experiences and personal strengths that form the foundation of caring partnerships. The aim of person-centered care is to assist individuals and families in facing the challenges that arise from combinations of emotional and mental health conditions, substance use issues, cognitive and intellectual disabilities and brain injuries, trauma, physical health problems, and myriad social wellbeing concerns. By ensuring that all services are person-centered, the mental health system in Milwaukee County will empower all individuals and families to live their vision of happiness .

Individuals seeking mental health services in Milwaukee County will be welcomed as full collaborative partners whose values and informed choices guide the evolution of the mental health system and the ongoing provision of recovery-oriented, culturally competent services throughout the community, including expanded peer support and consumer-operated services to increase satisfaction, increase participation in services, and facilitate easier navigation between various access points and levels of care. Informed choice includes the maximization of options available to individuals and families enabling them to choose how, when, and where they can access services.

Public and private stakeholders will incorporate the principles of trauma-informed care and person-centered recovery into policies and procedures, hiring and training processes, and service delivery at all levels, and the application of the Comprehensive, Continuous, Integrated System of Care (Minkoff & Cline, 2004, 2005) will be expanded to create accessible and therapeutic environments for persons with mental health needs throughout the community.

In order to create educated and responsive communities, move beyond the medical model, and maximize the independence of consumers to experience recovery in least restrictive environments, information about prevention, early signs and symptoms, and the spectrum of available services will be freely and easily accessible in multiple media, written in understandable language, promoted by outreach efforts, and maintained for accuracy.

This team anticipates providing guidance for the implementation and monitoring of the recommendations it has endorsed. An entity such as this team – comprised of consumers, providers, and other mental health stakeholders – should periodically convene throughout the redesign and the coming transitions in the system to ensure ongoing adherence to the principles of person-centered care and recovery. Training will be necessary at all levels of service delivery to achieve the vision articulated here, and we are eager to work with an entity such as the Workforce Action Team to determine specific training needs and strategies for workforce development. Additionally, this team anticipates collaborating with the Quality Action Team (or a QA/QI Steering Committee, per that team's vision) to identify outcome measures and fidelity tools to achieve consistent, system-wide application of our envisioned principles.

The redesigned, recovery-oriented system will support person-centered and self-directed approaches to care that build upon the strengths of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery.

Glossary of terms

Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the four underserved/underrepresented racial/ethnic groups, their families, and communities. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in determining an individual's mental wellness/illness and incorporating those variables into assessment and treatment. (*SAMHSA*)

Person-centered care is an ongoing, interactive process between consumers, caregivers, and others that honor an individual's dignity and choices in directing his or her daily life. This is accomplished through communication, education, and collaboration. (*Wisconsin Coalition for Person Directed Care*)

Person-centered planning . . . is widely respected as a best practice to design effective networks of services and supports that enable people to have a higher quality of life and to achieve full citizenship and integration into their communities. (*Yale Program for Recovery and Community Health* – http://www.yale.edu/PRCH/index.html)

Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential. Recovery:

- Is person-driven;
- Occurs via many pathways;
- Is holistic;
- Is supported by peers;
- Is supported through relationships;
- Is culturally-based and influenced;
- Is supported by addressing trauma;
- Involves individual, family, and community strengths and responsibility;
- Is based on respect; and
- Emerges from hope. (*SAMHSA*)

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. (*SAMHSA-NCTIC*)

Action Team: Continuum of Care
Mental Health Redesign and Implementation Task Force

Behavioral health services at all levels should be person-centered, recovery-oriented, holistic, and accessible. Accessibility – particularly to community-based services – and flexibility must be hallmarks of the redesigned continuum of care, with consumers able to transition between types and levels of care in response to their changing needs and desires. Consumer-directed services should be a prominent feature throughout this continuum, using peer specialists and the experience of peers to assist consumers in system navigation, the development of individualized recovery plans, and the provision of services.

Community-Based Outpatient Services:

Fundamental to this redesign is the commitment to immediately increasing and sustainably supporting community-based behavioral health services to ensure accessibility so that all consumers receive the most appropriate type and level of care in the least restrictive environment. Resources within the system should be shifted to increase the availability of services and supports that promote recovery. Priorities should include:

- Expansion of community-based services, including increasing the availability of counseling and medication options for uninsured and underinsured consumers;
- Expansion of services that provide necessary specialization and Evidence-Based Practices consistent with SAMHSA guidance;
- Increasing the geographic diversity of service locations, ensuring coverage in high-need areas of the community;
- Development of alternative housing services to accommodate specialty populations;
- Expansion of small, community-based, short-term residential options capable of meeting the most challenging behavioral needs of some individuals with developmental disabilities, including specialized training for all support staff;
- Encouraging continued state level discussion towards the expansion of community-based rehabilitative services offered through Section 1937 of the Social Security Act.

Crisis Services & Reduction of Emergency Detentions:

The County should further commit to increasing community-based knowledge of crisis intervention training for law enforcement and health care personnel through participation in Crisis Intervention Team (CIT) and Crisis Intervention Partner (CIP) training programs.

Increasing the availability of mobile crisis services to assist law enforcement, residential providers, and families in helping consumers experiencing an acute behavioral episode is an essential component of building the community capacity to deal with crisis situations and direct consumers to appropriate community resources. A mobile crisis team should include expertise in mental illness, developmental disabilities, and substance use disorders.

Alternative crisis services such as the Crisis Resource Center (CRC) should be developed and expanded to enable diversions from unnecessary emergency care or hospitalization. The development of additional CRCs in the northern part of Milwaukee County is a priority.

Inpatient Downsizing & Discharge:

Recommendations for significantly downsizing the acute inpatient and long-term care capacity at the Mental Health Complex cannot be undertaken responsibly until there are sufficient services and supports in the community to maintain health, enhance recovery, and promote the independence and self-determination of the people served. This team supports recommendations to downsize inpatient capacity, provided that adequate community-based supports are in place and patient discharges are carefully planned and monitored.

There must be a realized effort on the part of all stakeholders to adjust culture and build the clinical capacity to support persons with severe psychiatric symptoms and complex psychosocial needs. Milwaukee County should continue to work with the provider community to accomplish this goal.

The ongoing initiative to downsize the Hilltop facility must ensure that a spectrum of services is in place and accessible for individuals with developmental disabilities to be successful in their communities before any kind of downsizing occurs. This team supports the downsizing initiative and the recommendations of the Community Linkages team regarding increased community-based crisis capacity for the affected population.

Collaboration among private, public, and consumer stakeholders is essential to reduce unnecessary inpatient admissions and promptly facilitate appropriate discharges from inpatient care to community programs and services.

Conclusion:

Throughout all of the recommendations that comprise this vision for the continuum of mental health services in Milwaukee County, the principles of recovery and person-centered planning are paramount and should guide the decision-making process from the direct service level to the systems level.

Action Team: Community Linkages
Mental Health Redesign and Implementation Task Force

Housing:

First and foremost among the recommendations supported by this team is the expansion of housing options in Milwaukee County, as virtually every other recommendation related to community linkages and supports leads back to the essential need for safe and stable housing. There is a well documented lack of permanent supportive housing units; the Milwaukee Continuum of Care – in its *10-Year Plan to End Homelessness* – estimated that 1,280 units of supportive housing need to be developed over the next ten years.

Milwaukee County will continue to focus on the expansion of various supportive housing options in all areas of the County. The Housing Division will continue to actively partner with developers, landlords, and service providers using the successful "blended management" approach. The County will also continue its working relationship with the City of Milwaukee to maximize public dollars for construction and collectively will begin to forge a new strategic partnership with the private sector to attract additional gap financing dollars. The Housing Division will continue to pursue and maintain partnerships to produce new housing units for individuals with developmental disabilities within the Family Care system.

Due to the cost advantages of supportive housing, many new units can be created with the downsizing of a relatively small number of Community Based Residential Facility beds. The Action Team recommends the downsizing of approximately 10% of Milwaukee County's contracted CBRF beds. This reduction would occur: 1) as providers begin to fill vacant County contracted beds with Family Care individuals, as has been the practice this past year; and 2) by an aggressive utilization process with additional stakeholders that have a broad range of housing knowledge and experience to ensure individuals have increased recovery-oriented housing options. Milwaukee County will also explore a new housing model that will be a "step-down" from a CBRF to ensure individuals are able to live in a least restrictive setting if consumers are not able to live in permanent supportive housing.

Law enforcement & crisis resources:

A community-based Mobile Crisis Team (or Teams) should be supported and expanded to meet the needs of the community and improve slow response times. The Team(s) should collaborate closely with law enforcement personnel engaged in Crisis Intervention Team (CIT) training. CIT is consistent with evidence-based practices, and the successful partnership of mobile clinicians and a crisis-equipped police force could greatly reduce emergency detentions and ensure appropriate, responsive care for individuals in mental health crisis situations. Opportunities for diversion from Psychiatric Crisis Service and inpatient admission should be consistently sought and evaluated by law enforcement, mobile crisis staff, hospital emergency departments, and all service providers interacting with consumers with challenging behaviors.

This team urges the County to support a data link between the Behavioral Health Division and the criminal justice system to facilitate better discharge planning and produce better outcomes for mental health consumers. Regular cross-training activities between BHD and the jail should likewise be supported.

Developmental disability & Family Care:

We support the downsizing of Hilltop and the development of additional community-based crisis intervention and stabilization capacity to support the independence of individuals with developmental disabilities, including those with co-occurring mental illness. Crisis stabilization services must be enhanced to ensure 24-hour access for individuals in need.

Milwaukee County should also increase crisis respite bed capacity for individuals with developmental disabilities to provide another alternative to Psychiatric Crisis Service and inpatient admission for individuals experiencing periods of acute behavioral issues or other short-term emergency needs.

The County should establish a workgroup including Family Care managed care organizations (and IRIS) and the Aging and Disability Resource Centers to streamline procedures to facilitate timely enrollment in Family Care for eligible individuals who are admitted to BHD or discharged/relocated from Hilltop, including both those who have and have not previously enrolled in Family Care. The workgroup would aim to increase consumer independence and community integration while reducing unnecessary inpatient admissions.

Milwaukee County should convene a workgroup including DHHS Special Needs Housing, Family Care managed care organizations and IRIS, and the Aging and Disability Resource Centers to explore funding options that support development of accessible housing alternatives for individuals eligible for Family Care.

Peer support:

The use of Certified Peer Specialists (CPS) should be increased throughout the behavioral health system to help empower consumers as partners in their own recovery and be of direct assistance to the treatment team. They can assist consumers by ensuring their basic needs are being met, forming a wellness plan, connecting them with community resources (including employment), and assisting them in transitions between types and levels of care. Peer support should be incorporated into CSP and TCM programs, Crisis Resource Centers, supportive housing, inpatient units and throughout community agencies. The role and expectations of Certified Peer Specialists need to be clearly defined and communicated to the entire treatment team. Training for the CPS and all team members may be essential for effective integration. We urge Milwaukee County to support CPS trainings, and we strongly supports efforts by NAMI to utilize Community Development Block Grant funds for this purpose. Non-crisis peer-supported listening and referral services should be sustained and expanded to serve more consumers. A few successful peer-supported models already exist in the community, such as Warmline, Mental Health America of Wisconsin, Disability Rights Wisconsin, and NAMI (PeerLink). These models should be replicated wherever appropriate and relevant throughout the community.

Discharge planning:

Discharge planning from acute inpatient and long-term care must be improved to ensure that consumers have secured sufficient community-based services to prevent avoidable emergency care or readmission to inpatient care. Planners throughout the system should maintain current information on the options available in the community for persons being discharged. We recommend that system stakeholders establish a clearinghouse of current, accurate, accessible information about resources related to behavioral health. These resources would include housing, employment training and support, legal, family resources, support groups, crisis lines and more. Resources would be available in print, online, and over the phone. Community groups such as 211, Mental Health America, Disability Rights Wisconsin, and Community Advocates might serve as valuable collaborators for this purpose.

Benefits counseling is also a vital component of planning, and the County can increase access and ensure maximum revenue to fund services by prioritizing benefits counseling for consumers throughout the system.

Community Intervention Specialist:

Ensuring timely linkages to appropriate services for consumers requires interagency and interdisciplinary collaboration. We propose that an Intervention Specialist with co-occurring, trauma-informed, clinical mental health knowledge be designated as the liaison between the various public and private entities commonly interacting with individuals in the community with the most complex and challenging mental health needs. The primary role of the Specialist is to secure appropriate housing placements for consumers, including individuals who may not be eligible for long-term placement services through the Behavioral Health Division. The Intervention Specialist would consult with the jail, private hospitals, employers and the shelter system.

Community Interdisciplinary Consultation Team:

The Intervention Specialist will also serve as the main point of contact for a new Community Interdisciplinary Consultation Team (CICT). The team discussed several examples of individuals for whom the community was unable to find creative solutions. In some cases, this led to extremely long and costly inpatient stays and poor outcomes. The Committee believes that if the decision makers had access to others in the community for consultation, timely solutions could be found. The CICT would consist of representatives from several agencies throughout the County, including (but not limited to) BHD staff, consumers, shelter system staff, criminal justice representatives, private hospitals, housing providers, employers, and others. Providers that need assistance on specific cases can ask for a consult from the CICT through the Community Intervention Specialist. The Specialist would find the appropriate members of the CICT that could best assess the situation and arrange the consult.

Action Team: Workforce

Mental Health Redesign and Implementation Task Force

This team has evaluated recommendations from previous studies and assessed challenges facing providers, consumers, and employers related to the mental health workforce. The resulting consensus outlined here assumes a policy direction that improves and "right-sizes" acute care and expands the mental health workforce operating in a variety of community settings. The team recognizes, however, that the mental health workforce ultimately will reflect the continuum of care, quality, person-centered care, and community linkage strategies which embody the work of the Task Force as a whole. While we cannot fully anticipate the work of our colleagues, we believe these recommendations are an important piece of the final puzzle. We wish to thank all stakeholders who have participated in this redesign process to date, particularly the individuals and organizations responsible for producing the reports and recommendations that led to the establishment of the Mental Health Redesign and Implementation Task Force.

Points of emphasis:

- The system must better engage consumers and their families through varied means including the expansion of peer support specialists and recognition of consumer-operated programs as a part of the service mix.
- Recognizing the long-term benefits of retaining skilled people in mental health services, retention emerged as a concern in our discussions.
- Workforce discussions often focus on individual positions and skills, but consumer recovery will be driven by *teams* involving doctors, nurses, and peer support teammates. Nonetheless, some specific workforce skills are in short supply and pose a challenge.
- These recommendations are offered to BHD, organizations that contract with BHD, and providers seeking to enter the mental health system in Milwaukee County. Recommendations herein are not intended to apply to any one employer or worksite in particular unless the recommendation so stipulates. As reviewers will note, many target worksite culture and practices associated with improving skills among the existing mental health workforce.
- Due to time constraints in this phase, major challenges remain to be carefully assessed; this presentation is a threshold for further study and work in 2012. To appropriately complete our work beyond this phase, additional skills should be represented on the team, including persons who work with oral and sign language translators and interpreters, larger private behavioral health employers, and at least one school of nursing.

Recruitment, hiring, and retention:

A core principle for the mental health workforce should be achieving diversity. Employers within the system should strive to retain a workforce that is reflective of and sensitive to the consumer population. Providers throughout the mental health system – as well as in interacting systems such as Family Care managed care organizations – should also exercise a preference (to the greatest extent possible) for hiring staff with expertise in serving dually diagnosed individuals and people with disabilities.

BHD leaders and managers should seek a review of the hiring process with the Milwaukee County Department of Human Resources and Department of Administrative Services to create a more responsive and timely hiring procedure. Concurrently, the County and other mental health service providers should emphasize trauma-informed care as a skill for new hires and a priority in professional development for existing staff

Public sector entities must strategize on ways to become more competitive with the private sector – including reviewing and adjusting compensation, particularly for licensed professionals – to improve recruitment and retention of quality providers and ensure consistently high quality services throughout the system. A variety of incentives may be useful to consider, ranging from student loan forgiveness to professional development incentives.

Consumer-operated services such as non-crisis support lines should be expanded, and the cost-effective and evidence-based practice of peer support should be utilized to its optimal potential throughout the system. Certified Peer Specialists (CPS) can empower consumers as partners in their own recovery and aid their navigation between various types and levels of care. Training programs for CPS should be expanded to meet the needs of consumers in recovery throughout the community; this will also create a larger pool from which to hire. CPS should receive regular training and evaluation to ensure consistent and high quality service system-wide. CPS wages should be adjusted with a goal to ensure compensation that is reflective of the demand for peer support and commensurate with the value of the services being provided.

Education and training:

According to employers and program operators, Milwaukee County faces a number of challenges in staffing a redesigned, community-oriented mental health system. It is incumbent upon stakeholders to assess and strategize about how to ensure that future supply will be in place to meet the demand for numerous positions, including (but not limited to): Psychiatrists (with various specialties including inpatient, child, addiction, geriatric, consultation/liaison, general adult), registered nurses and nurse practitioners with mental health certification, psychiatric nurse managers and executives, psychologists, occupational therapists, and psychotherapists with certification in substance abuse.

System stakeholders should foster partnerships with higher education institutions to increase and enhance interdisciplinary teams, focusing on recruitment, retention, and education of licensed professionals, including social workers, psychologists, nurses, nursing aides, as well as those listed above. BHD and other employers in the mental health system must collaborate to devise strategies to encourage psychiatry and psychiatric nursing as career paths to combat an acute shortage of providers. To that end, the County could benefit from providing more clinical experience hours to medical and nursing schools requesting them. Seeking opportunities with community providers is also an option to pursue.

Educational curricula at nursing and medical schools should be updated to align with evidence-based practices and the principles of recovery and person-centered planning. Mental health stakeholders – including the County – should engage nursing schools about including psychiatry requirements and educational opportunities as part of core curriculum.

Employers should emphasize a culture of learning, interdisciplinary fluency (systems thinking), and professional development, with enhanced initial and ongoing training at BHD (Educational Services) and compulsory cross-training for CNAs and unit clerks on behavioral health and disabilities. A normalization of minimum skill and training requirements should be put into place for persons working in behavioral health, including a basic knowledge of human development.

Providers – especially case managers – should be trained and evaluated on their use of motivational and person-centered approaches, such as motivational interviewing, which could promote increased participation in services.

Community-wide and position-wide competencies and training standards should be established and regularly evaluated for trauma-informed care, recovery, and person-centered planning. Providers throughout the system must ensure timely access to adequately trained interpreters and translators with proficiencies in person-centered care and trauma-informed care, and clinicians should likewise be trained in how to make appropriate use of interpretation services. Providers should participate in

ongoing training and periodic self-assessment to improve cultural competency, including how to identify and respond to diverse cultural, language, and service needs. Providers must be well versed in cross-cultural communication as well as aware of their own biases. Improving cultural competency may correlate to reducing service refusal.

Community engagement:

The County should continue to partner with hospitals and other health systems to expand necessary capacity in the mental health continuum. Community providers will need to adjust workplace culture and build clinical capacity to treat persons with more severe symptoms and complex psychosocial needs.

Such a partnership should include the development of better training for hospital emergency departments to deal with crises and address challenging behaviors to reduce emergency detention referrals to the Psychiatric Crisis Service.

It also is important to cast a broad net to collaborate on access to services and professional development. For instance, school nurses and nurses employed in county correctional settings are two instances where there is (reportedly) a high incidence of mental health service requests outside a formal mental health treatment setting.

Conclusion:

There is a group of natural resource partners in the broader community that could be key allies in creating an enhanced mental health workforce in Milwaukee County. These include the Workforce Investment Board, Department of Workforce Development, Division of Vocational Rehabilitation, private funders, and Wisconsin Works (W-2). With an even broader partnership to include other key players such as health systems and FQHCs, additional sources may be available at the Federal level.

Action Team: Quality
Mental Health Redesign and Implementation Task Force

Strong quality assurance and quality improvement (QA/QI) processes are essential to the success of a community-based mental health system. The Quality Action Team presents this consensus report with the qualification that significant work lies ahead. The principles presented here are a good first step, and the future efforts of this team and the Task Force should include review of best practices and models used in other urban community-based mental health systems.

Coordinated QA/QI Process:

The Quality Action Team recommends the development of a QA/QI Steering Committee to monitor core outcome measures, identify process indicators (as deemed appropriate), and develop a dashboard for reporting system-wide. This Committee should engage senior management personnel from public and private entities, staff members from various levels within those entities, consumers of mental health services, representatives of mental health advocacy organizations, and representatives of disciplines including (but not limited to) the following: Psychiatry; Psychology; Internal Medicine; Nursing; Operations; and Data Analysis. A charter document for the Committee should enumerate the purpose, scope, and guidelines for open and collaborative participation. The Committee will oversee the operation of subcommittees charged with ongoing standards and outcomes review; subcommittees may include (but not be limited to): Inpatient Services, Crisis Services, Community-Based/Outpatient Services, Residential Services, and Linkages/Social Services.

This Team supports the establishment of a set of system-wide performance and outcomes indicators and goals addressing the following areas:

- Service utilization:
    - Inpatient
    - Crisis
    - Outpatient
    - Case management
    - Benefits counseling and advocacy
    - Peer support
    - Employment services
- System monitors:
    - Consumer satisfaction
    - Quality of life
        - Independent living
        - Meaningful life options (e.g., housing, employment, education, etc.)
    - Emergency detentions
    - Discharge planning
        - Continuity of engagement in community-based services
    - Person-centered planning and recovery orientation
    - Cultural competency
    - Trauma-informed care
    - Evidence-based practices (EBP)
        - Utilization of and fidelity to EBPs are complex and resource intensive but can yield savings by increasing independence and stability of consumers. Adequate resources should be available to support EBPs.
        - Peer support is an EBP currently being utilized in Milwaukee County, and it should be expanded and regularly evaluated for fidelity.

- The Human Services Research Institute (HSRI) suggests and our team supports Permanent Supportive Housing, Supported Employment, Integrated Dual Disorder Treatment, and Assertive Community Treatment as priorities for Milwaukee County based on identified gaps in services, as well as consumer input. This team supports equally thoughtful consideration of EBPs not specifically noted by HSRI.

Adequate Resources:

To develop and sustain quality services, there must be adequate resources committed to the QA/QI process. This team recommends a review of current resources available from all stakeholders, including a consideration of adding Quality Assurance staff at BHD, including a Peer Specialist.

We also recommends the development of a management information system to collect and report common data elements, with the understanding of the cost and investment limitations of providers. Data points should be mutually agreed upon, and a process should be collaboratively designed to store, share, and act upon data accurately and reliably. This recommendation will require further discussion with system stakeholders to fully develop.

Provider Contracts:

We recommend that a QA/QI performance evaluation be considered when reviewing proposals for adult community services such as Targeted Case Management and Community Support Programs. Additionally, we recommend the review of other models of ongoing monitoring and system review (e.g., Wraparound Milwaukee) for potential guidance.

Cultural Competency & Language Access:

The Team supports a system-wide commitment to cultural competence and recommends that private and public entities conduct initial and ongoing self-assessments to identify cultural, language, and service needs and gaps. This analysis should include an in-depth review of community demographic data. The system must ensure effective communication with individuals with Limited English Proficiency and the deaf community, including training and evaluating staff on culturally and linguistically appropriate service delivery.