Appendices

Appendix 1

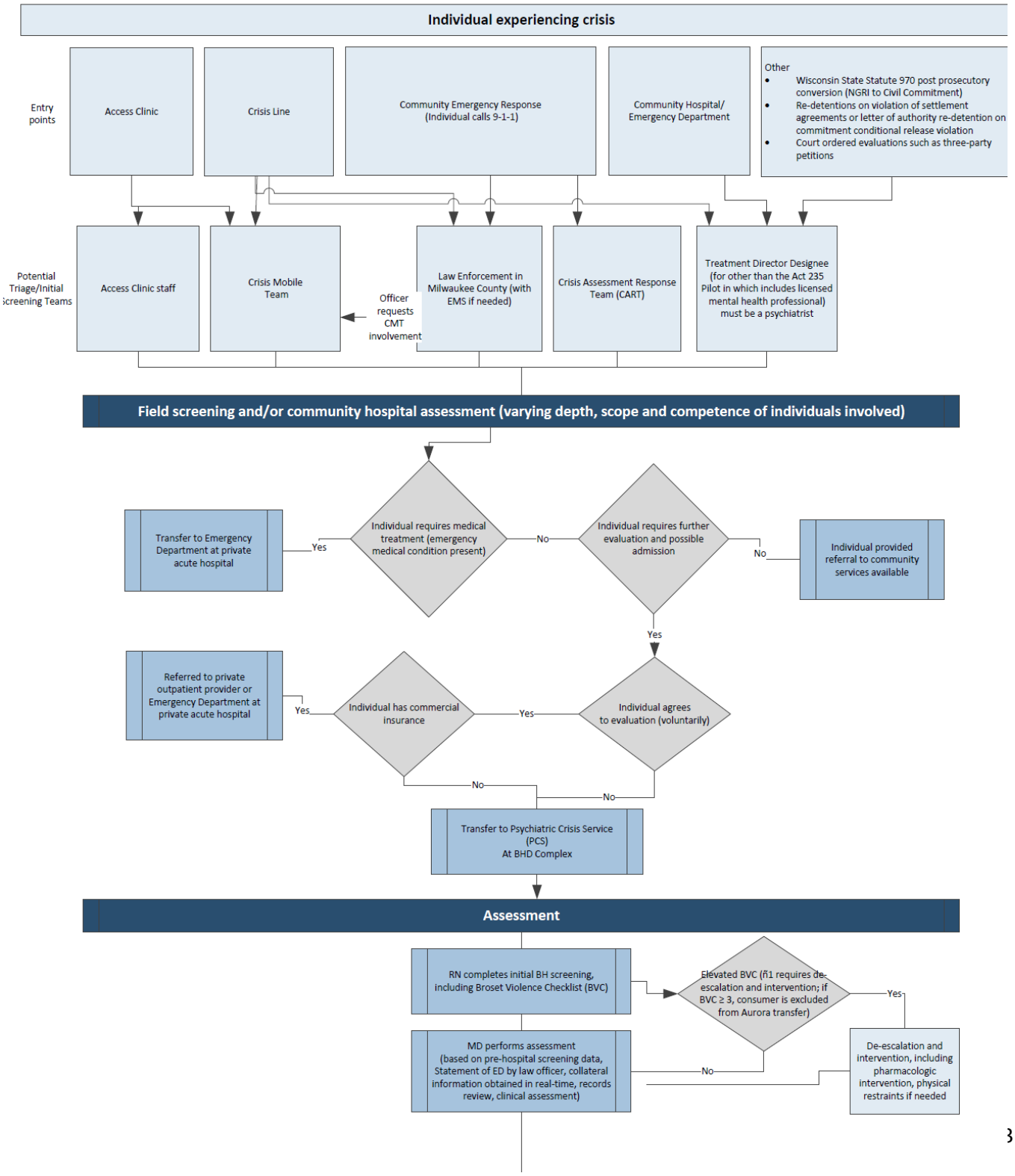
Key Informant, Consumer, Advocate Interviewees

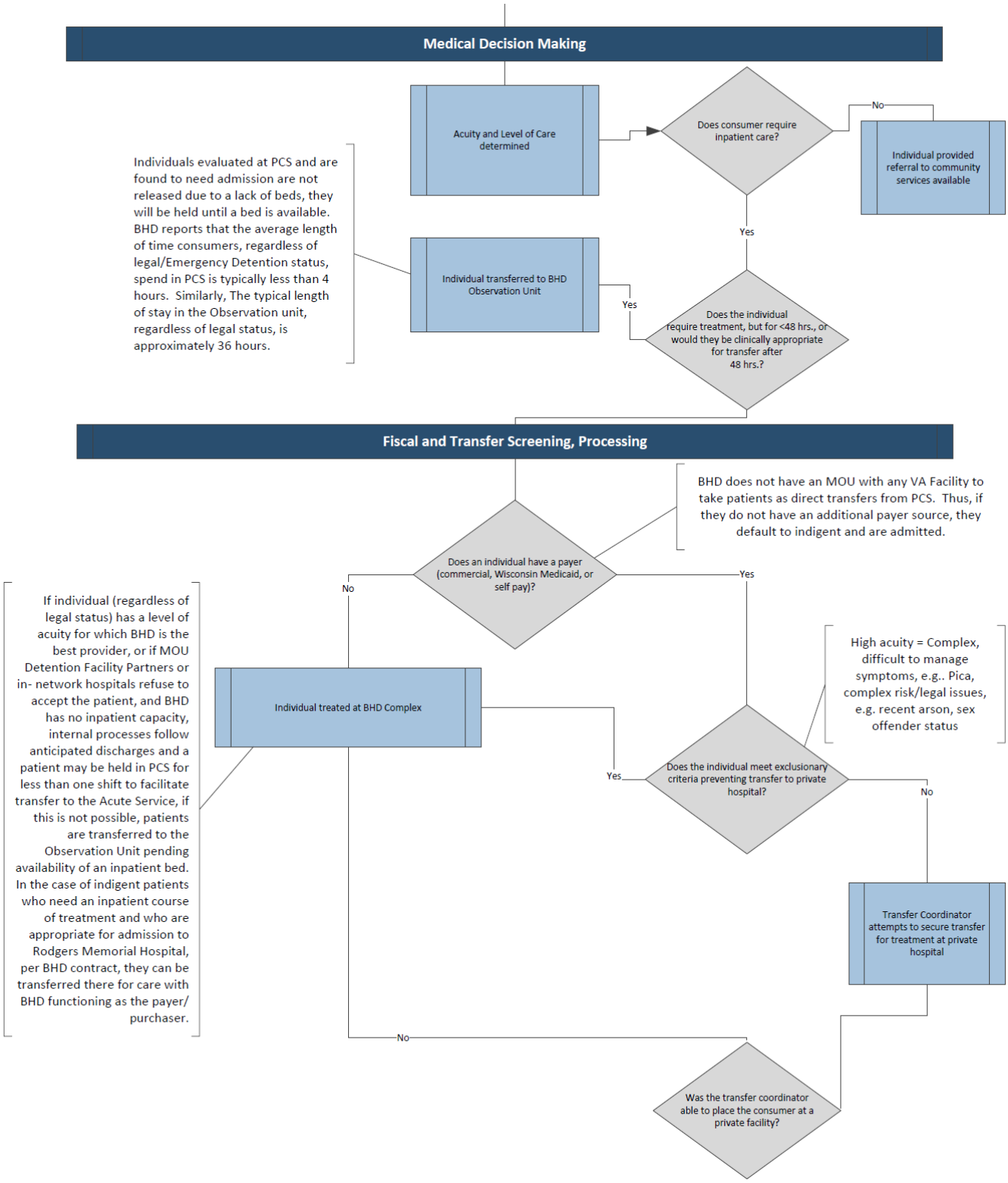
The following are some of the meetings and follow-up telephone interviews conducted for this purpose:

1. DHHS Leadership: Hector Colon (Director); September 11, 2014
2. BHD Leadership: Patricia Schroeder (Administrator); Jim Kubicek (Deputy Administrator), Susan Gadacz (Deputy Administrator); September 11, 2014
3. Mental Health Task Force (MHTF): Mary Neubauer (Mental Health Task Force Member (Co-Chair of Steering Committee, Consumer), Mental Health Board – Voting Member), Barbara Beckert (Mental Health Task Force Member (Coordinator of Steering Committee)), Serge Blasberg (Mental Health Task Force Member (Steering Committee, Consumer)), Peter Hoeffel (Mental Health Task Force Member (Not Steering Committee), Beth Burazin (Mental Health Task Force Member (Not Steering Committee, Consumer); September 23, 2014 Focus Group Sessions attended by 30 individuals and follow-up phone call with one individual
4. Milwaukee County Mental Health Board (MCMHB): Pete Carlson (Mental Health Board – Voting Member, Mental Health Task Force – Co-Chair), Kimberly Walker (Mental Health Board – Voting Member); September 24, 2014
5. Public Policy Forum: Rob Henken (President); September 24, 2014
6. Redesign Task Force (Redesign TF): Joy Tapper (Mental Health Task Force Member (Not Steering Committee), Executive Director of Milwaukee Health Care Partnership); Phone call on October 10, 2014

Appendix 2

BHD Complex Intake and Referral Process



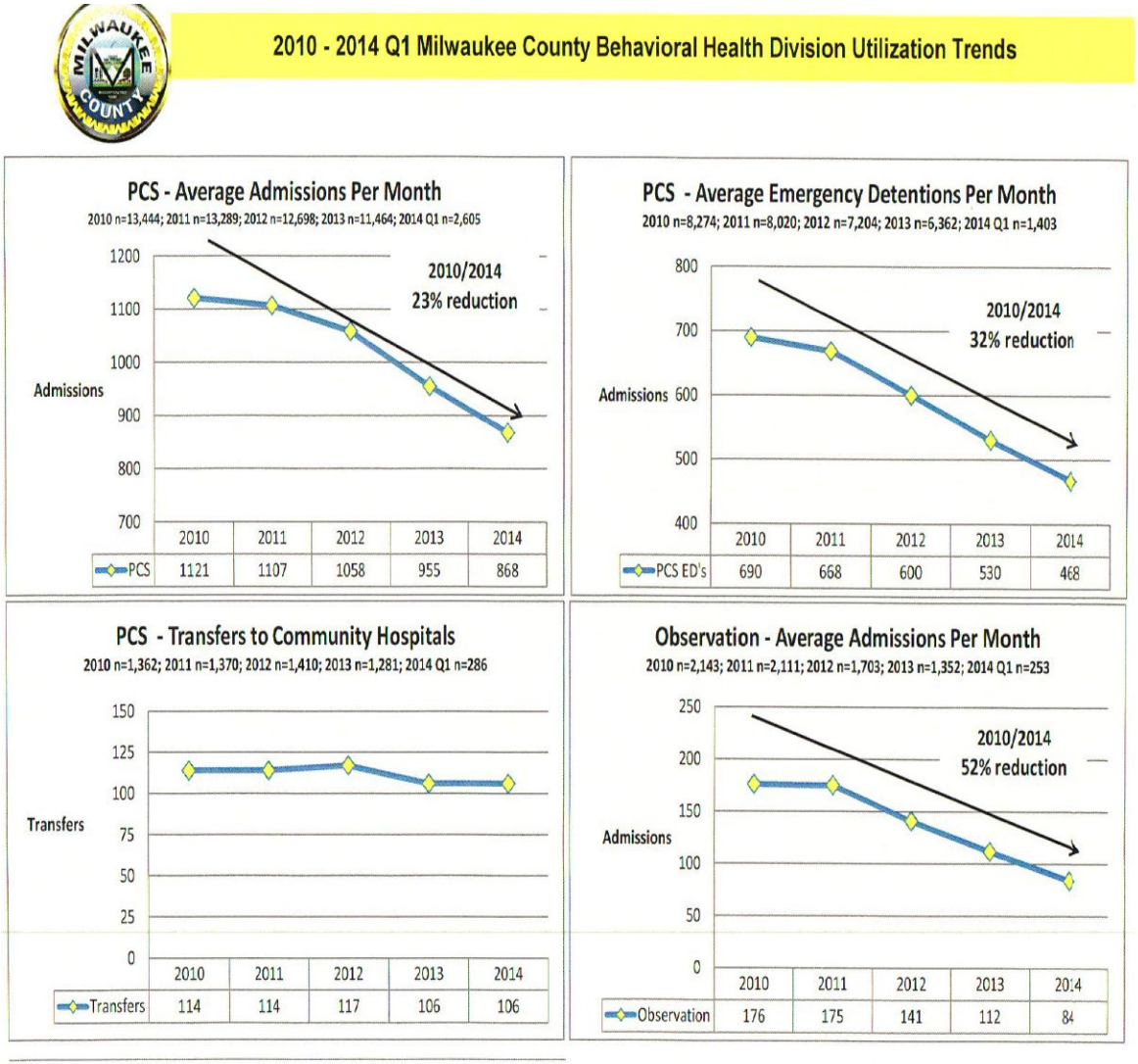

Medical Decision Making
Acuity and Level of Care determined
Does consumer require inpatient care?
No
Individual provided referral to community services available
Yes
Individuals evaluated at PCS and are found to need admission are not released due to a lack of beds, they will be held until a bed is available. BHD reports that the average length of time consumers, regardless of legal/Emergency Detention status, spend in PCS is typically less than 4 hours. Similarly, The typical length of stay in the Observation unit, regardless of legal status, is approximately 36 hours.
Individual transferred to BHD Observation Unit
Yes
Does the individual require treatment, but for <48 hrs., or would they be clinically appropriate for transfer after 48 hrs.?
Fiscal and Transfer Screening, Processing
BHD does not have an MOU with any VA Facility to take patients as direct transfers from PCS. Thus, if they do not have an additional payer source, they default to indigent and are admitted.
Does an individual have a payer (commercial, Wisconsin Medicaid, or self pay)?
No
Yes
If individual (regardless of legal status) has a level of acuity for which BHD is the best provider, or if MOU Detention Facility Partners or in- network hospitals refuse to accept the patient, and BHD has no inpatient capacity, internal processes follow anticipated discharges and a patient may be held in PCS for less than one shift to facilitate transfer to the Acute Service, if this is not possible, patients are transferred to the Observation Unit pending availability of an inpatient bed. In the case of indigent patients who need an inpatient course of treatment and who are appropriate for admission to Rodgers Memorial Hospital, per BHD contract, they can be transferred there for care with BHD functioning as the payer/ purchaser.
Individual treated at BHD Complex
High acuity = Complex, difficult to manage symptoms, e.g.. Pica, complex risk/legal issues, e.g. recent arson, sex offender status
Yes
Does the individual meet exclusionary criteria preventing transfer to private hospital?
No
Transfer Coordinator attempts to secure transfer for treatment at private hospital
No
Was the transfer coordinator able to place the consumer at a private facility?

Informational Points about Process (per BHD)

- Access Clinic – Consumers who are in an acute emergency and not appropriate for solely urgent assessment and medication interventions are referred directly to PCS (or community ER if concurrent or primary emergency medical condition).
- Crisis Line –Contacting the crisis line, based upon the clinicians triaging of need (and known benefits), may refer to services (or service entry point, ie contact insurance for list of in-network providers) including Access Clinic. In addition clinician may contact 911 for EMS/Law Enforcement Response, refer to local hospital (medical or psychiatric) voluntarily, refer to PCS Voluntarily and/or send Crisis Mobile Team.
- Response from 911 – Law Enforcement, with EMS if needed, is dispatched from 911, the CART can be dispatched from 911 and they can self-dispatch from monitoring the emergency calls radio. For the Crisis Mobile Team to be called, the responding Law Enforcement must assertively ask for Crisis Mobile involvement.
- There is a large percentage of police-escorted voluntary patients (approximately 35%) who are brought directly to PCS (as opposed to using an EMS/Community Hospital catchment where they proceed to the closest Emergency Room/Hospital) and second, while procedural alignment with Milwaukee Police Department is good (including continued plans for CART and CIT expansion), coordination with the other 14+ smaller municipalities is challenging at best.
- Treatment Director Designee – A Treatment Director Designee (for other than the Act 235 Pilot) must be a psychiatrist and per state statute can only place a treatment directors hold, the Treatment Directors' Affidavit (TDA) on patients who are currently an inpatient in a psychiatric unit.
- 24-Hour Evaluation Deadline – Under Wisconsin State Statutes for the Treatment Directors Supplement (TDS) requirement in Milwaukee County, the certification of the Emergency Detention by Law Officer meeting the commitment requirements and the patient not being appropriate for voluntary treatment must be completed within 24 hours of detention, but with the new language allowing tolling of time spent in medical clearance.
- A BHD transfer coordinator attempts to find a bed at a partner MOU facility (patients on emergency detention) or any in-network provider for voluntary patients. Despite this, the MOU facility, per Wisconsin State Statute 51.15(2), may refuse to detain the patient. All rational for refusals are tracked by our transfer coordinator. Physicians use clinical judgment and may place some patients they believe will either not need treatment beyond 48 hours or would be clinically appropriate for transfer after 48 hours of rapid stabilization on the observation unit pending consideration of transfer to an MOU partner facility. All other patients are admitted to one of the acute units.

Appendix 3

Utilization Report



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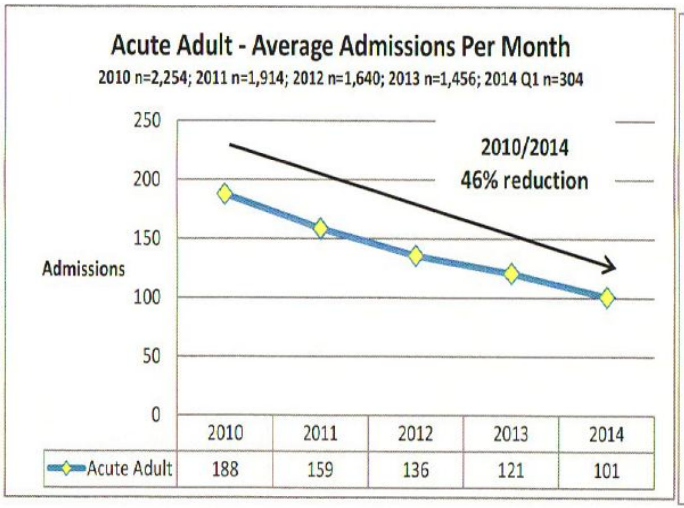
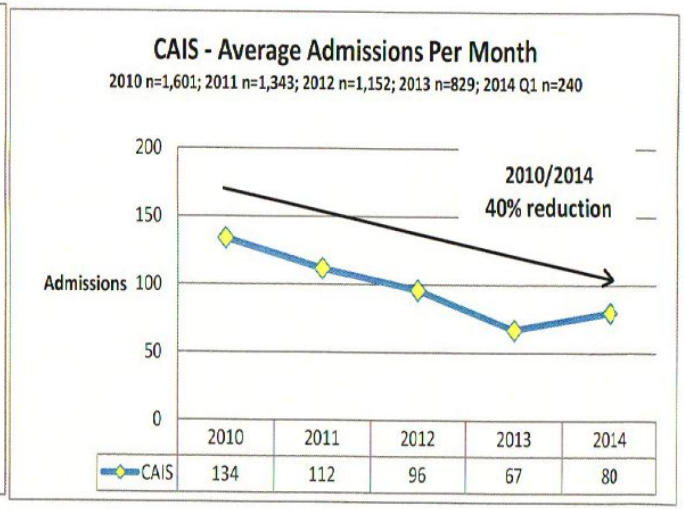
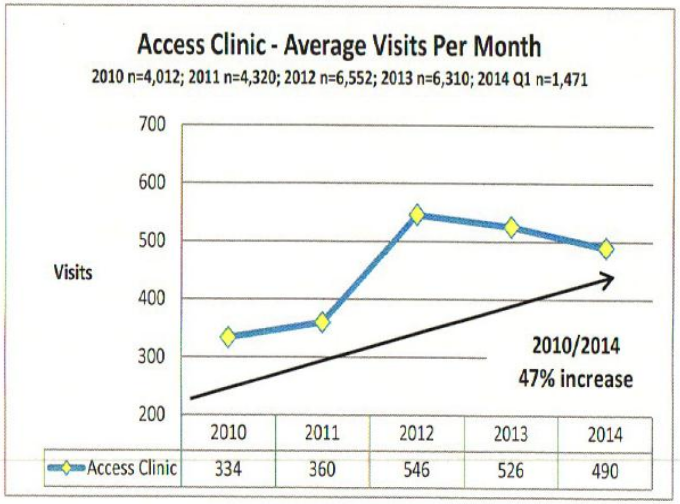

Acute Adult - Average Admissions Per Month
2010 n=2,254; 2011 n=1,914; 2012 n=1,640; 2013 n=1,456; 2014 Q1 n=304
Admissions
250
200
150
100
50
0
2010/2014
46% reduction
2010 2011 2012 2013 2014
Acute Adult 188 159 136 121 101


CAIS - Average Admissions Per Month
2010 n=1,601; 2011 n=1,343; 2012 n=1,152; 2013 n=829; 2014 Q1 n=240
Admissions
200
150
100
50
0
2010/2014
40% reduction
2010 2011 2012 2013 2014
CAIS 134 112 96 67 80


Access Clinic - Average Visits Per Month
2010 n=4,012; 2011 n=4,320; 2012 n=6,552; 2013 n=6,310; 2014 Q1 n=1,471
Visits
700
600
500
400
300
200
2010/2014
47% increase
2010 2011 2012 2013 2014
Access Clinic 334 360 546 526 490

Appendix 4

BHD Complex Staffing Information (per BHD)

BHD Inpatient Unit Staffing Ratios

IPU	RN to Patient Ratio	CNA: patient ratio	Notes
ITU	1:4 to 1:6	1:8	Other professionals assigned to this unit include one (1) Psychiatrist, two (2) Psychologists, two (2) Social Workers, .5 Music Therapist, and one (1)1 Occupational Therapist. More CNA staff is assigned to cover patients on 1:1 Observation as necessary. On any given day, approximately 15 patients have 1:1 coverage.
ATU	1:6 to 1:8	1:8	Other professionals assigned to this unit include one (1) Psychiatrist FTE (2 different Psychiatrists), two (2) Psychologists, two (2) Social Workers, .5 Music Therapist, and one (1) Occupational Therapist. ATU has Medical Residents assisting in providing care to patients.
WTU	1:6 to 1:8	1:8	Other professionals assigned to this unit include one (1) Psychiatrist FTE (2 different Psychiatrists), two (2) Psychologists, two (2) Social Workers, .5 Music Therapist, and one (1) Occupational Therapist.
CAIS	1:6 -1:8	1:8	Other professionals assigned to this unit are 1.5 Psychiatrists (3 Physicians), one (1) Psychologist, Medical Students, two (2) Social Workers, .5 Music Therapist, one (1) Occupational Therapist. During the school day, there are also two (2) teachers on the unit.

According to BHD, assessment of staffing needs is based on census, patient needs, patient behavior, and staff hours available. Decisions on these issues related to staffing are made prior to every shift, every day, by the Nursing Management team (Managers and Supervisors).

BHD Inpatient Unit Registered Nurse and Certified Nurse Assistant Staffing Rates

The base Nursing staffing rates are listed below for each of the program areas. Base is the preferred number of staff per shift. Budget is how many positions (FTEs) the base number equates to in order to provide year round coverage.

For the Crisis Branch this is the number required for both PCS and Observation, Nursing staff will frequently float back and forth between the 2 services based on census, acuity, number of admissions etc. in each service, so they are staffed with an aggregate number. This is also the case for Psychiatry staff. Psychiatry staff will often work in both service areas based on clinical need. Additionally on the observation unit there is also a FT- OT staff, Clinical Social Work position and a Peer specialist position. Coverage on the Observation unit is also handled by Clinical staff on the Mobile Team

Crisis			
Shift		Base	Budget
1	RNs	5	8
	CNAs	4	6.5
2	RNs	6	10
	CNAs	4	6.5
3	RNs	5	8
	CNAs	4	6.5
total	RNs	16	26
	CNAs	12	19.5

In CAIS (Child Adolescent Inpatient Service), census fluctuates widely. Staff can either be pulled in to the service or out of the service based on Clinical factors not only on CAIS but the entire facility. Listed below is the base numbers that are budgeted to the service.

CAIS			
Shift		Base	Budget
1	RNs	3	5
	CNAs	2	3
2	RNs	3	5
	CNAs	2	3
3	RNs	2	3
	CNAs	0	0
total	RNs	11	13
	CNAs	4	6

The preferred staffing ratio for RN is 1 RN to 6 Patients for units 43B and 43C, and either 1 to 4 or 1 to 5 on the intensive treatment unit. The minimum staffing ratio is 1 to 8 on units 43B and 43C and 1 to 6 on 43A. The base staffing number is adjusted based on census caps.

Acute Adult				
unit	shift		Base	Budget
43A Intensive Treatment Census cap 18	1	RNs	4	6.5
		CNAs	3	6
	2	RNs	4	6.5
		CNAs	3	6
	3	RNs	2	3
		CNAs	2	4
43B General Treatment Unit Census Cap 24	1	RNs	4	6.5
		CNAs	3	6
	2	RNs	4	6.5
		CNAs	3	6
	3	RNs	1	2
		CNAs	2	4
43C Women's Treatment Unit Census Cap 24	1	RNs	4	6.5
		CNAs	3	6
	2	RNs	4	6.5
		CNAs	3	6
	3	RNs	1	2
		CNAs	2	4
	total	RNs		46
		CNAs		42

Appendix 5

Consumer and Advocate Interview Questionnaire

Stakeholder Sessions for Milwaukee County Behavioral Health System Assessment (MCBHSA)

Objective:

To hear from individuals with lived experience and the individuals who advocate on their behalf regarding input on the strengths, progress, challenges and gaps of the Milwaukee County behavioral health system, in order to gain insights on the broader redesign and system issues, including impact on such areas as access, quality, recovery and best practices.

Various community stakeholders provided input to previous studies by the Human Services Research Institute (HSRI), Technical Assistance Collaborative (TAC) and Public Policy Forum (PPF), including the 2010 study report on the adult mental health system in Milwaukee County and the more recent capacity study this past April. We'd especially like to build on the input from those previous studies to capture any new or updated information on the progress that has been make or issues that have emerged since then.

Stakeholder Questions **(*please base your comments on your own experience or those of others who have sought MH/SA services from Milwaukee County)*:**

1. What do you think is working well in the Milwaukee County behavioral health system?
2. What is not working well?
3. What problems do people who are eligible for publicly funded MH/SA services in Milwaukee County have around getting the services that they need?
4. Are there any services that you would refuse? Why?
5. We are interested in hearing from you about the 2010 HSRI study that solicited input from a broader group of stakeholders. Have you seen improvements in any of the following areas outlined in the 2010 report:
    a. Recovery-oriented and consumer-centered system
    b. Rebalancing the service system for a greater focus on community-based services
    c. System capacity to divert individuals in crisis from inpatient and emergency services
    d. Inpatient capacity and role of local hospitals in admitting individuals with complex needs
    e. Quality and innovation in the service delivery system
    f. Integration of MH/SA services with primary health care, and coordination with law enforcement and private health systems
6. What is the biggest need for change or improvement to the overall Milwaukee County behavioral health system?
7. Do you think that you and others with lived experience have an active voice in shaping improvements to the overall system of behavioral health services that are available in Milwaukee County?

If you have questions or would like to provide additional comments, please contact Heidi Pankoke from TMG at heidi.pankoke@tmg-wis.com

Appendix 6

Key Sources

Behavioral Health Division Request for Information. Community-Based Long-Term care Options.' http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/Contracts/2014/Final_CommSvcstoSupportCenral-.pdf. Accessed August 20, 2014.

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WHA Behavioral Health Task Force Whitepaper.' Wisconsin Hospital Association, Inc.. http://legis.wisconsin.gov/lc/committees/study/2012/12CH51/files/oct4whitepaper_ch51.pdf. 2010. Accessed September 2, 2014.

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Multiple data sources from BHD, DHS MHSAS and HCAA available (18MB file)