COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: November 25, 2013

TO: Sup. Peggy Romo West, Chairwoman, Committee on Health and Human Needs

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Susan Gadacz, Director, Community Services Branch Behavioral Health Division, Co-Chair of the Mental Health Redesign and Implementation Task Force

SUBJECT: **From the Director, Department of Health and Human Services, submitting an informational report on the current activities of the Mental Health Redesign and Implementation Task Force**

Issue

In April 2011, the County Board of Supervisors passed a resolution (File No. 11-173) supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign and Implementation Task Force (Redesign Task Force) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities. The Chairwoman of the Committee on Health and Human Needs requested monthly informational reporting on the activities of the Redesign Task Force.

Background

The Redesign Task Force first convened in 2011, delegating Action Teams (AT) to prioritize recommendations for system enhancements within the key areas of Person-Centered Care, Continuum of Care, Community Linkages, Workforce, and Quality. The AT co-chairs presented their initial prioritized recommendations to the Committee on Health and Human Needs in January 2012 and at a public summit in February 2012, where consultants from the Human Service Research Institute (HSRI) provided feedback and guidance. The Redesign Task Force, the Task Force Executive Committee, and DHHS and BHD leadership resolved in March 2012 to issue a Request for Proposals (RFP) for technical assistance in implementing the affirmed recommendations. DHHS subsequently contracted with a consultation team comprised of ZiaPartners, Inc., and three subcontractors from September 2012 through July 2013.

In December 2012, the DHHS Director presented an informational report to the Committee on Health and Human Needs on the progress and activities of the Redesign Task Force, including a framework for planning, tracking, and recording progress on all redesign implementation activities, including those already accomplished or underway. The implementation activities were then framed within SMART Goals – Specific, Measurable, Attainable, Realistic, and Time-bound – to promote greater accountability and clearer reporting. In March 2013, the County Board of Supervisors passed a resolution (File No. 13-266) authorizing the DHHS Director to implement the initiatives outlined in the SMART Goals in collaboration with the Redesign Task

Force and community stakeholders. With that authorization, the Redesign Task Force, ATs, and their staff partners are presently at work on the numerous Tactical Objectives of the SMART Goals, in pursuit of the specific performance targets to be achieved in 2013 and 2014.

Discussion

The Redesign Task Force completed a six-month self-assessment of its progress toward the SMART Goals since they were adopted by the County Board. Action Team leaders, Task Force members, and County staff working with the Quality Action Team have provided the data progress reflected below. These progress assessments addressed the SMART Goals specifically but should also be understood as building upon those redesign-related initiatives that preceded the SMART Goals. In addition to the SMART Goals as the measurable foundation of the Task Force's activities, the continued use of the HSRI report and recommendations were critical to the achievement thus far of the Task Force goals.

The HSRI report continues to be used as a guide by the Task Force. Attached is a separate report related to the HSRI recommendations that show significant progress towards implementing these recommendations (see Attachment A). For ease of reporting, the progress report is laid out in the goal order in which the goals have been completed. To date, eight goals with their respective performance target and end dates of July 2014 have been completed. Two goals are ahead of pace and the corresponding HSRI recommendation is also reflected. The attached SMART Goals (see Attachment B) may be used as a cross reference.

SMART Goal 4: Expand the network of Certified Peer Specialists who are well trained, appropriately compensated, effectively engaged with peers, and whose services are eligible for Medicaid reimbursement

- Performance Target 4.1: Increase number of Certified Peer Specialists by 20% (July 2014)
    - Status: Completed – Increased from 52 to 81 = 50% increase

HSRI Recommendation 6: Promote a recovery-oriented system through person-centered approaches & peer supports

SMART Goal 5: Improve the coordination and flexibility of public and private funding committed to mental health services

- Performance Target 5.2: Approval of CRS implementation by Milwaukee County government (January 2014)
    - Status: Completed CRS implementation approved in July 2013

HSRI Recommendation 5: Expand & reorganize community-based services

SMART Goal 8: Improve crisis access and response to reduce Emergency Detentions

- Performance Target 8.3: Increase percentage of individuals seen at Psychiatric Crisis Services (PCS) who have Person Centered Crisis Plans (July 2014)
    - Status: Completed – BHD Crisis Services had crisis plans on file for 350 individuals (157% increase over 2012) through May 2013.
    - Since 2010, emergency detentions have decreased 19%.

HSRI Recommendation 4: Reduce emergency detentions

SMART Goal 9: Improve the flexible availability and continuity of community-based recovery supports

- Performance Target 9.1: Establish four-level continuum of TCM services (July 2014)
    - Status: Completed – Recovery Case Management (piloted by Milwaukee Mental Health Associates) added in April 2013, complementing three existing levels of TCM
- Performance Target 9.2: Increase number of TCM slots by 6% (90 slots) (July 2014)
    - Status: Completed – Addition of Recovery Case Management level of care, plus additional Level I caseloads contracted with Bell Therapy in April 2013
- Performance Target 9.3: Establish two additional psychosocial rehabilitation benefits – Comprehensive Community Services (CCS) and Community Recovery Services (CRS) (December 2014)
    - Status: Completed the implementation of CRS, first client enrolled in November 2013

HSRI Recommendation 5: Expand & reorganize community-based services

SMART Goal 10: Improve the success of community transitions after psychiatric hospital admission

- Performance Target 10.2: Decrease BHD inpatient 90-day readmission rates from 24.1% to 22.0% (July 2014)
    - Status: Ahead of pace – 2013 YTD Acute Adult 90-day readmission rate is currently 19.8%
    - Hired a Community Intervention Specialist to assist with discharge transition of individuals leaving private psychiatric hospitals.

HSRI Recommendation 1: Downsize & redistribute inpatient capacity

SMART Goal 13: Improve access to (and retention in) recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately housed

- Performance Target 13.3: Create 25 new units of permanent supportive housing for persons with mental illness (July 2014)
    - Status: Completed and more units planned for 2014. Pathways to Permanent Housing was also established and opened in 2013 as a new level of transitional housing. In addition, there are plans for over 80 new units of permanent supportive housing in 2014.

HSRI Recommendation 7: Enhance & emphasize housing supports

SMART Goal 15: Improve access to non-hospital intervention and diversion services for people in a mental health crisis to reduce unnecessary acute hospital admissions

- Performance Target 15.2: Decrease BHD inpatient 90-day readmission rates from 24.1% to 22.0% (July 2014)

- Status: Ahead of pace – 2013 YTD Acute Adult 90-day readmission rate is currently 19.8%
- Since 2008, Acute adult inpatient admissions have decreased 40%

HSRI Recommendation 1: Downsize & redistribute inpatient capacity

The Redesign Task Force will use these progress assessments to determine its continued scope of work and the appropriate focal points for its Action Teams and stakeholders, noting areas of needed emphasis as well as those of strength. The Task Force continues to be attentive to the July 2014 target date for many of the SMART Goals. It is important to recognize that this is a mid-term progress update of accomplishments since the SMART Goals were developed and approved. Furthermore, the SMART Goals are a time-bound road map for specific initiatives spanning March 2013 to December 2014, but they are not an exhaustive inventory of all activities contributing to the improvement and redesign of the local mental health system.

The Redesign Task Force operates as a community-wide collaboration in pursuit of goals and objectives that are complementary of – but largely distinct from – major County-specific initiatives. These initiatives include, but are not limited to, implementation of Electronic Medical Records, the use of evidence based programming within the Community Services Branch, continuing the expansion of the Access Clinic by adding a south side location, and transitioning long-term care consumers into person-centered, community-based settings.

The Task Force will meet on January 9 and on the first Wednesday of subsequent months. County officials and any other interested parties are encouraged to visit the website that hosts resources and updates related to redesign activities, including a meeting schedule for the Redesign Task Force, Action Teams, and related workgroups. The site is http://county.milwaukee.gov/MHRedesign.htm. Comments or inquiries about redesign activities may be directed to David Johnson at david.johnson@milwcnty.com.

Recommendation

This is an informational report. No action is necessary.

Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
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