MILWAUKEE COUNTY IMSSO PROJECT

SELF OPERATION INITIAL DECISION PAPER

NCCHC Resources

INTRODUCTORY COMMENTS

On December 6, 2018, the Milwaukee County Board of Supervisors passed Resolution 18-898, requiring the self-operation of health care services for inmate-patients housed in the Milwaukee County Jail (MCJ) and the House of Correction (HOC). The evaluation of requirements for, and a plan for implementation of, self-operation of inmate medical care is identified in Resolution 18-898 as the responsibility of the following Departments and Divisions:

- The House of Correction;
- The Office of the Sheriff;
- The Office of Corporation Counsel;
- The Office of the Comptroller; and
- The Department of Administrative Services.

WORKING DEFINITION OF SELF-OPERATION

In the absence of a specific definition of self-operation, NRI and the project team offer our current working definition. Self operation, for purposes of this project, shall mean the following:

> *"The provision of inmate medical care, including dental and mental health care, by Milwaukee County through the conversion of the existing 128.8 full- and part-time roles, currently identified as required positions under the Christensen Consent Decree, from contract staff positions provided through the County's medical services vendor to permanent County employee roles overseen by County authority. This shall include all contracted staff required in the 128.8 roles and through the County's medical services contract with its medical services vendor, regardless of whether those staff persons are provided directly by the medical services vendor or through third-party agencies or locum tenens arrangements."*

Under this working definition, County employees are not expected to provide any services currently provided by subcontractors or third-party entities otherwise engaged in a business relationship with the medical services vendor; however, oversight of any such needed contracts will become a County responsibility under the self-operation model.

This definition eliminates the following items from the definition of self-operation:

- Specialty care providers, such as Surgeons, Cardiologists, Endocrinologists, Dermatologists, Anesthesiologists, OB/GYNs, Nephrologists, Orthopedists, Oncologists, Optometrists and Opthalmologists, Pathologists, Physical Therapists, Radiologists, Urologists, etc;
- Emergency care and transport, such as ER services, surgery, trauma care, ambulance or life flight services, etc;

- Pharmacy services, including filling and delivery of prescriptions (County will be responsible for dispensing medications to inmate-patients and management of on-site pharmacy); and
- Other third party contracts, including, but not limited to, provision of biohazardous waste disposal services; service and maintenance of medical equipment; provision of forensic laboratory services; provision of specialty programs and services (equine therapy, substance abuse programs, etc).

SELF-OPERATION ANALYSIS ASSUMPTIONS

The following assumptions were made in providing the recommendations in this Decision Document:

1. **It is assumed that the County must transition to a self-operated model of inmate-patient care on or before April 1, 2021.**

   This assumption is based upon Resolution 18-898 and the current Wellpath contract, as the project team understands those documents and their related timelines.

2. **It is assumed that the most effective method to ensure the provision of quality healthcare to inmate-patients in a corrections environment is a single, unified governance structure**.

   Efficient and consistent self-operation is achieved under a unified governance structure so that there is clear direction and oversight of clinical and related functions. This will enable fiscal and legal control of the medical, mental health and dental services that the County is constitutionally required to provide. Such a unified structure will also align with the method of oversight of inmate health services currently provided by the contracted health services provider.

3. **Based on the information in assumption #2, is assumed that the County will move from its current bifurcated governance structure (HOC and MCSO) to a unified governance structure for the provision of medical care**.

   Bifurcated systems and models of governance, while possible, were not considered in this document based on this assumption.

4. **It is assumed that, based on assumptions #2 and #3, it will be necessary for the County to create a new entity, either a Department or a Division, that will be tasked specifically with the provision of inmate medical care.**

   This Department or Division will be responsible for all matters relating to the oversight and control of the 128.8 medical staff persons and any additional compliance, administrative, or fiscal staff requests that may be necessary within the new Department or Division and/or within other Departments and Divisions to support the

success of the new Department/Division. For purposes of this document, we will refer to the new Department/Division as the **Correctional Health Care Division (CHCD).**

a. **It is further assumed that, based on assumption #4 and with respect to NCCHC accreditation, the CHCD (or a person or office within) will assume the role of the Responsible Health Authority (RHA) for health operations.**

b. **It is further assumed that, based on assumption #4, the CHCD will be led by an appropriately trained and credentialed County staff member and will be the governing entity that oversees administration, safety of staff and inmates, personnel and training, patient care and treatment, health promotion, special needs and services, health records, and medical and legal issues, all within the context of NCCHC standards.**

5. **It is assumed that Public-Public or Public-Private partnerships for the provision of medical care (such as a cooperative agreement between the County and the Medical College of Wisconsin) do not fall under the definition of self-operation as NRI and the project team currently understand that term.**

   Based on this assumption, any models of care and care governance involving a Public-Public or Public-Private partnership were not considered as options in this report.

6. **It is assumed that the scope of NRI's work in its current contract with the County, and therefore the scope of the IMSSO Project, is limited to the assessment and enactment of a single governance model for the provision of medical care to inmate-patients.**

   Because each potential governance model can vary substantially in its requirements – new staff, new structures, new contracts, etc – it is understood that only one model can be selected and assessed during the course of the next eight months. Selection of multiple models for assessment and planning will add additional time and potential cost to the process and that method was not considered the best use of consultant and project team time, especially given the short time frame between evaluation and implementation (on or before April 1, 2021.)

   a. **Therefore, it is further assumed that, based on assumption #6, the County stakeholders understand and acknowledge that only one model will be treated in future steps of this project.**

      It is further understood that any differences between the chosen governance model and other potential governance models, including potential cost savings or increases of other models, potential improvements in care, or other similar variations and concerns between the selected model and other possible models will not be treated in the September report.

b. **However, it is further assumed that, based on assumption #1 and #6, that potential enhancements to the selected model may be proposed, if obstacles are encountered which require such enhancement or other creative solutions to ensure enactment of self-operation by April 1, 2021.**

7. **It is assumed that the monthly group will select a model based on this Decision Document and will document that decision via a sign-off following the meeting on March 4, 2019 to permit technical subject matter experts and NRI consultants to move forward with next steps in the project.**

   Failure to select a governance model and document the selection may result in project delays.

CURRENTLY CONSIDERED MODELS

After a brief analysis of viable options, several have surfaced as offering a high probability of success, given the short implementation timeline, working definition of self-operation, current infrastructure, and existing functional relationships within the County (as currently understood by NRI).

Option 1: County Executive – Direct Report

The elected County Executive (CEX) oversees numerous agency department heads within the County and is in a position to provide effective administrative oversight. The CEX is well versed in the fiscal aspects of administration, especially as these cross the lines of each department under the CEX's authority. The CEX currently has direct oversight of broad and diverse aspects of the County government. A direct reporting will ensure focus and attention to the complex mission of correctional health care.

Option 2: County Executive – Report to the Superintendent of the House of Correction

The Milwaukee County HOC operates under the authority of the County Executive (via an appointed Superintendent) and has the overall mission of safe and secure housing of sentenced inmates with short sentences. Other inmates are housed at the HOC as authorized. Of the two correctional facilities in Milwaukee County, the HOC holds the largest number of inmates; however, inmates with more acute clinical issues tend to be housed at the Jail. The Option 2 model would most closely mirror the current structure of health services, although the administrative management of approximately 128 employees (or more, as needed) would now fall directly under the Superintendent through the new Correctional Health Care Division, rather than his current responsibility for contract oversight.

This model may present cultural hurdles, as the HOC is overseen by the CEX and the MCJ is overseen by the Sheriff. While health services are unified and currently provided under the

contract with the HOC, the presence of HOC-employed personnel is masked by the fact that the health workers are contractors. It is unclear how a cadre of HOC employees working in the Jail would be perceived by all sides. The Sheriff's deputies working in the Jail belong to a distinct law enforcement-derived culture that may not be readily compatible with the distinct culture of the HOC.

Option 3: Report to the Department of Health and Human Services

The Milwaukee County Department of Health and Human Services (DHHS) is a large and dynamic public entity that plays a substantial role in the health of the community. DHHS is a semiautonomous division reporting to the elected County Executive and to the Milwaukee County Board of Supervisors. The CEX provides oversight and administrative support to the Department. The County Board provides legislative oversight through the enactment of ordinances and County policies, and approves the proposed Departmental budget on an annual basis. DHHS and its various divisions have years of experience in direct and indirect patient services, with an emphasis on behavioral health, all of which align with correctional health care needs and support continuity of care within the broader community.

It is understood that DHHS-BHD, the Behavioral Health Division, operates semi-autonomously under the Director of DHHS. However, unlike DHHS generally, BHD is overseen by an independent Board – the Mental Health Board – which approves BHD's budget, spend, and provides legislative oversight through the enactment of mental-health related policies. If the new Department were to report through BHD, it is further understood that approval of contract items and spend would fall to the Mental Health Board and not to the County Board of Supervisors.

Option 4: Report to the Office of the Sheriff

The MCJ falls under the authority of the elected Sheriff and currently provides essentially all acute care services for incarcerated patients in the County. Health staff at the Jail currently perform all intake screening for both MCJ and HOC inmates, with the exception of facility transfer intake screenings at the HOC. MCJ also houses the acute mental health unit for the treatment of inmates with mental illness and Jail inmates under suicide prevention protocols. The HOC utilizes isolation/segregation areas to provide treatment to HOC inmates under suicide prevention protocols. Despite this experience with health care, the Sheriff does not currently maintain oversight of the health care operation. As with the HOC-led model above (Option 2), having Sheriff staff work in the HOC may create unforeseen cultural friction, resulting in distractions and inefficiencies in health care delivery.

CURRENT HIGH-POTENTIAL MODELS

The two models that appear to have the greatest potential for success in Milwaukee County are as follows:

Direct Report to the County Executive

The CEX has greater experience in overseeing various departments within the County. The office has greater access to and works closely with leaders in fiscal, legal, human resources and other essential County functions. The office of CEX has a higher level of familiarity with the overall needs of the County correctional health services system and has a developed an indirect relationship with health service staff within the HOC and MCJ systems. The CEX is knowledgeable about the Christensen Consent Decree and all that is required to satisfy it.

However, the CEX office has very little direct experience with health care, especially in the unique environment of corrections. This can be mitigated by carefully selecting a CHCD leader with appropriate experience in health services delivery, such as a senior-level physician, nurse, midlevel health provider, or health services administrator with education and experience in organizational management and supervision of clinical staff.

Report to the Department of Health and Human Services

DHHS has vast experience in direct services of mental health programs. This experience would be valuable in the creation of the jail health services division. There is already a component of care provided under the supervision of the Behavioral Health Division, working within the Milwaukee correctional health system. DHHS has experience with recruiting and hiring health staff and offers an organic support continuum, bolstered by the oversight boards that exist within the overall DHHS system.

However, DHHS does not have experience in medical or dental services, and no comprehensive experience with the criminal justice system or inmate health services. The department may not have clear knowledge of the Christensen Consent Decree or the requirements for satisfying all of its elements. Training and immersion into the project would be the solution to this. It would also be necessary to determine whether the new department would report through BHD and the Mental Health Board, or through DHHS generally, and the County Board of Supervisors. The medical expertise of the Mental Health Board may create efficiencies and encourage support of the medical-specific requirements of the new department. However, the Mental Health Board also lacks experience in medical and dental services, and may be unprepared to assume oversight of the new department.

OTHER MODELS

A number of other models exist but are not favored based on assumptions (see Section – ASSUMPTIONS) or other concerns.

A newly created stand-alone public entity: This model offers a high level of customization and flexibility but is inherently more cumbersome and time and resource intensive to establish. There is a potential for unforeseen negative public perception of a new and expensive county mission (focused on the incarcerated), and the legality of establishing an entirely new component of government must be explored.

Safety net or academic medical system: This model offers vast experience in delivering comprehensive health care but provides limited experience in a correctional environment. There is already a six-institution network (the Milwaukee Regional Medical Center), which includes the DHHS BHD. Importantly, this model does not meet the working definition of self-operated.

Blended models: This model allows for the selection of components from different sources in order to provide a tailored blend of services. However, this model would be difficult to fit under the current definition of self-operated and would create complexities, inefficiencies, and expense, which decrease its appeal.