Behavioral Health Redesign Steering Committee (BHRSC)
May 23, 2013

Call to Order. Chair Flanagan called the meeting of the Behavioral Health Redesign Steering Committee to order at 12:05 P.M. in the Courthouse Conference Center, second floor, Rock County Courthouse-East.

Committee Members Present: Supervisor Billy Bob Grahn, Tim Perry, Julie Lenzendorf, Lance Horozewski, Cmdr. Erik Chellevold, Kate Flanagan, Tom Gubbin, Neil Deupree, Kim Kempken, Kelley Everson (alt. for Faith Mattison), and Greg Ammon.

Committee Members Absent: Dannie Evans, Laura Binkley, Judge James Daley, Sheila Deforest, Brian Gies, Linda Scott-Hoag, Deputy Chief John Olsen, Denny Luster, and Dr. Marko Pease.

Staff Members Present: Elizabeth Pohlman McQuillen, Criminal Justice System Planner/Analyst.

Others Present: Representative Deb Kolste and Supervisor Steve Howland.

Approval of the Agenda. Mr. Ammon moved approval of the agenda as presented, second by Ms. Lenzendorf. ADOPTED.

Approval of the Minutes of May 7, 2013. Mr. Gubbin moved approval of the minutes as presented, second by Mr. Horozewski. ADOPTED.

Chair Flanagan asked that everyone introduce themselves.

Follow-up from Zia Site Visit and Discussion regarding "Homework" and Next Steps. Chair Flanagan went over the "Suggestions for Next Steps" document. She said one of the assignments is to work on the workgroups. Mr. Perry asked if we could go over which workgroups were already established. The group discussed the workgroups and who would be the primary contacts for each workgroup as follows:

Recommended Workgroup	Already in Existence?	Primary Contact People
Data	Yes, as a part of Zia project	Patrick Singer and Jim Zahniser
Kid's Continuum	Yes, internal HSD group and CST committee	Lance Horozewski
Consumer/Family	Yes, Grassroots Empowerment and subcommittee of CST	Kate Flanagan
Crisis Redesign	Yes, CCRG	Melissa Meboe
Prescribers	No, but Greg organizing one	Greg Ammon
Adult MH Continuum of Care	Internally as HSD MH Supervisory team	Kate Flanagan
Funding Planning	No, Don't need now.	
Primary Health	No, Not a priority at this point	
Integrated Prevention	No, needs to be developed	
AODA Continuum of Care	Yes, AODA providers meeting through HSD	Rebecca Rudolph

Chair Flanagan said she has been thinking as to whether criminal justice /diversion should be a separate workgroup or incorporated into the Adult Continuum of Care. The group decided that once TriWest presents its data report that may help guide that decision.

Chair Flanagan went over page two of the "Suggestions for Next Steps" document. The group agreed that a survey of the questions on the document would be sent to all BHRSC members/agencies and other partners/stakeholders to have results back by the next BHRSC meeting.

Mr. Deupree asked about cultural competency. The group agreed that should be a part of everything that we are doing. Mr. Perry said trauma informed care should also be a part of it all.

The group then discussed adding members to the BHRSC. Ms. Pohlman McQuillen said she would talk with Corporation Counsel to find out how it should be done.

Discussion regarding Strategic Plan and Review of SMART Goals. The group reviewed Milwaukee County's SMART Goals document. Chair Flanagan asked if something like this, combined with a narrative plan be a good format for our strategic plan. Mr. Ammon said he liked its structure. Mr. Horozewski said he liked the focus it provides. Mr. Perry agreed it has good structure and was put together with needed specificity. The group all agreed this would be an appropriate format for the strategic plan for Zia to provide to us.

Data Group Update. Nothing new to report.

Citizen Participation and Announcements. Representative Kolste gave an update on the Speaker's Taskforce on Mental Health. She said they have identified many problems and the easiest to fix is with regard to HIPAA harmonization. She further stated that primary care doctors deliver at least 90% of initial mental health care and they are looking at a model for implementing call centers to assist these primary care physicians in dealing with patients with mental health concerns. She added that they are looking at increasing peer specialists, more CIT training, a need for more providers and resources, as well as stigma reduction.

Mr. Gubbin announced that the CJCC's annual Community Resource Fair will be held on Thursday, June 6th, from 1:00-3:30 p.m. at the Job Center.

Time and Date for Future Meetings. Thursday, June 20, 2013, at Noon in Rooms N1 & N2, Fifth Floor, Courthouse East.

Adjournment. The meeting adjourned at 1:03 p.m. by acclamation.

Respectfully submitted,
Elizabeth Pohlman McQuillen
Criminal Justice System Planner/Analyst

NOT OFFICIAL UNTIL APPROVED BY COMMITTEE.

- **Do you have ideas about how you could better collaborate with other partners in the Redesign? What would you like to offer? What can other agencies offer that would be helpful to you? (*Think first about collaborations that involve no new resources*)**

- **Other comments and ideas about how to advance the Redesign process.**

Assignments for BHRSC: Once this material is provided, the BHRSC should discuss how to incorporate this information into priorities for the Strategic Plan, as follows. We recommend focusing first on the Workgroup information, and next on the individual organization information.

Workgroup Assignments:

1. **Of the suggested workgroups listed in the Draft Charter, which ones do we want to have as part of our Redesign, and which ones do we want to postpone till a future date? Are there any workgroups that we need that are not listed (e.g. Cultural Competency)?**

2. **Discuss the proposed mission and objectives that each Workgroup identified in its assignment, and suggest changes and modifications. Collect the edited results into a single document (both for BHRSC and for ZiaPartners to review) (NOTE – these do not have to be perfect – we will edit them, so just focus on the important ideas that you want to convey)**

Individual Partner Agency/Orgn Assignments:

1. **Review the COMPASS-EZ and SOCAT, as well as any other suggested tools.**

2. **Review the responses from the members, and indicate where is there general agreement and where there are questions or concerns. Share that information with ZiaPartners.** (This will assist us in developing the Strategic Plan and the Charter)

3. **Identify missing members/agencies/organizations from the emerging partnership at BHRSC, and identify how to FORMALLY invite those members to the BHRSC. (**Note that your process has progressed to the point that formal invitation from both County leadership and BHRSC leadership is warranted).

ZIAPARTNERS FOLLOW UP TO MAY 7 VISIT

SUGGESTIONS FOR NEXT STEPS

To the Rock County Behavioral Health Redesign Steering Committee:

We (Dr. Minkoff and Dr. Cline) are delighted by the work that you have been doing in the BHRSC, and the progress that was made in the discussions on May 7. As we discussed during our visit, we have some specific ideas for next steps that will help make progress toward the development of a BH Redesign Strategic Plan, with associated SMART Goals/Objectives, and a Consensus/Charter Document to outline the activities of various partners in the Redesign.

Timeline of Next Steps: Our hope is that if the work proposed in these suggested assignments is accomplished between now and the end of June, that we can provide you an initial draft of these materials during July, for you to review during July and August, so that we can hopefully propose a nearly final draft for discussion during our final visit in this contract, which we would expect to occur in September.

Assignment for Existing or Proposed Workgroups: Note that the some of the current or potential workgroups listed in the Draft Charter are fully formed (eg CCRG, Data Workgroup) and others are in evolution (Children's SOC), while others have not started but are just being started (Psychiatrists) or considered (Consumers, Faith-based or Cultural Diversity). Our recommendation is that for each current or proposed workgroup – as it is – the workgroup leader(s) or other assigned individual should complete the "assignment" below to bring to the next BHRSC Meeting.

Name of Workgroup (Current or Proposed)

Name of Leaders (if identified)

Current and Proposed Members (individuals or constituencies)

Proposed Mission or Goal of the Workgroup (one or two sentences)

Proposed Objectives for the Workgroup in the next year (3- 5 specific next steps, if you can).

Other comments about how this workgroup might contribute to the Redesign process.

Assignment for Current Partners in BHRSC: This assignment is related to the current steps for individual agencies or organizations that are listed in the current draft of the Charter document, but they have been modified to be more flexible based on the discussions on May 7.

Name of Agency or Organization (e.g, Beloit Area Health Center, Janesville PD)

Name of Agency/Orgn Leader(s)

Name of Representative(s) in the Redesign (if different from above)

With regard to the vision of developing a person/family centered trauma informed integrated system of care, please answer the following questions:

- **Is your agency/org'n willing and able to make a formal commitment to participate in this process?**
- **Are you willing to identify an internal change team that will be responsible for your work in the Redesign?**
- **Can you identify some initial individuals representing the front line of our organization who are potential Change Agents in this process?**
- **Please identify some potential Change Agents who might be willing to come to an initial meeting about being a Rock County Change Agent.**

- **Would you be willing to perform a self-assessment of where your agency/orgn is in relation to the vision, using a tool (or one of several tools) that are approved by the BHRSC? (***Note that we provided info on the* ***COMPASS-EZ*** *which is a tool for treatment/service providers; we also shared with Lance a tool called the* ***SOCAT****, which is a tool for system partners (eg Probation, Child Welfare, Police, Education); you could consider other tools as well based on what might fit for different organizations, provided the tools are helpful to advance toward the vision***)**

- **Would you be willing to develop an achievable improvement plan to work toward the vision along with the other partners in this process? The improvement plan could work on any area that was identified as contributing to progress (e.g., welcoming, data collection, trauma informed responses, complexity capability)**

- **Are you willing to contribute representatives for participation in the Workgroups as needed?**

Mental Health Redesign SMART[1] Goals: 2013 – 2014

Mental Health **Redesign** Task Force

TIMEFRAME

Redesign is about designing a system that promotes life and hope for people in Milwaukee County with mental health needs by transitioning to a more fully community-based system of care. Redesign is as a multi-year process with ambitious targets. Initial SMART Goal implementation is focused on identifying attainable and measurable goals/objectives that can be achieved within the next 12-18 months.

There will then be Annual Updates of the SMART Goals to define measurable progress toward the highest possible standards for all services.

[1] Specific, Measurable, Attainable, Realistic, and Time-bound

SCOPE

The Mental Health Redesign addresses the improvement of mental health services for Milwaukee County residents served by public and private systems and organizations. Initial SMART Goals focus heavily on changes in the public sector system operated by the Milwaukee County Department of Health and Human Services while implementation planning continues on broader communitywide improvements involving major hospital systems, provider organizations, advocates, and persons with lived experience. Monthly progress reports on the SMART Goals and Improvement Areas will continue to be made to the County Board and the community.

ORGANIZATION OF SMART GOALS

Goals are organized into five improvement areas consistent with the monthly progress reports that have been provided on the Redesign process:

1) System of Care
2) Crisis System Redesign
3) Continuum of Community-Based Services
4) Integrated Multi-System Partnerships
5) Reduction of Inpatient Utilization

SMART Goal 2013-2014

one

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Improve consumer satisfaction and recovery outcomes by:

- Providing services that are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable;
- Improving system-wide implementation of such services;
- Increasing the use of self-directed recovery action plans;
- Completing the functional integration of substance use disorder and mental health service components of the Milwaukee County Community Services Branch; and
- Using person-centered experiences to inform system improvement.

1

PERFORMANCE TARGETS

By July 2014:

1) Consumer satisfaction as measured by the MHSIP (Mental Health Statistics Improvement Program) Consumer Survey will show measurable improvement for Milwaukee County Behavioral Health Division's Acute Adult Inpatient and Community Services Branch, including residential, supported apartments, community support programs, targeted case management programs, and day treatment with the long range goal of meeting/exceeding the National Research Institute consumer satisfaction standards.
2) Consumer satisfaction as measured by the Vital Voices consumer satisfaction interviews will show measurable improvement for Milwaukee County Crisis Services.
3) 80% of Milwaukee County Behavioral Health Division directly operated services and contracted services will demonstrate adherence to the Mental Health Redesign Core Competencies relative to the principles of person-centered care. (See Goal 3)
4) Integration of substance use disorder and mental health services in the Milwaukee County will be achieved.
5) Consistent mechanism for using person-centered stories in quality improvement is established.

TACTICAL OBJECTIVES

1.1 Review MHSIP and Vital Voices survey instruments to determine if enhancements are required to capture person-centered principles.

1.2 Continue implementation of evidence-based practices to improve the extent to which services are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable; and anchor those improvements in policy and contract.

1.3 Coordinate the activities of MC3 (Milwaukee County Co-Occurring Cadre) Evaluation Subcommittee with the efforts of the Redesign Quality Action Team to insure representation of person-centered stories in quality improvement.

1.4 Develop and implement strategies to increase the use of self-directed recovery action plans by establishing a baseline of current use, identifying training opportunities, and measuring adoption by peers.

1.5 Lead the integration of substance use disorder and mental health services into a co-occurring capable system by functionally integrating SAIL and WIser Choice at the Community Services Branch and provider levels.

RESPONSIBILITY

Lead BHD Staff:
Jennifer Wittwer

Action Team Involvement:
Person-Centered and Quality

Partners:
Persons with lived experience; Community Services Branch; MC3; providers; Vital Voices; Families United; Mental Health Task Force

SMART Goal 2013-2014

two

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Promote stigma reduction in Milwaukee County through:

- Evidence-based MH/AODA stigma reduction public education presentations that include presentations by persons with lived experience to over 1000 residents in Milwaukee County supervisor districts.
- Partnering with community efforts already underway led by NAMI, Rogers Memorial Hospital, and the Center for Urban Population Health Project Launch.

2

PERFORMANCE TARGETS

By July 2014:

1) Presentations are conducted in 18 supervisor districts with an average of 55 residents in attendance at each (total of 1,000 residents).
2) Stigma reduction message is received by a minimum of 20,000 Milwaukee County residents.

TACTICAL OBJECTIVES

2.1 Develop a program to be delivered within each supervisor district that includes an evidence-based stigma reduction model and a presentation by one or more persons with lived experience.

2.2 Provide support and technical assistance to community efforts to reduce stigma.

RESPONSIBILITY

Lead BHD Staff:
E. Marie Broussard

Action Team Involvement:
Person-Centered

Partners:
Milwaukee County Supervisors; Mental Health Task Force; NAMI; Rogers Memorial Hospital; Center for Urban Population Health; Persons with lived experience

three

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Improve the quality of the mental health workforce through:

a. Implementation of workforce competencies aligned with person-centered care;
b. Improved mental health nursing recruitment and retention;
c. Improved recruitment and retention of psychiatrists; and
d. Improved workforce diversity and cultural competency.

3

PERFORMANCE TARGETS

By July 2014:

1) Establish person-centered workforce competencies.
2) 50% of Milwaukee County contracted behavioral health providers will adopt person-centered workforce competencies.
3) Plan to improve the retention of mental health nurses is completed.
4) One (1) training slot is established for the 2014-2015 involving a partnership of the Medical College of Wisconsin Department of Psychiatry and the Milwaukee County Behavioral Health Division.
5) A baseline on the current racial/ethnic composition of the mental health workforce is established.

TACTICAL OBJECTIVES

3.1 Develop person-centered workforce competencies that are recovery-oriented, trauma-informed, co-occurring capable, and culturally-competent.

3.2 Develop and implement a plan to introduce the competencies to public and private entities and achieve their adoption.

3.3 Develop and implement a plan to improve the quality and retention of mental health nurses.

3.4 Establish a sustainable partnership between the Medical College of Wisconsin and Milwaukee County to support the annual commitment of one (1) training slot.

3.5 Work with representatives of underserved and underrepresented populations to improve the recruitment and retention of mental health professionals from those community sectors.

RESPONSIBILITY

Lead BHD Staff:
Lora Dooley

Action Team Involvement:
Workforce and Person-Centered

Partners:
Nursing's Voice; Faye McBeath Foundation; University of Wisconsin-Milwaukee; Medical College of Wisconsin; Employers

four

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

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

- Increasing the number Certified Peer Specialists;
- Recruiting and training Certified Peer Specialists with bilingual (Spanish) capability;
- Increasing the number of programs that employ Certified Peer Specialists;
- Establishing a Certified Peer Specialist-operated program; and
- Advocating for quality in the delivery of Certified Peer Specialist services.

4

PERFORMANCE TARGETS

By July 2014:

1) Increase the number of Certified Peer Specialists by 20% (10) over the 2013 baseline of 52 Certified Peer Specialists.
2) Increase the number of programs meeting identified target for employing Certified Peer Specialists by from the 2013 baseline of eight (8) programs to fifteen (15) programs.
3) Implement one (1) Certified Peer Specialist-operated program.

TACTICAL OBJECTIVES

4.1 Continue implementation of the Certified Peer Specialist Pipeline program supported by the Community Services Branch.

4.2 Establish a web-based clearinghouse to post Certified Peer Specialist opportunities.

4.3 Using the fall 2012 Employer Summit as the model, continue efforts to improve employers' effective utilization of Certified Peer Specialists in their programs.

4.4 Continue to incorporate targets for Certified Peer Specialist employment into policy and contracts.

4.5 Support the provision of Certified Peer Specialist training using state-approved curricula.

4.6 Develop and implement a plan to establish a program operated by Certified Peer Specialists.

RESPONSIBILITY

Lead BHD Staff:
Jennifer Bergersen

Action Team Involvement:
Workforce

Partners:
Persons with lived experience; Certified Peer Specialist Training Programs; Wisconsin Peer Specialist Employment Initiative

five

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Improve the coordination and flexibility of public and private funding committed to mental health services.

5

PERFORMANCE TARGETS

By October 2013:

1) Redesign Task Force will complete an analysis (mapping) of public and private resources that support mental health services including analysis of Affordable Care Act implications.

By January 2014:

2) Milwaukee County will approve implementation of CRS (Community Recovery Services) consistent with the Wisconsin Medicaid State Plan Amendment under 1915 (i) to create more flexible application of Medicaid waiver funding within appropriate fiscal constraints.

TACTICAL OBJECTIVES

5.1 Establish Resource Strategy Team comprised of finance experts from foundations, private hospital systems, Milwaukee County, State of Wisconsin, and the Public Policy Forum.

5.2 Publish a report on Mental Health Redesign Financing for dissemination and discussion by key stakeholders.

5.3 Designate the Continuum of Care Action Team or form a new CRS Planning Workgroup to advise Milwaukee County on the design of CRS.

5.4 Conduct a review of program and fiscal data to inform the development of the CRS implementation plan.

5.5 Submit the CRS implementation plan to the Milwaukee County Board for review and approval.

RESPONSIBILITY

Lead BHD Staff:
Jim Kubicek and Alex Kotze

Action Team Involvement:
Resource Strategy and Continuum of Care

Partners:
Wisconsin Department of Health Services

six

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Establish a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals.

6

PERFORMANCE TARGETS

By October 2013:

1) Publish and widely disseminate the first annual Milwaukee County Mental Health Dashboard and Community Progress Report to chart progress on Redesign SMART Goals.

TACTICAL OBJECTIVES

6.1 Establish public/private system quality indicators aligned with the overall system vision.

6.2 Identify and coordinate existing data sets and data sources.

6.3 Determine how to include consumer experiences in the improvement process.

6.4 Identify how improvement targets in SMART Goals will be measured and reported.

6.5 Create information-sharing agreements.

6.6 Prepare initial format for review and modification.

RESPONSIBILITY

Lead BHD Staff:
Sue Gadacz

Action Team Involvement:
Quality Action Team

Partners:
Persons with lived experience; Data providers

seven

Improvement Area 1 – System of Care
Creating a system of care that is person-centered, recovery-oriented, trauma-informed, integrated and culturally competent for all programs and persons providing care.

Develop a structure for ongoing system improvement and oversight of the Mental Health Redesign process.

7

PERFORMANCE TARGETS

By January 2014:

1) Define and implement a formal partnership structure and process for continuing system improvement that will review progress, address implementation challenges, and pursue opportunities for further enhancement of the Milwaukee County community mental health system.

TACTICAL OBJECTIVES

7.1 Review current membership, charter, and functioning of the Redesign TF.

7.2 Determine need for and objectives of ongoing system improvement partnership.

7.3 Describe and draft a proposed charter, membership, and accountability of the proposed continuing structure.

7.4 Identify a mechanism for formalizing and implementing the continuing structure and process.

RESPONSIBILITY

Lead BHD Staff:
Paula Lucey with the Redesign Task Force

Action Team Involvement:
NA

Partners: NA

SMART Goal 2013-2014

eight

Improvement Area 2 – Crisis System Redesign
Creating and sustaining a community-based continuum of crisis services to reduce involuntary commitments and undue reliance on acute inpatient care.

Improve crisis access and response to reduce Emergency Detentions (Chapter 51, Involuntary Commitment for Treatment).

8

PERFORMANCE TARGETS

By July 2014:

1) The number of Emergency Detentions at the Milwaukee County Behavioral Health Division will decrease by 10% (720) from the 2012 baseline of 7,204 Emergency Detentions.
2) The percentage of crisis intervention events which are voluntary will increase from 43.2% (2012 baseline) to 48.9% or greater.
3) The number of individuals seen at the Milwaukee County Psychiatric Crisis Service (PCS) who have person-centered crisis plans will increase by 30% over the 2012 baseline of 136.
4) Maintain high volume of Access Clinic service at 2012 baseline of 6,536 visits.

TACTICAL OBJECTIVES

8.1 Develop a partnership between the Redesign Task Force and the current implementation process for developing an integrated, welcoming crisis continuum of care.

8.2 Support the increased utilization of person-centered crisis plans for the prevention of, and early intervention in, crisis situations through training and technical assistance provided countywide.

8.3 Prioritize expansion of the availability and responsiveness of mobile crisis services as well as other community crisis diversion services including walk-in services, clubhouse, and crisis bed options of all types.

8.4 Facilitate earlier access to assistance for a crisis situation for individuals and families through improved public information on how to access the range of crisis intervention services in the community.

8.5 Improve the capacity of law enforcement (Milwaukee Police Department, Sheriff's Office, and municipal police departments) to effectively intervene in crisis situations through expanded Crisis Intervention Training.

8.6 Identify and improve policies and procedures related to crisis response in contracted services to reduce the likelihood that crisis events lead to emergency detention.

RESPONSIBILITY

Lead BHD Staff:
Amy Lorenz

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience; community crisis services providers; mobile crisis services; private hospital systems/ emergency departments; law enforcement; Community Intervention

nine

Improvement Area 3 – Continuum of Community-Based Services
Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

Improve the flexible availability and continuity of community-based recovery supports.

9

PERFORMANCE TARGETS

By July 2014:

1) Establish a continuum of Targeted Case Management (TCM) services that includes four components: Intensive, Crisis, Level I (regular case management), and Recovery.
2) Increase the number of TCM slots by 6% (90) over the 2012 baseline of 1,472 slots.
3) Establish two additional psycho-social rehabilitation benefits (Community Recovery Services (CRS) and Community Support Services (CSS)) to provide flexible recovery support in the community.

TACTICAL OBJECTIVES

9.1 Develop, pilot and implement a mechanism for flexible utilization management that supports individualized matching of service intensity with the continuum of case management and other recovery supports.

9.2 Develop, pilot and implement procedures to move from higher to lower levels of support (and conversely) in response to changing circumstances, e.g. crisis.

9.3 Organize a flexible continuum of community recovery supports to be made available to eligible individuals through CRS and CSS.

9.4 Establish metrics to assess the financial and program impacts of this approach.

RESPONSIBILITY

Lead BHD Staff:
Sue Gadacz

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience; Milwaukee County Community Services Branch; Community providers

ten

Improvement Area 3 – Continuum of Community-Based Services
Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

Improve the success of community transitions after psychiatric hospital admission.

10

PERFORMANCE TARGETS

By July 2014:

1) The percentage of individuals who are discharged from Milwaukee County Psychiatric Crisis Service (PCS) who return to PCS within 90 days will decrease from the 2012 baseline of 32.2% to 27.0%.
2) The percentage of individuals who are discharged from Milwaukee County Acute Adult Inpatient Services who return to that service within 90 days will decrease from the 2012 baseline of 24.1% to 22.0%.

TACTICAL OBJECTIVES

10.1 Establish a flexible, community-based continuum of care that includes formal services and informal community supports. (Goal 9)
10.2 Maintain and strengthen crisis prevention, intervention, and diversion services in the community. (Goal 8)
10.3 Establish a partnership between Redesign Task Force efforts and existing discharge and transition planning improvement activities at the Behavioral Health Division and private hospital partners.
10.4 Work in partnership with inpatient, crisis, community, housing, and peer support providers to develop and implement an improvement plan for facilitating transitions from any hospital in the county.
10.5 Develop and implement a plan to track 90 day readmission data for all hospital partners.

RESPONSIBILITY

Lead BHD Staff:
Director of Acute Services (TBA)

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience; public and private hospitals; community providers; crisis prevention and intervention services; peer support providers; housing providers

eleven

Improvement Area 3 – Continuum of Community-Based Services
Creating and sustaining an integrated and accessible continuum of community-based behavioral health services to support recovery in the least restrictive settings.

Improve the economic security of persons with mental illness by increasing utilization of disability-related benefits including SSI/SSDI and Medicaid.

11

PERFORMANCE TARGETS

By July 2014:

1) There will be a measurable increase in the number of persons who receive assistance in completing SSI/SSDI applications.
2) There will be a measurable increase in the number of persons whose applications for SSI/SSDI are approved.

TACTICAL OBJECTIVES

11.1 Establish a 2012 baseline for the number of persons who received assistance in completing SSI/SSDI applications.
11.2 Establish a 2012 baseline for the number of persons whose SSI/SSDI applications were approved.
11.3 Develop a partnership involving the Social Security Administration, benefits counseling programs, SOAR trainers, Protective Payee providers, and persons with lived experience to develop, pilot and implement a plan to improve access to application assistance.
11.4 Increase access to recovery-oriented Protective Payee services for people needed this service.

RESPONSIBILITY

Lead BHD Staff:
Jena Scherer

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience, SSI/SSDI application assistance providers, Protective Payee programs, Social Security Administration, community providers

SMART Goal 2013-2014

twelve

Improvement Area 4 – Integrated Multi-System Partnerships
Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

Increase the number of individuals with mental illness who are engaged in employment, education, or other vocational-related activities.

12

PERFORMANCE TARGETS

By July 2014:

1) The percentage of mental health consumers enrolled in SAIL who are employed will increase from the 2012 baseline of .03% employed and .06% looking for work (at 6 month follow-up) to 1.0% employed and 2.0% looking for work.
2) The percentage of persons enrolled in WIser Choice who are employed full or part time will increase from the 2012 baseline of 26.7% (at 6 month follow0up) to 28.0%.

TACTICAL OBJECTIVES

12.1 Begin implementation of the IPS (Individual Placement and Support) Program by the Community Services Branch and its partners.
12.2 Establish a partnership with community mental health services providers, employment service providers, Milwaukee Area Workforce Investment Board, Division of Vocational Rehabilitation, Department of Workforce Development, and employers to identify and address barriers to employment for persons with mental illness.
12.3 Continue work on CRS implementation to obtain support for evidence-based employment practices.
12.4 Utilize Medicaid-supported benefits to assist persons in job and school readiness and employment and education support.
12.5 Work with the Social Security Administration to develop a strategy to address concerns regarding loss of benefits due to employment.
12.6 Leverage existing partnerships with employers and schools to create expanded options.
12.7 Align employment efforts with the expansion of Certified Peer Specialist network. (Goal 4)
12.8 Involve employers and employment assistance providers (public and private) in stigma reduction activities. (Goal 2)
12.9 Fund a job creation project using Milwaukee County CDBG dollars.

RESPONSIBILITY

Lead BHD/DHHS Staff:
Sue Gadacz and Jim Mathy

Action Team Involvement:
Community Linkages

Partners:
Persons with lived experience, Community Services Branch, Milwaukee Area Workforce Investment Board, Time Exchange, Flexible Workforce Coalition, Division of Vocational Rehabilitation, Department of Workforce Development, employers, schools and colleges

thirteen

Improvement Area 4 – Integrated Multi-System Partnerships
Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

Improve access to, and retention in, recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately/unsafely housed.

13

PERFORMANCE TARGETS

By July 2014:

1) Achieve a 10% measurable increase in the number of persons discharged from inpatient services and CBRFs that transition to supportive housing compared to 2012 baseline.
2) Increase the percentage of consumers in Milwaukee County (HUD-supported) Shelter + Care who are retained for six months or more from the 2012 baseline of 88% to 90%.
3) Create 25 new units of permanent supportive housing for persons with mental illness.
4) Achieve a measurable decrease in the number of persons who are identified as homeless in the Homeless Management Information System who were previously tenants in Milwaukee County (HUD-supported) Shelter + Care.

TACTICAL OBJECTIVES

13.1 Organize existing supportive housing resources including Permanent Supportive Housing, Shelter + Care, group homes, step-down housing, and other residential resources into a flexible, recovery-oriented continuum that is responsive to persons' needs and preferences.
13.2 Develop the role of the Community Intervention Specialist in assisting with access to housing and retention in housing for people at risk.
13.3 Develop, pilot and implement an intervention approach to provide additional provider, peer and family support services for those at risk of housing loss.
13.4 Improve the capability of supportive housing to provide person-centered, co-occurring capable services in partnership with MC3.
13.5 Develop new housing options specifically for young adults transitioning from foster care.
13.6 Advocate for increased Section 8 and other housing supports.
13.7 Maintain and develop strong partnerships with nonprofit and private housing developers, WHEDA, banks, county and city housing trust funds, and other key stakeholders focused on the development of new supportive housing.

RESPONSIBILITY

Lead BHD/DHHS Staff:
Jim Mathy

Action Team Involvement:
Community Linkages

Partners:
Milwaukee County Housing Division, Milwaukee Continuum of Care, MC3, WHEDA, banks, housing trust funds, CDBG/HOME, providers, persons with lived experience

fourteen

Improvement Area 4 – Integrated Multi-System Partnerships
Create welcoming partnerships between behavioral health stakeholders and other community systems to maximize access to services that promote recovery and health.

Improve criminal justice and mental health system collaboration to reduce inappropriate incarceration of people with mental illness by:

- Establishing a data link between the Milwaukee County criminal justice system and Behavioral Health Division that respects privacy and confidentiality requirements and helps prevent inappropriate incarceration of persons with mental illness; and
- Supporting a continuum of criminal justice diversion services for persons with behavioral health needs.
- Participating in the Community Justice Council as the primary vehicle for communication and planning.

14

PERFORMANCE TARGETS

By July 2014:

1) There is an operating data link that allows individuals with behavioral health needs who have police contact to be diverted to crisis intervention services and the data link has been used successfully for that purpose.

TACTICAL OBJECTIVES

14.1 Monitor the development of the data link project being implemented by the Milwaukee Community Justice Council and offer assistance when appropriate.

14.2 Participate in effort to explore additional diversion initiatives including a mental health court and other evidence-based practices that promote diversion of persons with mental health needs.

RESPONSIBILITY

Lead BHD Staff:
Jim Kubicek

Action Team Involvement:
Community Linkages

Partners:
Community Justice Council

fifteen

Improvement Area 5 – Reduction of Inpatient Utilization
Supporting a recovery-oriented system that permits the reduction of both acute care utilization and long-term care bed utilization.

Reduce the number of people who experience acute hospital admissions through improved access to, and utilization of, non-hospital crisis intervention and diversion services for people in mental health crisis.

15

PERFORMANCE TARGETS

By July 2014:

1) Reduce admissions to Milwaukee County Behavioral Health Division Acute Adult Inpatient Service by 15% (248) over 2012 baseline of 1,650.
2) Reduce the percentage of persons who are readmitted to the Milwaukee County Behavioral Health Division Acute Adult Inpatient Services within 90 days of discharge from the 2012 baseline of 24.1% to 22.0%.

TACTICAL OBJECTIVES

15.1 Successfully implement to tactical objectives in Goals 8, 9, 10, 13, and 14.

15.2 Involve all types of providers in the partnership to reduce admissions including crisis services, peer support, clubhouse, case management, and informal community supports.

15.3 Focus on improvement of policies, procedures and practices that facilitate early access to crisis intervention by community providers and law enforcement, continuity of care, diversion from hospitalization into crisis resource centers, and rapid step down from hospitalization into intermediate levels of support. (Goal 8)

15.4 Develop a countywide mechanism for triaging bed availability and flow between high and lower systems of care.

15.5 Develop a plan for collecting baseline data and tracking hospital diversion and utilization percentages across the county.

RESPONSIBILITY

Lead BHD Staff: Amy Lorenz and Director of Acute Services (TBA)

Action Team Involvement:
Continuum of Care

Partners: Persons with lived experience, Behavioral Health Division, private hospital systems, providers, crisis services, faith-based and other community-based resources, law enforcement