Transforming the Adult Mental Health Care Delivery System in Milwaukee County

Final Report

Submitted by:

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Executive Summary

This report presents the findings from a comprehensive planning effort to redesign the mental health care system in Milwaukee County, conducted by Human Services Research Institute in partnership with the Public Policy Forum and the Technical Assistance Collaborative, Inc.

The project was initiated in October 2008 by the Milwaukee Health Care Partnership, the Medical Society of Milwaukee County, and the Milwaukee County Behavioral Health Division. Other stakeholders were added during the early stages of the project, including the Wisconsin Department of Health Services, the Medical College of Wisconsin, the Greater Milwaukee Foundation, the Faye McBeath Foundation, Disability Rights Wisconsin, Rogers Memorial Hospital, the Milwaukee Mental Health Task Force, and several other members of the provider, payer and civic communities.

1. Background and Approach

The challenges facing the mental health care delivery system in Milwaukee County have been widely discussed at various forums and meetings involving advocates, administrators, consumers and providers. Several of the issues have also been covered by the local news media. To address these issues and challenges, key public and private stakeholders initiated the development of a planning process aimed at redesigning the mental health care delivery and financing system in Milwaukee County.

Guiding Principles

An initial step in the project was to convene stakeholders including individuals from consumer and advocacy communities, mental health providers, system administrators, county and state officials, and individuals representing private health care organizations to define the following guiding principles:

Principle 1: The system should be *recovery-oriented* and *consumer-centered*
Principle 2: The use of *community-based services* should be encouraged
Principle 3: Mental health *system capacity* should be developed
Principle 4: Improve the *quality* of services delivered
Principle 5: Systems that interact with persons with mental illness should be *coordinated and integrated*
Principle 6: *Disparities* in service delivery and outcomes should be eliminated
Principle 7: There should be a focus on *community and public health*

These principles have guided each step of the planning process and should ultimately inform the implementation of the redesign recommendations.

Data Sources

This project used an encompassing data-driven approach that examined services needed and received and reasons for differences, access and quality of services, service utilization and outcomes. The approach involved obtaining information from diverse stakeholders including consumers, providers, family members, and advocates using various methodologies. The project team collected data from each of the data sources outlined below.

- *Community Meetings:* In collaboration with the advisory group, the project team convened three community meetings to solicit feedback on the redesign project.

- *Key Informant Interviews and Group Meetings:* The project team conducted interviews and otherwise obtained input from more than 50 people and organizations over the period of June 2009 to March 2010.
- *Service Planning and Evaluation Surveys*: The project team implemented a series of surveys to obtain information about service needs, quality and access of services, and reasons for service disparity. Case managers, physicians, inpatient discharge planners, and consumers were surveyed.
- *Health System Administrator Surveys:* The project team implemented a survey to better understand the role and capacity of the public and private health systems from the perspective of system administrators.
- *Service Utilization and Outcome Data:* To understand the rates of service utilization and the ways in which individuals move in and out of the mental health service system in Milwaukee County, the project team analyzed both state and county-level administrative data.

2. Findings and Themes

The project team collected and analyzed data from the multiple sources outlined above and found that five key issues and themes emerged.

Consumer Refusals

Multiple data sources showed that consumers in Milwaukee County are refusing services at a very high rate. The analysis suggests that consumers are refusing services for a number of reasons, including a desire for more shared or independent decision-making and a need for more education regarding available services. The extremely high number of involuntary commitments to the system also may explain the high rate of refusals.

Opportunities to Increase and Expand Community-Based Services

Our analysis found that very few individuals are receiving an adequate amount of community-based services, including outpatient care. Accessibility issues included limited service capacity and issues with insurance. Taken together, the data suggests the need for a re-evaluation of the structure and amounts of community-based services, including outpatient and case management services.

Peer-Operated and Peer Support Services

Analysis of the data demonstrated that it will be important to further develop peer-operated and peer support services in the mental health system in Milwaukee County. The data suggest a need for the expansion of peer-operated services as well as for consumer and provider education regarding the benefits of these services.

Use of Crisis Services

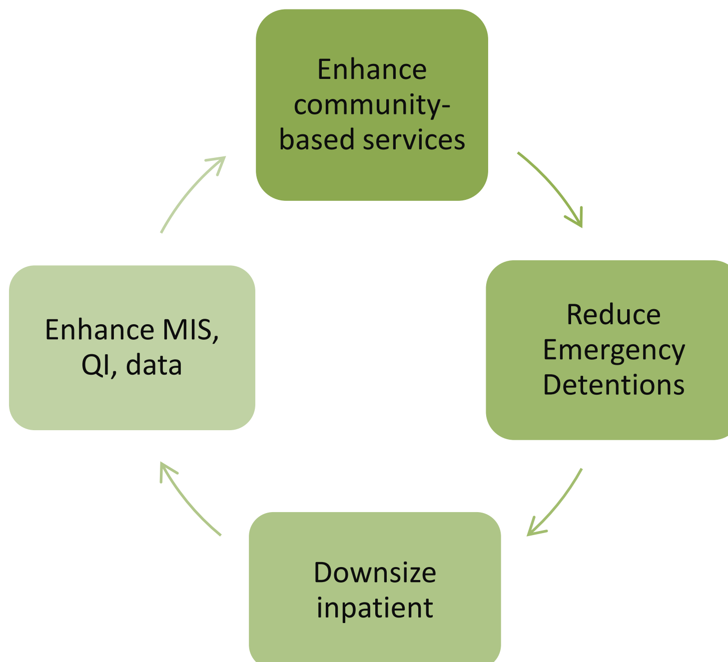
Milwaukee County consumers are receiving crisis services more often than any other services, and the frequency of emergency detentions are a major challenge for all system stakeholders. Some key informants expressed a hope for greater availability of crisis prevention and crisis alternative services such as drop-in centers, crisis phone lines, and crisis respite.

Inpatient Service Capacity

Stakeholders at all levels are similarly concerned about the efficiency and accessibility of inpatient care in the County. Our analysis found that while there is sufficient inpatient capacity, there is a need to reorganize care so that the existing beds are used more efficiently.

3. Recommendations

Based on the above analyses, the system redesign project team has developed a set of recommendations for moving forward. It is critical that system stakeholders pay ongoing attention to the sequencing and inter-related nature of the interventions. Although the recommendations below are presented as a list, they should by no means be implemented sequentially. Rather, as shown in the diagram below, the recommendations should be implemented concurrently, with special attention paid to the ways the success of certain interventions hinges on the implementation of others.



Recommendation 1: Downsize and redistribute inpatient capacity.

Downsizing inpatient capacity, reallocating resources devoted to acute inpatient care, and using the remaining capacity in a more efficient manner will better serve the County. Specific recommendations include:

1.1 Gradually reduce inpatient units at the current BHD complex.

1.2 Work with the State and the County Department of Health and Human Services to develop and implement a plan to phase down the 72-bed Hilltop facility, which serves individuals with a dual diagnosis of developmental disability and mental illness.

Recommendation 2: Involve private health systems in a more active role.

Outsourcing acute inpatient care to private health systems provides an opportunity for the BHD to shift resources away from inpatient care to more appropriate outpatient or community-based care. Specific recommendations for this area include:

2.1 Outsource additional BHD inpatient bed capacity to the private health systems.
2.2 Private health systems should continue with their plans to expand capacity by hiring more psychiatrists and other mental health professionals, where possible.
2.3 To provide clinically appropriate care, private providers will need to adjust culture and build clinical capacity to treat persons with more severe psychiatric symptoms and complex psychosocial needs.

Recommendation 3: Reorganize crisis services and expand alternatives.

Crisis services are often the first point of entry for the Milwaukee County mental health system. Reorganizing and expanding crisis services will create more access to services for people who need them in a more timely fashion, which will in turn reduce the need for costly inpatient care. Specific recommendations for this area include:

3.1 Shift crisis services to a more central location.
3.2 Develop and expand alternative crisis services.

Recommendation 4: Reduce emergency detentions.

Emergency detentions must be reduced to appropriately serve Milwaukee County residents and decrease the need for inpatient care. The specific recommendation for this area is:

4.1 Enhance emergency provider and law enforcement trainings.

Recommendation 5: Reorganize and expand community-based services.

Community-based services, including outpatient care, are a critical aspect of supporting individuals to live independently in the community. The data for this project consistently showed that improvements are needed in the quantity and availability of community-based services in Milwaukee County. Specific recommendations include:

5.1 Continue working with the State to secure funding for Community Recovery Services under the 1915(i) State Plan Option.
5.2 Shift resources from inpatient to community-based services.
5.3 Explore partnerships with FQHCs and approaches to integrating care.
5.4 Expand evidence-based practices.
5.5 Adopt alternative case management models.
5.6 Improve discharge planning from acute inpatient stays.
5.7 Use benefits counseling to ensure maximum revenue to fund services.
5.8 Substitute some traditional treatments with alternative options for outpatient care.

Recommendation 6: Promote a recovery-oriented system through person-centered approaches and peer supports.

The Milwaukee County mental health system will benefit from a shift towards a stronger recovery orientation at every level of service delivery. Specific recommendations in this area include:

6.1 Employ the use of motivational and person-centered approaches system wide.
6.2 Increase consumer education about recovery-oriented and community-based services.
6.3 Expand peer support and consumer-operated services.

Recommendation 7: Enhance and emphasize housing supports.

Access to safe, adequate, and affordable housing is a critical element in supporting individuals to live independently in their communities. While considerable progress has been made in this area during the past three years, there are a number of areas on which the County can focus to improve its housing services and address the needs of homeless individuals in the system. Specific recommendations include:

7.1 Re-allocate resources being used for group homes.

7.2 Expand permanent supportive housing.

7.3 Establish a full and active partnership with the homeless service system.

Recommendation 8: Ensure cultural competency.

The growing diversity of the Milwaukee population necessitates changes in the approach to delivering effective mental health services. Specific recommendations include:

8.1 Enhance overall commitment to cultural competence.

8.2 Identify cultural, language, and service needs.

8.3 Ensure effective communication with individuals with limited English proficiency.

8.4 Implement training in cultural issues and culturally and linguistically appropriate service delivery.

8.5 Conduct initial and ongoing organizational self-assessments of cultural competence and include them in quality improvement initiatives.

8.6 Involve communities and consumers in enhancing the cultural competency of the system.

Recommendation 9: Ensure trauma-informed care (TIC).

It is critical that any mental health system redesign effort take into account the importance of delivering care that is trauma-informed. Specific recommendations include:

9.1 Commit to a TIC organizational mission and dedicate resources to support it.

9.2 Conduct universal screening for trauma for all individuals.

9.3 Incorporate values and approaches focused on safety and prevention for individuals served by the system and staff.

9.4 Create strength-based environments and practices that allow for individual empowerment.

9.5 Provide ongoing TIC staff training and education

9.6 Improve and target staff hiring practices for TIC.

9.7 Update policies and procedures to reflect new TIC mission.

Recommendation 10: Enhance quality assessment and improvement programs.

This report recommends that existing quality improvement efforts be expanded and enhanced to create a comprehensive, system-wide quality assurance program. Specific recommendations include:

10.1 Develop a coordinated QI process.

10.2 Select a set of performance and outcome indicators and goals for the system.

10.3 Make changes to management information systems to collect and report common data elements.

Because of the multi-faceted and interconnected nature of the above recommendations, the project team recommends that County and other system administrators work to develop a comprehensive implementation plan for moving forward. Specific recommendations include:

- Re-convene system stakeholders.
- Form oversight steering committee.
- Establish work groups to address common themes identified in this report.
- Ensure full and active inclusion of consumer groups in all phases of implementation.

Introduction

This report presents the findings from Phase 2 of a planning effort to redesign the mental health care delivery and financing system in Milwaukee County, conducted by Human Services Research Institute (HSRI) in partnership with the Public Policy Forum (PPF) and the Technical Assistance Collaborative, Inc. (TAC).

1. Structure of This Report

This report begins with a discussion of background information relevant to the system redesign project, including the impetus for and first phase of the redesign project, key organizations and stakeholder groups, and local and national initiatives currently underway. Next, the report outlines the approach of this phase of the redesign project, including information about the development and use of guiding principles, descriptions of the numerous data sources, and a discussion of the survey instruments and methodology used in collecting data and conducting analyses. The report then presents findings organized by data source followed by an identification of issues and themes that emerged from the data. Based on the findings and key themes, the report offers a series of recommendations for moving forward. These recommendations are accompanied by a series of short and long-term action steps to be taken at both the state and county levels.

2. Planning Effort: Phase One

The challenges facing the mental health care delivery system in Milwaukee County have been widely discussed at various forums and meetings involving advocates, administrators, consumers and providers. Several of the issues have also been covered by the local news media. To address these issues and challenges, several key public and private stakeholders expressed interest in developing a planning process aimed at redesigning the mental health care delivery and financing system. In October 2008, the Milwaukee Health Care Partnership, the Medical Society of Milwaukee County, the Faye McBeath Foundation and the Greater Milwaukee Foundation agreed to fund a proposal developed by the PPF to conduct Phase 1 planning for this effort. That proposal was designed to lay the groundwork for a comprehensive system improvement effort by exploring how other states and counties have undertaken similar system transformation efforts, and by developing a detailed proposal for a comprehensive planning effort in Milwaukee County.

The Phase 1 effort generated the following problem statement, which established the fundamental purpose of the system redesign project:

> *The public and private mental health "system" in Milwaukee County suffers from lack of capacity, synchronization, resources and appropriate alignment of provider-based incentives. In fact, what ideally should be a system based on principles of access, quality, recovery and accountability (as defined by use of evidence-based practices and measurement of outcomes) actually is a largely uncoordinated set of public and private sector programs and services based primarily on statutory and regulatory requirements and obligations. In terms of capacity, it is unclear to what extent challenges in this area stem from too few inpatient and crisis beds and facilities, or inadequate, poorly coordinated and/or insufficient community-based clinical treatment and support services. A community-wide planning effort is needed to analyze this overall problem and determine what types of system-wide, sustainable improvements, policy reforms and funding/reimbursement initiatives are necessary to transform the*

system by ensuring sufficient provider capacity and improved coverage, access and outcomes for adults seeking and needing mental health care and treatment in Milwaukee County.

3. Planning Effort: Phase Two

Phase two of the system redesign project began in June 2009. Phase 2 involved conducting a systematic review of the mental health services issues facing Milwaukee County, leading to priorities and resource allocations in an attempt to improve consumer outcomes.

Goal of the Project

Driven by the problem statement, the aim of the redesign project is to create a 21st century mental health system driven by quality and scientific merit, financed through appropriate alignment of provider-based incentives, efficient in coordinating service provisions with multiple agencies that interact with consumers, and focused on outcomes leading to recovery with minimized barriers to access.

Scope of Work

The scope of this project is limited primarily to the adult mental health delivery system, as opposed to both the mental health and Alcohol and Other Drug Abuse (AODA) systems. It is designed to address systemic issues involving service access and delivery, while specifically excluding consideration of treatment philosophies and frameworks/specifics of clinical practice. Its focus is the non-elderly adult population, with a particular focus on low-income uninsured individuals and individuals served by government programs. Although services for people with developmental disabilities and substance use disorders are outside the scope of the report, these areas are touched on in brief because of important linkages and impacts for people with mental illness that both are in need of further analysis and integration. The primary emphasis of the project is on health care and support services capacity and access issues (inpatient, crisis/emergency, community-based and consumer-run/led services).

Participating Organizations

A review of other planning efforts and consideration of project goals led to the decision to retain a national consultant with technical expertise in mental health system design to lead the project. HSRI was chosen for this task. Because of their valuable expertise in systems planning, HSRI recruited TAC as a subcontractor for this project. PPF was retained as the local consultant and has worked closely with HSRI to provide local research and expertise, project facilitation, and fiscal agent duties. Provided below are descriptions of PPF, HSRI, and TAC.

Public Policy Forum

For the past 97 years, PPF has served as a nonpartisan public policy research organization that helps ensure that local governments are committed to providing taxpayers with good value and that local policy makers have access to impartial and factual public policy research on topical issues. Over the past decade, PPF's mission has expanded to include policy analysis of issues important to all of southeastern Wisconsin. PPF's extensive experience in policy research in southeastern Wisconsin, and PPF's previous experience convening and facilitating stakeholders groups to plan initiatives in areas such as water quality and regional cooperation, made it ideally suited to serve as lead local consultant.

Human Services Research Institute

HSRI has been engaged in science-driven mental health systems planning efforts for over 30 years. HSRI is a non-profit organization located in Cambridge, MA and Portland, OR. In the fields of intellectual and developmental disabilities, substance use and prevention, mental health and child and family services HSRI works to:

- Assist public managers and human service organizations to develop services and supports that work for children, adults, and families
- Enhance the involvement of individuals and their families in shaping policy, priorities and practice
- Improve the capacity of systems, organizations, and individuals to cope with changes in fiscal, administrative, and political realities
- Expand the use of research, performance measurement and evaluation to improve and enrich lives

The mental health team at HSRI works to provide sustainable ways to improve services that lead to recovery and advance the quality of life for persons with serious mental illness. HSRI has devoted its organizational life to supporting federal, state, and local decision makers to confront challenges through technologies for policy planning and analysis and by providing technical assistance and training. HSRI provides assistance to policy makers concerned with implementing the statutory, regulatory, and administrative change necessary to assure that persons with serious mental illness enjoy those basic civil rights to which all citizens are entitled. HSRI evaluates current human service programs and procedures and develops sound strategies for their reform as needed. The team at HSRI works with key stakeholders to design and implement mental health program planning, budgeting, needs assessment, gap analysis, quality assurance, and administrative systems for improved service delivery.

Technical Assistance Collaborative, Inc

The TAC serves as consultants in the areas of strategic service integration and funding streams. TAC is a national non-profit organization that advances proven solutions to the housing and community support needs of vulnerable low-income people with significant and long-term disabilities. TAC's goal is to achieve sustainable public sector systems change through evidenced-based and promising approaches in mental health, substance abuse, human services, and affordable and permanent supportive housing.

Founded in 1992, TAC's core mission focuses at the intersection of affordable housing, health care and human services policy and systems development. TAC's highly successful collaborative consulting model deploys interdisciplinary teams of national experts with a wealth of experience in finding real-world solutions to complex social and public policy challenges, such as homelessness, unnecessary institutionalization, serious mental illness, addiction, and poverty.

Stakeholder Groups

A diverse group of stakeholders were involved in Phase 2 of the redesign project. Their expertise and perspectives were integral to the effort from its inception to the reporting of results.

Advisory Group

Phase 1 and Phase 2 of the redesign project received input from an advisory group. The advisory group's purpose was to provide high-level guidance to the project team in its research and deliberations. The advisory group generally met at least once every four to six weeks during both phases of the project and provided

invaluable input in areas that included public, consumer and key informant roles and participation; characteristics of the public and private mental health delivery systems; survey mechanisms and participants; sources and uses of project funds; coordination with other state and local mental health research and planning efforts; and dissemination of findings and recommendations.

The project advisory group for Phase 2 consists of the following individuals:

Table 1: Project Advisory Group Members

Member Name	Title	Organization
Barbara Beckert	Milwaukee Office Director	Disability Rights Wisconsin
John Chianelli[1]	(Former) Administrator	Milwaukee County BHD
Bruce Kruger[2]	(Former) Executive Vice President	Medical Society of Milwaukee County
Lyn Malofsky	Executive Director	Warmline, Inc.
Joy Tapper	Executive Director	Milwaukee Health Care Partnership

Milwaukee Mental Health Task Force

The Milwaukee Mental Health Task Force is a coalition of over 40 groups that was established in 2004. It works collaboratively to identify policy issues faced by people affected by mental illness, facilitate improvements in services, give consumers and families a strong voice, reduce stigma, and implement recovery principles. The Milwaukee Mental Health Task Force has played a leadership role in the implementation of Crisis Intervention Training, which trains law enforcement and other first responders on how to respond in a mental health crisis, advocating for mental health parity, and promoting diversion by developing alternatives to traditional crisis and inpatient services such as the Crisis Resource Center. The project team met with the full Task Force and its leaders on multiple occasions during the project to obtain feedback on key project deliverables, including guiding principles and data findings.

Community Stakeholder Group

Phase 2 also received input from a lengthy list of key informants and stakeholders. This list included representatives from the Wisconsin Department of Health Services (DHS); the Milwaukee County Behavioral Health Division (BHD) and Department of Health and Human Services; the Medical College of Wisconsin; private health systems; Milwaukee area foundations; the Wisconsin Hospital Association; the Milwaukee Mental Health Task Force; the Behavioral Health Advisory Committee; the Wisconsin Public Defender's office; the Milwaukee County Corporation Counsel's office; consumers/family members; Medicaid managed care entities; federally qualified health centers (FQHCs); private primary care providers; payers/insurers; mental health community-based providers, advocacy and support groups; and the Milwaukee County Board of Supervisors. These key informants and stakeholders supported the consultants' efforts to acquire accurate information about the structure, gaps and needs of the mental health system. A list of key informants and stakeholders who participated in this project either through one-on-one interviews or in group feedback sessions can be found in Appendix A.

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[1] John Chianelli left his position with the BHD in August 2010 and was replaced on the Advisory Group by interim Director of Milwaukee County Department of Health and Human Services Geri Lyday.

[2] Bruce Kruger left his position with the Medical Society of Milwaukee County in July 2010 and was replaced on the Advisory Group by Interim Medical Society Executive Vice President Larry Pheifer.

Background

This section describes the local and national context of the redesign project. It describes the structure and current initiatives of the Milwaukee County mental health system as well as the state and national contexts, including relevant initiatives currently underway.

1. Local Context for Milwaukee County

The effort to redesign the adult mental health system in Milwaukee County that has produced this report is not the first attempt to change the way people with mental illness are served in this region. This redesign effort is unique in its involvement of both public and private health systems, as well as in its use of a national consultant (HSRI) combined with a local facilitator (PPF), both of which are guided by a local advisory group comprised of diverse stakeholders. The project has been mindful of the need to avoid replicating prior projects and reports.

Brief Milwaukee History and Key Issues

What is now known as the deinstitutionalization movement has its roots in Milwaukee County, spurred by a 1976 lawsuit (Lessard v. Schmidt). The lawsuit created a stricter definition of the requirements for involuntary commitment of persons with mental illness and was part of a nationwide shift away from committing people to long stays in institutions and toward more community-based care. In Milwaukee, as elsewhere, a key expectation associated with this shift was that budget savings associated with reduced inpatient and long-term care beds would be transferred to mental health services consumers could access in their own communities.

Milwaukee County, like many communities, is still navigating the impact of this shift in treatment philosophy. In 2006, a yearlong series of articles in the Milwaukee Journal Sentinel revealed substandard housing for persons with mental illness and cited alleged problems in the Milwaukee County BHD's delivery of inpatient services. This series was influential in bringing greater public attention to the quality of mental health services in metro Milwaukee and, to some, demonstrated that reductions in inpatient capacity had not been accompanied by provision of sufficient community-based services and supports. The series also spurred concerted and joint action by both Milwaukee County and the City of Milwaukee to facilitate the development of supportive housing for persons with mental illness, which has resulted in the construction or planning of several hundred such units during the past three years.

The middle part of this decade featured episodic instances of long wait times for service at the County's Psychiatric Crisis Service (PCS), which required police officers to wait for hours in their cars while trying to drop off individuals facing mental health crises. A Behavioral Health Advisory Committee – including health care system leaders from the County and private health systems – was formed to respond to this situation. The BHD now diverts many of its patients with payer sources to private hospitals, a solution that has been very effective in reducing backups, but one that has further exacerbated BHD's financial challenges.

The past five years also have featured extensive debate over how to address the physical limitations and problems of Milwaukee County's Mental Health Complex, which has been cited for numerous code violations by federal and state inspectors, and which many have argued is outdated and over-sized. A proposal by the County executive and BHD administrators to move the Complex from its present location at the Milwaukee County Grounds in Wauwatosa to a redesigned St. Michael's hospital on Milwaukee's north side was rejected by the

Milwaukee County Board of Supervisors in early 2009. At the time, supervisors voiced an interest in building a new facility at the County Grounds, but little progress has been made until recently to pursue that initiative.

In early 2010, the sexual assault of a patient at the Mental Health Complex led to an investigation by the federal Center for Medicare and Medicaid Services and a threat to cut off funding to BHD, which was lifted in April following improvements in County practices. BHD also is under orders from the state to fix multiple physical shortcomings, which is estimated to cost more than $2 million. The county executive and county board subsequently created a new Community Advisory Board to review patient safety and develop recommendations for improvements. A report that details these ongoing issues is forthcoming from Disability Rights Wisconsin, a protection and advocacy organization for people with disabilities.

Finally, in August 2010, another series of articles in the Milwaukee Journal Sentinel again placed the issue of quality of care at the Mental Health Complex into the public spotlight, and also discussed the impact of the County's excruciating budget difficulties on BHD's services and performance. While it is difficult to say definitively what the impact of funding challenges has been, limited resources clearly have been an ongoing issue for BHD and, given the County and State's bleak fiscal outlook, will continue to be.

Local Socioeconomic Issues

The city and county of Milwaukee have numerous strengths and positive features, as well as many hardworking people devoting their expertise to tackling tough issues. However, potential improvements to the behavioral health system in Milwaukee County must be debated and understood in the context of the area's interconnected socio-economic issues.

With 959,000 residents, Milwaukee County is the most populous county in the state of Wisconsin. The County contains the largest city in the state, Milwaukee, which has about 600,000 residents. Milwaukee County residents are 68% White, 26% African American, 3% Asian, 2% more than one race, and 1% American Indian. Twelve percent of the White residents also are categorized by the Census as Hispanic or Latino (U.S. Census Bureau). Milwaukee often appears on lists of the country's most segregated cities due to the high concentration of African American households on the city's north and northwest sides, which tend to be low-income areas. A 2009 University of Wisconsin-Milwaukee (UWM) analysis of Milwaukee's inner city neighborhoods found that in these areas, there are 25 job seekers for every available full-time job opening (University of Wisconsin-Milwaukee Employment and Training Institute, 2009).

While Milwaukee County contains some wealthy suburbs, residents in need of behavioral health services are disproportionately low-income, minority, and urban. The city of Milwaukee faces social and economic issues accompanying urban poverty – interconnected issues which can intensify a population's need for behavioral health services, while also at times competing for funding and support. More than 25% of residents in the city of Milwaukee are below the poverty level, ranking it fourth highest in the nation. The UWM report found that in 2007, an estimated 62% of employed Milwaukee parents had incomes below 185% of the poverty line, and 33% of all employed Milwaukee families with children had income below poverty.[3] A report by the Greater Milwaukee Foundation (2010) found that one in five Milwaukee County residents and one in two children do not have private health insurance and rely on the federal/state health insurance program. The report also found

[3] Based on 2007 state income tax returns, filed in 2008.

that one in five Milwaukee County residents – more than 208,000 – uses food stamps. The percentage of students in the Milwaukee school district receiving free or reduced-price lunches is 76.8% (Helpap, Schmidt, Dickman, & Henken, 2009).

Challenges in Milwaukee extend to education and public health. Wisconsin's African American fourth-grade boys, most of who reside in the city of Milwaukee, have the lowest reading scores in the country (Richards, 2010). The Milwaukee Public School System has a graduation rate of 67% (Milwaukee Public Schools, 2010). Milwaukee's infant mortality rate of 9.8 deaths per 1,000 live births is higher than the national average of 6.7. For African Americans, the infant mortality rate is 14.5. Milwaukee is ranked 46th among the 53 largest cities in the country for infant mortality (City of Milwaukee Health Department, 2007).

Milwaukee-Specific Aspects of Behavioral Health Services

While many aspects of Milwaukee County's behavioral health system mirror other urban systems, there are some distinctions that offer context for the subsequent analysis.

Institutions for Mental Disease Exclusion

The purpose of the Medicaid Institution for Mental Disease (IMD) exclusion was to provide an incentive for systemic reform by discouraging the use of large segregated institutional settings and promoting smaller, integrated settings that have better outcomes and provide a less restrictive environment. Because BHD's inpatient hospital is categorized as an IMD, it is excluded from pursuing reimbursement for services provided to most adults that would normally be covered by Medicaid. Consequently, a system under constant budget pressure cannot access millions of federal dollars annually that an institution not classified as an IMD could receive.

Counties as Arms of the State

In Wisconsin, state statues dictate the role of counties in providing behavioral health services. Wisconsin counties, in fact, are commonly referred to as "arms of state government" that were created by the State specifically to provide services on its behalf. While there are many states in which counties administer health and human services on behalf of state government, many state governments play a stronger role than Wisconsin's in terms of establishing statewide policies and objectives and funding mental health services at the local level to ensure consistent service levels across counties. Wisconsin appears somewhat unique in the extent to which it leaves both administration and significant funding responsibility for behavioral health services in the hands of county governments, as reflected by the following passage in NAMI's *Grading the States* report (Aron et al., 2009):

> *"The state [of Wisconsin] funds services in 72 counties, but the counties provide the nonfederal share of Medicaid funding and are responsible for providing or purchasing most services. Counties and localities contribute varying amounts to mental health care spending, above what the state provides. The decentralized nature of the system limits the Division of Mental Health and Substance Abuse Services' (DMHSAS) control over local services. Availability and quality vary widely."*

The BHD provides a variety of inpatient, emergency and community-based care and treatment to children and adults with mental health and substance abuse disorders. Wisconsin Statutes specifically assign to Milwaukee County government responsibility for the "management, operation, maintenance and improvement of human

services" in the County, including mental health treatment and alcohol and substance abuse services (Section 46.21). Section 51.42 of the Wisconsin Statutes lays out more specifically the mandated role for Milwaukee County pertaining to the provision of behavioral health services:

> *"The county board of supervisors has the primary responsibility for the wellbeing, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services. This primary responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds."*

The County has interpreted this language as a legal requirement to provide immediate emergency services for persons with mental illness and substance abuse disorders. That interpretation, in turn, has been defined as a requirement that the County also provide a broad range of inpatient, long-term care and outpatient services to indigent persons in order to curtail the need for emergency services and meet the more general statutory language pertaining to well-being, treatment and care.

2. Mental Health Services in Milwaukee County

A large number of organizations provide mental health services in Milwaukee County. These include the BHD itself as well as several private health systems, a teaching hospital (Medical College of Wisconsin), and FQHCs.

The County's BHD comprises the second-largest budget of all organizational units in Milwaukee County government ($172 million in 2009). The BHD also is the second largest county organizational unit in terms of its number of employees, with 859 full-time equivalent employees in the 2009 budget. Behavioral health is one of the County's largest functions in terms of individuals served. For example, the 2009 budget estimated BHD would handle more than 4,000 inpatient and 13,000 PCS admissions, provide services to more than 2,000 individuals in Targeted Case Management (TCM) or the Community Support Program (CSP), and provide community-based substance abuse services to more than 4,500 individuals. The BHD runs a hospital and provides these services in an atmosphere very different from that in which private hospitals are administered. The BHD is administered amidst the County's overall budget difficulties, must absorb huge "legacy costs" associated with retirement benefits promised to its employees and retirees ($14.3 million in 2008), must compete for resources with other county priorities, must adhere to a set of complex personnel rules, and must cope with a damaged reputation that hurts recruitment and retention of medical and nursing personnel. Those factors have led some to argue that county government is not equipped to effectively govern a mental health hospital and emergency department, which requires the type of administrative flexibility and independence that cannot be accommodated under the county governance structure. In addition, some have asserted that alternate service arrangements should be considered in Milwaukee County to shield mental health services from shifts in political oversight and funding preferences, and to bypass the legacy costs that make such services costly to taxpayers.

Current Milwaukee County Mental Health System Service Structure

Below is a brief outline of the adult inpatient and community-based mental health services currently available that are relevant to this redesign project.

Crisis Services

Milwaukee County relies primarily on emergency services as its first line of support for people needing mental health care who are not connected with community-based services. Services include screening and assessment, crisis counseling and intervention, medication, emergency services coordination and free referral information. The BHD currently provides for the following crisis and emergency services for individuals who are in need of crisis services but do not require inpatient hospitalization:

- Psychiatric Crisis Service and Admission Center: Psychiatric emergency services are available at the PCS 24 hours per day, 7 days per week.
- Observation Unit: Provides client observation for up to 48 hours as needed.
- Crisis Respite Services: The BHD contracts for the operation of two eight-bed crisis respite houses for individuals who are in need of crisis services but do not require hospitalization.
- Mobile Crisis Teams: A mobile team that provides on-site assessments, interventions, or referrals.
- Crisis Line: A 24-hour mental health and suicide crisis line where professionals are available to provide immediate psychiatric crisis intervention services.
- Crisis Walk-in Center: Persons are seen on a first come, first served basis Monday through Friday from 9am to 5pm.

While there is some limited capacity for crisis services within the private system, our analysis found that the majority of low-income uninsured and individuals served by public insurance (the primary population of focus for this report) receive mental health crisis services through the BHD.

Inpatient Services

Providers in Milwaukee County offer both acute and long-term psychiatric inpatient services. In addition to BHD services, several private hospitals provide some inpatient mental health services. As with crisis services however, BHD-operated services tend to serve the majority of individuals without insurance or with only public insurance. These services are described below:

- Acute Adult Inpatient Psychiatric Services: The BHD operates four 24-bed units where short-term inpatient stabilization services are provided to adults who need the support of a hospital environment. Admission is completed after a thorough evaluation at the BHD PCS.
- Nursing Facility Services: Two licensed Rehabilitation Centers provide long-term care to patients with complex medical, rehabilitative, and psychosocial needs as well as developmental disabilities. The Rehabilitation Center-Central consists of three units with 70 beds that serve individuals with complex and interacting medical, rehabilitative, and psychosocial needs. The Rehabilitation Center-Hilltop is a 72-bed facility that provides services to individuals dually diagnosed with developmental disabilities and serious behavioral health conditions.

Community-Based Services

Community-based services in Milwaukee County are provided through a variety of entities, including private hospital outpatient clinics and FQHCs. Additionally, the BHD provides some community-based services directly and through contracts with community agencies. Within the BHD, the Service Access to Independent Living (SAIL) unit within the Community Services Branch centrally manages access to long-term community-based services. Eligibility for long-term community-based services, initiated through the SAIL program, is restricted to persons who are most in need of services and who have not been adequately served through traditional outpatient services. Behavioral and medical providers must initiate a referral to SAIL. Referrals involve a psychiatric evaluation, two psychiatric hospital discharge summaries, and a SAIL assessment. The purpose of this lengthy assessment process is to determine that community services are being delivered to those most in need. Outpatient services are also accessed through the crisis walk-in center and inpatient hospital.

The primary community-based services are currently available in Milwaukee County:

- Community Support Program: The CSP is based on the Assertive Community Treatment (ACT) model of case management, although it is not a true ACT program. It is the most intensive case management service available in Milwaukee County.
- Targeted Case Management: TCM is a less intensive case management program designed to involve fewer contacts with clients and a focus on ongoing monitoring and service coordination.
- Community Residential: Residential treatment is available in varying intensities in community-based residential facilities and transitional housing programs.
- Outpatient Treatment: Services available through outpatient treatment include medication management and individual and group psychotherapy.
- Day Treatment Partial Hospitalization Program: This program is currently in the process of being reorganized to deliver treatments such as Dialectical Behavior Therapy (DBT) to high-risk individuals with serious mental illness through one highly specialized, multi-disciplinary treatment team.

In addition to other community-based services, there are a number of places in Milwaukee County where consumers of mental health services can receive support from peers who share a lived experience of receiving mental health services. These services include:

- Warmline, Inc.: Warmline is a non-crisis, peer-run support line for people with mental illness. The program is staffed by volunteers and operates six days per week.
- Grand Avenue Club: Based on the clubhouse model of psychiatric rehabilitation, the Grand Avenue Club is run through a partnership of members working with peer and non-peer staff. An array of services is offered, including employment and education supports.

Current Behavioral Health Division Initiatives

The BHD has several initiatives underway that are important to the service delivery system. Some of these initiatives are summarized below.

Quest for Recovery

The Quest for Recovery initiative (QUEST) has as its vision that by 2012 “The Milwaukee County BHD will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.” Its

core values of patient centered care, best practice standards and outcomes, accountability at all levels, recovery support in the least restrictive environment, and integrated service delivery are echoed in the guiding principles of this redesign project, which are discussed below. As part of the QUEST Initiative, the BHD plans to submit an application to The Joint Commission (TJC, formerly JCAHO) by 2012. TJC is a well-established accreditation organization that is widely used by health and behavioral health care providers nationwide to ensure safe and high quality health care and top organizational performance.

Comprehensive, Continuous, and Integrated System of Care (CCISC) Initiative

In concert with this Mental Health System Redesign project and other system improvement initiatives, the BHD has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing countywide systems change to improve access to services and recovery for individuals and families with co-occurring conditions. The CCISC model is based on the premise that co-occurring issues are an expectation, not an exception (Minkoff & Cline, 2004). In the CCISC model, systems are designed to meet the complex needs of individuals at every level (policy, program, procedure, and practice), regardless of their entry-point into the system. The BHD is in the early stages of implementing this model. In the summer of 2010, members of the Co-Occurring Steering Committee drafted a charter, which includes a series of action steps to be taken in the coming year.

3. State Context

Wisconsin's Insurance Programs

The federal government mandates that every state participate in certain Medicaid programs that serve low-income children and their caretakers, pregnant women, the elderly, and people with disabilities. Many states, including Wisconsin, have chosen to create Medicaid programs that serve other optional target populations. For example, the Wisconsin BadgerCare Plus Program and the Medical Assistance Purchase Plan have expanded Medicaid to cover certain groups with incomes above the federally mandated Medicaid income limits. A more detailed discussion of Wisconsin's Medicaid program can be found in Appendix B.

Family Care is a managed care program (MCO) that provides long term care services for adults with physical disabilities or developmental disabilities and older adults. Milwaukee County has had Family Care in place for frail elderly ages 60 and over for 10 years (now serving around 7000 people), and the program is now moving forward with an expansion initiative to serve younger people ages 18 to 59. This expansion has an initial focus of enrolling people previously in Medicaid waiver programs and those on the waiting list (should total 5000 to 6000 people) over a three-year period.

Data from the Long Term Care Functional Screen[4] show that 38.5% of Family Care members have serious mental illnesses such as schizophrenia, bi-polar disorder, psychosis, or depression. Additionally, 24% have personality disorders, anxiety disorders, or other mental health problems, and 5.4% have substance abuse disorders. The

[4] The Wisconsin Functional Screen is a web-based application used to collect information about functional status, health and need for assistance for various programs that serve the frail elderly and people with developmental or physical disabilities: http://www.dhs.wisconsin.gov/ltcare/FunctionalScreen

percentages of persons with these diagnoses are even higher in Partnership programs. MCOs are supposed to provide a full array of mental health services to their members including access to CSP when appropriate.

1915(i) State Plan Amendment

Section 1915(i) of the Federal Medicaid statute allows states greater opportunities to apply to the Federal government to provide home and community-based services to individuals with mental health service needs. Using the 1915(i), states and counties can secure partial Medicaid reimbursement for services that were previously funded using local monies. Wisconsin is one of five states that have amended its state Medicaid plan to take up the 1915(i) option to provide services to individuals with serious mental illness (SMI) (Wisconsin DHS, 2009). From the list of allowable services, Wisconsin has elected to provide one service category, Community Recovery Services. Three services in particular are covered under the umbrella of Community Recovery Services:

- Community Living Supportive Services: Community living supportive services are designed to assist individuals to live in the community with a maximum level of independence. Services consist of meal planning/preparation, household cleaning, personal hygiene, medication management and monitoring, parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. These services are made available to individuals in their places of residence.
- Supported Employment: This service is designed to assist individuals to obtain and maintain competitive employment. Supported employment services are designed to be continuous and individualized, based on consumer choice and preference, and closely integrated with mental health treatment. The service covers intake, assessment, job development, job placement, work-related symptom management, employment crisis support, and follow-along supports by an employment specialist.
- Peer/Advocate Supports: This service supports the use of Peer Specialists, individuals who are trained and certified to serve as advocates and provide peer support in emergency, outpatient, community, and inpatient settings. Peer Specialists function as role models demonstrating techniques in recovery and in ongoing coping skills.

As part of the Affordable Care Act of 2010, Congress made a number of additional changes to the way Medicaid administers the 1915(i) option (Centers for Medicare and Medicaid Services [CMS], 2010). Among these changes are the following:

- The requirement that individuals must meet an institutional level of care in order to qualify for services has been removed.
- Individuals with incomes up to 300% of the SSI Federal Benefit Rate are now eligible to receive services.
- Services can now be targeted to certain populations, including individuals with mental illness.

These changes, which are scheduled to go into effect in October 2010, will remove some of the barriers to providing home and community-based services to individuals living with mental illness.

Milwaukee County was the first county in the state to apply to the state to participate in the 1915(i). Currently, the county is in the final stages of completing the process. Milwaukee County has led the state in engaging in the 1915(i) process. However, some concerns remain regarding the population of individuals who will be eligible

for services under 1915(i) and the county's capacity to pay for the non-Medicaid share of new services. Discussions between the BHD and the State are ongoing on this issue.

Other State Initiatives

Wisconsin, as with other states across the country, has turned its attention to the importance of promoting trauma-informed care (TIC) with its human services providers across the state. TIC is treatment that incorporates an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services and a thorough understanding of the profound neurological, biological, psychological, and social effects of trauma and violence on individuals (Jennings, 2004). The Wisconsin DHS Division of Mental Health and Substance Abuse Services recently launched "*Shift Your Perspective,*" an educational campaign. This campaign promotes the use of trauma-informed approaches and care in human services throughout the state through working with the media to promote provider education and adoption of TIC principles.

Additionally, the state DHS recently commissioned an infrastructure of Wisconsin's public mental health and substance abuse service delivery systems.[5] In the next phase of this initiative, which begins in September, there will be grants available for counties to implement pilot programs related to the infrastructure initiative. These programs could include the use of evidence-based practices (EBPs), flexibility in funding streams, and other system enhancements. As the County moves forward in its system redesign efforts, it will be important to work with the State to take advantage of the opportunities available through this initiative.

4. National Context

The redesign project is taking place within the broader context of national mental health system transformation. The goals, initiatives, and principles of federal transformation efforts are outlined below. As this report will demonstrate in coming sections, these national efforts are aligned with local efforts in Milwaukee County.

New Freedom Commission

This system transformation was articulated in the 2003 Report of the President's New Freedom Commission on Mental Health (NFC). The aim of the system redesign project in Milwaukee County is in harmony with the vision of the NFC: a recovery-oriented mental health system in which all individuals have access to high quality services that support full community integration (NFC, 2003).

The NFC outlined six core goals for mental health system transformation in the coming years. These are outlined below in Table 2. The redesign project Guiding Principles, which are outlined in the next section, are in harmony with these goals.

Table 2: New Freedom Commission Goals

Goal 1	Americans Understand that Mental Health Is Essential to Overall Health.
Goal 2	Mental Health Care Is Consumer and Family Driven.
Goal 3	Disparities in Mental Health Services Are Eliminated.
Goal 4	Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.
Goal 5	Excellent Mental Health Care Is Delivered and Research Is Accelerated.
Goal 6	Technology Is Used to Access Mental Health Care and Information.

[5] For more information about the infrastructure initiative, visit http://www.dhs.wisconsin.gov/mentalhealth/infrastructure

By working to create an improved and integrated mental health system that contributes to greater overall public health of its citizens, Milwaukee County is demonstrating a commitment to NFC Goal 1. In terms of NFC Goal 2, the redesign project itself is committed to consumer involvement at all levels. The project is also focused on establishing more opportunities for consumer involvement throughout the entire system – from the establishment of more peer-operated services to the development of services that are more person-centered. Disparities in services have been identified in this redesign project, and the project is working to eliminate these disparities, thus furthering Goal 3. By creating a more streamlined, integrated, and accessible system of care, the redesign project also furthers NFC Goal 4. Finally, the redesign project's commitment to high quality mental health services reflects NFC goals 5 and 6.

Substance Abuse and Mental Health Service Administration's Priorities

The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services (DHHS) that was created to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders, has outlined its key mental health transformation priorities in its Federal Mental Health Action Agenda and Strategic Initiatives.

Federal Mental Health Action Agenda

In response to and guided by the NFC report, SAMHSA worked with other key Federal agencies to develop a Federal Mental Health Action Agenda, a long-term strategy to work towards the fundamental system transformation envisioned by the NFC (SAMHSA, 2005). This agenda is guided by a set of five principles, outlined in Table 3. As with the NFC goals, these Federal principles are very much in harmony with Milwaukee County's local efforts to transform its system. The public health vision, commitment to cost-effectiveness, and community focus of the local redesign project are also a commitment on a federal level.

Table 3: SAMHSA's Federal Mental Health Action Agenda Principles

Principle A	Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
Principle B	Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
Principle C	Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.
Principle D	Consider how mental health research findings can be used most effectively to influence the delivery of services.
Principle E	Follow the principles of Federalism, and ensure that [the Commission's] recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

Strategic Initiatives

Additionally, this project intersects with each of SAMHSA's 10 strategic initiatives, which are outlined in Table 4 (SAMHSA, 2010). In particular, this project will help Milwaukee County to enhance the quality and accountability of its services, continue to develop and maintain a high-quality behavioral health workforce, and provide integrated and coordinated services that take into account the needs of special populations such as veterans, those involved in the justice system, and people who are homeless.

Table 4: SAMHSA's Strategic Initiatives

1	Prevention of Substance Abuse and Mental Illness
2	Trauma and Justice
3	Military Families – Active, Guard, Reserve, and Veteran
4	Health Reform
5	Housing and Homelessness
6	Jobs and Economy
7	Health Information Technology for Behavioral Health Providers
8	Behavioral Health Workforce – In Primary and Specialty Care Settings
9	Data, Outcomes, and Quality – Demonstrating Results
10	Public Awareness and Support

The strong concordance of federal and local transformation efforts is promising for both Milwaukee County and the nation as a whole. The agreement in guiding principles, goals, and strategies paints a hopeful vision of sustained mental health system transformation in Milwaukee and nationwide.

Guiding Principles

Stakeholders in the adult mental health system in Milwaukee County are invested in overcoming the issues and challenges that the system currently faces. An initial step in the project was to convene stakeholders from the consumer and advocacy communities, mental health providers, system administrators, county and state officials, and private organizations to define the guiding principles. These guiding principles are listed in detail in

Table 5.

Table 5: Guiding Principles

Principle 1: The system should be *recovery-oriented* and *consumer-centered* A recovery-oriented, consumer-centered mental health system emphasizes consumer choice and empowerment. It promotes hope, but also recognizes that consumers must take responsibility for their own lives. Consumer and provider education on the potential for recovery is essential for individual and community resiliency. Consumers should be respected as the best source of knowledge about their recovery; this includes building peer support systems and opportunities for action in the greater system at all levels. Services should be based on consumers' strengths, take into account a holistic vision of the person, and recognize that although recovery may be non-linear, every person has the potential to thrive.
Principle 2: The use of *community-based services* should be encouraged Community-based services allow consumers to live, work, and thrive alongside other county residents. Services should be based on best available evidence and accountable for fidelity to evidence-based models of care. Community-based services should seek to reduce the need for inpatient utilization. Promoting community-based services includes further developing services such as case management, which provide support to consumers on an on-going basis and are targeted to their level of need. Ensuring that consumers utilize community-based services means increasing access and quality. Building on existing successful programs is essential. Recovery should be supported in the least restrictive setting possible.
Principle 3: Mental health *system capacity* should be developed Building capacity means creating processes that maximize current capacity, and aligning payment incentives with priorities. Building capacity will allow the system the capability to divert consumers in crisis to appropriate care in a timely, efficient, and effective manner. Building the capacity of the mental health system includes workforce development efforts such as recruitment, training, and re-training of current staff. Strengthening the workforce also entails ensuring worker satisfaction and encouraging team building, as this increases the efficacy of the system in supporting consumer recovery and operating efficiently. Developing system capacity also includes collaborating with those outside the mental health system—such as the police force—as well as fostering the implementation of current effective services such as mobile crisis teams. Building

system capacity will align and increase resources, and support cost-efficient and effective care delivery.

Principle 4: Improve the *quality* of services delivered
A high quality mental health system uses innovative ideas to tackle old problems. High quality services employ evidence-based and cost-effective service models. Quality assessment and improvement depends on the enhancement of IT and data systems in order to track progress and implement new initiatives. High quality services must take into account consumer satisfaction and consumer-centered care delivery.

Principle 5: Systems that interact with persons with mental illness should be *coordinated and integrated*
The county mental health system is interdependent with the private system and exists within the context of State statutes, policy guidelines and funding streams. There is also interdependence between crisis, inpatient, outpatient, rehabilitative, and housing services that serve people with mental illnesses. Mental health system users are also high users of substance abuse and criminal justice systems. Therefore it is important that the mental health system reaches synchronization—connoting that all of these services and regulatory systems are in communication with each other about objectives, and continue their commitment to working together to design a superior set of supports, recognizing the intricacy of relationships with one another. It is also essential that the system support the vision of integrating physical health care with mental health care. Mental health care and physical health care can work together to support consumer recovery and reduce morbidity and mortality. The primary care and mental health care systems should strive to be fully integrated, with providers from each discipline in communication about individual consumers and the needs of the population.

Principle 6: *Disparities* in service delivery and outcomes should be eliminated
Milwaukee County is a highly diverse, densely populated community. As such, the mental health system should seek to cater services to the needs of all its residents in the context of their racial, ethnic, cultural, socio-economic, and gendered identities. Culturally competent services and service providers have the potential to reduce disparities and promote empowerment and recovery for all service users. Ensuring that each neighborhood and community is served equally and appropriately can also reduce disparities.

Principle 7: There should be a focus on *community and public health*
The health of mental health consumers exists in the environment of the community. A public health approach includes focusing prevention services at the population level, and promoting the use of appropriate assessment and treatment. A public health approach also means accounting for social determinants of mental health, including poverty, cultural biases, and level of education. A community and public health approach would include promoting education about mental illness, as well as efforts to reduce stigma and raise community awareness and investment.

The guiding principles are in concordance with the defined principles, goals, and recommendations produced by other government efforts. At the federal level, these guiding principles overlap with those of the NFC and the SAMHSA's Federal Mental Health Action Agenda. The guiding principles of the Milwaukee County Adult Mental Health System Redesign Project also concur with guiding principles found in numerous other state and county system transformation efforts. These principles have guided each step of the planning process and should ultimately inform the implementation of the redesign recommendations.

Data Collection Approach

This project used an encompassing data-driven approach that examined services needed and received and reasons for differences, access and quality of services, service utilization and outcomes. The approach involved obtaining the above information from diverse stakeholders including consumers, providers, family members, and advocates using various methodologies including community meetings, stakeholder interviews, surveys, systematic reviews of documents, and the analysis of service utilization and outcome data. The approach also includes presenting the results in formats that are useful for priority setting and program planning.

This goal of this approach is to provide the following benefits:

- Better use of community resources

- Ensuring appropriate capacity
- Making best use of available resources
- Promoting access, quality, recovery, and accountability
- Improving communication with other agencies and the public
- Using data gathered to leverage additional funds
- Promoting synchronization (reducing fragmentation)

1. Community Meetings

In collaboration with the advisory group and PPF, HSRI convened three community meetings to solicit feedback on the redesign project. IndependenceFirst on September 8th, 2009; the Black Health Coalition of Wisconsin on September 9th, 2009; and the Milwaukee Latino Health Coalition and United Community Center (UCC) on October 20th, 2009 sponsored these meetings. The meetings were conducted using a "World Café" format where participants sat in small groups to discuss open-ended questions. There were two questions posed to participants:

- What are the most pressing issues and challenges for people receiving services in the mental health system in Milwaukee County?
- What is your vision for an improved adult mental health system five years from now?

2. Key Informant Interviews and Group Meetings

HSRI conducted interviews and otherwise obtained input from over 50 people and organizations over the period June 2009 to March 2010. Informants who were interviewed included private providers, county providers, consumer advocates, peer specialists, administrators and clinical staff from the BHD, former BHD administrators, state officials, representatives from managed care organizations and FQHCs, law enforcement and justice system officials, union representatives, and representatives of diverse racial/ethnic communities. In addition, members of the Behavioral Health Advisory Committee and Milwaukee Mental Health Task Force were engaged as a group on multiple occasions.

HSRI used a protocol to conduct open-ended interviews to gather information from unique perspectives. Interviewers asked informants what they saw as issues in the system and possible solutions. A copy of the key informant interview questionnaire is in Appendix C. Interviewers collected written notes and recorded observations. Data were then analyzed using a qualitative data analysis software program called NVivo.

3. Surveys

HSRI implemented a series of surveys to obtain information about service needs, quality and access of services, and reasons for service disparity. Surveys were conducted with case managers, consumers, providers, and system administrators in Milwaukee County. The surveys are discussed in more detail below.

The Service Planning and Evaluation Survey and Resource-Associated Functional Level Scale

The Service Planning and Evaluation Survey (SPES) was developed by HSRI and has been used in numerous system planning projects nationwide. The SPES is used to determine the service needs (types and amounts) of consumers at differing levels of functioning. The SPES also gathers information regarding the reasons that needed or recommended services were not delivered in appropriate amounts. In this redesign project, HSRI

developed three versions of the SPES to be filled out by different stakeholder groups: one for case managers, a second for public and private inpatient personnel completing discharge interviews, and a third for consumers. These surveys will be discussed in more detail below. All three versions of the SPES were tailored to this system redesign project, using service descriptions that were specific to Milwaukee County.

To measure functional level, the SPES uses the Resource Associated Functional Level Scale (RAFLS). The RAFLS was developed by HSRI and has been used in numerous system-planning projects nationwide both as a planning tool and an outcome measure. The scale identifies consumers at one of seven levels of functioning at a particular point in time. These functional levels are states, not traits, meaning that they change over time. The seven functional levels and their descriptions are found below in Table 6. More detailed descriptions of the RAFLS can be found in Appendix D.

Table 6: RAFLS Descriptions

FL1	Dangerous to self or others, unable or unwilling to participate in own care.
FL2	Unable to function, current, acute psychiatric symptoms, able and willing to participate in own care.
FL3	Lacks activities of daily living (ADL)/personal care skills.
FL4	Lacks community living skills.
FL5	Needs role support and training.
FL6	Needs support/treatment to cope with extreme stress or seeks treatment to maintain or enhance personal development.
FL7	System independent; can get support from friends and family and does not currently need professional mental health services.

Mental health professionals in a number of inpatient and outpatient settings have found the RAFLS to be easy to understand and apply. The RAFLS can be cross-walked to most other level of functioning systems, including the Axis V Global Assessment of Functioning Scale (GAF) and Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).

Case Manager Surveys

To apply the needs assessment system, the SPES survey was administered to BHD-funded case managers who work for county-funded and community-based systems. The case management group was selected to participate in the needs assessment process because of their particular perspective and expertise on the needs of persons receiving mental health services. Case managers in TCM and CSP completed a SPES for each client on their caseload. The TCM and CSP case managers provided information on the individual's level of functioning (using the RAFLS), the number of times the person was seen in the month, the services needed and received, and the reasons for differences between needed and received amounts of services. A copy of the SPES for Case Managers can be found in Appendix E.

The focus of the data collection was the month of January 2010. After receiving a training regarding appropriate use of the SPES and an introduction to the functional levels, case managers were given an online link to complete surveys during the first two weeks of February. Survey results were analyzed using the data analysis software SPSS.

Shortly after the analysis of the case management SPES was completed, HSRI released two brief newsletters outlining preliminary findings for the CSP and TCM programs. These newsletters can be found in Appendices F and G.

Public and Private Inpatient Hospital Discharge Survey

In addition to understanding the service needs of consumers in case management programs, it is also important to understand the service needs of individuals who are being discharged from inpatient care to the community. To better understand the needs of this population, the project team implemented the SPES with discharge case managers in BHD inpatient facilities and one private facility in the months of February and March 2010.

Consumer Survey

Project staff consulted with Milwaukee stakeholders to create the Consumer SPES. The Consumer SPES asked individuals to rate their functional level (a RAFLS scale was adapted from the case management survey for this purpose) and their needs as they relate to 20 services. The consumer SPES is the first of its kind and was developed specifically for this system redesign project. After developing an initial version with the input of stakeholders from the advisory group, the survey was pilot tested with consumers in Milwaukee. The survey was then revised and administered to a larger group of consumers with the assistance of over 20 partners on the ground in Milwaukee. The survey was completed at the service locations of these partners during the month of April 2010. It was available in English and translated into a Spanish-language version as well. Consumers at the partner locations filled out the survey in hard copy. These paper copies were then sent to HSRI for data entry and analysis. Included in Appendix H is a copy of the Consumer SPES. A newsletter reporting preliminary findings from the Consumer SPES can be found in Appendix I.

Physician Survey

HSRI conducted a review of provider surveys used in other assessments of community mental health needs and consulted with the advisory group to develop a survey of physicians and other individuals who provide mental health services in Milwaukee County. The final online survey consisted of 13 questions. Survey respondents were asked to comment on the accessibility and quality of mental health services in the County. They were asked to identify services most in need of attention from the project. Providers were also asked to identify the most significant service delivery problems from the perspective of the individual provider and from the perspective of the people who are served by the mental health system. A copy of the provider survey can be found in Appendix J, and a newsletter reporting preliminary findings to the provider community is found in Appendix K.

Private Health System and BHD Surveys

To better understand the role and perspective of the private health systems in Milwaukee County, the project team implemented a Private Health System Survey of five private health systems: Rogers Memorial Hospital, Aurora Health Care, Columbia St. Mary's, Froedtert Memorial Lutheran Hospital, and Wheaton Franciscan Health Care. Project staff also collected data from the Medical College of Wisconsin and the four FQHCs: Westside Healthcare Association, Health Care for the Homeless of Milwaukee, Milwaukee Health Services, and 16th Street Community Health Center. In February 2010, representatives from each of these facilities completed an online survey about their psychiatric inpatient, outpatient, and provider capacity. The survey was composed of 30 questions and was completed by one individual in each system that is knowledgeable or in a senior

position. The survey was designed with the help of members of the project's advisory council who represent these private health care systems. Included in Appendix L is a copy of the Private Health System Survey.

The project implemented a system survey to better understand the issues faced by the BHD from the perspective of administrators and key stakeholders within BHD programs. The online BHD survey was similar to the Private Health System Survey, asking about capacity and staffing in the following BHD-operated programs: Outpatient Services (individual therapy, group therapy, and medication management), Case Management, Day Treatment, Crisis Respite Services, Crisis Resource Center, Observation Unit, Crisis Walk-in Center, Crisis Mobile Service, and Acute Adult Inpatient. These surveys were completed in July 2010.

4. Service Utilization and Outcome Data

To understand the rates of service utilization and the ways in which individuals move in and out of the mental health service system in Milwaukee County, the project team analyzed both state and county-level administrative data. The project team reviewed Medicaid Administrative Data for the two most recent years (2007 and 2008). The data sets reviewed for the project included Fee for Service Claims (35 million), HMO Encounters (12 million), and CMO (Family Care) Encounters (590,000). Medicaid data was available for a total of 243,000 members. Milwaukee County Administrative and Assessment Data were reviewed for the two most recent years (2007-2009). The data sets reviewed included Brief Psychiatric Rating Scale (BPRS) File (which contained 2,619 records), Episode Assessment File (35,859 records), Role Functioning Scale (RFS) File (1,360 records), Registration and Assessment Packet (RAPS) (11,682 records), Demographic Files (14,545 records), and Services (231,370 records). Using service utilization data for the two-year period, HSRI calculated the percentage of consumers (snapshot plus arrival) who used the service and, for those who use the service, how much of the service was used on average. This data was used to compare to systems that are considered to be employing best practices.

The project team had originally intended to use the functional level assessment data to generate an algorithm to translate functional level assessments used at the state level into a single functional level scale that can be used to compare functional levels throughout the system. However, the information on functional level was difficult to obtain from the data that is currently available. The number of individuals for whom a functional level assessment was completed on more than one occasion was only a small sub-sample of the larger population. This small sample was not sufficient to generate enough statistical power to make reliable inferences about the Milwaukee County mental health system. Therefore, the redesign project team focused on current service availability and utilization for this phase of the redesign project.

Findings

The project team collected a large quantity of data from each of the data sources outlined above. The findings from these data collection efforts are detailed in this section. Findings are organized by data source.

1. Community Meetings

Community meeting participants identified a number of pressing issues and challenges for people receiving mental health services in Milwaukee County. Several issues were raised multiple times by diverse stakeholders across the series of community meetings. Participants noted waiting lists for care, limited points to enter into

the system, and gate-keeping by insurers as having a negative impact on access to care. They also pointed to basic needs such as housing, food, and transportation that were currently experienced by the population receiving public mental health services in Milwaukee County. Participants identified a need for more providers and for coordination of services through increased communication between providers. Many participants noted that stigma is a significant barrier for people seeking mental health services.

Community meeting participants also articulated a vision for an improved adult mental health system. From the perspective of community meeting participants, an improved adult mental health system includes more consumer involvement, leadership, and empowerment. Participants noted that the increased use of person-centered recovery plans and more availability of peer supports would contribute to an improved system. Additionally, participants said that more education and training for providers and consumers would improve services and access. Participants envisioned a more culturally competent system that offers bilingual and interpreter services for individuals with limited English proficiency. Participants also envisioned a system of integrated primary care, mental health and substance abuse services.

2. Key Informant Interviews Organized by Guiding Principles

In this analysis, the key informant interview data is organized by Guiding Principles. Within those principles, sub-themes were identified. These were themes that emerged in multiple interviews with informants from various parts of the system. Results are presented below by guiding principle and sub-theme.

Principle 1: Recovery Oriented and Consumer-Centered System

Vision and Culture

Informants had much to say about the importance of recovery and consumer-centeredness for this system redesign project. Many assets were identified, but also many challenges. Informants highlighted the importance of education at all levels of the system and the need for more recovery-oriented and consumer-centered services. Based on the interviews, it was clear that the BHD leadership had a vision for a recovery-oriented mental health system. However, it was also clear that more education is needed regarding rehabilitation and recovery for policymakers as well as members of the community. This education will serve to both clarify the vision of the BHD leadership and elicit buy-in from all system stakeholders.

More Opportunities for Consumers Participation Needed

Many informants observed that Milwaukee County consumers and advocates are not as active or influential as consumers and advocates in other communities with which they are familiar. The Milwaukee Mental Health Task Force and other organizations have created opportunities for consumer participation, and some peer specialist positions exist in the BHD and elsewhere. However, informants agreed that more such opportunities are needed throughout the entire mental health system.

Recovery-Oriented and Consumer-Operated Services

There was a concern amongst informants that because Milwaukee County has not had a long history of community-based, recovery-oriented services, both consumers and providers may be less familiar with them and less likely to seek them out. This lack of understanding may lead to fewer provider referrals, or to consumer refusals of recovery-oriented services. Informants noted that peer supports such as peer specialists and venues such as Warmline, Inc., Grand Avenue Club, Our Space, and Independence*First* are a valuable component of the

system. Informants expressed the hope that peer support services in particular and recovery-oriented services in general be expanded and promoted.

Informants noted a number of opportunities for Milwaukee County to increase and enhance its recovery-oriented service offerings in the near future. The 1915(i) state plan option has the potential to increase the availability of supported employment and peer-operated services. This, as well as recently instituted peer specialist certification may help with integrating more peer supports into traditional services, creating more peer-operated services, and allowing more mechanisms for reimbursement of these services.

Provider Education about Recovery

In addition to broad public and system-wide education about recovery, more recovery education is needed for providers in particular. Informants asserted that recovery education should be built into all provider trainings and orientations. Currently, the BHD does offer some recovery components in its trainings, but some informants were concerned that providers in the private sector may not be receiving the same exposure to recovery principles.

Some informants asserted that more recovery education is needed for case management services in particular, and that case managers should be trained and encouraged to use an approach in which consumers are more self-directed. In particular, informants believed that case managers should be given the resources to take a more collaborative and person-centered approach to treatment planning.

Consumer Education about Resources

Informants noted a need for increased consumer education regarding the availability of services. The Crisis Resource Center provides some materials and assistance in this regard, but informants felt that many consumers were not aware of this service. One interviewee noted that more illness and wellness self-management tools such as the Wellness Recovery Action Plan (WRAP) should be made available to consumers. Other informants said that comprehensive resource guides would be helpful for consumers. Informants further noted that peer specialists would be helpful in providing education for consumers.

Principle 2: Community-Based Services

Outpatient Services

Most informants identified significant capacity and access issues with outpatient services in Milwaukee County. Some discussed the possibility of more shared responsibility for outpatient services with providers outside of the BHD, including those in private systems. However, informants also acknowledged that it may be difficult for other providers to offer services to consumers at the same level of need given safety issues, complications with payment, and difficulties with engagement in treatment.

Continuum of Care

Informants expressed concern regarding the lack of continuity between inpatient and outpatient services. This lack of continuity frequently leads to individuals receiving inadequate or inaccessible community care and returning to crisis services. Because of these problems with the continuum of care in Milwaukee County, both inpatient and outpatient providers expressed concern regarding their ability to serve individuals in the least restrictive environment.

Case Management

Informants said that case management is an important service for individuals with a high need for services and supports. Informants shared that TCM tends to serve individuals who are newer to the system and that there exists a culture of mutual support in this program. In contrast, one interviewee noted that case managers in the CSP might feel “less energetic” because they serve individuals experiencing more chronicity. Some informants suggested that a continuum of case management intensity would allow more people to receive services without expanding capacity. Individuals may be released from case management when they reach a higher functional level but still receive ongoing “recovery check-ins” with the opportunity to enter back into regular case management if the needs become more acute.

Principle 3: System Capacity

Crisis Services

Informants identified a need to divert individuals in crisis from inpatient and emergency services. There has been a concerted effort on the part of the County to reduce emergency department and ED use in recent years. However, EDs have more than doubled in the past ten years; one interviewee reported that in 2000 there were 2,657 EDs, and in 2009 there were 6,058. One reason for this increase is that police officers and emergency personnel may be “overly cautious” because of past events and liability concerns.

Informants pointed to various alternatives to inpatient emergency treatment such as the Crisis Resource Center and crisis respite services, crisis prevention services such as Warmline, Inc. and mobile crisis services. Such services can provide prevention and/or diversion from more costly and coercive crisis services and allow individuals to remain in the community.

Inpatient Capacity

All key informants identified inpatient capacity as a significant issue faced by Milwaukee County, though there were differing opinions regarding the nature of the issue and potential solutions. One frequently mentioned option was for the County to build additional inpatient capacity among the private health systems by contracting out for additional inpatient services. It was acknowledged, however, that this is a complex issue, as the opportunity for sufficient reimbursement for certain low-income or indigent individuals may not exist, and sufficient private sector capacity and expertise is not currently available to appropriately care for those with the highest levels of acuity.

Informants also expressed concern that BHD’s successful effort to reduce inpatient overcrowding by referring individuals with insurance to private health systems had exacerbated its fiscal concerns by causing it to serve an even more disproportionate number of people without insurance.

Insurance and Payment

Several informants discussed the potential impacts of BadgerCare’s new insurance program for childless adults. The introduction of BadgerCare Core has created more opportunities for consumers to seek outpatient care. However, there are limits on the benefits that can lead to problems with access. The Wisconsin Parity Act does not yet affect the BadgerCare service package, although some informants recommended during interviews that DHS make changes. Because BadgerCare Core covers psychiatry but not other outpatient and community services, it is possible that Milwaukee County will experience an increase in demand for psychiatry.

As in many systems, no-shows are a problem for private providers in Milwaukee County because insurers do not reimburse providers when individuals fail to show up for an appointment. FQHCs were identified as having the potential to maximize capacity because they receive cost-based reimbursement. In interviews, it was suggested that if FQHCs could expand capacity, including physical space, they could take on more outpatient care. Some representatives expressed concern about the level of engagement and symptom acuity of persons who would use outpatient services at FQHCs.

Several informants noted because other facilities and health centers require that a person have insurance in order to provide services other than emergency care, the county-funded system serves a disproportionate number of individuals with no health insurance. Thus the BHD is frequently the sole mental health care provider for individuals with no insurance, leaving less capacity for insured individuals.

Workforce Development

Informants in multiple interviews suggested using psychiatry residents on rotation at various service locations including crisis services, FQHCs, and other outpatient settings. This would expand the available workforce at these locations as well as provide a training opportunity for residents.

Informants expressed a need for increased training for case management, inpatient, and outpatient service providers on new and alternative crisis services such as the Crisis Resource Center. There is also an ongoing training need for incumbent workers. Informants identified a need for more training opportunities for all providers, and possibly more mandatory case manager trainings.

Principle 4: Quality

Accountability

Many informants noted that the BHD is working towards TJC accreditation in 2012 as part of the Quest for Recovery initiative. Representatives of BHD recognize that this is an important and significant achievement. Some speculated that private facilities might currently have more oversight and accountability mechanisms than BHD because BHD is not subject to TJC oversight at this time.

Allocation of Resources

Informants expressed concern that a large percentage of county resources are expended on services for which there has been little to no scientific evidence demonstrating that they are effective. There was hope that some resources could be shifted to practices for which an evidence-base has been established such as ACT, permanent supportive housing (PSH), and supported employment. Some EBPs are currently available in Milwaukee County, but only in very limited supply. A re-allocation of resources to EBPs could lead to a more efficient use of public dollars and better outcomes for consumers.

Information Technology and Data Systems

Currently, a health information exchange connects all of the emergency rooms in Milwaukee County, including PCS. The FQHCs also participate in this network. This has the potential to provide real-time information on persons coming into emergency rooms.

Informants said that BHD has trouble tracking people who are re-admitted to the emergency or inpatient unit and people in the community because there is no link with Medicaid data. Informants relayed that if data

systems were coordinated with private health systems, providers would not have to rely on self-reporting by consumers about their history, medications, and medical/psychiatric status.

The Importance of Innovation

Informants acknowledged the importance of innovation in establishing high quality mental health services to people in Milwaukee County. Programs like the Crisis Resource Center and practices such as recovery check-ins were noted to be the "future of crisis services". However, it was noted that these alternatives could never fully replace inpatient care. Informants emphasized the importance of strategies for early intervention and the implementation of more EBPs.

Principle 5: Coordinated & Integrated Systems

Primary Care/MH/AODA Integration

The integration of primary care, mental health, and substance use services are a state as well as a county priority. Informants noted that FQHCs could be looked to as a model because they have been able to successfully integrate primary care and mental health services. For example, a person may come into a FQHC for mental health services but also see a medical nurse, a doctor, and get lab work done. The BHD would like to see more integration of this kind, including interventions for social problems, such as assistance managing housing needs and addressing issues such as poverty. One interviewee suggested that hiring doctors dually trained in primary care and psychiatry could build a capacity for more integrated care.

Coordination with Law Enforcement

Informants expressed a need for increasing and expanding Crisis Intervention Training for police officers in Milwaukee County. There was a consensus that more coordination between mental health providers and police officers could reduce the need for EDs. Also, informants noted that the frequent use of EDs by law enforcement likely was a key contributor to significant backlogs at BHD's PCS that frequently occurred during the middle part of the last decade.

Coordination with Private Systems

It was noted that there is greater commitment by private systems in Milwaukee County than in other places. There was agreement that interdependence and partnerships between the BHD and the private health systems are essential to success of the mental health system. Informants also highlighted the importance of a thoughtful distribution of services based on client characteristics, so that individuals are provided services in a setting that is equipped to manage their particular needs. There was hope that the private hospitals would increase their capacity to work with people at lower functional levels and adjust services to meet the needs of higher acuity patients.

Many informants suggested that in addition to enhancing capacity, it might be more cost efficient for BHD to contract for additional inpatient services, particularly since it is unable to obtain Medicaid reimbursement for eligible patients because of its designation as an IMD. However, this would require private systems to make a commitment to developing the capacity to serve the current population served by BHD Inpatient, and it might also require a mechanism for ensuring that private hospitals receive some compensation for serving uninsured individuals.

Principle 6: Reduce Disparities

Workforce Capacity

In terms of workforce capacity, informants identified a need for more culturally competent services, including more providers who are bilingual and come from diverse backgrounds. This could be accomplished through incentives for bilingual and multi-cultural providers to "step up" into more active roles in the treatment community. Additionally, informants noted a need for more training in cultural competency for all providers.

Bilingual Services

Some informants noted that language could be a problem in emergency settings if there is no staff person present who can communicate with an individual who is in crisis. In addition to adding more bilingual providers to the behavioral health workforce, this problem can also be addressed through increased availability of interpreters.

Disparities in Neighborhoods

Residents in some neighborhoods experience problems with service availability, according to the informants. In particular, transportation to and from important services is highly problematic. Important services, including crisis services, are offered in locations that are difficult to reach by public transportation. Additionally, informants noted that perceptions of discrimination and prejudice against racially and ethnically diverse groups might lead some individuals to not seek out needed services, or not return to services after an initial visit.

Principle 7: Community & Public Health

Mental Health Cannot be Separated from Issues in the Community and Social Problems

A common theme that emerged in the key informant interviews was that mental health is integral not only to overall physical health but also to the health and wellbeing of the entire community. Mental health is often only one facet of myriad social problems faced by communities in Milwaukee County. Informants stated that there is a strong need for more capacity within all systems, including but not limited to the mental health system, to integrate solutions to larger social problems.

Outreach to Communities

Informants expressed more need for public education about mental health as well as recovery. This education should be coupled with prevention and early intervention strategies so that communities can identify and address mental health issues as they arise.

Shared Moral Responsibility

Informants identified the critical importance of shared moral responsibility amongst all system and community stakeholders. All members of the community must make a social commitment to mental health as a public health issue. However, integrating mental health systems with other health systems as well as with public health entities has been and remains a significant challenge.

3. Case Management Survey

Discussed below are the findings from the surveys completed by case managers in the CSP and TCM programs. Case managers were asked to fill out surveys for each individual under their care for the month of January 2010. Surveys were completed for 2,315 of 2,410 individuals, a 96% response rate. Case managers from the TCM

program completed surveys for 1,102 individuals, and CSP case managers completed surveys for 1,213 individuals. The total sample size for the final analysis was 2,208 because 97 individuals left services during the month.

Case Management Program Characteristics

During the one-month period in which data was collected, a total of 97 individuals left services, 76 from TCM and 21 from CSP. Table 7 details the reasons that were given for individuals leaving services during the study period.

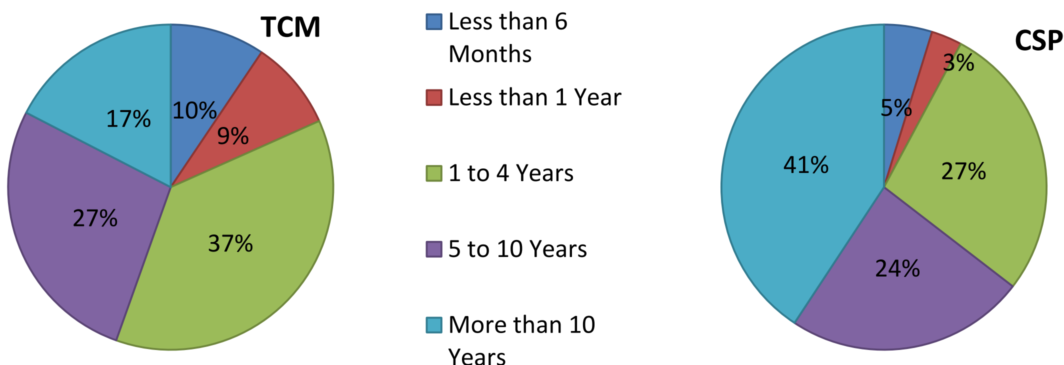
Table 7: Reasons for Leaving Services

Reason	Number	Percent
Targeted Case Management (n=76)		
In Jail	26	34%
Disappeared	19	25%
Moved	11	14%
Discharged	11	14%
Unable to Locate, Presumed Homeless	9	12%
Community Support Program (n=21)		
In Jail	11	52%
Moved	6	29%
Unable to Locate, Presumed Homeless	3	14%
Disappeared	1	5%

The most common reason for leaving both programs was that the individual was in jail (34% and 52% in TCM and CSP respectively). Other common reasons included disappearance, moving out of the Milwaukee County area, and an inability to locate the person because of presumed homelessness. While 11 individuals (14% of all service leavers) were discharged from the TCM program, no individuals were discharged from CSP services during the data collection period.

Case managers were asked how long each of their clients had been receiving case management services. This information is shown for the TCM and CSP programs in Figure 1 below.

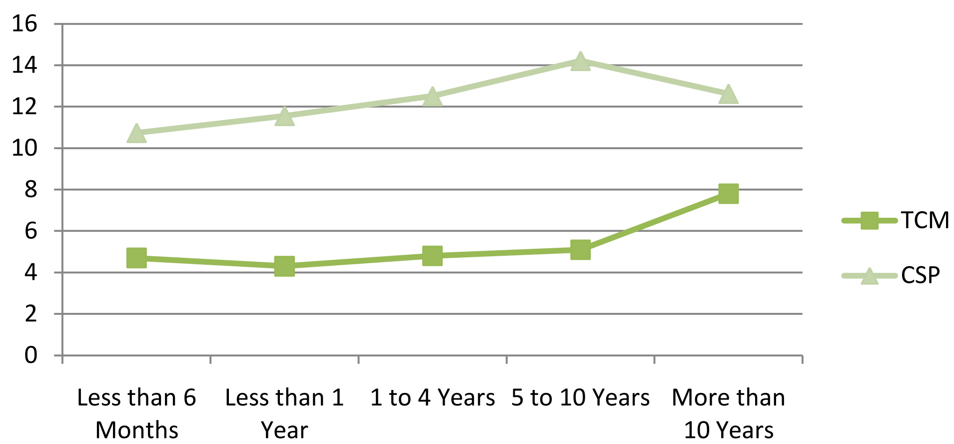
Figure 1: Time Spent in Case Management



A total of 64% of individuals (27% plus 37%, n=491) in TCM had been receiving those services for five or more years. A slightly higher percentage of individuals in CSP (41% plus 24% totaling 65%, n=783) received services for five or more years. The TCM program served 202 individuals (10% plus 9%, totaling 19%) who were new to services within one year, and the CSP program served 95 individuals (5% plus 3%, totaling 8%) new to services within one year.

To determine the amount of case management services being delivered to individuals enrolled in the TCM and CSP programs, case managers were asked to document how frequently they had been in contact with each client on their caseload. The average frequency of contacts relative to the length of time the client had been receiving case management services is detailed in Figure 2.

Figure 2: Average Monthly Contacts by Time Spent in Program



The data reflects that CSP services are designed to be more intensive than TCM services and are thus associated with more contacts per month on average. However, an interesting finding is that in general, the longer individuals received case management services, the more frequently they were in contact with their case managers during the month of January 2010. Individuals who had been in TCM for more than 10 years had approximately eight contacts per month, whereas those who had been in TCM services for one year or less had less than five contacts per month on average. In the CSP program, average monthly contacts ranged from approximately 11 to 14 times per month. Individuals who had been in the program between five and ten years were seen most frequently, an average of approximately 14 times per month. Those newer to the CSP program were seen an average of approximately 11 times per month.

Current and Ideal Service Amounts

Based on the information provided by the case managers, the system redesign team calculated whether individuals receiving services from Milwaukee County's mental health system were receiving the types and amounts of services that were appropriate for their needs. Case managers in both the TCM and CSP programs felt that individuals needed more services than they actually received. Tables presenting this data along with case manager-rated functional level information can be found in Appendix M. These tables are intended for assistance with service system planning.

A simplified version of this data highlighting differences between current and ideal service amounts for a selection of services is found below in Table 8. The first two columns (Service Type and Unit) represent the service type and the unit in which the service is measured. The third and fourth columns (Difference in Units) show the differences between the service amount that was determined to be ideal by the case manager and the service amount that the individual actually received. For all of the services listed below, individuals received a less-than-ideal amount of service, as evidenced by the negative numbers. The final two columns (% Needs Met) represent the percentage of needed services that were actually delivered.

Table 8: Differences Between Current and Ideal Service Amounts

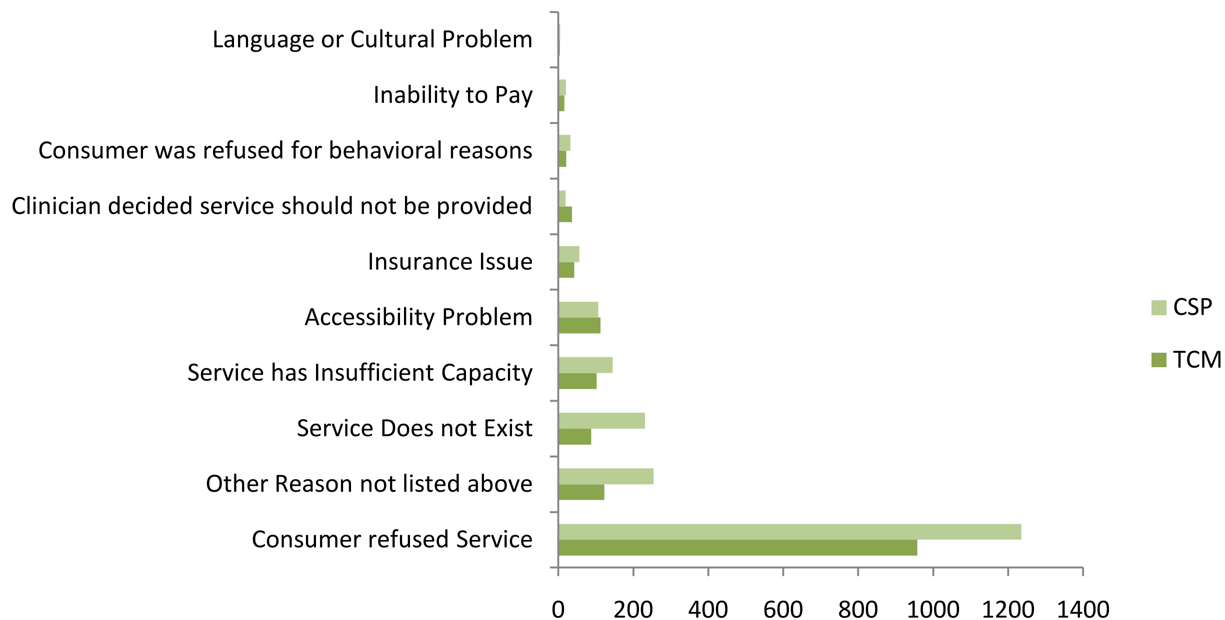
Service Type (Unit)	Difference in Units		% Needs Met	
	TCM	CSP	TCM	CSP
24 Hour CBRF (Days)	-211	-495	74%	71%
Activities of Daily Living (Hours)	-927	-832	39%	76%
Supported Apartments (Days)	-1184	-716	56%	60%
Social & Recreational Skills (Hours)	-900	-1173	35%	64%
Group Therapy (Hours)	-207	-506	27%	51%
Individual Therapy (Hours)	-484	-504	37%	48%
Drop-in Social Club (Hours)	-1998	-3423	33%	25%
Supported Employment (Hours)	-662	-1154	37%	18%
Employment-Related Services (Hours)	-459	-1361	31%	14%
Day Treatment (Days)	-926	-859	22%	10%
Substance Abuse Counseling (Hours)	-1195	-859	12%	10%
Detoxification Program (Days)	-185	-448	5%	8%

The proportion of service needs that were met ranged from 5% to 76%. Case managers consistently reported that the individuals on their caseloads were receiving less than ideal amounts of substance use services (5% to 12% of needs met). Case managers reported that individuals receiving case management had a relatively high percentage of needs met by 24 Hour Community Based Residential Facilities (74% TCM and 71% CSP). While individuals in the CSP program were rated as having a relatively high proportion of Activities of Daily Living (ADL) service needs met (76%), only 39% of individuals in the TCM program were receiving the ideal amount of ADL supports.

In total, the survey indicates that individuals receiving case management need more services that can help them live and work in the community. Case managers felt that individuals receiving case management services needed more support finding and maintaining employment and housing, as well as developing social skills and positive relationships. Case managers also expressed that many individuals on their caseloads are in need of services that help them with substance abuse problems.

For each needed service that was not delivered (or not delivered in the needed amount), case managers were asked to indicate what they believed was the reason for the discrepancy. These reasons, broken out by TCM and CSP, are presented in Figure 3.

Figure 3: Reasons Amount of Service Was Less Than Ideal



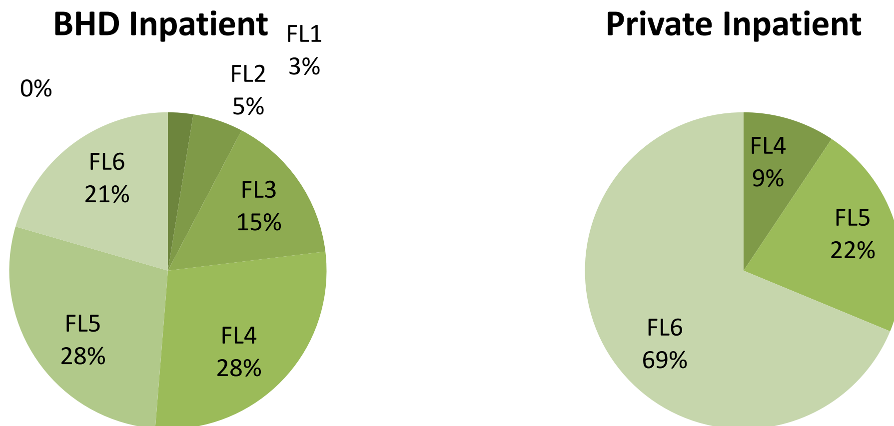
The most common reason given was that the consumer refused the service. Consumer refusal was indicated as the reason 64% of the time (n=958) for TCM clients and 59% of the time (n=1,235) for CSP clients. The second most frequent reason was the "Other Reason" category, in which some respondents wrote in other reasons. Commonly written-in reasons were that the person was not interested (n=28), the person was hospitalized and/or dealing with serious medical issues (n=17), a language or cultural barrier as a secondary reason (n=16), and the person did not attend scheduled appointments (n=15). The third most common reason was that the service did not exist (given 231 times or 11% of reasons for CSP and 88 times or 6% of reasons for TCM). Other common reasons included that the service has insufficient capacity (given 145 times or 7% of reasons for CSP and given 102 times or 7% of reasons for TCM), and that there was a problem with the accessibility of the service (given 106 times or 5% of reasons for CSP and given 112 times or 5% of reasons for TCM). In total, problems with the service accounted for 23% (n=482) of discrepancies between needed and delivered services for CSP and 20% (n=302) of discrepancies for individuals in the TCM program.

4. Public and Private Inpatient Hospital Discharge Survey

To provide a more complete picture of the service needs of individuals in Milwaukee County, the project team modified the SPES to be used by inpatient hospital personnel to document the service needs of individuals as they are being discharged from inpatient care to the community. A SPES was completed for 39 individuals being discharged from the Milwaukee County BHD Acute Care Facility, and 32 individuals being discharged from one private inpatient facility.

Figure 4 below illustrates the distribution of provider-rated functional levels of the individuals being discharged from the BHD (n=39) and Private (n=32) inpatient facilities.

Figure 4: Functional Levels of Consumers Being Discharged from Inpatient Facilities



In both the private and public facilities, the majority of individuals were at a FL 4, 5, or 6 (30 or 77% of individuals from the BHD and 32 or 100% from the private inpatient facility). Each of these levels indicates an ability to live safely in the community with varying levels of services and supports. Six individuals (15%) who were discharged from the BHD inpatient facility were rated a FL 3, which indicates an ability to live in the community with 24-hour supports. Three individuals (8%) were discharged from public inpatient services with a FL 1 or 2. No individuals discharged from the private facility were rated lower than a FL 4. As reported by discharge personnel, individuals discharged from the private inpatient facility were discharged at higher levels of functioning than individuals discharged from BHD inpatient. These differences between functional levels in the BHD and the private hospital may be attributable to the fact that the BHD serves a higher proportion of individuals who are receiving care involuntarily.

Table 9 below shows the percentage of service needs that were met upon discharge for the BHD (39 total individuals) and private inpatient (32 total individuals) facilities. The first column (Service Type) indicates the service and the unit in which it is measured. The Amount Prescribed column is the total amount of units that were prescribed to all individuals discharged from the facility during the data collection period. The Amount Confirmed column indicates the amount of each service that has actually been confirmed for the individual upon discharge (the amount of the service that the survey respondent expects the individual will actually receive). The Needs Met column is the percentage of needs the survey respondent expected to be met after the individual's discharge.

Table 9: Prescribed Service Amounts Received After Discharge

Services		BHD Inpatient			Private Inpatient		
Service Type	Units	Amount Prescribed	Amount Confirmed	Needs Met	Amount Prescribed	Amount Confirmed	Needs Met
Psychiatric Follow-up	hours	42	48	114%	11	8	73%
Medication Management	hours	158	96	62%	38	26	68%
Transitional Housing	days	60	31	52%	0	0	n/a
Case Management	hours	147	61	41%	143	79	55%
24 Hour CBRF	days	107	31	29%	0	0	n/a
Individual Therapy	hours	44	12	27%	34	40	118%
Day Treatment	days	112	20	18%	127	89	70%
Social/Recreational Skills	hours	38	7	18%	16	0	0%
Employment-Related Services	hours	57	8	14%	2	1	50%
Long-Term Care	days	395	30	8%	0	0	n/a
Substance Abuse Counseling	hours	185	6	3%	10	2	20%

Table 9 demonstrates that inpatient staff completing the SPES believed that a large proportion of needed services would not be available to individuals upon discharge. On the whole, this was more pronounced for those being discharged from the BHD facility as opposed to the private facility. For example, individuals being discharged from BHD had only 27% of individual therapy services met, whereas those being discharged from the private inpatient facility were anticipated to receive more than the prescribed amount of individual therapy (118%) needs met. On the BHD side, service needs were met less than half of the time for a total of eight services; on the private inpatient side, service needs were met less than half of the time for only one service, substance abuse counseling.

An exception to this trend is psychiatric follow-up services; those discharged from the BHD were expected to receive more follow-up services than needed (114%), whereas those discharged from private inpatient were expected to have only 73% of psychiatric follow-up needs met. The amounts of medication management service needs met were approximately the same for public and private inpatient discharges (62% for BHD and 68% for private).

There were also differences in the amounts and types of services prescribed for the two groups. No individuals being discharged from the private inpatient facility were prescribed transitional housing, CBRF, or long-term care services, for example. Substance abuse counseling and employment-related services were also prescribed in much higher amounts for those being discharged from BHD inpatient (substance abuse counseling: 185 hours versus 10 hours; employment-related service: 57 hours versus 2 hours).

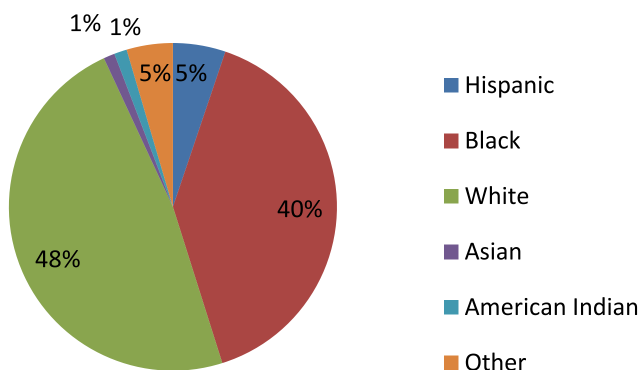
5. Consumer Survey

The system redesign team developed and implemented a consumer version of the SPES to obtain consumer perspectives on their own service needs. This survey is the first time that SPES has been developed for use with consumers and will inform future revisions and implementation of the consumer SPES.

Consumer Characteristics

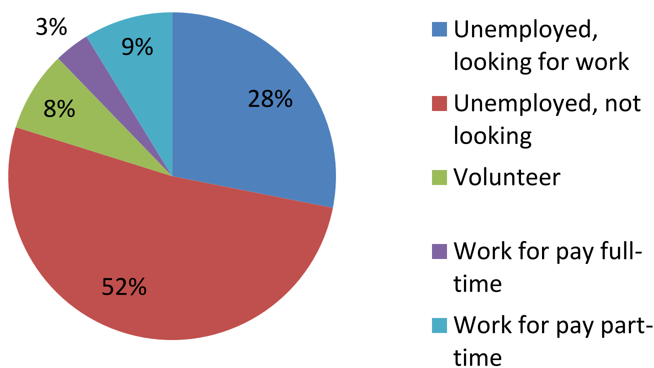
A total of 614 consumers filled out the survey, which was available in English and Spanish. Although an effort was made to reach out to all consumers, because the survey was lengthy, there may have been lower representation of persons with limited reading skills. The average age of survey respondents is 45 years. A little over half of the respondents (55%, n= 327) are women. As shown in Figure 5, the respondents are racially and ethnically diverse: 48% (n=305) identify as white, 40% (n=254) African American, and 5% (n=33) Hispanic. Asians, Native Hawaiians, and American Indians are also represented. Although not reflective of the demographic makeup of Milwaukee County as a whole, the demographics of the consumer SPES respondents are similar to those of the populations receiving mental health services from the County. The racial and ethnic diversity of the respondents is also comparable to the group that responded to the Mental Health Statistics Improvement Program (MHSIP) survey conducted each year by Vital Voices for Mental Health, an advocacy organization in Milwaukee County.

Figure 5: Race and Ethnicity of Respondents



As shown in Figure 6, 80% (n=483) of the survey respondents were unemployed, with 52% (n=313) not looking for work and 28% (n=170) looking for work. Only twelve-percent (12% n=74) were working either part-time or full-time.

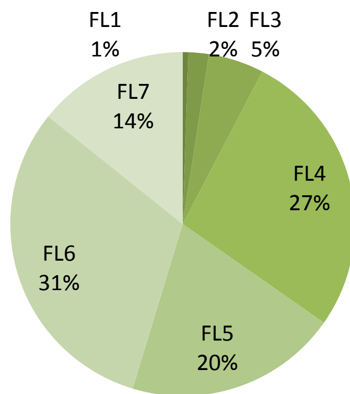
Figure 6: Employment Status of Respondents



For this survey, consumers were asked to rate their own functional level both on the day they took the survey and 30 days before the survey, and to provide an average functional level for the past 30 days. Figure 7 shows

how consumers reported their average functional level over the past 30 days. The self-rated functional levels over the past 30 days are comparable to the other two functional level ratings consumers were asked to report.

Figure 7: Self-Rated Average Functional Level Past 30 Days

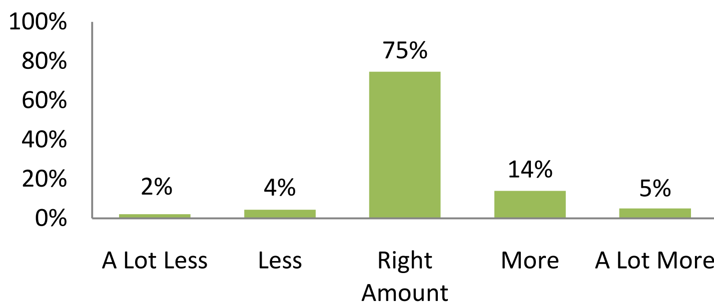


A total of 82 respondents (14%) reported that they were able to function independently of the mental health system (FL 7). Another 179 individuals (31%) reported a FL 6, which indicates that they felt they needed professional support only for extreme or unusual stresses. Over half of the respondents (52%, n=301) rated themselves at a FL 3, 4, or 5, indicating that they use mental health services on a regular basis to cope with day-to-day stresses and to help with ADLs. Only a small number of respondents (3%, n=14) rated themselves at a FL 1 or 2.

Service Needs and Reasons for Service Need Disparities

The SPES asked consumers whether they were getting the right amount of certain services. Services included emergency and crisis stabilization services as well as community-based services and peer-operated supports. Consumers were asked whether they received a lot less, less, the right amount, more, or a lot more of a service than was needed. As shown in Figure 8, consumers reported that they were getting the right amount of services 75% of the time.

Figure 8: Consumer-Rated Needed Service Amounts

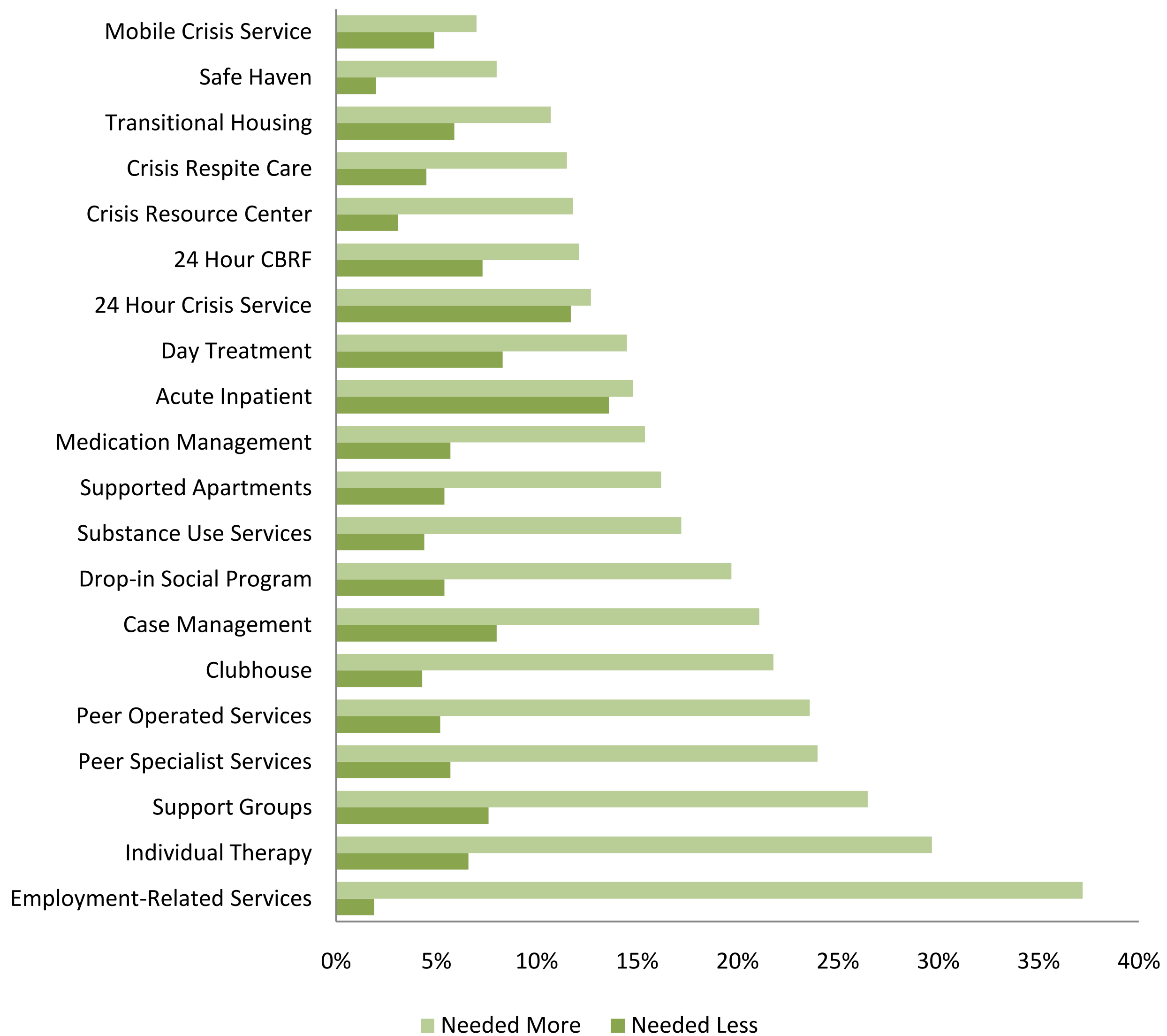


In general, consumer and patient surveys tend to be biased towards demonstrating more satisfaction with quality and amounts of services than may be accurate, in part because some consumers or patients have never experienced anything other than the care to which they are accustomed (Epstein, Fiscella, Lesser, & Stange, 2010). It is important that the redesign project focus on what consumers in the system need more and less of,

and what needs to change, while not discounting that individuals may in fact feel that they are getting the right amount of some services some of the time.

Although the majority of consumers reported they were getting the right amount of services most of the time, reports of service needs varied depending on the type of service. Figure 9 below provides a breakdown of perceived service needs by type of service.

Figure 9: Consumer-Rated Needed Service Amounts by Service Type

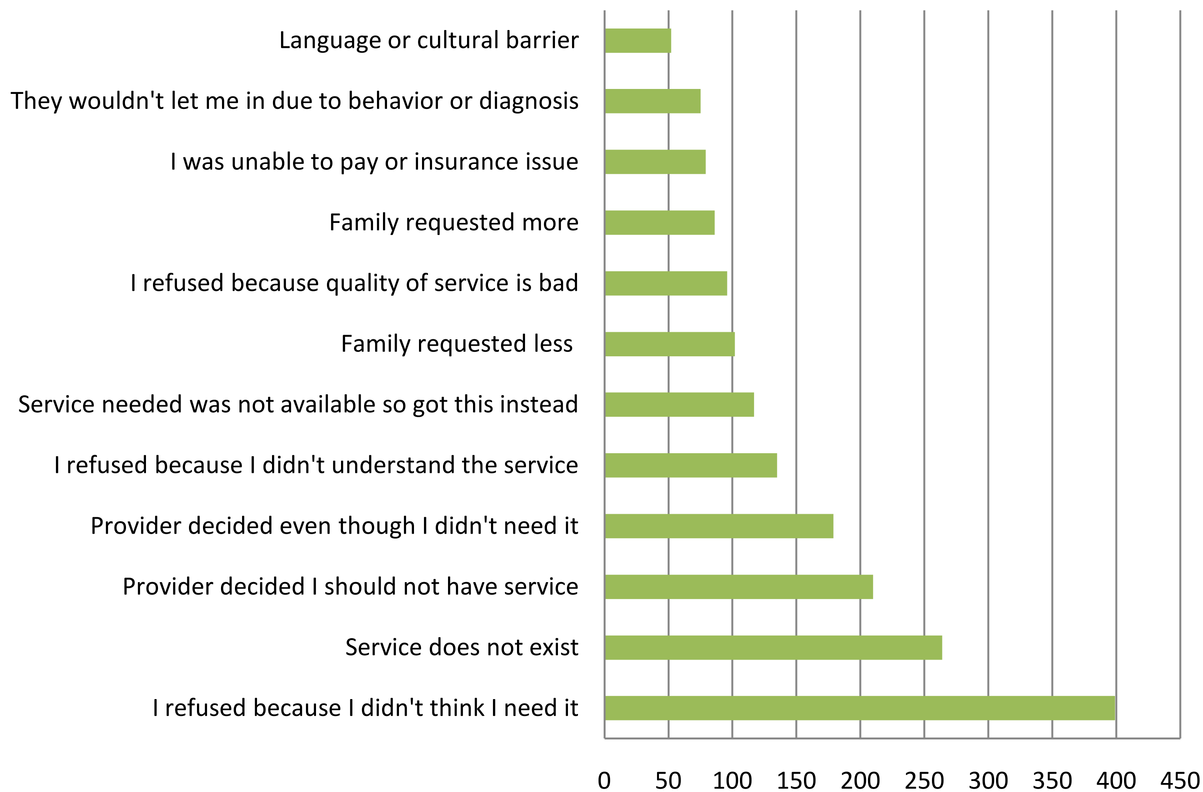


Consumers most frequently identified that they needed more employment-related services. Although 61% (n=131) of consumers felt that they got the right amount of employment-related services, 37% (n=80) felt that they needed more. This result is important to the redesign project because of the high number of unemployed individuals who took the survey, indicating a great need for employment services.

In general, a large proportion of consumers indicated that they needed more community-based, recovery-oriented services including individual therapy, support groups, and peer-operated services. While some individuals indicated that they needed more 24-hour and acute inpatient crisis services, a similar proportion indicated that they needed less of these services.

In addition to inquiring about service needs, the SPES also asked consumers to indicate the reasons why they were receiving too much or too little of a service. Reasons were related to service availability, provider decisions, family requests, insurance and payment issues, language or cultural barriers, or personal choice. These reasons are detailed below in Figure 10.

Figure 10: Reasons Provided for Not Receiving Needed Amounts of Services

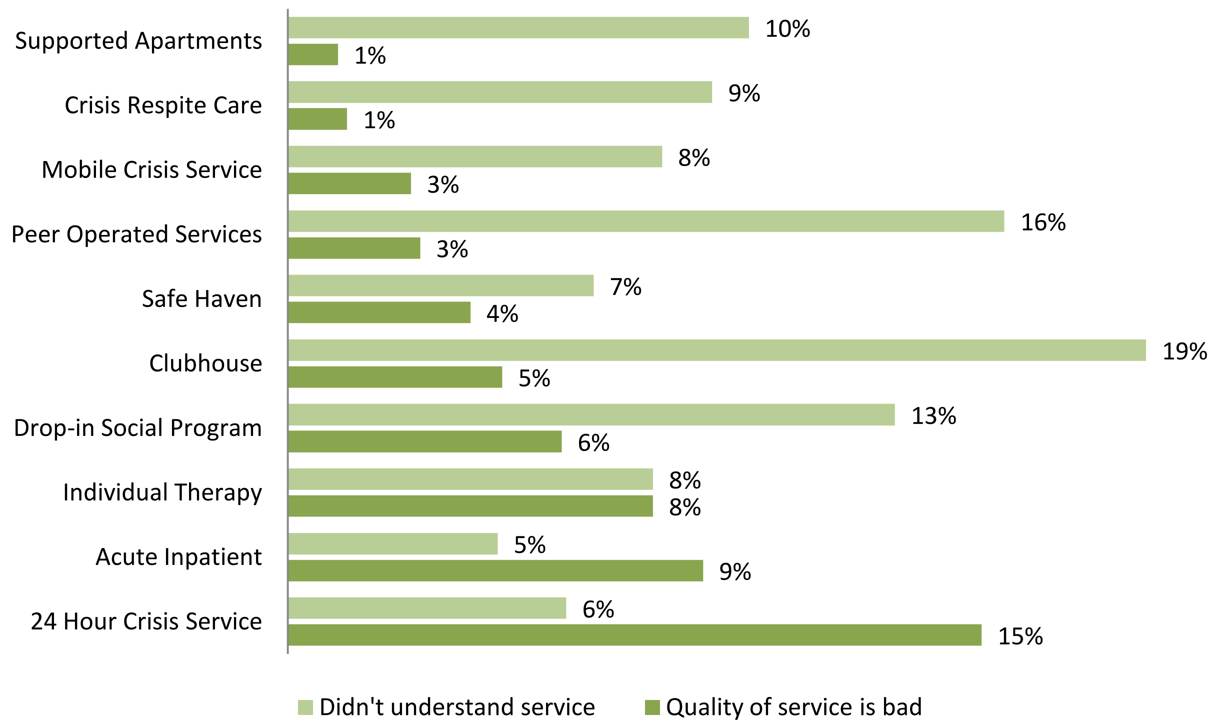


The most common reason for receiving too little of a service was that the person refused because he or she felt that the service was not needed. This reason was given 399 times. A total of 127 individuals (21% of the sample) used this as a reason at least once. This finding is similar to the case management SPES, which ranked consumer refusal as the primary reason that individuals do not receive needed services. It was also common for consumers to indicate that needed services were not available to them. The most common reason for receiving too much of a service was that the provider decided to enroll the person in the service even though the person felt that it was not needed.

Although the majority of respondents refused because they didn't think they needed the service, a large number of respondents also reported that they refused services because the "quality of the service is bad" and because they "didn't understand what the service was." To further understand these reasons for consumer refusals, the

redesign project team analyzed reasons for refusals broken out by service type. This information is provided below in Figure 11.

Figure 11: Refusal Reasons by Service Type



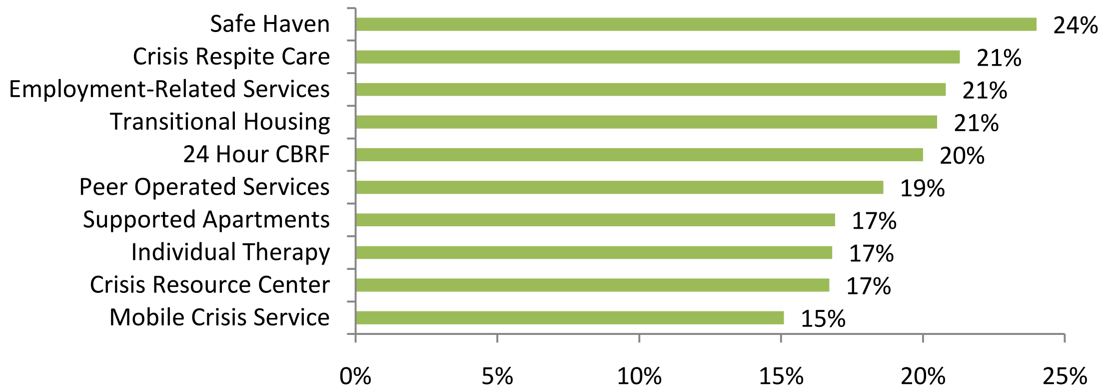
For the above services, people most frequently gave "I refused because I didn't understand what the service is" and "I refused because the quality of the service is bad" as secondary reasons. This could indicate that people perceive that they have no need for services that they also do not understand or perceive to be of poor quality. This means that refusal "because I didn't need it" is more complex than a lack of insight.

The service for which the reason "I refused because I didn't think I needed it" was given most frequently was acute inpatient (40 times, or 23% of the time). However, the most frequent secondary reasons for refusing this service were that the service does not exist and that the person's provider decided they should have it even though he or she didn't need it. Refusals because of poor service quality were most frequently given for 24-hour crisis services (15% of reasons) and acute inpatient (9% of reasons).

The refusal because of lack of understanding was particularly pertinent for more recovery-oriented services that may not be familiar to respondents. These services include peer-operated services (16% of reasons) and clubhouse programs (19% of reasons). These findings suggest a need for more consumer education regarding recovery-oriented services.

Another interesting finding was that many consumers reported that they did not receive an adequate amount of services because the service did not exist. Consumers sometimes reported that services did not exist when in fact they were available in the community. The frequencies with which consumers reported not receiving the needed amount of a service for this reason are presented in Figure 12.

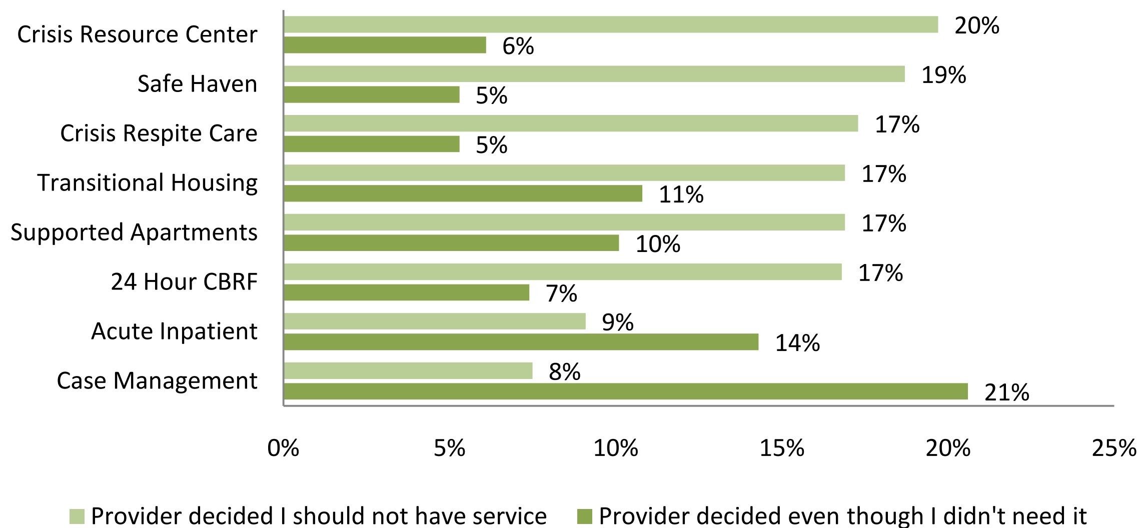
Figure 12: Consumer Reports that Service Does Not Exist



As Figure 12 demonstrates, many consumers believed that important services and supports such as employment-related services, housing support services, and crisis alternatives such as the Crisis Resource Center and crisis respite care were not available to them, although these services are currently available in the community (albeit in limited amounts). These findings further suggest a need for more consumer education, in this case regarding services and supports that are currently available in the community.

Two other reasons for service discrepancies are worth noting. The first is the frequency with which consumers felt that they were receiving too much or too little of a service because of decisions made by their providers. These reasons are illustrated in Figure 13 below.

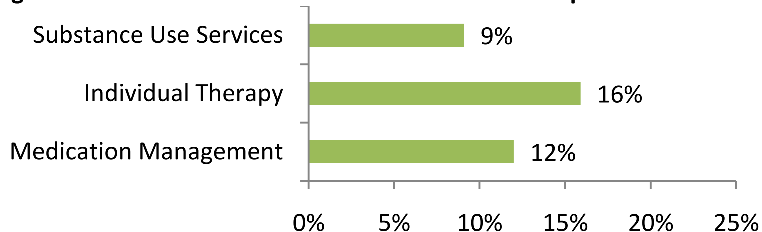
Figure 13: Reasons for Service Discrepancies Related to Provider Decisions



Consumers identified provider decisions as being the reasons for receiving too little of a service 15 to 20% of the time for housing services (transitional housing, supported apartments, and 24-hour CBRF, and Safe Haven) and two crisis services (crisis respite care and the Crisis Resource Center). When consumers felt that they received too much case management, they identified the provider's decision as the reason 21% of the time. Similarly, when consumers received more acute inpatient services than were needed, they felt that this was due to their provider's decisions 14% of the time.

A second common reason for discrepancies between needed and received services was issues with insurance. Amounts are shown below in Figure 14

Figure 14: Insurance-Related Reasons for Service Disparities



In particular, consumers reported insurance as a barrier for three service types: substance use services, individual therapy, and medication management.

6. Physician Survey

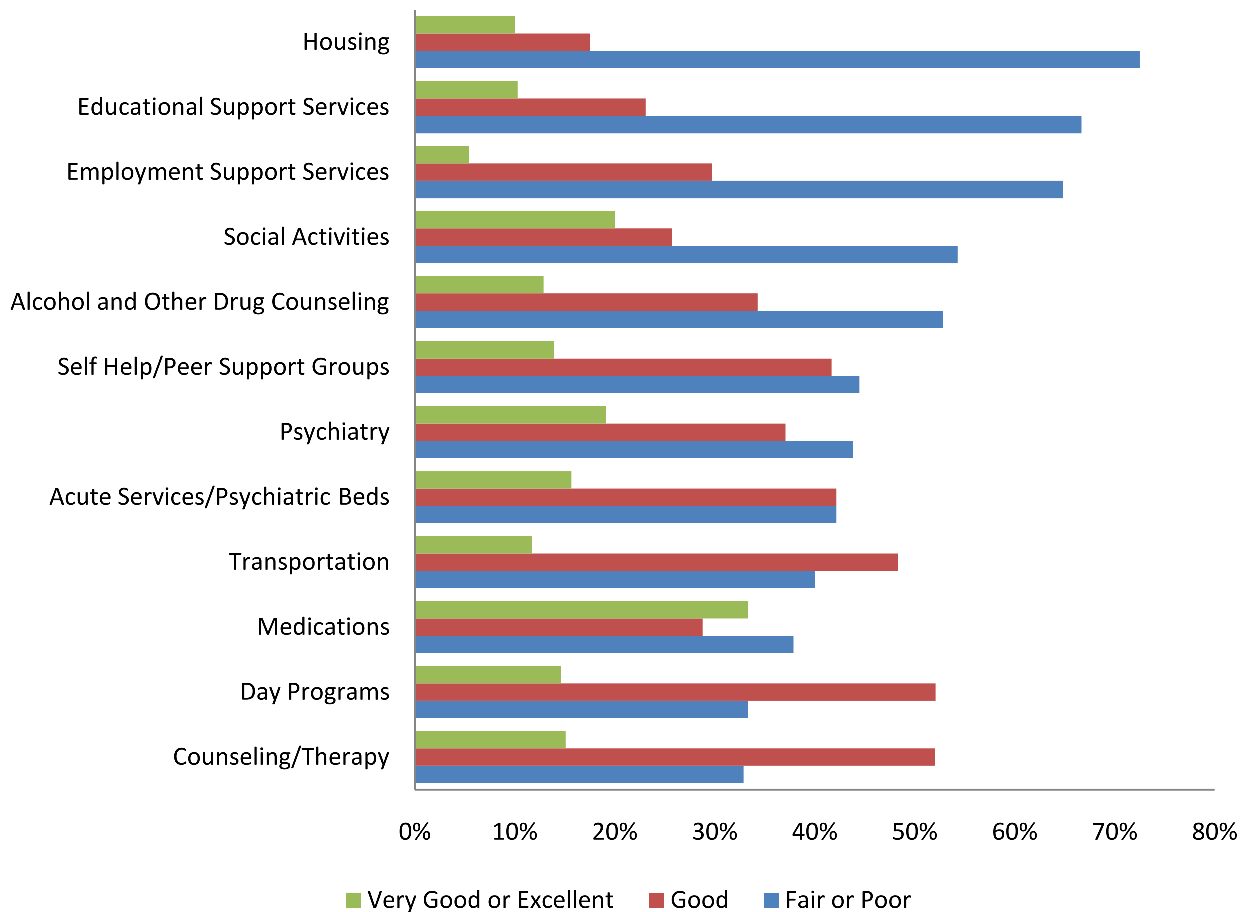
To gain the perspective of medical professionals outside of the Milwaukee County mental health system who nonetheless encounter patients with mental health needs, we conducted surveys with physicians from a list provided by the Medical Society of Milwaukee County.

A total of 157 providers responded to the online survey, 118 of whom indicated they serve individuals with mental health service needs. Providers came from a variety of professional disciplines, including primary care and internal medicine, psychiatry, emergency services, and physical health specialties. The place of practice for the majority of respondents was a health system medical group (68%, n=50), with 28% (n=20), in private practice and 26% (n=19), at the Medical College of Wisconsin. A small proportion worked in other organizations, including the Veteran's Administration, county hospitals, and FQHCs. Survey respondents provided a range of services to individuals with mental health needs, including mental health assessments, referrals to mental health services, medication management, physical health services, emergency or crisis services, and counseling.

Survey respondents were asked to rate the quality of services that are currently available in Milwaukee County. Physicians were also given the option of indicating if they did not know enough about services to rate their quality.

A large proportion of the survey respondents indicated that they did not know about services; over half of all providers who responded to the survey did not know about the quality of educational and employment support services, housing supports, self-help and peer support groups, and social skills training services. This finding suggests a need for more integration of care and more education for providers regarding the services and supports that are available to the individuals they serve. Ratings of service quality from providers who did feel that they knew enough to comment are found below in Figure 15.

Figure 15: Physician-Rated Quality of Services

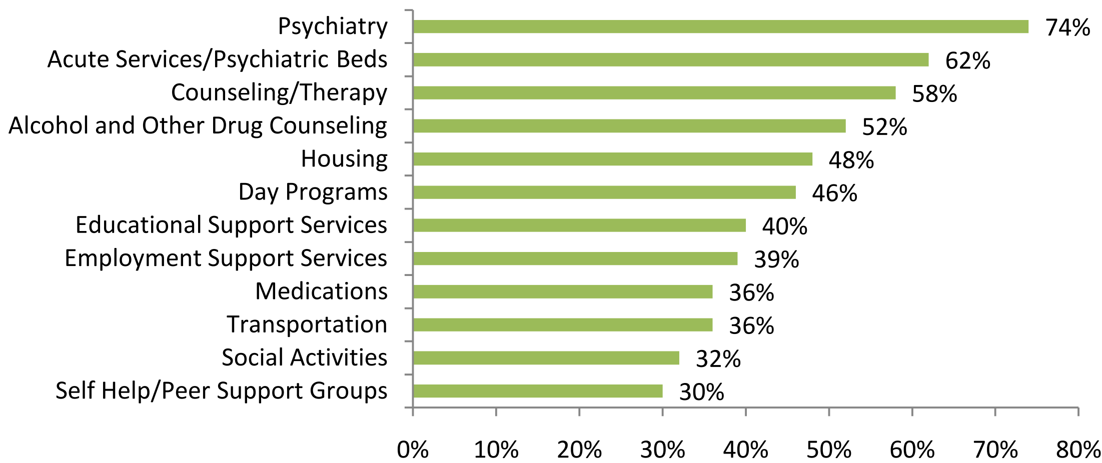


The survey results indicate that providers differed in their opinions of the quality of services for individuals with mental health needs in Milwaukee County. However, providers consistently rated many services fair or poor, and no single service was consistently rated very good or excellent. The services receiving fair or poor ratings most consistently were related to community supports such as housing (73%, n=29), employment (65%, n=24) and education (67%, n=26) support services, and alcohol and other drug counseling services (53%, n=37). Medication management services received the highest number of very good or excellent ratings (33%, n=22), although ratings on this service remained fairly mixed (38% or n=25 rated medications fair or poor, and 29% or n=19 ranked them good).

In addition to rating the quality of services, providers were asked to rate a series of services as either "Difficult to Access" or "Easier to Access" with the additional option of indicating if they did not know or were unsure about the accessibility of a service.

Close to 50% of providers indicated that they did not know or were unsure about the accessibility of many community support services, including self-help/peer support groups, social activities, and employment and educational support services. Survey respondents also identified a large number of services as being difficult to access. These ratings are detailed in Figure 16 below.

Figure 16: Services Rated Difficult to Access



Psychiatry was most frequently rated “Difficult to Access” at 74% (n=71), followed by acute services at 62% (n=59) and counseling and therapy at 58% (n=55). Housing had the fewest “Easier to Access” ratings at 8% (n=8).

When asked whether there were important services and supports that are unavailable to the people they serve, 56% (n=49) of providers answered yes. Providers consistently identified two services categories in particular as lacking: outpatient services such as counseling and psychiatry and community rehabilitative services such as supported employment. Many survey respondents also noted that uninsured patients face a significant barrier to receiving services and often go without much-needed supports such as mental health counseling and drug and alcohol services.

7. Private and Public Health System Surveys

To gain the perspective of administrators and others in leadership positions in the private and public health systems, redesign project staff conducted a survey of administrators.

Private Health System Survey

A total of 11 individuals responded to the survey of private health system administrators. Six respondents represented private hospitals, one respondent represented a teaching hospital, and four represented FQHCs. Five of the respondents were Behavioral Health Administrators, two were Chief Executive Officers, one was a Chief Operating Officer, and two were providers.

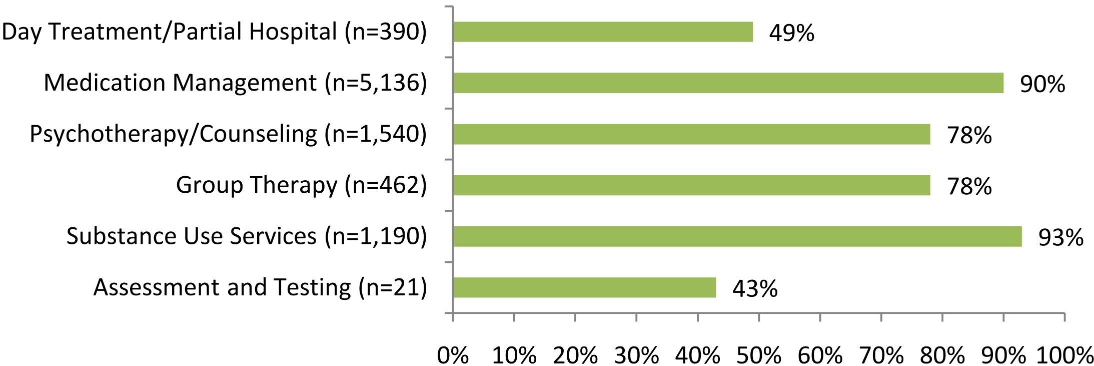
Private Health System Capacity

Four of the responding systems provide inpatient psychiatric care: Rogers Memorial Hospital, Columbia-St. Mary’s, Aurora Health Care, and Wheaton Franciscan Health Care. Between these four systems there are a total of 376 licensed acute psychiatric beds and 255 staffed beds. Three of the four private health systems indicated that their beds were filled to capacity 75-99% of the time in the past 12 months. One system indicated that its beds were filled to capacity 50-74% of the time.

Respondents expressed mixed opinions as to whether their inpatient capacity was sufficient to meet the needs of the people they serve. Half of respondents felt that they had enough inpatient beds, while the other half felt that they had enough inpatient beds most of the time, but not all of the time. Four respondents felt that private health systems in Milwaukee County need to increase acute inpatient psychiatric beds; another three respondents felt that there are enough beds in Milwaukee County, but they need to be used more efficiently. No systems reported plans to increase their number of beds in the next 12 months.

Respondents from six health care systems reported that they provide outpatient psychiatric programs and services: Columbia-St. Mary's, Aurora Health Care, Wheaton Franciscan Health Care, Medical College of Wisconsin, Milwaukee Health Services, and Health Care for the Homeless of Milwaukee. Figure 17 shows the number of slots by service along with the average percentage of the time across systems that these programs were filled to capacity. The service with the most capacity was medication management (5,136 slots), representing over half of all available slots for any service. A very small number of slots (21 in total) for assessment and testing were available across the six responding health care systems. The frequency with which services were filled to capacity varied a great deal by service type.

Figure 17: Percentage of Time Outpatient Services are Filled to Capacity



Only one respondent reported that the number of outpatient slots were adequate in his or her facility. The majority of respondents (four in total) indicated that they have enough capacity most of the time, but not all of the time. Another two respondents reported that they do not have enough capacity in their outpatient programs. Six systems plan to grow outpatient capacity in the next 12 months. These responses include two systems that do not currently provide outpatient psychiatric services and four systems that do currently provide outpatient psychiatric services. Six of eight respondents felt that private health systems in Milwaukee County needed to expand outpatient capacity. The other two respondents felt that Milwaukee County has sufficient outpatient capacity but needs to use it more efficiently.

Survey respondents were asked to comment on the number of mental health professionals currently staffing their inpatient and outpatient programs. Eight health systems reported a total of 75 psychiatrists employed, contracted, or available as voluntary, independent medical staff members. Eight systems report that they plan to recruit more psychiatrists in the next 12 months, and one system reported that they do not. Nine health systems reported a total of 175 therapy professionals (including psychologists, social workers, and other therapy

professionals) employed or contracted in their system. Five systems reported that they plan to recruit additional therapy professionals in the next twelve months, and four reported that they do not.

Reasons for Turning Individuals Away

Respondents from the private health systems indicated that their system has to turn consumers away from inpatient care about half of the time. Five out of five responding systems reported that they had to turn people away from their outpatient psychiatric programs about half of the time. Respondents were asked to report the three most frequent reasons for having to turn consumers away from acute inpatient and outpatient psychiatric services. The results are in Figure 18 and Figure 19. The number to the right of the bar represents the number of respondents who chose that answer as one of the top three reasons.

Figure 18: Reasons for Turning Individuals Away from Inpatient Services

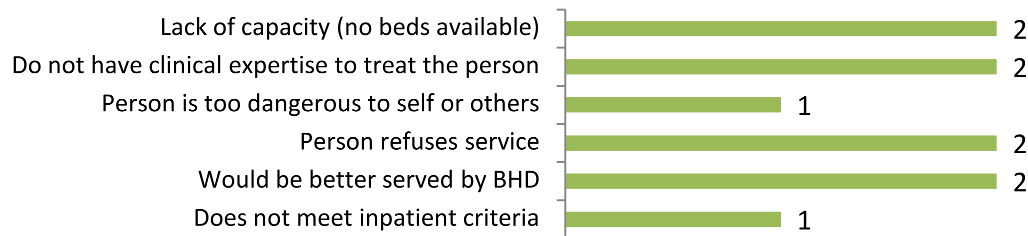
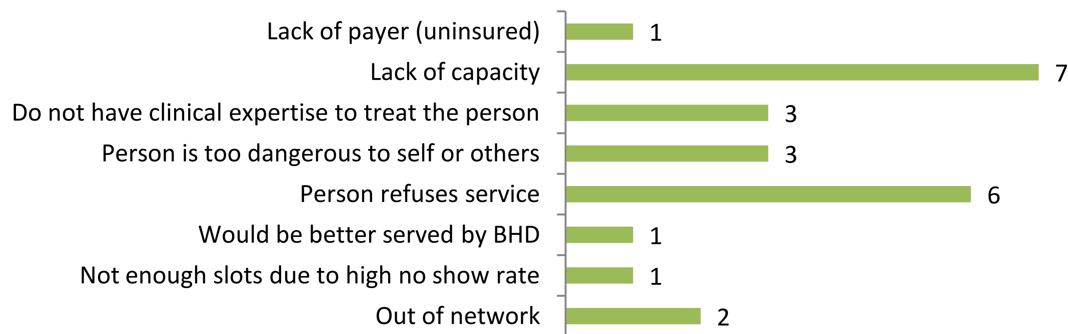


Figure 19: Reasons for Turning Individuals Away From Outpatient Services



According to survey respondents, it is relatively common (two respondents indicated a top-three reason) for private inpatient providers to turn individuals away because they would be better served by the BHD. Other common reasons include a lack of clinical expertise or capacity and refusals. Consumer refusals were also a common reason for turning individuals away from outpatient services, as shown in Figure 19. The issue of consumer refusals has emerged in multiple surveys and will be discussed in greater detail later in the report. A lack of capacity was also a very common reason for turning individuals away from outpatient services (given as a top-three reason seven times).

Public Health System Survey

A total of four administrator/directors responded to the public health system surveys. They represented crisis services, day treatment, outpatient services including case management, and inpatient services.

Administrators were asked to indicate the capacity for each BHD-operated service and to comment regarding the capacity of those services. The results are presented below in Table 10.

Table 10: BHD Service Capacity

Service	Capacity (units)	Usage Rate	Enough Capacity?
Crisis Respite	16 (beds)	87%	most of the time, but not all of the time
Crisis Resource Center	7 (slots)	65%	no
Observation Unit	18 (beds)	75%	yes
Crisis Walk-in Center	25 (units per day)	80%	yes
Crisis Mobile Service	10-15 (served per day)	30%	yes
Day Treatment	144 (billable hours)	100%	most of the time, but not all of the time
Individual Therapy	912 (slots)	100%	no
Group therapy	113 (slots)	100%	no
Medication Management	4, 079 (slots)	100%	no
CSP	1,264 (slots)	100%	no
TCM	1,117 (slots)	100%	no
BHD Inpatient	96 (beds)	86.5%	yes

In general, the survey respondents felt that capacity was sufficient for inpatient and crisis services, with the exceptions being crisis respite and the Crisis Resource Center. Respondents felt that there was insufficient capacity for all outpatient services, the exception being day treatment, which was said to have enough capacity most of the time.

One survey respondent commented that individuals for whom Medicaid benefits are secured are frequently transferred out of BHD-contracted outpatient services at the Medical College of Wisconsin because MCW is not an FQHC and as such loses money when serving Medicaid patients. Similarly, it was noted that one of the most significant problems faced by case managers is helping individuals to access outpatient services when they have Medicaid. The respondent noted that very few outpatient providers are willing to accept individuals with Medicaid because of low reimbursement rates. The most frequent reason given for transferring individuals from the BHD's acute inpatient service is that they have private insurance or Medicaid and can go to a private hospital.

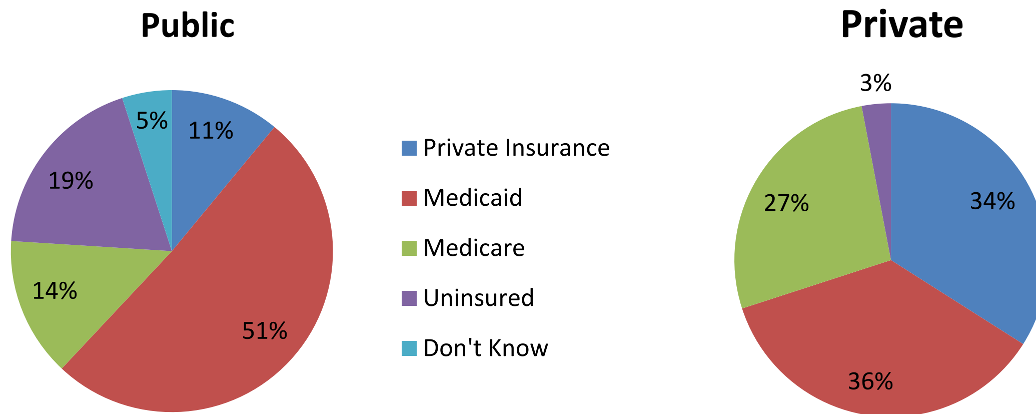
An estimated 65-70% of individuals receiving adult acute inpatient through the BHD are said to present with co-occurring mental health and substance use issues. One respondent indicated a need for more integration of co-occurring care on the inpatient units.

Public and Private Inpatient Payer Mix

Respondents to the public and private surveys were asked to report on the mix of payer types for inpatient services. The results are presented below in

Figure 20.

Figure 20: Public and Private Inpatient Payer Mix



A comparison of the payer mix of the two hospitals shows that the public inpatient system serves a higher proportion of individuals who are uninsured (19% of total population in the public system versus only 3% in the private system) and have Medicaid (51% in the public system versus 36% in the private system).

8. Behavioral Health Service Utilization Data

The goal of the analysis of service utilization data was to develop an understanding of how individuals enter into the Milwaukee County mental health system (become linked up with mental health services), the services and supports they receive once they are in the system, and the ways in which individuals leave the system (stop receiving mental health services).

Because of the absence of needed data regarding functional levels, it was not feasible for the project team to run simulations regarding service utilization and costs at this time. As Milwaukee County increases its use of service utilization and functional level data, this application will become possible. At the current time, however, the service utilization data can be used to provide an insight into the current state of the mental health system. Additionally, this data can be used as a basis of comparison to other locations for the mix of services. For examples of the service distributions of other states and localities, please refer to Appendix N.

To better understand these system dynamics, the project team examined three subsets of service utilization data covering the two most recent years (2007 – 2008):

Those who received *only* Medicaid (state-funded) services, detailed below in Table 11 below details the state-funded service utilization information for all services. Because information regarding functional level was not available for the data associated with Medicaid (state-funded) services, service utilization data is reported for individuals at all levels.

1. Table 11
2. Those who received *only* BHD (county-funded) services, detailed below in Table 12
3. Those who received *both* state and county-funded services, detailed below in Table 13

Each of these tables reports the number of monthly arrivals, a snapshot of the current month, and a disappearance rate. For the purposes of this data, an arrival is defined as a person entering services after receiving no services in the prior three months. Thus, if a person leaves services for three months and then returns to the same services, that individual is considered an arrival. In all three tables, the arrival figure refers to the average number of new arrivals who enter into the system each month. The snapshot refers to the average number of persons who were continuously served by the system during a single month. Using the snapshot and the arrivals, the project team calculated a projected total of the number of individuals who receive services through the mental health system in a given year. The disappearance rate reflects the percentage of the total number of individuals who leave services in a given month.

Service utilization data is presented by service type as a percentage as well as a number of units. The service types are grouped by five general categories: residential; emergency; hospital/inpatient; outpatient treatment; and community-based services. The service utilization percentage refers to the average percentage of the entire system population who received that particular service in a given month. The average units per month reflect the average amount of each service that was received.

Service utilization by functional level is reported in Table 12 and Table 13; however, there was very little data regarding the functional level of the majority of consumers in the sample. The majority of the individuals have functional level that is unknown (FL UNK). Therefore, the service utilization data that is most relevant to this analysis is reported in the FL UNK column.

State-Funded Mental Health Services

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Table 11 below details the state-funded service utilization information for all services. Because information regarding functional level was not available for the data associated with Medicaid (state-funded) services, service utilization data is reported for individuals at all levels.

Table 11: Service Utilization for Medicaid (State-Funded) Mental Health Services

Arrivals (average number of new persons entering the system each month) = 690			
Snapshot (average number of persons continuously served by the system) = 5,141			
Projected Yearly Total (at current rate of arrivals) = 12,731*			
Disappearance Rate = 15%			
Avg. % Receiving Service in a Month			**Avg. Units in a Month**
All FL	**Service**	**Units**	**All FL**
	Residential		
0.3%	Community-Based Residential (CBRF)	day	22
	Emergency		
4%	Observation/Unit/ER	hour	4
1%	Crisis	hour	9
	Hospital		
3%	Acute Inpatient	day	8
1%	Hospital Discharge	Hour	1
	Outpatient Treatment		
10%	Evaluation/Assessment	hour	1
19%	Medication Management	visit	1
26%	Individual Therapy	hour	2
1%	Group Therapy	hour	3
2%	Substance Abuse Counseling	hour	3
2%	Day Treatment	hour	26
3%	Drug/Alcohol Test	hour	12
0.3%	Family Psychotherapy	hour	2
3%	Methadone Maintenance	hour	13
	Community-Based Services		
0.3%	Social/Recreational Skills	hour	12
22%	Case Management	hour	17
0%	Peer Operated Services	hour	0
1%	Personal Care	hour	234

*Projected Yearly Total for 12 months is calculated by multiplying the total number of arrivals that month by 11 and adding the average number of individuals being served that month (snapshot)

As shown in Table 11 below details the state-funded service utilization information for all services. Because information regarding functional level was not available for the data associated with Medicaid (state-funded) services, service utilization data is reported for individuals at all levels.

Table 11, an average of 690 individuals are new to receiving Medicaid-funded mental health services each month. On average, 5,141 individuals receive mental health services funded by Medicaid in Milwaukee County in a given month. The most common Medicaid-funded services are individual therapy (26% receive services at an average quantity of two hours per month), case management (22% at an average of 17 hours per month), and medication management (19% at an average of one visit per month). Less than 5% of individuals receive any of the other services in an average month, including crisis stabilization services, substance use treatment, group therapy, and residential treatment.

County-Funded Mental Health Services

Table 12 outlines the service types and amounts delivered through the county-funded mental health system. This data is reflective of the services that are utilized by individuals who are not currently receiving state-funded health insurance and who rely entirely on the mental health services that are available at the county level. The project team could calculate functional level for only a small proportion of individuals; therefore, the unknown functional level column contains the largest proportion of the sample (99% of arrivals and 89% of the snapshot population).

Table 12: Service Utilization for BHD (County-Funded) Mental Health Services

Arrivals (average new persons entering system per month)								Projected Yearly Total (at current rate of arrivals) = 9,328*							
FL UNK	FL 1	FL2	FL 3	FL 4	FL 5	FL 6	Total								
712	1	1	2	1	2	0	719								
99%	0%	0%	0%	0%	0%	0%	100%								
Snapshot (average persons continuously served)									**Disappearance**						
FL UNK	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**	**Total**		**FL UNK**	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**
1256	2	22	35	41	39	24	1419		38%	53%	54%	51%	54%	52%	65%
89%	0%	2%	2%	3%	3%	2%	100%								
Percent that Received Service (% per month)									**Number of Units (average per month)**						
FL UNK	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**	**Service**	**Units**	**FL UNK**	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**
							Residential								
0%	0%	0%	0%	0%	0%	0%	CBRF	day	0	0	0	0	0	0	0
							Emergency								
29%	6%	20%	14%	11%	15%	13%	Observation/Unit/ER	hour	1	2	2	1	2	2	2
52%	42%	41%	28%	40%	33%	30%	Crisis	hour	2	5	3	3	6	4	4
							Hospital								
11%	13%	21%	11%	13%	8%	9%	Acute Inpatient	day	8	10	9	9	8	8	8
6%	13%	15%	11%	8%	5%	4%	Hospital Discharge	hour	1	1	1	1	1	1	1
							Outpatient Treatment								
13%	6%	15%	8%	8%	10%	6%	Evaluation/Assessment	hour	1	2	1	1	1	1	1
24%	16%	13%	13%	6%	15%	11%	Medication Management	cases	1	5	3	2	1	2	1
15%	23%	15%	5%	5%	8%	7%	Individual Therapy	hour	2	5	5	5	4	4	2
1%	0%	2%	1%	5%	7%	4%	Group Therapy	hour	12	0	11	9	14	12	11
0%	0%	0%	0%	0%	0%	0%	Substance Use Counseling	hour	0	0	0	0	0	0	0
0%	0%	0%	0%	0%	0%	0%	Day Treatment	hour	0	0	0	0	0	0	0
0%	0%	0%	0%	0%	0%	0%	Drug/Alcohol Test	hour	0	0	0	0	0	0	0
0.1%	0%	0%	0%	0%	0%	0%	Family Psychotherapy	hour	1	0	0	0	0	0	0
0%	0%	0%	0%	0%	0%	0%	Methadone Maintenance	hour	0	0	0	0	0	0	0
							Community-Based Services								
0%	0%	0%	0%	0%	0%	0%	Social Skills	hour	0	0	0	0	0	0	0
9%	0%	7%	16%	1%	6%	3%	Case Management	hour	4	0	23	10	2	10	3
0%	0%	0%	0%	0%	0%	0%	Peer Operated Services	hour	0	0	0	0	0	0	0
0%	0%	0%	0%	0%	0%	0%	Personal Care	hour	0	0	0	0	0	0	0
0%	0%	0%	0%	0%	0%	0%	Psych Rehabilitation	hour	0	0	0	0	0	0	0

*Projected Yearly Total for 12 months is calculated by multiplying the total number of arrivals that month by 11 and adding the average number of individuals being served that month (snapshot)

According to the data in Table 12, an average of 719 individuals are new to services each month, and in an average month, 1,410 individuals receive county-funded mental health services. The disappearance rate for those with an unknown FL is 38%. The disappearance rate for individuals at a functional level 2 is 54%, meaning that of the 22 individuals who were assessed as unable to function in the community, over half left the system and are no longer receiving services.

For those with an unknown functional level receiving county-funded services, the majority of the services received are emergency support services (29% observation unit or emergency room services at an average of one hour per month; 52% other crisis services at an average of two hours per month). It is interesting to note that across all functional levels, between 42% and 61% of all county services fell into the emergency services category. This is true even for those at a functional level 4, 5, and 6. Individuals at these levels of functioning generally do not rely on emergency services at this frequency (see Appendix N for examples from other localities). While anyone may experience a crisis at any functional level, alternatives to traditional crisis services would probably be more suitable for these individuals.

Similarly, a significant proportion of individuals at higher functional levels receive acute inpatient an average of eight days per month (13% of those at FL 4, 8% of individuals at FL5, and 9% at FL 6). These sample sizes are somewhat small, so these results may not necessarily reflect an ongoing trend. However, the data suggests that a high proportion of individuals at all functional levels are receiving large amounts of costly inpatient care. Approximately 11% of the 1,256 individuals at unknown functional levels receive an average of eight hours of inpatient per month.

The outpatient treatment services that are currently being utilized in Milwaukee County are limited to three categories: evaluation/assessment (13% of those with an unknown functional level receive an average of one hour per month), medication management (24% of those with an unknown functional level receive one case per month), and individual therapy (15% of those with an unknown functional level receive an average of two hours per month). Individuals at all functional levels receive no community-based services, with the exception of case management (9% of those at unknown functional levels receive an average of four hours per month).

Combined State and County-Funded Mental Health Services

Table 13 outlines the service utilization data for individuals who received services funded by both the State and the County. As with the data in Table 12, the majority of the sample is represented by individuals at an unknown functional level (95% of the snapshot population and 97% of new arrivals).

Table 13: Service Utilization for BHD and Medicaid (State and County Funded) Services

Arrivals (average new persons entering system per month)								Projected Yearly Total (at current rate of arrivals) = 3,479*							
FL UNK	FL 1	FL2	FL 3	FL 4	FL 5	FL 6	Total								
172	0	1	2	2	1	0	178								
97%	0%	1%	1%	1%	1%	0%	100%								
Snapshot (average persons continuously served)									**Disappearance**						
FL UNK	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**	**Total**		**FL UNK**	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**
1442	1	10	17	20	19	12	1521		12%	29%	29%	23%	19%	26%	31%
95%	0%	1%	1%	1%	1%	1%	100%								
Percent that Received Service (% per month)									**Number of Units (average per month)**						
FL UNK	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**	**Service**	**Units**	**FL UNK**	**FL1**	**FL2**	**FL 3**	**FL 4**	**FL 5**	**FL 6**
							Residential								
0.1%	0%	0%	0%	0%	0%	0%	CBRF	day	25	0	0	0	0	0	0
							Emergency								
16%	5%	11%	9%	6%	11%	8%	Observation/Unit/ER	hour	4	1	2	2	2	3	3
21%	11%	20%	16%	20%	23%	19%	Crisis	hour	2	3	5	5	11	7	7
							Hospital								
11%	3%	12%	9%	7%	7%	5%	Acute Inpatient	day	10	8	14	12	13	11	9
6%	2%	6%	6%	3%	4%	4%	Hospital Discharge	hour	1	1	2	1	1	1	1
							Outpatient Treatment								
14%	3%	10%	7%	7%	8%	7%	Evaluation/Assessment	hour	2	2	3	3	1	1	1
17%	11%	7%	11%	7%	12%	15%	Medication Management	cases	2	4	3	2	1	1	1
21%	9%	11%	8%	10%	19%	19%	Individual Therapy	hour	2	4	4	3	2	3	2
2%	0%	1%	0.2%	2%	6%	3%	Group Therapy	hour	9	0	11	5	14	10	8
2%	0%	0%	0.2%	0%	0%	1%	Substance Use Counseling	hour	4	0	0	2	0	0	1
2%	0%	2%	2%	1%	3%	1%	Day Treatment	hour	25	0	55	32	44	17	21
2%	0%	0%	0%	0%	0%	1%	Drug/Alcohol Test	hour	12	0	0	0	0	0	12
0.1	0%	0%	0%	0%	0.1%	0.1%	Family Psychotherapy	hour	1	0	0	0	0	2	1
2%	0%	0%	0%	0%	0%	1%	Methadone Maintenance	hour	16	0	0	0	0	0	22
							Community-Based Services								
0%	0%	0%	0%	0%	0%	0%	Social Skills	hour	0	0	0	0	0	0	0
21%	2%	13%	20%	42%	58%	66%	Case Management	hour	22	31	32	23	19	21	16
0%	0%	0%	0%	0%	0%	0%	Peer Operated Services	hour	0	0	0	0	0	0	0
1%	0%	0%	1%	2%	0%	0%	Personal Care	hour	198	0	0	22	56	0	0
25%	84%	75%	69%	42%	22%	15%	Psych Rehabilitation	hour	53	61	64	61	63	70	42

*Projected Yearly Total for 12 months is calculated by multiplying the total number of arrivals that month by 11 and adding the average number of individuals being served that month (snapshot)

A total of 1,521 individuals receive both state and county-funded mental health services in a given month. On average, 178 individuals are new to the system each month. The system disappearance rate is 12% for individuals at unknown functional levels.

Although the percentages of individuals who received emergency and hospital services were smaller in this sample, these services still made up a significant proportion of total services utilized. Each month, up to 37% of individuals at an unknown functional level received emergency services (16% received an average of four hours of observation unit or emergency rooms services; 21% received an average of two hours of other crisis services). These numbers were similar for individuals at higher functional levels (up to 26% at FL 4, 34% at FL 5, and 27% at FL 6 used emergency services), although caution should be exercised in interpreting these results because the sample sizes are small (n=20, 19, and 12 for FLs 4, 5, and 6 respectively).

The majority of delivered outpatient services are evaluation/assessment (14% of those at an unknown functional level receive an average of two hours per month), medication management (17% of individuals at an unknown functional level receive an average of two cases per month), and individual therapy (21% of individuals at an unknown functional level receive an average of two hours per month). Group therapy, substance abuse counseling, day treatment, drug and alcohol testing, family psychotherapy, and methadone maintenance services were all provided to a relatively small proportion of individuals in the sample (3% or less per month for all functional levels).

A larger proportion of individuals in the combined state and county-funded service group received community-based services, particularly case management (21% of individuals at unknown functional levels received an average of 22 hours per month) and psychiatric rehabilitation services (25% of individuals at an unknown functional level received an average of 53 hours per month). Individuals in this group received no social/recreational skills training or peer-operated services funded by state or county dollars.

Number of Unique Services Used

In addition to examining utilization data by service, the project team also examined the number of unique services that individuals receiving mental health services tend to use. This analysis was intended to explore whether individuals were more likely to receive a package of services (for example, medication management and individual therapy) or just a single service.

The analysis found that almost three-quarters (73%, n=5,382) of the individuals served by the BHD receive two unique services, and 56% (n=4,128) receive three services or less. Approximately 24% (n=1,769) of the individuals served by BHD receive only one unique service. For 88% (n=1,557) of those individuals, the single service received is a crisis-related service.

For the population receiving Medicaid-funded mental health services, 82% (n=11,920) used two services and in the Medicaid-only population, 57% (n=8,286) utilized only one unique service, which was typically medication management, individual psychotherapy, or evaluation/assessment.

9. Physical Health Service Utilization Data

In recognition of the fact that individuals with mental health service needs often experience co-morbid medical problems, the project team analyzed physical health service utilization data for the populations receiving state-funded (n=14,537) mental health services.

This analysis found that 20% (n=2,907) of individuals receiving Medicaid-funded mental health services had inpatient admissions for physical health issues. These individuals had on average had 2.5 admissions per year. A subset of 4% (n=116) of these individuals had more than ten inpatient stays for physical health issues. The average length of stay in inpatient physical health services for this subset was 5.8 days.

In addition to using inpatient physical health services, our analysis found that the mental health service user population also relied on emergency rooms for physical health issues. Over half of the individuals in the sample (51%, n=7,414) visited emergency departments for physical health issues in the past year. On average, individuals had five visits to emergency departments per year. Approximately 17% of emergency room users (n=1,260) had more than eight visits to emergency departments in a year, and 3% (n=222) had over 30 visits to the emergency departments per year.

10. Inpatient Bed Capacity and Utilization[6]

HSRI also examined the number of inpatient beds available in Milwaukee County and compared it to other systems. Milwaukee County directly operates 96 beds of adult psychiatric inpatient (or inpatient-like) care in four acute care units. It also operates two 70-bed long-term care rehabilitation facilities and 18 facility-based observation beds (which are reported to serve primarily people under EDs). Milwaukee County has an additional 376 adult inpatient acute psychiatric beds that admit involuntary patients in a combination of private psychiatric hospitals and general hospitals.

Estimates of the appropriate number of adult psychiatric beds in a mature well-managed mental health system should be in the range of 18 to 22 beds per 100,000 adults. Thus, the range of beds theoretically needed for a system the size of Milwaukee County would be between 126 and 154. With 472 public and private acute care beds, 140 extended care rehab beds, and 18 observation beds, Milwaukee County far exceeds the number of beds deemed necessary for inpatient psychiatric care for adults. For example, Franklin County (Columbus) uses about one half the numbers of involuntary beds as Milwaukee County. Franklin County has a larger population than Milwaukee (1.13 million and .95 million, respectively). Franklin County has a fully developed community support and community-based crisis system, which if emulated in Milwaukee County could result in reduced inpatient bed utilization similar to that achieved in Franklin County.

Milwaukee County spends about 56% of its budget on inpatient and long-term care, including crisis services. The cost of a day in the acute inpatient unit is $1,031. The national average for spending of this sort is 36%; the average for the state of Wisconsin is 34%.

In the comparisons above it is important to keep in mind that no single county is alike, and a wide range of factors can influence the need for psychiatric inpatient beds. Further, in the project team's experience, there are virtually no other counties in the United States that have county-operated acute, rehabilitation (extended care),

[6] Comparison data is from unpublished data and reports collected by the Technical Assistance Collaborative

and long term care for both adults and youth. The comparison data that was used in this analysis was the best that the project team was able to find under the circumstances, but it is acknowledged that Milwaukee County's own unique characteristics make such comparisons difficult.

11. Use of Emergency Detentions[7]

Finally, HSRI examined the use of EDs in Milwaukee County and compared it to other systems. Milwaukee County admits around 2,750 adults per year to the county-operated inpatient unit. This number does not include admits to the observation beds, diversions from the crisis center or observations to other hospitals, or direct admits of people from hospital emergency rooms to general or private psychiatric hospital inpatient facilities. About 80% of these are reported to be already on ED status when presented for admission and admitted (or held). According to data obtained from the Milwaukee County Corporation Counsel's office, EDs have more than doubled since 2000.

In Pennsylvania, the state average adult admission rate is 3.1 per 1,000 individuals. This ratio applied to Milwaukee County's 700,000 adult population would produce about 2,170 admits per year (about 27% fewer than Milwaukee County's current experience). In Maryland, 21% of all emergency room psychiatric admissions resulted from emergency petitions, and about 41% of psychiatric admissions resulted from emergency petitions. This is about half the rate of ED admissions experienced in Milwaukee County. In a sub-state region (county) in Pennsylvania it was found that 30% of psychiatric admissions were the result of emergency petitions. This was considered high and the community has taken steps to intervene before an emergency petition is filed.

It is important to note that there are differences between the ED commitment standard in Wisconsin versus that of other states. There are further differences between Milwaukee County and other counties in Wisconsin because of the 48-hour versus 72-hour duration of the ED. It is not known how much those differences might account for the higher ED rate in Milwaukee County.

12. Functional Level Transition Rates

There are many approaches to modeling systems planning and evaluation, including different versions of Markov Transition Probability Analysis or MTPA (Catalano, McConnell, Forster, McFarland, & Thornton, 2003; Levin & Roberts, 1976; Pettiti, 2000; Willan & Briggs 2006). MTPA applied to health is based on the idea that at any point in some time period (e.g., day, month, or year) a person occupies one of some number of outcome states defined by a condition of interest. A second MTPA idea is that from one time period to the next the person may transition from the state that he or she is in to some other state. MTPA states can be ones from which persons can transition, or they can be ones from which persons cannot exit (absorbing states). Disappearance or no longer receiving services in a given time period is an example of an absorbing state.

Cohort models describe outcomes for proportions of persons in groups in contrast to individual (Monte Carlo) models (Briggs & Sculpher, 1998).

Health services scientists have shown that MTPA outcome states can be used in needs assessment (Hargreaves, 1986), cost-effective analysis (Bala & Mauskopf, 2006; Brennan, Chick, & Davies, 2006; Briggs and Sculpher, 1998; Sonnenberg & Beck, 1993), performance measurement (Miley, Lively, & McDonald, 1978), estimating

[7] Comparison data is from unpublished data and reports collected by the Technical Assistance Collaborative

incidence, prevalence and course (Bala & Mauskopf, 2006; Patten & Lee, 2004; Patten, 2005), and for system services planning (including both types and amounts) and resource allocation (Bala & Mauskopf, 2006; James, Sugar, Desai, & Rosenheck, 2006; Leff & Hughes, in press).

There are at least three important advantages MTPA has over single number (e.g., means) measures of outcome.

- First, single number outcomes, like means, promote the misconception that if a treatment or service is effective on average, every person receiving the treatment or service is characterized by the mean. In fact, even for interventions effective on average, some people improve, while others remain the same, and still others actually become worse. MTPA captures this more detailed view of outcomes, useful for treatment and program planning (James, Sugar, Desai, & Rosenheck, 2006; Kent & Hayward, 2009). Given information on who did not respond to interventions or responded negatively, researchers can investigate the reasons for this and what treatments and programs might be effective for these subgroups.
- A second advantage of MTPA is that any type of weighting can be associated with health states, including costs, revenues, utilities (e.g., QALYS), performance weightings (Miley, Lively, & McDonald, 1978), and preferences (Lenert et al., 2004).
- A third advantage of MTPA is that transition probabilities, if they pass certain statistical tests, can be used to project for any number of time periods outcomes for service plan options. We also can project any service and utility measures associated with these outcomes (Briggs & Sculpher, 1998; James, Sugar, Desai, & Rosenheck, 2006). These projections then can be used in selecting service options. This is the “planning for outcomes” part.

For these reasons, we are recommending that Milwaukee County track functional level in a more consistent manner and at least quarterly.

As part of its dynamic planning model, HSRI calculates functional level transitional rates, which reflect individuals’ fluctuation in functional level over time as they receive services in the mental health system. Although information regarding functional level over time was somewhat scarce in the data available for the system redesign effort, the project team calculated two sets of functional level transition rates, one using the state and county service utilization data, and another using the functional level ratings from the case management SPES.x`

The functional level transition rates from the service utilization data are presented in Table 14. The table presents a grid of the percentages of individuals who transitioned from one functional level to another over a one-month period. The disappearance rate (Dis.) is also presented. The percentages presented in bold type are the likelihood that an individual at that functional level will remain at the same level from one month to the next. For example, an individual at a FL 4 has a 75% likelihood of remaining at a FL 4 having remained in the system for one month. There is a 2% likelihood that the individual will transition to a FL 3 (needing more services and supports), and a 2% likelihood that he or she will transition to a FL 5 (needing fewer services and supports). There is also a 19% chance the individual will disappear from the system (cease receiving mental health services in Milwaukee County).

Table 14: Functional Level Transition Rates from Utilization Data

	Dis.	FL1	FL2	FL3	FL4	FL5	FL6	FL7	Total
FL1	29%	**65%**	2%	2%	2%	0%	0%	0%	100%
FL2	28%	.5%	**65%**	2%	2%	2%	.5%	0%	100%
FL3	23%	0%	2%	**72%**	1%	1%	1%	0%	100%
FL4	19%	0%	1%	2%	**75%**	2%	1%	0%	100%
FL5	26%	0%	.7%	1%	1%	**68%**	3%	.3%	100%
FL6	31%	0%	.1%	0%	.4%	2%	**66%**	.3%	100%

These data show that individuals are most likely to remain at their current functional levels rather than transition to a higher or lower functional level within a month. These data also show that consumers at lower functional levels are "disappearing" from the system at slightly higher rates (29% of consumers at FL 1 are likely to disappear; 28% of consumers at FL 2 are likely to disappear) than those at FLs 3, 4, and 5.

Table 15 presents the functional level transition rates from the data obtained through the case management SPES. As with the data presented in the table above, these percentages reflect the likelihood that an individual at a given functional level (rows) will transition to another functional level (columns). This data is presented for a subset of case management clients only. Transition rates were only computed on persons active in case management; therefore, there were no disappearance rates by functional level. The overall disappearance rate for the one-month sample period was 4%, which is very low compared to the examples provided below.

Table 15: Functional Level Transition Rates from Case Management Survey

	FL1	FL2	FL3	FL4	FL5	FL6	FL7	Total
FL1	**50%**	27%	12%	8%	0%	4%	0%	100%
FL2	6%	**70%**	10%	12%	1%	0%	0%	100%
FL3	1%	3%	**85%**	10%	1%	0%	0%	100%
FL4	1%	1%	3%	**92%**	4%	0%	0%	100%
FL5	0%	0%	0%	3%	**94%**	3%	0%	100%
FL6	0%	0%	0%	0%	3%	**96%**	0%	100%
FL7	0%	0%	0%	0%	0%	0%	**100%**	100%

Compared with the larger population represented in the service utilization data, the individuals in case management are more likely to remain at the same functional level from month to month, according to case managers.

The functional level transition rate data from both sources show that consumers are more likely to stay at their current level of functioning than to change. There is a very small probability that persons will progress to a higher level, but there is also a small probability that consumers will move to a lower functional level. This characterizes Milwaukee County as what might be called a "maintenance system." However, it is difficult to make any confident inferences from this data given the limitations of the data on functional levels.

Tables found in Appendix O provide functional level transition rates from other states that have participated in HSRI's systems planning process that serve as a comparison to current Milwaukee County rates, and that also could be used for comparisons in the future if the County elects to collect this data in a way that will allow for

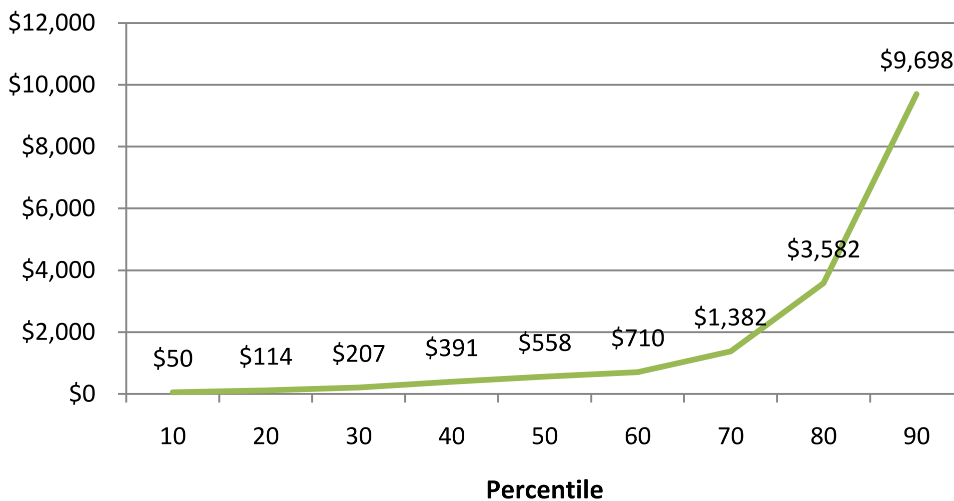
reporting on everyone in the system. In brief, one comparison state (State A in Appendix O) shows high disappearance levels and more positive forward steps, but also backwards steps at higher functional levels. Another comparison state (State B in Appendix O) has more forward movement and much lower disappearance rate than Milwaukee County (see case management service percentage as a reason for low disappearance). A third comparison state (State C in Appendix O) has lower disappearance rates and small amount of movement forward and backward.

In order to understand the functional level rates, it is also important to refer to the service packages that are being provided. These are available in Appendix M as indicated above. This can serve as a guide for analyzing service percentage rates and associated outcomes in systems using specific service packages.

13. System Costs and Resources

As part of the project, HSRI examined state and county service costs through available administrative data sources. The system serves 16,662 individuals and spends $76,625,643 on services (not including the costs on county inpatient services). The mean cost of services per person is $4,600 with a median cost per person of $558. Figure 21 below presents the state and county expenditures for individuals by population percentile.

Figure 21: Expenditures by Population Percentile



The above figure shows that small amounts of dollars are spent on a large number of individuals and that large amounts of dollars are spent on a relatively small number. For example, $558 or less is spent on 50% of the individuals served by the system. Only 20% of the individuals served by the system had costs over $3,582, and 10% had costs of over $9,698. This shape of the distribution is typical of other systems that were reviewed with larger numbers using small amounts of service as noted above.

Per Capita Resources

The project team compared the per capita funding of Milwaukee County to that of Wisconsin and the national average. The current Milwaukee County per capita funding is $181.89. The national average per capita for 2006 (which is the latest data available) was $112.30. In 2006, the Wisconsin per capita funding was $107.81, which is

close to the national average. Only five states (Alaska, Maine, New York, Pennsylvania, and Vermont) and the District of Columbia had higher per capita mental health spending allocations than Milwaukee County.

Inpatient versus Community Spending

The project team also compared the amounts Milwaukee spends on inpatient and community services. Milwaukee County spends about 44% of its budget on community-based mental health services (including Wraparound Milwaukee, which serves children and youth). Milwaukee County spends about 56% of its overall budget on inpatient acute and long term care, including crisis services which are primarily facility-based (the observation unit) or related to addressing EDs. Nationally, the average proportion of funds spend on inpatient facility-related care was 36% in 2006. The last year in which national average expenditure on inpatient care approached Milwaukee County's 56% figure was in 1995, which was almost 15 years ago. In Wisconsin, the average proportion of funds spent on inpatient care was 37%, which was very close to the national average.

It is important to note that spending figures for the BHD (and all other county departments) are skewed somewhat by the manner in which the County assigns costs for fringe benefits. In the 2010 budget, for example, BHD is budgeted to spend about $31 million on fringe benefits, vs. $44 million on salaries, which is a fringe rate of 70%. This is misleading, however, because it includes an artificial number assigned to the BHD by the central budget office for its hypothetical share of the County's pension fund contribution and retiree health care costs. In other words, the active BHD employee is not receiving a fringe benefits package equal to 70%, but each worker is assigned a significant additional cost related to retirees. This inflates the inpatient percentage to a small degree because the county provides inpatient services, whereas community-based services are provided through multiple entities. However, this fact alone does not change the conclusion that the County's proportion of inpatient expenditures is higher than most other communities.

Identification of Issues and Themes That Emerged From Data

A number of issues and themes emerged from the data described above. These themes are examined in more detail in this section.

1. Consumer Refusals

The first is a theme of consumers refusing services. Multiple data sources showed that consumers in Milwaukee County are refusing services at a much higher rate than we have seen in other parts of the country. In the **case management survey**, the project team found that the most frequent reason for consumers not getting the services that case managers believed they needed was because the consumer refused the service. The **survey of the private health systems** showed that "person refuses service" was one of the most common reasons for not being able to serve individuals in outpatient and inpatient settings. These results were echoed in the **consumer survey**. The most frequent reason, again, that consumers did not receive the ideal amount of services was because the individual refused the service because he or she did not believe it was needed. A more nuanced analysis of the consumer survey data suggests that there is more to the picture than consumers refusing because they do not think they need services, which could be interpreted as a lack of insight. Rather, the secondary reasons given for refusals suggest that individuals in Milwaukee County may be refusing services for a variety of reasons, including a desire for more shared or independent decision-making and a need for more education regarding available services. This line of analysis is supported by results from the **key informant**

interviews and **community meetings**, in which stakeholders expressed concern that stigma and a lack of understanding of available services might lead to consumer refusals.

The data suggests that there are many steps Milwaukee County can take to reduce the instances of consumers refusing services and create a shared partnership for mental health. To reduce refusals the system can focus on improving quality of services, educating consumers and providers, and increasing the availability of services that support recovery in the community, including peer-operated services and employment support services. It also should be noted that the high proportion of refusals also might be attributed, to some extent, to the high proportion of individuals who enter the system involuntarily through an ED. That is another important theme that is discussed later in this section.

2. Opportunities to Increase and Expand Community-Based Services

A second related theme that emerged from the data is need for an expanded network of recovery-oriented, community-based services and outpatient care. Our analysis of the **service utilization data** showed that very few individuals are receiving community-based services other than case management. In this analysis, community-based and outpatient services include social/recreational skills training, peer operated services, personal care, psychiatric rehabilitation, employment-related services, case management, individual therapy, medication management and psychiatry, group therapy, day treatment, evaluation and assessment, and substance use services. The **case management survey** also demonstrated that this group felt that the individuals they served were receiving a less-than-ideal amount of a number of community-based services including employment-related services, substance use counseling, assistance with ADLs, drop-in and social club services, and peer-operated services. In the **consumer survey**, respondents indicated that they needed more of several community-based services, including individual therapy and medication management. Similarly, stakeholders who participated in the **physician survey**, **community meetings** and **key informant interviews** repeatedly identified access to community-based services as an issue.

Accessibility issues included limited service capacity and issues with insurance. Respondents in the **physician survey** ranked counseling/therapy as the third most difficult-to-access service, and psychiatry as the most difficult. Outpatient services had some of the highest numbers of unmet needs reported by respondents to the **case management survey**. In the **public and private health system surveys**, health system administrators reported that they did not have enough capacity for outpatient services, and all private systems reported that they had to turn consumers away because of a lack of capacity for outpatient services. Multiple stakeholders in **key informant interviews** identified access and capacity issues with community-based services, pointing in particular to issues of payment (lack of health insurance) and coordination between public and private health systems.

Case management stands in contrast to other community-based services. Data from the case **management survey**, the **consumer survey**, and others suggest that the consumers who are currently receiving case management are receiving an adequate (and sometimes more than adequate) amount and are receiving case management services continuously over a period of years. In the most intensive case management model, CSP, over 40 percent of consumers have been receiving services for over 10 years. Although a proportion of mental health consumers are receiving adequate amounts of case management, the **key informant interview** data suggests that others who would benefit from case management are not receiving it because of limited capacity.

Of all the community-based services in Milwaukee County, our analysis suggests that employment support services are in particular need of attention. The **consumer**, **case management**, **and provider surveys** show that a large proportion of mental health consumers in Milwaukee County are unemployed but would like to receive supports to gain and maintain employment. We see from the **service utilization data**, however, that very few individuals are currently receiving employment support services, and these services are being delivered in very small amounts. Multiple entities share responsibility for promoting employment support services, including the County as well as the state DHS and Department of Workforce Development's Division of Vocational Rehabilitation (DVR). While the project team acknowledges that the current economic climate contributes further to the issue, it remains important to begin to develop a service infrastructure for employment supports.

Taken together, the data suggests the need for a re-evaluation of the structure and amounts of community-based services, including outpatient and case management services. By re-organizing, diversifying, and increasing its offerings of community-based services, Milwaukee County has an opportunity to serve a greater number of individuals in a more efficient manner.

3. Peer-Operated and Peer Support Services

Analysis of the data demonstrated that peer-operated and peer support services are important to further develop in the mental health system in Milwaukee County. Participants in **community meetings** stated in an improved mental health service system, there would be a wider availability of peer-operated services, and these services would be reimbursed at higher rates. Similarly, stakeholders who participated in **key informant interviews** expressed a hope that consumer-operated services would be expanded and promoted as part of this system redesign effort. **Service utilization data** show that no consumers are receiving peer-operated services (Warmline, Inc., the only peer operated service in the County, is not captured in the service utilization data because it is a separately funded program). Respondents in the **case management survey** reported unmet needs for peer-operated services and peer supports. Consumer reports of needs met in the **consumer survey** showed that approximately one quarter of consumers felt that they needed more or a lot more of peer specialist and peer-operated services. As noted previously, this amount might have been higher if consumers were educated regarding the benefits of such services. Similarly, data from the **physician survey** indicate a need for more provider education about consumer-operated services; close to half of the respondents indicated that they did not know enough about peer support services to comment on their quality or accessibility. The data suggest a need for the expansion of peer-operated services as well as for consumer and provider education regarding the benefits of these services.

4. Use of Crisis Services

Utilization patterns and perspectives on the use of crisis services is another theme that we have observed. **Service utilization data** suggests that Milwaukee County consumers are receiving crisis services more often than any other services. Results from the **consumer and case management surveys**, as well as **service utilization and functional level data**, suggest that consumers are using more crisis services than are needed or desired. In the **physician survey**, a majority of respondents rated acute services difficult to access.

In addition to the quantitative data that we have about crisis and acute services in Milwaukee County, our qualitative analysis of **key informant interviews** showed that EDs are a major challenge for all system stakeholders. Frequent use of EDs likely was a major contributor to the significant back-ups at the BHD PCS that

frequently occurred during the middle part of the last decade, and such use remains a significant contributor to the high volumes of patients coming to PCS today.

Some key informants expressed a hope for greater availability of crisis prevention and crisis alternative services such as drop-in centers, crisis phone lines, and crisis respite. This was echoed in the **consumer survey**, in which crisis alternatives such as crisis respite and the Crisis Resource Center were desired more about 23% of the time. **Key informants** also expressed a need for improved training for first responders such as law enforcement personnel.

5. Inpatient Service Capacity

Stakeholders at all levels are similarly concerned about issues of inpatient capacity. Respondents from multiple data sources identified issues with the efficiency and accessibility of inpatient care in Milwaukee County. The **inpatient hospital discharge survey** found that 23% of individuals being discharged from the public inpatient facility were rated as being at a functional level that required an intensive level of care that may not be available in the community. Results from the **consumer survey** suggest that some individuals who are in need of inpatient care are not receiving it, while others who received inpatient care did not think that it was needed. A majority of respondents from the **physician survey** rated inpatient services difficult to access. Multiple stakeholders in **key informant interviews** similarly identified issues with access and capacity for inpatient care.

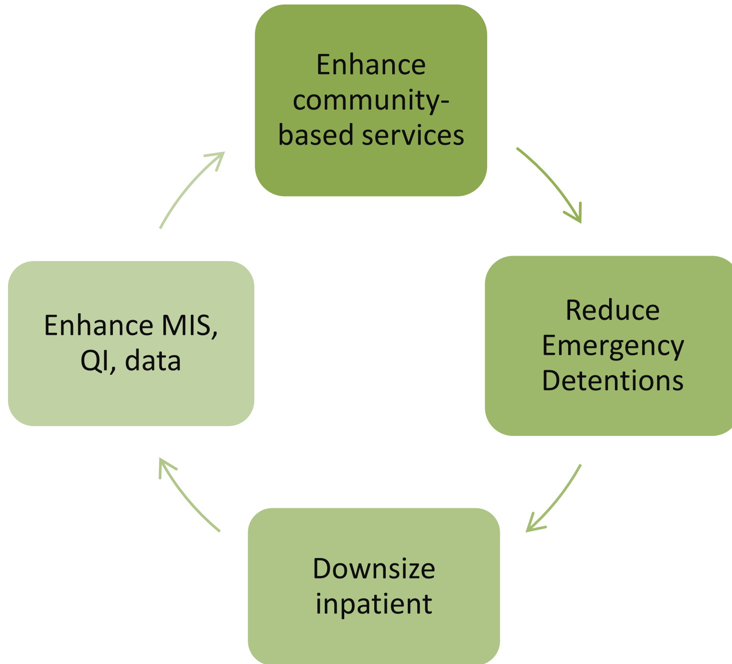
Our **comparisons of inpatient capacity** and **service utilization data** between Milwaukee County and other localities suggest that the issue at hand is more complex than one of capacity alone. The amount of funds Milwaukee County spends on inpatient care is higher than the national average. The data show that Milwaukee County does have more than appropriate capacity and funding for inpatient services. The **public health system survey** similarly showed that there is sufficient capacity in BHD-provided inpatient services. Thus, it is possible that the issue is not the *number* of beds, but the efficient and appropriate use of beds.

Recommendations

Based on the above analyses, the system redesign project has developed the following recommendations for moving forward. Included below are a number of recommendations in a number of key areas. Some of the recommendations are specific to the adult mental health system in Milwaukee County, while other recommendations are general system best practices (e.g. cultural competence, trauma informed care, quality improvement) that align with federal recommendations, but have been difficult to implement in many communities. Thus, the recommendations in this report include both a table summary of the key recommendations that are specific to the system in Milwaukee County, including indicators of success, strategies to be utilized, responsible entities, and financing opportunities; and a more detailed description of each category of recommendations with several sub-recommendations under each category.

It is critical that system stakeholders pay ongoing attention to the sequencing and inter-related nature of the recommendations. Although the interventions are presented as a list, they should by no means be implemented sequentially. Rather, the recommendations ideally should be implemented concurrently, with special attention paid to the ways the success of certain interventions hinge on the implementation of others.

Figure 22: Interconnected Recommendations



As the above figure shows, four of the key recommendation areas are highly inter-related. The result of increased community-based services will lead to a reduction in the need for emergency detentions, which will lessen the burden on acute care facilities and enable the County to work with system stakeholders to safely and successfully phase down its inpatient capacity, while continuously enhancing quality management and data collection efforts to track the success of interventions taken and monitor the needs of the community.

1. Brief Summary of Key Recommendations

The key recommendations contained in this report are summarized briefly in Table 16.

Table 16: Summary of Key Recommendations[8]

Recommendation Area	Specific Recommendation	Target/Indicator	Strategy	Entity Responsible	Financing/Capacity
Inpatient capacity	1. Reduce BHD inpatient beds 2. Shift responsibility and phase down Hilltop	1. BHD unit(s) at 16 beds 2. Reduced inpatient admissions 3. New or enhanced transfer agreements with private hospitals 4. Number of community transitions from Hilltop	1. Transfer more beds to private hospitals 2. Create dedicated units 3. Expand community- based capacity and services, including crisis services	County, state, private systems	1. Incentives for *private* hospitals (e.g. contracted dedicated units) 2. Potential for BHD inpatient to become Medicaid reimbursable 3. Medicaid 4. Family Care
Emergency Detentions	Reduce Emergency detentions	1. Lower to state-wide average 2. Enhanced and expanded crisis alternatives	Crisis Intervention Training, ER staff training, new and enhanced crisis services	County, privates, law enforcement	1. DOJ funding 2. Law enforcement funding
Community-based Services	Implement evidence-based practices	1. ACT 2. PSH 3. IDDT 4. Supported Employment	Planning, training, implementing	County, state	1. Medicaid 2. Shifting County resources 3. 1915(i) 4. MHBG 5. State infrastructure initiative
Community-based Services	Explore alternative case management models	Continuum of service intensity	Reorganizing models, training case managers	County, contracted case management providers	Existing county resources put towards reworked case manager training and system
Recovery-oriented System	Promote person-centered and motivational approaches	Lower refusal rates/ better outcomes	Shared decision-making, decision aids and other clinical tools and trainings	Providers (public and private)	1. 1915 (i) 2. SAMHSA
Recovery-oriented System	Increase consumer education	Lower refusal rates/ higher treatment engagement	Make resources widely available, create “learning centers”	Advocates/ consumer organizations	1. Foundations 2. Advocate resources 3. SAMHSA
Recovery-oriented System	Provide peer specialist supports	Certified Peer Specialists in all service areas	Increase peers certified, lobby state for increased rates	County, state, advocate orgs.	1. Medicaid 2. 1915(i) 3. Foundations

[8] Acronyms in this table are as follows: MOU - Memorandum of Understanding; DOJ – Department of Justice; ACT – Assertive Community Treatment; PSH – Permanent Supportive Housing; IDDT – Integrated Dual Disorder Treatment; MHBG – Mental Health Block Grant

2. Detailed Recommendations

Recommendation 1: Downsize and redistribute inpatient capacity.
Our analysis has found that downsizing its inpatient capacity, reallocating resources devoted to acute inpatient, and using the remaining capacity in a more efficient manner will better serve the County.

1.1 Gradually reduce inpatient units at the current BHD complex.

The total number of beds operated by the BHD can be downsized as beds are shifted to private hospitals and community-based alternatives are enhanced. Existing agreements between the BHD and the private hospitals could be expanded to increase private inpatient capacity as the BHD capacity is scaled down. Ideally, the BHD complex would be reduced to one or more units with 16 beds or less. In addition to supporting community integration and furthering recovery, this adjustment could make BHD's inpatient services Medicaid-reimbursable by eliminating the restriction created by the IMD exclusion if BHD is able to affiliate its new unit(s) with a private hospital.

This will require a multi-year plan that involves collaboration with community providers and private hospitals to phase down the current number of beds. The gradual phase down will need to be closely monitored and implemented alongside the development of community-based options to ensure appropriate capacity. It will also be important to collect regular functional level data on consumers to better compute inpatient capacity needs as community services are enhanced and other system improvements have been implemented (this is discussed in greater detail in Recommendation 10).

Planning is critical to successful closure or downsizing of inpatient facilities, given the impact on the system overall and the wide range of stakeholders involved. The planning process required of the nine states receiving SAMHSA transformation grants provides excellent examples of how to go about planning for large scale system changes, including feedback and buy-in from the public, consumers and other agencies and stakeholders.[9]

1.2 Work with the State and the County Department of Health and Human Services to develop and implement a plan to phase down the Hilltop Inpatient Program.

The Hilltop Program was initially understood to be somewhat outside the scope of this mental health redesign project because it serves individuals with co-occurring mental health and intellectual and developmental disabilities (IDD). However, the project team quickly found that the program presents the County with significant challenges that must be addressed if it is to successfully redesign its mental health services.

The Hilltop Program currently costs much more on a per diem basis than it can earn through reimbursement. The existence of the program under the BHD might also give other entities a reason to send people with IDD to the BHD crisis and inpatient service. The program should be phased down, with as many beds as possible transferred to smaller privately operated facilities in the community, and any remaining beds the county may need to retain transferred to the County's Disabilities Services Division (DSD). When moved to the community or transferred to DSD, it might be worth considering conversion of part of the facility's program to a START-type crisis respite and diversion program for people with IDD.

[9] These processes and their results are described in detail on many of the state Transformation Websites, for example Missouri at http://missouridmh.typepad.com/transformation

This could be completed in a multi-year phase down plan and would involve negotiating with private ICF/MRs to accept transfer of individuals requiring that level of care over the next three to five years. Another important step would be to initiate person-centered planning with current residents and their families or other representatives to design community options that meet the needs and choices of the current residents.

The County and other system stakeholders should also commit to phasing down Rehab Central as much as possible over a period of several years. The plan should involve a prioritization of residential service capacity in the community for these individuals. This will require many of the other recommendations being in place in order to have options for services at the front door (referrals to community services and housing options) and the back door (transitioning to community residential programs and services).

As individuals are discharged from inpatient programs, it will be critical that they are connected to community services as soon as possible. The County and other system stakeholders should work with the state to ensure that people being discharged have access to entitlements and benefits. The expansion of Family Care in Milwaukee County to serve adults with disabilities under the age of 60 provides a significant opportunity to accomplish that goal. Additionally, mental health system administrators will need to work with community providers to ensure that they can provide services at the needed level of care for this population.

Recommendation 2: Involve private health systems in a more active role.

Private health systems have shown a willingness to take on an enhanced role in care of the population with SMI in coordination with BHD. Their role can be enhanced even further through additional strategic collaboration with BHD and other stakeholders, though this will require additional capacity building, training and quality improvement strategies.

2.1 Outsource BHD inpatient bed capacity to the private health systems.

Outsourcing acute inpatient care to private health systems provides an opportunity for the BHD to shift resources away from inpatient care to more appropriate outpatient or community-based care. The private hospitals are well equipped to provide mental health services for several reasons. The private hospitals have a strong infrastructure, including a well-established electronic medical record (EMR) system. They are also in a better position to recruit well-trained mental health professionals in the fields of psychiatry and nursing. Finally, the private hospitals have TJC accreditation. Each of these factors contributes to greater capacity to provide high quality care to some of the county’s most needy individuals and play a key role in improving the mental health system overall.

While community services are being enhanced and developed, the BHD could contract a unit from one of the hospitals that is dedicated for BHD clients to provide a temporary safety net for these individuals. In the future, more acute inpatient care could continue to be provided by the private health systems in more integrated units. However, adequate incentives will need to be provided to the private health systems, either through reimbursement rate structures created by the BHD, or by adding incentives (e.g. guaranteed revenue from dedicated beds). Building capacity in a dedicated unit is a complex endeavor and will take time to plan the phase-down and build-up of the new unit if that is a selected option. It will be important to have detailed agreements in place ahead of time and specific plans for transition in order for this to work for all parties and be a smooth transition for consumers.

2.3 Private health systems should continue with their plans to expand capacity by hiring more psychiatrists and other mental health professionals, where possible.

2.4 To provide clinically appropriate care, private providers will need to adjust culture and build clinical capacity to treat persons with more severe psychiatric symptoms and complex psychosocial needs.

The most direct way to increase the participation of the private sector in providing mental health services is, of course, privatization through purchase-of-service contracting. The Massachusetts Department of Mental Health has long been a pioneer in this area. The agency has developed considerable expertise in effective and efficient approaches to purchase of service contracting, both in large-scale activities such as the nation's first Medicaid behavioral health carve-out program in 1995 and the more recent expansion of insurance coverage, and in smaller-scale initiatives over the years that gradually shifted the locus of care from state hospitals and community mental health centers to community-based private sector providers. Many of these initiatives could provide models for BHD transitions. New Mexico has advanced the process of contracting by creating the New Mexico Behavioral Health Collaborative, a cabinet-level group comprising 15 state agencies that is charged with transforming the way the state organizes, finances and delivers behavioral health services. Among its tasks has been to streamline the purchase of service process by means of a Behavioral Health Purchasing Collaborative that contracts with a single, statewide services purchasing entity.[10]

While expansion of Medicaid coverage is not a panacea for engaging the private sector in providing services to persons with SMI, it is probably the most critical as a foundation on which to build. Across-the-board increases in Medicaid reimbursement rates would probably do the most to create incentives for the private sector, but this is probably not feasible at least in the near future. A number of other smaller-scale and less resource-intensive alternatives have been developed by many state and county mental health agencies.

One possibility for enhancing the participation of the private sector could be certain modifications of the Medicaid benefits package. Though obviously a complex and probably long-term undertaking, this may at least be more feasible than increasing reimbursement rates across the board. An example of this approach is New Mexico's addition of Multi-Systemic Therapy (MST) as a reimbursable service. On a larger scale, as discussed earlier in this report, the 1915(i) State Plan Option is a way of providing additional support for Medicaid beneficiaries with mental illness. Connecticut is an example of a state that has recently taken this step.

Another approach to expanding private sector provision through Medicaid without across-the-board increases in reimbursement rates is to insure that regulations allow participation by lower cost providers, notably social workers and psychiatric nurses. This approach was taken by Washington State to increase access to mental health services for children. It may also be beneficial to coordinate with the Medicaid agency to ensure that certification and licensure processes are streamlined to encourage participation. The Washington State mental health agency, which contracts with highly autonomous county-based mental health agencies known as Regional Service, recently modified rules to allow these entities to sub-contract with individual licensed mental health professionals to increase access, particularly in specialty areas such as services for minority populations.

[10] The Collaborative maintains a website at: http://www.bhc.state.nm.us, and an evaluation of the program recently conducted by the Robert Wood Johnson is available at http://www.rwjf.org/vulnerablepopulations

Ohio recently resolved a long-standing issue that related to discontinuities in Medicaid coverage for persons being discharged from institutions (jail, prison or state hospitals) that resulted in increased public sector care. Previously, Medicaid eligibility was suspended during the institutional stay, thus requiring an extended reapplication period during which the individual has no option except the public sector for needed mental health services. After many years of effort by the state mental health agency, the issue was resolved relatively simply by a change in Medicaid rules that suspends, rather than terminates, coverage during institutional stays. Washington State accomplished a similar modification known as Expedited Medical Eligibility determination.

Outreach and training, especially for primary care providers, is a mechanism employed by many mental health agencies to engage the private sector in serving the SMI population. For example, Oklahoma provides training in SAMHSA's Screening, Brief Intervention and Referral to Treatment (SBIRT) intervention in hospitals and primary care clinics.[11] Though targeted specifically to substance abuse rather than mental health, training in various types of screening will help to draw attention to persons with mental illness and their treatment needs in the general medical population. Of course, some of this will simply result in referrals back to the public sector, but at least some will stick, especially as health care reform proceeds with promoting integrated care.

Interaction with the private sector in the form of health care provider organizations may be enhanced by joint research activities, which creates incentives especially for academic centers. Oklahoma's mental health agency, for example, pursues grant-funding opportunities through the OK Innovation Center, Oklahoma Department of Mental Health and Substance Abuse Services Decision Support Services and Science to Service Panel.

Recommendation 3: Reorganize crisis services and expand alternatives.

Crisis services are often the first point of entry for the Milwaukee County mental health system. Reorganizing and expanding crisis services will create more access to services for people who need them in a more timely fashion, which will in turn reduce the need for costly inpatient care.

3.1 Shift crisis services to a more central location.

As a last phase of downsizing the BHD complex, Milwaukee County should consider shifting crisis services to a more central area in Milwaukee near consumers who use the services with an attached 16-bed (or less) unit. This will provide an option to maintain a limited number of county-run beds while also serving as a centralized intake area where consumers can be referred to other services options in the community when appropriate.

3.2 Develop and expand alternative crisis services.

Alternative crisis services can provide the necessary clinical resources to divert people from acute inpatient and reduce the need for inpatient care. Crisis alternatives such as the Crisis Resource Center currently exist in Milwaukee County, but they are used sparsely. Other crisis alternatives, such as peer-run crisis respites, are being adopted throughout the nation and could be introduced in Milwaukee County. Clinicians, law enforcement, and consumers should be made more aware of existing crisis alternatives such as the Crisis Resource Center. Consumers can then be brought directly to these alternatives, bypassing the need for PCS. Crisis alternatives can also be used as a "step down" from inpatient to shorten stays and improve continuity of care. Existing and new crisis alternatives should be expanded. More immediately, the County should work to ensure that the Crisis Resource Center retains its funding.

[11] Information about SBIRT can be found at http://sbirt.samhsa.gov

Crisis alternatives may never fully replace inpatient care, but they can be helpful in some situations to reduce utilization and recidivism. Evidence shows that crisis alternatives normalize crisis experiences, which can lead to more expedient recovery and return to the community (Hawthorne et al., 2005; Rakfeldt et al., 1997). To facilitate linkages between individuals in crisis and the appropriate crisis alternatives, providers need to be educated about the availability and effectiveness of such crisis services.

County and other system stakeholders will need to work with alternative crisis service providers to ensure that there is sufficient funding to keep these resources available to individuals throughout the system redesign process. In the long-term, funding for alternative crisis services can be found in cost-savings associated with reductions in EDs and crisis inpatient services. In the short term, county funds may need to be directed to these resources to ensure their viability.

Recommendation 4: Reduce emergency detentions.

EDs need to be reduced to appropriately serve the population and decrease the need for inpatient care.

4.1 Enhance emergency provider and law enforcement trainings.

Reducing EDs will require emergency providers and law enforcement training. Training police officers using crisis intervention training (CIT) is a first step in equipping the police force to better manage crisis situations encountered with individuals with mental illness, and can help to either diffuse the situation or enable individuals to make a voluntary decision to enter inpatient care (Bahora, Hanafi, Chien, & Compton, 2008; Jambunathan & Bellaire, 1996). Emergency and crisis department personnel also need training in engaging individuals in a voluntary decision to seek inpatient care or seek a safe and effective alternative.

Although CIT is currently used in Milwaukee County, more effort to promote the training is needed so that all first responders are trained in a continuous and comprehensive manner. We support following the recommendations of the Council of State Government's Criminal Justice / Mental Health Consensus Project (2002), which was developed by a broad group of mental health and criminal justice system stakeholders to improve the response to individuals with mental illness who come in contact with the criminal justice system. The report makes the following specific recommendations on training for law enforcement personnel:

4.1.1. Provide at least two hours of new skills training regarding mental health issues to all law enforcement personnel who come into contact with people with mental illness.

4.1.2 Incorporate at least eight (and as many as fifteen) hours of training in general mental health issues into existing recruit (academy-level) training programs for law enforcement staff.

4.1.3 Provide to patrol officers at least twenty hours, over a three-year cycle, of in-service training about mental illness that includes in-depth reviews of topics covered generally in recruit training and on additional topics.

4.1.4 Prepare select law enforcement staff to serve on a special team by providing them with advanced skills training on the fullest range of mental health topics every three years.

4.1.5 Train communications personnel (call takers and dispatchers) that work with law enforcement on how to manage with calls that may involve mental illness.

Recommendation 5: Expand and reorganize community-based services.

Community-based services, including outpatient care, are a critical aspect of supporting individuals to live independently in the community. Nationally, mental health systems are engaged in reducing the use of inpatient services and increasing the use of community-based services, especially those that have been shown to be effective. The NFC Report on Mental Health (2003) emphasized that in order for individuals to recover from even the most serious mental illnesses, they need access in their communities to treatment and supports that are tailored to their needs. The NFC recommended replacing unnecessary institutional care with efficient, effective and dependable community services. The data for this project consistently showed that improvements are needed in the quantity and availability of community-based services in Milwaukee County.

5.1 Continue working with the State to secure funding for Community Recovery Services under the 1915(i) State Plan Option.

Milwaukee County has been a leader in the process using the 1915(i) option to offer Community Recovery Services. Participation in this program is a great opportunity to jumpstart the development of community-based services in Milwaukee. Through the 1915(i), the County can institute services identified as lacking in our data sources, including Community Living Supportive Services, Supported Employment, and Peer/Advocate Supports. This will represent an expense to the County, but the federal share for those eligible for Medicaid will cover a significant portion of the cost. The BHD is justifiably concerned about the financial risk associated with this program, which may require the County to expand services to hundreds of additional individuals who are not currently part of the BHD system. While Medicaid would cover between 60% and 70% of the costs (depending on ARRA adjustments) associated with those individuals, County property tax levy would be required to fund the remainder. Despite this concern, it also is important for the County to weigh the financial and programmatic advantages of being able to offer consumers a much broader array of community-based supports that would be supported by Medicaid reimbursement. This could significantly reduce the demand for tax levy-funded emergency, inpatient and long-term care services that the County is currently supporting without financial assistance from Medicaid.

The County is currently working with the State on the appropriate eligibility criteria for these services. When the State originally submitted the application to CMS, waitlists for capped programs in specific geographic areas were allowed. Federal healthcare reform legislation has removed these features of the program, making the services an entitlement for the Medicaid population. Moving forward, the County should work with the State to explore and promote greater incentives for participation.

5.2 Shift resources from inpatient to community-based services.

A more cost-effective use of mental health system resources would be to fund more community-based, recovery-oriented, and evidence-based services. This funding can come from some of the activities described in Recommendation 1, including shifting resources from the BHD inpatient complex, reducing inpatient stays, and potentially taking advantage of funds that become available as BHD inpatient services become Medicaid-reimbursable. The recommended community-based services would also be Medicaid-reimbursable, creating further savings for the County. Shifting resources from inpatient to community-based services would require coordination of efforts (such as creating a unit outsourced to a private hospital while creating other services). The project team recognizes that additional resources may not be available, and that the implementation of this recommendation will take careful planning and implementation in order to ensure that the population is

adequately served without experiencing significant gaps in support. Other systems, such as the Mendota Institute in Madison, have done this by leveraging federal funding. One possibility is to seek SAMHSA demonstration or transformation project dollars as they become available, in addition to shifting to service arrangements that are supported by Medicaid federal matching funds.

5.3 Explore partnerships with FQHCs and approaches to integrating care.

This analysis has found significant barriers to accessing outpatient mental health care in Milwaukee County. One significant barrier is a lack of capacity for outpatient services. Many respondents reported that Medicaid eligible individuals cannot find a psychiatrist who will see them and the BHD available slots have been decreasing over the last three years. Leaders in the mental health redesign effort should work with FQHCs to establish partnerships to create more capacity for mental health care in the County. If outpatient mental health services are co-located with primary care and other physical health services, there will be opportunities to improve quality and reduce costs through care coordination and integration. FQHCs have indicated a willingness to expand capacity if they can find a way to expand their physical space to accommodate more consumers. The expansion of outpatient options combined with efforts to reduce no show rates using peer specialists and transportation options will also make it more attractive to FQHCs and other outpatient providers.

5.4 Expand evidence-based practices.

Moving forward, the system redesign efforts should place a major emphasis on providing community-based services that are also evidenced-based. EBPs are interventions for which there is consistent scientific evidence showing that they improve consumer outcomes (Drake et al., 2001).

It is important that when developing or expanding community-based services, an emphasis be placed on expanding and developing the use of evidence-based and recovery-oriented practices. Data from this study shows that in Milwaukee County, the use of evidence-based and recovery-oriented practices and services is limited. Moreover, there is a need for services in many areas (housing, employment, substance use/dual-diagnosis services) in which EBPs are available. Thus, we recommend that providers throughout Milwaukee County implement more EBPs, and expand existing practices that are evidence-based and recovery-oriented. Consumer-operated or consumer/peer run services should be emphasized along with services that enhance employment and educational opportunities.

There are free resources that can assist in the expansion of evidence-based and recovery-oriented services and practices, such as the SAMHSA CMHS EBP KITs. More information regarding the KITs and other web-based materials that can support the implementation of EBPs can be found in Appendix P.

The project team has determined that the types of EBPs that would be useful within Milwaukee County are Permanent Supportive Housing (PSH), Supported Employment, and building up Integrated Dual Disorder Treatment (IDDT) and ACT.

Planning and implementing EBPs includes consensus building, integrating EBPs into policies and procedures, developing an EBP training structure, developing a monitoring and evaluation structure, and maximizing the effectiveness by making services culturally competent. The project team recognizes that undertaking the implementation of EBPs can be resource intensive, both financially and in terms of system and provider changes in practice. However, expanding the use of practices that promote recovery will lead to consumers becoming

more independent of the mental health system and save future resources that would be used to maintain people in the system.

It is very important that information and training about the EBPs be provided to the different stakeholders. In particular, providers, case managers, and consumers need to be better informed given the data finding that a primary reason for disparity between received and ideal services is that consumers refuse services because they do not think they would benefit from them or do not understand them. Educating consumers about new services is as important as educating providers.

5.5 Adopt alternative case management models.

This analysis has found that the current system of case management needs to be changed so that more individuals can access case management services in conjunction with other community supports. Based on a review of the literature on case management, Bedell, Cohen and Sullivan (2000) identified three models of case management: full service, brokered, and hybrid.

- **Full service** case management attempts to provide all services through the case management program "in vivo" through the efforts of a specially trained interdisciplinary team.
- **Brokered** case management involves linking clients to existing community services without providing any direct services through the case management program.
- **Hybrid** case management involves a mix of brokered and directly provided services.

From the data collected in this study, it seems as though the case management provided in Milwaukee County leans more heavily on the model of brokered case management, which tends to be less effective in communities where there are minimal existing community resources. Based on our analysis of the utilization and capacity of the case management programs in Milwaukee, we recommend that the County adopt a case management model that provides a continuum of case management services to a larger number of people.

A report published by the California Institute of Mental Health emphasizes the need for flexibility in case management systems, with intensity and duration determined by individual need (Forster, 2001). The report cites research indicating that intensive case management increases costs if provided to consumers who are not high service users, and that long-term case management is usually unnecessary to maintain consumers in the community. Shifting to shorter-term case management and targeting those who truly need this increased level of support would be a more efficient use of case management for Milwaukee County.

Case management might be improved by changing practice models so that the majority of case managers use their time with clients to link to community-based services (rather than provide these services). Case management models should also become more recovery-oriented, such as by moving long-term clients out of intensive case management. Case management program administrators could then adjust criteria for entry into case management to make it more accessible to more people. The County might institute practices such as "recovery check-ins," whereby consumers can be moved out of case management to lower intensity service levels, while maintaining links to the system. This will allow for more persons to enter the case management system who need it, as well as for ongoing support as needed for individuals who experience greater stability in recovery.

Existing models that are currently in use in other states and counties can inform the development of a case management continuum. The National Association of Case Management defines three intensity levels of case management (Hodge & Giesler, 1997). The levels serve different populations and have different caseloads (smaller to greater), different contact frequency (more to least frequently), and different functions for case managers. The two more intensive levels have a multi-disciplinary team composition with contacts in vivo in the community, while the least intensive level is largely office-based with case managers collaborating with other providers and contacts either in person or by phone. The treatment plans for the more intensive levels are updated and reviewed for continued stay every 90 days, and treatment plans in the least intensive levels are updated and reviewed twice per year and include the development of crisis prevention plans.

The Arizona Department of Health Services' Division of Behavioral Health Services employs a case management model with three levels of service and resource intensity that might inform Milwaukee County's efforts (Arizona Department of Health Services, 2001):

- The **Assertive** case management model is the most intensive, providing a service package similar to that of ACT. Rather than providing linkages to services, the Assertive model provides services to individuals who have the most acute service needs.
- **Supportive** case management is designed to support a larger population of individuals with more moderate needs. Its focus is on fostering and maximizing community resources and the coordination of care.
- The **Connective** case management model is designed to support a small number of individuals who have achieved stability and met their recovery goals. Connective case management supports these individuals in maintaining their current level of functioning in the community.

A detailed description of the case management models from the National Association of Case Management and the models used in Arizona are outlined in more detail in Appendix Q.

As the case management program is reorganized and clients are matched to programs based on need and service intensity, it will be important to keep in mind the reimbursement structures for the existing programs.

Because CSP receives a higher level of Medicaid reimbursement than the TCM program, administrators should place renewed emphasis on shifting individuals with more intensive service needs to the CSP program while orienting the TCM model towards providing more purely brokered services for individuals who need less intensive supports.

5.6 Improve discharge planning from acute inpatient stays.

Concurrent with efforts to expand and improve community-based and outpatient services and supports, the discharge planning process needs to be re-evaluated. Our analyses showed that only a small proportion of individuals discharged from inpatient care have sufficient services secured for them in the community. It is likely that this has led to increased inpatient re-admissions and increased use of costly emergency care.

Discharge planners in both the BHD and private systems should be trained regarding current and newly available community-based options for consumers to use when they leave the hospital. Additionally, more resources are needed to facilitate a smooth transition back to the community. Referrals to community services should be in

place upon discharge, and consumers should be connected to case management where appropriate. Additionally, staff from inpatient and community programs should work together to facilitate working relationships between the individual and community providers as well as peer support networks. There is evidence that the inclusion of peer supports as well as traditional care providers in the process of transitioning to the community after discharge can lead to reduced re-admissions and greater cost-savings (Forchuk et al., 2007; Reynolds et al., 2004). The inclusion of peer providers to support transitions in the discharge process may help to keep individuals connected to recovery support services in the community, leading to more linkages and reduced need for emergency and inpatient care. Discharge planning should include a data tracking system on recidivism and successful linkages to community and outpatient service options.

5.7 Use benefits counseling to ensure maximum revenue to fund services.

Our analysis found that there are many individuals without insurance who are in need of mental health services. With proper counseling and assistance, many of these individuals could secure health insurance and other benefits and entitlements. This would in turn lead to more reimbursement of services and a lessened burden on the mental health system as a whole. There are some benefits counseling programs currently operating in Milwaukee County; however, these programs are operating with limited resources. By prioritizing benefits counseling services, the County can increase access and ensure maximum revenue to fund services.

5.8 Substitute some traditional treatments with alternative options for outpatient care.

Outpatient service capacity issues can be addressed by substituting currently used service providers and traditional treatments with innovative and creative options for outpatient care. Often, doctoral level psychologists and psychiatrists deliver many outpatient services, such as individual therapy and medication management. An increased use of Master’s level clinicians (LMHCs, LICSWs, and MFTs) and nurse practitioners who can prescribe medications can expand capacity.

Systems are moving away from providing longer-term day treatment services toward a network of recovery-oriented supports that have a rehabilitation focus. Services such as day treatment can be substituted with skills building services, supported education and employment, illness management and recovery, family psychoeducation, peer-operated services, and other support services. The focus should be on services that promote employment, independent living skills, and recovery. It is important to include EBPs (discussed in Recommendation 3) among these service offerings. All outpatient services should be culturally relevant and appropriate.

Recommendation 6: Promote a recovery-oriented system through person-centered approaches and peer supports.

Recovery-oriented care, including peer supports, should be further developed throughout the system. While there are numerous such supports and programs in place in the County, this analysis finds that more are needed. Further, the system as a whole will benefit from a shift towards a stronger recovery orientation at every level of service delivery.

6.1 Employ the use of motivational and person-centered approaches system wide.

Person-centered planning is an approach to planning that is driven by the individual needs and preferences of the consumer. In person-centered planning, the consumer and provider participate as equals in planning for an

individual's recovery. Motivational techniques involve a focus on the individual and the development of a relationship that is non-judgmental and non-adversarial.

It is possible that using motivational and person-centered approaches can reduce the amount of consumer refusal of services in the mental health system in Milwaukee County. In a study of treatment avoidance for both medical and psychological problems, Moore et al. (2004) found that four factors were associated with treatment adherence and avoidance: time spent with physicians, respect shown by physicians, physicians' confirmation of patient understanding, and physicians listening to patient concerns. Negative experiences of a treatment relationship in the past determine current treatment-seeking behaviors. In the context of Milwaukee County, it is possible that the high rate of refusals stem in part from consumers' experience with providers who have not had the time or resources to adequately build a therapeutic relationship and use person-centered principles for interaction.

Providers, especially case managers, should be trained in these approaches. Quality improvement processes and ongoing training can monitor improvements in consumer refusal rates.

6.2 Increase consumer education about recovery-oriented and community-based services.

Educating consumers about community-based and recovery-oriented services could lead to a reduction in consumer refusal of services. Involving consumers in decisions about their care is essential in this process. There should also be more opportunities for consumers to participate at the systems level to change culture and practice so that services are more welcoming for consumers.

In a study of 174 consumers in a community rehabilitative service setting in England, Macpherson, Alexander, and Jerrom (1998) found that of the 61 individuals who refused treatment (medication in this case), 85% reconsidered their refusal and engaged in treatment within one month. The study found that community keyworkers (health professionals responsible for the coordination of care) were most effective in reversing these refusals through explanation, education, and encouragement. The authors found that in their sample, only 6% of individuals were firm in their refusals. The remaining individuals initially refused but responded to reassurance and discussion with their providers. This study suggests that consumer refusals are often the product of ambivalence and fluctuating attitudes towards mental health treatment. They emphasize the importance of the relationship between the provider and the consumer in addressing the root cause of refusals through education and encouragement. They also emphasize that in many cases, providers (particularly those who have a rapport with consumers) could work with individuals who refuse services so that they make fully informed decisions about their care.

6.3 Expand peer support and consumer-operated services.

The Center for Medicare and Medicaid Services (CMS) has identified peer supports as an evidence-based mental health practice that can promote community integration (Mann, 2010). CMS is encouraging states to increase the role of peers in the mental health workforce. If Medicaid-funded peer supports are used, they must be integrated into care coordination through an individual's treatment plan, be supervised by a mental health clinician, and have complete certification as defined by the state (Smith, 2007). Peer specialists can be integrated into traditional settings and will empower consumers and provide inspiration for recovery and

mutuality in service provision. Consumer-operated services can be an alternative to traditional services, and may be more effective in providing support for recovery.

Peers have been shown to be an effective component of inpatient hospital care. Research into this kind of support has shown increased peer support in hospital-based care can shorten length of stay, decrease re-admissions, and reduce overall treatment costs (Chinman, Weingarten, Stayner, & Davidson, 2001). Increasingly, peers are being integrated into inpatient and emergency settings (Vine, 2010). Peers are also being integrated into outpatient clinics. Peer support has been shown to effectively engage consumers in mental health care and increase access to physical health care. In a study of adults with serious mental illness, consumers with peer supports were significantly more likely to make connections to primary care (Griswold, Pastore, Homish, & Henke, 2010). Integrating peers into inpatient, emergency, and outpatient settings can promote recovery and consumer participation in care.

As part of the Pillars of Peer Support Services Summit held in 2009 at the Carter Center in Atlanta, Georgia, the 23 states that provide Medicaid billable peer support services participated in a survey of peer support services in their state. Wisconsin was one of the survey respondents. Respondents were asked about the roles of peer specialists in their state, reimbursement rates, and the challenges that peer specialists face. Reimbursement rates in the sampled states ranged from $3 to $19 per fifteen-minute service delivery interval. Wisconsin represents the only state with a rate of $3 per 15 minutes, making its reimbursement rate the lowest in the country for states that have Medicaid-billable peer services (Daniels et al., 2010).

Peers could be effectively integrated into the mental health workforce in Milwaukee County in a fiscally sustainable way if the rate of reimbursement could be raised to an adequate level to cover overhead for agencies that utilize this workforce while providing peer specialists an acceptable wage to entice employment. The Wisconsin respondents to the Pillars of Peer Support survey responded that in order to promote the use of peer support specialists and consumer-operated services, a state needed to "Ensure that a leader with authority champions the development of Peer Specialists and participates with others of differing views in defining the details of the state vision" (Daniels et al., 2010). Advocates in Milwaukee County must work with state and county leaders to increase the Medicaid reimbursement rate in order to make a peer workforce a viable option. Federal Medicaid supports action to increase the peer supports as part of local mental health systems (Mann, 2010; Smith, 2007). In its system redesign efforts, Milwaukee County has the opportunity to lead the state in increasing and expanding its network of peer support services.

The County should also consider creating a peer-provided case management program. While it is not yet an EBP, peer-provided case management holds promise for promoting improved care for individuals with SMI (Davidson, Chinman, Sells, & Rowe, 2006). Studies suggest the use of peer providers in case management can contribute to a stronger treatment relationship and greater participation in treatment. Sells, Davidson, Jewell, Falzer, and Rowe (2006) found that, early in treatment, case management clients who struggled with engagement were more likely to keep appointments with peer case managers than non-peers. The peer providers were able to establish a trusting relationship more quickly. These findings were echoed in a later study examining peer case managers, which found that consumers reported more validating experiences with peer case managers than non-peers (Sells, Black, Davidson, & Rowe, 2008).

In terms of supporting consumer-operated peer support organizations, one strategy is for these organizations (as they are developed) to join managed care organization (MCO) networks. If a consumer-operated organization joins an MCO network, they can receive referrals and payment by the insurance company. Consumer-operated services can then become part of an individual's routine treatment. This arrangement provides consumer-operated organizations with sustainable income. This was done in the state of Tennessee when the Tennessee Mental Health Consumers' Association joined the AmeriChoice/Optum network. The consumer-operated organization has been a member of the MCO network for the past three years, with an increased budget of 500% (Blau et al., 2010). The MCO benefits by providing more recovery-oriented services to its members and diversifying referral options. In order to do this, a consumer-operated organization would need to be licensed, credentialed, issued a National Provider Identification Number (NPIN), develop billing infrastructure, and be willing to be subject to auditing and utilization review by the MCO (Blau et al., 2010).

Recommendation 7: Enhance and emphasize housing supports.

Access to safe, adequate, and affordable housing is a critical element in supporting individuals to live independently in their communities (NFC, 2003). The high number of individuals on waiting lists for supportive housing in the County indicates that the need for such services currently exceeds the supply. While considerable progress has been made in this area during the past three years, there are a number of areas on which the County can focus to improve its housing services and address the needs of homeless individuals in the system.

7.1 Re-allocate resources being used for group homes.

Milwaukee County has a small number of group homes, and some respondents expressed a need to have more group homes to solve the problem of speeding discharge from inpatient and/or rehab care. We did not review the specific group home programs or analyze utilization by type of consumer, length of stay, etc. We were told that lengths of stay are very long and that vacancies are very infrequent. More careful analysis should be conducted before any additional group home beds are authorized or funded. To our knowledge, there are no mental health systems anywhere in the U.S. that are intentionally expanding their congregate group home programs. There is no evidence in the peer-reviewed literature that group homes produce positive outcomes for people, and there is ample evidence that independent, affordable and permanent supportive housing does produce positive outcomes. When provided informed choices, consumers always opt for more integrated independent living models as opposed to congregate living. As with the inpatient, central rehab and nursing home programs, there may be opportunities to use the resources associated with group homes to better advantage in the overall public mental health system in Milwaukee County.

7.1.1 Work with current group home residents to facilitate transition to integrated community housing.

The first step would be to assure the provision of active training, skill building, and housing-related supports to existing residents of group homes to facilitate informed choice and access to affordable housing units integrated in the community. The goal would be to reduce group home lengths of stay and increase vacancies that could then be used for people with a legitimate barrier to integrated community living or ineligibility for federal housing assistance.

7.1.2 Prioritize needs of consumers with legitimate barriers to integrated community living.

The second step would be for BHD and other system stakeholders to exercise greater central control over which priority consumers (e.g. adults with SMI) access the vacancies created through these community living strategies.

7.1.3 Enhance utilization management practices for group homes.

The third step would be for the County to exercise greater utilization management over the group homes and also to implement quality improvement strategies to assure that group homes focus on recovery and independent living skill building for residents.

7.1.4 Separate housing and service components.

The fourth step would be to see if there are ways to separate the housing component from the services components of the group homes. This could allow housing affordability resources, as opposed to County services resources, to be used to subsidize housing-related costs. It also could provide a platform for County staff to work in group home settings to serve the highest risk consumers now "stuck" in the rehab or nursing home facilities.

7.2 Expand permanent supportive housing (PSH).

Milwaukee County has initiated the development of a substantial number of PSH units. The funding and development of these units is creative and reflective of best practices in other jurisdictions. It is hoped that the County and its housing funding and development partners will continue to put PSH units into the development pipeline and will find other ways (i.e., non-elderly Housing Choice Vouchers; new Section 811 PRAC demonstration; etc.) to expand PSH opportunities for high priority consumers. The key issue for the short term will be how tenants are selected for these units and who actually gets to move in. Our observations of the behavioral health system in Milwaukee County indicate there may be a risk that many ideal candidates for PSH will be excluded as being "not ready" for PSH. If this happens, the policy goals of the system with regard to serving the highest risk people, and also making best and most cost effective use of all public resources in the behavioral health system will not be attained. Another key issue will be to expand evidence-based and promising practices to provide flexible, mobile and person-centered services and supports to tenants in PSH to sustain tenancy. Expanded community support team, intensive case management and ACT services are typically used in other jurisdictions to support tenants in PSH.

7.3 Establish a full and active partnership with the homeless service system.

In general, we were given the impression that the public behavioral health system and the homeless service system run in parallel and have only a few effective connections. These connections include a relationship with Health Care for the Homeless and current SAMHSA grants to improve treatment for people who are homeless. While these grants are important, more coordination is needed to address the critical issue of housing for individuals who receive mental health services in Milwaukee County. Insufficient coordination between mental health and housing supports is very common in urban jurisdictions, but it results in a number of problems. First, the mental health system loses a number of opportunities to identify risk factors and to intervene early to prevent crisis from becoming so serious that an ED is triggered and hospitalization (or at least a stay in the PCS observation beds) ensues. Second, people who are homeless or chronically homeless end up isolated from behavioral health services, which results in more frequent emergency room presentations for health- and

AODA-related issues as well as mental health issues. There are lost opportunities to engage homeless people with SMI and co-occurring AODA disabilities with mainstream services under SAIL, which if overcome would increase successful tenancy in Shelter Plus Care units for people who are chronically homeless. There are also some inherent inefficiencies associated with trying on a case-by-case basis to bridge the lack of connections and communication between the two systems. Public and private mental health system administrators should become full and active partners in the County's efforts to end and prevent homelessness.

Recommendation 8: Ensure cultural competency.

The growing diversity of the Milwaukee population necessitates changes in the approach to delivering effective mental health services. Nationally, disparities in mental health care for racial and ethnic minorities have been described in many landmark documents (DHHS, 2001; Smedley, Stith & Nelson, 2002). Additionally, there is a need for services and supports that meet the needs of individuals with hearing impairments. These disparities include less availability, reduced access to services, lower likelihood of receiving needed services, greater likelihood of receiving poorer quality of care, and under-representation in mental health research. The authors of these reports and others in the field have identified the provision of culturally competent care as an important means of eliminating disparities in mental health care (NFC, 2003; Smedley, Stith & Nelson, 2002). Our analysis suggests that the cultural competency of the mental health system in Milwaukee could be enhanced. This is an issue that is not particular to Milwaukee but that is widespread and affects many mental health systems.

The enhancement of the system's cultural and linguistic competence is important for TJC accreditation. The TJC views the provision of culturally and linguistically appropriate health care services as an important quality and safety issue, and as a key element in individual-centered care.

There are many definitions of cultural competency, but the most commonly used is one developed by Cross, Bazron, Dennis and Isaacs (1989), who defined cultural competency as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professional to work effectively in cross-cultural situations. While the focus of these recommendations is primarily on individuals from racial and ethnic minority backgrounds and with limited English proficiency, mental health system stakeholders should also ensure that the system is culturally competent in dealing with other cultural groups, such as individuals who are deaf and hard of hearing, individuals with physical disabilities, individuals that are members of the lesbian, gay, bisexual and transgender community, etc.

Based on the existing literature and knowledge base on cultural competency, HSRI has identified some areas to focus efforts. For a listing of publicly available resources developed by leading experts in the field that can assist leadership in advancing the system's cultural competency, please refer to Appendix P.

8.1 Enhance overall commitment to cultural competence.

The Milwaukee County mental health system can enhance its overall commitment to cultural competence in several ways. It can begin by including cultural competence as part of organizational missions and visions and in any major initiative such as the BHD's Quest for Recovery. Other initiatives in this area include: identifying one management-level person who is responsible for cultural competence; having a dedicated budget for cultural competence activities; developing a written cultural competence plan that outlines clear goals and objectives,

strategies, and implementation timetables; and developing policies on cultural and linguistic competency for the entire system or as they relate to specific services (crisis, inpatient, community-based services).

8.2 Identify cultural, language, and service needs.

Mental health system administrators should collect consistent data on race, ethnicity, and spoken and written languages for all individuals who enter into the mental health system. This information should be entered into the management information system and aggregated to identify the cultures and language needs of individuals served by the mental health system. System administrators should also maintain a current demographic, cultural, and epidemiological profile of the County and, if possible, conduct a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the County. To identify disparities in the location of services, service utilization, and outcomes, system administrators should conduct data analyses examining racial and ethnic minority populations.

8.3 Ensure effective communication with individuals with Limited English Proficiency.

All mental health providers in the County should ensure that there is sufficient staff to meet the language needs of its service users. If there is not sufficient staff, there should be a commitment to recruit, hire, and retain staff that are from or have experience working with the most prevalent cultural groups and that meet the language needs of individuals in the system.

When using interpreter services, leadership should ensure that the interpreters have been formally trained and certified or have received cultural competency trainings. Access to bilingual staff and interpreter services as well as American Sign Language (ASL) services should be available at all points of contact and in a timely manner.

The County and other system stakeholders should also ensure that all key or essential documents and forms have been translated into the most prevalent languages of its service users. Some key documents and forms include those related to consent to treat, release of information, medication information (specifically instructions and dangerous side effects), and rights and grievance procedures. Service descriptions and educational materials should also be translated for individuals with limited English proficiency and should be provided in formats that can be understood by individuals with limited reading skills.

8.4 Implement training in cultural issues and culturally and linguistically appropriate service delivery.

Public and private system administrators should directly provide or make available to staff at all levels of the system (administrative, direct care, and non-direct care, etc) educational activities or training in cultural issues and culturally and linguistically appropriate service delivery. Ideally, trainings should be available yearly and there should be requirements regarding the amounts of trainings specific staff (administrative, direct care, non-direct care, etc) should receive.

8.5 Conduct initial and ongoing organizational self-assessments of cultural competence and include them in quality improvement initiatives.

Public and private system administrators should perform organizational self-assessments related to cultural competence. The self-assessments should be conducted at multiple levels (central office, crisis services, inpatient services, community-based services). Ideally, the self-assessments should include analysis of populations served, state and county demographics, race/ethnicity/gender of staff, and language capacities. The

self-assessments should be used to understand how the system promotes cultural competence both formally and informally. The data obtained from the self-assessments can be utilized to identify potential disparities or areas to be improved and to monitor changes over time. It is important that data collected in the area of cultural competence be included in a quality improvement and accountability framework so that cultural competence is an integral component of management and services.

8.6 Involve communities and consumers in enhancing the cultural competency of the system.
As the public and private administrators work to enhance the system's cultural competency, they should develop and maintain collaborative partnerships with consumers, providers, and other key stakeholders in the community that predominantly serve or work with individuals that are racial and ethnic minorities, including those with limited English proficiency. Informal and formal mechanisms for involvement should be explored.

Recommendation 9: Ensure trauma-informed care.

A high prevalence of histories of interpersonal trauma, such as from sexual and physical abuse and assault, has been well documented among adults served by mental health systems (Goodman, Johnson, Dutton & Harris, 1997; Mueser, Bond, Drake, & Resnick, 1998; National Association of State Mental Health Program Directors [NASMHPD], 2005). Therefore, it is universally understood that almost all individuals seeking services from public mental health systems have trauma histories. It has also been well- documented that there are many common procedures and experiences in service settings that serve to re-trigger trauma reactions in individuals and that are considered to be emotionally unsafe and disempowering for survivors of trauma (Frueh et al., 2005; Harris & Fallot, 2001). This includes the use of coercive interventions such as the use of seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment instead of empowerment and choice (NASMHPD, 2005).

Consequently, there has been a call for systems to promote trauma-informed care (TIC). TIC incorporates an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services and a thorough understanding of the profound neurological, biological, psychological, and social effects of trauma and violence on individuals (Jennings, 2004). More resources on TIC can be found in Appendix P.

As part of the Quest for Recovery Initiative, the BHD has recently made a commitment to enhancing TIC in its service delivery systems. The BHD has formed a TIC team that will work to incorporate concepts of TIC into the day-to-day operations of the BHD. These efforts are in conjunction with the State's *"Shift Your Perspective"* campaign, which seeks to promote TIC amongst providers statewide. This report recognizes these important steps towards enhancing the quality of services and recommends that this effort be sustained throughout the system redesign project efforts.

The project team recommends that the BHD TIC team follow the actions that National Center for Trauma-Informed Care identified systems can take to begin the transformation to trauma-informed environments:

9.1 Commit to a TIC organizational mission and dedicate resources to support it.
9.2 Conduct universal screening for trauma for all individuals.
9.3 Incorporate values and approaches focused on safety and prevention for individuals served by the system and staff.

9.4 Create strength based environments and practices that allow for individual empowerment.

9.5 Provide ongoing TIC staff training and education

9.6 Improve and target staff hiring practices for TIC.

9.7 Update policies and procedures to reflect new TIC mission.

As noted by the National Center for Trauma Informed Care (NCTIC), trauma-informed care is a framework that is focused on healing and recovery, under which the premise for organizing services shifts from looking at "what is wrong with you?" to "what happened to you?" This requires an organizational shift from a traditional "top-down" environment to one that is based on collaboration with consumers and survivors.

Recommendation 10: Enhance quality assessment and improvement programs.

This report acknowledges that there are some quality improvement (QI) activities underway at the BHD and among private systems. However, this report recommends that existing QI efforts be expanded and enhanced to create a comprehensive, system-wide QI program. It is important that all system stakeholders know and communicate how they are performing, the outcomes they are achieving, and how the performance and outcomes compare to system wide goals.

10.1 Develop a coordinated QI process.

The County and other system stakeholders should ensure that the QI program is highly coordinated across the system and has adequate resources, especially for data collection and analysis. The QI program should be managed and implemented by senior staff (typically nursing) sufficient to establish authority and credibility. A team should be formed or an existing organizational component should be adapted that has the expertise and resources to conduct high quality performance improvement projects. Conducting effective QI projects is challenging, but numerous guides and other resource materials are available. Some can be found in Appendix P. It is important that the results of the QI program or projects be shared with stakeholders and that the information is tailored to suit the needs of the various stakeholders (consumers, family members, advocates, providers, etc). It may be necessary to seek expert consultation and/or training if the necessary expertise is not available.

10.2 Select a set of performance and outcome indicators and goals for the system.

Administrators throughout the system should identify a set of performance and outcome indicators to track. They should also identify clear and measureable goals to be achieved, though the initial number of process and outcome measures should be limited to a manageable number. Consumers, families, providers, advocates, and other key stakeholders should be involved in the identification and selection of the performance and outcome indicators for the system.

It is important that both process and short term and long-term outcome measures are included. Process measures capture how services and treatments are provided and allow system stakeholders to compare the quality of services across the County and to identify trends and exceptions to trends. Outcomes measures are the results of the treatments or services. When choosing measures for the system, stakeholders should examine the reporting requirements for federal and accreditation agencies (i.e., TJC) so that measures can be aligned. For resources and background information regarding quality efforts and tools, please refer to Appendix P.

Based on the analysis in this report, the project team recommends the following list of areas for which quality measures should be developed:

- Inpatient and Crisis Utilization: The County should continue to monitor its inpatient and crisis service utilization rates but with increased coordination with private hospitals. System stakeholders should also establish measures to track the use of crisis alternatives such as the Crisis Resource Center and peer-operated crisis services.
- Emergency Detentions: Similarly, the system stakeholders should continue tracking ED rates while also establishing performance measures to track the reductions and diversions as well as the completeness of the CIT training program. These efforts have the potential to create incentives for behavior and culture change within the system.
- Discharge Planning: System stakeholders should develop quality measures related to the continuity of services for individuals who are discharged from inpatient stays. These measures should include engagement continuity with community-based services but also use of crisis services.
- Evidence-based Practices: In addition to tracking the utilization of EBPs, the County and other system stakeholders should establish ongoing monitoring of the fidelity to the EBPs that are implemented.
- Case Management: benchmarks and goals for individuals moving out of case management, treatment planning, assessment of matching functional level to services, and others. For examples of core functions and performance measures used to monitor a case management program, see Appendix R.
- Benefits Counseling: Given the findings that many Milwaukee County residents are in need of benefits and entitlements counseling, system stakeholders should establish measures that track the availability and delivery of benefits counseling services and the extent to which Milwaukee County residents are receiving the benefits they are entitled to, particularly health insurance.
- Person-Centered Planning and Recovery Orientation: To promote a strong orientation towards mental health recovery, the quality infrastructure should include measures that track the extent to which services are promoting recovery.
- Cultural Competency and Trauma-Informed Care: Similarly, system stakeholders should develop measures that establish the extent to which services are meeting the diverse needs of the population, including services that are culturally appropriate and trauma-informed.

10.3 Make changes to management information systems to collect and report common data elements.

The hallmark of QI is continuous data collection and analysis. The first task of the QI program staff should be to assess the availability and quality of the following elements:

- Administrative information (e.g., claims and encounter data)
- Socio-demographic characteristics of the consumer population
- Patterns of service use, especially by vulnerable sub-populations (e.g. elderly, racial and ethnic minorities)
- Services or processes of care that are provided in high volume and/or offer the greatest potential for harm (e.g. psychiatric medication prescribing, seclusion and restraint)
- Areas which are known to be prone to problems based on organizational experience

- Sentinel events (critical incidents involving death or serious injury or a high risk of these, requiring immediate response)

This information will be the basis for identifying appropriate targets for a QI project and assessing the results of the project. It is important that data be accurate, timely, and consistent in order to produce timely reports for planning and decision-making. Data for this redesign project showed that improvements are needed in the availability of data within Milwaukee County, particularly in the area of assessments and outcome data. It would also be in the best interest of the County to regularly link county data with state data to understand the full packages of services that are currently being received. A common data system or common data elements across the systems (County and Medicaid) will allow an improved count of the number of unduplicated persons served, the identification of types and number of services, and outcomes. It will also allow the tracking of unique individuals across various service settings and sites. This will require a substantial investment by the County in up front resources, but will improve billing practices that will bring in more revenue and provide necessary information for management and improvement.

BHD and private providers need to ensure that there is strong connection between client and service information and financial management systems used for billing so that they can accurately track the exact amounts of services paid for specific clients and measure results associated with those payments and services. This will require a substantial investment in up front resources, but will improve billing practices that will bring in more revenue and provide necessary information for management and system improvement.

3. Develop a comprehensive implementation plan.

Because of the multi-faceted and interconnected nature of the above recommendations, the project team recommends that County and other system administrators work to develop a comprehensive implementation plan for moving forward.

Re-convene system stakeholders.

The system stakeholders involved in Phases 1 and 2 of this planning project along with any other relevant system stakeholders should be re-convened to discuss the analyses and recommendations in this report and develop a comprehensive and collaborative plan for moving forward with the implementation phase.

Form oversight steering committee.

As part of the implementation plan, a strong foundation of oversight should be established through a steering committee. This committee should include experts in the County who represent each of the stakeholder groups that will be involved in the system redesign.

Establish work groups to address common themes identified in this report.

To complement and enhance the implementation and oversight efforts of the steering committee, smaller more focused work groups should be established to create more detailed work plans in key areas that were identified in this report. Some areas include:

- Quality Improvement and Management Information Systems
- Inpatient phase-down
- Expanding community-based services

- Emergency detentions
- Cultural Competency and trauma-informed care
- Consumer/provider/public education
- Consumer satisfaction

Ensure full and active inclusion of consumer groups in all phases of implementation.
Because the ultimate goal of this system redesign effort is to create a mental health system that best meets the needs of the community and promotes recovery at all levels, it is critical that consumers are fully involved in all aspects of the implementation phase. The full involvement of consumers is consistent with state and national initiatives, including NFC Goal 3 that mental health care is consumer driven (Carroll, Manderscheid, Daniels, & Compagni, 2006; NFC, 2003). Our experience has shown that in order to reduce the effect of tokenism and promote full and active involvement, it is necessary to have more than one consumer of mental health services represented on every committee as well as each sub-committee or working group. Because consumers are themselves a diverse group, care should be taken to involve individuals who are reflective of the diversity of Milwaukee County.

4. Cost Implications

The project team recognizes that the Milwaukee County mental health system is working with extremely limited resources. The above recommendations have been crafted with budgetary considerations in mind. While some of the recommendations in this report will require an up-front investment of considerable resources by the County and/or other system stakeholders, the implementation of other recommendations will represent considerable cost savings. For example, a reduction in inpatient capacity by 20%, which will bring Milwaukee County to the national average inpatient utilization, will free up funds that can be used to strengthen the community-based services, which will in turn reduce the need for costly crisis and acute inpatient services. It is our hope that the readers of this report will take a wide view of the issues that have been raised, understanding that an up-front investment will not only reduce costs in the long-run but will also improve the quality of and access to mental health services for all Milwaukee County residents.

Limitations

Because many of the recommendations in this report have been developed based on the data collected as part of the system redesign project, it is important to discuss the limitations of that data. These limitations have been kept in mind when analyzing and interpreting the data, and they have also been taken into account in the recommendations regarding improvements in management of data.

1. Consumer SPES Data

Understanding the perspective of service system users is in keeping with the values of the project team and with the guiding principles of this system redesign effort. This project marks the first occasion in which HSRI has adapted the SPES for use with consumers of mental health services. The project team worked diligently with partners in the County to develop, pilot, and administer the survey, and the high response rate and richness of the data that was collected holds great promise in the future for those administering the consumer SPES.

However, because of the unprecedented nature of this effort, there are significant limitations associated with the data.

Most importantly, the survey itself was very lengthy and somewhat complex, which could have contributed to a response bias. A copy of the Consumer SPES can be found in Appendix H. In addition to its length of 23 pages, the survey covered issues ranging from functional level at different points in time throughout the month, to service needs and capacities. Some individuals may have had more difficulty understanding and responding to the survey than others. This may have resulted in an over-representation of a group who had an easier time filling out the lengthy and complex survey, and an under-representation of individuals who had a difficult time completing the survey.

In general, the Consumer SPES will need to undergo more testing and validating before results can be interpreted with high levels of confidence. However, the project team felt that the results of this preliminary effort were still relevant to the system redesign effort, despite its limitations.

2. Service Utilization Data

A number of limitations are also associated with the service utilization data collected from the State and County. Some of these limitations are common to all types of administrative data in any system planning effort, while others are specific to Milwaukee County's current data management systems.

Because the service utilization data was based on services and supports that were billed to either Medicaid (state data) or the BHD (county data), it is impossible to capture a complete service summary. Some programs, such as Warmline, Inc. receive separate funding and do not bill services based on individual service users. Thus, these programs were not captured in the service utilization data, although many service users may be using them as part of their service packages. Additionally, our data do not capture services and supports that were delivered outside of the behavioral health authority through other state and county agencies or social service organizations that do not bill Medicaid or BHD.

Also, any analysis of claims data is subject to administrative errors associated with that data. Further, this analysis linked state and county data to develop a picture of the ways in which these services overlap. This process was not automated and could thus lead to further administrative errors.

3. Outcome Data

As noted in earlier sections of this report, the project team encountered significant difficulties collecting reliable data on client outcomes, particularly functional levels. This functional level information is usually translated into HSRI's RAFLS scale and used to compare service usage and needs across the system. In the state-level data that was available for this system redesign project, however, no such functional level data was recorded. For the functional level data that was recorded, assessments were not frequent and not completed for a large number of individuals, resulting in estimates of current functioning and utilization on subsets of the population that are likely not representative of the population as a whole.

4. Inpatient Service Capacity Data

In the project team's analysis of inpatient capacity service utilization, data regarding typical inpatient usage strongly suggested that the bed capacity in Milwaukee County is comparable to or higher than other localities of

this size. However, it is important to keep in mind that no single county is alike, and a wide range of factors can influence the need for psychiatric inpatient beds. Further, in the project team's experience, there are virtually no other counties in the United States that have county-operated acute, rehabilitation (extended care) and long term care for both adults and youth. The comparison data that was used in this analysis was the best that the project team was able to find under the circumstances, but it is acknowledged that Milwaukee County's own unique characteristics make such comparisons difficult.

Conclusion

An underlying theme of this report is the need for stakeholders in Milwaukee County to pursue a gradual expansion of community-based services alongside a phasing down of inpatient services. The rationale for these recommendations is threefold:

1. This is the law – to serve people in the least restrictive environment. Based on the Supreme Court's decision in *Olmstead*, it is imperative to end the county's over-reliance on institutional models of care.
2. A shift to community care will lead to better outcomes and quality of life. As compared with other communities, county resources are disproportionally invested in inpatient and crisis care while community services are underfunded. The county must invest in integrated community services that help consumers maintain their health and independence.
3. It is ultimately more cost-effective to provide services in the community as opposed to inpatient settings.

This project presented an opportunity for all the entities that plan, fund, deliver, and receive mental health and/or substance abuse services in Milwaukee County to work collaboratively to assess needs and identify gaps in services and resources. The process itself is an important tool for identifying system issues and barriers. The Project Team recognizes the challenges this created for those individuals and organizations and commends all involved for their openness, willingness to work together, and ability to look at themselves, their work, and their position in the system with a critical eye.

This project and this report should be the beginning of Milwaukee County's assessment and analysis efforts. No single report can tell the entire story of a county's populations in need, and the services required or the barriers that exist to meeting those needs. Furthermore, no single report can be as detailed as stakeholders might like for issues of interest. However, the information in this report and the process by which the information was developed has provided an impetus for additional assessment and analysis by various stakeholders in the public and private sectors. This information also can provide the basis for future planning efforts to create an improved behavioral health system throughout Milwaukee County.

A system of mental health services with as many identified gaps as Milwaukee County's cannot be changed in a few months or even a few years. However, gains can be made quickly if those in positions to take action can agree on goals, priorities and actions. This report is designed to provide data and information that can be used by county officials, community leaders, consumers and families, legislators and advocates to:

- Determine what needs to be added to these materials
- Determine what needs to be known that is not currently available

- Determine mechanisms for developing additional information and conducting additional analyses as national or state-specific data become available
- Develop plans and proposals
- Identify critical collaborators for system change
- Select critical system barriers to address individually and collectively
- Make critical decisions about service delivery philosophy and directions
- Determine services, populations, and geographic areas that should be targeted for investment of additional resources as they are available

The Project Team acknowledges that this report may serve as a solid basis for asking good questions, as opposed to a resource for answering every question first posed. It is the Team's hope, however, that this project initiates a continued and longstanding process of collaboration across the County to fill some of the gaps and remove some of the barriers identified in this report.

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Appendix A: List of Key Informants Involved in the Milwaukee Mental Health System Redesign Project

The following groups and individuals were involved as key informants in this project. Informants participated in multiple aspects of the redesign project, including the development of guiding principles, interviews, and community meetings.

Behavioral Health Advisory Committee

- Bill Bazan, Wisconsin Hospital Association
- Barbara Beckert, Disability Rights Wisconsin
- Pat Bellittiere, Froedtert Memorial Lutheran Hospital
- Jennifer Bergersen, Milwaukee County Behavioral Health Division
- Jon Berlin, MD, Milwaukee County Behavioral Health Division
- Pete Carlson, Aurora Psychiatric Hospital
- Jennifer Collins, Milwaukee County Board of Supervisors
- John Easterday, WI Department of Health Services
- Tom Harding, MD, Milwaukee County Behavioral Health Division
- Thomas Heinrich, MD, Medical College of Wisconsin
- Rob Henken, Public Policy Forum
- William Henricks, Columbia St. Mary's Hospital
- Carol Hess, Wheaton Franciscan Health Care
- Julie Hueller, Wheaton Franciscan Health & Addiction Care
- Jim Kubicek, Milwaukee County Behavioral Health Division
- Walter Laux, Milwaukee County Behavioral Health Division
- Geri Lyday, Milwaukee County Behavioral Health Division
- Joy Mead-Meucci, Aurora Behavioral Health Services
- Paul Mueller, Rogers Memorial Hospital
- Mary Neubauer, Consumer
- Andrew Norton, MD, Froedtert Memorial Lutheran Hospital
- Clare Reardon, Froedtert Memorial Lutheran Hospital
- Laura Roberts, MD, Medical College of Wisconsin
- Chief Francis C. Springob, Greenfield Police Department
- Carol Swiderski, Wheaton Franciscan Health & Addiction Center
- Joy Tapper, Milwaukee Health Care Partnership
- Zachary Timm, Froedtert Memorial Lutheran Hospital
- Paul West, Sixteenth Street Community Health Center
- Chief Ann Wellens, South Milwaukee Police Department
- Janet Wimmer, Wisconsin Community Services
- Jennifer Wittwer, Milwaukee County Behavioral Health Division
- Carianne Yerkes, Milwaukee Police Department

Behavioral Health Division Leadership Team

- Jennifer M. Bergersen, MSW, CAPSW, Director, Acute Inpatient Services
- Jon Berlin, M.D., Medical Director, Psychiatric Crisis Center
- Mary Boltik, Medical Records Director
- Chris Collentine, MSN, RN, Director of Educational Services
- Lynn Gram, Assistant Hospital Administrator, Environment of Care
- Thomas Harding, M.D., Medical Director
- David Jaet, Ph.D., Integrated Service Coordinator
- Bruce Kamradt, Administrator, Child and Adolescent Community Services
- Dennis Kozel, M.D., CAIS Medical Director
- Alexandra Kotze, Fiscal & Management Analyst
- Keith Kalberer, Operations Coordinator
- James P. Kubicek, LCSW, Director, Crisis Services
- Walter Laux, Administrator, Adult Community Mental Health and AODA Services
- Brian Lecus, BHD Project Manager, Accenture
- Mary Kay Luzi, Ph.D., Associate Director of Clinical Operations
- Yvonne Makowski, Human Resources Coordinator
- Rodney Maybin, Administrator, Nursing Home Services
- Patricia Meehan, R.N., Director, Quality Assurance/Quality Improvement
- Susan Moeser, Ph.D., Fiscal Director, Patient Accounts
- Christopher Ovide, Ph.D., Director of Legal Services & President of Medical Staff
- Dawn Puls, M.D., Medical Director, Hilltop and Rehab Central
- Laura Riggle, Ph.D., Chief Psychologist/Director of Day Hospital
- Jael Robles, M.D., Medical Director, Acute Adult Inpatient Services
- Cheryl Schloegl, R.N., Associate Administrator of Nursing
- Jim Tietjen, Associate Director, DHHS Operations
- Pat Walslager, CPA, Associate Mental Health Administrator-Fiscal
- Jennifer Wittwer, MSW, Associate Director of Adult Community Services

Milwaukee Mental Health Task Force Steering Committee

- Mary Neubauer, Co-chair
- Marilyn Walczak, Co-chair
- Peter Hoeffel, Immediate Past Chair
- Bob Curry
- Colleen Dublinski
- Martina Gollin-Graves
- Jim Hill
- Walter Laux
- Rachel Morgan

- Robin Pederson
- Brenda Wesley
- Kenyatta Yamel
- Barbara Beckert, Coordinator

Milwaukee Mental Health Task Force Participating Organizations

- Abri Health Plan
- Aurora Health Care
- Behavior Health Provider Group
- Bell Therapy
- Benedict Center
- Black Health Coalition of Wisconsin
- Cenpatico Behavioral Health
- Centene
- Charles E. Kubly Foundation
- Columbia College of Nursing
- Community Advocates
- Community Care
- The Counseling Center of Milwaukee, Inc.
- Depression and Bipolar Support Alliance
- Disability Rights Wisconsin
- Division of Community Corrections
- Dryhootch of America
- Encompass Effective Mental Health Services
- Faye McBeath Foundation
- Grand Avenue Club
- Greater Milwaukee Foundation
- Health Care for the Homeless
- Impact
- Independence*First*
- I-Care
- Jewish Community Mental Health Education Project
- Justice 2000
- La Causa
- Latino Health Coalition
- Legal Aid Society
- Managed Health Services
- Make It Work Milwaukee Coalition
- Medical College of Wisconsin
- Mental Health America of Wisconsin

- Milwaukee Center for Independence
- Milwaukee Clinicians of Color
- Milwaukee County Behavioral Health Division
- Milwaukee County Disability Services Division
- Milwaukee County District Attorney's Office
- Milwaukee County Housing Division
- Milwaukee County Pretrial Services
- Milwaukee County Sheriff's Office
- Milwaukee Health Department
- Milwaukee Latino Health Coalition
- Milwaukee Police Department
- NAMI Greater Milwaukee
- Our Space
- Rogers Memorial Hospital
- Sixteenth Street Community Health Center
- Social Rehab
- Sojourner Family Peace Center, Inc.
- State Public Defender's Office
- Transitional Living Services
- United Way of Greater Milwaukee
- University of Wisconsin-Milwaukee
- Veterans Association
- Vital Voices for Mental Health
- Warmline, Inc.
- Wheaton Franciscan Healthcare
- Willowglen Academy
- Wilberg Community Planning, LLC
- Wisconsin Community Services
- Youth Mental Health Connection

Key Informant Interview Participants (not listed as part of other groups above)

- Karen Avery, Independence*First*
- Dan Baker, Crisis Resource Center
- Lynne DeBruin, Milwaukee County Supervisor
- Kathy Eilers, former BHD Administrator
- Colleen Foley, Milwaukee County Corporation Counsel
- Rachel Forman, Grand Avenue Club
- William Henrichs, Columbia St. Mary's and Rogers Memorial Hospital
- Tom Lutzow and staff, *i*Care
- Dr. Kenneth Minkoff

- Janet Malmon, Vital Voices
- Candice Owley, Wisconsin Federation of Nurses and Health Professionals
- Tom Reed, Wisconsin Public Defenders Office
- Dr. Laura Roberts, former Director of Psychiatry, Medical College of Wisconsin
- Joe Volk, Community Advocates
- CEOs and Behavioral Health Directors, Federally Qualified Health Centers
- Behavioral Health Leaders, Major Milwaukee Area Health Systems

Community Meeting Participants

Over 200 community members participated in meetings hosted by the following organizations:

- Hosted by the Milwaukee Mental Health Task Force at Independence*First* on September 8th, 2009
- Hosted by the Black Health Coalition of Wisconsin at Independence*First* on September 9th, 2009
- Hosted by the Milwaukee Latino Coalition at United Community Center (UCC) on October 20th, 2009.

In addition, Disability Rights Wisconsin organized two smaller meetings with behavioral health stakeholders from the African American and Hispanic Communities.

Appendix B: Wisconsin Public Insurance Coverage of Mental Health Services

Medicaid in Wisconsin

The Medicaid public health insurance program was established in 1965 under the federal Social Security Act as a medical assistance program for low-income individuals. Medicaid is now administered and funded jointly by federal and state governments. The federal government mandates that every state participate in certain Medicaid programs that serve low-income children and their caretakers, pregnant women, the elderly, and people with disabilities. Many states, including Wisconsin, have chosen to create Medicaid programs that serve other optional target populations. For example, the Wisconsin BadgerCare Plus Program and the Medical Assistance Purchase Plan[12] have expanded Medicaid to cover certain groups with incomes above the federally mandated Medicaid income limits.

A large share of the Medicaid program targets people who are elderly, blind, or disabled. Some people with mental health needs who also fall into one or more of these categories, such as people with mental illness who have had a disability determination, may receive mental health-related services covered by Medicaid. Other programs, described below, target low-income people who are not elderly, blind, or disabled.

Family Medicaid Programs for Low-Income Families and Childless Adults

In Wisconsin, "family" Medicaid programs are known as either BadgerCare Plus or BadgerCare Core. **BadgerCare Plus** provides insurance to low-income families with children. A year-old program, **BadgerCare Core** provides insurance to low-income childless adults (this program currently has a waiting list and new enrollments are suspended). Both programs feature co-payments for most participants.

BadgerCare Plus benefits depend on income:

- Families with income below 200% of the Federal Poverty Level (FPL) are enrolled in the **Standard Plan**.
- Families with income above 200% of the FPL, or people who are self-employed, are enrolled in the **Benchmark Plan**. The Benchmark Plan was originally much more limited in its coverage of mental health services than the Standard Plan, but federal mental health parity legislation has broadened the Benchmark Plan's coverage.

BadgerCare Plus Standard Plan Coverage of Mental Health Services

The Standard Plan's coverage related to mental health is comprised of the following[13]:

- Case management
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease[14] who are:

[12] The Wisconsin Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to buy health care coverage through the Wisconsin Medicaid Program. http://www.dhs.wisconsin.gov/wipathways/MAPP.htm

[13] To see all services covered: http://www.dhs.wisconsin.gov/BadgerCarePlus/standard.htm.

    - Under 21 years of age
    - Under 22 years of age and was getting services when patient turned 21 years of age
    - 65 years of age or older
- Intermediate care facility services, other than services at an institution for mental disease
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program

BadgerCare Plus Benchmark Plan Coverage of Mental Health Services

In 2010, federal mental health parity laws eliminated the BadgerCare Plus Benchmark Plan's dollar amount service limitations for mental health and substance abuse treatment. Limits on the number of days of inpatient treatment to be covered were also eliminated. Mental health services/treatments covered under the Benchmark Plan include the following:[15]

- Child/adolescent mental health day treatment
- Inpatient hospital stays for mental health and substance abuse treatment at acute care general hospitals and Institutes for Mental Disease (IMDs) (limit of $7,000 in coverage per year)
- Mental health day treatment for adults
- Outpatient mental health treatment
- Generic prescription drugs

BadgerCare Plus' Benchmark Plan does not cover the following mental health-related services:

- Community Support Program services
- Comprehensive community services
- Crisis intervention
- Intensive in-home mental health treatment services for children
- Outpatient services in the home and community for adults

BadgerCare Core Coverage of Mental Health Services

BadgerCare Core[16] for childless adults does not cover inpatient mental health and substance abuse treatment services. Mental health visits are covered only when they are with a psychiatrist. Mental health drugs are covered.

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[14] An Institution for Mental Diseases (IMD) is a hospital, nursing facility, or other institution of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases. Milwaukee County's Behavioral Health Division includes an IMD.
[15] http://www.dhs.wisconsin.gov/BadgerCarePlus/benchmark.htm
[16] http://www.dhs.wisconsin.gov/BadgerCarePlus/core/gampfs.htm

Appendix C: Key Informant Interview Questionnaire

Respondent Information

1. Tell me about yourself/your organization.
    - Mission? How long in the area?
    - Services provided or issue you work on?
    - How do you define your organization/community/service area?

Populations in Need of Services

2. Are there any specific populations that are not being adequately served or not being served at all?
    - What do you think is preventing these individuals from being served?
    - Are there population groups that are being served well? If so, please describe.
    - Are there any populations currently receiving services or utilizing service capacities/funding resources that you believe should not be receiving those services or should be receiving services elsewhere?
    - Are there any special needs that are not being met or are being met inadequately?
        - Individuals with needs in adult corrections, including jail/prison and those on parole or in transition to the community?
        - Individuals with co-occurring disorders of substance abuse and mental illness?
        - Individuals with a dual diagnosis or dual needs of DD and mental illness?
        - Persons who are homeless, including adults and families with children?
        - Racial and ethnic minority populations?
        - Individuals who are aged 18-21 and in transition from the child/adolescent service system to the adult service system?

Service and Support Needs

3. What is the experience of getting mental health services like?
    - Where do people first go for mental health care? Outpatient services? Case management? Emergency Room/Crisis services?
    - What about people who are brand new to the system?
    - What about people with no health insurance?
4. Are the services provided by the mental health system adequate?
    - What services are missing or inadequately available?
    - Are there services that should be preserved or expanded?
    - Are there services that you think are not useful or should be curtailed?

System and Financial Issues

5. How are the formal and informal policies or practices of providers, managed care entities, insurers, or funders affecting the delivery of mental health services?
    - Are there any policies that are impeding the delivery of mental health services?
    - Are there any policies that are helping to ensure adequate services are available?
6. Are rates being paid to providers adequate for them to provide high quality services?

- Can you give examples?
- Are any rates too high?

7. Do you believe providers, managed care companies, insurers, and/or funders are conducting adequate oversight processes to assure that services are of high quality?
    - Can you give examples?

Community and Consumer Involvement

8. Is there sufficient public input into service delivery decisions?
    - Are there forums for the public to have a voice in the service delivery systems?
    - Do entities within the mental health system reach out to the public to seek their views?
    - Are they receptive to feedback from the community?
    - Are there specific groups in the community that are given fewer opportunities to give feedback, or from whom feedback is not responded to?
9. Is there sufficient consumer input into service delivery decisions?
    - Are there forums for consumers to have a voice in the service delivery systems?
    - Do entities within the mental health system reach out to consumers to seek their views?
    - Are they receptive to consumer feedback?

Human Resource and Provider Capacity Issues

10. Are there sufficient numbers of qualified service provider agencies and individual practitioners in Milwaukee County?
    - Which are available in adequate numbers?
    - Which aren't available in adequate numbers?
11. What factors do you believe influence the recruitment and retention of high quality service providers and practitioners?
    - What are the barriers to recruitment and retention?
    - What training and information needs are being met, and what needs remain unmet?
    - Are there exemplary practices or projects to recruit and retain providers and practitioners that we should know about?

Sources of Information

12. Are there documents, needs assessments, or data that you believe would be helpful to this project?
    - If so, what are they, and where can we get them?
13. Are there other people or groups you believe we should be talking to about the needs in your area?
    - Who are they, and how do we contact them?

General Questions

14. What ideas for changes do you have that would make the system work better?
15. Is there anything else that you think is important to know about the mental health service system in Milwaukee County that we did not get to today?

Appendix D: Resource Associated Functional Level Scale (RAFLS)

The approach to planning services used by HSRI is based on consumer functional level. In order to assess consumer functional level, HSRI uses the Resource Associated Functional Level Scale (RAFLS) that divides consumers into seven levels of functioning. The first six of these functional levels describe individuals who may require services from the mental health system.

1. **At-Risk**: At-risk to self or others, or to property of value. Unable or unwilling to participate in one's own care or to cooperate in control of violent or aggressive behavior. May require continuous (24-hour) supervision, high staff/consumer ratio.
2. **Unable to Function, Current, Acute Psychiatric Symptoms:** Acute symptoms may result in behavior that is seriously disruptive or at-risk to self or others, but if so, is able/willing to control impulses with assistance and willing to participate in own care. Alternatively, acute symptoms seriously impair role functioning. Examples of acute symptoms: lack of reality testing, hallucinations or delusions, impaired judgment, impaired communication, or manic behavior. Nonetheless, may be able to carry out *some* ADLs. May require continuous supervision, or moderate staff/consumer ratio.
3. **Lacks ADL/Personal Care Skills:** Lacks ADL due to active symptoms that do not result in behavior that is seriously disruptive or dangerous. Unable or unwilling to make use of sufficient ADL and/or personal care skills to carry out basic role functions. May require continuous (24-hour) prompting, skill training, and encouragement.
4. **Lacks Community Living Skills:** Able to carry out ADL personal care skills. Role functioning impaired by lack of community living skills or motivation to perform. Community living skills include: money management, ability to engage in competitive employment, maintaining interpersonal contacts. May require regular and substantial but not necessarily continuous training, prompting, and encouragement.
5. **Community Living Skills but Vulnerable to Stresses of Everyday Life:** Can perform role functions, at least minimally, in familiar settings and with frequent support to deal with the ordinary stresses of everyday life; although may need the regular assistance of a roommate, homemaker-aide, etc., or can work outside of sheltered situations with on-site support or counseling. Requires support under the stresses associated with the frustrations of everyday life and novel situations. May require frequent (e.g., weekly) information, encouragement, and instrumental assistance.
6. **Community Living Skills and Only Needs Support/Treatment to Cope with Extreme Stress or Seeks Treatment to Maintain or Enhance Personal Development:** Can perform role functions adequately except under extreme or unusual stress. At these times, the support of natural or generic helpers such as family, friends, or clergy is not sufficient. Mental health services are required for the duration of stress. Performs role functions adequately, but seeks mental health services because of feelings of persistent dissatisfaction with self or personal relationships. Intensity and duration of treatment can vary.
7. S**ystem Independent:** Can obtain support from natural helpers or generic services. Does not require or seek mental health services.

Appendix E: Case Management Service Planning and Evaluation Survey

BHD ID: ____________________

Reporting Unit Number: ____________________

Date: ____________________

Functional Level RAFLS Scores:	Beginning of the Month	End of the Month	Typical Day in the Month

This survey should only be completed for individuals who received services for the entire month of January

Unable to report____

Reason for being unable to report: ___Moved ___Jail ___Unable to locate, presumed homeless ___Disappeared ___Discharged

For how many months has the person been receiving CSP/TCM Services? ______ Years ______ Months

How many times did you see the person in the month of January? ______ Times

(A) Service Component	(B) Service Unit	(C) Services Consumer Should Ideally Receive (Units/Mo)	(D) Units Actually Provided to Consumer	(E) Reasons for Discrepancies Between Columns C & D
Locked Facilities				
Acute Inpatient	Days	C	D	E
Long-Term Care	Days	C	D	E
Detoxification Program	Days	C	D	E
Residential Programs				
24-Hour Community-Based Residential Facility	Days	C	D	E
Transitional Housing Program	Days	C	D	E
Safe Haven	Days	C	D	E

If amount received was less than the ideal:

1. Service does not exist
2. Service has insufficient capacity
3. Consumer was refused for behavioral reasons
4. Inability to pay
5. Accessibility problem
6. Language or cultural problem
7. Consumer refused service
8. Family/other request
9. Clinician decided service should not be

(A)` Service Component	(B) Service Unit	(C) Services Consumer Should Ideally Receive(Units/Mo)	(D) Units Actually Provided to Consumer	(E) Reasons for Discrepancies Between Columns C & D
My Home	Days	C	D	E
Crisis Services				
24-Hour Crisis Service (Telephone and Walk-In)	Hours	C	D	E
Mobile Crisis Service	Hours	C	D	E
Obs. Unit/ Emergency Hosp.	Days	C	D	E
Crisis Resource Center	Hours	C	D	E
Crisis Case Management	Hours	C	D	E
Crisis Respite Care	Days	C	D	E
Outpatient Treatment				
Evaluation/Assessment	Hours	C	D	E
Medication Management	Hours	C	D	E
Individual Psychotherapy	Hours	C	D	E
Group Psychotherapy	Hours	C	D	E
Substance Abuse Counseling	Hours	C	D	E
Day Treatment	Days	C	D	E
Community-Based Services				
Social and Recreational Skills Training	Hours	C	D	E
Activities of Daily Living Services	Hours	C	D	E
Employment-Related Services	Hours	C	D	E
Case Management and Support Services	Hours	C	D	E
Drop-In/Social Club	Hours	C	D	E
Peer-Operated Services	Hours	C	D	E

provided
10. Other reason not listed above
11. Insurance issue
12. Diagnosis exclusion

If amount received was more than the ideal:
11. Service substitute for ideal service
12. Clinician decided service should be provided
13. Consumer requested service be provided
14. Family requested service be provided
15. Other reason not listed above

COMMUNITY RECOVERY SERVICES – 1915(I) WAIVER				
Supported Employment	Hours	C	D	E
Peer/Advocate Supports	Hours	C	D	E
Other Services Not Listed Above – Specify Service Type and Units				
Specify:	Units	C	D	E
Specify:	Units	C	D	E
Specify:	Units	C		

Appendix F: Targeted Case Management SPES Newsletter

Transforming the Adult Mental Health Care System in Milwaukee County

Results from the Targeted Case Management Survey

Redesigning the Adult Mental Health System in Milwaukee County

97%

...was the response rate for the case manager survey. Well done!

Special points of interest:

- More than half of all TCM clients have been receiving services for over five years.
- Clients who have been receiving TCM services for more than ten years have and average of three more contacts per month than those who have received services for less than one year.
- Case managers identified a need for some services, including substance abuse treatment and help with employment and housing .

For more details, see Page 2.

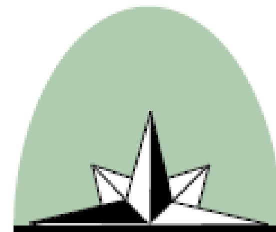
The Service Planning and Evaluation Survey (SPES) for Targeted Case Management

The Human Services Research Institute (HSRI), a partner in the Milwaukee County Mental Health System Redesign project, has developed a system to assist in assessing mental health service needs for persons with severe and persistent mental illness. The system uses judgments about service needs, survey data, interviews, unit cost information, and a dynamic computer model in assessing need. The system provides decision makers with estimates of what service utilization, costs, and client outcomes to expect. This knowledge can then be used to develop a well-functioning mental health service system.

One question that needed to be answered to apply the needs assessment system is what types and amounts of service consumers at different levels should receive. The information case managers provided was used to address this question. Case managers were selected to participate in the needs assessment process because of this group's particular perspective and expertise on the needs of persons receiving mental health services.

During the first two weeks of February this year, Milwaukee County case managers participated in the Milwaukee County Mental Health System Redesign Project by filling out a SPES for each client on their caseload. Case managers indicated the individual's level of functioning, the number of times the person was seen in the past month, and the services they needed and received.

This survey is one important part of a comprehensive redesign project. The project team will also be collecting information from a number of stakeholders, including consumers and other service providers. The project team will also be comparing county service utilization data to national data.



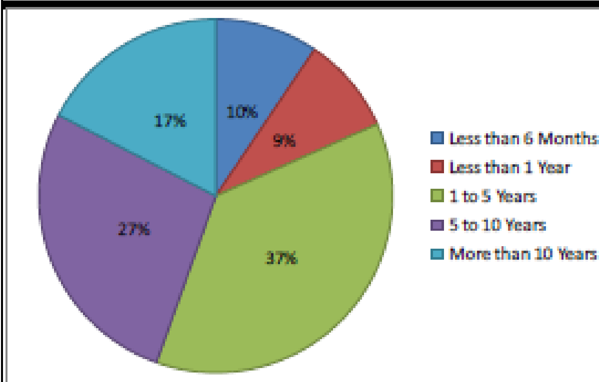
The project staff would like to extend a sincere THANK YOU to the case managers for participating in this very important part of the Milwaukee County Redesign Project.

Differences Between Current and Ideal Service Amounts

Based on the information provided by case managers, HSRI was able to calculate whether individuals were receiving the types and amounts of services that were appropriate for their needs. A list of these services and the percentage of needs that were met are listed in the table to the right. The "Difference in Units" column was created by subtracting the amount of services that were provided from the amount case managers recommended.

The survey indicates a need for more services that help individuals to live and work in the community. Case managers felt that TCM clients needed more support finding and maintaining employment and housing, as well as developing social skills and positive relationships. Case managers also expressed that many individuals on their caseloads are in need of services that help them with substance abuse problems.

Service Type	Unit	Difference in Units	% Needs Met
24 Hour CBRF	Day	-211	74%
Activities of Daily Living	Hour	-927	39%
Supported Apartments	Day	-1184	56%
Social & Recreational Skills	Hour	-900	35%
Group Therapy	Hour	-207	27%
Individual Therapy	Hour	-484	37%
Drop-in Social Club	Hour	-1998	33%
Supported Employment	Hour	-662	37%
Employment-Related Services	Hour	-459	31%
Day Treatment	Day	-926	22%
Substance Abuse Counseling	Hour	-1195	12%
Detoxification Program	Day	-185	5%



Amount of Time Spent in Targeted Case Management

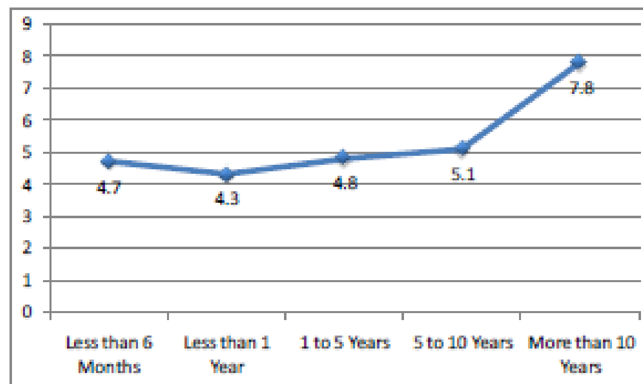
The survey found that 44% of clients have been receiving TCM services for over five years. Approximately 9% of individuals are new to case management services this year. 76 individuals left TCM services during the one-month study period. Reasons for leaving included going to jail, moving out of the area, and becoming unable to be located by case managers. A total of 11 individuals were formally discharged from TCM services during the month of January.

Longer Term Clients Have More Contacts Per Month

The graph to the right shows the number of contacts that case managers reported having with their clients based on the length of time that the clients have been receiving TCM services.

Clients who have been in case management services for less than six months saw their case managers an average of about 5 times per month. Clients who have received TCM services for more than 10 years had an average of about 8 contacts per month.

In general, the longer individuals received TCM services, the more frequently they were in contact with their case managers.



Appendix G: Community Support Program SPES Newsletter

Transforming the Adult Mental Health Care System in Milwaukee County

Results from the Community Support Program Survey

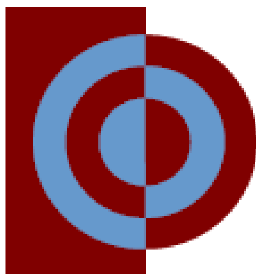
97%

...was the response rate for the case manager survey. Well done!

Special points of interest:

- Approximately two-thirds of all CSP clients have been receiving services for over five years.
- CSP clients had frequent contact with case managers. Most CSP case managers are in touch with clients more than ten times per month.
- CSP case managers identified a need for some services, including substance abuse treatment and help with employment and housing.

For more details, see Page 2.



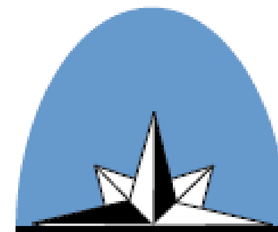
The Service Planning and Evaluation Survey (SPES) for CSP Case Managers

The Human Services Research Institute (HSRI), a partner in the Milwaukee County Mental Health System Redesign project, has developed a system to assist in assessing mental health service needs for persons with severe and persistent mental illness. The system uses judgments about service needs, survey data, interviews, unit cost information, and a dynamic computer model in assessing need. The system provides decision makers with estimates of what service utilization, costs, and client outcomes to expect. This knowledge can then be used to develop a well-functioning mental health service system.

One question that needed to be answered to apply the needs assessment system is what types and amounts of service consumers at different levels should receive. The information case managers provided was used to address this question. Case managers were selected to participate in the needs assessment process because of this group's particular perspective and expertise on the needs of persons receiving mental health services.

During the first two weeks of February this year, Milwaukee County case managers participated in the Milwaukee County Mental Health System Redesign Project by filling out a SPES for each client on their caseload. Case managers indicated the individual's level of functioning, the number of times the person was seen in the past month, and the services they needed and received.

This survey is one important part of a comprehensive redesign project. The project team will also be collecting information from a number of stakeholders, including consumers and other service providers. The project team will also be comparing county service utilization data to national data.



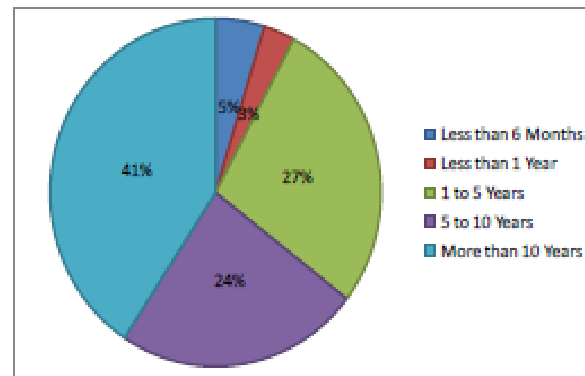
The project staff would like to extend a sincere THANK YOU to the case managers for participating in this very important part of the Milwaukee County Redesign Project.

Differences Between Current and Ideal Service Amounts

Based on the information provided by the CSP case managers, HSRI was able to calculate whether individuals were receiving the types and amounts of services that were appropriate for their needs. A list of these services and the percentage of needs that were met are listed in the table to the right. The "Difference in Units" column was created by subtracting the amount of services that were provided from the amount case managers recommended.

The survey indicates a need for more services that help individuals to live and work in the community. CSP case managers felt that their clients needed more support finding and maintaining employment and housing, as well as developing social skills and positive relationships. CSP case managers also expressed that many individuals on their caseloads are in need of services that help them with substance abuse problems.

Service Type	Unit	Difference in Units	% Needs Met
24 Hour CBRF	Day	-495	71%
Activities of Daily Living	Hour	-832	76%
Supported Apartments	Day	-716	60%
Social & Recreational Skills	Hour	-1173	64%
Group Therapy	Hour	-506	51%
Individual Therapy	Hour	-504	48%
Drop-in Social Club	Hour	-3423	25%
Supported Employment	Hour	-1154	18%
Employment-Related Services	Hour	-1361	14%
Day Treatment	Day	-859	10%
Substance Abuse Counseling	Hour	-859	10%
Detoxification Program	Day	-448	8%

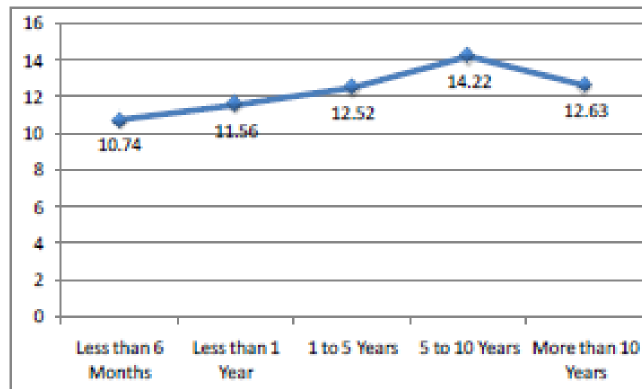


Amount of Time Spent in the Community Support Program

The survey found that the majority (65%) of clients have been receiving case management services for over five years. Approximately 8% of individuals are new to CSP services this year. A total of 21 people left CSP services in the one-month study period. Reasons for leaving included going to jail, moving out of the area, and becoming unable to be located by case managers. No individuals were formally discharged from CSP services during the month of January.

CSP Clients Have More Than Ten Contacts Per Month

The graph to the right shows the number of contacts that CSP case managers reported having with their clients based on the length of time that the clients have been receiving CSP services. Clients who have been in case management services for less than six months saw their case managers an average of about 11 times per month. Clients who have received case management services for more than 10 years had an average of about 13 contacts per month, and individuals receiving CSP services for five to ten years had contact with case managers over 14 times per month.



Appendix H: Consumer Service Planning and Evaluation Survey

Survey of Your Mental Health Services

This survey asks about your mental health services **for the past 30 days**. It also asks about what services you think you needed more of, and what services you think you needed less of. **Please complete every section – even if you did not receive the services asked about.** Even if you did not receive any services in the past 30 days, we want to know whether you needed them. There is also a page at the back of this survey to make comments about services you did or didn't get.

We also want to know how well you were doing at different points in the past 30 days.

Level Now *(please put a number from the levels below)*: ______

Level 30 days ago *(please put a number from the levels below)*: ______

Average level over the past 30 days *(please put a number from the levels below)*: _____

This scale goes from 1 to 7. There is a brief description of each level next to the number. We want to know how well you are able to do things. It is not your level of sadness, anger, or happiness. It is about ability to do practical things.

Level	Description of the level
1	Can get support from family, friends, or others in my life that is not mental health professionals. Do not need mental health services.
2	Able to take care of myself and use my skills in the community. Don't need support to deal with day-to-day stresses, but need support to cope with extreme or unusual stresses.
3	Able to take care of myself and use my skills in the community. Need a lot of support to deal with day-to-day stresses.
4	Able to take care of myself, but have trouble doing things in the community like managing my money, working, or connecting with people. Need regular support to do these things.
5	Unable to take care of my living space or myself. Need constant support to be able to attend to my daily living skills.
6	Want to hurt myself or others, but able to control my behavior. Able and want to get help or care.
7	Want to hurt myself or others, and not able to control my behavior. Unable to participate in care or don't want to get help.

Acute Inpatient

This is when you go to a hospital when you or others think you are in a crisis and can't take care of yourself.

I had _______ days of acute inpatient in the past 30 days (fill in the blank with number of days, or put a 0 if you did not get any).

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

Please check all that apply to you:

☐ *Service **does not exist** or there was **no room** for me*

☐ ***My family requested** that I have more or less*

☐ *My **provider decided** I should have this service **even though I didn't need it***

☐ *I refused because **I didn't think I needed the service***

☐ *There was a **language** or **cultural barrier***

☐ *The service I needed or preferred was not available so **I got this service instead***

☐ *I refused because **the quality of the service is bad***

☐ *I was **unable to pay** or there was an **insurance issue***

☐ *My **provider decided I should not** have this service*

☐ *They **wouldn't let me into** this service because of my **behavior** or my **diagnosis***

☐ *I refused because **I didn't understand what the service is**.*

COMMENTS (optional):

24 Hour Community Based Residential Facility (CBRF)

This is a place where you live with other people. Staff is there 24 hours per day, 7 days per week to provide support to you.

I had _______ days of 24-hour community based residential facility in the past 30 days (fill in the blank with number of days, or put a 0 if you did not get any)

I needed ___________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

Please check all that apply to you:

☐ *Service **does not exist** or there was **no room** for me*

☐ ***My family requested** that I have more or less*

☐ *My **provider decided** I should have this service **even though I didn't need it***

☐ *I refused because **I didn't think I needed the service***

☐ *There was a **language** or **cultural barrier***

☐ *The service I needed or preferred was not available so **I got this service instead***

☐ *I refused because **the quality of the service is bad***

☐ *I was **unable to pay** or there was an **insurance issue***

☐ *My **provider decided I should not** have this service*

☐ *They **wouldn't let me into** this service because of my **behavior** or my **diagnosis***

☐ *I refused because **I didn't understand what the service is**.*

COMMENTS (optional):

Transitional Housing

This could be a room or apartment or other place where you live temporarily while you are looking for permanent housing. There is staff there, but they may not be there 24 hours/day.

I had _______ days of transitional housing in the past 30 days (fill in the blank with number of days, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

Please check all that apply to you:

☐ *Service **does not exist** or there was **no room** for me*

☐ ***My family requested** that I have more or less*

☐ *My **provider decided** I should have this service **even though I didn't need it***

☐ *I refused because **I didn't think I needed the service***

☐ *There was a **language** or **cultural barrier***

☐ *The service I needed or preferred was not available so **I got this service instead***

☐ *I refused because **the quality of the service is bad***

☐ *I was **unable to pay** or there was an **insurance issue***

☐ *My **provider decided I should not** have this service*

☐ *They **wouldn't let me into** this service because of my **behavior** or my **diagnosis***

☐ *I refused because **I didn't understand what the service is**.*

COMMENTS (optional):

Supportive Apartments

This is an apartment you live in permanently. There is staff on site or staff that stop by to provide you with support. You may move here after being in transitional housing.

I had _______ days in a supportive apartment in the past 30 days (fill in the blank with number of days, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

Please check all that apply to you:

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☐ *I refused because **I didn't understand what the service is**.*

COMMENTS (optional):

Safe Haven

This is a long-term shelter for people who are experiencing homelessness.

I had _______ days at Safe Haven in the past 30 days (fill in the blank with number of days, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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COMMENTS (optional):

24-Hour Crisis Services

This is a service you use when you are in crisis. It may be a crisis line, or a place that you can walk into to get support or referral (like psychiatric emergency services [PCS] or an emergency room). These services, by phone or in person, are available 24 hours/day. Note: This does not include non-crisis help lines such as Warmline.

I had _______ hours of 24-hour crisis services (fill in the blank with number of hours, or put a 0 if you did not get any)

I needed __________________ services than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

Please check all that apply to you:

☐ *Service* ***does not exist*** *or there was* ***no room*** *for me*

☐ ***My family requested*** *that I have more or less*

☐ *My* ***provider decided*** *I should have this service* ***even though I didn't need it***

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☐ *There was a* ***language*** *or* ***cultural barrier***

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☐ *My* ***provider decided I should not*** *have this service*

☐ *They* ***wouldn't let me into*** *this service because of my* ***behavior*** *or my* ***diagnosis***

☐ *I refused because* ***I didn't understand what the service is****.*

COMMENTS (optional):

Mobile Crisis Services

This is a service where clinicians come to your home or visit you someplace else when you are in crisis to give you support or refer you to another service.

I had _______ hours of mobile crisis services in the past 30 days (fill in the blank with number of hours, or put a 0 if you did not get any)

I needed __________________ services than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

Please check all that apply to you:

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☐ *They **wouldn't let me into** this service because of my **behavior** or my **diagnosis***

☐ *I refused because **I didn't understand what the service is**.*

COMMENTS (optional):

Crisis Resource Center

This is the homelike place located on South 14th Street where you go when you are experiencing a psychiatric crisis. You may go for information, support, or to stay the night. The Crisis Resource Center has short-term services, peer support, and can help you link to community resources. It is an alternative to psychiatric inpatient hospitalization. You stay there only a short period of time.

I had _______ days or ____ hours at the crisis resource center (fill in the blank with number of days or hours, or put a 0 if you did not get any)

I needed __________________ services than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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COMMENTS (optional):

Crisis Respite Care

This is a place where you go when you are in a crisis and stay overnight. It is different than a hospital. You may go here after a hospitalization or instead of going for an acute inpatient stay. The Crisis Respite provides supportive services 24 hours/day, including peer support. You are able to stay for up to 2 weeks. You may access it through the MCBHD Central Walk in Clinic, (257-7222).

I had _______ days of crisis respite care in the past 30 days (fill in the blank with number of days, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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COMMENTS (optional):

Medication Management

This is a service provided by a psychiatrist, other physician (such as your primary care doctor), or nurse practitioner. It is when psychiatric medications are prescribed or the doctor or nurse checks in with you about your medications. He or she may change them during this visit.

I had _______ visits for medication management in the past 30 days (fill in the blank with number of visits, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

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COMMENTS (optional):

Individual Psychotherapy

This is when you go to your individual therapist. A therapist may be a psychologist, social worker, or licensed counselor. Individual psychotherapy is when you talk about managing symptoms, changing your behavior, coping with stress, and personal growth.

I had _______ visits for individual psychotherapy in the past 30 days (fill in the blank with number of visits, or put a 0 if you did not get any)

I needed ___________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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COMMENTS (optional):

Support Groups

This is a group that you go to get emotional or practical support from other consumers. There may be a provider there, or a peer specialist or peer facilitator. NAMI, DBSA, Jewish Family Services, and MHA offer support groups (but there may be others that you should include). This may also include family-to-family support groups.

I had _______ hours in a support group in the past 30 days (fill in the blank with number of visits, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

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COMMENTS (optional):

Substance Use Services

This is when you go see a counselor or other addiction professional to talk about using or abusing legal or illegal drugs (such as to discuss problems with alcohol or other drugs). The focus may be on reducing use, abstinence, and recovery. This includes substance abuse counseling services that are provided in residential (overnight) or outpatient settings.

I had _______ visits for substance use services in the past 30 days (fill in the blank with number of visits, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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COMMENTS (optional):

Day Treatment/ Partial Hospital Program

This is a service where you go for a number of sessions in one day. You may participate there in counseling, case management, group therapy, substance abuse services, or medication management.

I had _______ days of day treatment in the past 30 days (fill in the blank with number of days, or put a 0 if you did not get any)

I needed ___________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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☐ *I refused because **I didn't understand what the service is**.*

COMMENTS (optional):

Employment Services

These are services related to finding, getting, and keeping a job. You may make a plan with a vocational counselor to get a job. This also includes what is called “supported employment,” Integrated employment, working with DVR, etc.

I had _______ visits for employment services in the past 30 days (fill in the blank with number of visits, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don’t know
☐	☐	☐	☐	☐	☐

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COMMENTS (optional):

Case Management

This is when you go see your case manager. Your case manager helps coordinate and plan other services for you. He or she may help you with your Social Security benefits (SSI/SSDI) or health insurance, coordinating treatment, serve as a payee, provide medication monitoring, finding housing, or help finding legal services. Case management may also include help with ADLs (activities of daily living) like personal hygiene, household tasks, and community skills like transportation needs.

I had _______ visits with a case manager (fill in the blank with number of visits, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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COMMENTS (optional):

Drop-in/Social Program

This is a community living support service where you may participate in social, educational, or pre-vocational programs or get peer support. Our Space is a drop-in/social program.

I attended a drop-in/social program ____ times in the past 30 days (fill in the blank with number of times you attended, or put a 0 if you did not get any)

I needed ___________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

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COMMENTS (optional):

Clubhouse

A Clubhouse offers its members a strong Work-Ordered Day, whereby they work side-by-side with staff to do everything that is needed to run the program, an Employment Program, a Supported Education Program and an Evening, Weekend and Holiday Program. The Clubhouse is open 365 days a year. Grand Avenue Club is the only Certified Clubhouse in Milwaukee County.

I attended a clubhouse ________ times in the past 30 days (fill in the blank with number of times you attended, or put a 0 if you did not get any)

I needed ___________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

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COMMENTS (optional):

Peer Specialist Services

These are services or supports provided by peer specialists (other people who are mental health consumers who have training in providing services). This may include peer support/mutual support groups, and other consumer organized activities. They may be provided in a traditional treatment or provider setting such as a hospital that is not peer-run.

I had _______ hours of peer delivered services (fill in the blank with number of hours, or put a 0 if you did not get any)

I needed __________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

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COMMENTS (optional):

Peer Operated Services

These are services or programs that are run by consumers or peers. This means that a peer manages the program and it employs trained peers. Warmline, Inc. is the only peer-operated service in Milwaukee County at this time, but you may think that you need more peer-operated services even if they don't exist now.

I had _______ hours of peer-operated services (fill in the blank with number of hours, or put a 0 if you did not get any)

I needed ___________________ of this service than I got (check one below):

None/ a lot less	less	Had right amount	more	a lot more	Don't know
☐	☐	☐	☐	☐	☐

These are possible reasons *why* you got more or less of a service than you needed.

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COMMENTS (optional):

COMMENTS PAGE (OPTIONAL)

If you have additional comments regarding mental health services you received or wanted to receive, please note your comments here.

DEMOGRAPHIC INFORMATION
We would like to finish up by asking a few questions about you.

Gender
□ Male
□ Female
□ Other ______________________(Please specify)

Your date of birth?
__/ __ /____

Are you Hispanic or Latino?
□ Yes
□ No

What is your race (check all that apply)?
□ White
□ Black or African American
□ Asian
□ Native Hawaiian or other Pacific Islander
□ American Indian or Alaska Native
□ Other

What is your current marital status?
□ Married /Civil Union
□ Not married but living with a partner
□ Separated
□ Divorced
□ Widowed
□ Single/ Never been married

What is the highest grade or level of school that you have completed?
□ 8th grade or less
□ Some high school, but did not graduate
□ High school graduate or GED
□ Some college or 2-year degree
□ 4-year college degree
□ More than 4-year college degree

Can you tell me about your current employment status? Are you:
□ Unemployed, looking for work
□ Unemployed, not looking for work
□ Volunteer
□ Work for pay full-time
□ Work for pay part-time

Appendix I: Consumer SPES Newsletter

Milwaukee County Mental Health Redesign Project

May 2010

Results from the Consumer Survey

Project staff would like to extend a sincere THANK YOU to the survey respondents for participating in this very important part of the Milwaukee County Mental Health Redesign Project.

The Service Planning and Evaluation Survey (SPES) for Consumers

The Human Services Research Institute (HSRI), a partner in the Milwaukee County Mental Health System Redesign project, uses a data-driven approach to understand mental health service needs. The approach uses assessments of service need, survey data, service data from the state and county, key informant interviews, unit cost information, and a dynamic computer model. The approach provides decision makers with estimates of what service utilization, costs, and consumer outcomes to expect under different scenarios. This knowledge can then be used to develop a high-performance mental health system.

This spring, over 600 consumers of mental health services filled out a Service Planning and Evaluation Survey (SPES). Representatives from Disability Rights Wisconsin and Warmline, Inc. helped to design and implement the survey. Consumers reported their current service needs, whether they got the right amount of services, and the reasons they didn't get the right amounts. The results of the survey are detailed in this report.

This survey is one important part of a comprehensive redesign project. The project team will also be collecting information from a number of other stakeholders and comparing county service utilization data to national data.

Who Took the Survey?

A total of 614 consumers filled out the survey, which was available in English and Spanish. Although an effort was made to reach out to all consumers, because the survey was lengthy, there may have been lower representation of persons with limited reading skills. The average age of survey respondents is 45 years. A little over half of the respondents (55%) are women. The respondents are racially/ethnically diverse: 48% identify as white, 42% African American, and 5% Hispanic. Asians, Native Hawaiians, and American Indians are also represented. This demographic makeup is similar in diversity to the Mental Health Statistics Improvement Program (MHSIP) survey conducted each year by Vital Voices for Mental Health, an advocacy organization in Milwaukee County.

Redesigning the Adult Mental Health System in Milwaukee County

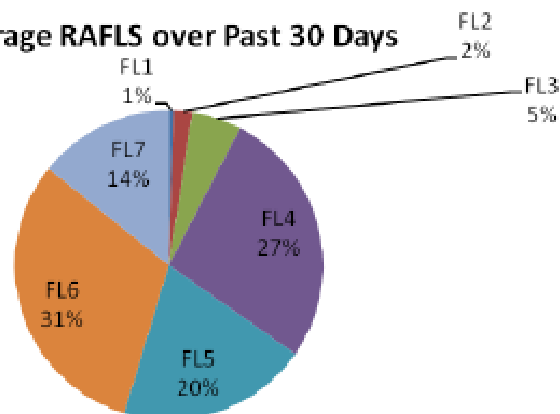
Redesigning the Adult Mental Health System in Milwaukee County

Thank you to the following organizations for assisting with the survey:

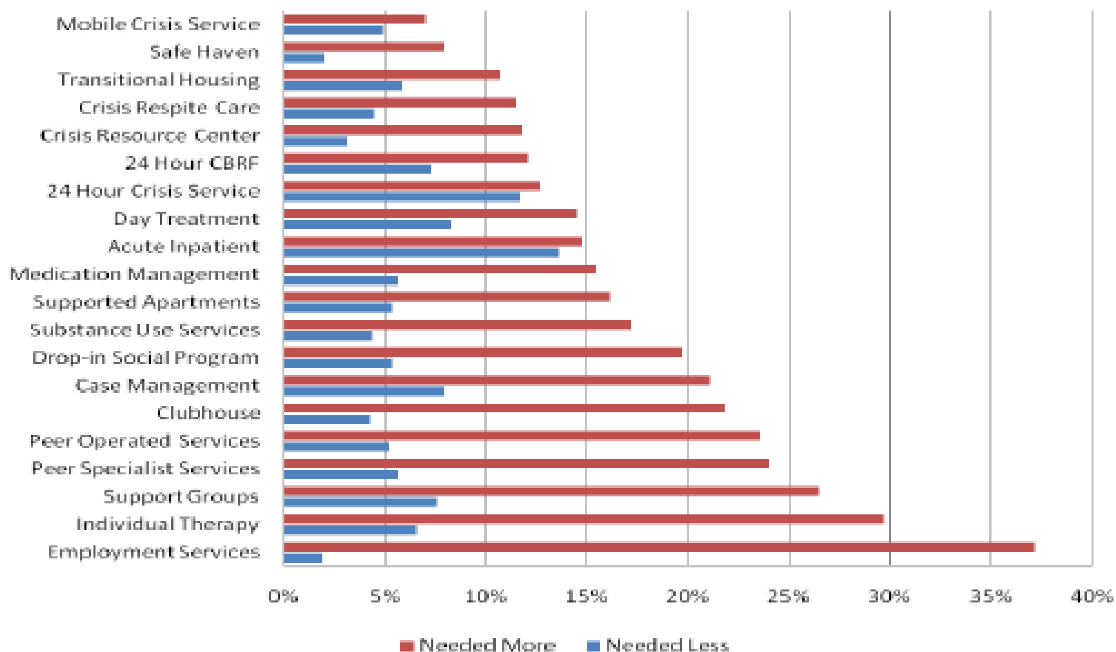
- Aurora Health Care
- Autumn West
- Bell Therapy
- Columbia St. Mary's
- Crisis Resource Center
- Disability Rights Wisconsin
- Fardale
- Grand Avenue Club
- Health Care for the Homeless
- Health Care Partnership
- Independence*First*
- Jewish Family Services
- Justice 2000
- Mental Health America of Wisconsin
- Milwaukee County BHD
- Milwaukee Mental Health Task Force
- NAMI Greater Milwaukee
- Our Space
- Project Access
- Transitional Living Services
- United House
- Warmline, Inc.
- Wisconsin Community Services

The Resource Associated Functional Level Scale (RAFLS)

HSRI's approach to planning services is based on consumer functional level. In order to assess consumer functional level, HSRI uses the Resource Associated Functional Level Scale (RAFLS) which identifies consumers at seven levels of functioning. The RAFLS does not measure personality traits or feelings. Rather, it measures a person's ability to do practical things at a certain point in time. The scale ranges from one to seven. A RAFLS level of 7 means that the person can get support from friends and family and does not need any professional mental health services at that time. A RAFLS level 1 indicates that a person is currently unable to control his or her behavior and is having a hard time getting help. For this survey, consumers rated their own functional level on the day they took the survey, 30 days before the survey, and to provide an average RAFLS level for the past 30 days. The graph shows how consumers reported their RAFLS levels. A total of 82 respondents reported that they were able to function independently of the mental health system. Another 179 individuals reported a RAFLS of 6, which indicates that they only need support for extreme or unusual stresses. 301 respondents rated themselves at a RAFLS level 3, 4, or 5, indicating that they use mental health services on a regular basis to cope with day to day stresses and to help with activities of daily living. Only a small number of respondents (14 in all) rated themselves at a RAFLS 1 or 2.



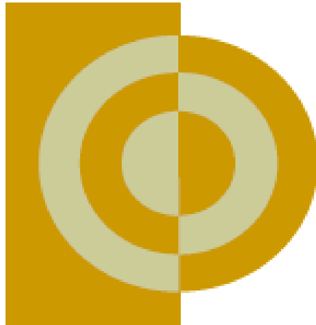
Service Needs: More, Less, or Just Right?



The SPES asked consumers whether they were getting the right amount of certain services. They ranged from emergency and crisis stabilization services to community-based and peer-operated supports. In general, consumer and patient surveys tend to be biased towards demonstrating more satisfaction with quality and amounts of services than may be accurate. It is important to the redesign effort to focus on what consumers in the system need more and less of, and what needs to change, while not discounting that individuals may in fact be getting the right amount of some services some of the time.

Overall, consumers reported that they were getting the right amount of services about 75% of the time. However, reports of service needs varied depending on the type of service. 61% of consumers felt that they got the right amount of employment-related services, while 37% felt that they needed more. 30% of respondents said they needed more individual therapy, and 27% needed more support groups. Some consumers also expressed a need for more peer services and clubhouse services. 14% of respondents felt that they received more acute inpatient services than they needed, although 15% felt that they did not receive enough acute inpatient supports. This pattern is similar with 24-hour crisis services, indicating that there are individualized needs for acute service needs amongst consumers. In general, consumers felt they needed more of community-based, recovery-oriented services such as employment services, individual therapy, and peer-delivered services, and less of crisis and inpatient services.

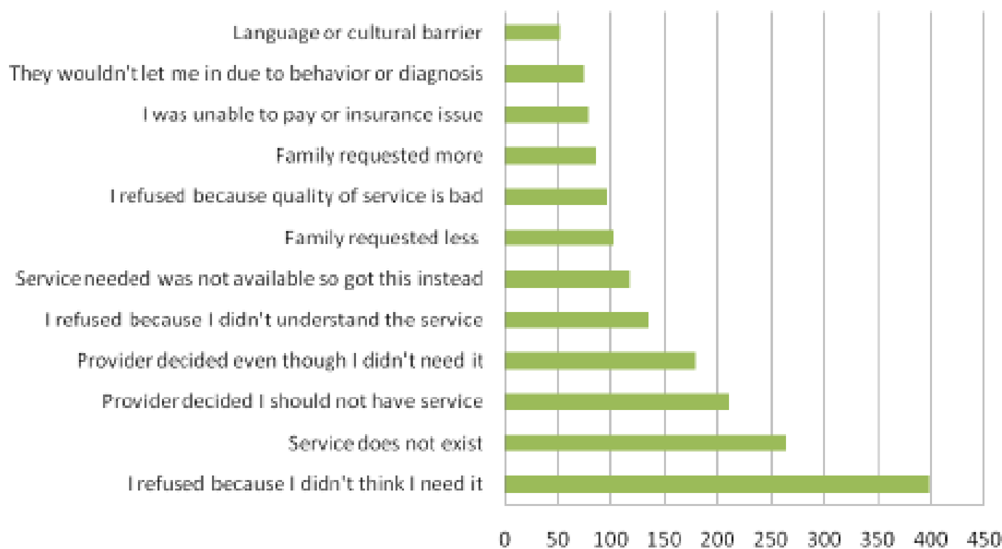
Redesigning the Adult Mental Health System in Milwaukee County



Reasons for Service Need Disparities

In addition to inquiring about service needs, the SPES also asked consumers to indicate why they were receiving too much or too little of a service. Some reasons were related to service availability, while others were related to provider and family recommendations. Some respondents identified barriers such as issues with insurance or issues with language and culture. Other respondents indicated that they refused services for various reasons.

The most common reason for receiving too little of a service was that the person refused because he or she thought the service was not needed. It was also common for consumers to indicate that needed services were not available to them. The most common reason for receiving too much of a service was that the provider decided to enroll the person in the service even though the person felt that it was not needed.



Thank you for your participation!

The consumer SPES results are essential to understanding service use patterns, gaps in the appropriateness of service delivery, and consumer preferences and choice. The consumers who participated in this survey played an important role in the Milwaukee County Mental Health Redesign Project. Thank you to all who participated and who added their voice to the efforts to improve Milwaukee's mental health system.

Appendix J: Provider Survey

Thank you for taking the time to complete this brief survey, a part of the Milwaukee County Mental Health System Redesign project, which aims to strengthen mental health services in Milwaukee County through an in-depth assessment of current services and the needs of the community. Because of your unique position as a provider of health services to persons with mental illness, your feedback is critical to this project and will supply valuable information that will help in improving the mental health system in Milwaukee County.

1. **Do you provide services to persons with mental illnesses?** [ ] Yes [ ] No

2. **How many people do you currently serve?** ______

3. W**hat percentage of these individuals has a mental illness?** _____%

4. **What is your professional medical discipline?**

[ ] Psychiatrist
[ ] Psychologist
[ ] Primary care/internal medicine physician
[ ] Physical health specialty physician
[ ] Emergency services provider
[ ] Other: ___________________

5. **What services do you provide to persons with mental illnesses?** (Check all that apply)

[ ] Primary care or specialty physical health care
[ ] Emergency/Crisis services
[ ] Psychiatric/Mental health assessment
[ ] Referral to mental health services
[ ] Psychiatric medication management
[ ] Psychotherapeutic services/Counseling
[ ] Other (Please specify: ____)

6. **What is your place of practice?**

[ ] County system [ ] Health System Medical Group
[ ] Private practice [ ] FQHC [ ] Other: _______________

7. **What is your payer mix (this may be an estimate)?**

____% Medicaid ____% Medicare ____% Commercial insurance
____% Uninsured ____% Other payer type

8. **In dealing with people who have a serious mental illness, how would you rate the following services in terms of quality** (Poor = 1, Excellent = 5) **and access** (No = difficult to access, Yes = easier to access in general)**?**

	Quality						Access		
Service	**1**	**2**	**3**	**4**	**5**	**Don't Know/ Unsure**	**No**	**Yes**	**Don't Know/ Unsure**
Psychiatry									
Acute Services/Psychiatric Beds									
Counseling/Therapy									
Day Programs									
Educational Support Services									
Employment Support Services									
Housing									
Medications									
Self Help/Peer Support Groups									
Social Activities									
Alcohol and Other Drug Counseling									
Transportation									

9. What are the top three services, from this list, you believe are in need of the most attention from the Milwaukee Mental Health System Redesign Project?

1. ____
2. ____
3. ____

10. Are there any important supports or services that are currently unavailable to the people you serve?

[ ] Yes (Please specify: ____)

[ ] No

11. What is the most significant service delivery problem for you as a provider for persons with serious mental illness?

____

____

____

12. What do you believe is the most significant service delivery problem for the persons you serve with a mental illness?

____

____

____

Appendix K: Provider Survey Newsletter

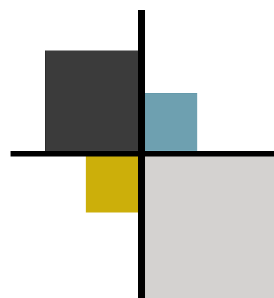
Transforming the Adult Mental Health Care System in Milwaukee County

Results from the Provider Survey

Redesigning the Adult Mental Health System in Milwaukee County

Characteristics of Survey Respondents:

* 118 providers who served individuals with mental health issues completed the survey
* 48% provided primary care services
* 30% were psychiatrists
* 20% of respondents provided emergency services and 7% provided physical health specialty services
* 67% practiced as part of a health system medical group
* 28% were in private practice and 26% at the Medical College of Wisconsin

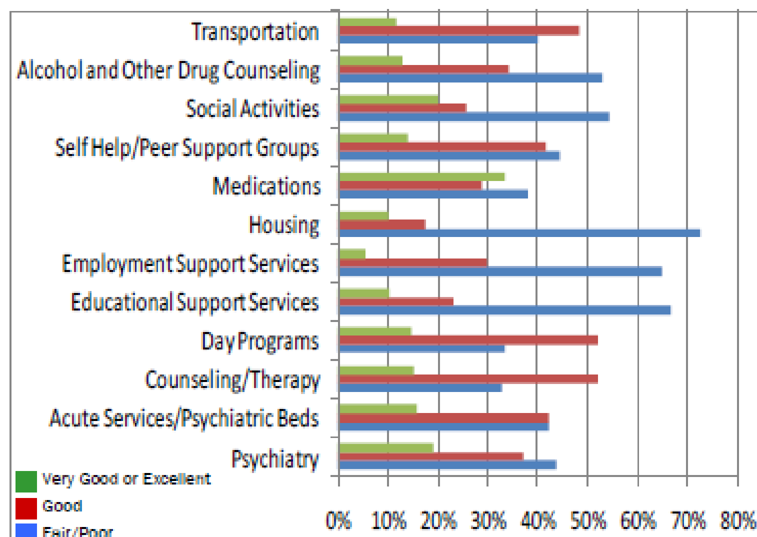


Survey Development and Respondent Characteristics

In consultation with Bruce Kruger and the rest of the Project Steering Committee, Milwaukee Mental Health Redesign project staff developed and implemented an online survey of mental health service providers in Milwaukee County. A total of 157 providers responded to the survey. Of these respondents, 118 respondents served individuals with mental health needs. Providers came from a variety of professional disciplines, including primary care and internal medicine (48%), psychiatry (30%), emergency services (20%),and physical health specialties (7%). The place of practice for the majority of respondents was a health system medical group (67%), with 28% in private practice and 26% at the Medical College of Wisconsin. A small proportion worked in other organizations, including the Veteran's Administration, county hospitals, and federally qualified health centers. Survey respondents provided a range of services to individuals with mental health needs, including mental health assessments and referrals, medication management, physical health services, emergency and crisis services, and counseling. Survey respondents were asked to comment on the accessibility and quality of mental health services in the county. They were asked to identify services most in need of attention from the project. Providers were also asked to identify the most significant service delivery problems from the perspective of the individual provider and from the perspective of the people who are served by the mental health system. The data from this survey will be used as part of a comprehensive redesign project to identify needs and develop recommendations for improving the quality of mental health services in Milwaukee County. The project team will be collecting information from other stakeholders, including consumers, program leadership, and case managers. The project team will also compare county service utilization data to national data.

The project staff would like to extend a sincere THANK YOU to the providers who participated in this very important part of the Milwaukee County Mental Health Redesign Project.

Quality of Many Services Ranked "Fair" or "Poor"



Survey respondents were asked to rate the quality of a set of services and were also given the option to check "Don't Know or Unsure". The survey results indicate that providers differed in their opinions of the quality of services for individuals with mental health needs in Milwaukee County. However, providers consistently ranked many services "Fair" or "Poor", and no single service was consistently ranked "Very Good" or "Excellent." The services receiving the most consistently poor ratings were related to community supports such as housing, employment and education support services, and alcohol and other drug counseling services. Medications received the highest number of "Very Good" or "Excellent" ratings.

Unavailable Services and Supports Identified

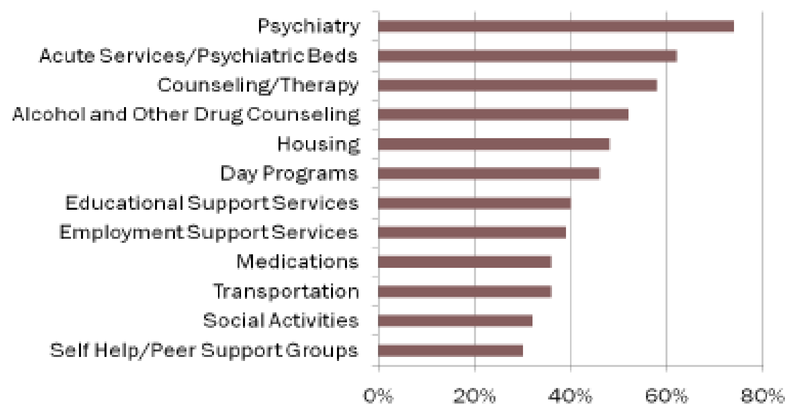
When asked whether there were important services and supports that are unavailable to the people they serve, 57% of providers answered yes.

Providers consistently identified two services categories in particular as lacking: outpatient services such as counseling and psychiatry and community rehabilitative services such as supported employment. Many survey respondents also noted that uninsured patients face a significant barrier to receiving services and often go without much-needed supports such as mental health counseling and drug and alcohol services.

Many Services Rated "Difficult to Access"

Providers were asked to rank a series of services as either "Difficult to Access" or "Easier to Access" with an additional option to check "Don't Know or Unsure."

Survey respondents identified a large number of services as being difficult to access. Psychiatry was most frequently rated "Difficult to Access" at 74%, followed by acute services at 63% and counseling and therapy at 60%. Additionally, close to 50% of providers indicated that they did not know or were unsure about the accessibility of many community support services, including self-help/peer support groups, social activities, and employment and educational support services. Housing had the fewest "Easier to Access" ratings at 8%.



Appendix L: Private Health System Survey

About Person Completing Survey

What health system are you reporting on in this survey? (Please only choose one. If you would like to report on more than one health system, please complete another survey).

- ☐ Aurora Health Care
- ☐ Rogers Memorial
- ☐ Columbia St. Mary's
- ☐ Froedtert
- ☐ Medical College of Wisconsin
- ☐ Wheaton Franciscan
- ☐ Federally Qualified Health Center (Please provide name____________________)

1. What is your position in this health system?
   - ☐ Behavioral Health Administrator
   - ☐ Medical director
   - ☐ Chief of psychiatry
   - ☐ Nursing director
   - ☐ Psychiatric nursing director
   - ☐ Chief Operating Officer
   - ☐ Chief Executive Officer
   - ☐ Physician/Psychiatrist/Psychologist/Nurse
   - ☐ Other (Please specify) ____
2. How long have you been in this position?
   - ☐ Less than 1 year
   - ☐ 1-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

   Please provide your name and contact information (email or telephone) for us to contact you if we need any clarification:

Psychiatric Inpatient Capacity

1. How many licensed acute psychiatric beds does your health system have?
   Please fill in number ______________________
2. How many staffed acute psychiatric beds does your health system have?
   Please fill in number __________________________
3. What has been your occupancy rate for staffed beds in the past 12 months?
   - ☐ 100%
   - ☐ 75-99%
   - ☐ 50-74%
   - ☐ Less than 50%
   - ☐ Don't know

4. What has been your system's payer mix for inpatient psychiatric care in the past 12 months? (Please estimate if you do not know)
   Private/commercial insurance ____________%
   Medicaid ____________%
   Medicare ____________%
   Uninsured ____________%
   Don't know ☐
5. Do you feel you have enough beds for the people you serve?
   ☐ Yes
   ☐ No
   ☐ Most of the time, but not all of the time
6. How frequently do you have to turn consumers/patients away from your psychiatric beds?
   ☐ Never
   ☐ About half the time
   ☐ More than half the time
7. What are the three most common reasons for having to turn consumers/patients away from acute psychiatric beds in your health system?
   ☐ Lack of payer (uninsured)
   ☐ Reimbursement rate too low
   ☐ Lack of capacity (no beds available)
   ☐ Do not have clinical expertise to treat the person
   ☐ Person is too dangerous to self or others
   ☐ Emergency detention/involuntary
   ☐ Person refuses service
   ☐ Would be better served by BHD
   ☐ Other (Please specify) ____
8. Do you think that private health systems need to increase capacity for inpatient and acute psychiatric care in Milwaukee County?
   ☐ Yes
   ☐ No, we have sufficient capacity
   ☐ We have sufficient capacity but need to use it more efficiently
9. Does your health system plan to grow inpatient capacity within the next 12 months?
   ☐ Yes
   ☐ No

Outpatient Psychiatric Program Capacity

1. What outpatient service or programs does your health system provide?

Program/Service	Capacity	Frequency filled	Payer mix
Day treatment/Partial hospital			Private/commercial insurance ____________% Medicaid ____________% Medicare ____________% Uninsured ____________%

Medication management clinic			Private/commercial insurance ____________% Medicaid ____________% Medicare ____________% Uninsured ____________%
Psychotherapy/counseling			Private/commercial insurance ____________% Medicaid ____________% Medicare ____________% Uninsured ____________%
Group therapy			Private/commercial insurance ____________% Medicaid ____________% Medicare ____________% Uninsured ____________%
Outpatient substance abuse services			Private/commercial insurance ____________% Medicaid ____________% Medicare ____________% Uninsured ____________%
Assessment and testing			Private/commercial insurance ____________% Medicaid ____________% Medicare ____________% Uninsured ____________%
Other (Please specify)			Private/commercial insurance ____________% Medicaid ____________% Medicare ____________% Uninsured ____________%

2. Do you feel you have enough slots/outpatient capacity for the people you serve?
   - ☐ Yes
   - ☐ No
   - ☐ Most of the time, but not all of the time
3. How frequently do you have to turn consumers/patients away from your programs/services?
   - ☐ Never
   - ☐ About half the time
   - ☐ More than half the time
4. What are the three most common reasons for having to turn consumers/patients away from outpatient services in your health system?
   - ☐ Lack of payer (uninsured)
   - ☐ Reimbursement rate too low
   - ☐ Lack of capacity (no slots available)
   - ☐ Do not have clinical expertise to treat the person
   - ☐ Person is too dangerous to self or others
   - ☐ Emergency detention/involuntary

☐ Person refuses service
☐ Would be better served by BHD
☐ Other (Please specify) ____

5. Do you think that private health systems need to increase capacity for outpatient psychiatric care in Milwaukee County?
☐ Yes
☐ No, we have sufficient capacity
☐ We have sufficient capacity but need to use it more efficiently

10. Does your health system plan to grow outpatient capacity within the next 12 months?
☐ Yes
☐ No

Provider Capacity

1. How many psychiatrists work within your system?
Employed (#) _________________________________
1a. What is the payer mix for employed psychiatrists?
Private/commercial insurance ____________%
Medicaid ____________%
Medicare ____________%
Uninsured ____________%
Don't know ☐
Contracted (#) ___________________________
Voluntary, independent medical staff members (#) ______________________

2. Do you intend to recruit additional psychiatrists within the next 12 months?
☐ Yes
☐ No

3. How many psychologists, social workers, and other therapy professionals work within your system?
Employed (#) _________________________________
3a. What is the payer mix for employed psychologists, social workers, and other therapy professionals?
Private/commercial insurance ____________%
Medicaid ____________%
Medicare ____________%
Uninsured ____________%
Don't know ☐
Contracted (#) ___________________________

4. Do you intend to recruit additional psychologists, social workers, and other therapy professionals within the next 12 months?
☐ Yes
☐ No

Appendix M: Case Management SPES Ideal and Actual Service Amounts by Functional Level

CSP Case Management SPES Ideal Service Amounts															
Typical RAFLS Distribution															
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Total**	**Missing** (also missing RAFLS begin and end)							
12	110	252	474	252	75	5	1180	33							
1%	9%	21%	40%	21%	6%	0%	100%								
Percent Ideally Receiving (%/mo.)								**Ideal Amounts (avg. units/mo.)**							
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**
							Residential								
8%	11%	6%	1%	0%	0%	0%	24-Hr Community Based	day	5	31	18	17	31	0	0
0%	6%	6%	5%	5%	1%	0%	Supported Apartments	day	0	31	31	30	31	31	0
0%	0%	0%	0%	0%	0%	0%	Safe Haven	day	0	0	0	0	0	0	0
17%	2%	2%	4%	0%	3%	0%	Transitional Housing	day	31	31	29	31	25	25	0
0%	6%	5%	9%	9%	12%	0%	My Home	day	0	31	31	30	26	30	0
							Emergency								
0%	1%	1%	1%	0%	0%	0%	Mobile Crisis Service	hour	0	2	2	2	0	0	0
50%	6%	4%	1%	0%	1%	0%	Observation Unit/ER	hour	2	11	8	40	6	8	0
0%	5%	0%	1%	0%	0%	0%	Crisis Resource Center	hour	0	3	0	5	2	0	0
0%	6%	3%	3%	0%	3%	0%	Crisis Case Management	hour	0	13	12	14	13	13	0
50%	2%	1%	0%	0%	1%	0%	Crisis Respite Care	day	8	13	18	12	0	12	0
							Locked (Inpatient) Facilities								
50%	20%	5%	2%	1%	1%	0%	Acute Inpatient	day	26	17	18	11	7	17	0
8%	2%	0%	0%	0%	0%	0%	Long-Term Care	day	10	10	10	10	0	0	0
8%	2%	4%	2%	3%	0%	0%	Detoxification Program	day	31	2	17	11	5	0	0
							Outpatient Treatment								
42%	34%	33%	35%	26%	25%	0%	Evaluation/Assessment	hour	1	2	1	1	1	1	0
67%	54%	70%	62%	61%	60%	20%	Medication Management	hour	7	4	7	6	4	2	1
25%	17%	16%	19%	27%	31%	0%	Individual Therapy	hour	5	4	4	3	3	3	0
17%	10%	15%	16%	19%	16%	0%	Group Therapy	hour	8	8	4	4	3	4	0
0%	14%	18%	20%	14%	8%	0%	Substance Use Couns.	hour	49	49	12	8	6	6	0
8%	11%	8%	6%	4%	4%	0%	Day Treatment	hour	14	16	15	15	15	10	0
42%	34%	33%	35%	26%	25%	0%	Methadone Maintenance	hour	1	2	1	1	1	1	0
							Community-Based Services								
42%	36%	46%	40%	36%	29%	0%	Social/Recreational Skills	hour	8	10	15	9	7	23	0
25%	30%	54%	37%	23%	24%	0%	Activities of Daily Living	hour	20	14	11	9	8	12	0
8%	6%	11%	19%	15%	9%	0%	Employment-Related	hour	20	20	7	9	7	7	0
92%	98%	93%	93%	88%	92%	60%	Case Management	hour	13	10	4	4	4	3	2
17%	14%	31%	30%	32%	21%	0%	Drop-In/Social Club	hour	14	14	9	13	14	13	0
17%	1%	1%	1%	3%	1%	0%	Peer Operated Services	hour	40	7	11	11	16	7	0
							Community Recovery Services								
0%	3%	4%	7%	8%	9%	0%	Supported Employment	hour	0	8	8	22	28	16	0
8%	1%	2%	3%	2%	3%	0%	Peer/Advocate Supports	hour	7	7	7	11	3	21	0

CSP Case Management SPES Actual Service Amounts															
Typical RAFLS Distribution															
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Total**	**Missing** (also missing RAFLS begin and end)							
12	110	252	474	252	75	5	1180	33							
1%	9%	21%	40%	21%	6%	0%	100%								
Percent Actually Receiving (%/mo.)								**Actual Amounts (avg. units/mo.)**							
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**
							Residential								
8%	9%	3%	1%	0%	0%	0%	24-Hr Community Based	day	1	30	21	17	31	0	0
0%	2%	4%	3%	4%	1%	0%	Supported Apartments	day	0	28	27	30	31	31	0
0%	0%	0%	0%	0%	0%	0%	Safe Haven	day	0	0	0	10	0	0	0
0%	0%	2%	3%	0%	3%	0%	Transitional Housing	day	0	0	24	31	28	28	0
0%	6%	4%	8%	8%	11%	0%	My Home	day	0	31	31	29	26	30	31
							Emergency								
0%	0%	1%	0%	0%	0%	0%	Mobile Crisis Service	hour	0	0	2	2	0	0	0
0%	7%	6%	1%	0%	1%	0%	Observation Unit/ER	hour	0	6	33	20	5	8	0
0%	0%	0%	0%	0%	0%	0%	Crisis Resource Center	hour	0	0	0	0	0	0	0
0%	9%	3%	2%	1%	3%	0%	Crisis Case Management	hour	0	12	12	9	18	16	0
0%	0%	2%	0%	0%	0%	0%	Crisis Respite Care	day	0	0	25	9	0	0	0
							Locked (Inpatient) Facilities								
0%	17%	6%	3%	2%	1%	0%	Acute Inpatient	day	0	12	12	11	6	18	0
0%	2%	0%	0%	0%	0%	0%	Long-Term Care	day	0	31	31	0	0	0	0
0%	0%	2%	0%	0%	0%	0%	Detoxification Program	day	0	0	9	3	0	0	0
							Outpatient Treatment								
42%	33%	33%	37%	26%	24%	0%	Evaluation/Assessment	hour	1	1	1	1	1	1	0
50%	44%	66%	62%	60%	64%	20%	Medication Management	hour	1	6	6	6	4	3	1
17%	7%	9%	13%	17%	20%	0%	Individual Therapy	hour	5	5	2	2	2	2	0
17%	6%	8%	7%	10%	1%	0%	Group Therapy	hour	4	4	1	3	2	4	0
0%	6%	4%	6%	5%	4%	0%	Substance Use Couns.	hour	0	14	4	10	7	5	0
0%	2%	0%	1%	1%	3%	0%	Day Treatment	hour	0	5	15	14	13	10	0
42%	33%	33%	37%	26%	24%	0%	Methadone Maintenance	hour	1	1	1	1	1	1	0
							Community-Based Services								
33%	22%	24%	26%	20%	20%	0%	Social/Recreational Skills	hour	18	11	82	19	4	5	0
25%	20%	34%	31%	16%	16%	0%	Activities of Daily Living	hour	20	1	17	6	4	17	0
0%	0%	2%	4%	4%	3%	0%	Employment-Related	hour	0	0	6	7	3	11	0
83%	98%	96%	94%	89%	96%	80%	Case Management	hour	16	9	4	4	4	4	2
8%	1%	9%	6%	10%	5%	0%	Drop-In/Social Club	hour	11	8	12	15	23	14	0
17%	1%	1%	1%	3%	1%	0%	Peer Operated Services	hour	10	3	8	4	36	8	0
							Community Recovery Services								
0%	0%	0%	0%	2%	4%	0%	Supported Employment	hour	0	0	0	11	27	13	0
8%	0%	0%	1%	2%	0%	0%	Peer/Advocate Supports	hour	8	0	0	3	3	0	0

TCM Case Management SPES Ideal Service Amounts															
Typical RAFLS Distribution															
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Total**	**Missing** (also missing RAFLS begin and end)							
10	27	116	383	291	188	13	1028	74							
1%	3%	11%	37%	28%	18%	1%	99%								
Percent Ideally Receiving (%/mo.)								**Ideal Amounts (avg. units/mo.)**							
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**
							Residential								
0%	19%	5%	2%	1%	1%	0%	24-Hr Community Based	day	0	31	18	17	31	26	0
0%	11%	15%	13%	5%	1%	0%	Supported Apartments	day	0	31	31	30	31	31	0
0%	0%	0%	1%	1%	0%	0%	Safe Haven	day	0	0	0	14	31	0	0
0%	0%	3%	1%	2%	0%	0%	Transitional Housing	day	0	0	29	31	25	0	0
10%	11%	11%	11%	16%	21%	8%	My Home	day	31	31	31	30	26	30	31
							Emergency								
10%	7%	1%	0%	0%	0%	0%	Mobile Crisis Service	hour	4	2	2	0	2	0	0
10%	15%	1%	0%	1%	1%	0%	Observation Unit/ER	hour	1	11	8	40	6	8	0
0%	7%	1%	1%	1%	1%	0%	Crisis Resource Center	hour	0	3	6	5	2	4	0
40%	26%	3%	3%	1%	2%	0%	Crisis Case Management	hour	8	13	12	14	13	13	0
20%	19%	3%	2%	0%	0%	0%	Crisis Respite Care	day	10	13	18	12	14	0	0
							Locked (Inpatient) Facilities								
50%	56%	5%	3%	1%	1%	0%	Acute Inpatient	day	26	17	18	11	7	17	0
0%	0%	0%	0%	0%	0%	0%	Long-Term Care	day	0	0	0	0	0	0	0
10%	4%	4%	2%	1%	1%	0%	Detoxification Program	day	31	2	17	11	5	3	0
							Outpatient Treatment								
20%	22%	22%	19%	13%	21%	8%	Evaluation/Assessment	hour	1	2	1	1	1	1	1
50%	44%	74%	68%	47%	28%	15%	Medication Management	hour	7	4	7	6	4	2	1
40%	41%	20%	21%	26%	30%	8%	Individual Therapy	hour	5	4	4	3	3	3	1
10%	7%	10%	8%	4%	5%	0%	Group Therapy	hour	8	8	4	4	3	4	0
30%	22%	17%	14%	9%	7%	0%	Substance Use Couns.	hour	49	49	12	8	6	6	0
20%	15%	16%	10%	5%	4%	0%	Day Treatment	hour	14	16	15	15	15	10	0
20%	22%	22%	19%	13%	21%	8%	Methadone Maintenance	hour	1	2	1	1	1	1	1
							Community-Based Services								
20%	15%	21%	15%	10%	6%	8%	Social/Recreational Skills	hour	8	10	15	9	7	23	10
10%	19%	37%	15%	10%	8%	8%	Activities of Daily Living	hour	20	14	11	9	8	12	10
0%	7%	5%	8%	7%	14%	0%	Employment-Related	hour	0	20	7	9	7	7	0
80%	82%	89%	85%	95%	94%	77%	Case Management	hour	13	10	4	4	4	3	2
0%	26%	22%	24%	21%	22%	15%	Drop-In/Social Club	hour	0	14	9	13	14	13	19
0%	4%	0%	2%	1%	3%	0%	Peer Operated Services	hour	40	7	0	11	16	7	0
							Community Recovery Services								
0%	0%	4%	5%	4%	6%	8%	Supported Employment	hour	0	0	8	22	28	16	90
0%	0%	2%	1%	2%	2%	0%	Peer/Advocate Supports	hour	0	0	7	11	3	21	0

TCM Case Management SPES Actual Service Amounts

Typical RAFLS Distribution															
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Total**	**Missing** (also missing RAFLS begin and end)							
10	27	116	383	291	188	13	1028	74							
1%	3%	11%	37%	28%	18%	1%	99%								
Percent Actually Receiving (%/mo.)								**Actual Amounts (avg. units/mo.)**							
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**FL7**
							Residential								
10%	11%	5%	4%	1%	1%	0%	24-Hr Community Based	day	1	30	21	17	31	26	0
0%	0%	7%	7%	5%	0%	0%	Supported Apartments	day	0	0	27	30	31	0	0
0%	0%	0%	1%	0%	0%	0%	Safe Haven	day	0	0	0	10	31	0	0
0%	0%	1%	1%	1%	0%	0%	Transitional Housing	day	0	0	24	31	28	0	0
10%	4%	10%	10%	15%	21%	8%	My Home	day	31	31	31	29	26	30	31
							Emergency								
0%	7%	1%	0%	0%	0%	0%	Mobile Crisis Service	hour	0	2	2	0	0	0	0
10%	11%	1%	0%	1%	1%	0%	Observation Unit/ER	hour	1	6	33	20	5	8	0
0%	0%	0%	0%	0%	1%	0%	Crisis Resource Center	hour	0	0	0	10	0	4	0
30%	22%	3%	2%	1%	1%	0%	Crisis Case Management	hour	3	12	12	9	18	16	0
10%	4%	1%	1%	0%	0%	0%	Crisis Respite Care	day	8	2	25	9	0	0	0
							Locked (Inpatient) Facilities								
40%	21%	6%	4%	1%	1%	0%	Acute Inpatient	day	18	12	12	11	6	18	0
0%	2%	0%	0%	0%	0%	0%	Long-Term Care	day	0	0	0	0	0	0	0
0%	1%	0%	0%	0%	0%	0%	Detoxification Program	day	0	2	0	3	5	0	0
							Outpatient Treatment								
10%	11%	14%	13%	12%	17%	8%	Evaluation/Assessment	hour	1	1	1	1	1	1	1
10%	26%	58%	58%	40%	25%	15%	Medication Management	hour	1	6	6	6	4	3	1
0%	7%	8%	9%	14%	19%	8%	Individual Therapy	hour	0	5	2	2	2	2	1
0%	4%	3%	3%	1%	1%	0%	Group Therapy	hour	0	4	1	3	2	4	0
0%	4%	2%	3%	1%	1%	0%	Substance Use Couns.	hour	0	14	4	10	7	5	0
10%	4%	2%	2%	2%	2%	0%	Day Treatment	hour	8	5	15	14	13	10	0
							Methadone Maintenance	hour							
							Community-Based Services								
0%	0%	2%	2%	1%	2%	0%	Social/Recreational Skills	hour	0	0	82	19	4	43	0
10%	4%	10%	6%	5%	4%	0%	Activities of Daily Living	hour	20	1	17	6	4	17	0
0%	0%	2%	2%	3%	6%	0%	Employment-Related	hour	0	0	6	7	3	11	0
70%	74%	82%	82%	92%	90%	62%	Case Management	hour	16	9	4	4	4	4	2
0%	4%	3%	5%	6%	8%	8%	Drop-In/Social Club	hour	0	8	12	15	23	14	30
0%	4%	0%	2%	1%	3%	0%	Peer Operated Services	hour	0	3	0	4	36	8	0
							Community Recovery Services								
0%	0%	1%	1%	2%	1%	8%	Supported Employment	hour	0	0	10	11	43	13	90
0%	0%	1%	0%	1%	2%	0%	Peer/Advocate Supports	hour	0	0	6	0	3	24	0

Appendix N: Other State and County Service Utilization Data for Comparison

State A Population and Current Service Utilization													
Arrivals (average numbers of new persons entering the system each month)													
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**							
21	51	222	880	1412	42	2636							
1%	2%	8%	33%	54%	2%	100%							
Snapshot (average number of consumers continuously serviced by the system)													
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**							
82	224	12333	4619	8262	316	14779							
1%	2%	8%	31%	56%	2%	100%							
Percent Ideally Receiving (%/mo.)								**Ideal Amounts (avg. units/mo.)**					
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**
						Residential							
32%	13%	8%	2%	1%	1%	24 Hour Residential Services	day	12	12	12	14	16	6
						Emergency							
1%	2%	2%	2%	1%	1%	Crisis Intervention	hour	2	2	2	2	2	2
3%	17%	12%	4%	2%	1%	Crisis Stabilization	hour	51	61	71	56	56	2015
11%	5%	3%	1%	0%	0%	Respite Care	hour	98	97	92	98	0	0
						Hospital							
3%	2%	0%	0%	0%	0%	MH Inpatient	day	4	2	0	0	0	0
						Treatment							
3%	7%	9%	12%	14%	17%	Assessment	hour	2	1	2	2	93	82
13%	20%	22%	26%	27%	25%	Evaluation	hour	2	1	1	2	87	78
18%	28%	30%	27%	28%	27%	MH Service Planning	hour	1	1	1	1	1	1
9%	19%	26%	28%	27%	19%	Individual Therapy	hour	11	9	5	4	4	6
5%	7%	7%	15%	18%	17%	Behavioral Management	hour	1	54	50	35	31	27
38%	29%	27%	8%	2%	1%	Day Treatment	hour	68	61	41	38	46	48
0%	2%	2%	1%	1%	1%	Comprehensive Community Support Services	hour	0	14	14	15	11	6
1%	0%	1%	1%	0%	0%	Assertive Comm. Treatment	hour	6	0	7	7	0	0
						Rehabilitation							
0%	2%	1%	0%	0%	0%	Supported Employment	hour	0	22	30	0	0	0
0%	1%	1%	0%	0%	0%	Living Skills	hour	0	38	29	0	0	0
0%	1%	1%	0%	0%	0%	Skills Training	hour	0	31	45	0	0	0
						Support							
28%	40%	40%	39%	45%	48%	Medication Management	15 min	1	2	2	1	1	0
63%	69%	68%	46%	33%	28%	Case Management	hour	5	4	3	2	2	1
1%	0%	1%	1%	1%	0%	Drop-in Center	hour	134	0	75	56	36	0
24%	28%	25%	11%	6%	4%	Transportation	mile	3480	645	545	520	590	288

State B Population and Current Service Utilization														
Arrivals (average numbers of new persons entering the system each month)														
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**								
15	23	4	41	179	3	265								
6%	9%	1%	15%	68%	1%	100%								
Snapshot (average number of consumers continuously serviced by the system)														
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**								
470	1196	380	3403	10055	128	15631								
3%	8%	2%	22%	64%	1%	100%								
Percent Ideally Receiving (%/mo.)								**Ideal Amounts (avg. units/mo.)**						
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	
						Residential								
0%	1%	18%	0%	0%	0%	Long Term Residential	day	0	21	23	0	0	0	
4%	3%	47%	1%	0%	1%	Short Term Residential	day	13	12	15	16	0	1	
						Emergency								
16%	23%	5%	3%	2%	2%	Crisis Intervention (mobile)	hour	2	2	2	2	2	2	
						Hospital								
12%	10%	3%	2%	1%	1%	Inpatient	day	3	2	2	2	2	2	
						Outpatient								
9%	9%	7%	8%	5%	5%	Assessment	hour	1	1	1	1	1	1	
16%	14%	15%	11%	8%	9%	Evaluation	hour	2	2	2	1	1	1	
23%	23%	15%	25%	16%	39%	Individual Therapy	hour	3	5	10	5	3	2	
1%	1%	1%	1%	1%	7%	Methadone	hour	12	13	6	13	14	18	
3%	3%	4%	7%	1%	0%	Behavioral Health Prevention	hour	3	4	3	3	2	0	
4%	7%	7%	16%	1%	1%	Day Treatment	hour	4	5	7	6	4	2	
						Rehabilitation								
2%	1%	2%	3%	1%	4%	Employment Services	hour	4	5	4	4	4	2	
16%	19%	29%	37%	4%	4%	Skills Training/Development	hour	5	6	7	7	3	3	
1%	1%	2%	3%	0%	0%	Living Skills Training	hour	3	2	3	2	0	0	
						Support								
39%	45%	41%	41%	35%	35%	Medication Management	15 min	2	2	2	3	1	2	
98%	98%	98%	97%	96%	81%	Case Management	15 min	8	8	8	6	4	3	
24%	26%	23%	14%	11%	9%	Consultation	hour	2	2	2	2	1	1	
1%	1%	0%	1%	0%	0%	Home Care Training - Family	hour	2	1	0	2	0	0	
0%	1%	2%	1%	0%	1%	Peer Support	hour	0	3	3	3	0	4	
3%	7%	5%	12%	1%	2%	Personal Care Services	hour	18	18	14	18	13	2	
6%	8%	13%	15%	4%	7%	Psychoeducational Services	hour	3	3	6	4	3	2	
6%	8%	9%	8%	1%	2%	Self-Help/Peer Services	hour	3	3	5	3	3	2	
3%	6%	6%	9%	0%	0%	Supported Housing	15 min	17	21	23	23	0	0	
31%	36%	40%	34%	17%	13%	Transportation	trip	4	5	6	7	3	2	

State C Population and Current Service Utilization													
Arrivals (average numbers of new persons entering the system each month)													
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**							
16	70	281	568	213	3	1152							
1%	6%	24%	49%	18%	0%	100%							
Snapshot (average number of consumers continuously serviced by the system)													
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**							
126	681	2644	5372	1978	31	10834							
1%	6%	24%	50%	18%	0%	100%							
Percent Ideally Receiving (%/mo.)								**Ideal Amounts (avg. units/mo.)**					
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**
						Residential							
0%	0.7%	0.4%	0%	0%	0%	Long Term Residential	day	0	12	19	0	0	0
						Emergency							
1%	0%	0%	0%	0%	0%	Crisis	hour	1	0	0	0	0	0
1%	1%	1%	1%	0%	1%	Respite Care	hour	5	7	6	5	0	2
						Outpatient							
10%	10%	10%	12%	11%	15%	Assessment	hour	1	1	1	1	1	1
20%	32%	34%	35%	35%	31%	Individual Psychotherapy	hour	3	4	4	3	2	2
3%	7%	7%	9%	9%	7%	Group Psychotherapy	hour	2	2	2	2	2	2
5%	6%	8%	9%	8%	6%	Family Psychotherapy	hour	4	5	3	2	2	1
6%	11%	7%	4%	3%	1%	Daily Structure and Support	hour	8	7	6	6	5	7
0%	1%	0%	0%	0%	0%	Day Treatment	hour	0	11	0	0	0	0
1%	3%	3%	3%	4%	6%	Activity Therapy	hour	9	4	3	2	2	2
1%	1%	1%	1%	1%	0%	Assertive Community Treatment	hour	4	7	3	5	5	0
						Rehabilitation							
0%	0%	1%	1%	1%	0%	Employment	hour	0	0	4	4	4	0
16%	19%	29%	37%	4%	4%	Skills Training and Development	hour	5	6	7	7	3	3
						Support							
53%	47%	39%	29%	26%	23%	Medication Management	15 min	2	2	2	2	1	1
40%	43%	37%	29%	26%	25%	Case Management	hour	3	3	3	2	2	2
3%	5%	4%	2%	1%	1%	Skills Training - Individual	hour	4	4	4	3	3	3
2%	4%	3%	2%	3%	3%	Skills Training Group	hour	6	4	4	3	2	2

State D Population and Current Service Utilization													
Arrivals (average numbers of new persons entering the system each month)													
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**							
147	581	525	3033	1154	46	5486							
3%	11%	10%	55%	21%	1%	100%							
Snapshot (average number of consumers continuously serviced by the system)													
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Total**							
1068	3784	3243	23573	7633	237	39538							
3%	10%	8%	60%	19%	1%	100%							
Percent Ideally Receiving (%/mo.)								**Ideal Amounts (avg. units/mo.)**					
FL1	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**	**Service**	**Units**	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**
						Residential							
1%	1%	1%	1%	0%	3%	Transitional & Long Term	day	18	17	20	20	19	17
0%	0%	0%	0%	0%	3%	Semi-Supervised	day	0	31	31	21	18	30
1%	2%	2%	1%	0%	3%	Residential (Board & Care)	day	13	14	14	15	13	10
						Emergency							
82%	39%	52%	24%	18%	16%	Crisis Intervention	hour	4	5	5	3	3	4
17%	44%	43%	12%	21%	24%	Crisis Stabilization (ER)	hour	17	20	20	15	12	9
1%	1%	2%	0%	0%	3%	Crisis Residential	day	12	13	13	13	13	2
						Inpatient/Hospital							
3%	9%	8%	3%	3%	5%	Inpatient (General)	day	10	8	9	8	7	5
2%	7%	9%	1%	0%	3%	Inpatient (Specialty)	day	11	9	10	9	9	8
						Treatment							
2%	21%	5%	52%	54%	55%	Diagnostic Interview (Psych)	hour	2	3	3	3	3	2
1%	1%	0%	1%	0%	3%	Diagnostic Interview	hour	2	2	2	2	2	1
3%	6%	3%	13%	17%	12%	Individual Psychotherapy	hour	2	3	3	2	2	2
7%	7%	6%	6%	4%	3%	Group Psychotherapy	hour	2	1	2	1	1	2
0%	0%	0%	0%	1%	5%	Testing & Assessment	hour	0	5	5	6	7	5
1%	0%	0%	0%	1%	3%	Outpatient Consultation	hour	2	1	1	1	1	1
1%	0%	0%	0%	0%	0%	Evaluation & Management	hour	0	3	4	3	1	0
11%	24%	15%	40%	30%	15%	Medication Management	15min	6	7	7	6	6	5
1%	1%	1%	1%	0%	0%	Day Rehabilitation	day	9	11	8	11	9	0
1%	1%	1%	0%	0%	0%	Acute Care (Non-Hospital)	day	14	14	15	12	7	0
7%	15%	7%	16%	12%	7%	Individual Rehabilitation	hour	5	3	4	3	2	3
2%	4%	2%	4%	2%	4%	Group Rehabilitation	hour	3	3	3	2	1	2
						Rehabilitation							
0%	0%	0%	0%	0%	0%	Vocational Counseling	hour	0	0	0	0	0	0
1%	0%	0%	0%	0%	0%	Therapeutic Behavior	hour	53	56	0	21	36	0
1%	0%	0%	0%	0%	0%	Employment Maintenance	hour	3	3	3	2	2	0
15%	23%	16%	31%	26%	17%	Targeted Case Management	hour	3	3	3	2	2	2
0%	0%	0%	0%	0%	0%	Socialization	hour	0	6	6	9	9	0
7%	10%	6%	13%	12%	8%	Case Consultation	hour	2	1	2	1	1	1

Appendix O: Functional Level Transition Rates in Comparison States

State A

	Dis.	FL1	FL2	FL3	FL4	FL5	FL6	FL7	Total
FL1	43%	**28%**	2%	3%	13%	10%	0%	0%	100%
FL2	20%	0%	**48%**	22%	6%	4%	0%	0%	100%
FL3	18%	0%	5%	**65%**	8%	3%	0%	0%	100%
FL4	29%	0%	1%	3%	**58%**	8%	0%	0%	100%
FL5	33%	0%	0%	1%	4%	**62%**	0%	0%	100%
FL6	35%	0%	0%	1%	1%	8%	**53%**	1%	100%

State B

	Dis.	FL1	FL2	FL3	FL4	FL5	FL6	FL7	Total
FL1	2%	**34%**	10%	0%	12%	33%	9%	1%	100%
FL2	2%	8%	**45%**	0%	12%	26%	7%	1%	100%
FL3	0%	0%	0%	**96%**	0%	2%	2%	0%	100%
FL4	1%	2%	3%	0%	**69%**	18%	7%	1%	100%
FL5	2%	2%	2%	0%	6%	**60%**	27%	1%	100%
FL6	9%	1%	1%	0%	2%	28%	**55%**	4%	100%

State C

	Dis.	FL1	FL2	FL3	FL4	FL5	FL6	FL7	Total
FL1	20%	**74%**	2%	2%	2%	0%	0%	0%	100%
FL2	13%	0%	**81%**	4%	2%	0%	0%	0%	100%
FL3	15%	0%	1%	**80%**	4%	0%	0%	0%	100%
FL4	18%	0%	0%	2%	**78%**	2%	0%	0%	100%
FL5	20%	0%	0%	1%	4%	**75%**	0%	0%	100%
FL6	32%	0%	1%	0%	3%	8%	**55%**	0%	100%

State D

	Dis.	FL1	FL2	FL3	FL4	FL5	FL6	FL7	Total
FL1	33%	**55%**	3%	3%	5%	1%	0%	0%	100%
FL2	20%	0%	**73%**	2%	4%	1%	0%	0%	100%
FL3	30%	1%	3%	**59%**	6%	1%	0%	0%	100%
FL4	13%	0%	0%	0%	**85%**	1%	0%	0%	100%
FL5	10%	0%	0%	0%	2%	**81%**	0%	6%	100%
FL6	18%	0%	0%	0%	2%	1%	**68%**	9%	100%

Appendix P: Overview of Publicly Available Resources to Assist in Redesign Efforts

The following resources may assist system stakeholders in implementing some of the recommendations outlined in this report.

SAMHSA's Evidence-based Practice KITs

To encourage the use of EBPs, the SAMHSA CMHS has funded the development of seven EBP KITs (KIT stands for Knowledge Informing Transformation) in the areas of Illness Management and Recovery, ACT, Family Psychoeducation, Supportive Employment, Co-Occurring Disorders, IDDT, and PSH.[17] Future topics for the EBP KITs include the following: Consumer-Operated Services, Treatment of Depression in Older Adults, Supported Education, and Mental Health Promotion and Prevention of Behavioral Problems.

The EBP KITs provide detailed guidance on how to get started with the EBP which includes consensus building, integrating EBPs into policies and procedures, developing an EBP training structure, developing a monitoring and evaluation structure, and maximizing the effectiveness by making services culturally competent. The KITs also provide tips for public mental health authorities to support EBP implementation, resources for training frontline staff on knowledge and skills needed to deliver the EBP, and resources for evaluating the program including EBP specific process and outcome measures. The KITs include introductory materials in various formats (PowerPoint presentations, brochures, practice workbooks and exercises, DVDs, CD-ROMS, etc) to explain the principles of the specific EBP and how it helps consumers and families for use with all stakeholders.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)

The SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) is available for the identification and selection of other EBPs.[18] NREPP includes a course module that provides guidance to facilitate the selection and implementation of the practices available in NREPP.[19] The course helps users select the program that best matches their organization's needs and carry out the steps necessary to implementing the chosen program.

National Association of State Mental Health Program Directors Guide to Cultural Competence

A resource that may be useful in developing greater cultural competency is from the National Association of State Mental Health Program Directors (NASMHPD). NASMHPD convened in 2003 national experts to develop recommendations to guide State Mental Health Authorities (SMHA) Directors and Commissioners in the development of culturally competent systems of care and to guide the development of baseline performance

[17] The EBP KITS are available at: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/about.asp
[18] Information about NREPP is available at: http://www.nrepp.samhsa.gov/Search.aspx
[19] NREPP course module available at: http://www.nrepp.samhsa.gov/AboutLearn.aspx

indicators for states to measure system readiness and progress.[20] While the report was developed for SMHAs, it can be also be used by county mental health authorities.

Resources for Developing Standards and Contractual Requirements Related to Cultural Competence

Another initiative that would enhance the County's overall commitment to cultural competence is the development of standards and contractual requirements related to cultural competence for its providers. This is one of the recommendations in the NASMHPD report. There are two documents that may be useful in this area:

1) SAMHSA's *Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups*[21]
2) The U.S. Office of Minority Health's *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care*[22]

The Joint Commission Document on Promoting Effective Communication

TJC provides information on how to address language barriers and identifies resources for language access in the publication *Promoting Effective Communication-Language Access Services in Health Care*.[23]

Cultural Competency Assessment Tools

The NASMHPD report noted previously includes a State Mental Health Agency Cultural Competence Activities Assessment that can be modified for use by system stakeholders. There is also a *Cultural Competency Assessment Scale for Outpatient Service Delivery Agencies* that was developed by the Nathan S. Kline Institute for Psychiatric Research that may also be useful in this area. [24]

Other Resources from the Joint Commission

TJC views the issue of the provision of culturally and linguistically appropriate health care services as an important quality and safety issue and a key element in individual-centered care. They have made several efforts to provide guidance to organizations in effective communication, cultural competence, and patient and family-centered care. In their website, TJC has identified their own standards that support the provision of care, treatment, and services in a manner that is conducive to the communication, cultural, language, health literacy, and spiritual/religious needs of individuals.[25] They have also listed resources on standards and regulations, training tools, reports, websites, and general resources focused on the issues of culture and language. [26]

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[20] The 2004 final report *Cultural Competence: Measurement as a Strategy for Moving Knowledge into Practice in State Mental Health Systems* can be downloaded from http://www.nasmhpd.org/general_files/publications/cult%20comp.pdf

[21] The publication is available at http://mentalhealth.samhsa.gov/publications/allpubs/sma00-3457/default.asp

[22] The publication is available at http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

[23] The document is available at: http://www.jointcommission.org/NR/rdonlyres/ACAFA57F-5F50-427A-BB98-73431D68A5E4/0/Perspectives_Article_Feb_2008.pdf

[24] The Cultural Competency Assessment Scale is available at http://ssrdqst.rfmh.org/cecc/sites/ssrdqst.rfmh.org.cecc/UserFiles/CCAS.PDF

[25] They can be viewed at

Resources Related to Trauma-Informed Care

In 2005, the SAMHSA CMHS created the National Center for Trauma Informed Care (NCTIC) to provide consultation, technical assistance, and training for systems as they transform into trauma informed systems. The NCTIC website contains multiple TIC related resources.[27, 28]

SAMHSA's National Outcome Measures (NOMs)

SAMHSA has chosen the NOMs in ten domains that are seen as showing outcomes for people who are striving to attain and sustain recovery and to work, learn, live and participate fully in their communities.[29] The NOMs domain/measures are:

- Increased level of functioning
- Increased or retained employment and school enrollment/school attendance
- Decreased involvement with the criminal justice system
- Increased stability in housing
- Increased social support/social connectedness
- Perception of care
- Increased access to services
- Number of persons served by age, gender, race and ethnicity
- Decreased utilization of psychiatric inpatient beds/readmissions to State psychiatric hospitals
- Increased cost effectiveness
- Increased use of EBPs

National Inventory of Mental Health Quality Measures

The above referenced toolkit includes guidance for using the National Inventory of Mental Health Quality Measures an interactive database of single item process measures of quality.[30]

Quality Improvement Materials Developed by HSRI

HSRI collaborated with Dr. Richard Herman to develop a toolkit that may be useful for selecting performance indicators. The toolkit, *Selecting Process Measures for Quality Improvement in Mental Healthcare* (2002) is a

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http://www.jointcommission.org/PatientSafety/HLC/HLC_Joint_Commission_Standards.htm

[26] See website at http://www.jointcommission.org/PatientSafety/HLC/HLC_Selected_Resources.htm

[27] National Center for Trauma-Informed Care, *Revolutionizing Mental Health and Human Services. Brochure* available at *http://download.ncadi.samhsa.gov/ken/pdf/NCTIC/NCTIC_Brochure.pdf*

[28] Information about NCTIC and how to obtain services can be obtained at: http://mentalhealth.samhsa.gov/nctic/default.asp.

[29] Information about the SAMHSA NOMs can be viewed at: http://www.nationaloutcomemeasures.samhsa.gov/

[30] The database is available at www.cqaimh.org.

resource for identifying and selecting process measures for use in quality assessment and improvement activities.[31]

In collaboration with the National Association of County Behavioral Health Directors and the California Institute for Mental Health, HSRI developed *The Performance Improvement Project: a Technical Assistance Manual,* which may be useful. This manual provides a step-by-step approach to all phases of developing, implementing, and evaluating Performance Improvement Projects, with detailed information and resources presented in format and language designed to be readily utilized by local county-sponsored behavioral health authorities.[32]

[31] The toolkit can be downloaded from: http://tecathsri.org/materials.asp.
[32] The manual can be downloaded from: http://tecathsri.org/materials.asp.

Appendix Q: Alternative Models of Case Management

National Association of Case Management Model (Hodge & Giesler, 1997)			
	Level 1	**Level 2**	**Level 3**
Support	Very Intensive	Moderately intensive	Least intensive
Populations	Experiencing significant impairment Recently discharged from institutions Co-occurring substance abuse Homeless Forensic populations	Actively working on recovery goals Achieved some stability Require specialized interventions (i.e. supported employment, DBT, substance abuse treatment)	Made significant progress in recovery or unwilling to participate in a more intensive level of case management
Team composition	Multi-disciplinary, includes psychiatry and nursing, vocational specialist, housing specialist	Multi-disciplinary, includes psychiatry and nursing, vocational specialist, housing specialist	Largely office-based, collaborates with other providers
Caseload	10-13	20-30	60-80
Availability	24 hours per day 7 days per week	24 hours per day 7 days per week linked	40 hours per week with on call arrangements
Contact frequency	Daily to weekly	4 to 11 contacts per month	Once per month, at least four times annually
Location	In vivo, in the community	In vivo, in the community	Contacts are either in person in the office or on the phone
Case manager functions	Support with day to day living Teach independent living skills Support with housing and employment	Teaching skills Connecting individuals with services Monitoring progress	Providing information about resources, opportunities, rights protection Oversight of appointments Crisis intervention Referral to services
Update treatment plan and review for continued stay	Every 90 days	Every 90 days	Twice per year, includes development of crisis prevention plans

Arizona's Multi-Level Case Management
(Arizona Department of Health Services, 2001)

	ASSERTIVE	SUPPORTIVE	CONNECTIVE
Description	-Modified ACT Model -Mobile treatment team -Provides most services directly, "in vivo" -24 hours per day, 7 days per week	-Multi-disciplinary team -Community-focused coordination of care -Significant inclusion of providers and state agencies -Monday to Friday, 8am-5pm	-Small, clinic -based treatment team - Psychopharmacological treatment, monitoring and service linkages -Monday to Friday, 8am-5pm
Target Population	-Consumers in greatest need with severe functional impairment -Require intensive support to remain in the community -Less than 10% of total population	-Consumers with severe to moderate functional Impairment -Require assistance and support to achieve goal of recovery -Approximately 80% of total population	Consumers with moderate functional impairment Require outpatient services to maintain recovery Approximately 10% of total population
Focus	-Functional Stabilization	-Rehabilitation	-Maintenance of Recovery Goals
Goals	-Decreasing debilitating symptoms/side effects -Increasing independence -Minimizing periods of crisis -Establishing sense of self and personal aspiration	-Choosing and pursuing rehabilitation and recovery goals -Recovering functioning in multiple life areas	-Maintaining stability and independence -Prescribing -Single point of contact for linkage to services
Team Composition	Prescriber (Psychiatrist), Team Coordinator, Psychiatric Nurse(s), Rehabilitation, Housing, and Substance Abuse Specialists, Behavioral Health Techs, Paraprofessional Mental Health Workers (Employment Specialist, Transportation Specialist, Peer Support Worker)	Prescriber (Psychiatrist, Nurse Practitioner, PA under Psych. supervision), Team Coordinator, Psychiatric Nurse, Rehabilitation Specialist, Behavioral Health Techs, Stakeholders/Providers *at least one team member will function as a Substance Abuse or Housing Specialist)	Prescriber (Psychiatrist, Nurse Practitioner, PA under Psychiatrist supervision), Psychiatric Nurse, Behavioral Health Tech (only as needed)
Clinical Authority	· Prescriber provides medical supervision · Team Coordinator provides clinical and administrative supervision for nonmedical staff · Entire clinical team has authority for clinical decisions	· Prescriber provides medical supervision · Lead Clinician provides clinical and administrative supervision for nonmedical staff · Entire clinical team has authority for clinical decisions	· Prescriber provides medical and clinical supervision for the team · Lead Clinician provides clinical and administrative supervision, if services other than medical are required
Caseload Size	12	30	70
Stakeholder Role	Most services provided by team	Significant inclusion of network providers and state agencies	Linkage and referrals as appropriate

Appendix R: Case Management Core Functions and Performance Measures

Based on a review of the case management literature and a convened panel of experts, the Ontario Government developed a set of core functions and performance standards which may inform performance management efforts for Milwaukee's case management program (Ontario Ministry of Health and Long-Term Care, 2005). These core functions and performance are described in detail below.

Function	Standards
Outreach and Consumer Identification	• Assertive outreach is offered to engage potential consumers in their place of choice, considering the safety and security of the consumer and the provider. • Services establish alternative approaches to identify and serve consumers that reflect varied consumer needs (for example, cultural or linguistic needs). • There is a documented intake process including criteria to determine eligibility for service. The intake process is initiated within 10 working days after initial contact. • There is a plan to manage the waiting list. The plan is reviewed on an annual basis. • If referral to additional services or diversion to another service is recommended, the referral is developed in consultation with the consumer.
Assessment and Planning	• Upon completion of the intake process, an agency standardized needs assessment for service is initiated within 10 working days • A comprehensive, individualized service plan is developed mutually by the case manager and the consumer and reflects the stated goals and needs of the consumer. The plan includes strategies for managing crises, and outlines a timeframe for goal attainment. • The service plan must identify other resources to address the full range of a consumer's needs.
Direct Service Provision/ Intervention	• Service provision must be focused in the community, not the office. • Service provision must be managed in a manner that responds to consumer need. • A case manager-consumer ratio of no more than 1:20 must be maintained where possible. • Case management services are available a minimum of eight hours a day, five days a week. • Written protocols must be established for consumers to access service/support in off-service hours, seven days a week, 24 hours a day, and should be documented in consumer service plans as part of emergency/crisis planning. • Front line staff are trained in a variety of issues, to the best extent possible, supported through professional development agreements.
Monitoring, Evaluation and Follow-up	• Consumers will participate in a review of their service plan at least annually. A senior staff member or supervisor should also review the plan annually. • Consumer satisfaction (including consumers, families and outside agencies) must be surveyed regularly, and the results used to make service improvements. • All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards. • A written discharge plan must be developed upon completion of service that would include criteria for follow-up, re-entry and linkage with other services. • Written protocols are developed for a complaint process to receive and act upon the concerns of consumers and families. Consumers are informed of this process. • An annual review of standards must be undertaken (including implementation and compliance).
Information, Liaison, Advocacy, Consultation and Collaboration	• The service provider agency must develop partnership or service agreements with other agencies or community services or primary care providers to ensure continuity of service provision. • The case manager must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information. • The case manager must also advocate for services that are relevant to the consumer's needs. • The service provider agency must develop a written plan that identifies community resources, linkages, and staff training requirements. The plan must be reviewed annually for appropriateness.

A final resource in the area of quality measures for case management is available from the Center for Quality Assessment and Improvement in Mental Health (CQAIMH).[33] The CQAIMH measure database offers a small number of quality measures for case management programs that serve individuals with SMI. Although these measures were developed through expert opinion, there is little evidence to support them at this time. They are measures are described in the table below.

Measure Name	Denominator	Numerator
Incomplete Referrals for Mental Health Services	The total number of consumers enrolled in a health plan's case management program who respond to a consumer survey at a specified point in time.	Of those consumers in the denominator, the number who report on the consumer survey that they were referred for a mental health service by a case manager but did not receive the service.
Consumer Assessments of Case Management	The number of consumers who participate in a case management program and respond to a biannual consumer survey.	Of those in the denominator, the number of consumers who report that their case manager assisted them to obtain all necessary mental health and substance abuse services.
Case Manager Involvement in Discharge Planning	Consumers enrolled in case management programs who are discharged from an inpatient or 24-hour residential facility within a six-month period in time.	Those consumers from the denominator whose medical record documents case manager involvement in the discharge planning process.
Case Management for Dual Diagnosis	The number of dually diagnosed individuals participating in mental health case management services who respond to a biannual consumer survey at a specified point in time.	The number of participants from the denominator who report their mental health case manager assisted them to obtain substance abuse treatment.
Case Management of Medical Co-morbidity	The number of consumers who participate in a case management program and respond to a biannual consumer survey.	Of those in the denominator, the number of consumers who report that their mental health case manager helped them to address their medical care needs.
Case Management Use for Disabling Schizophrenia	Consumers between the age 18-65 who were in outpatient treatment for at least three months, had less than 21 inpatient days and at least one psychiatrist visit during this period and diagnosed with schizophrenia or schizoaffective disorder with a GAF scale score of <40.	Consumers included in the denominator who have experienced at least one contact with a case manager during the 3 months prior to review.

[33] A searchable database of quality measures is available at the CQAIMH website: http://www.cqaimh.org

Appendix S: Planning Best Practices Suggested by Sources Shown and Organized by Domains

The following tables outline approaches to system planning organized by four common domains: 1) Enlisting Interest; 2) Plan Development; 3) Plan Implementation; and 4) Monitoring and Managing Plan Implementation.

	1. Enlisting Interest		
Participatory And Evidence-Based Systems Planning	Reach out to relevant stakeholders	Frame the planning task	Identify, operationally define and prioritize goals and/or objectives
Council On Linkages (2010)			Define problem
Bardach (2009)			Define problem
Lakoff (2008)	Identify actors		Identify destinations (goals)
World Health Organization (2007)	Promote interactions among stakeholders	Set out vision, values, principles	Set out objectives of policy
Miller (1991)		Conception of the Problem	Desired outcome
Reinke (1988)	Developing planning competence	Statement of policy and broad goals	Priority statement of health problems
Friedman (1987)			Formulate goals, objectives
Mayer (1985)			Determination of goals
Nutt (1984)		Formulation	
Swain (1981)		Problem identification	Statement of objectives and measures
Jones (1977)		Issue creation	

	2. Plan Development				
Participatory And Evidence-Based Systems Planning	Assess consumer needs, given goals	Identify alternative courses of action	Estimate required and available resources, outcomes	Compare alternatives	Choose safest, most efficient courses of action consistent with goals, objectives
Council On Linkages (2010)		State options	Collect, summarize, interpret information relevant to issue; State feasibility and	Use current decision analysis techniques; Articulate health, fiscal, administrative, legal,	Decide on appropriate course of action

			expected outcomes	social, political implications of options	
Bardach (2009)		Construct alternatives	Assemble evidence; Project outcome	Select criteria; Confront trade-offs	Decide
Lakoff (2008)		Assess locations (states)		Estimate values and probabilities of actions to achieve purpose	Choose direction
World Health Organization (2007)	Assess population's needs	Determine areas for action	Gather evidence for effective strategies; Determine costs, available resources, budget	Consultation and negotiation	Determine strategies and time frames
Miller (1991)		Potential for achieving outcomes through currently available & efficient means			
Reinke (1988)			Information for planning	Plan outline with statement of major alternative proposals	Development of detailed plan with target and standards
Friedman (1987)		Identify design of major alternatives for reaching goals identified with given decision making situation	Predict major sets of consequences that would follow adoption of each alternative	Evaluate consequences in relation to desired objectives, other important values	Decide on alternatives based on information provided in preceding steps
Mayer (1985)	Assessment of needs; Specification of objectives	Design of alternative actions	Estimation of consequences of alternative actions		Select of courses of actions
Nutt (1984)		Conceptualization		Detailing	Evaluation
Swain (1981)		Generation of alternatives	Construct models; Data collection		Evaluation; User satisfied
Jones (1977)				Policy design	Governmental decision making

	3. Plan Implementation	***4. Monitoring and Managing Plan Implementation***		
Participatory And Evidence-Based Systems Planning	Translate plan into action steps and implement	Track plan implementation	Conduct quality improvement, evaluation activities	Re-engage stakeholders, restart planning to identify mid-course corrections suggested by quality improvement and evaluation
Council On Linkages (2010)	Develop a plan to implement including goals, outcomes, process objectives, and implementation steps; translate plan into organizational plan	Develop mechanism to monitor and evaluate for effectiveness and quality		
Bardach (2009)				Tell your story
Lakoff (2008)	Achieve a purpose			
World Health Organization (2007)	Determine major activities; Identify major roles, responsibilities of different sectors	Set up monitoring, evaluation processes	Set indicators and targets	Disseminate policy
Miller (1991)				
Reinke (1988)	Implementation as part of planning process		Evaluation and re-planning	
Friedman (1987)	Implement decision through appropriate institutions	Feedback of actual program results and their assessment in light of new decision situation[s]		
Mayer (1985)	Implementation		Evaluation	Feedback
Nutt (1984)	Implementation			
Swain (1981)	Take action			
Jones (1977)	Implementation		Evaluation	

The tables above referenced the following sources:

Bardach, E. (2009). A practical guide for policy analysis : the eightfold path to more effective problem solving. Washington, D.C., CQ Press.

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Swain, R. W. (1981). Health systems analysis. Columbus, Ohio, Grid, inc.

World Health Organization (2007). Overview of the 'Stepped Proces" for Developing a Mental health Policy & Plan. W. H. Organization.

Appendix T: Other Mental Health System Initiatives

The following initiatives are examples of efforts being undertaken by other localities to improve their mental health systems. For more information about these or related initiatives, please click on the associated links or contact HSRI.

Development of Crisis Alternatives

Crisis Intervention Training (CIT) for Law Enforcement

The Crisis Intervention Training is designed to improved outcomes of police interactions with people who suffer from mental illnesses. Through specialized training, law enforcement officers gain knowledge for responding more safely and compassionately to people with SMI while improving public safety, reducing officer injuries, reducing mental health stigma, and decreasing unnecessary hospitalization and arrests. Training formats included lecture, didactical, and community experiences.

- *Local Initiative:* Information about the IT Training Program used by Washington State can be found at http://mhtransformation.wa.gov/MHTG/citmanual.shtml.

Psychiatric Advance Directives (PADs)

PADs are legal instruments used by an individual to document his or her preferences for mental health treatment during acute episodes of psychiatric illness.

- For more information, visit the National Resource Center on Psychiatric Advance Directives website at http://www.nrc-pad.org.
- *Local Initiative:* The state of Hawaii is using a community-based, public education forum to link mental health consumers to local attorneys who will provide free assistance in the development of PADs.
- *Local Initiative:* As part of its system transformation efforts, Connecticut's Department of Mental Health and Addiction Services has developed procedures for documenting, tracking, and supporting the use of PADs.

Mental Health First Aid

Mental Health First Aid refers to the help delivered to an individual who is experiencing a psychiatric crisis before he or she accesses professional treatment. As part of their system transformation efforts, many states have offered the 12-hour training course to first responders such as police officers, ambulance personnel, and fire officers.

- For more information, visit the Mental Health First Aid website at http://www.mhfa.com.au.
- *Local Initiatives:* As part of their system transformation efforts, Missouri, Maryland, and Washington State have implemented Mental Health First Aid Trainings.

Improving Outpatient Services

Collaborative Care

Collaborative care is an integrated health care model in which physical and mental health providers partner to manage mental health treatment in the primary care setting.

- For more information, see the Hogg Foundation's guide to Integrated Health Care: http://www.hogg.utexas.edu/programs_ihc.html.
- *Local Initiative:* As part of its mental health transformation efforts, Missouri's Department of Mental Health is launching the Collaborative Care Model in its CMHCs and FQHCs.

Web-Based Health Risk Assessments

Web-based health risk assessments are technology-based health-risk assessments that are designed to provide enhanced assessment services and enhance integrated care in clinics that have traditionally addressed either physical or mental health needs. The implementation of web-based health risk assessments involves a change process—modifying clinical workflow at the local level—to review assessments and provide appropriate referral or follow-up care as well as creating peer supports for a healthy lifestyle.

- *Local Initiative:* Currently in use in Community Collaboratives across Texas. For more information: http://www.mhtransformation.org/ha.

Comprehensive, Continuous, and Integrated System of Care (CCISC) Model for Co-Occurring Disorders

Several states and localities nationwide are implementing the CCISC model to bring together all organizations within a community serving those with co-occurring mental health and substance use disorders.

- An initiative to implement this initiative in Milwaukee is currently underway.
- For more information visit http://www.kenminkoff.com/ccisc.html.

Workforce Development Initiatives

Workforce Collaboratives

System redesign efforts sometimes involve the development of workforce collaborative, which are permanent bodies charged with planning, coordinating, and implementing interventions to strengthen the workforce.

- *Local Initiative*: Connecticut's Behavioral Health Workforce Collaborative's website is www.cwcbh.org.

Workforce Expansion through University-Based Training

The behavioral health authority might partner with a local university to enhance the local mental health workforce. Efforts may involve the creation of a training program that supports students entering into the local mental health workforce or collaboration with faculty to generate curricula that support local initiatives.

Enhancing Recovery-Oriented Care

Common Ground

Common Ground is an online survey system that allows consumers to provide specific feedback about medications that they are taking to their doctors so that the doctor will be more informed and better prepared for appointments.

- For more information see http://www.patdeegan.com/common_ground_training.htm.
- *Local Initiatives:* Several states, including Washington, Connecticut, and Oklahoma are supporting the implementation Common Ground in hospitals and CMHCs as part of system transformation efforts.

Consumer-Driven Continuous Quality Improvement

Several states administer surveys using trained peer interviewers to assess the recovery-based quality of services. Consumer-operated Service programs may use the Fidelity Assessment Common Ingredients (FACIT) scale to conduct fidelity self-assessment of their programs.

- The FACIT tool is available at http://www.mimh.edu/cstprogramarchive/consumer%20op/Multi-Site%20Activities/FACIT%20Protocol/FACIT%20Tool.pdf.

Recovery and Resiliency Training Programs

Teams composed of representative stakeholders develop training curricula, which includes consumers, providers, and administrators. Trainings focus on concepts of recovery and support the implementation of recovery-oriented initiatives and regulations. Trainings are required for all providers including case managers, psychiatrists, clinicians, and staff of inpatient and outpatient programs, rehabilitation programs, and consumer groups

Efforts to Transition Individuals in Inpatient Care Back to Community

WISE (Working for Integration, Support, and Empowerment) Program

The WISE program helps people with SMI avoid being placed in nursing homes and helps others transition back to the community.

- *Local Initiative:* The WISE program is available through a Home and Community-Based Services waiver in the state of Connecticut. An overview of Connecticut's Program can be found at http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=425724.

Discharge Planning Services

State Hospital Community Resource Needs Interview

Interviews are developed and implemented to document needs identified by consumers for use in discharge planning.

- *Local Initiatives:* Initiatives in Maryland and Connecticut use peer interviewers to work with patients to identify resources they would need to return to the community and support recovery.

Continuity of Care Agreements

Continuity of Care Agreements are entered into by community and inpatient providers to work together to provide supportive transitions between hospital and community services.

- *Local Initiative:* Ohio has instituted Continuity of Care Agreements to increase treatment continuity between community and state hospitals and community mental health outpatient services.

Increasing the Use of Evidence-Based Practices

EBP Utilization Tracking System

An online tracking system may be developed and maintained by the behavioral health authority to track and report the use of EBPs by all provider organizations.

- *Local Initiative:* To support the development and statewide use of EBPs, New Mexico's Behavioral Health Authority has set up a utilization tracking system. These efforts were accompanied by an EBP conference to increase knowledge about EBPs

EBP Clearinghouse

A comprehensive listing of resources for practices designated as EBPs may be posted online to make information about EBPs available to provider organizations, advocacy groups, and the general public.

- *Local Initiative:* As part of its system transformation efforts, the state of Texas developed a Behavioral Health Clearinghouse, which includes information about EBPs. To visit the Clearinghouse go to http://www.mhtransformation.org/clearinghouse.

Local Initiatives to Increase Specific EBPs

The following initiatives are some examples of efforts undertaken by state mental health authorities to increase the use of EBPs in their states.

- Ohio has created initiatives to increase implementation supports to create incentives for providers to start-up and implement IDDT.
- Ohio has also targeted organizations to implement the emerging EBP Wellness Management and Recovery, a program designed to improve recovery and overall health.
- Oklahoma has changed policies to increase the implementation of Illness Management and Recovery (IMR) for psychiatric rehabilitation service consumers.
- Maryland and other states have in place initiatives to increase the number of programs implementing ACT.
- Maryland, Ohio, and other states and localities have increased the number of programs implementing the EBP Supported Employment. Teams have been trained and receiving ongoing technical assistance and implementing and using the principles of the model.

Improve Housing Supports

Supportive Housing Training

As a resource to consumers, a behavioral health authority may work to provide trainings to promote and facilitate supportive housing.

- *Local Initiative:* Washington State has instituted a training program in Supportive Housing for adult consumers, youth, state agencies serving people with mental illness, and local providers.
- *Local Initiative:* The Washington State Supportive Housing Institute also creates interagency partnerships to identify housing options for persons with mental illness. For more information see: http://www.dshs.wa.gov/pdf/hrsa/mh/Supportive_Housing_Institute_Brochure_2_08.pdf.

"Home for Good" Campaign

As part of transformation efforts, some states may work to increase awareness regarding the need for housing supports in the community.

- *Local Initiative:* Through an interagency agreement between the Ohio Department of Mental Health, Ohio Department of Developmental Disabilities, Ohio Department of Job and Family Services, Ohio Department of Alcohol and Drug Addiction Services, Ohio Department of Rehabilitation and Correction, and Ohio Department of Use Services, the "Home for Good" campaign raises awareness around both the importance of and the critical need for additional units of supportive housing in Ohio.

Improve Employment Support Services

WRAP Employment Readiness Trainings

As a resource to consumers, a behavioral health authority may work to provide trainings to support the transition to work using the WRAP model.

- *Local Initiative:* Training program offered to adult mental health consumers in Washington State interested in returning to the workforce. The curriculum focused on the importance of making lists of personal wellness tools and using these tools to write a WRAP, support and peer support, changing negative thoughts to positive, community integration, building self-confidence and self-esteem, relaxation and stress reduction, diet, exercise, focusing, and addressing trauma issues.

Supporting the Transition from Benefits to Work Training

As a resource to consumers, a behavioral health authority may work to provide trainings to promote and facilitate employment by assisting consumers to navigate the complicated process of transitioning from public benefits to the workforce.

- *Local Initiative:* A training program to support the transition from benefits to work was developed for Washington State by the Washington Institute for Mental Health Research and Training. The ultimate goal of the in-person training is to help support the transition from benefits to work for people with a mental illness. Adults with mental illness are given 90-minute trainings in the areas of Medicaid Buy-In, resources, qualifications and the application process.

Strategies to Promote Consumer Empowerment

Training and Technical Assistance Center

As a resource to consumers, a behavioral health authority may create a Training and Technical Assistance Center to support consumer empowerment at multiple levels.

- *Local Initiative:* As part of its system redesign efforts, Texas supported the formation of a new organization, ViaHOPE, that provides training and technical assistance related to mental health issues for consumers, youth, family, professionals, and other stakeholders. ViaHOPE also fosters consumer, youth, and family network development, and leads the development and implementation of peer training and credentialing. For more information visit: http://www.viahope.org.

Mental Health Recovery Trainings

As a resource to consumers, a behavioral health authority may work to provide trainings to promote and support mental health recovery.

- *Local Initiative:* Washington State's Mental Health Recovery Principles training covers the 11 recovery components outlined in the SAMHSA consensus statement and show participants how to assist in their own recovery efforts and support those of people with mental illness in their community. The goal is to foster individuals' personal recovery and resilience.
- *Local Initiative:* Washington State's Train-the-Trainer Trainings are offered to train adults living with a mental health condition how to co-facilitate a weekly Connection Recovery Support Group. The training takes 3 days and the students agree to co-facilitate weekly Connection Recovery Support Groups for one year in their local area.
- *Local Initiative:* In Texas, ViaHOPE provided resources to conduct the In Our Own Voice: Living with Mental Illness training for consumers of mental health services.

- *Local Initiative:* As part of its system transformation efforts, Maryland offered a Wellness Recovery Action Planning (WRAP) training, a three-day training which includes the core concepts of recovery, and daily maintenance, early warning signs and action plans, breakdown and crisis plans, and post crisis plans.

Efforts to Establish Consumer Networks

As part of system transformation efforts, some states worked to create and support a robust consumer network.

- *Local Initiative:* Washington State's Consumer Voice and Leadership Training is designed to educate, empower, support and increase networking for consumers. The curriculum covered Taking Charge; Consumer Rights; Complaints, Grievances, Appeals and Fair Hearings; Ombuds Service and Quality Review Team; On the Road to Recovery; Legislative Information; Grant Writing; WAC and RCW; and Resources.
- *Local Initiative:* Oklahoma's Department of Mental Health and Substance Abuse Services partnered with NAMI and other advocacy organizations to offer leadership training to consumers interested in attaining leadership skills.
- *Local Initiative:* Missouri's Department of Mental Health established a contract to secure Procovery proprietary support services and materials to implement Procovery Circles statewide. For more information about Procovery, visit: www.procovery.com.
- *Local Initiative:* Missouri worked to increase consumer involvement in statewide networks through an organizational agreement with NAMI to waive membership fees for consumers who wish to participate.

Expanding Peer Support Services

Wellness/Health Advocate Training

As a resource to consumers, a behavioral health authority may work to provide training and certification programs for peer support services.

- *Local Initiative:* The Wellness/Health Advocate Training is offered to mental health professionals and certified peer support specialists in Washington State. The Wellness Training is intended to equip direct staff (mental health professionals and certified peer counselors) in community mental health settings with the knowledge, skills and tools to become more effective health and wellness advocates. The training employed a diffusion model, training attendees to create and run Wellness Self Management groups to help clients take charge of their own health and wellness.

Recovery Employment Consultation Service

As part of system transformation efforts, a behavioral health authority may create an employment consultation service that functions as a network to place consumers into positions in the behavioral health care workforce.

- *Local Initiative:* The Connecticut Recovery Employment Consultation Service (C-RECS) is available to consumers in Connecticut to support employment in the behavioral health workforce. The initiative began with a survey of all state-run and state-funded mental health service providers regarding currently filled and currently available positions for persons in recovery. Recruitment and placement services include an on-line job bank, training and support for persons in recovery to facilitate and sustain their role in the workforce, and consultation and technical assistance to mental health provider agencies in integrating persons in recovery into their workforce. C-RECS also provides technical assistance and

consultation services to provider agencies to enhance receptivity and capacity to integrate persons in recovery to their workforce. For more information visit: http://www.crecs.org.

Enhance Cultural Competence

Cultural Competence Workgroups

System redesign efforts sometimes involve the development of cultural competence workgroups, which are permanent bodies charged with planning, coordinating, and implementing interventions to strengthen the cultural competence of the behavioral health system.

- *Local Initiative:* Through legislation signed by the governor of Maryland in May 2007, Maryland formally created a Cultural Competence Workgroup to address issues of cultural competence in mental health. The group produced a report outlining recommendations regarding cultural competency training needs of mental health providers and issues affecting the recruitment and retention of a culturally and diverse mental health workforce.
- *Local Initiative:* Connecticut passed similar legislation, establishing a Minority Mental Health Advisory Commission. Its mission is to work to eliminate disparities in health status based on race, ethnicity, and linguistic ability and improve the quality of health for all state residents.

Cultural Competence Trainings

To promote cultural competence system-wide, the behavioral health authority may require that its staff complete cultural competence trainings. These trainings may also be offered to consumers and the general public.

- *Local Initiative:* Trainings are available to a cross section of Maryland's Department of Mental Hygiene agency staff, consumers, board members and community partners such as faith-based leaders, policy makers, and civic organizations of the selected Core service agencies and providers. Program is designed to train and coach individuals to become leaders in reducing health care disparities and advance the knowledge, understanding, and improvement of mental health service delivery.
- *Local Initiative:* In Texas, trainings have been developed to provide effective and evidence-based Cultural Linguistic Competence training for all system of care organizations, community leaders and stakeholders, and direct care practitioners.
- *Local Initiative:* Washington State developed a web-based curriculum for state employees and service providers on cultural competence, along with management assessment tools.

Enhance Trauma-Informed Care

Trainings in Trauma-Informed Care

To promote the use of trauma-informed care system-wide, the behavioral health authority may require that its staff complete trauma-informed care trainings. These trainings may also be offered to consumers and the general public.

- *Local Initiative:* Connecticut expanded its training program for trauma-informed care to all staff at the two state psychiatric hospitals.
- *Local Initiative:* Washington State's Training on Trauma-Informed Care focuses on the impact of trauma as it affects the person's personal recovery and resilience, the meanings of trauma, and the delivery of

trauma informed care. The training was provided to public and private mental health providers, state agency staff providing services to person with mental health disabilities, Regional Support Network Employees, consumers, primary care providers, family members, law enforcement, other first responders and correctional staff at a Trauma-Informed Care Symposium. For more information visit: http://mhtransformation.wa.gov/MHTG/articles/20080709.shtml.

- *Local Initiative:* In Hawaii, individuals from Trauma and Recovery Consulting Services delivered a motivational presentation to almost 200 providers on the topic of personal recovery stories of surviving lived experience of trauma, and re-traumatization of those experiences within the mental health and criminal justice systems.
- *Local Initiative:* In Texas, ViaHOPE provided resources to conduct the Damaging and Devastating Effects of Trauma training for consumers of mental health services.