OFFICE OF THE COUNTY EXECUTIVE

Milwaukee County

SCOTT WALKER • COUNTY EXECUTIVE

Date: April 14, 2010

To: Lee Holloway, Chairman, County Board of Supervisors

From: Scott Walker, County Executive

Subject: Appointment to Aging and Disability Resource Center (ADRC) Governing Board

Pursuant to State Statute 46.283(6), I am hereby appointing Ms. Rosemary Crump to the newly created Aging and Disability Resource Center (ADRC) Governing Board. Ms. Crump's appointment will fill a position on the ADRC board in the category of Parent of a child with a developmental disability. Attached is a copy of Ms. Crump's resume. The term of service for this appointment is 2 years. It will expire April 30, 2012.

Your consideration and review of this appointment is appreciated.

Scott Walker
Milwaukee County Executive

Cc: Supervisor Peggy West, Chairman, Health and Human Needs Committee
Terry Cooley
Delores Hervey
Jodi Mapp
Stephanie Sue Stein, Director Milwaukee County Department on Aging
Ms. Rosemary Crump

ROOM 306, COURTHOUSE • 901 NORTH 9TH STREET • MILWAUKEE, WISCONSIN 53233
PHONE: 414-278-4211 • FAX: 414-223-1375

ACCESS MEDICAL INC.

Phone: 262-436-1130 ▪ FAX 262-436-1135
TOLL FREE NUMBER: 888-443-0011

ROSEMARY CRUMP
8139 S. Four Oaks Drive
Franklin, WI 53132
414-525-9660

SUMMARY OF ABILITIES

- Proven record of generating marketing and sales opportunities
- Experienced staff trainer and recruiter
- Extensive management experience and business owner
- Increased market share for all employers

SALES AND MARKETING EXPERIENCE

1995-Present Owner/President
Access Medical Inc.

- Direct overall business/marketing development in Wisconsin
- Responsible for overall financial planning and budget
- Direct entire marketing and customer service operations
- Developed a Wisconsin client base of approximately 100 referral sources
- Developed a country wide medical expert base of over 800 physicians, vocational experts, rehabilitation nurses, ergonomic specialists, occupational and physical therapists
- Supervise and train all customer service staff
- Responsible for all administration decisions

RESULTS
Created a unique network of diverse medical experts and evaluations

1993-1994 Regional Marketing Director
Diversified Medical Inc, a National Independent Evaluations

- Responsible for Market Development in Wisconsin, Michigan and Illinois
- Recruited medical experts in three states

- Marketed referral sources (attorneys, insurance companies and employers) in three states
- Director customer service operations
- Supervised and trained a professional marketing staff
- Developed marketing strategy for Upper Midwest region
- Developed a budget for a three state area

RESULTS:

- Increased market penetration in all three states
- IME's increased by over $60,000 per month in a three month period
- Market awareness was generated in a three state parameter

1991-1993 Marketing Manager
CHIRON, LTD, Milwaukee, Wisconsin

- Developed and acquired referral sources throughout the State of Wisconsin and Northern Illinois
- Structured a company wide marketing plan
- Designed marketing materials, brochures, letters, handouts, and newsletters
- Supervised and trained professional staff in marketing
- Coordinated all marketing activities and budgets
- Structured and coordinated all seminars, workshops and meetings

RESULTS:

- Increased market penetration in the State of Wisconsin with insurance resources, self insured companies and third party administrators
- IME's increased an additional 400 month
- Dollar volume increased 2.5 million in 18 months

1990-1991 Marketing/Sales Manager
Occupational Medical Clinics of America, Milwaukee, Wisconsin

- Supervised marketing staff of six people
- Structured, organized and implemented marketing plan
- Responsible for re-organization of telemarketing and direct sales areas

RESULTS:

Created new business, organized effective marketing programs and created a 1 million dollar increase in profit within the first year

Other Pertinent Work Experience

- Owned and marketed my own public relations and marketing company for several years
- Started in the insurance industry as a public relations supervisor, later promoted to manager
- Served as a lobbyist in four states for ALLSTATE INSURNCE COMPANY

EDUCATION

Bachelor of Arts: Communications, History and Secondary Education
MIDLAND LUTHERAN COLLEGE, FREMONT NEBRASKA
Master of Science Program: Business Management
CARDINAL STRICH COLLEGE, MILWAUKEE, WISCONSIN

REFERENCES AVAILABLE UPON REQUEST

MEMORANDUM

Date: May 4, 2010

To: Supervisor Lee Holloway, Chairman, Milwaukee County Board
Supervisor Peggy West, Chair, Committee on Health and Human Needs
Supervisor Elizabeth Coggs, Chair, Committee on Finance and Audit

From: Stephanie Sue Stein, Director, Department on Aging

Subject: Request for authorization to create the Milwaukee County Department of Family Care as a free-standing department of county government which, separate from the Department on Aging and the Department of Health and Human Services, shall be responsible for the operation and administration of the Family Care-Care Management Organization (CMO) function as required by the Wisconsin Department of Health Services (DHS) in connection with the expansion of the Family Care program

I respectfully request that the attached resolution be scheduled for consideration by both (1) the Committee on Health and Human Needs at its meeting on May 19, 2010 and (2) the Committee on Finance and Audit at its meeting on May 20, 2010.

The resolution authorizes the creation of a Milwaukee County Department of Family Care as a free-standing department of county government which, separate from the Department on Aging and the Department of Health and Human Services, shall be responsible for the operation and administration of the Family Care-Care Management Organization (CMO) function as required by the Wisconsin Department of Health Services (DHS) in connection with expansion of the Family Care program.

Creation of a Department of Family Care

The Wisconsin Department of Health Services (DHS) requires that as a Family Care CMO, Milwaukee County is required to separate organizationally the Care Management Organization (CMO) from the Aging Resource Center (ARC), currently both divisions of the Milwaukee County Department on Aging.

BACKGROUND

Family Care is an initiative of the State of Wisconsin to reorganize its Long Term Care programs for older adults and persons with disabilities. Family Care consolidates long term care services as funded by the state under Medicaid along with the Community Options Program, Community Options Program Waiver, and other Long Term Care programs and was created as an entitlement to Home and Community Based Care alongside the entitlement to institutional care under Medicaid.

The major disadvantage of the state's traditional Long Term Care programs was that they funded services through a fixed annual allocation that served only a limited number of persons each year and led to long waitlists of people in need of services throughout the state. By eliminating waitlists, Family Care provides timely services thereby preventing deterioration in client health and functional abilities and reducing the need for costly services later.

To provide access to and to administer its benefits, Family Care created two new entities – the Resource Center (RC) and the Care Management Organization (CMO). Resource Centers provide a single point of access to Family Care by conducting a comprehensive functional and financial eligibility screen on all persons who request assistance. A Care Management Organization administers the Family Care benefit for persons determined to be eligible by a Resource Center. The CMO is responsible for creating a comprehensive plan of care for each client; contracting with a wide range of service providers; and monitoring the quality of services that clients receive.

The Milwaukee County Board of Supervisors has authorized the Milwaukee County Department on Aging to participate as the Care Management Organization (CMO) serving persons age 60 or older under Family Care since 2000. Family Care in Milwaukee County was recently expanded to serve persons age 18 to 59 with physical and development disabilities. Calendar year 2010 is the first full-year in which Milwaukee County operates both an Aging Resource Center (serving individuals age 60 and older) and a Disability Resource Center (serving individuals age 18 to 59). It is also the first full-year the CMO serves both populations in need of long-term care services.

Under Milwaukee County's existing contract with DHS, the CMO must operate separately from both the Aging Resource Center and the Disability Resource Center. A primary reason for the separation is that more than one Care Management Organization now exists within the community to administer the Family Care benefit – Milwaukee County (MCDA-CMO) as well as the nonprofit corporation Community Care, Inc. Since it is the responsibility of a Resource Center to objectively inform persons in need of long-term care about the options available to them if choosing a CMO that can best addresses their needs, DHS considers the organizational separation of the two functions as an essential element in administration of the Family Care benefit and the successful operation of each CMO.

MCDA-CMO

The Milwaukee Country Department on Aging (MCDA) has successfully operated a Family Care program for older adults age 60 and older, has met certification requirements annually, and has entered into a Health and Community Supports contract with the State of Wisconsin annually

since the inception of the Family Care program. The program serves all target groups in accordance with the home and community-based waivers granted by the State of Wisconsin in order to serve people in need of long-term care services within a managed care environment.

Flexibility has and remains an essential element to the successful administration of the Family Care program, including (1) the ability to respond to challenges, foreseen and unforeseen; (2) the ability to provide cost-effective program administration consistent with a capitated rate structure, (3) maintaining adequate risk reserves, and (4) retaining the support of Family Care members, elected offices, and the community.

For nearly ten years, the MCDA-CMO has delivered member-centered, community-based, outcome-focused, managed long-term care services and member-centered care planning for all Family Care members. The MCDA-CMO developed and has refined systems, policies, procedures, and training to ensure its members receive individualized services that maintain both member independence and choice. In addition, the MCDA-CMO is critically linked to community needs through established relationships with universities, advocacy groups, and service providers, along with active community involvement through participation in public meetings and informational forums.

The MCDA-CMO has successfully served more than 15,000 members during the past ten years by embracing a set of core values and a philosophy that is the foundation of the Family Care program.

ORGANIZATIONAL SEPARATION

With the introduction of an additional CMO operating within Milwaukee County, the Wisconsin Department of Health Services has stated as part of the certification process:

> The Department will contract for managed long-term care only in areas that are served by an ADRC. It is the intent of the Department to contract only with an MCO that is organizationally separate from the ADRC, or will be organizationally separate within twelve months of the MCO signing a contract for the provision of long-term care services with the Department. Organizationally separate means that while the ADRC and the MCO may report to the same county board, they may not be operated by the same county agency.

In the statement above, DHS clarified that “agency” means a department of county government. At present, the CMO is not organizationally separate from the Milwaukee County Department on Aging Resource Center. The creation of a Department of Family Care would resolve that issue.

During the past several months the CMO and Department on Aging have worked collaboratively in developing a transition plan to ensure a smooth operation of internal and external services once separation is completed. All positions within the CMO will continue in the new department (see attached organization chart). In addition to maintaining current positions, the CMO will add the positions of Deputy Director of Finance and Deputy Director of Administration. Both Deputy Director positions will report to the Director of Family Care who in turn will report to the County Executive. The Department on Aging will continue with its existing organizational structure and positions minus the CMO.

The CMO Governing Board, per Milwaukee County Ordinance 16.02, will continue to provide the CMO with oversight and guidance in carrying out its mission under the Family Care program as provided under Wis. Stats. s. 46.284, including developing policy recommendations, seeking improvements in operations and fiscal accountability, required reporting, and maintaining quality assurance.

Under the existing Family Care contract between DHS and Milwaukee County, the Department of Family Care must be created and operational by November 1, 2010. If you have questions, please contact me at 2-6876.

Respectfully submitted,

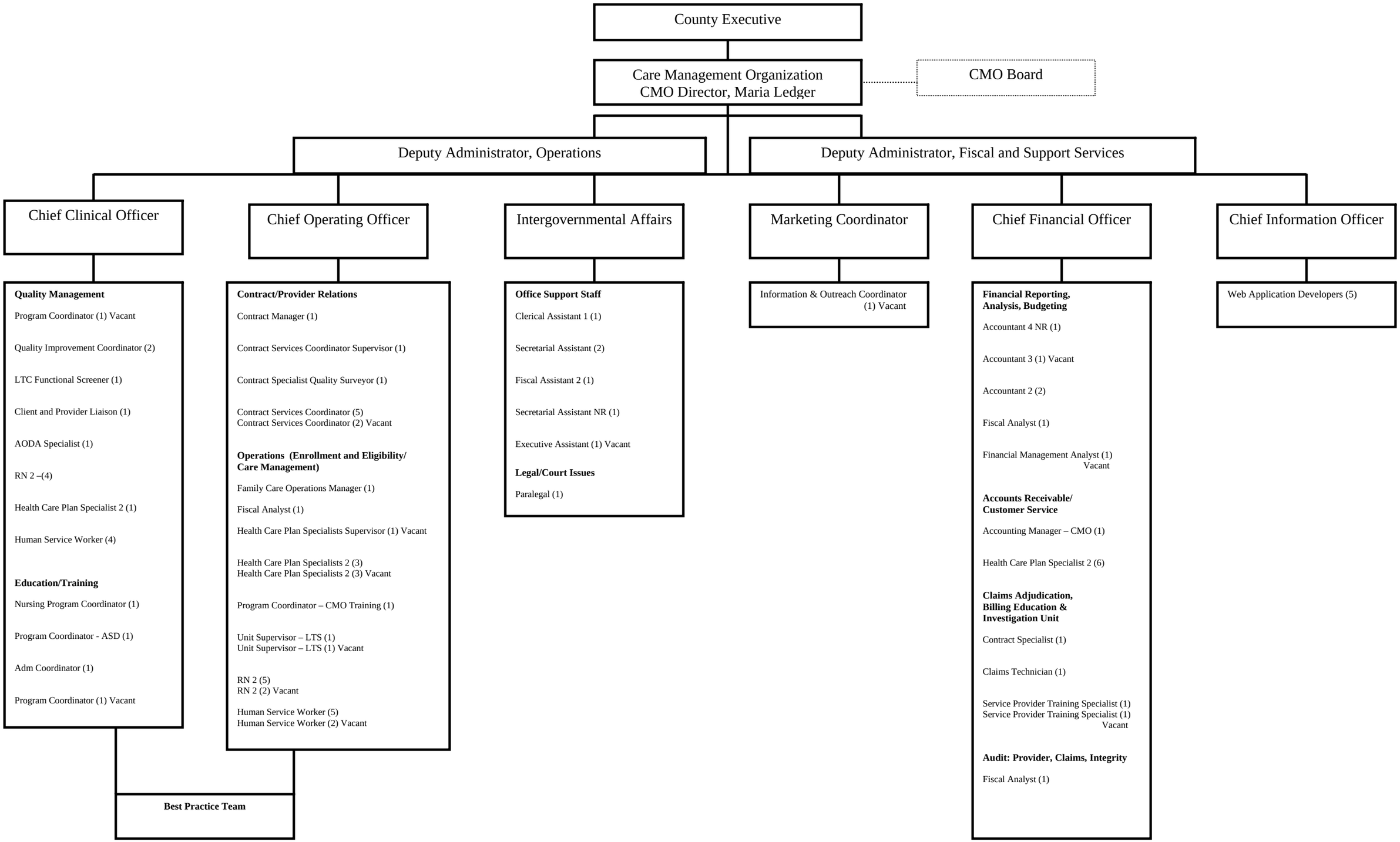
_____

Stephanie Sue Stein, Director
Milwaukee County Department on Aging

Attachments

cc: County Executive Scott Walker
Tom Nardelli
Terry Cooley
Cynthia Archer
Steve Kreklow
John Ruggini
Joesph Carey
Toni Bailey-Thomas
Steve Cady
Jennifer Collins
Maria Ledger
Jim Hodson
Linda Murphy
Eva Williams
Edward Eberle
Lisa Marks
Geri Lyday
Jeanne Dorff
Jonette Arms
Mary Proctor Brown
Nubia Serrano
Gary Portenier
Greg Reiman
Pat Rogers

Milwaukee County Care Management Organization - Organizational Chart 2010



A RESOLUTION

To Create the Milwaukee County Department of Family Care as a free-standing department of county government, separate from the Department on Aging and the Department of Health and Human Services, which shall be responsible for the operation and administration of the Family Care-Care Management Organization (CMO) function as required by the Wisconsin Department of Health Services (DHS) in connection with the expansion of the Family Care program.

WHEREAS, For over nine years, the Department on Aging-Care Management Organization (MCDA-CMO) has been delivering member-centered, community-based, outcome-focused, managed long-term care services and member-centered care planning to all Family Care target groups; and

WHEREAS, The MCDA-CMO developed and refined systems, policies and procedures, and training to ensure its members receive individualized services that maintain member independence and choice; and

WHEREAS, the Department on Aging-Care Management Organization is required by the State of Wisconsin to formally separate from the Department on Aging as part of the long term care program expansion; and

WHEREAS, the CMO, currently a division of the Milwaukee County Department on Aging, will reorganize no later than November 1, 2010 by becoming an independent department within Milwaukee County Government; and

WHEREAS, the initiative to create a separate department to administer the CMO has been reviewed and approved by the CMO Governing Board at its meeting on March 23, 2010; and

WHEREAS, the newly created entity of the Milwaukee County Department of Family Care will have a Director appointed by the County Executive and confirmed by the County Board to serve at the County Executive's pleasure as part of the Executive Branch; and

WHEREAS, the newly created Milwaukee County Department of Family Care will continue managing the service delivery component of the Family Care program for residents of Milwaukee County; and

WHEREAS, The CMO staff will draft language to change the charter of the MCDA-CMO Governing Board and all sub committees to reflect the newly created department; and

WHEREAS, the CMO contracts will be updated as necessary to reflect these changes; and

WHEREAS, the Members, providers, advocates, and stakeholders will be notified of the change; now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors does herby authorize and establish the Milwaukee County Department of Family Care as a separate department of county government, distinct from the Department on Aging and the Department of Health and Human Services, which shall be responsible for the operation and administration of the Family Care-Care Management Organization (CMO) function as required by the Wisconsin Department of Health Services (DHS) in connection with the expansion of the Family Care program, as required by the Wisconsin Department of Health Services (DHS), and will be part of the contract Milwaukee County executed with DHS; and

BE IT FURTHER RESOLVED, that the Milwaukee County Board of Supervisors approves the structure outlined in the organization chart for the new department, allowing for the transfer of those positions that have no change in classification, position description or title code and their incumbents from the Department on Aging to the new department as soon as administratively practicable, and for new positions required to staff the management structure described in the org chart be created, including establishing the qualifications, duties, titles and compensation for those positions, in conformity with the applicable ordinances and rules; and

BE IT FURTHER RESOLVED, that the Milwaukee County Board of Supervisors does hereby adopt the following ordinance:

AN ORDINANCE

To amend Section 16.03 of the General Ordinances of Milwaukee County relating to the local care management organization governing board.

The County Board of Supervisors of the County of Milwaukee does ordain as follows:

Milwaukee County ordinance 16.03 be amended to read:

SECTION 1. The local care management organization governing board shall consist of sixteen (16) members, reflecting the ethnic and economic diversity of Milwaukee County. The total membership of the board will include representation by at least five (5) ~~older~~ people or their family members, guardians, or other advocates who are representative of the CMO membership. The remaining board membership will consist of people residing in Milwaukee County with recognized ability and demonstrated interest in long-term care and managed care and up to three (3) members of the Milwaukee County Board of supervisors or other elected officials. Designation of representatives on the governing board shall be in accordance with section 16.02 of the chapter unless otherwise amended by the county board as a result of federal, state, or county requirements.

SECTION 2. The ordinance shall become effective upon passage and publication.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: May 5, 2010

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Request for authorization to create the Milwaukee County Department of Family Care as a free-standing department of county government which, separate from the Department on Aging and the Department of Health and Human Services, shall be responsible for the operation and administrationof the Family Care-Care Management Organization (CMO) function asrequired by the Wisconsin Department of Health Services (DHS) in connection with the expansion of the Family Care program

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☒ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	**Current Year**	**Subsequent Year**
Operating Budget	Expenditure	0	
	Revenue	0	
	Net Cost	0	
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.[1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

The resolution authorizes the creation of a Department of Family Care as a free-standing department of Milwaukee County government which, separate from the Department on Aging and the Department of Health and Human Services, shall be responsible for the operation and administrationof the Family Care Care Management Organization (CMO) function as required by the Wisconsin Department of Health Services (DHS) in connection with the recent expansion of the Family Care program.

Most of the funding is derived from prospective per member per month (pmpm) capitated payments by the State. The remainder of the funding is provided, where applicable, through member costs shares, and/or room and board payments of patient liabilities paid by members. The newly created Department of Family Care (DFC) must maintain restricted reserve to guarantee that they can meet contractual requirements to provide continuity of care for enrolled CMO members in the event of an operating deficit.

No county positions will be lost as a result of the creation of the new department and the separation of the CMO from Aging. All applicable cross-charges (IMSD, Corporation Counsel, Central Accounting etc) will be charged directly to the appropriate department based on established allocation methods. There will be continuing discussions about the allocations of responsibilities and resources between the two departments.

The adoption of this resolution will not require the expenditure of any County Tax Levy not previously authorized in the 2010 Adopted Budget.

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

This resolution has no fiscal impact on 2010 other than the allocation of staff time required to prepare the accompanying report and resolution.

Department/Prepared By Department on Aging / Gary W. Portenier, Program Planning Coordinator

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

3

COUNTY OF MILWAUKEE
Inter-Office Communication

Date: June 2, 2010

To: Supervisor Elizabeth M. Coggs, Chair, Finance and Audit Committee
Supervisor Peggy West, Chair, Health and Human Needs Committee

From: Stephanie Sue Stein, Director, Department on Aging

Subject: MCDA-CMO Year-End Income Statement for 2009

The attached MCDA-CMO Year-End Income Statement summarizes results of the Care Management Organization (CMO) under Family Care for 2009. In addition, it shows the variance of those results compared to the 2009 adjusted budget.

The CMO is showing a preliminary actual Net Income of $201,443 for 2009. Comparing that to the adjusted budgeted Net Income of $236,916 creates a negative Net Income Variance of ($35,473) as of the reporting date. The results can change due to changes in member service utilization (IBNR), outstanding receivables, internal charges, or other regulatory changes. While preliminary results for 2009 show (1) actual revenues below budgeted revenue and (2) actual expenditures below budgeted expenditures, the differences between actual expenditures and actual revenues result in the positive Net Income for the year.

CMO enrollment as of December 31, 2009 was 7,085 members, a net increase of 367 members from the March 31, 2009 enrollment of 6,718. In addition, CMO enrollment of 7,085 members as of December 31, 2009 indicates a net increase of 393 members from the December 31, 2008 enrollment of 6,692.

If you have questions concerning the attached income statement, please contact Director Stein at 289-6876.

Stephanie Sue Stein, Director
Milwaukee County Department on Aging

Attachment

cc: County Executive Scott Walker
Supervisor Lee Holloway
Thomas Nardelli
Stephen Cady
Jennifer Collins
Joseph Carey
Antionette Thomas-Bailey
Cynthia Archer
Steve Kreklow
Jeanne Dorff
Maria Ledger
Jim Hodson
Linda Murphy
Eva Williams
Jonette Arms
Nubia Serrano
Mary Proctor Brown
Chester Kuzminski
Gary Portenier
Greg Reiman
Pat Rogers

MCDA-CMO Income Statement
For Period of January 1, 2009 thru December 31, 2009

Revenues	1/1/09 - 12/31/09 Actual (Unaudited)	1/1/09 - 12/31/09 Adjusted Budget
Capitation Revenues	$193,784,469	$193,893,863
Member Obligation Revenues	$24,484,773	$24,491,751
Other Revenues	$653,769	$809,628
Total Revenues	$218,923,011	$219,195,242
Expenses		
Member Service Expenses	$205,367,401	$203,711,435
Administrative Expenses:		
---Labor & Fringes	$5,923,516	$6,080,159
---Vendor Contracts	$3,730,894	$3,735,429
---Cross Charges/internal transfers	$1,778,544	$3,065,056
---Other expenses (supplies, mileage, etc.)	$1,921,213	$2,366,247
--- Est. contribution to reserve		
Total Expenses	$218,721,568	$218,958,326
Net Surplus/(Deficit)	**$201,443**	**$236,916**

December 2009 CMO Enrollment:	
Nursing Home (Comprehensive)	7,046
Non-Nursing Home (Intermediate)	39
Total Members Served - 12/31/09	7,085

Note: The above financial summary represent actual results as of the reporting date, however, the result can change due to changes occurring in member service utilization (IBNR), outstanding receivables, internal charges or other regulatory changes. Any change from a prior period is accounted for in the year-to-date aggregate results. Prior period reporting is not restated.

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COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION

Date: May 27, 2010

To: Supervisor Lee Holloway, County Board Chairman

From: John Barrett - Clerk of Circuit Court/Director of Court Services

Subject: Permanency Plan Reviews

Request
The Clerk of Circuit Court is requesting authorization to enter into a contract with the Wisconsin Department of Health and Family Services in the amount of $316,428 for the period of July 1, 2010 through December 31, 2010 to conduct permanency plan reviews for all Milwaukee County children in out-of-home care. This is a continuation of a six-month contract that the Courts and the Wisconsin Department of Children and Families have entered into in January. The $316,428 shall offset the cost of 4.8 positions and all related operating costs for six months.

The County continues calendaring permanency plan reviews for cases that meet the requirements set forth in sec. 48.38(2) when the dispositional order for CHIPS extensions expired on or after Monday, February 26, 2001.

The State will fund the 4.8 County positions needed to staff the case processing of the permanency plan reviews at Children's Court in Milwaukee County. These 4.8 positions consist of one full-time Court Commissioner, one .4 Court Commissioner, one Administrative Assistant III, one Clerical Assistant I position, one full-time and one .4 Deputy Court Clerk/Judicial Assistant.

Fiscal
Approval of this contract will have no tax levy effect, as the State will fully fund all related expenditures.

John Barrett

JB/smg

cc: Supervisor Peggy West, Chairperson, Health & Human Needs Committee
Jodi Mapp

File No.

(ITEM *) From the Clerk of Circuit Court requesting authorization to enter into a contract with the Wisconsin Department of Children and Families for the period of July 1, 2010 through December 31, 2010 to conduct permanency plan reviews for all Milwaukee County youth in out-of-home care.

A RESOLUTION

WHEREAS, Milwaukee County schedules plan reviews for all cases that meet the requirements set forth in Section 48.38(2) of the Wisconsin Statutes when the dispositional order for CHIPS extensions expired on or after Monday, February 26, 2001; and

WHEREAS, the Clerk of Circuit Court is requesting authorization to enter into a contract with the Wisconsin Department of Children and Families in the amount of $316,428 for the period of July 1, 2010 through December 31, 2010 to conduct permanency plan reviews for all Milwaukee County children in out-of-home care; and

WHEREAS, this is a continuation of a six-month contract that the Courts and the Wisconsin Department of Children and Families have entered into in January; and

WHEREAS, the existing County positions needed to staff the case processing of the permanency plan reviews at Children's Court in Milwaukee County consist of:

- 1.0 FTE Court Commissioner
- 0.4 FTE Court Commissioner
- 1.0 FTE Administrative Assistant III
- 1.0 FTE Clerical Assistant I position
- 1.0 FTE Deputy Court Clerk/Judicial Assistant
- 0.4 FTE Deputy Court Clerk/Judicial Assistant

; and

WHEREAS, the $316,428 in State funding shall offset the cost of the existing positions and permanency plan reviews operating costs for six months; and

WHEREAS, this is a sixth month contract whereby the Courts and the Wisconsin Department of Children and Families have negotiated terms for the remainder of the year; now, therefore,

BE IT RESOLVED, that the County Board of Supervisors hereby authorizes the Clerk of Circuit Court to enter into a contract with the Wisconsin Department of Children and Families in the amount of $316,428 for the period of July 1, 2010 through December 31, 2010 to cover the necessary positions and operating costs associated with conducting permanency plan reviews for all Milwaukee County children in out-of-home care.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: May 27, 2010

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Execution of Contract

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	316,428	0
	Revenue	316,428	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A) The proposed contract will allow Milwaukee County Clerk of Circuit Court, Children's Division the ability to continue conducting Permanency Plan Reviews for all Milwaukee County children in out-of-home care for the period July 1, 2010 through December 31, 2010.

B) The dollar cost to Milwaukee County to perform these services will be $316,428. The State of Wisconsin has agreed to reimburse Milwaukee County for these costs. There will be no tax levy impact for Milwaukee County.

C) There are sufficient funds to cover the cost of the contract in org. 2864. Although uncertain of the dollar costs in subsequent years, it is anticipated the State of Wisconsin will continue to fund the program.

D) The State of Wisconsin has agreed to fund expenditures of $316,428 for this program for the last six months of 2010.

Department/Prepared by: Deborah Bachun

Authorized Signature: _____

Did DAS Fiscal Staff Review? Yes No

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By _

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☐ No

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE: May 25, 2010

TO: Supervisor Lee Holloway, Chairman, Milwaukee County Board of Supervisors

FROM: Lisa Marks, Interim Director, Department of Health and Human Services
Prepared by: Dennis Buesing, Administrator – DHHS Contract Administration

SUBJECT: **REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REQUESTING AUTHORIZATION TO AMEND A 2010 CONTRACT WITH THE SOCIAL DEVELOPMENT COMMISSION IN ORDER TO INCREASE THE AMOUNT AVAILABLE FOR ENERGY ASSISTANCE – PUBLIC BENEFIT CRISIS SERVICES**

Issue

Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. Per Section 46.09, the Interim Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase the existing 2010 purchase of service contract with the Social Development Commission (SDC) for energy assistance by $335,188 for Public Benefit Crisis Services, for a total contract of $2,054,145. This increase will eliminate the $344,172 reduction in SDC's 2010 Energy Assistance funding as compared to 2009, as well as bring into parity the percentage of overall Crisis funding allocated to SDC with the percentage of overall Crisis applications they have processed year-to-date for FFY 2010. This request results from supplemental Public Benefit Crisis Services funding provided by the State of Wisconsin Department of Administration (DOA), Division of Energy Services (DES).

Background

In December 2009, DHHS recommended, and the Milwaukee County Board of Supervisors approved, a nine month contract for SDC to continue the provision of services under the Wisconsin Home Energy Assistance Program (WHEAP) for their customer base. In April 2010, DHHS recommended, and the Milwaukee County Board of Supervisors approved, a contract amendment for SDC, increasing the amount of their Crisis Client Services operations funding by $230,606. This increase only partially restored the reduced funding awarded for the 2010 energy season, resulting in an amended 2010 contract $113,566 below SDC's 2009 contract.

In May of this year, DES provided an additional $1,340,753 to Milwaukee County DHHS due to DOA's release of additional Public Benefit Crisis Client Services funding for WHEAP agencies for crisis assistance needs related to high electric costs. Regular energy assistance ends May 15, 2010. Crisis Assistance is a year-round program that provides services to households experiencing actual energy emergencies or those at risk of an emergency. Seventy-five percent of the additional funding ($1,005,565) is for client benefits in the form of grants to customers for utility (electric) costs incurred. Twenty-five percent ($335,188) is for SDC's costs related to delivery of Public Benefit crisis assistance.

The recommended contract increase for SDC in the amount of $335,188 will eliminate the reduction in funding awarded for the 2010 energy season, and will bring into parity the ratio of Crisis Client Services funds awarded to SDC with the ratio of total Crisis applications processed by SDC.

Recommendation

It is recommended that the County Board of Supervisors authorize the Interim Director of the Department of Health and Human Services, or her designee, to execute a 2010 contract amendment with SDC increasing the contract by $335,188 in the area of Public Benefit Crisis Client Services, resulting in a total contract of $2,054,145. The amended contract would be effective for the period of May 1, 2010 through September 30, 2010.

Fiscal Effect

The Wisconsin DOA has authorized the release of additional funds to Milwaukee County DHHS. These funds were released in May, 2010, $335,188 for Public Benefit Crisis Client Services operations, and $1,005,565 for Crisis Client Benefits.

Approval of this recommendation would authorize DHHS to increase SDC's WHEAP contract by an additional $335,188 during the remainder of the 2010 energy season, ending September 30, 2010. The additional Public Benefit Crisis Client Services funds from DOA will serve to cover the contract amendment recommended in this report. Therefore, there would be no tax levy impact associated with this proposal. A fiscal note form is attached.

Respectfully Submitted,

_____

Lisa Marks, Interim Director
Department of Health and Human Services

cc: County Executive Scott Walker
Cindy Archer, Director – DAS
Antionette Bailey-Thomas, Analyst - DAS
Jennifer Collins, Analyst - County Board
Jodi Mapp, Committee Clerk - County Board

File No.
(Journal,)

(ITEM) From the Interim Director, Department of Health and Human Services, requesting authorization to amend the 2010 purchase of service contract with the Social Development Commission in order to increase the amount available for Energy Assistance services, by recommending adoption of the following:

A RESOLUTION

WHEREAS, per Section 46.09 of the Milwaukee County Code of General Ordinances, the Interim Director of the Department of Health and Human Services (DHHS) has requested authorization to increase the existing 2010 purchase of service contract with the Social Development Commission (SDC) by an amount not to exceed $335,188 for Public Benefit Crisis Client Services to eliminate a reduction in SDC's 2010 Energy Assistance allocation; and

WHEREAS, this request results from supplemental Wisconsin Home Energy Assistance Program (WHEAP) funding provided by the State of Wisconsin in the amount of $1,340,753, of which 75% ($1,005,565) is for client benefits in the form of grants to customers for utility costs (electric) and 25% ($335,188) is for costs related to delivery of Public Benefit crisis assistance; and

WHEREAS, in December 2009, DHHS recommended – and the County Board approved – a new contract for SDC to continue the provision of services under the Wisconsin Home Energy Assistance Program (WHEAP); and

WHEREAS, Management Services Division's (MSD) 2010 WHEAP contract allocation for the Social Development Commission was reduced by $344,172 due to a reduction in 2010 Energy Assistance funding from the State of Wisconsin; and

WHEREAS, MSD received supplemental Crisis Client Services funding in March of this year, and the County Board approved a $230,606 increase in its SDC contract to partially offset the cut in funding; and

WHEREAS, MSD received supplemental Public Benefit Crisis Client services funding in May of this year, and is now recommending a $335,188 increase in its SDC contract to eliminate the $344,172 reduction in SDC's 2010 Energy Assistance funding.

WHEREAS, this amendment would bring into parity the ratio of Crisis Client Services funding awarded to SDC with the ratio of total Crisis applications processed by SDC; and

WHEREAS, the contract approved in December 2009 was in the amount of $1,488,351 for the nine month period of January 1, 2010 through September 30, 2010, the April amendment increased that amount to $1,718,957, and this amendment would increase that amount to $2,054,145; now, therefore,

BE IT RESOLVED, that the County Board of Supervisors hereby authorizes the Interim Director of DHHS, or her designee, to increase the contract with SDC by the amount of $335,188 in the area of Public Benefit Crisis Client Services, to eliminate the $344,172 reduction in SDC's 2010 Energy Assistance funding and bring into parity the ratio of Crisis Client Services funding received by SDC with the ratio of total Crisis applications processed by SDC, resulting in a total nine month contract not to exceed $2,054,145.

BE IT FUTHER RESOLVED, that the contract amendment would be effective for the period from May 1, 2010 through September 30, 2010.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 5/25/10

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Interim Director, Department of Health and Human Services (DHHS), requesting authorization to amend a 2010 contract with the Social Development Commission (SDC) to increase the amount available for Public Benefits Crisis Services.

FISCAL EFFECT:

☐ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☒ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☒ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	**Current Year**	**Subsequent Year**
Operating Budget	Expenditure	335,188	0
	Revenue	335,188	0
	Net Cost		0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.

B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.

C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.

D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. Approval of the request would permit the DHHS Management Services Division to amend a 2010 Purchase of Service contract with SDC for the Wisconsin Home Energy Assistance Program (WHEAP).

B.) Due to cuts in the State contract for Energy, SDC's original 2010 contract allocation was reduced by $344,172 compared to its 2009 allocation. In March, the State announced an amendment in the amount of $230,606 for additional Crisis Client Services funding. DHHS recommended and the County Board approved an increase to SDC's contract for the same amount in April.

In May, the State of Wisconsin Department of Administration released an additional $335,188 in Public Benefits Crisis Services funding to Milwaukee County for costs related to the delivery of Public Benefits crisis assistance. The State also released $1,005,565 in Public Benefits Crisis Benefits funding for crisis assistance needs related to high electric costs. This funding is for grants to customer in the form of direct payments to utilities (electric) for costs incurred.

DHHS is recommending that the additional $335,188 in Public Benefits Crisis Services funding be provided to SDC. This action would increase the 2010 SDC contract to $2,054,145 from $1,718,957.

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[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

The term of this contract is January 1 through September 30, 2010. In September 2010, DHHS plans to seek approval of a 12-month (Oct. 1, 2010 thru September 30, 2011) contract with SDC so that the contract will follow the federal fiscal year and the funding award by the State.

C.) Approving the contract amendment would increase expenditures and revenues by $335,188. DHHS has also submitted an appropriation transfer this cycle to align the budget due to the March and May amendments provided by State DOA for the Energy program.

D. This fiscal note assumes expenditures cannot exceed the amounts authorized for the Purchase of Service contract.

Department/Prepared By Clare O'Brien, DAS assigend to DHHS

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

COUNTY OF MILWAUKEE
Inter-Office Communication

6

DATE: May 24, 2010

TO: Lee Holloway, Chairman, Milwaukee County Board of Supervisors

FROM: Lisa Marks, Interim Director, Department of Health and Human Services
Prepared by: Eric Meaux, Administrator, Delinquency and Court Services Division

SUBJECT: **REPORT FROM THE INTERIM DIRECTOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES, REQUESTING AUTHORIZATION TO ACCEPT GRANT DOLLARS TOTALING $97,578 FROM THE WISCONSIN OFFICE OF JUSTICE ASSISTANCE (OJA) FOR PROGRAMS WITHIN THE DELINQUENCY AND COURT SERVICES DIVISION**

Issue

Per section 56.06 of the County Ordinances, the Interim Director of the Department of Health and Human Services (DHHS) is seeking approval to accept grant dollars from the Wisconsin Office of Justice Assistance (OJA) for programs within the Delinquency and Court Services Division (DCSD).

Background

Historically, DCSD has successfully applied for and received State and Federal dollars to fund new initiatives that have directly resulted in strategic programming for specific target populations served by the Division. These funding opportunities allow the Division to pilot new services/strategies that will improve the Division's response to youth involved in the juvenile justice system.

Juvenile Accountability Incentive Block Grant (JAIBG) funds were initially awarded to Milwaukee County in 1999 to target youth found to be in possession of a firearm. This funding became available at a critical time when there was both a large number of youth being committed to State correctional facilities; and a high demand for structured, community services for delinquent youth. These community services were viewed as effective in reducing youth re-offenders, while maintaining community safety and cost-effectiveness.

Due to the success of the Firearm Supervision Project, the Division has continued to be eligible for JAIBG funds on an annual basis since 1999. Due to the annual allocation of these funds by OJA, the Division has planned for these grant funds during the annual budget development.

Similarly to the Firearm Project, the Serious Chronic Offender program, targets a specific juvenile subpopulation. In early 2009, in response to changing subpopulation demands for service, the current provider and the Division mutually agreed to combine the contract allocations for the respective target populations to improve overall service capacity and provide program efficiencies. This has removed episodic waitlist issues that are problematic for the courts and Division.

The Division received confirmation on 5/19/2010 that the funds requested were approved and

anticipates approval of the expanded target population.

Target Subpopulations

Firearm and Serious Chronic Offenders

This project will support juveniles participation in the Targeted Monitoring Program currently operated by the Running Rebels Community Organization. The Targeted Monitoring Program comprises two components that focus on two separate juvenile subpopulations: 1) firearm offenders and 2) serious chronic offenders.

The Targeted Monitoring Program allows youth to remain in the community as an alternative to correctional placement. The program is intended to hold youth accountable to the courts and minimize a youth's risk for re-offense. Program services are targeted enhancements to regular probation services. All youth referred to the program have been adjudicated and are serving a probationary period under the supervision of a probation officer. Many youth are on a stayed order to juvenile corrections. Communication between the program, courts, and probation is essential to ensure the program's effectiveness and credibility.

The award amount of $97,578 will allow the Division to maintain the current service capacity of 105 youth per day. This amount includes a 10% match that is required for Milwaukee County to utilize the grant dollars for this project.

Recommendation

It is recommended that the County Board of Supervisors authorize the Interim Director of DHHS, or her designee, to accept funds from the State of Wisconsin Office of Justice Assistance that targets firearm and serious chronic offenders. Local match is required for this project in the amount of $9,758.

Fiscal Effect

Approval of this request will result in no additional expenditures in 2010. The local match requirement is met with existing tax levy that supports over 90% of total program costs. A fiscal note form is attached.

_____

Lisa Marks, Interim Director
Department of Health and Human Services

cc: County Executive Scott Walker
Cynthia Archer, Director, DAS
Joseph Carey, Fiscal & Management Analyst, DAS
Jodi Mapp, Committee Clerk, County Board Staff
Jennifer Collins, Board Analyst, County Board Staff

File No.
(Journal,)

(Item *) From the Interim Director, Department of Health and Human Services, requesting authorization to accept grant dollars totaling $97,578 from the Wisconsin Office of Justice Assistance (OJA) for programs within the Delinquency and Court Services Division:

A RESOLUTION

WHEREAS, the Delinquency and Court Services Division (DCSD) has in the past successfully applied for and received Federal dollars through the State of Wisconsin – Office of Justice Assistance (OJA) to fund new initiatives that have directly resulted in programming for specific subpopulations served by the Division; and

WHEREAS, DCSD applied for additional grant funds that require local match funds, and the Division is now seeking authorization to accept such funds per Section 56.06 of the Code of General Ordinances; and

WHEREAS, the services that target both firearm offenders and serious chronic offenders has had a very positive impact on the lives of many youth and has produced significant fiscal savings directly related to reduced commitments to the Division of Juvenile Corrections from Milwaukee County; and

WHEREAS, it is anticipated that JAIBG funding in the amount of $97,578 will be available to support and continue these targeted services in 2010 and 2011 at current capacity, and a 10% match is required for Milwaukee County to utilize these grant dollars for this project; and

WHEREAS, approval of this grant award would result in no additional expenditures in 2010; and

WHEREAS, approval of this grant award would require a local match of $4,879 in 2010, which is currently available within the DCSD's 2010 adopted budget; now, therefore,

BE IT RESOLVED, that the County Board of Supervisors hereby authorizes the Interim Director of Health and Human Services, or her designee, to accept grant dollars from the State of Wisconsin Office of Justice Assistance for services targeting firearm offenders and serious chronic offenders.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 5/24/10

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Request from the Interim Director of the Department of Health and Human Services (DHHS) seeking authorization to accept grant dollars totaling $97,578 from the Wisconsin Office of Justice Assistance (OJA), for programs within the Delinquency and Court Services Division.

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Existing Staff Time Required

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.

B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.[0] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.

C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.

D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. The Interim Director of DHHS has requested approval accept grant dollars totaling $97,578 from the Wisconsin Office of Justice Assistance (OJA), for targeted monitoring services within the Delinquency and Court Services Division. The grant totals $97,578 and requires a local match contribution of $9,758. The funding period is 7/1/2010 through 6/30/2011.

B. Approval of this request will result in no additional expenditures in 2010. The Division anticpates claiming approximately 50% of available funds in 2010, which will result in a local match of $4,879. These funds are available within the 2010 adopted budget.

C. The Tax Levy needed to fund this request has been included as part of the Division's 2010 Adopted Budget.

D. No further assumptions are made.

Department/Prepared By Eric Meaux, Division Administrator, Delinquency and Court Services Division

Authorized Signature _____

Did DAS-Fiscal Staff Review? ☐ Yes ☐ No

[0] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: May 24, 2010

TO: Supervisor Peggy West, Chairperson, Committee on Health and Human Needs

FROM: Lisa Marks, Interim Director, Department of Health and Human Services
Prepared by: John Chianelli, Administrator, Behavioral Health Division

SUBJECT: INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR OF HEALTH AND HUMAN SERVICES REGARDING THE STATUS OF CONTRACTING OUT DIETARY SERVICES AREA

BACKGROUND
The 2009 budget included an initiative to contract food service operations at the Behavioral Health Division (BHD). On June 8, 2009, A'viands LLC, the selected vendor, began operating the BHD food service. At the March 5, 2010 meeting of the Health and Human Needs Committee, it was requested that BHD continue to provide quarterly status reports.

DISCUSSION

BHD works closely with A'viands LLC to monitor errors and ensure high quality food and service. A'viands keeps a complaint log listing the type and nature of any complaints received and the follow-up and resolution provided. Below is a table that summarizes the types and number of errors since they began tracking in October 2009:

Type of Complaint (October 2009 through May 2010)	**Number of Occurrences**
Dietary Error – Wrong texture served, inappropriate item served	6
Food Issue – Substitution from menu, overcooked, dislike item etc	50
Portion Size	9
Late Meals, Missing Meals	19
Administrative – Missing meal counts, tableware issue, in-service needs	12
TOTAL	**96**

The majority of the complaints are overcooked food, substitutions or displeasure with a menu item and late or missing meals Missing meals, incorrect food items and patient preferences are corrected immediately by A'viands at the point of service. A total of 96 complaints have been tracked over 33 weeks, which is an average of 2.90 per week. Over 460,000 meals were served during the same time frame. A'viands has been very responsive, addressing issues immediately and following up with a long-term solution within a few days of the event. The complaints are tracked by location and number of complaints per week and a summary is included as **Attachment A.**

BHD closely monitors the fiscal impact of the dietary contract with A'viands LLC. For the first four months of 2010, the average monthly cost for BHD meals was $431,262 and $28,822 for required supplements and snacks/nourishments. BHD also has four dieticians, unemployment costs, various small expenses and crosscharges, which averages $23,094 per month. Therefore, the total average monthly cost including BHD and contracted expenses for 2010 is $483,178. The actual monthly expenditure cost in 2008 for the BHD run dietary service was $621,932. This is an average monthly savings of $138,754 and translates into an annual savings of over $1.66 million.

Recommendation

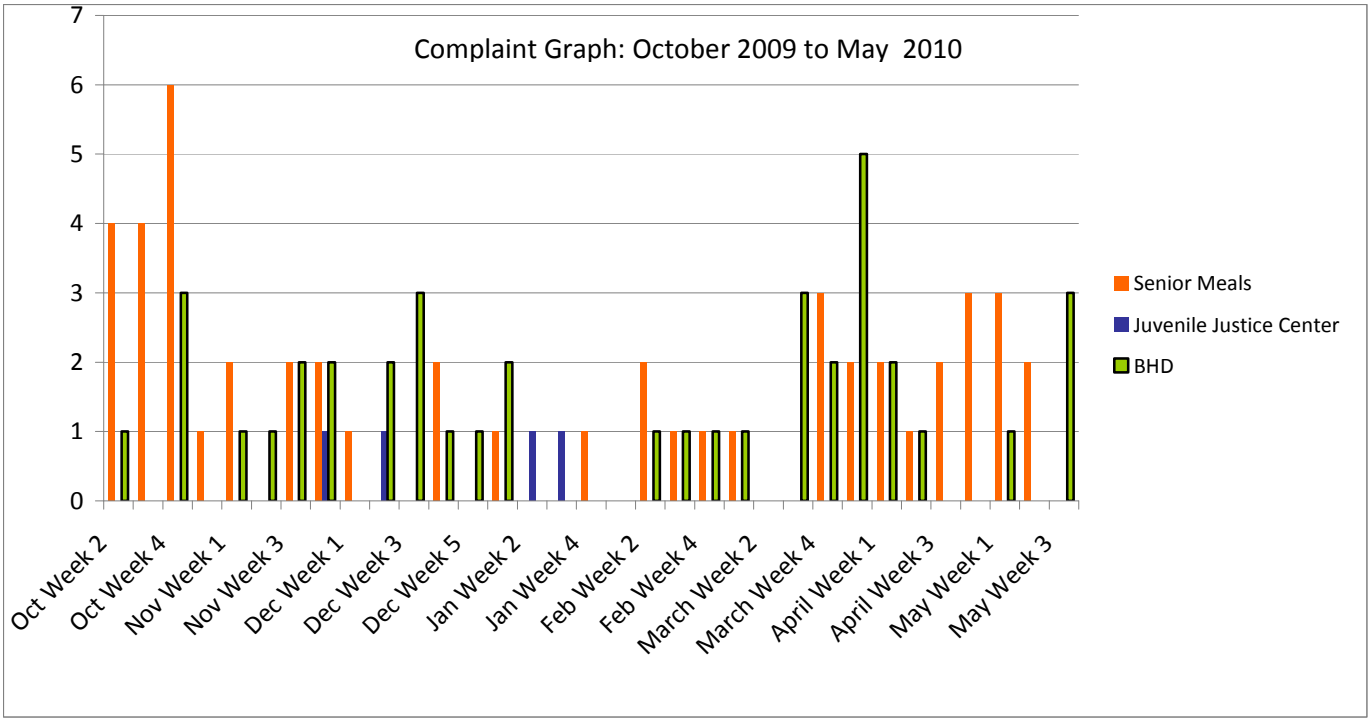
This is an informational report. No action is necessary.

Respectfully Submitted:

_____

Lisa Marks, Interim Director
Department of Health and Human Services

cc.: County Executive Scott Walker
Cynthia Archer, Director, DAS
Joseph Carey, Fiscal & Management Analyst, DAS
Jodi Mapp, Committee Clerk, County Board Staff
Jennifer Collins, Analyst, County Board Staff


Complaint Graph: October 2009 to May 2010
7
6
5
4
3
2
1
0
Oct Week 2
Oct Week 4
Nov Week 1
Nov Week 3
Dec Week 1
Dec Week 3
Dec Week 5
Jan Week 2
Jan Week 4
Feb Week 2
Feb Week 4
March Week 2
March Week 4
April Week 1
April Week 3
May Week 1
May Week 3
Senior Meals
Juvenile Justice Center
BHD

8

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: May 24, 2010

TO: Supervisor Peggy West, Chairperson, Committee on Health and Human Services
Supervisor Elizabeth Coggs, Chairperson, Committee on Finance and Audit

FROM: Lisa Marks, Interim Director, Department of Health and Human Services
Prepared by: John Chianelli, Administrator, Behavioral Health Division

SUBJECT: INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR OF HEALTH AND HUMAN SERVICES REGARDING THE STATUS OF THE 2010 HOUSEKEEPING OUTSOURCING INITIATIVE AT THE BEHAVIORAL HEALTH AND DELINQUENCY AND COURT SERVICES DIVISIONS

BACKGROUND

The 2010 County Budget included an initiative to contract for housekeeping services at the Behavioral Health Division (BHD) and the Department of Health and Human Services (DHHS) – Delinquency and Court Services Division (DCSD). Through the procurement process, Clean Power LLC was selected as the winning vendor and began providing housekeeping services at BHD on January 10, 2010 and at DCSD on February 1, 2010. At the May 2010 Health and Human Needs Committee meeting, it was requested that DHHS provide a monthly status report regarding the housekeeping outsourcing initiative. The report includes former BHD employee status; wage and benefit information from Clean Power; and the savings anticipated for the 2010 BHD budget.

DISCUSSION

DHHS, BHD, DTPW-Facilities Management and the Procurement division developed a Request for Proposals (RFP) for housekeeping services countywide. Clean Power LLC was the winning Procurement vendor for the two DHHS sites. Clean Power is a Milwaukee based company that has been in business since 1969. They clean over 38 million square feet everyday and have significant government and medical housekeeping experience.

BHD and DCSD staff are satisfied with all services provided by the vendor. BHD and DCSD continue to work closely with Clean Power to maintain high quality standards. The BHD housekeeping supervisory staff continue to conduct daily inspections of the BHD building and also provide weekly inspections at the DCSD facility.

In December 2009, all BHD housekeeping employees were offered applications for employment with Clean Power. Interviews were conducted on-site at BHD for all BHD employees that applied and offers were made. Below is an overview of the status as of May, 2010 of the 45 former BHD housekeeping employees:

- Of the 45 employees:
  - 2 were out on FMLA

- 12 chose to retire
- 13 were hired by Clean Power, of which 5 are also included as retirees and one has resigned
- 3 have other jobs within the County
- 19 did NOT apply to Clean Power:
  - 3 indicated they will pursue further schooling
  - 5 have jobs outside the County
  - 2 cited health concerns

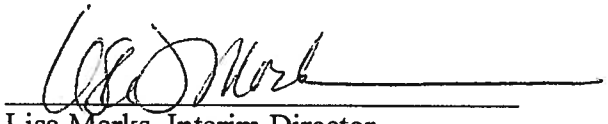
Clean Power has 56 employees working at BHD, of which 28 are full-time. The company offers benefits to all full-time (40 hours/week) employees. Life Insurance is included at no charge to the employee, health benefits for single coverage range from $45.71 to $59.37 per pay check (26 times per year) and $193.99 to $403.18 per pay check for family coverage depending on the deductible and number of people being covered, and dental insurance is offered for $13.60 to $43.41 per pay check depending on the size of family. The average pay rates range from $10.87 per hour for part-time to $11.34 per hour for full-time.

The final negotiated price for 2010 is $110,833 monthly ($1.33 million annually). Year-to-date, BHD has paid just over $59,000 in unemployment compensation, which is included in the total savings projection. The anticipated savings of $1.4 million for BHD included in the 2010 budget were due to a reduction of $2.7 million in personnel costs off-set by an increase in contractual services of $1.3 million. Based on current projections, BHD anticipates achieving the annual budgeted savings.

Recommendation

This is an informational report. No action is necessary.

Respectfully Submitted:



Lisa Marks, Interim Director
Department of Health and Human Services

cc: County Executive Scott Walker
Cynthia Archer, Director, DAS
Joseph Carey, Fiscal & Management Analyst, DAS
Dee Hervey, Committee Clerk, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff
Steve Cady, Analyst, County Board Staff
Jennifer Collins, Analyst, County Board Staff

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: May 24, 2010

TO: Supervisor Peggy West, Chairperson, Committee on Health and Human Needs

FROM: Lisa Marks, Interim Director, Department of Health and Human Services
Prepared by: John Chianelli, Administrator, Behavioral Health Division

SUBJECT: INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR OF HEALTH AND HUMAN SERVICES REGARDING MENTAL HEALTH PARITY AND THE BEHAVIORAL HEALTH DIVISION

Background

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law on October 2, 2008 as part of the Emergency Economic Stabilization Act (Public Law 110-343). MHPAEA applies to all plans covered by the Employee Retirement Income Security Act (ERISA), including multi-employer plans and public sector plans. It applies to both insured and self-insured plans. Self-insured public sector plans that have been able to opt out under the existing mental health parity law will still be able to opt out of MHPAEA. Small employers with 50 or fewer employees are exempt from the law. This report gives an overview of the MHPAEA and the potential effect for the Behavioral Health Division (BHD).

Discussion

On February 2, 2010 the Centers for Medicare and Medicaid Services published interim final regulations implementing MHPAE (75 Fed. Reg. 5410). The regulations became effective on April 5, 2010 and apply to plan years on or after July 1, 2010.

KEY PROVISIONS:

- Requires parity for substance use disorder benefits, not just mental health benefits.
- Applies parity to not only annual and lifetime dollar limits, but financial requirements such as deductibles, co-payments, coinsurance, and out-of-pocket expenses, as well as treatment limitations, which include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.
- If a plan covers medical/surgical benefits provided by out-of-network providers, it must provide out-of-network mental health or substance use disorder benefits.
- Plans cannot impose more restrictive non-quantitative treatment limitations than those governing medical and surgical benefits with respect to the use of medical management standards to limit or exclude benefits based on medical necessity, exclusions based upon the failure to complete a course of treatment, and pre-authorization.

- The rule identifies six categories of classification of benefits: inpatient in-network and out-of-network, outpatient in-network and out-of-network, emergency care, and prescription drugs.

The MHPAEA does not require that group health plans provide mental health or substance use disorder benefits. However, the MHPAEA states that, if a group health provides such benefits, the financial requirements and treatment limitations for these benefits may not be more restrictive than the most frequent financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered under the plan. Failure to comply with MHPAEA results in the imposition of excise taxes, generally in the amount of $100 per affected beneficiary for each day of non-compliance. Organizations such as the U.S. Chamber of Commerce, National Retail Federation and American Benefits Council are requesting that the compliance deadline be postponed to January 1, 2012 stating that many of the February 2010 rules are unanticipated and difficult to comply with.

EFFECT ON THE MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION:
MHPAEA should have a positive effect on revenues for the Milwaukee County Behavioral Health Division. It is not uncommon for BHD clients to exhaust the benefit days in their coverage. To the extent that compliance with the MHPAEA results in increased benefit days, added coverage will be available to cover the cost of BHD services. It is difficult, however, to determine the magnitude of the impact. BHD serves hundreds of insurance plans with very different levels of coverage, both for mental health benefits and for medical and surgical benefits.

In addition, insurance coverage is often denied for BHD clients due to judgments regarding medical necessity and prior authorization. To the degree that BHD clients have insurance in which these standards are currently different for medical and surgical plans, a positive revenue effect may occur.

FUTURE IMPACT:
The rule published on February 2, 2010 does not address every area of the MHPAEA and the accompanying guidance makes clear that additional rules will be issued on specific topics. For example, Medicaid managed care plans offering substance use disorder or mental health benefits must comply with the MHPAEA. The February 2 rule does not apply to those plans and additional guidance will be given at a later date by the Centers for Medicare and Medicaid Services (CMS).

In a white paper regarding implementation of MHPAEA, Advocates for Human Potential (AHP) Consulting Group recommends that behavioral health providers should anticipate that the new law will create a great deal of complexity and providers should plan to make investments in revenue management and information systems that will allow them to navigate that complexity successfully[1].

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[1] Special Report: MHPAEA Regulations, AHP Consulting Group White Paper #4, January 2010

WISCONSIN PARITY ACT:
On April 29, 2010 the Wisconsin Parity Act (2009 Wisconsin Act 218) was signed into law. The Wisconsin law expands mental health and substance abuse coverage to 700,000 Wisconsin employees whose companies are exempt from the federal law. In Wisconsin only companies with fewer than 10 employees are allowed to opt out of the coverage. Wisconsin law also **requires** that group health plans provide mental health and substance abuse treatment coverage.

Recommendation

This is an informational report. No action is necessary.

Respectfully Submitted:

_____
Lisa Marks, Interim Director
Department of Health and Human Services

cc: County Executive Scott Walker
Cynthia Archer, Director, DAS
Joseph Carey, Fiscal & Management Analyst, DAS
Jodi Mapp, Committee Clerk, County Board Staff
Jennifer Collins, Analyst, County Board Staff

COUNTY OF MILWAUKEE
Inter-Office Communication

11

Date: June 7, 2010

To: Supervisor Peggy West, Chairperson – Health & Human Needs Committee

From: Lisa Marks, Interim Director – Department of Health & Human Services
Prepared by: John Chianelli, Administrator – Behavioral Health Division

Subject: **INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES REGARDING A PRELIMINARY REPORT AND LITERATURE REVIEW REGARDING MIXED-GENDDER PATIENT CARE UNITS AT THE BEHAVIORAL HEALTH DIVISION**

Issue
On April 14, 2010, the Milwaukee County Committee on Health and Human Needs requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. The BHD Administrator assigned responsibility to the Medical Staff for evaluating the literature and making recommendations.

Discussion
The preliminary report from the BHD medical staff recognizes several main constructs important to the discussion of mixed-gender units. Attached is the *Milwaukee County BHD preliminary report to the BHD Administrator: Mixed-Gender Units*, submitted by the Gender Unit Work Group.

Recommendation
This is an informational report. No action is necessary.

Respectfully submitted:

_____
Lisa Marks, Interim Director
Department of Health & Human Services

Attachment

cc: County Executive Scott Walker
Lee Holloway, County Board Chairman
Cindy Archer, Director – DAS
Joseph Carey, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

PRELIMINARY REPORT TO BHD ADMINISTRATOR:

MIXED - GENDER UNITS

Submitted by the

GENDER UNIT WORK GROUP

May 22, 2010

EXECUTIVE SUMMARY

Background: On April 14, 2010, the Milwaukee County Committee on Health and Human Needs requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. The BHD Administrator assigned responsibility to the Medical Staff for evaluating the literature and making recommendations. A 12-member Gender Unit Work Group was formed comprised of senior Medical Staff and organizational leaders charged with providing an independent report to the Administrator. The following report explores the history of mixed-gender units, their prevalence, patient perceptions and staff attitudes. It recognizes the impact of past trauma on current vulnerability to abuse, which must be considered in efforts to improve overall safety, including sexual safety, on acute inpatient units.

Method: The Work Group undertook a comprehensive international literature review on mixed and single-gender units. Information was obtained on the use of such units by Wisconsin public psychiatric hospitals. BHD incident and inpatient consumer satisfaction data were reviewed. The Work Group met multiple times over the course of 3 weeks to analyze the findings and discuss their implication.

Results: Despite the growing recognition over the past decade that many female inpatients have histories of interpersonal violence, our literature search produced no studies on the gender composition of inpatient psychiatric units in the United States (U.S.). Even more surprising is the absence of any published articles in the U.S. even discussing the issue of mixed-gender units. Mixed-gender units appear to be the norm for the public hospital system in Wisconsin, with some provision for segregation of males and females via separate wings, corridors or room placement, similar to the practice at BHD. There is little research on the frequency of sexual activity, harassment and assault of women in psychiatric wards, particularly in the U.S. Available estimates indicate that sexual behavior on inpatient units is less common than in the outpatient community, ranging from 1.5 - 5% of inpatients on adult units over 1-2 years. Though the total of alleged, suspected and known sexual contacts between acute inpatients at BHD on a yearly basis is much lower by comparison (0.3%), BHD has a policy that sexual contact between inpatients is therapeutically contraindicated, prohibited and always a serious concern. Most of the studies on gender composition of inpatient psychiatric units and women's perceptions of safety have been conducted in the United Kingdom (U.K.). Though interesting, the studies have limited generalizability to other settings because of their small size, use of focus groups and subjective data, and cultural differences. There are few evidence-based studies

comparing single-sex and mixed-sex units and still fewer describing transitions between the two. With these limitations in mind, the U.K. literature shows a tendency for women to be more likely to prefer single-sex wards, though not necessarily if a same-sex day room and separate sleeping arrangements are available. Important factors identified in their patients' satisfaction are safety and privacy, staff attitudes and ward design. After 10 years of study, the emerging theme is that the quality of the inpatient unit environment and the vigilance of staff are more important than physical boundaries. Our report summarizes guidelines for developing such a therapeutic unit environment so that the privacy, dignity and sexual safety of patients are ensured.

Conclusions: The mixed-gender Acute Adult Inpatient units utilized by BHD are the norm among public psychiatric hospitals in Wisconsin and have been the standard model for inpatient psychiatric treatment for many decades. An extensive literature search failed to identify any published articles in the U.S. on the issue of mixed and single-gender units. Similarly, there is little research in the U.S. as to whether female inpatients consider gender segregation to be either desirable or likely to contribute to their sense of safety. In the U.K. where the topic of single-sex accommodation has received much attention, there is little empirical research comparing single-sex and mixed-sex units. Available studies are small in size, the settings variable and generalizability limited across other systems and cultures. The views of their female patients and staff are more complex and reflect concern about overall safety that may not be wholly resolved by the introduction of single-sex units. An informed, aware and safe unit milieu depends on many factors beyond patient gender mix. Whether the genders are physically segregated or integrated, safety - including sexual safety - still comes down to staff sensitivity and training, monitoring and environmental design solutions.

Recommendations: Protecting patient safety is crucial. There are different ways that psychiatric hospitals here and across the country accomplish this outcome. Before BHD decides to embark on a path to segregate some or all of our adult inpatient units, we must be fully aware of and prepared to deal with all of the multifaceted implications. Any revision to the existing practice of mixed-gender units must look carefully at assumptions regarding safety, choice, patient satisfaction and therapeutic benefit. For these reasons, the Gender Unit Work Group recommends more detailed evaluation of the various gender unit design options. Methods to be considered include the following: surveys of acute adult inpatients (particularly women) on preferences for unit gender composition and other means to increase safety; surveys of multidisciplinary staff on attitudes toward unit options and other possible changes to increase safety; listening sessions with consumer advocates, families and trauma-informed care experts on improving quality and safety on inpatient units; sexual safety audit of inpatient unit physical environment to assess feasibility of design options to enhance sexual safety on mixed-gender units; and identification of and communication with public psychiatric facilities in the U.S. with single-gender units regarding their experience. In the interim, it is recommended that BHD continue established and recently introduced practices to minimize risk and ensure a safe inpatient unit environment. These continuous improvements reflect many of the strategies recommended in published guidelines to promote a safe, therapeutic unit environment. They include: enhanced risk assessment; recovery planning, behavior monitoring and team communication focused on special risk behaviors; patient education and staff training regarding our no sexual contact policy; increased environmental surveillance; prompt grievance resolution; increased therapeutic programming; daily organization-wide safety report to communicate and remediate risks and incidents; and integration of trauma-informed care principles into all aspects of treatment through training, self-assessment and staff education.

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

PRELIMINARY REPORT TO BHD ADMINISTRATOR:

MIXED - GENDER UNITS

May 22, 2010

GENDER UNIT WORK GROUP

Mary Kay Luzi, Ph.D. (Chair) Associate Director of Clinical Operations, Medical Staff Critical Incident Committee-Chair, Medical Staff Peer Review Committee-Co-Chair

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Laura Riggle, Ph.D. Chief Psychologist, Ethics Committee-Chair, Director of Day Treatment Program, Medical Staff Executive Committee-Member

Cheryl Schloegl, R.N. Associate Administrator of Nursing, Medical Staff Critical Incident Committee-Member

INTRODUCTION

On April 14, 2010, Milwaukee County Supervisors called for a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. BHD Administrator, Mr. John Chianelli, assigned Medical Staff the responsibility for conducting the study, consistent with Joint Commission expectation that the medical staff have a leadership role in organizational performance improvement to enhance quality of care, treatment and service, and patient safety. A Gender Unit Work Group was formed, of diverse gender composition, consisting of Medical Staff and other organizational leaders with extensive clinical knowledge, direct experience in acute inpatient psychiatry, commitment to quality and patient safety, and capacity for open, critical inquiry.

METHODS

The Work Group undertook a comprehensive literature review, on mixed and single-gender units, from peer reviewed journals as well as other publications and reports, cross referencing from collected articles. The literature search was conducted with the assistance of expert reference librarians at the Medical College of Wisconsin Libraries using OVIDSP advanced search of multiple professional data bases. Articles were limited to those published after 1990. Information on current use of mixed and same-gender units was obtained from Wisconsin public psychiatric hospitals throughout the state. The Work Group reviewed internal BHD incident data, Acute Adult Inpatient admission data and consumer satisfaction data from the 2009 Acute Adult Inpatient MHSIP Survey. The Work Group met for a total of 14 hours over the course of 3 weeks, in addition to time outside of meetings to review collected articles. A note about language: the terms single/same and sex/gender are used interchangeably in describing the type of unit or ward. A number of terms are often used to refer to consumers of mental health resources. This report uses the term patient to refer to a person receiving treatment in an acute adult inpatient unit, consistent with language used for persons admitted to a general hospital and understandable to the public.

RESULTS

History of Mixed-Gender Units

Until the 1960's, women and men were segregated within psychiatric hospitals. During the enlightened age of social psychiatry that followed, the social determinants of mental health came to the forefront, prompting re-examination of gender-based segregation of inpatients. If men and women were going to rejoin the "outside world" in a socially acceptable manner, the institutional environment needed to become more "normalized" and replicate community living as closely as possible. This ushered in the movement to establish mixed-gender inpatient units.

During the age of deinstitutionalization in the 1970's, the average lengths of stay began to precipitously fall and community services were deemed more humane, naturalistic and therapeutic. Large state regional hospitals began to close and inpatient treatment was provided more within large urban hospitals. The average length of stay was 4 to 6 weeks and therapy groups focused on interpersonal skill development and social learning, with the inherent belief that developing these communication skills was enhanced by a more naturalistic framework of mixed male/female groups. By the time there was a wholesale move to community care, mixed-sex wards were taken for granted and were likely to have been necessary on the basis of economy of scale. Large state hospitals were

replaced with new psychiatric units within general hospitals, county institutions or free-standing hospitals, and inpatient stays diminished.

The average length of stay continued to fall related to hospital closures, emergence of crisis beds, partial hospitalization/day programs and managed care. With the growth of community-based services, psychiatric hospitals have increasingly provided brief admissions for very acute episodes of illness. Currently, the average length of stay in many general psychiatry inpatient units is 5 to 7 days. The average length of stay on BHD Acute Adult Inpatient units is 13.9 days (14.7 for females, 13.4 for males), with median length of stay being 7 days. More and more inpatient stays are focused on assessing acute symptoms, modifying medication regimens, stabilization and targeting the immediate crisis. The vast majority of psychotherapy and psychosocial skills training now takes place in the community.

Women and Trauma: Implications

Over the past decade, recognition has grown that many female inpatients have histories of interpersonal violence. It is well recognized that trauma can result in pervasive, long-term impacts on mental health and relational problems, emotional regulation difficulty and mistrust of others. In addition, the vulnerability of women with severe mental illness to further sexual and physical abuse has been documented. Indeed, the prevalence rate for sexual and physical abuse among women with serious mental illness is roughly twice that of the general population. Numerous studies have found that up to two-thirds of women with mental illness have suffered some form of childhood abuse, whether physical, sexual or emotional. Rates of re-victimization are high.

These higher rates of past sexual abuse and assault described in female psychiatric inpatients may make them particularly vulnerable to abuse and exploitation in any setting. Shorter average lengths of stay and increased recognition of relational problems that can arise from histories of trauma have led some to argue for gender-segregated inpatient units. The presumption has been that women will not be triggered as much, especially by men who may have aggressive outbursts or inappropriate social behaviors, thereby providing a safer and more therapeutic environment. As will be seen throughout this report, there is a surprising absence of discussion about this issue in the professional literature in the United States. There is a dearth of research evaluating mixed-gender and single-gender units, most of it being small group studies primarily from the United Kingdom (UK), Australia and Canada.

Sexual Behavior on Acute Adult Inpatient Units

When a person is admitted to an acute psychiatric inpatient unit, the primary purpose is treatment. Any sexual activity in this setting can be damaging for all concerned, irrespective of whether it is perceived to be consensual. Usual concepts of consent cannot be assumed when one or more parties are acutely unwell. Sexual activity is not appropriate to the treatment environment and the BHD policy reflects this. Any known violations of this policy may lead to criminal prosecution [as defined under Wisconsin Statute 940.225]. Psychiatric hospitals have an obligation to provide a safe, therapeutic and healing environment for all patients. A consistent approach is required to prevent sexual activity, manage sexual risk, and respond to allegations of sexual harassment, contact or assault on acute adult inpatient wards.

There is little research regarding the frequency of sexual activity, harassment and assault of women on psychiatric wards, particularly in the United States. Studies from the UK (acute/long-term settings, small samples) have shown that 33-55 % of female inpatients experienced unwanted sexual contacts,

pestering or molestation. Consenting sexual activity on inpatient units and what constitutes consent is a controversial issue. Other studies have found high rates of sexual activity among inpatients on psychiatric wards. Warner et al. (2004) surveyed 100 inpatients at three psychiatric units in London (average time since admission was 31 days) and 30% reported having engaged in some form of sexual activity. Closer to home, a survey of private acute-care mental health facilities in Ohio (Buckley & Wiechers, 1999) found that 3.6% of them cited sexual behavior as an ongoing problem, which was in contrast to a previous study (Buckley & Hyde, 1997) where 88% of 57 state hospital administrators surveyed considered sexual activity to be a clinical problem, probably because of the more long-term nature of these state facilities.

According to Ford et al. (2004), sexual behavior on inpatient units is less common than in the outpatient community, ranging from 1.5 to 5% of patients on adult units over one to two years. Though the total of alleged, suspected, and known sexual contacts between patients on BHD Acute Adult Inpatient units on a yearly basis is much lower by comparison (0.3%), we have serious concern whenever sexual contact is suspected. Among psychiatric units in the U.S., there is no agreed upon standard on the management of sexual behavior between patients and not all acute mental health facilities have written policies. Though an ambiguous and difficult issue, there is increasing awareness of the medicolegal risks of sexual activity on an acute psychiatric unit further complicated by varying definitions and degrees of decisional capacity. Since 1999, BHD has had a written policy regarding sexual contact between patients, in which sexual contact is considered inappropriate and therapeutically contraindicated during hospitalization [additional guidelines issued 09/24/09 clearly state that sexual contact is *prohibited*].

Women's Perceptions of Safety

References in the literature on the subject of women's perceptions of safety on inpatient psychiatric units are varying. Again, the studies largely have been done in the UK, Australia and Canada and often consist of small studies, focus groups and other subjective and anecdotal data. Due to these factors, the authors caution about generalizing the findings to other settings, not to mention other countries. With this caveat, the studies reveal concerns ranging from distress at disturbed men screaming to men not being adequately dressed at breakfast to discomfort when night-time checks are carried out by male staff. Some surveys in Australia found 58% of women feeling unsafe in mixed wards and 61% identifying having witnessed verbal and physical aggression, harassment, intimidation or abuse. Of 34 acute female inpatients at an inner London hospital, 52% wanted female-only wards, the commonest reason being that they would feel safer, have more privacy and not be subject to harassment from male patients (Barlow & Wolfson, 1997). However, 58% did not want female-only staff and said they would feel safer with male nurses on duty. Among other patient recommendations for improving safety and security were staff attitude, trained staff and architectural/design features. Curiously, there does not appear to be comparable studies about men's perceptions of safety.

There can also be a disparity between client and staff perceptions of what constitutes safety and dignity in the inpatient environment. In one small-sample study of patients in the UK with a length of stay of 29 weeks (Thomas et al., 1995), a high proportion of males and females reported harassment and victimization experiences (sexual, aggressive, threats) in contrast with relatively few reported serious incidents. Women experienced a significantly higher incidence of minor and serious sexual victimization. The authors suggest that the patients' victimization experiences, specifically the more subtle forms of intimidation and harassment, may go unrecognized. This finding would be in keeping with the under-reporting of sexual assault in the community and may reflect women's sense of powerlessness within, as well as outside, the hospital. Of interest, the majority of staff and patients

interviewed perceived their environment as safe despite most of them being aware of witnessing or experiencing harassment of some form. One explanation of this mismatch between perception and reality, the authors posit, is an increasing tolerance to regular episodes of violence superimposed on a background of tension, arguments and conflicts that all become desensitized to and which becomes the norm over time.

What is known about patients' perceptions of safety on Acute Adult Inpatient units at BHD? The closest data available, though not all specific to safety, come from the results of the 2009 MHSIP Survey. The National Association of State Mental Health Program Directors Research Institute (NRI) operates a Behavioral Health Performance Improvement System for state psychiatric facilities and created the MHSIP Inpatient Consumer Survey in 2001 to measure consumers' perceptions of services received during their inpatient episode of care. The NRI/MHSIP Inpatient Consumer Survey contains a total of 28 items which are designed to measure five major domains: *Outcome, Dignity, Rights, Participation* and *Environment*. Respondents indicate their level of agreement/disagreement with statements about the inpatient mental health services they received utilizing a 5-point scale: strongly agree, agree, neutral, disagree and strongly disagree. In 2003, BHD began administering the MHSIP to inpatients on Acute Adult Inpatient prior to discharge. The table below presents 2009 BHD aggregate positive (agree/strongly agree) response scores from 1,023 acute inpatients, along with the NRI aggregate scores. NRI aggregate scores represent data provided by approximately 85 state inpatient psychiatric facilities. While there will always be room for improvement, BHD scores exceed those of the national comparison group, with the exception of the *Rights* domain, which may be partly attributable to our high number of inpatients under involuntary treatment. With respect to *Environment*, 2 of the 4 questions under this domain ask about perception of privacy and safety in the hospital.

Domains	2009 NRI Aggregate	2009 BHD Aggregate
Dignity	80.0	82.4
Outcome	75.0	79.2
Participation	72.0	72.7
Environment	66.0	69.3
Rights	63.0	61.0

Mixed-Gender and Single-Gender Units

Prevalence of Single-Gender Units. The body of research in the U.S. about the abuse of women with mental illness has grown considerably over the past decade. However, our extensive search of peer reviewed journals produced no studies focused on the gender composition of inpatient psychiatric units in the U.S. The majority of the research is from the UK and Australia, with Canada a distant third, and is mostly of small group size and questionable generalizability. What was even more surprising was the inability to locate any articles in the U.S. even discussing or debating the issue of mixed-gender and single-gender psychiatric units. A good example is the newly released *Textbook of Hospital Psychiatry* (Sharstein et al., 2009). The 500-page textbook with 34 chapters by numerous experts discusses the safety and milieu management of every type of inpatient unit, with trauma-informed and recovery-oriented treatment a theme throughout. Only one chapter, on forensic units, even mentions the issue of gender mix and devotes a mere 4 sentences to it.

In the UK, the situation appears to be very different. A decade of persistent lobbying by mental health women's groups led to the NHS Executive government in Britain advocating for more single-sex

accommodations and phasing out of mixed-sex wards in 95% of health trusts by 2002 (NHS Executive, 2000). This has not been fully achieved. In Canada, the response has been weaker because of lack of firm research data. In the U.S., Buckley and Hyde (1997) surveyed 86 state facilities in 9 states (both acute and long-term facilities) and, of 57 who responded, 60% had mixed-sex units, 14% had only single-sex units and 26% had both. The Veterans Health Administration – Department of Veteran Affairs (2008) determined that all inpatient facilities must provide separate and secured sleeping and bathroom accommodations for women, including, but not limited to, door locks and proximity to staff. In testimony before the U.S. Senate Committee on Veterans' Affairs (2009), preliminary findings were reported on the provision of healthcare services to women veterans. On-site visits to 9 VAMCs chosen because of the numbers of women using services there, showed that all served female vets in mixed-gender units and none of the VAMCs had dedicated inpatient psychiatric units for women.

Closer to home, mixed-gender psychiatric units appear to be the norm in Wisconsin. Information obtained from the 8 public hospital systems in Wisconsin revealed that, of all the inpatient psychiatric units in those systems, there is only 1 same-gender unit (see Appendix I). That unit is the male-only forensic Civil Secure Treatment Unit at Mendota Mental Health Institute. The other 3 units at Mendota are mixed-gender, with males and females on separate hallways that can be locked, and male and female day rooms as well as a coed day room. Winnebago Mental Health Institute has been studying gender-specific wings. By comparison, BHD mixed-gender units are consistent with the norm in Wisconsin. BHD Acute Adult Inpatient Service consists of 4 mixed-gender units, 1 with a geropsychiatry specialty. Each unit is licensed for 24 beds. There are 2 corridors, one for females (4 rooms of double occupancy) and one primarily for males (9-10 rooms of double and single occupancy (see Appendix II for diagram). Each room has a private bathroom. The unit has a community bathroom that is locked and is opened by staff upon each request for use. BHD Acute Inpatient data show that approximately 41.1% of admissions are females and 58.9% are males (see Appendix I).

In summary, the mixed-gender acute adult inpatient units utilized at BHD are the norm for Wisconsin public psychiatric hospitals. There may well be acute-care psychiatric facilities in the U.S. who are utilizing single-gender units, and it would be beneficial to further attempt to identify and learn from their experience. However, our extensive search of the literature failed to produce any published articles on the topic. This indicates that, unlike in the UK, the establishment of mixed-gender units that began in the 1960's has not come under scrutiny in the U.S. or undergone a major shift back to single-gender units.

Patient Perception and Staff Attitude. There is little information in the U.S. as to whether women inpatients consider gender segregation to be either desirable or likely to contribute to their sense of safety. Even in the UK and Australia where the issue is alive, there is relatively little evidence-based literature comparing single-sex and mixed-sex units, and still less describing transitions between the two. Many of the articles are more anecdotal and theoretical than empirical. A number of articles identify common arguments against and rebuttals to separation of genders in psychiatric wards. One concern is loss of bed flexibility, which could be addressed by having some mixed-gender units and unallocated beds closest to the nursing station. These articles state that a second concern is staff difficulty coping with anticipated increased aggression level on all-male wards. But, as the UK literature notes, staff would have to be trained and resourced and it is not appropriate to use women as a "civilizing influence" for disturbed male patients [the same articles note a lack of research that conclusively proves that this is true in psychiatric settings]. The last concern is the cost that may be involved for reconfiguration of the physical environment.

On the other side, some caution against assuming women will be safer on single-sex wards. In the wider community, most violence against women is perpetrated by men and in the general population, men are more physically aggressive than women on numerous measures of aggression. However, specifically among psychiatric inpatients, similar numbers of men and women may exhibit assaultive behavior, but higher rates of men than women perpetuate assaults that result in physical injury. The kinds of violent events that happen on acute psychiatric wards should be considered and the perceived and actual safety of women on mixed and single-sex wards evaluated. There is no evidence that resegregated units will guarantee overall safety. Another concern about the re-introduction of single-sex wards is that they implicitly support the sexist assumption that only men are abusers and that they only sexually assault women. Men with mental illness have their own histories of childhood abuse and trauma, though they report lower rates than women. Occurrences of sexual contact and assault in psychiatric settings may be reduced by segregation but they will not be eliminated, as such contact occurs between same-gender patients.

What do we know about unit gender mix and patient perception and preference? All studies are from the UK. Among some of the studies of patients on acute wards, there was a tendency for women and patients over age 40, as well as those already on one, to prefer admission to a single-sex ward. More women than men in UK studies tended to prefer single-sex accommodation, saying they would feel safer, the unit would be less violent and they would have more privacy and be less harassed by men. Other small, qualitative studies using focus groups reported that, although women experienced problems with safety, they expressed preference for mixed-sex wards over single-sex wards, provided separate sleeping arrangements are provided. Inpatient feedback survey in 1994 of over 100 patients at Bethlehem and Maudsley hospital in London (Batcup, 1997) indicated that 51% of people thought an area set aside for female patients was a good idea, with more female than male patients supporting it. Virtually all male patients favored sharing the ward with women, whereas 25% of the female patients thought it was a bad idea to share the ward with men.

With the majority of units in the UK now single-sex, Leavey et al. (2006) examined whether preference for single-sex units still existed and how the patients and staff viewed the changeover in terms of safety, dignity and privacy. Of male and female patients from both mixed and single-sex units, patients overall were evenly split in preference for same-sex, but women were more likely to prefer segregated accommodations. Results revealed that safety and privacy were important factors in determining patients' satisfaction in a hospital and safety is the main reason why female patients are more likely to prefer a single-sex setting than men. But the author suggests that diagnosis and severity of illness as well as more private space were equally important in determining a safe, therapeutic environment. While staff members felt single-sex segregation provided a safer environment because of reduced possibility of male-female conflict, they believed it did not create a safer environment for staff. The main male staff concern was increased likelihood of being accused of sexual harassment, especially without training, and female staff was more concerned about jeopardizing normalization.

Of note is the scarcity of literature discussing the benefit for men of single-sex units. Views of staff have been studied even less. Cole (2003) surveyed over 109 staff on mixed wards in the UK. There was much uncertainty about whether single-sex provision would improve patients' quality of life but some tendency to believe this would not be the case for men. There is very little literature describing *transitions* from mixed-sex to single-sex services. One small study in the UK (Thomas et al., 2009) described the experience of nursing staff on an acute psychiatric ward during the transition from mixed-sex to all-male provision, and 9 months after. The sample size was very small and did not investigate transition to all-female provision. Staff generally experienced the change negatively, in particular concerns about ward environment becoming less therapeutic and more aggressive and jobs

becoming more stressful. An audit of UK NHS acute mental health services (Ryan et al., 2004) found pronounced recruitment difficulties for nursing staff on all-male wards. It is difficult to generalize from these studies, some of which were conducted on longer-staying patients and in a different system and culture.

Promoting Sexual Safety on Acute Adult Inpatient Units

Separating the sexes does not necessarily result in prevention of unacceptable behavior and may not necessarily be preferred by most patients. Sexual abuse, as well as verbal and physical, can occur on single-sex units. It is not the physical boundaries that are important, but primarily the quality of the environment and the vigilance of all staff members. The governments in the UK and Australia have produced guidelines to assist acute adult inpatient units in promoting a therapeutic environment that ensures the sexual safety, privacy and dignity of patients. They define "sexual safety" as a state in which physical and psychological boundaries of individuals are maintained and respected.

According to the Chief Psychiatrist's Guideline (Victorian Government Department of Health, 2009), a sexually safe environment is one that:

- *Recognises the right of all patients to an environment free from inappropriate sexual activity.*
- *Balances personal autonomy and decision making with duty of care to provide a safe and therapeutic environment for all patients.*
- *Has clear policies about acceptable and unacceptable behavior.*
- *Recognises the common need of patients for privacy and personal space, and that these needs may vary in different genders.*
- *Recognises the need for routine identification of sexual risk in all patients.*
- *Recognises the particular vulnerability of some patients due to past history, illness, emotional turmoil or need.*
- *Promotes treatment and early recovery, and actively manages potential disruptions to treatment and wellbeing as a result of sexual activity.*
- *Encourages and models positive relationships and mutual respect between staff, between staff and patients, and between patients.*
- *Responds sensitively to disclosures of past or current sexual assault.*
- *Promotes personal self-care, respect, resilience and self-determination. (p. 8).*

Management Elements. Important management elements to a culture of sexual safety include the following: (1) policies and procedures that emphasize the right to psychological and physical safety; (2) promotion of a policy that sexual activity in acute adult inpatient units is inappropriate; (3) developing a culture that promotes and models mutual respect in its relationships between staff, between staff and patients and between patients; (4) establishing accessible complaint mechanisms that support patients to speak out; (5) considers the different needs of men and women in service planning and delivery; (6) receives and reviews regular reports on sexual safety incidents of inappropriate sexual activity, personal safety or privacy issues; and (7) ensures staff training addresses sexual safety and assessing and responding to persons with histories of sexual abuse.

Physical Environment. Ward design can be vital in the provision of safety and privacy for patients. The higher turnover of a younger, more disturbed population on acute wards which are often cramped with few single rooms contributes to increased sexual harassment. Forced socialization in a relatively confined space seems to exacerbate the problem whereas having adequate body buffer zones attenuates it. Physical design in itself cannot completely ensure safety and privacy. Equally important are practices that minimize risks and provide a safe environment that fosters trust and feelings of security. Steps can be taken on any unit, regardless of gender composition, to make it safer and to prevent sexual activity. Examples may include policies on bed allocation to vulnerable or potentially harmful patients, noting unit areas requiring an increased level of observation, designating separate unit areas

(bedroom, bathroom, lounge facilities) for male and female patients. Safety on wards can be greatly expanded when there is constant staff presence out in common areas of the unit.

Assessment of Sexual Risk. Early identification of those who are vulnerable to risk of sexual activity is required so that strategies can be implemented to manage risk. Assessment of a person's sexual vulnerability and sexual risk should be a component of psychiatric and risk assessment, along with other risks such as risk of harm to self and others, and general history and physical examination should also include physical sexual health.

Treatment Planning. As with any other risk, all patients identified as vulnerable to or at risk of sexual activity should have a detailed treatment plan that specifies the risk behavior or vulnerability, the approach to be adopted to protect the patient, and regular updates by the treatment team.

Orientation to the Unit. Orientation of patients to the unit should include written and verbal explanation of right to a safe and therapeutic environment, expected behavior including that sexual activity is inappropriate, how to keep safe and how to make a complaint or report any incidents of inappropriate sexual activity.

Other Strategies. Other strategies to promote sexual safety may include: display of hospital policy on sexual safety on the inpatient unit; all staff being aware that inappropriate sexual activity is prohibited and must be taken seriously; discussing behavioral expectations and sexual safety in patient unit meetings; highlighting at risk patients in hand-off communication procedures; encouraging patient involvement in unit activities and programs; and reporting every episode of sexual activity through an incident report system.

CONCLUSIONS

In summary, the mixed-gender Acute Adult Inpatient units utilized by BHD are the norm among public psychiatric hospital systems in Wisconsin and have been the standard model for inpatient psychiatric treatment for decades. There are likely to be public hospitals in the U.S. who use single-gender psychiatric inpatient units. However, our extensive literature search failed to identify any published articles. This finding indicates that, unlike in the UK and a few Commonwealth countries, the establishment of mixed-gender units that began in the 1960's has not come under scrutiny in the U.S. or undergone a major shift back to single-gender units. Similarly, there is little research in the U.S. as to whether women inpatients consider gender segregation to be either desirable or likely to contribute to their sense of safety. Even in the UK and Australia where a changeover to single-sex accommodation is underway, there are few empirical studies comparing single-sex and mixed-sex units and still less describing transitions between the two.

Separating the sexes into segregated single-sex units does not necessarily result in prevention of unacceptable behavior and sexual abuse. In addition, verbal and physical abuse can occur on single-sex units. More females than males prefer same-sex accommodation, though not always. A move toward single-sex units is not a panacea. Studies of female patients, mostly in the UK, report a perceived improvement in safety, particularly when the option of a same-sex day area is available. Sample sizes are small, settings variable and generalizability questionable across culture and country. The maintenance of an informed, aware and safe unit milieu depends not only on the patient gender mix and the facilities, but also on the staff. Staff attitudes can be mixed and reflect the same stereotypes as

the general population. There is under-appreciation and under-recognition of trauma and its long-term impact on how women experience the world, much less an inpatient psychiatric unit.

Of course, resegregation by sex is not an all-or-nothing proposition. Women might be offered choice or there might be women-only areas on mixed units. Studies from the UK where the preference of the majority of women was for female-only wards indicated a need to feel safe from sexual harassment rather than a wish for strict segregation of decades ago. The focus, some say, should not be on resegregation alone, but on the broader issue of women and mental health and initiatives that address the issue of abuse and allow women to feel safer on mixed wards. Safety on mixed units is not compromised by possible male violence alone, but also by common staff practices that may need to be adjusted to promote environments that feel safe and respectful of women. It is not about one answer. It is a process. There are reasons for and reasons against each option. Whether the genders are physically segregated or integrated, safety, including sexual safety, still comes down to staff sensitivity, monitoring and physical environment solutions.

RECOMMENDATIONS

Protecting patient safety is critical. There are different ways that psychiatric hospitals here and across the country accomplish this outcome. Before we embark on a path to resegregate some or all of our adult inpatient units, many questions need to be addressed and we need to be fully aware and prepared to deal with all of the implications. Any revision to the existing practice of mixed-gender units must look carefully at assumptions regarding safety, choice, patient satisfaction and therapeutic benefit. For these reasons, it is the recommendation of the Gender Unit Work Group that BHD do a detailed study to more thoroughly evaluate the various gender unit design options (e.g., mixed-gender with additional sexual safety enhancements, all single-gender units, or some combination). There is a troubling absence of literature in the U.S. on single-gender units and lack of information from hospitals who may have undertaken a change from mixed-gender accommodation. The issues are too multifaceted to make a hasty decision. The study may include, but not be limited to, the following methods:

- Survey of Acute Adult inpatients (particularly women) on preferences for unit gender composition and other methods to increase safety; small focus groups with patients.
- Survey of multidisciplinary staff on Acute Adult Inpatient units on attitudes toward unit options and other possible changes to increase safety; small focus groups with staff.
- Listening sessions with consumer advocates, families and trauma-informed care experts on recommendations to improve quality and safety on inpatient units.
- Physical environment sexual safety audit of Acute Adult Inpatient units to assess feasibility of design options to increase sexual safety on mixed-gender units.
- Identification of public psychiatric inpatient facilities in the U.S. who have single-gender units and communicate with them regarding their experience.

CURRENT BHD SAFETY INITIATIVES

In the interim, it is recommended that BHD continue established and recently introduced processes and practices to minimize risk and ensure a safe inpatient unit environment. Of important note,

these continuous improvement actions include many of the recommended strategies to promote sexual safety discussed earlier in the report (initiation dates are in parentheses).

- Enhanced Assessment
  - PCS Risk Summary is done at admission for special risks, including violence and inappropriate sexual behavior (03/03/10).
  - Psychiatric/Psychological Inpatient Assessment has special risks section, including vulnerability to abuse and inappropriate sexual behavior (03/03/10).
  - History and Physical Examination covers sexual health risks (03/03/10).
- Behavior Monitoring, Recovery Planning, Team Communication
  - Individualized Recovery Plans identify specialized treatment objectives and interventions for special risk behaviors (01/22/10; 03/02/10).
  - Enhanced Behavior Monitoring lists specific risk behaviors to be observed and documented (01/22/10; 03/02/10).
  - Revised Cross-Shift Procedure includes communication regarding patients at increased risk (01/25/10).
- Patient Education
  - Sexual Contact Policy is reviewed with patients at admission and unit community meetings, reinforced in posters and Acute Non-Violent Statement, and by Client Rights Specialist and Peer Support Specialists (09/29/09).
- Staff Training
  - Multidisciplinary clinical and support staff received mandatory training on the sexual contact policy, post training assessment and pocket card reference (09/24/09; 01/22/10).
- Increased Environmental Surveillance
  - Inpatient Unit Zone Surveillance Plan is under implementation to improve surveillance of the milieu, particularly bedroom corridors (see Appendix II; 03/17/10).
  - Unit community bathroom is locked and opened only on request by staff (12/15/09).
  - Patient rounds duties are enhanced to provide increased structure in monitoring of patient safety (05/17/10).
  - Electronic video monitoring policy and procedure has been developed and is awaiting final approval before implementation (TBA)
- Grievance Resolution
  - Client Rights Specialist is a position dedicated to prompt response to grievances and consultations to assure patient's right to considerate, ethical care and personal dignity (10/06/08).
- Therapeutic Programming
  - Therapy and psychoeducational groups, along with sensory integration room, were increased to improve daily structure (10/2008).
- Daily BHD Safety Report
  - Management staff and unit staff, as needed, attend weekday Safety Report by Medical Director to identify and communicate incidents and risk so as to ensure prompt remediation and safety (01/22/08).
- Trauma-Informed Care
  - BHD trauma-informed care committee was formed and is participating in state training; develop TIC self-assessment and core training for all multidisciplinary staff and integrate into aspects of treatment (05/2009).

CLOSING WORDS

Over a decade ago Dawn Batcup (1997), Research Nurse at Bethlehem and Maudsley Trust hospital in London, discussed the process of doing research on a sensitive and politically charged topic: "mixed-sex" psychiatric wards. Her eloquent conclusion is every bit as relevant for BHD and Milwaukee County today:

> "Understandably, psychiatric management wanted a simple yes or no answer as to whether 'mixed' or 'single sex' wards were better so that they may intervene accordingly. However, the solution, like the problem, will be complex. It will not be found through a comprehensive segregation of the sexes, as was first intimated, nor will it be found through the abstraction of policies or codes of ethics. The only way to deal with the problem is to keep it on the agenda and avoid making seemingly progressive but probably knee jerk reactions to it...With this in mind, it becomes evident that segregation might be too simplistic and bound to miss the point about what women with mental health problems really want from mental health services...It may continue to raise more questions, paradoxes and complications, but in doing so, it also serves as a focus point for ideas, debate and action. It can also cause a consciousness raising which will enable people to reinterpret norms and that causes change." (p. 1022).

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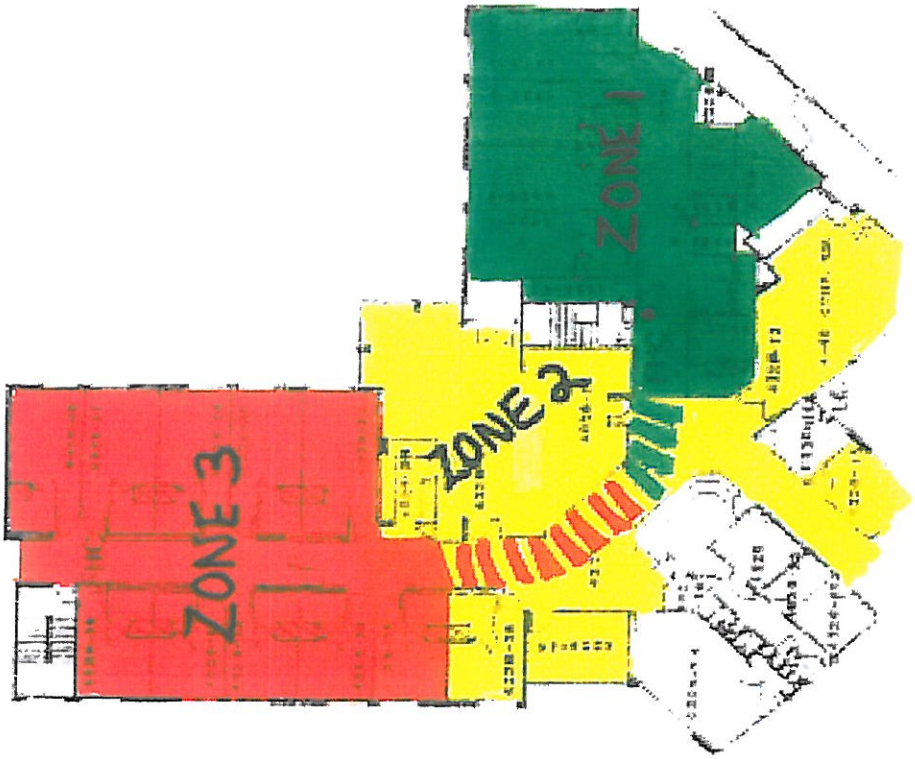
APPENDIX I
SURVEY OF WISCONSIN PUBLIC PSYCHIATRIC HOSPITALS
MIXED-GENDER and SAME-GENDER UNITS

PUBLIC HOSPITAL	MIXED-GENDER UNIT (S)	SAME-GENDER UNIT (S)	COMMENTS
Brown County Community Treatment Center (Green Bay)	X		4 wings – 2 designated for females and 2 for males; exception would be if there is a need to place opposite gender in one of 2 camera rooms or 2 bariatric rooms.
Fond du Lac County Dept of Community Programs	X		Males are on one side of the unit and females on the opposite side.
Mendota Mental Health Institute	X (AATU, GTU)	X (CSTU)	Civil Secure Treatment Unit (CSTU) is male only; Adult Assessment & Treatment Unit (AATU) is both male and female on separate hallways; hallways can be locked to keep them gender-specific; have male and female dayrooms as well as coed day room; Geriatric Treatment Unit (GTU) is co-ed and primarily serves patients with dementia.
North Central Health Care (Wausau)	X		
Aspirus Wausau Hospital	X		
Norwood Mental Health Center (Marshfield)	X		
Waukesha County Mental Health Center	X		
Winnebago Mental Health Institute	X		Have been exploring and researching gender-specific wings.

BHD ADMISSION DATA BY GENDER
(01/01/2009 – 03/31/2010)

GENDER	COUNT	PERCENTAGE
Female	1212	41.1%
Male	1738	58.9%

APPENDIX II - BHD Acute Adult Inpatient Unit Environmental Surveillance Zones (3/12/10)



ZONE	Staff Surveillance Responsibilities
ZONE #1: Interior Hallway: Unit Front Door through Laundry Room and all patient bedrooms and bathrooms on that wing (includes rounding up to mid point of outer nurses station but zone staff is not to be stationed there)	▪ Continuous surveillance of Zone 1 ▪ Monitor patients in bedrooms/bathrooms ▪ Provides frequently requested items from customer-service cart ▪ Assist Zone 1 patients with brief nursing care needs (includes urine collection) ▪ Monitor front door to unit, assisting persons (including visitors and staff) to safely enter/exit, monitor for elopement behaviors ▪ Monitor Community Bathroom, ensuring door is locked when not in use ▪ Supervise safe use of the Laundry Room if patient present and provision of linen from Linen Closet (and empties linen cart when delivered) ▪ Maintain rounds for Zone 1 patients and Behavior/SOS flow sheets for Zone 1 (except 1:1 flow sheets)
ZONE #2: Common/treatment areas: Day Room, Exam Room, Room 25, area in front of nurses station and room 26 (restraint room) and Conference Room	▪ Continuous surveillance of Zone 2 ▪ Can rove briefly into Zone 1 and Zone 3 ▪ Monitor patients in Day Room and Room 25, Room 26 (if restraint or LS intervention occurs) –also facilitates "fresh air" time for patients ▪ Assist Physical Care staff with monitoring of patients in Exam Room and assist phlebotomist with lab draws ▪ Assist with meal and snack service ▪ Provide 1:1 monitoring of LS or restraint for room 26 if needed ▪ *If Zone #2 staff needed for S&R monitoring, unit RN's coordinate with treatment team members to flex accountabilities to monitor Zone 2 during S&R* ▪ Communicate with Zone 1 & 3 staff and assist with completion of rounds and flow sheets for Zone #1 and Zone #3 patients.
ZONE #3: Exterior Hallway: From kitchen to exterior door and all patient bedrooms and bathrooms on that wing (includes rounding up to mid point of outer nurses station but zone staff is not to be stationed there)	▪ Continuous surveillance of Zone 3 ▪ Monitor patients in bedrooms/bathrooms ▪ Provides frequently requested items from customer-service cart ▪ Assist Zone 3 patients with brief nursing care needs (includes urine collection) ▪ Maintain rounds for Zone 3 pts and Behavior/SOS flow sheets for Zone 3 (except 1:1 flow sheets)

Zone Surveillance of Acute Adult Milieu on the Night Shift

Staff maintain a stationed presence roving and monitoring the hallways for Zone 1 and Zone 3. The RN will coordinate assignments with assigned Night Shift staff based on unit needs and patient acuity.