Chairperson: Kimberly Walker
Vice-Chairman: Peter Carlson
Secretary: Dr. Robert Chayer
Senior Executive Assistant: Jodi Mapp, 257-5202

SPECIAL MEETING
MILWAUKEE COUNTY MENTAL HEALTH BOARD

Wednesday, November 19, 2014 - 10:00 A.M.
Milwaukee Public Schools Central Services
Administration Building Auditorium
5225 West Vliet Street

MINUTES

PRESENT: Peter Carlson, Robert Chayer, Jon Lehrmann, Thomas Lutzow, Lyn Malofsky, Jeffrey Miller, *Mary Neubauer, Maria Perez, Duncan Shrout, Kimberly Walker, Brenda Wesley, and Nathan Zeiger
EXCUSED: Ronald Diamond

*Board Member Neubauer was not present at the time the roll was called but appeared shortly thereafter.

SCHEDULED ITEMS:

1. Approval of the minutes from the October 23, 2014, Milwaukee County Mental Health Board meeting.

   The minutes from the October 23, 2014, meeting were reviewed.

MOTION BY:	***(Shrout) Approve the minutes from the October 23, 2014, Milwaukee County Mental Health Board meeting. 10-0***
MOTION 2ND BY:	***(Miller)***
AYES:	Carlson, Chayer, Lutzow, Malofsky, Miller, Perez, Shrout, Walker, Wesley, and Zeiger - 10
NOES:	0
ABSTENTIONS:	0

A voice vote was taken on this item.

2. Priority topics for Milwaukee County Mental Health Board focus:

   APPEARANCES:
   Paul Bargren, Corporation Counsel
   Hector Colon, Director, Department of Health and Human Services

SCHEDULED ITEMS (CONTINUED):

Madame Chair explained the intent of this meeting is to address items for discussion in which Board Members expressed an interest. Board Member Zeiger indicated he submitted all agenda items reflected in an attempt to ensure the Board receives requested information regularly.

a. Outcomes, Data, and Reports

Board Member Zeiger stated he would be interested in receiving psychiatric, financial, and arrest record information. He also stated a report on Comprehensive Community Services would be helpful along with Request for Proposals process information and what happens to program savings dollars.

Board Member Lehrmann stated he would like to be provided with staffing level reports for both physicians and nurses inclusive of salary and benefits, in-patient numbers and bed capacity, the downsizing of long-term care units and reflective numbers, Joint Commission accreditation efforts, and a portfolio of out-patient programs and contracts.

Board Member Miller requested quality measurements for clients transitioned from a Community Support Program to private services, which should include readmission rates.

Vice-Chairman Carlson expressed an interest in utilization data by program with an understanding of the capacity of the program. He also indicated the Board needs a strategic plan in place by using current performance metrics.

Board Member Wesley stated she would like to see a feasibility study on a Northside Access Clinic and information regarding Crisis Intervention Team (CIT) Officers wait-time in the circular drive and the substance abuse delivery system.

Board Member Lutzow would like information on what the performance obligations are for which the Board is contractually bound and responsible.

Board Member Neubauer expressed community safety concerns due to the reduction of in-patient beds and would like more information. She also would like information regarding client/staff safety/injuries and dashboards by which quality of vendors is being measured.

Madame Chair indicated that for the December Board meeting, the Administration will provide the Mental Health Board with BHD's current strategic plan for review and to discuss metrics tracking and frequency.

b. 2015 Budget Process

Board Member Zeiger stated this item is to spark discussions around putting a process in place in preparation for BHD's 2016 Budget submission.

SCHEDULED ITEMS (CONTINUED):

Board Member Neubauer commented on the scrutiny the Mental Health Board (MHB) received regarding its handling of the budget process and the BHD employee fringe benefit contingency fund amendment approved by the County Board.

Madame Chair explained the Mental Health Board (MHB) was established in its entirety and convened during a time where the budget process for Milwaukee County had been well underway. There were time constraints relative to MHB's approval of the Budget without an ample opportunity to follow a labor intensive process. It was, however, discussed at two MHB meetings. Due to the time constraints, public comment was limited to written form. The format used for reviewing the 2015 Budget was in no way an indication of how future budgets would be handled.

Board Member Lehrmann suggested the Finance Sub-Committee be established now to further review the 2015 Budget for a better understanding in preparation for the 2016 Budget process.

Madame Chair indicated that the Finance Sub-Committee will be in place prior to the Board's December meeting.

Vice-Chairman Carlson suggested that a Quality Sub-Committee also be established to do credentialing reviews, look at patient satisfaction, quality metrics, and risk management issues.

Board Member Chayer suggested employee satisfaction be added to the list of reviewable issues for the Quality Sub-Committee.

Mr. Bargren summarized actions taken on BHD's budget outside of the MHB's approval of such.

Mr. Colon indicated that there are some optimistic surplus projections that are being looked into for next year due to some cost savings. Because of those cost savings, adjustments to offset employee fringe benefits can be made internally. This option would not need Board approval.

Madame Chair requested the Administration address employee fringe benefits and any adjustments made for the December Board meeting.

c. Mental Health Redesign Goals

Madame Chair indicated this is going to be an agenda item for the December Board meeting and could be discussed at that time.

SCHEDULED ITEMS (CONTINUED):

d. Community Initiatives

Madame Chair stated this topic was discussed in Item 2a among the list of requests from Board Members.

Mr. Zeiger suggested this item, in the future, would require some input from community partners.

e. Reports from Committees

Madame Chair stated once the sub-committees have been established, which will be prior to the December meeting, reporting frequency can be fully discussed.

Board Member Neubauer requested the resignation of the Transitional Liaison be scheduled for discussion in December.

The following people registered and spoke regarding Item 2 as a whole:
Eddie Sadowsky, Community Mental Health
David Eisner, District Council 48
Dave Somerschales, SEIU Local 1
Joseph Volk, Wisconsin Advocacy Project
Barbara Beckert, Disability Rights Wisconsin
Joel Garny
Jeff Weber, Wisconsin Federation of Nurses and Health Professionals
Jon Gudeman
Shawn Green, Faith Partnership
Rochelle Landingham, Cultural Intelligence Community West Care Wisconsin
Peter Hoeffel, National Alliance for Mental Illness of Greater Milwaukee (NAMI)
Serge Blasberg, NAMI
Dr. Andrew Calhoun, Grace Fellowship Church Pastors United

The Board took no action regarding this informational item.

3. Setting the Agenda for Regular Milwaukee County Mental Health Board Meetings:

a. Role of Board Members
b. Role of Behavioral Health Division Staff
c. Timelines

Sub-sections a, b, and c of Item 3 were addressed together. Discussions were held regarding the official charge of the Board, how often the Board as a whole should meet and where, and the possibility of allowing public comment at every meeting.

The Board took no action regarding this informational item.

SCHEDULED ITEMS (CONTINUED):

4. Adjournment.

MOTION BY: ***(Neubauer) Adjourn. 11-0***
MOTION 2ND BY: ***(Malofsky)***

There being no objections, Madame Chair ordered the meeting adjourned.

STAFF APPEARANCES:
Paul Bargren, Corporation Counsel
Hector Colon, Director, Department of Health and Human Services

This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.

Length of meeting: 10:05 a.m. to 12:20 p.m.

Adjourned,

Jodi Mapp
Senior Executive Assistant
Milwaukee County Mental Health Board

DEADLINE FOR THE MILWAUKEE COUNTY MENTAL HEALTH BOARD: **The next regular meeting for the Milwaukee County Mental Health Board is** **Thursday, December 18, 2014, @ 8:00 a.m.**
ADA accommodation requests should be filed with the Milwaukee County Office for Persons with Disabilities, 278-3932 (voice) or 711 (TRS), upon receipt of this notice.

The November 19, 2014, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled meeting of the Milwaukee County Mental Health Board.

Dr. Robert Chayer, Secretary
Milwaukee County Mental Health Board

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: December 1, 2014

TO: Kimberly Walker, Chairperson – Milwaukee County Mental Health Board

FROM: Patricia Schroeder, Administrator, Behavioral Health Division

SUBJECT: **Report from the Administrator, Behavioral Health Division, providing an Administrative Update**

Background

The purpose of this standing report is to highlight key activities or issues related to the Milwaukee County Behavioral Health Division (BHD) since the previous Board meeting and provide ongoing perspectives to the Milwaukee County Mental Health Board regarding the work of the organization and its leadership.

Discussion

1. Temporary Reduction in In-Patient Beds at BHD

   On Thursday, November 6, 2014, the Executive Team of BHD implemented the decision to temporarily reduce the numbers of in-patient beds based on shortages in Registered Nurse (RN) staffing. It is anticipated that this will remain in effect until January 2015, and we will be tracking and reevaluating capacity closely until then.

   In a message distributed to the organization, the Mental Health Board, other parts of Milwaukee County, and the private health care systems, it was cited that:

   Inpatient adult units (43A, 43B, and 43C), which typically run at 18 patients, 24 patients, and 24 patients will be capped at 16 patients each reducing the units by 18 patients total. The Child and Adolescent Treatment Services (CAIS) will be capped at 18 patients, with no voluntary admissions or Waukesha County transfers. All Crisis services will continue as is, including Psychiatric Crisis Services (PCS), Mobile Crisis Services, and the Observation beds (18).

   Data has been tracked carefully to assure that patients and needs in the community are being met. These data reflect that we are attending to time to wait of each patient. Weekly

data reports are being shared with all local health systems and Emergency Departments every Monday.

Unit staffing has been challenged for years. Data tracked over the past several years reflect that mandatory overtime has been used routinely for more than two years. This process results in requiring RNs or Certified Nursing Assistants (CNAs) to come in when called or stay for a double shift when staffing is low. If staff refuses, they have traditionally entered a disciplinary process. Mandatory overtime is a process used in many health care systems for short periods of time. It is not a sustainable model for years, which has occurred at BHD.

RN and CNA staffing has been addressed over the past months by securing a contract recruiter, who made inroads in filling vacancies. An analysis of processes in the Human Resources and Nursing departments has also been addressed. We are optimistic, in particular, with CNA staffing and believe that we are on a path in eliminating mandatory overtime for CNAs. Regarding RN recruitment, over the past three months, we hired and oriented 14 new nurses. Unfortunately during that window of time, we simultaneously had resignations from about 14 nurses leaving us without progress. We have created a new database of nurse positions to more effectively track vacancies and positions. The number one reason cited for resignation has been the fear and/or the realities of mandatory overtime. We have three open positions for nurse managers as well, with one acceptance currently. Hiring practices at the end of the year often have limited results in any health care system given the holidays. In addition, we recognize that staff has vacation hours to use prior to the end of the year.

We continue to be aggressive in our approaches to address RN hiring, orientation, and retention. Medical Unit personnel from the House of Correction and the Jail, including RNs, have been informed of positions both in person and in writing. At this time, we have multiple applicants who will be interviewed in the next week.

All managers and directors are participating in leadership development courses. There are discussions across the organization on strategies to enhance our environment and collaboration, including team building on the units. Efforts are being made to assure that nurse managers remain physically on clinical units during the days to provide leadership, coaching, and support. The nurse recruiter is continuing to provide support. We are working to clarify our "brand" for employment postings, using the messages of employees who describe why they work here. Data on applicants, interviews, offers, and acceptances is being reviewed weekly. We are very supportive of the budget request by the Human Resources Department to Milwaukee County for a functional human resources information and applicant tracking system, which we hope for implementation by March 2015. In addition, we are tracking resignations more closely, and are working to secure exit interview data. The Education Department is creating a new format for orientation of RNs who are experienced and cannot be onsite for the current six-week session. A development curriculum is being proposed to create more of a learning environment for all clinical staff.

Throughout these and other processes, employees are receiving these updates in monthly Town Hall meetings and in individual responses to questions and rounding.

2. Safety in Acute Environments

The safety of patients and staff in all clinical environments remains a very high priority. Any safety episodes are reported at a daily safety briefing of leaders from across all departments, as well as rapidly assessed and documented. Several nurses have been injured in patient related episodes over the past several months, which require immediate action. Each episode has been analyzed and actions taken.

Actions to improve the safety of the environment include reviews of patient care, the physical environment, staff education and development, leadership support, security supports, and staffing. Multifaceted actions are being implemented. Discussions with staff have occurred and will continue. We will continue to focus attentively on safety in our clinical environments.

3. Long-Term Care Transitions

The Hilltop transitions have continued attentively, with the units being scheduled for closure by December 31, 2014. Hilltop serves those with serious, chronic mental illness and intellectual disabilities. The meetings of the broad planning teams, including representatives of BHD, the state, and advocacy groups including Disability Rights Wisconsin and others, meet to discuss each individual resident and clarify their personal needs for safe, effective, and supportive care living in a least restrictive environment. In 2012, there were approximately 70 residents of Hilltop, some of whom had lived at BHD for 30 years. At the time of this writing, there are 20 residents remaining and scheduled for transition to a community living circumstance by the end of the year. Because this process is grounded in the needs of complex residents and their guardians, it is being guided very attentively. All residents have a managed care organization provider who is also a part of this process. We remain optimistic that the unit will officially close this year.

Rehab Central is a unit that serves those with serious and persistent mental illness who had needs that could not previously be met with available community services. As these residences and services get created, the former 70 residents have transitioned, and the unit now has 29 individuals living there at the time of this writing. We have reduced from three clinical units down to two. Rehab Central is scheduled to close in 2015. The same individual focused process by a broad team of stakeholders and supports meet every other week to assess and plan for Rehab Central residents.

We continue to track the successes of residents in their new living arrangements. Most are very positive, with residents living full lives in less restrictive environments.

Clinical staff members from Hilltop have been interviewed and many placed in staff positions in other services within BHD.

4. Crisis Mobile Team Expansion

The Crisis Mobile Team is expanding services to overnight hours. This service is contracted through LaCausa. Clinicians have been hired and will begin on call five days per week, with the intent to expand to seven days per week once fully staffed. Hours will be midnight to 7:00 a.m. with support and monitoring of services and clinical issues from the PCS attending staff.

5. Community Support Program (CSP) Transitions

The Downtown CSP is scheduled to close at the end of December 2014. Community Access to Recovery has completed two listening sessions and two focus groups with CSP clients that will transition from the operated CSP to our contracted agencies. A variance request was submitted to the Division of Quality Assurance (DQA)to assist in the transfer of the treatment record.

6. CCS Implementation Progress

Comprehensive Community Services (CCS) is on schedule with its implementation plan. Forty individuals are enrolled and five care coordination agencies are now certified by DQA. The next phase of implementation is with children and adolescents. Outreach and engagement efforts will continue into 2015.

7. Food for Employees on Campus

The Employee Cafeteria at BHD was shut down in approximately 2011, and food on campus has been provided through vending machines, fast food deliveries, and take-out services. A new Employee Food Service is being developed with minor physical modifications to the model apartment space in the 9201 building. It is projected to open by February 2015. A vendor, CityNet is being contracted following a Request for Proposals (RFP) several years ago, will sell prepared foods and beverages in this new space. BHD employees participated in a survey regarding their preferences for time, place, items for sale, and preferred range of costs. The service will be open from 6:30 a.m.-3:00 p.m., weekdays and will expand as needed. We anticipate this will be a positive addition to the campus and a positive support for employees.

8. Pharmacy RFP

An RFP has been launched to deliver pharmacy services for BHD. An RFP was previously launched in 2011/2012 and was officially withdrawn as needs changed for the organization, including our needs for technology and integration with the electronic health record. We anticipate reviews of proposals in January and February and granting of the contract and implementation in quarters 1 and 2 of 2015.

9. Organization Structure Planning

Planning regarding organizational structure, leadership roles, and accountabilities is ongoing and at this time is awaiting the recommendations from the State Audit. We anticipate refinement in the organizational chart and responsibilities in the next two months.

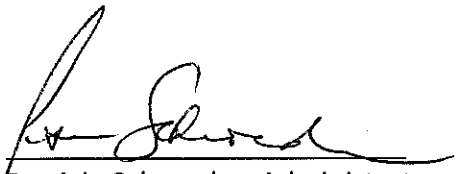
10. Strategic Plan

BHD has been awaiting the completion of several detailed studies to inform work on a BHD strategic plan. These include:

- Department of Health and Human Services Three-Year Strategic Plan – Completed in November 2014 and beginning implementation. (See attached.)
- In-Patient Bed Demand Analysis – Completed in September 2014 by the Public Policy Forum and HSRI
- Financial Re-Design Implications for BHD Continuum of Services- To be completed by December 2014 by the Public Policy Forum and HSRI
- Comprehensive Out-Patient and Community-Based Services in * - Underway and to be completed by March 2014
- State Audit – To be shared in 2014.

These documents will inform our Strategic Planning process and are necessary to thoughtfully complete a plan.

Respectfully Submitted,



Patricia Schroeder, Administrator
Milwaukee County Behavioral Health Division
Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

HÉCTOR COLÓN, MS, OT • Director
PATRICIA SCHROEDER, RN, MSN, MBA, FAAN • Division Administrator
JOHN SCHNEIDER, MD, FAPA • Executive Medical Director

MEMORANDUM
Subject: BHD Waitlist Usage Report
Date: Monday, December 1, 2014

Dates covered in report: Monday, November 24 through Sunday, November 30, 2014

Measure	Adult	Adult %	Child	Child %	MKE Area Average
Episodes of Waitlist	1	-	0	-	-
Number of Patients Waitlisted	8	-	0	-	-
Total Hours of Waitlist this Week	37.9 hours	22.6 %	0	-	-
Average length of Waitlist	10.1 hours	-	0	-	-
Maximum Time any Patient Waitlisted	35.5 hours	-	0	-	-
Number patients Diverted	0	-	0	-	-
Total Length of Diversions for this Week	0	0 %	0	0 %	5.25%

Definitions:

Waitlist: When there is a lack of available beds between the Acute Inpatient Units and the Observation Unit. Census cut off is 5 or less open beds. These actions are independent of acuity or volume issues in PCS.

Diversion: A total lack of capacity in PCS and a lack of Acute Inpatient and Observation Unit beds. It results in actual closing of the door with no admissions to PCS allowed. Moreover, it requires law enforcement notification and Chapter 51 patients re-routed.

Adult % or Child %: Numerator is Total Hours of Waitlist this Week or Total Length of Diversion for this Week, denominator is total hours for the week, namely 168 (24 hours x 7 days).

Milwaukee Area Average: Data is taken from Milwaukee County EMS Tracking system. Average for 4th Quarter 2013 is used for comparison (Average is 5.25% or 115.92 hours per 2208 hours – the Range was 0% to 17.82% or 0 to 393.4 hours). During that time period there is no similar measure to waitlist. The new tracking system started this year, will have data of this sort, when available (likely early 2015)

Steps taken during Waitlist Periods: As a reminder, we aim to have no one wait longer than 24 hours. As with every occurrence of wait list, we do the following:

The Crisis Mobile Team is prioritized to go visit all adult patients on the wait list to help the outside institution mitigate the issue. The role of and utilization of MUTT during Child and Adolescent Waitlist is under internal review.

We continue and attempt to increase the use of our Mobile Psychologist/Psychiatrist (with newly expanded hours in 4th Quarter 2014) to complete the Treatment Director Supplements (TDS) to further facilitate transfers to private hospitals.

We continue to use Mobile evaluations to facilitate transfers to Contracted Detox Facility.

Every attempt is made to call patients into BHD as soon and as often as bed availability emerges to help our community partners place the most urgent and acute patients, despite an ongoing or rolling waitlist period.

Every morning our PCS Psychiatrists call each outside facility to get updates and to communicate our status and priority list for resolving the wait list episode.

DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

HÉCTOR COLÓN, MS, OT • Director
PATRICIA SCHROEDER, RN, MSN, MBA, FAAN • Division Administrator
JOHN SCHNEIDER, MD, FAPA • Executive Medical Director

MEMORANDUM
Subject: BHD Waitlist Usage Report
Date: Monday, November 24, 2014

Dates covered in report: Monday, November 17 through Sunday, November 23, 2014

Measure	Adult	Adult %	Child	Child %	MKE Area Average
Episodes of Waitlist	1	-	0	-	-
Number of Patients Waitlisted	5	-	0	-	-
Total Hours of Waitlist this Week	19.7 hours	11.7%	0	-	-
Average length of Waitlist	1.4 hours	-	0	-	-
Maximum Time any Patient Waitlisted	4 hours	-	0	-	-
Number patients Diverted	0	-	0	-	-
Total Length of Diversions for this Week	0	0 %	0	0 %	5.25%

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MILWAUKEE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES:

WHO WE ARE & WHERE WE'RE HEADED

DRAFT MISSION:

The mission of the Milwaukee County Department of Health and Human Services is to enhance the quality of life for individuals who need support living healthy, independent, and safe lives within our community.

DRAFT VISION:

Recognized as the public model of excellence and leadership in human services driving superior outcomes for our community.

DRAFT VALUES:

- We respect the dignity and worth of all individuals.
- We act with honesty and integrity, adhering to the highest standards of moral and ethical principles through our professional and personal behavior.
- We strive for excellence, implementing best practices and measuring performance toward optimal outcomes.
- We work collaboratively, fostering partnerships with others in our service networks and with the community.
- We are good stewards of the resources entrusted to us, using them efficiently and effectively, to fulfill our mission.
- We strive to be culturally intelligent in our practices and services.

DRAFT PURPOSE / MOTTO:

Do The Right Thing.

DRAFT DHHS STRATEGIC PLAN GOALS

1. Workforce Investment and Engagement

1A: DHHS will be a desirable employer that will attract, recruit, and retain a talented, committed, and culturally diverse workforce at all levels of the organization.

1B: DHHS employees will have consistent and equitable opportunities for professional development, input, recognition, and advancement.

1C: The DHHS workforce will be responsive to meet the business needs now and in the future.

1D: DHHS will cultivate a workplace culture of accountability and performance management.

2. Community and Partner Engagement

2A: DHHS will be accessible, responsive, and transparent to its partners and the larger community.

2B: DHHS will engage with partners and the larger community to build meaningful community involvement in decision making and planning.

2C: DHHS will create welcoming and effective partnerships, including public-private or regional partnerships, which advance our mission and leverage resources to maximize access to services.

3. Optimal Operations and Administrative Efficiencies

3A: Work processes and practices within DHHS will be streamlined, standardized, relevant, risk-mitigating, and clearly documented and communicated to staff.

3B: DHHS will respond to a changing environment by adopting available technologies to achieve operational efficiencies.

3C: DHHS facilities will be fully physically accessible, welcoming, and safe for all employees and visitors.

4. Financial Health and Sustainability

4A: DHHS will exercise an efficient and responsible approach to financial management that plans for future sustainability.

4B: DHHS will maximize and retain revenues through new and existing funding sources / financing structures.

5. High Quality and Accountable Service Delivery

5A: The service delivery approach of DHHS providers and programs will reflect DHHS values and be person-centered, recovery-oriented, trauma-informed, integrated and culturally intelligent.

5B: DHHS will foster a satisfying and continuously improving client experience.

5C: DHHS will provide services that keep apace of current research-informed best practices/ evidence-based practices and will engage in evaluation of services to determine effectiveness.

5D: DHHS will manage performance of all services, whether provided directly or through partners, through ongoing, standardized, and proactive quality assurance/quality improvement (QA/QI) practices and performance improvement.

DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

HECTOR COLON, MS, OT - Director, DHHS
PATRICIA SCHROEDER, RN, MSN, MBA, FAAN - Administrator, BHD

Behavioral Health Division
QUALITY PLAN
2015-2016

Introduction: *Mission, Vision, Scope of Service*

Mission: The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious mental health and substance use disorders.

Vision: The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

Core Values:

1. Patient* Centered Care
2. Best Practice Standards and Outcomes
3. Accountability at All Levels
4. Recovery Support in the Least Restrictive Environment
5. Integrated Service Delivery

*For the purpose of this document we have chosen to use patient for readability. All the manifold meanings and intents in the terms patient, client and consumer, in their best light is intended.

Guiding Elements:

Patient Centered Care: All BHD staff and contracted staff members embrace a person centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: All treatment and services incorporate current best practice standards to achieve efficacious outcomes. Every caregiver is committed to an environment of care that ensures safety, limits risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: BHD annually conducts strategic planning, by Service areas, with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for a financially viable and future growth oriented system of care.

Strategic Initiatives – Who we are and where we are going in 2015-2016:

- The Behavioral Health Division is undergoing an organizational transition of the closure of the Skilled Nursing Facility licensed BHD Rehabilitation Centers – Hilltop by 2014 and Central by the end of year 2015.
- The size and scope of BHD services will be guided by ongoing annual analysis of factors including needs assessment, cost-efficacy, outcomes and evolving evidence based best practices.
- The focus of care and service delivery will be person centered, recovery oriented, trauma informed, culturally intelligent and community directed.
- Individuals with lived experience including Peer Specialists as well as behavioral health advocates, patients and families will be partners and active participants in ensuring quality services across the care continuum.
- Leadership will be provided by a high functioning team driven by quality, best practice, data driven approaches and a relentless passion for the clients, families and community we serve and the workforce we lead.
- Organizational culture will support a positive learning environment oriented around continuously improving the safety and therapeutic impact for clients, families and the community served.
- BHD will work in partnership with other community healthcare organizations.
- BHD will explore options to reside in a different physical space to assure a positive operational and therapeutic environment, patient and staff safety and greater efficiency.
- The organization will obtain Joint Commission Accreditation.
- The organization will continue with the implementation of an Electronic Health Record across the continuum of care.
- BHD will be a Center for Excellence for patient engagement, patient experience, patient satisfaction and quality outcomes.

The BHD Quality Plan

Scope

- Comprehensive to all BHD services and programs.
- Extends to all facets of the organization, including clinical, managerial, administrative and facility-related.
- Ensures organizational compliance with regulatory, accreditation and policy requirements.

The Quality Plan will serve as the Behavioral Health Division's call to action and evidence of commitment to continuously assess and improve the quality of the treatment and services it provides. All services and programs within the service continuum will incorporate measurement and data represented in *Balanced Scorecards for Key Performance Indicators* and include attention to:

- Improving the Patient Experience - Customer Satisfaction and Well-being.
- Patient Outcomes.

- Service Utilization Data.
- Quality Assurance and Improvement Activities.
- Required Public Data reporting and benchmark comparisons.
- Workforce Development.
- Financial Impact and Cost.

Service Quality

Service Quality is care, treatment and services that are provided in a safe, effective, patient-centered, timely, equitable, and recovery-oriented manner. BHD is committed to the ongoing improvement of the quality of care patients receive, as evidenced by the outcomes of that care.

The organization continuously strives to ensure that:

- The treatment provided incorporates evidence based, effective practices.
- The treatment and services are appropriate to each patient's needs, and available when needed.
- Risk to patients, providers and others are minimized, and errors in the delivery of services are prevented.
- Patient's individual needs and expectations are respected.
- The patient or those whom they designate have the opportunity to participate in decisions regarding their treatment.
- All care and services are provided with empathy, understanding, caring and trauma informed focus.
- Procedures, treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and with all providers of care.

Quality Improvement Principles

Quality improvement is a systematic approach to assessing care and services and improving them on a priority basis. The Behavioral Health Division's approach to quality improvement is based on the following principles:

- **Customer Satisfaction Focus**. High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations; customer satisfaction.
- **Recovery-Oriented Philosophy of Care**. Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit person-centered services.
- **Employee Empowerment**. Effective programs involve people at all levels of the organization in improving quality.
- **Leadership Involvement**. Strong leadership, direction and support of quality assurance and quality improvement activities by the Governing Board, Chief Executive Officer, Executive

Team and the Medical Staff Leadership are key. The involvement of organizational leadership assures that quality improvement initiatives are consistent with our mission and strategic plan.

- **Data Informed Practice**. Successful Quality Improvement processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.
- **Statistical Tools**. For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. BHD, like Continuous Quality Improvement organizations, will use defined analytic tools such as run charts, cause and effect diagrams, flowcharts, histograms, and control charts to turn data into information.
- **Prevention over Correction**. Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- **Continuous Improvement**. Processes must be continually assessed, reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities

Quality improvement activities emerge from a systematic and organized framework for improvement. The framework adopted by the BHD leadership will be understood, accepted and utilized throughout the organization. In addition, adoption is supported by continuous education and involvement of all staff in performance improvement.

Quality Improvement will involve two primary activities:

- Measuring and assessing the performance of care and service delivery through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the:
  - Design of new services, and/or
  - Improvement of existing services.

Section 2 Leadership and Organization

Leadership

The key to the success of the Continuous Quality Improvement process is leadership. The following describes how the leaders of the Behavioral Health Division provide support to quality improvement activities.

The ***Mental Health Board of Directors*** is ultimately accountable for quality and safety and provides governance level leadership for the Quality Plan by:

- Supporting and guiding implementation of quality improvement activities at BHD.
- Reviewing, evaluating and approving the Quality Plan annually.

The ***BHD Quality, Compliance and Patient Safety Council*** is Division-Wide and provides ongoing operational leadership and oversight of continuous quality improvement activities. The Council consists of the Chief Quality Officer, other core Executive Team Members, Organizational Leaders, and other individuals responsible for quality oversight. The Council meets at least ten (10) times per year.

BHD is extending an invitation to the following individuals to be core participants of the Council:

- Two Mental Health Board members
- Two individuals with Lived Experience and/or Advocates
- Office of Consumer Affairs representative.

The responsibilities of the Council include:

- Developing and recommending to the Board for approval the BHD Quality Plan.
- As part of the Plan, establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of care and services.
- Developing indicators of quality on a priority basis.
- Prospectively review, assess and analyze quality dashboards, data and initiatives and thereby directing change, including pursing additional opportunities in improve safety, quality and outcomes.
- Conduct annual institutional quality self-assessment and incorporate specific quality improvement initiatives to remediate gaps into the annual Quality Plan.
- Reviewing and supporting additional programmatic quality improvement initiatives.
- Reporting to the Board of Directors on quality improvement activities on a regular basis.
- Reviewing, standardizing and adopting specific approaches and methods to be utilized for Quality Improvement activities.

The responsibilities of the **Executive/Program Leadership Teams and Discipline Leads** include the following. The Executive Leadership will work in cooperation with the Medical Executive Committee to develop, guide and supervise all aspects of quality within the organization. Including developing organized teams, committees and structures to support all ongoing and developing quality activity needs and reporting requirements. Program leadership and the Clinical Discipline Lead will have responsibility for championing all aspects of quality and safety, to include participation and promotion of the BHD Culture of Quality and Safety. Each sub-group/sub-program leadership will be responsible to report their quality improvement activities and performance toward goals to their direct report and the *Quality, Compliance and Patient Safety Council.*

Leadership Communication Responsibility:

BHD Leadership will facilitate input, critical discussion and coordination of all quality activities through planned and focused communication with stakeholders. This includes planned and ad hoc coordination and communication. Types of information shared can include summary data and analysis of measurement activities, Quality Initiative outcomes and Dashboards of Key Performance Indicators. BHD Leadership and staff values the process of sharing outcome and quality results with Board of Directors, patients, families, advocacy groups, and the community to ensure they have knowledge of and input into our quality planning and improvement opportunities.

Section 3 Goals and Objectives

BHD Quality Plan Goals and Objectives 2015-2016

The ***BHD Quality, Compliance and Patient Safety Council*** will identify and define goals and specific objectives to be accomplished each year. Goals and objectives will be embedded in all aspects of operational and clinical planning in all parts of BHD. Alignment of Goals and Objectives will cascade down into each leadership committee and every staff annual performance review. Progress in meeting these goals and objectives will be periodically reviewed, reported and progress adjusted as needed.

QUALITY PLAN GOALS FOR 2015-2016:

1. Ensuring all services enable peoples' ability to have maximum quality of life and health while living in the community.
2. Improving the patient experience in all services.
3. Evolving state of the art quality structures, processes and a culture of safety in all we do.

QUALITY PLAN OBJECTIVES FOR 2015:

1. Simplify the "Front Door" access and ability to navigate health care options in Milwaukee County.
2. Focus all services on engaging patients around their self-selection of health outcomes.
3. Develop programming and coordination for increasing family/support system involvement and engagement in all services.
4. Increase staff competency around human interactions.
5. Train all staff on basic quality improvement principles.
6. Implement Key Performance Indicators for all programs and leadership committees.

Section 4 **Quality Improvement Initiative**

QUALITY IMPROVEMENT INITIATIVES FOR 2015

1. Develop a Community Key Performance Indicator Dashboard of meaningful patient outcome measures.
2. Develop a best practice update of our Suicide Assessment and Prevention interventions in support of the Zero Suicide in Health and Behavioral Health Care goal of the National Action Alliance.
3. Develop and implement integration of pharmacy, electronic health record and staff practice for an updated state of the art medication management policy and procedure.

Section 5 **Evaluation**

Review of the progress and effectiveness of the plan will be completed quarterly, with a formal outcome analysis also included at year end. Formal reporting of the outcome of the years plan will be made to the Governing Board. The year-end outcome evaluation will summarize the goals and objectives of the BHD Quality Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings.

BHD will:

- Summarize the progress towards meeting the Plan's Goals and Annual Objectives.
- For each of the goals a brief summary of progress will be included.
- For newly implemented Key Performance Indicators, a brief summary including outcomes, analysis and subsequent improvement actions taken will be included.
- For each Quality Initiative a brief description of interventions, results and outcomes will be summarized.

Section 6 **Conclusion**

The quality of care and outcomes and the safety of our patients and staff must be the highest calling of the Behavioral Health Division Team. Our pursuit of excellence must be innovative, include all parts of our organization, and be continuous. We must always work to achieve better and better outcomes.

Section 7 References

This plan was created from the following resources and tools (References):

- The Quality Management Plan: A Practical, Patient Centered Template National Association of Community Health Centers
- Developing and Implementing a QI Plan (US DHHS). Available at: http://www.hrsa.gov/quality/toolbox/508pdfs/developingqiplan.pdf
- Plan Template: https://www.omh.ny.gov/omhweb/cqi/plan_template.html

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: December 9, 2014

TO: Kimberly Walker, Chairperson – Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Susan Gadacz, Deputy Administrator, Community Access to Recovery Services

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to execute 2015 purchase of service contracts with a value in excess of $100,000 for the Behavioral Health Division (BHD) Community Access to Recovery Services (CARS) for the provision of adult and child mental health services and substance use disorder services**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least $100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board (MHB). Per the statute, the Director of the Department of Health and Human Services (DHHS) is requesting authorization for BHD/CARS to execute adult and child mental health and Alcohol and Other Drug Abuse (AODA) contracts for 2015.

Background

Approval of the recommended contract allocations will allow BHD/CARS to provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders and children with serious emotional disturbances.

Discussion

Adult Mental Health and Alcohol and Other Drug Abuse (AODA) Overview
In 2015, the significant focus will be placed on ensuring that the county is at full implementation with the Comprehensive Community Services (CCS) benefit. It is anticipated that CCS will become the largest most populous level of care within the county as it serves Medicaid beneficiaries who experience either a mental health or substance use disorder. CARS will continue its emphasis on strengthening our welcoming, co-occurring capability and moving the service model to a recovery oriented system of care. Our partnerships with the Bureau of Milwaukee Child Welfare and our court diversion programs are a high priority. Family

intactness, early intervention, and engagement will be key areas within our child welfare partnership. In addition, ensuring that Family Drug Treatment Court receives the necessary resources related to recovery, such as housing assistance and evidence based employment approaches that will be coordinated through the Division of Housing and employment agencies that are using the supported employment model. Pursuing the creation of a preferred provider network of care for Adult Drug Treatment Court and our Mental Health Court pilot will be completed with the goal of improving quality of care and performance outcomes. CARS will continue the partnership on all levels with the Division of Housing. Lastly, CARS will be pursuing a new evidence-based model of care that addresses first episode psychoses for youth that is culturally intelligent and will be developed in partnership with Wraparound Milwaukee.

Community Based Crisis Services

Community Linkages and Stabilization Program (CLASP)
CLASP provides post-hospitalization extended support and treatment designed to support an individual's recovery, increase ability to function independently in the community, and reduce incidents of emergency room contacts and re-hospitalizations through individual support from Certified Peer Specialists under the supervision of a clinical coordinator. CLASP provides a safe, welcoming, and recovery-oriented environment, and all services are delivered in a person-centered, trauma-informed, culturally competent, and recovery oriented focus of care. La Causa, Inc. receives $404,714 annually for the CLASP contract.

Access Clinic – South
The Access Clinic is a walk-in, no appointment location for individuals without insurance to be seen by a prescriber and have linkages for mental health outpatient services as necessary. The goals of the Access Clinic are to: provide timely clinical assessments and crisis interventions for individuals experiencing mental illness and co-occurring conditions, including substance use disorders; employ and adequately train qualified clinicians to ensure appropriate determinations of levels of care, i.e., therapy, medication evaluation, or both; and make referrals and schedule appointments for consumers to access appropriate health services in the community based on assessed needs and consumer choices. La Causa, Inc. receives $429,594 annually to operate this Access Clinic.

Crisis Mobile Team
The Milwaukee Police Department (MPD) will expand their successful partnership with BHD of adding a police officer to the mobile crisis teams. MPD will work directly with clinicians as first responders to emergency detention (ED) calls with the goal of reducing involuntary EDs. MPD will receive $187,500 annually. In addition, during 2014 BHD expanded mobile crisis to third shift coverage. La Causa was the successful applicant of a competitive request for proposal to provide this valuable service. La Causa will receive $200,000 annually for third shift mobile crisis.

Crisis Stabilization
The crisis stabilization homes serve adults who live with a mental illness or co-occurring disorder and are in need of further stabilization after an inpatient hospitalization. It is also warranted for individuals who are awaiting a residential placement and require the need for structure and support to ensure a smooth transition into the residential placement. Crisis stabilization may also provide temporary supported accommodation for people with mental health needs during a crisis or when they need longer term stabilization from living at home. Bell Therapy operates two crisis stabilization homes; one receives $279,135 annually the other at $298,000 annually. In addition, Transitional Living Service (TLS) also operates a crisis stabilization home at $250,000 annually.

Crisis Resource Center (CRC)
CRC serves adults who reside in Milwaukee County who live with a mental illness and are in need of crisis intervention and/or short term stabilization rather than hospitalization. CRC serves adults with mental illness and may include individuals with a co-occurring substance use disorder who are experiencing psychiatric crises. It is a safe, welcoming, and recovery-oriented environment for people in need of stabilization and peer support to prevent hospitalization. Transitional Living Service (TLS) operates two CRCs in the county; a north side location with an annual contract of $500,000 and a south side location with and annual contract of $250,000.

Community Consultation Team (CCT)
The CCT is a crisis mobile team that specializes in community-based interventions for individuals with both intellectual developmental disabilities and mental illness. The goal of the CCT is to provide individuals with intellectual developmental disabilities with services in the community as a way to support their community placements and thereby reduce the need for admissions to higher levels of care such as emergency room visits and hospitalizations. Dungarvin receives $154,544 on an annual basis for the CCT.

Mental Health Purchase of Service

Community Support Programs
Community Support Programs (CSP) serves individuals with a severe and persistent mental illness or co-occurring substance use disorder. CSP is the most comprehensive and intensive community treatment model. A CSP is a coordinated care and treatment program that provides a comprehensive range of treatment, rehabilitation and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement and person-centered treatment where participants live, work and socialize. Services are individually tailored with each participant through relationship building, individualized assessment and planning, and active involvement to achieve individual goals. In addition, all CSP agencies are piloting the Assertive Community Treatment/Integrated Dual Disorder Treatment (ACT/IDDT) model.

Agency	Annual Award
Bell Therapy North & South	$1,767,472
Milwaukee Mental Health Association	$885,847
Outreach Community Health Center	$669,582
Project Access, Inc.	$912,139
Transitional Living Service (TLS)	$1,207,580
Wisconsin Community Services	$986,758
Total	**$6,429,378**

Targeted Case Management for Mental Health& Substance Use Disorders
Targeted Case Management (TCM) is a modality of mental health & substance use disorder practice that addresses the overall maintenance of community based care. These services include, but are not limited to, addressing the individual's physical, psychological, medical, and social environment with the goal of facilitating personal health, community participation, empowerment and supporting an individual's recovery. There are three levels of TCM service delivery; Level I is outreach based case management and care coordination; Level II, is intensive clinic based case management services; and, Level III is recovery case management for clients who require less intensive services than what is provided in Level I.

In addition, CARS implemented alcohol and other drug abuse (AODA) TCM in 2014 that will be sustained and expanded in 2015.

Agency	Annual Amount
Level I	
Alternatives in Psychological Consultation	$457,610
Bell Therapy	$100,000
Horizon Healthcare, Inc.	$348,505
La Causa, Inc.	$201,194
Milwaukee Mental Health Associates	$213,723
Outreach Community Health Center	$456,703
Transitional Living Services (TLS)	$685,002
Wisconsin Community Services	$100,000
Total Level I	**$2,562,737**
Level II	
Wisconsin Community Services	$1,115,418
Total Level II	**$1,115,418**
Level III	
Milwaukee Mental Health Associates, Inc. (MMHA)	$50,000
Total Level III	**$50,000**
AODA TCM	
Alternatives in Psychological Consultation	$50,000

LaCausa, Inc.	$100,000
Total AODA TCM	**$150,000**

Outpatient Mental Health Clinics
BHD/CARS contracts with two providers: the Medical College of Wisconsin and Outreach Community Health Center to provide outpatient mental health counseling services to uninsured individuals who are seen at the Access Clinic and require immediate short term mental health counseling and prescribing services. The Medical College of Wisconsin receives $697,771 annually and Outreach Community Health Center receives $597,732.

Outpatient Prescriber Capacity Building
With the inception of the Affordable Care Act (ACA) many more individuals are able to access health care coverage. What is concerning is the low number of prescribers in the Milwaukee area that will accept Medicaid or T-19. This initiative in 2015 is to provide one-time financing strategies to two federally qualified health centers (FQHC) to expand their internal capacity to serve more individuals who have Medicaid but are finding it difficult to secure a prescriber. The Sixteenth Street Clinic will receive $100,000 and Outreach Community Health Centers will also receive $100,000 to achieve this capacity expansion.

Clubhouse Model
The Grand Avenue Club is a model of rehabilitation for individuals living with a mental illness and/or co-occurring disorders; the clubhouse operates with participants as members, who engage in partnership with staff in the running of the clubhouse. This includes involvement in the planning processes and all other operations of the club. Grand Avenue Club receives $200,000 annually.

Drop-in Center
Psychosocial drop-in centers provide a low-pressure environment for education, recreation, socialization, pre-vocational activities and occupational therapy opportunities for individuals experiencing severe and persistent mental illness and/or co-occurring disorders. They are based on a concept of membership and utilize peer support as a central tenet of the model. Our Space, Inc. provides individuals with a mechanism of social connectedness so that they may further their own recovery. Our Space, Inc. receives $250,962 annually for this activity.

Office of Consumer Affairs
Horizon Healthcare supports the operation of the Office of Consumer Affairs. This includes a dedicated Certified Peer Specialist (CPS) in a supervisory capacity, as well as the hiring and supervision of 12 CPS who are employed in the four adult acute inpatient units, day treatment program, the Downtown and Southside Community Support Programs, and/or the crisis stabilization homes of BHD. Office of Consumer Affairs also provides a mechanism for the reimbursement for consumer participation in accordance with the BHD Consumer

Reimbursement Policy. This is solely for the reimbursement of BHD sponsored activities with prior authorization. Horizon Healthcare receives $240,000 annually for these activities.

Peer Run Recovery Center
The peer run recovery center is similar to the psychosocial drop-in center by providing a low-pressure environment for education, recreation, socialization, pre-vocational activities, and occupational therapy opportunities for individuals experiencing severe and persistent mental illness and/or co-occurring disorders. A key element of the peer-run concept is the active engagement of members in the planning, direction, and evaluation of recovery center activities. Membership is voluntary, and members decide upon their own level of participation, but there will be a strong and consistent emphasis on members taking initiative and exercising leadership in the management and day-to-day operations. LaCausa Inc. receives $278,000 annually for this activity.

Consumer Satisfaction Evaluation and Advocacy
Vital Voices is the evaluation entity for the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey. This survey was developed for use in the public mental hygiene system and is now widely used by state and local governments in both substance abuse and mental health programs. The MHSIP survey assesses four areas of consumer perceptions: overall satisfaction; access to services; quality and appropriateness of services; and consumer reported outcomes. MHSIP is used to evaluate both mental health and substance abuse services in the CARS and for the Comprehensive Community Services benefit and assists in determining continuous quality improvement efforts for the upcoming year. The administration of the ROSI – Recovery Oriented System Indicator is also being rolled out in 2015. The ROSI assesses the recovery orientation of community mental health system for adults with serious and prolonged psychiatric disorders. Vital Voices receives $160,961 annually.

Benefits Advocacy
The Winged Victory Program of TLS assists individuals in accessing, applying for, and maintaining disability benefits. Winged Victory helps eligible consumers navigate the Medicaid and Social Security application process, submits medical documentation to the Disability Determination Bureau and accesses benefit programs in a timely manner. TLS receives $331,984 annually for this activity.

Information and Referral
Mental Health America of Wisconsin is the recipient of $44,000 annually for Information and referral services that are designed to assist individuals and their families in obtaining information and linking them with appropriate public and private resources.

IMPACT 211 Line
IMPACT 2-1-1 is a central access point for people in need. During times of personal crisis or community disaster, the free, confidential helpline and online resource directory make it easy for residents to get connected to information and assistance. In 2013, IMPACT had over 200,000 contacts (an increase of 11.3 percent from the previous year) from Milwaukee County families seeking information and assistance on various health and human service needs. CARS provides $100,000 to IMPACT on an annual basis for this valuable service to our community.

Substance Abuse Purchase of Service
Community Advocates
Community Advocates provides the administration and staff support for the work of the Milwaukee Coalition of Substance Abuse Prevention (MCSAP). This 40-member coalition is comprised of Milwaukee County citizens, substance abuse service professionals and individuals who are familiar with the consequences of alcohol and other drug abuse. Utilizing the Strategic Prevention Framework (SPF) as its model, Community Advocates will also subcontract via a competitive request for proposal, with agencies and coalitions to address population level prevention strategies. Community Advocates will receive funding at $500,000 annually to continue these prevention activities.

AIDS Resource Center of Wisconsin (ARCW)
ARCW provides substance abuse, fatal opiate overdose, HIV, and Hepatitis C prevention services including outreach, counseling, testing, and referral services throughout Milwaukee County. ARCW will also provide fatal opiate overdose prevention training to injection and other drug users in Milwaukee County. ARCW is recommended for prevention funding at $96,213 annually.

Meta House
Delivers the Celebrating Families!™ selective prevention initiative. Celebrating Families is an evidence-based 16 week curriculum that addresses the needs of children and parents in families that have serious problems with alcohol and other drugs. The curriculum engages every member of the family, ages three through adult, to foster the development of healthy and addiction-free individuals; a typical cycle serves 6 to 15 families. Meta House receives $50,000 annually.

Families Moving Forward
Families Moving Forward is a community of concerned service providers that are dedicated to the empowerment of families and individuals by providing collaborative strength-based services designed to improve their quality of life. Families Moving Forward will ensure that African American consumers and their families receive holistic enhanced quality care from our agencies using a collaborative network that will result in a healthier Milwaukee. M&S Clinical Services Inc., serves as the fiscal agent for Families Moving Forward and will receive $150,000 annually.

United Community Center (UCC) – Familias Sanas
United Community Center in partnership with the Sixteenth Street Community Health Center will work to strengthen their bilingual, bicultural service delivery in preparation for the Affordable Care Act. A comprehensive needs assessment was completed on the Hispanic community's readiness for the combined delivery of physical health, mental health, and substance use disorder care that addresses cultural sensitivities of Hispanic individuals. An annual allocation of $45,000 will be used to implement the findings of the needs assessment.

Mental Health America – Suicide Prevention
Suicide remains a significant public health problem in Wisconsin. The extraordinary costs of suicide are both economic and emotional. Suicidal behavior imposes a substantial financial burden on the families of decedents and results in lost productivity in the workforce. Moreover, the pain and suffering endured by friends, families, and communities affected by suicide are immeasurable. MHA receives $40,000 annually for this effort.

Horizon Healthcare, Inc. – Detoxification Services
CARS ensures medically monitored and ambulatory detoxification services for immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs. An assessment is conducted to determine whether a risk exists based on the individual's level of intoxication and whether a risk exists for severe withdrawal symptoms or seizures, based on the amount, frequency, chronicity, and recency of discontinuation of, or significant reduction in, alcohol or other drug. The amount is $2,572,145 annually to provide these services. This contract was placed on competitive bid in 2014 for a January 2015 start date with Horizon Healthcare, Inc./Matt Talbot Recovery Center as the vendor. The current detox vendor, Genesis Behavioral Services, Inc., will be paid under a fee-for-service agreement on a month-to-month basis until the appropriate certifications are obtained by Horizon from the State Division of Quality Assurance.

Central Intake Unit – WIser Choice
The Central Intake Unit (CIU) is the front door for WIser Choice, and is the first point of contact for individuals seeking treatment or recovery support services for a substance use disorder. The CIU's determine eligibility and administer a comprehensive assessment, establish a clinical level of care for placement at a treatment facility, and gather evaluative information. When individuals are found eligible, a referral is made to the treatment provider of choice selected by the service recipient. Treatment is provided by an extensive network of agencies on a fee-for-service basis. There are four agencies that provide Central Intake Unit (CIU) services for WIser Choice: M&S Clinical Services at $547,700 annually, IMPACT at $509,412 annually, Wisconsin Community Services at $258,963 and JusticePoint at $45,000 annually.

Training and Technical Assistance Coordination
St. Charles Youth and Family Services, Inc., coordinates the training and technical assistance functions for the CARS. Many of the federal and state grants received by BHD require training

and technical assistance as a condition of the receipt of funding. St. Charles Youth and Family Services, in partnership with CARS, coordinates the logistics and delivery of the training and technical assistance to community-based providers and stakeholders. A dedicated staff person to coordinate these activities is needed to fulfill the training and technical assistance. The training and services includes, but is not limited to, trauma informed care, Comprehensive, Continuous, Integrated System of Care (CCISC), basics in community treatment, fetal alcohol spectrum disorders, gender specific treatment, the neuroscience of addiction, IDDT, cultural intelligence, and other required areas. St. Charles receives $403,126 annually for these activities.

Faith Partnership Network
The Faith Partnership Network provides training and technical assistance to the non-secular providers within the WIser Choice network. There is a focus on Medicaid certification and credentialing necessary for service provision within the ACA, the use of evidence-based strategies, linkages with the Substance Abuse and Mental Health Services Administration, and the focus on service that are based in cultural intelligence. Faith Partnership Network receives $51,000 annually.

Wraparound Milwaukee Overview
Overall contract allocations for 2015 in BHD's Child and Adolescent Community Services Branch will be slightly less in 2015 versus 2014 as enrollment growth has slowed from previous years. BHD will again contract with a number of community agencies for care coordination and other services that support the operation of the nationally recognized Wraparound Milwaukee Program, REACH (Reaching, Engaging and Assisting Children), FISS (Family Intervention and Support Services), Project O-YEAH (Young Emerging Adult Heroes), and MUTT (Mobile Urgent Treatment Team). As a special, 1915a Managed Care program under Medicaid, all remaining services are purchased on a fee-for-service basis through agencies participating in the Wraparound Milwaukee Provider Network. Individual purchase of service contract allocations being recommended are enumerated in this report.

Care Coordination Services
Care Coordination is a key service in Wraparound as those workers facilitate the care planning team, help the family develop the individual treatment plans, arrange, provide, and monitor the provision of mental health and other services and provide reports and testify in Children's Court. For 2015, the Behavioral Health Division-Wraparound Milwaukee Program has decided for administrative and programmatic efficiency to reduce the number of care coordination agencies it contracts with from eight agencies to six agencies. A new Request for Proposals (RFP) was issued for 2015 indicating the possibility that BHD would contract with as few as six providers for regular care coordination.

Based on the results of the RFP process and receiving the highest average scores, those agencies selected for 2015 in order are: Alternatives in Psychological Consultation, LaCausa,

Inc., Willowglen Community Care, AJA Counseling Center, St. Charles Youth and Family Services, and SaintA. Of the two remaining agencies that had contracts in 2014, Aurora Family Service chose not to provide care coordination services in 2015 and My Home, Your Home, which finished 7th in the RFP process, was not selected to provide these services in 2015.

For the voluntary REACH program, a separate RFP was issued and the four agencies with the highest RFP scores were selected to provide these services. In order of finish, those four agencies are: LaCausa, Inc., Alternatives in Psychological Consultation, AJA Counseling Center, and SaintA. My Home, Your Home, which had a contract in 2014, finished 5th and was not selected to provide care coordination services for the REACH program in 2015. My Home, Your Home will be paid on a fee-for-service basis for any remaining families needing to be transitioned to other care coordination agencies in 2015.

Project O-YEAH provides care coordination services to youth and young adults, age 17-24, who have serious emotional and mental health needs and are usually transitioning out of foster care or other out-of-home care. The two agencies that bid on providing these services in 2015, St. Charles Youth and Family Service and LaCausa, Inc., are both being recommended to provide these services in 2015.

All agencies receiving care coordination contracts go through an extensive Annual Performance Review (APR) done at six month intervals and reviewed with the supervisors/managers of the agency.

The total number of youth/families projected to be served in 2015 is 1,700 families with an average projected daily enrollment of 1,100 families across regular, court-ordered Wraparound, REACH and Project O-YEAH.

The six agencies providing care coordination services across the three programs, including screening/assessment services are as follows:

Care Coordination Agency	Service Type	2015 Proposed Contract
Alternatives in Psychological Consultation	Regular Care Coordination	$1,168,000
	REACH	$ 642,400
		$1,810,400
Willowglen Community Care	Regular Care Coordination	$1,168,000
	Screening/Assessment	$ 150,000
		$1,318,000
AJA Counseling Center	Regular Care Coordination	$1,168,000
	REACH	$ 722,700
	Screening/Assessment	$ 75,000
		$1,965,700

LaCausa, Inc.	Regular Care Coordination	$1,752,000
	REACH	$ 963,600
	Project O-YEAH	$ 303,862
	Screening/Assessment	$ 300,000
		$3,319,462
SaintA	Regular Care Coordination	$1,051,200
	REACH	$ 803,300
	Screening/Assessment	$ 75,000
		$1,929,500
St. Charles Youth and Family Services	Regular Care Coordination	$1,168,000
	Project O-YEAH	$ 405,150
	Screening/Assessment	$ 160,000
		$1,733,150
Care Coordination Total:		**$12,076,212**

Support Services for Wraparound Milwaukee

For 2015, BHD recommends continuing an agreement with the Wisconsin Department of Health Services (DHS) to have the Wisconsin Council on Children and Families provide, or arrange for; program evaluation, staff training, management information and IT, and other technical support necessary to maintain the Medicaid Capitation contract with DHS. This will assure continued approval by the Center for Medicare/Medicaid Service (CMS) for BHD's 1915a status.

BHD also proposes to contract again with Families United of Milwaukee for advocacy and educational support for families served by Wraparound Milwaukee. Families United was selected through the RFP process and was the sole bidder on this program for 2015. This minority-owned and operated agency continues to represent and advocate for families of youth with serious mental and behavioral needs. It also provides educational advocacy to help enrolled youth obtain an Individual Education Plan (IEP), achieve appropriate school placements, and reduce unnecessary residential and day treatment services. Fiscal intermediary services support the purchase of services from relative caregivers for youth and BHD recommends that this contract with Milwaukee Center for Independence be continued in 2015.

Support Services for Wraparound	Service Type	2015 Proposed Contract
Wisconsin Council on Children and Families	Program Evaluation, Training Technical Assistance and IT	$ 649,623

	Support	
Families United of Milwaukee	Family and Educational Advocacy	$ 525,000
Milwaukee Center for Independence	Fiscal Intermediary	$ 25,000
Support Services for Wraparound Total:		**$1,199,623**

Mobile Urgent Treatment Services

For 2015, Wraparound Milwaukee will again operate 24/7 mental health crisis intervention services for all Milwaukee County families. The Mobile Urgent Treatment Team (MUTT) will serve an estimated 1,800 families in 2015. Additionally, the Bureau of Milwaukee Child Welfare will again fully fund a dedicated MUTT team for foster families (MUTT-FF). The MUTT-FF team has been effective at reducing the incidence of failed foster placements through the provision of 24/7 crisis intervention services to foster families who are experiencing a mental health or behavioral crisis with a child in their care.

To support BHD's professional team of county psychologists and psychiatric social workers assigned to the MUTT program, St. Charles Youth and Family Services will provide up to ten crisis support workers for MUTT to ensure 24 hour, seven-day-per-week coverage. St. Charles was the only agency to submit a bid to provide these services for the current RFP period.

St. Charles is providing additional child psychiatrist coverage for the medication clinics and psychiatric consultation for Wraparound Milwaukee. It was chosen through the last RFP process to provide an eight-bed crisis group home called Haven House for boys placed through the MUTT team and Wraparound Program. Alternatives in Psychological Consultation is providing a 0.5 (FTE) RN in 2015 for assessment and healthcare services.

Started under the recently completed Federal Healthy Transitions Grant, Wraparound Milwaukee is contracting with St. Charles Youth and Family Services for the operation of the youth/young adult resource center (Owen's Place) and for the provision of the resource center manager and several young adult peer specialists. Peer Specialists are now Medicaid reimbursable under our contract with the Wisconsin Department of Health and those service costs get incorporated in our capitation rate.

Agency Providing Support Services	**Service Type**	**2015 Proposed Contract**
St. Charles Youth and Family Services	Crisis Group Home (Haven House)	$ 475,000
	Mobile Crisis and other Clinical Services	$1,235,873
	Resource Center/Peer Specialists	$ 250,000

Alternatives in Psychological Consultation	0.5 Nurse for Assessment	$ 50,000
MUTT Support Services Total:		**$2,010,873**

Family Intervention and Support Services (FISS)
The BHD-Wraparound Program will continue to operate the entire Family Intervention Support and Services Program (FISS) for the Bureau of Milwaukee Child Welfare and Milwaukee County Children's Court.

The assessment services component of FISS is targeted to conduct about 800 assessments in 2015 as well as serve over 200 families in the case management component. FISS targets adolescents who are experiencing parent-child conflicts manifesting in school truancy, chronic running away from home, and other issues of uncontrollability. FISS is a voluntary, early intervention alternative for parents who can receive a range of mental health and support services as an alternative to filing a formal CHIPS petition. FISS is fully funded by the Bureau of Milwaukee Child Welfare.

St. Charles Youth and Family Services, which has been providing case management services for this program, was selected through an RFP process to operate the assessment and case management services.

Agency Providing FISS Program Services	Service Type	2015 Proposed Contract
St. Charles Youth and Family Services	FISS Assessment and Case Management	$ 416,876
FISS Support Services Total:		**$ 416,876**

Fiscal Effect

The total amount recommended in 2015 purchase of service contracts for the Community Access to Recovery Services (CARS) is $37,334,173. This amount reflects a total of $21,630,589 for the Community Services Branch and $15,703,584 for Wraparound. The total cost of these contracts are contained in BHD's 2015 Budget. A fiscal note form is attached.

Respectfully Submitted:

Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Don Tyler, Director, DAS
Josh Fudge, Fiscal & Budget Administrator, DAS
Matt Fortman, DAS Fiscal & Management Analyst
Scott Manske, Comptroller

Attachment 1

Community Access to Recovery Services
2015 Purchase of Service Allocations

Contract Agency	Program Description	2014	2015	2015/2014 Variance
Community Services Branch				
Alternatives in Psych Consultation	TCM	$ 457,610	$ 457,610	$ -
	AODA-TCM		$ 50,000	$ 50,000
	Total	$ 457,610	$ 507,610	$ 50,000
AIDS Resource Center of WI	AODA Prevention	$ 96,213	$ 96,213	$ -
	Total	$ 96,213	$ 96,213	$ -
Bell Therapy (Phoenix)	CSP North	$ 1,386,916	$ 1,675,996	$ 289,080
	CSP South	$ 91,476	$ 91,476	$ -
	Respite Stablization Existing	$ 279,135	$ 279,135	$ -
	Respite Stablization 2012	$ 298,000	$ 298,000	$ -
	TCM	$ 100,000	$ 100,000	$ -
	Total	$ 2,155,527	$ 2,444,607	$ 289,080
Community Advocates	AODA Prevention	$ 571,700	$ 500,000	$ (71,700)
	Total	$ 571,700	$ 500,000	$ (71,700)
Dungarvin	Community Consultation Services		$ 154,544	$ 154,544
	Total		$ 154,544	$ 154,544
Faith Partnerhship Network	WIser Resource Center	$ 51,000	$ 51,000	$ -
	Total	$ 51,000	$ 51,000	$ -
Genesis	Detoxification	$ 2,572,145		$ (2,572,145)
	Total	$ 2,572,145	$ -	$ (2,572,145)
Grand Avenue Club	Club House	$ 200,000	$ 200,000	$ -
	Total	$ 200,000	$ 200,000	$ -
Horizon Healthcare	TCM	$ 298,505	$ 348,505	$ 50,000
	Consumer Affairs	$ 240,000	$ 240,000	$ -
	Detoxification Services		$ 2,572,145 [1]	$ 2,572,145
	Total	$ 538,505	$ 3,160,650	$ 2,622,145
IMPACT	CIU	$ 509,412	$ 509,412	$ -
	211 Line	$ -	$ 100,000	$ 100,000
	Total	$ 509,412	$ 609,412	$ 100,000
JusticePoint	CIU/Drug Court	$ 45,000	$ 45,000	$ -
	Total	$ 45,000	$ 45,000	$ -
LaCausa	CLASP	$ 404,714	$ 404,714	$ -
	TCM	$ 201,194	$ 201,194	$ -
	AODA-TCM	$ 50,000	$ 100,000	$ 50,000
	3rd Shift Crisis Mobile		$ 200,000	$ 200,000
	PeerRun Recovery Cnt		$ 278,000	$ 278,000
	SS Access Clinic	$ 250,000	$ 429,194	$ 179,194
	Total	$ 655,908	$ 1,613,102	$ 957,194
Medical College of Wisconsin	Outpatient MH	$ 897,771	$ 697,771	$ (200,000)
	Total	$ 897,771	$ 697,771	$ (200,000)
M&S Clinical Services	CIU	$ 547,700	$ 547,700	$ -
	Families Moving Forward	$ 150,000	$ 150,000	$ -
	Total	$ 697,700	$ 697,700	$ -
Mental Health America	Info/Referral	$ 44,000	$ 44,000	$ -
	Crisis Grant	$ 228,300		$ (228,300)
	Suicide Prevention	$ 40,000	$ 40,000	$ -
	Total	$ 312,300	$ 84,000	$ (228,300)
Meta House	AODA Prevention	$ 50,000	$ 50,000	$ -
	Total	$ 50,000	$ 50,000	$ -
Milwaukee Mental Health Associates	CSP	$ 644,947	$ 885,847	$ 240,900
	TCM	$ 213,723	$ 213,723	$ -
	Recovery Case Management	$ 50,000	$ 50,000	$ -
	Total	$ 908,670	$ 1,149,570	$ 240,900
Milwaukee Police Department	Crisis Mobile	$ 187,500	$ 187,500	$ -
	Total	$ 187,500	$ 187,500	$ -

Attachment 1

Community Access to Recovery Services
2015 Purchase of Service Allocations

Contract Agency	Program Description	2014	2015	2015/2014 Variance
Outreach Community Health Center	CSP	$ 380,502	$ 669,582	$ 289,080
	TCM	$ 456,703	$ 456,703	$ -
	Outpatient MH	$ 697,732	$ 597,732	$ (100,000)
	Outpatient Capacity Bldg.		$ 100,000	$ 100,000
	Housing Case Manager	$ 39,000	$ -	$ (39,000.00)
	Total	$ 1,573,937	$ 1,824,017	$ 250,080
Our Space, Inc.	Drop-in Center	$ 250,962	$ 250,962	$ -
	Total	$ 250,962	$ 250,962	$ -
Project Access, Inc.	CSP	$ 671,239	$ 912,139	$ 240,900
	Total	$ 671,239	$ 912,139	$ 240,900
St. Charles Youth & Family	Training & Consultation	$ 403,126	$ 403,126	$ -
	Total	$ 403,126	$ 403,126	$ -
				$ -
Sixteenth Street Clinic	Outpatient Capacity Bldg		$ 100,000	$ 100,000
	Total		$ 100,000	$ 100,000
Transitional Living Services	CSP	$ 966,590	$ 1,207,580	$ 240,990
	TCM	$ 635,002	$ 685,002	$ 50,000
	Benefits Advocacy/WVP	$ 201,984	$ 331,984	$ 130,000
	CRC	$ 250,000	$ 250,000	$ -
	Northside CRC	$ 500,000	$ 500,000	$ -
	Respite Stabilization	$ 250,000	$ 250,000	$ -
	Total	$ 2,803,576	$ 3,224,566	$ 420,990
United Community Center	Familias Sanas	$ 45,000	$ 45,000	$ -
	Total	$ 45,000	$ 45,000	$ -
				$ -
Vital Voices	MHSIP - MH	$ 111,025	$ 121,025	$ 10,000
	MHSIP- AODA	$ 29,936	$ 39,936	$ 10,000
	Total	$ 140,961	$ 160,961	$ 20,000
Wisconsin Community Services	CSP	$ 745,768	$ 986,758	$ 240,990
	TCM/Level II	$ 1,165,418	$ 1,115,418	$ (50,000)
	TCM/Level I		$ 100,000	$ 100,000
	CIU/CJ Population	$ 258,963	$ 258,963	$ -
	Total	$ 2,170,149	$ 2,461,139	$ 290,990
CSB Total		**$ 18,965,911**	**$ 21,630,589**	**$ 2,664,678**

[1]The total amount budgeted for detoxification services in 2015 is $2,572,145. Until the new vendor, Horizon Healthcare, receives the requisite certification from the State, the current vendor, Genesis, will provide these services month-to-month on a fee-for-service basis. Any costs incurred by Genesis will be deducted from the amount awarded to Horizon.

Wraparound Milwaukee Contracts

Contract Agency	Program Description	2014	2015	2015/2014 Variance
AJA Counseling Center	Regular Care Coordination	$ 957,760	$ 1,168,000	$ 210,240
	REACH	$ 883,300	$ 722,700	$ (160,600)
	Screening/Assessment	$ 80,000	$ 75,000	$ (5,000)
	Total	$ 1,921,060	$ 1,965,700	$ 44,640
Alternatives in Psychological Consultation	Regular Care Coordination	$ 957,760	$ 1,168,000	$ 210,240
	REACH		$ 642,400	$ 642,400
	. 50 FTE Nurse for Assessment		$ 50,000	$ 50,000
	Total	$ 957,760	$ 1,860,400	$ 902,640
Aurora Family Services	Regular Care Coordination	$ 957,760		$ (957,760)

Attachment 1

Community Access to Recovery Services
2015 Purchase of Service Allocations

Contract Agency	Program Description	2014	2015	2015/2014 Variance
	Total	$ 957,760	$ -	$ (957,760)
Families United in Milwaukee	Family & Educational Advocacy	$ 525,000	$ 525,000	$ -
	Total	$ 525,000	$ 525,000	$ -
LaCausa, Inc.	Regular Care Coordination	$ 1,752,000	$ 1,752,000	$ -
	REACH	$ 947,540	$ 963,600	$ 16,060
	Project O-YEAH		$ 303,862	$ 303,862
	Screening/Assessment	$ 250,000	$ 300,000	$ 50,000
	Total	$ 2,949,540	$ 3,319,462	$ 369,922
Milwaukee Center for Independence	Fiscal Intermediary		$ 25,000	$ 25,000
	Total	$ -	$ 25,000	$ 25,000
My Home, Your Home	Regular Care Coordination	$ 957,760		$ (957,760)
	REACH	$ 642,400		$ (642,400)
	Screening/Assessment	$ 85,000		$ (85,000)
	Total	$ 1,685,160	$ -	$ (1,685,160)
SaintA	Regular Care Coordination	$ 1,051,200	$ 1,051,200	$ -
	REACH	$ 883,300	$ 803,300	$ (80,000)
	Screening/Assessment	$ 80,000	$ 75,000	$ (5,000)
	Total	$ 2,014,500	$ 1,929,500	$ (85,000)
St. Charles Youth and Family Services	Regular Care Coordination	$ 957,760	$ 1,168,000	$ 210,240
	Project O-YEAH		$ 405,150	$ 405,150
	Screening/Assessment	$ 204,000	$ 160,000	$ (44,000)
	HTI Transitional Specialist	$ 328,370		$ (328,370)
	Crisis Group Home	$ 456,000	$ 475,000	$ 19,000
	Mobile Crisis & Other Clinical Services	$ 1,194,293	$ 1,235,873	$ 41,580
	Resource Center/Peer Specialists	$ 198,372	$ 250,000	$ 51,628
	FISS Assessment & Case Management	$ 439,888	$ 416,876	$ (23,012)
	Total	$ 3,778,683	$ 4,110,899	$ 332,216
Willowglen Community Care	Regular Care Coordination	$ 957,760	$ 1,168,000	$ 210,240
	Screening/Assessment	$ 160,000	$ 150,000	$ (10,000)
	Total	$ 1,117,760	$ 1,318,000	$ 200,240
Wisconsin Council on Children and Families	Program Eval, Training, TA & IT	$ 643,436	$ 649,623	$ 6,187
	Total	$ 643,436	$ 649,623	$ 6,187
				$ -
Wraparound Total		**$ 16,550,659**	**$ 15,703,584**	**$ (847,075)**
Grand CARS Total		**$ 35,516,570**	**$ 37,334,173**	**$ 1,817,603**

REVISED

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 12/9/14

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services, requesting authorization to execute 2015 purchase of service contracts for the Behavioral Health Division (BHD) for the provision of adult and child mental health services and Alcohol and Other Drug Abuse (AODA) 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	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

REVISED

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 Director of the Department of Health and Human Services (DHHS) is requesting authorization to enter into 2015 purchase of service contracts in the Behavioral Health Division (BHD) for the provision of Adult and Child Mental Health services and Alcohol and Other Drug Abuse (AODA) services.

Approval of the recommended contract allocations will allow the Behavioral Health Division to continue to provide a broad range of rehabilitation and support services in the community to adults with mental illness and/or substance abuse problems and children with serious emotional disturbances for the period January 1, 2015 through December 31, 2015.

B. Total 2015 expenditures included in this request are $37,334,173.

C. There is no tax levy impact associated with approval of this request in 2015 as funds sufficient to cover associated expenditures are included as part of the Behavioral Health Division's 2015 Budget.

D. No assumptions are made.

Department/Prepared By Clare O'Brien, DHHS Fiscal & Management Analyst

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.

REVISED

Did CDPB Staff Review? ☐ Yes ☐ No ☒ Not Required

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: December 8, 2014

TO: Kimberly Walker, JD, Chairwoman, Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Jim Kubicek, Deputy Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to Enter into 2015 Professional Services Contracts for the Behavioral Health Division (BHD)**

Issue

Wisconsin Statutes 51.41(10) requires Milwaukee County Mental Health Board approval for professional services contracts with a value of $100,000 or greater. Per the statute, the Director, Department of Health and Human Services (DHHS), is requesting authorization for BHD to enter into a variety of professional services contracts for 2015.

Background

BHD uses several professional services contracts to support various essential staff activities, including pharmacy services, supportive medical services, and medical program planning. Each of these contracts supports functions that are critical to patient care and are necessary to maintain hospital, nursing home and crisis services licensure and maintain compliance with Medicare conditions of participation. A discussion of all new or renewed 2015 professional services contract recommendations follows.

Medical College of Wisconsin – Affiliated Hospitals
BHD contracts with the Medical College of Wisconsin – Affiliated Hospitals (MCWAH) for residency and fellowship stipends as part of BHD's affiliation and training site designation with the psychiatry training programs. The residents and fellows assigned to BHD serve as house staff and provide medical care within the BHD acute inpatient, crisis and community services, with oversight and direction from BHD psychiatry staff.

BHD is recommending a two-year contract for the term of July 1, 2015 through June 30, 2017 in an amount of $654,000 annually. This is the same amount as in 2014.

Medical College of Wisconsin
BHD is recommending that a total contract of $69,794 for partial support of the MCW Residency Director ($59,794) and for bioethics consultation ($10,000) be extended for the term of July 1, 2015 through June 30, 2017.

Roeschen's Omnicare Pharmacy
Currently, Roeschen's Omnicare provides all pharmacy services to the Behavioral Health Division, including outpatient clients. In 2015, the Long Term Care units will be closed. Roeschens utilizes an off-site pharmacy for long term care pharmacy services. As such, the contract for pharmacy services will be divided into two separate contracts. The contract for long term care services will continue until the closure. The contract for all other pharmacy services will contain a 90-day termination clause. BHD is currently in the RFP process for facility-based pharmacy services. As such, it is anticipated that a vendor recommendation will be made in early 2015. Due to the nature of the services and their impact on direct client services, BHD is seeking an extension of the current contract with Roeschen's Omnicare.

Therefore, BHD is recommending a one-year extension (with termination clauses as listed above) starting January 1, 2015 through December 31, 2015 in the amount of $3,891,432, which is $245,847 more than the 2014 contract of $3,645,585. The contract amount of $3,891,432 is contained in BHD's 2015 Budget.

The increased budgetary amount reflects a shift in inventory management approach for pharmaceuticals that will occur in 2015. Currently, Roeschen's Omnicare owns the inventory and bills BHD based on prescription usage. In 2015, BHD will own the inventory; this increase reflects the future need to purchase inventory proactively. It is anticipated that this method of inventory management will ultimately provide a cost savings due to purchasing incentives and rebates that BHD will be able to directly receive as a result of owning the inventory.

Of the overall $3.8 million total pharmacy cost, the portion for Rehab Central will be $50,000 and will be contracted for in a separate long term care services contract as described above. The remaining balance of $3,841,432 will be contained in a second contract.

Dr. Robert Clark
BHD wishes to extend the contract arrangement with Dr. Robert Clark to provide for essential psychiatry services to cover an existing full-time inpatient vacancy, while continuing permanent placement recruitment efforts. Given the current market, the average time to recruit a full-time psychiatrist is greater than one year. Adequate numbers of full-time psychiatrists are necessary to cover all hours needed to sufficiently and safely fulfill all inpatient psychiatric patient care needs. Dr. Clark, a fully trained and Board certified psychiatrist, has agreed to continue to provide services on a contract basis for the Acute inpatient Intensive Treatment Unit. Services include evaluation, diagnosis, treatment, medication management, and consultation services.

BHD is recommending a one-year contract for psychiatry services from Dr. Clark, from January 1, 2015 through December 31, 2015, in a not-to-exceed amount of $320,000. As BHD is able to permanently fill this inpatient psychiatry position, the use of this contract will be decreased or discontinued.

Clean Power
Cleaning services for BHD are currently being provided by Clean Power under a three-year price agreement which is set to expire on December 31, 2014. BHD has been paying just over $1.4 million annually for these services. BHD is recommending approval to execute a month-to month contract in 2015. As of the writing of this document, the final month-to-month contract amount has not been determined. This amount will be reported at the December board meeting and will be reflected in the minutes.

Over the course of a full calendar year, the amount negotiated will be consistent with the 2015 Budget. This number will take into account the reduction in three Hilltop Units and one Rehab Central Unit. BHD is recommending a month-to-month contract be approved until a decision is reached as to whether or not to release an RFP for cleaning services in 2015. As additional long term care units continue to close over the course of 2015, a reduction in cleaning costs of $3,700 per month, per unit is anticipated.

Recommendation

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to execute the professional services agreements for 2015 identified in this report and for the amounts enumerated in the table below.

Vendor Name	Description of Service	Start Date	End Date	Annual Contract Amount
Medical College of Wisconsin - Affiliated Hospitals (MCWAH)	Residency Program	7/1/2015	6/30/2017	$ 654,000
Medical College of Wisconsin	Bioethical consultation	7/1/2015	6/30/2017	$ 69,794
Roeschen's Omnicare	Pharmacy services	1/1/2015	12/31/2015	$ 3,891,432
Dr. Robert Clark	Psychiatrist Services	1/1/2015	12/31/2015	$ 320,000
Clean Power	Cleaning Services[1]	Monthly		
			Total	**$ 4,935,226**

Fiscal Effect

BHD's 2015 Budget contains sufficient appropriations to support the total amount of $4,935,226 recommended for these contracts. A fiscal note form is attached.

Héctor Colón, Director
Department of Health and Human Services

[1] BHD is recommending approval to execute a month-to month contract in 2015. As of the writing of this document, the final month-to-month contract amount has not been determined. This amount will be reported at the December board meeting and will be reflected in the minutes.

REVISED

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 12/8/14

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services, requesting authorization to enter 2015 professional services contracts for the Behavioral Health Division (BHD)

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	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

REVISED

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 Director of the Department of Health and Human Services (DHHS) is requesting authorization to execute professional services contracts with a variety of community vendors for the Behavioral Health Division (BHD) in 2015.

Approval of this request will allow BHD to continue to support functions that are critical to patient care.

B. Expenditures included in this request total $4,935,226. The contract for cleaning services is not included in this figure as BHD is still in negotiations with Clean Power. However, BHD is recommending approval to execute a month-to month contract in 2015 and will report the contract amount at the December board meeting. This amount will also be reflected in the minutes.

C. There is no tax levy impact associated with approval of this request as funds sufficient to cover associated expenditures are included as part of the Behavioral Health Division's 2015 Budget.

D. A few of the contracts reflect multi-year terms as identified in the report. Therefore, this fiscal note assumes that appropriations for these services will continue in future budgets.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CBDP Staff Review? ☐ Yes ☐ No ☒ Not Required

[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.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: December 4, 2014

TO: Kimberly Walker, Chairperson, Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Susan Gadacz, Deputy Administrator, Community Access to Recovery Services, Co-Chair, Mental Health Redesign and Implementation Task Force

SUBJECT: **From the Mental Health Redesign and Implementation Task Force, submitting an informational report on system redesign efforts and the 2013-2014 SMART Goals**

Background

The Mental Health Redesign and Implementation Task Force was chartered in 2011 with the purpose of developing and implementing a data-driven plan for the effective and sustainable redesign of the mental health system in Milwaukee County (see Attachment 1, *Mental Health Redesign and Implementation Task Force Charter*).

The Task Force established Action Teams to address key areas of the redesign effort: Person-Centered Care, Continuum of Care, Community Linkages, Workforce, and Quality. (A Cultural Intelligence Action Team was added in 2013.) The initial deliberations of the Action Teams were based on various proposals recognized by the County Board of Supervisors in its charge to the Task Force:

- *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* by Human Services Research Institute in partnership with the Public Policy Forum and the Technical Assistance Collaborative, Inc.
- Reports to the Board of Supervisors from the Community Advisory Board for Mental Health
- *System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division* by the Milwaukee County Department of Audit
- *Follow-Up Report to BHD Administrator: Mixed-Gender Units* by the Gender Unit Work Group
- *Milwaukee County Executive's Mental Health Vision and Initiative* by Chairman Lee Holloway, Milwaukee County Board of Supervisors
- Reports to the Milwaukee County Board of Supervisors from the New Behavioral Health Facility Study Committee

The studies yielded over 120 recommendations, which were categorized and assigned to Action Teams for review, adaptation, and prioritization starting in October 2011 (see Attachment 2, *Task Force and Action Team Organizational Chart*). The Action Team co-chairs presented their prioritized recommendations to the Health and Human Needs Committee in January 2012 and at a public summit in February 2012, where consultants from the Human Service Research Institute (HSRI) provided feedback and guidance. The Task Force, DHHS, and BHD leadership resolved in March 2012 to issue a Request for Proposals for technical assistance in implementing the recommendations. DHHS contracted with a consultation team led by ZiaPartners, Inc., from September 2012 through July 2013. To promote clear reporting, implementation activities were framed as SMART Goals (see Attachment 3) – Specific, Measurable, Attainable, Realistic, and Time-bound. The County Board of Supervisors passed a resolution

in March 2013 authorizing the DHHS Director to implement the initiatives outlined in the SMART Goals in collaboration with the Task Force and community stakeholders. The Task Force, Action Teams, and numerous public- and private-sector partners worked throughout 2013 and 2014 to complete the SMART Goals, and a Mental Health Redesign Working Forum brought together nearly 100 partners to assess progress, address remaining tasks toward SMART Goal completion, and strategize for future collaboration for system improvement (summary report at county.milwaukee.gov/MHRedesign.htm). The Task Force and Action Teams – as well as affiliated workgroups – have continued to meet since the Forum to assess and support SMART Goal progress.

Discussion

Each of the SMART Goals was developed around a particular aim with a number of performance targets and tactical objectives to support that aim. The overarching aims of these SMART Goals have been achieved. Selected progress points for each SMART Goal are presented below. A more comprehensive table of SMART Goals achievements and activities is attached (see Attachment 4, *SMART Goal Achievements and Opportunities*).

Goal 1. Improve satisfaction and recovery outcomes

- Revised MHSIP satisfaction survey to be more welcoming, person-centered
- Improvement in all MHSIP domains on BHD adult inpatient units; high marks (above 75%) in community services
- Implemented Integrated Dual Disorder Treatment at CARS and community providers

Goal 2. Reduce stigma around mental illness

- Developed stigma reduction curriculum for community events, including personal stories from persons with lived experience of mental illness
- Presented education and stigma reduction program at multiple public events; Action Team working with Pastors United and UCC to organize presentations in churches and in Spanish
- NAMI presented an anti-stigma, recovery-themed theatrical production (*Pieces: In My Own Voice*) in various venues

Goal 3. Workforce development and improvement

- Over 500 individuals from dozens of community agencies involved in MC3 activities
- Employee trainings on trauma-informed care, co-occurring competencies, etc.
- Faye McBeath Foundation led a collaborative partnership called Nursing's Voice to address the supply and capacity of mental health nurses in the Milwaukee area

Goal 4. Expand network of Certified Peer Specialists

- Increased Certified Peer Specialists in Milwaukee County sevenfold since 2011
- Established Peer Pipeline website (hosted by Mental Health America)
- Conducted trainings for employers on integration of peer support into service array
- Conducted training for Spanish-speaking peers

Goal 5. Improve coordination and flexibility of mental health funding

- Implemented Community Recovery Services (CRS) and Comprehensive Community Services (CCS) to expand array of Medicaid-reimbursable services

Goal 6. Publicly chart system quality indicators

- Published data dashboard on County website in January 2014, updated quarterly

Goal 7. Structure for ongoing system improvement and oversight

- Maintained productive partnership of public and private stakeholders since July 2011
- MC3 Change Agent network plans and conducts quality improvement projects

Goal 8. Improve crisis response, reduce emergency detentions
- EDs reduced overall and as a percentage of total PCS admissions
- Expanded hours for mobile crisis services
- Increase in person-centered crisis plans on file for BHD clients

Goal 9. Flexible availability and continuity of community-based recovery supports
- Expanded Targeted Case Management slots, including new Recovery level
- Implemented CRS and CCS, new Medicaid psychosocial rehabilitation benefits
- Added new Access Clinic location on south side of Milwaukee

Goal 10. Improve transitions after hospital admission
- Established Community Linkages and Stabilization Program (CLASP)
- Housing Division created Community Intervention Specialist position to facilitate discharge planning, housing placements

Goal 11. Improve economic security of persons with mental illness
- Winged Victory provided benefits application assistance to more individuals, increased percentage of approvals
- CARS has 5 Certified Application Counselors (CAC) and has worked with community providers to answer Medicaid and Affordable Care Act enrollment questions.
- All Central Intake Units are CAC organizations enrolling nearly 300 individuals into the marketplace or Medicaid from late 2013 to September 2014

Goal 12. Increase consumer engagement in employment, education
- Implemented Individual Placement and Support (IPS) employment model
- Improved employment status of CARS consumers from intake to six-month follow-up

Goal 13. Recovery-oriented supportive housing
- Opened Pathways to Permanent Housing program
- Supported Clarke Square neighborhood initiative for transitional youth
- Increased number of supportive housing units

Goal 14. Collaboration between mental health and criminal justice systems
- Participated in Community Justice Council analysis of high utilizers of both systems
- Targeted interventions to stabilize repeat users of resource-intensive services

Goal 15. Improve access to non-hospital interventions, reduce hospitalizations
- Reduced BHD Adult Inpatient admissions from 1,650 in 2012 to 1,163 in 2014 (projected), completing a 48.4% decrease since 2010
- Serving 14% more individuals (4,572) in community-based services than in 2010
- Expanded array of community services (e.g. CCS, CRS) to respond to diverse needs

Goal 16. Improve cultural intelligence
- Developed cultural intelligence training curriculum and began trainings of Action Team leaders, CARS staff, and other partners

The SMART Goals were developed as a time-bound road map for specific initiatives in 2013 and 2014, but they are not an exhaustive inventory of all activities contributing to the improvement and redesign of the local mental health system. The Task Force has operated as a community-wide collaboration in pursuit of goals and objectives that are complementary to – but largely distinct from – other major County-specific initiatives. These initiatives include, but are not limited to, implementation of Electronic Medical Records, the use of evidence-based programming within CARS, and transitioning long-term care consumers from BHD into person-centered, community-based settings.

While the redesign initiatives that were facilitated, aided, or observed by the Task Force shouldn't be construed as conclusive, it is important to recognize that the mental health system in Milwaukee County

has seen significant, positive change since 2011. There is a steady, thoughtful, enthusiastic, and ongoing shift toward more recovery-oriented, person-centered care. With the completion of the SMART Goals, the Task Force now looks to the Mental Health Board to build upon these changes as it fulfills its charge.

Recommendations

The Mental Health Board should support the work of a **Prevention and Early Intervention Action Team**, which emerged as an area of interest at the Working Forum. The CARS Prevention Coordinator presented to the Task Force and has begun recruitment and planning for this group to move forward.

- Receive periodic informational reports from the Prevention and Early Intervention Action Team on its activities related to the charge of the Board.

Improving cultural intelligence remains a priority for all stakeholders beyond the time-bound scope of SMART Goal 16. The Board should support the continuing work of the **Cultural Intelligence Action Team** (CQAT) and receive periodic reports from the CQAT chairs. The goal of the CQAT is "to conceptualize the framework to expand and ensure that cultural intelligence endures throughout and beyond the Redesign efforts. This framework should instruct, equip, and offer care providers the tools to effectively interact with care recipients in culturally intelligent and appropriate manners as deemed by the care recipients." A comprehensive report from the CQAT is included with this report (see Attachment 5).

- Receive periodic informational reports from the Cultural Intelligence Action Team on its activities as they relate to the charge of the Board.

The Quality Action Team (QAT) has focused on establishing a mechanism to publicly chart system quality indicators. Its monthly meetings engaged roughly 30 participants from more than a dozen different public and private organizations, and work was delegated to three subgroups: System Mapping, Personal/Family Stories, and Dashboard. In partnership with Rogers InHealth and the Wisconsin Initiative for Stigma Elimination (WISE), the **Personal/Family Stories** group established a mechanism for collecting video vignettes of personal stories to be used for quality improvement, and the first story was recorded in July 2014. This work should be continued and supported. Another QAT product to be maintained is the **online data dashboard** published in January 2014 and updated quarterly (pursuant to SMART Goal 6). The Board should consider how to refresh this tool periodically and add or remove indicators to ensure continuing relevance and transparency. The QAT recommends that the Board **pursue data-sharing agreements with private hospitals** to consolidate County-wide data for presentation on the public dashboard, initially focusing on psychiatric inpatient admissions. Tracking system-wide inpatient admission data across public and private systems will help administrators and policy makers assess the impact of redesign initiatives, such as expanding community-based services, enhancing crisis services, and downsizing inpatient and long-term care units, as well as to identify and monitor areas of continuing or emergent service needs. Successful and mutually beneficial data-sharing agreements and dashboarding may warrant the addition of more data points,e.g., recidivism, acuity.

- Receive periodic informational reports from the Quality Action Team (or affiliated County staff) on the incorporation of personal stories into quality improvement processes.
- Review quarterly updates to the online data dashboard, and provide guidance on the addition or removal of content (http://county.milwaukee.gov/MHRedesign/Dashboard.htm).
    - Work with private hospital systems to establish data-sharing agreements to present both public *and* private data on the online dashboard, e.g., inpatient admissions.

The Board should support and establish regular communication with the **Milwaukee Co-Occurring Competency Cadre (MC3)** and its subcommittees, including the **Person-Centered Care Action Team**. The MC3 brings together Change Agents from all types of community providers, promoting self-assessments,

stigma reduction trainings, and quality improvement projects. Related to SMART Goal 1, the Person-Centered Care Action Team recommends that BHD work with an academic partner to process satisfaction data.

- Receive informational reports (as needed or relevant) from the MC3 steering committee.
- Explore potential relationships between BHD and academic partners for timely processing of satisfaction data.

The Continuum of Care Action Team pursued the idea of a **SOAR Collaborative** to assist eligible clients with benefit applications, but the execution of the plan ran short of time and personnel. This should be considered again with the support of the Board.

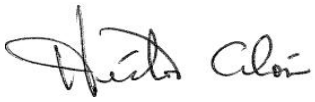
- Receive an initial informational report and/or presentation on SOAR, and consider how the Board and/or BHD may support a SOAR Collaborative.

Lastly, the Task Force recognizes that further efforts are needed to **promote employment and education** as components of mental health recovery. The Board should consider how it might take action or support other efforts to that effect.

- Request updates on client engagement in employment/education and the status of any programs or services related to promoting employment/education as a component of recovery.

The successes of the Redesign Task Force and Action Teams attest to the collective capability and passion of the more than one hundred contributors from dozens of public and private entities who stepped up to channel their efforts into this fruitful collaboration. The Task Force has been a central force in the ongoing adaptation of our mental health system to better promote recovery, and the Mental Health Board should strongly consider how it might build upon the achievement of the SMART Goals and utilize the structures and relationships that this work has cultivated.

Respectfully Submitted,



_____
Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kathleen Eilers, BHD Consultant
Jodi Mapp, Senior Executive Assistant, BHD

Mental Health Redesign and Implementation Task Force Charter

Purpose: To develop and implement a data-driven plan for the effective and sustainable redesign of the mental health system in Milwaukee County

Background and Rationale:
Mental health service delivery in Milwaukee County has been the subject of considerable research and scrutiny in recent years. Numerous public and private entities have issued reports on how to modernize and improve the mental health system generally as well as the Behavioral Health Division specifically, including (but not limited to):

- *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* by Human Services Research Institute in partnership with the Public Policy Forum and the Technical Assistance Collaborative, Inc.
- Reports to the Milwaukee County Board of Supervisors from the Community Advisory Board for Mental Health
- *System Changes are Needed to Help Ensure Patient and Staff Safety at the Milwaukee County Behavioral Health Division* by the Milwaukee County Department of Audit
- *Follow-Up Report to BHD Administrator: Mixed-Gender Units* by the Gender Unit Work Group
- *Milwaukee County Executive's Mental Health Vision and Initiative* by Chairman Lee Holloway, Milwaukee County Board of Supervisors
- Reports to the Milwaukee County Board of Supervisors from the New Behavioral Health Facility Study Committee

The Board of Supervisors approved a resolution in April 2011 to create a task force charged with evaluating and selectively implementing recommendations contained in the various reports.

Guiding Principles:

- Adherence to SAMHSA recovery principles: Self-Direction, Individualized and Person-Centered, Empowerment, Holistic, Non-Linear, Strengths-Based, Peer Support, Respect, Responsibility, and Hope
- Ensuring access to high quality services and supports in community-based settings
- Reducing reliance on emergency services and unnecessary inpatient care
- Commitment to full inclusion of consumers as well as family members and advocates
- Partnership between public and private stakeholders
- Compliance with the integration mandate of the ADA and *Olmstead v. L.C.*
- Diversity and cultural competency
- Moving beyond the medical model to a philosophy of independent living

Scope and Boundaries:

- Included:
  - Geography: Milwaukee County (and inpatient programs within the five-county region)
  - Focus: Redesign of Milwaukee County Behavioral Health Division services in coordination with reconfiguration and expansion of private and State-sponsored programs and services
  - Age Demographic: Initial focus on adults (including geriatric patients) and transitional youth
  - Range of Services: Inpatient, outpatient, emergency/crisis, case management, peer support, long-term care, residential, prevention, substance abuse services, and community-based services including (but not limited to) CSP, TCM, Day Treatment, and Family Care
  - Clinical Populations: Persons with mental illness and substance abuse, including those with a dual diagnosis and/or developmental disabilities
  - Focus on vulnerable, low-income populations, including the uninsured, Medicaid beneficiaries (and dual eligibles), older adults, and persons under emergency detention

    - System and structural redesign of the delivery system
    - Legal and public policy changes associated with emergency detention services
    - *Interaction* with external systems, e.g., housing, employment, education, justice, etc.
- Excluded:
    - Areas outside of Milwaukee County (excepting certain other inpatient programs within the five-county region)
    - Day-to-day operations and improvements at the Behavioral Health Division
    - Children's mental health
    - *Redesign* of external systems
        - e.g., housing, employment, education, criminal justice, etc.

Objectives/Deliverables:

- Review, prioritize, and implement recommendations from evidence-based plans and proposals
- Improve access to timely and appropriate mental health services
- Expand public and private community-based mental health services
- Reduce unnecessary and costly reliance on inpatient treatment
- Determine and achieve optimal capacities in public and private inpatient facilities and the Hilltop units at the BHD
- Minimize use of emergency detentions
- Improve consumer satisfaction and quality of care
- Achieve system-wide application of principles of recovery and trauma-informed care
- Increase independence, community integration, and quality of life for consumers
- Manage or reduce overall costs within the mental health system
- Garner and maintain support from the governing boards of mental health stakeholder entities, notably those represented on the Task Force
- Achieve and maintain an efficient, well trained workforce through strong recruitment, retention, and continuing education efforts

Outcome Measures:

- Expansion of community-based services
- Shift of inpatient capacity from public to private facilities
- Decreased emergency detentions
- Decreased readmissions
- Establishment of a set of common quality metrics
- Increased application of the recovery model and trauma-informed care
- Increased consumer satisfaction

Related Initiatives/Teams:

- Behavioral Health Advisory Committee
- Mental Health Task Force
- Milwaukee Continuum of Care
- Community Advocates – AODA Initiative

Resources Required:

- Project management support
- Technical assistance (fiscal analysis, policy implementation expertise)

Timeframe:

- Quarterly reports to the Committee on Health and Human Needs
- Major report on implementation plans to County Board in January 2012

Attachment 2 – Progress on HSRI 2011 Report Recommendations

HSRI Rec 1: Downsize & redistribute inpatient capacity

- BHD has continually reduced the number of inpatient units and the total occupancy.
    - *Closed a unit (43D) in 2012, a 24 inpatient bed reduction.*
    - *On the Acute Inpatient Units, in 2011 BHD staffed 108 beds. In 2013 those beds the number of staffed beds was down to 78. That is a 39% reduction in the total number of beds.*
    - *There has been a 48% reduction in the average daily census from 2008 – 2014.*
    - *Care has been redistributed to private institutions and community providers.*
    - *Projected admissions to acute inpatient in 2014 is 1,163; this is down from 2,254 in 2010.*
- DHHS/BHD has also worked with the State to develop and implement plans to phase down the long term care units (Hilltop & Central).
    - *In February 2013 the County Executive announced plans to close the long-term care units. This summer the State approved closure plans for both Hilltop and Central Services to be delivered in smaller community homes with support*
    - *On the long term care units, 18 individuals have been relocated to the community from Hilltop through the downsizing relocation plan from 2012.*
    - *In September 2010 the census at Hilltop was 68; in November 2013 the census is 50, in September 2014 the census is 34.*
    - *In September 2010, the licensed bed capacity at Central was 70, the census as of November 2013 is 50, and the census in September 2014 is 34.*

HSRI Rec 2: Involve private systems in a more active role

- BHD has been working with private providers to build clinical capacity to treat persons with more severe psychiatric symptoms and needs.
    - *In 2012 Aurora opened a 24 bed unit specifically dedicated to take higher acuity patients from BHD.*
    - *BHD is in discussions with private health system providers in the community to establish contracts to taking on indigent persons in need of mental health services.*
    - Rogers has plans to add 26 adult psychiatric beds in their brown deer facility in 2015.
    - The Hospital systems now operate 68% of the psychiatric beds in this community while also accounting for 85% of total psychiatric admissions. That will likely go up in 2015.
    - *28% of individuals were transferred from our Psychiatric Crisis Service to private treatment facilities.*

HSRI Rec 3: Reorganize crisis services & expand alternatives

- Since 2012, BHD has two Crisis Resource Centers located in the northern and southern parts of the county in order provide easier access for consumers.
- In 2012, two additional crisis stabilization/respite homes were opened. One respite location for individuals with intellectual disabilities and one stabilization home for individuals who live with mental illness.
- As of September 2014 there are 53 crisis stabilization beds.
- The Community Linkages and Stabilization Program (CLASP) launched in 2012. CLASP is a program that focuses on a successful discharge planning and community reintegration that is delivered in a peer-to-peer approach.
- Mobile Crisis Team expanded to provide a maximum amount of availability with 24/7 coverage.
- In 2013, Milwaukee Police Department also added a member to the Mobile Crisis Team and will enhance their partnership with BHD by adding another member in the upcoming year.
- In September 2014, a contract with La Causa was established to create a 3rd shift Crisis Mobile Services.

HSRI Rec 4: Reduce emergency detentions

- There has been a 29.6% decrease in Emergency Detentions from 2010- 2014
- In 2014, a change to state statutes that broadened the definition of who is authorized under Chapter 51 to make Emergency Detention determinations will likely result in diverting emergency detentions for other alternatives
- The Housing Division is working more closely with private hospitals and the House of Corrections to enhance successful discharge planning via a newly hired Community Intervention Specialist position, which was developed out of the Community Linkages Action Team.

HSRI Rec 5: Expand & reorganize community-based services

- Received authorization in August 2013 to implement the Community Recovery Services (CRS) benefit via the 1915i Medicaid Waiver as of September 2014, 66 clients are enrolled in CRS.
- BHD made a significant investment in shifting resources to community-based services and expanding community-based capacity.
    - CEX $3 million in 2012 & 2013, some of the funded initiatives included:
        - *CLASP*
        - *Northside CRC*
        - *Crisis Respite for individuals with an intellectual disability*
        - *Crisis Stabilization Home for individuals living with at mental illness*
        - *Expansion of Targeted Case Management to serve 90 additional individuals*
        - *Created the Community Intervention Specialist , Quality Assurance Coordinator, and Behavioral Health Prevention Coordinator positions*
        - *Pathways to Permanent Housing*
        - *Additional Supported Housing units*
        - *Peer Pipeline Infrastructure*
    - *CEX $4.4 million in 2013 & 2014*
        - *COLA for the CSP agencies*
        - *ACT/IDDT Implementation*
        - *Peer Run Recovery Center*
        - *Southside Access Clinic*
        - *Expansion of 3rd Shift Mobile Crisis*
        - *TCM for the AODA Population*
        - *Relocation funds for Rehab Central Clients*
- Increased the use of evidence based practices with the Individual Placement and Support (IPS) supported employment program.
- In 2014 four Community Support Programs adopted an Assertive Community Treatment/Integrated Dual Disorder Treatment (ACT/IDDT) model.
- Developed a continuum of care in Targeted Case Management (TCM) so individuals in need of TCM service have more choice that is based on clinical acuity; there are now three levels of TCM service. Level I is outreach based case management and care coordination that assists individuals with referrals and information; Level II, is intensive clinic based case management services; and, Level III which is called Recovery Case Management for clients who require less intensive services than what is provided in Level I such as those in need of case management services that reside in a supported apartment.
- 2014 expanded Targeted Case Management to individuals with a substance use disorder, currently 40 clients are enrolled.
- September 2014 received approval for Comprehensive Community Services (CCS) in the County, with 41 clients currently enrolled.

- Improved discharge planning for acute inpatient stays by completing a discharge conference with every individual prior to release to collaboratively review the discharge plan, discuss community resources, and address questions.
- BHD has implemented a multipronged approach toward benefits counseling to ensure maximum revenue to fund services.
    - Social workers work with clients on financial questions and connect individuals with the fiscal department to assist with some components of the benefits application.
    - In addition, Winged Victory Program staff, all of whom are certified application counselors (CAC) for ACA, work with clients in the hospital, PCS, and the Access Clinic to enroll in Medicaid, the Marketplace, and/or social security benefits.
    - Social workers across the network assist clients with the insurance enrollment process.
    - The Community Services Branch has 5 CAC and has worked with our community providers to answer Medicaid and ACA enrollment questions.
    - All Central Intake Units are CAC organizations enrolling nearly 300 individuals into the marketplace or Medicaid from late 2013 to September 2014.

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

- Milwaukee currently has 111 certified peer specialists- the most in the state.
- Offered training though Our Space, Inc., and La Causa and continuing education opportunities for Certified Peer Specialists.
- In 2014, all contracted TCM and CSP providers employed a Certified Peer Specialist.
- Division of Housing utilized peer specialist in their supported housing programs
- In September 2012 and in September 2013, held a summit for employers on how to recruit/hire/utilize Peer Specialists, second summit occurred in November 2013 and showcased the newly developed Employer Tool Kit
- Sponsored training for local peers as facilitators in developing individualized person-centered Wellness Recovery Action Plan (WRAP).
- Training for bilingual Certified Peer Specialists.
- One community partner, Our Space Inc., employs 25 peer specialists.
- Crisis Services has had significant gains in the number of clients with individualized crisis plans on file with an increase of 206% from 2010 – 2014..
- Peer Pipeline website was created and is maintained by Mental Health America, with up-to-date resources on educational and employment opportunities for peer specialists.
- Aurora Behavioral Health hired their first peer specialist in November 2013.

HSRI Rec 7: Enhance & emphasize housing supports

- The creation of 519 supportive housing units has been developed an increase of 109.3% since 2010.
- The creation of a new supportive services program has been developed for homeless veterans.
- Opened Pathways to Permanent Housing program in June 2013.
- In 2013, the housing division began to use CDGB to fund services in supportive housing including peer support.
- Permanent supportive housing options have been expanded through an increased number of permanent supportive housing units in the community, in addition to 40 scattered site supportive housing options.
- Housing Division has created case management slots for homeless veterans to give individuals access to Shelter Plus Care rental assistance funds. Homeless prevention activities will also be funded from this contract.
- Funds have been committed in 2013 to provide supportive housing for individuals who are aging out of the foster care system and are receiving services through Wraparound. These units will be placed in service in early 2014.

- Finally, as part of establishing a full and active partnership with the homeless service system the Division of Housing has a community intervention specialist who is dedicated to be that bridge between the homeless and mental health systems.
- The housing division created a community intervention specialist position to assist correction institutions, private hospitals and shelters with housing discharge plans.

HSRI Rec 8: Ensure cultural competency

- Cultural Intelligence Action Team (CQAT) established in June 2013 and playing an active role in system redesign efforts.
- Families Moving Forward and the Faith Partnership Network developed and implemented preventative intervention strategies for the African American community in Milwaukee and delivered these interventions in environments needed for effective service.
- United Community Center (UCC) in partnership with the 16th Street Clinic (an FQHC) developed and implemented a collaborative engagement, screening and referral pilot project called *Familias Sanas*. The collaborative project was designed as the pilot for developing systems to increase participation in integrated treatment services (Medical, Mental Health and Substance Use Disorder (SUD) services) for Hispanic population within Milwaukee County.
- A major part of the SMART goals has been enhancing the inclusion of diverse perspectives and increasing the cultural intelligence of mental health and substance use disorder professionals and the public at large.
- In April 2014, 26 individuals participated in the first cultural intelligence (CQI) training and subsequent training is scheduled for November 2014.
- CQI will become a regular training in the Basics of Community Treatment.

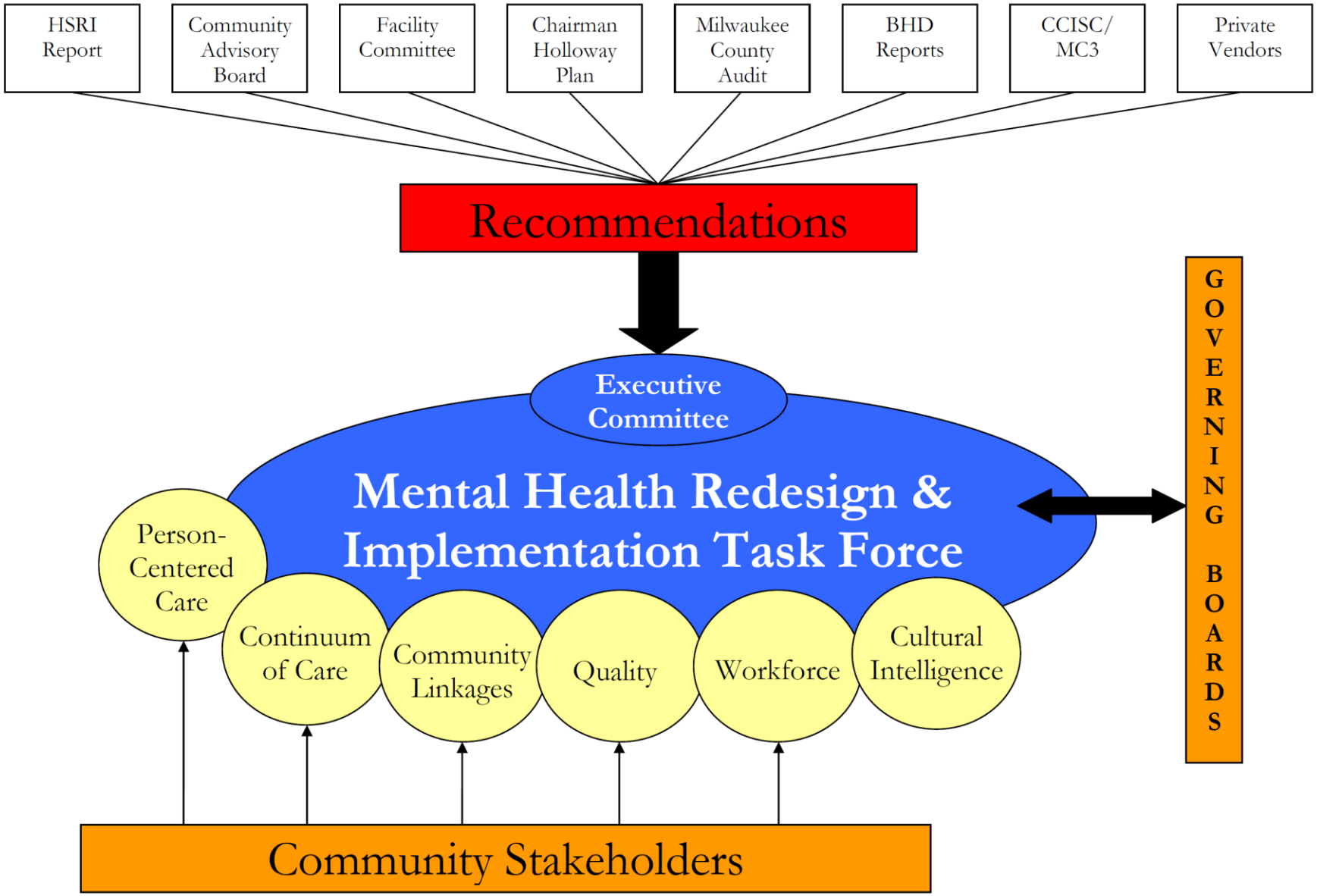
HSRI Rec 9: Ensure trauma-informed care

- A division-wide Trauma Informed Care (TIC) Committee was created.
- Providing BHD staff ongoing TIC based education such as the Mandt System.
- As part of The Joint Commission accreditation preparation process, BHD has updated Division policies and procedures to reflect our trauma informed care approach.
- Incorporated trauma related questions into our universal screening process.
- The Community Services Branch has trained over 500 clinical and recovery support providers on the use of TIC with the curriculum developed by Stephanie Covington.
- Three evidence based trauma treatment models are used in community services – those models are Seeking Safety, Beyond Trauma, and TREM/M-TREM.

HSRI Rec 10: Enhance quality assessment & improvement programs.

- Created an Office of Compliance, Safety & Integrity and have a Chief Compliance Officer overseeing the quality assurance and safety for the Division.
- Revised and improved out QI process to improve the tracking of patient outcomes and effectives of methods being utilized.
- Implementing the EMR system (Avatar) which is a major change to our whole division's management information systems that allows us to collect and report common data.
- With technical assistance from SAMSHA, BHD implemented a self-assessment tool that is being used in 60% of the behavioral health programs.
- Safety and prevention has been a major focus exemplified in the Falls Prevention program which has helped to significantly reduce the number of fall incident among our residents.
- Added a Quality Assurance Coordinator in 2014 dedicated to crisis services.

Attachment 3 – Task Force and Action Team Organizational Chart



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

Mental Health **Redesign** Task Force

TIMEFRAME

Redesign is about designing a system that promotes life and hope for people in Milwaukee County with mental health needs by transitioning to a more fully community-based system of care. Redesign is a multi-year process with ambitious targets. Initial SMART Goal implementation is focused on identifying attainable and measurable goals/objectives that can be achieved within the next 12-18 months. There will then be Annual Community Progress Reports of the SMART Goals to chart progress toward the highest possible standards for all services.

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

SCOPE

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

ORGANIZATION OF SMART GOALS

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

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

SMART Goal 2013-2014

one

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

Improve satisfaction and recovery outcomes by:

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

1

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

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

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

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

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

RESPONSIBILITY

Action Team Involvement:
Person-Centered and Quality

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

BHD Staff Partner:
Jennifer Wittwer

SMART Goal 2013-2014

two

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

Promote stigma reduction in Milwaukee County through:

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

2

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

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

RESPONSIBILITY

Action Team Involvement: Person-Centered

Partners: Milwaukee County Supervisors; Mental Health Task Force; NAMI; Rogers InHealth; Wisconsin's Initiative for Stigma Elimination (WISE); Center for Urban Population Health; Persons with lived experience

BHD /DHHS Staff Partner: Tonya Simpson

three

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

Improve the quality of the mental health workforce through:

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

3

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

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

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

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

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

RESPONSIBILITY

Action Team Involvement: Workforce and Person-Centered

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

BHD Staff Partner: Lora Dooley

four

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

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

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

4

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

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

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

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

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

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

RESPONSIBILITY

Action Team Involvement: Workforce

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

BHD Staff Partner: Jennifer Bergersen

five

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

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

5

PERFORMANCE TARGETS

By October 2013:

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

By January 2014:

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

TACTICAL OBJECTIVES

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

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

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

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

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

RESPONSIBILITY

Action Team Involvement: Resource Strategy and Continuum of Care

Partners: Wisconsin Department of Health Services

BHD Staff Partner: Jim Kubicek, Alex Kotze and Sue Gadacz

six

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

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

6

PERFORMANCE TARGETS

By October 2013:

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

TACTICAL OBJECTIVES

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

6.2 Identify and coordinate existing data sets and data sources.

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

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

6.5 Create information-sharing agreements.

6.6 Prepare initial format for review and modification.

RESPONSIBILITY

Action Team Involvement: Quality

Partners: Persons with lived experience; Data providers

BHD Staff Partner: Sue Gadacz

seven

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

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

7

PERFORMANCE TARGETS

By January 2014:

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

TACTICAL OBJECTIVES

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

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

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

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

RESPONSIBILITY

Action Team Involvement: NA

Partners: NA

BHD Staff Partner: Sue Gadacz with the Redesign Task Force

eight

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

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

8

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

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

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

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

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

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

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

Partners:
Persons with lived experience; community crisis services providers; private hospital systems; law enforcement; Community Intervention Training

BHD Staff Partner:
Amy Lorenz

nine

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

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

9

PERFORMANCE TARGETS

By July 2014:

1) Establish a continuum of Targeted Case Management (TCM) services that includes four components: Intensive, Crisis, Level I (regular case management), and Recovery.
2) Increase the number of TCM slots by 6% (90) over the 2012 baseline of 1,472 slots.

By December 2014:

3) Establish two additional psycho-social rehabilitation benefits — Community Recovery Services (CRS) and Comprehensive Community Services (CCS) — to provide flexible recovery support in the community.

TACTICAL OBJECTIVES

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

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

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

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

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

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

BHD Staff Partner:
Sue Gadacz

ten

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

Improve the success of community transitions after psychiatric hospital admission.

10

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

10.1 Establish a flexible, community-based continuum of care that includes formal services and informal community supports. (Goal 9)

10.2 Maintain and strengthen crisis prevention, intervention, and diversion services in the community. (Goal 8)

10.3 Establish a partnership between Redesign Task Force efforts and existing discharge and transition planning improvement activities at the Behavioral Health Division and private hospital partners.

10.4 Work in partnership with inpatient, crisis, community, housing, and peer support providers to develop and implement an improvement plan for facilitating transitions from any hospital in the county.

10.5 Develop and implement a plan to track 90 day readmission data for all hospital partners.

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

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

BHD Staff Partner:
Nancyann Marigomen

eleven

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

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

11

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

11.1 Establish a 2012 baseline for the number of persons who received assistance in completing SSI/SSDI applications.

11.2 Establish a 2012 baseline for the number of persons whose SSI/SSDI applications were approved.

11.3 Develop a partnership involving the Social Security Administration, benefits counseling programs, SOAR trainers, Protective Payee providers, and persons with lived experience to develop, pilot and implement a plan to improve access to application assistance.

11.4 Increase access to recovery-oriented Protective Payee services for people needing this service.

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

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

BHD Staff Partner:
Jena Scherer

twelve

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

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

12

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

RESPONSIBILITY

Action Team Involvement:
Community Linkages

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

BHD/DHHS Staff Partner:
Sue Gadacz and Jim Mathy

thirteen

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

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

13

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

RESPONSIBILITY

Action Team Involvement:
Community Linkages

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

BHD/DHHS Staff Partner:
Jim Mathy

fourteen

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

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

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

14

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

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

RESPONSIBILITY

Action Team Involvement:
Community Linkages

Partners:
Community Justice Council

BHD Staff Partner:
Jim Kubicek

fifteen

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

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

15

PERFORMANCE TARGETS

By July 2014:

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

TACTICAL OBJECTIVES

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

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

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

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

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

RESPONSIBILITY

Action Team Involvement:
Continuum of Care

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

BHD Staff Partner:
Amy Lorenz and Nancyann Marigomen

sixteen

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

Improve the level of cultural intelligence (CQ) operating in all components of the behavioral health system by:

- Developing a CQ knowledge base for the system;
- Incorporating CQ standards into program standards and clinical policies and procedures;
- Instituting workforce development strategies that promote CQ;
- Developing an adequately resources and CQ translator and interpreter network;
- Integrating CQ into each SMART Goal in the MH Redesign; and
- Establishing a CQ system improvement plan based on the components listed above.

16

PERFORMANCE TARGETS

By July 2014:

1) CQ System Improvement Plan will be completed.
2) CQ Assessment Instrument is identified/created and used to assess CQ in 60% of Milwaukee County behavioral health system programs.
3) CQ training program established and implemented for a minimum of 75% of staff.
4) Collaboration with community-based organizations focused on the needs of specific ethnic/racial groups will be improved with a key result being improved access to translator and interpreter services.

TACTICAL OBJECTIVES

16.1 Partner with MC3 to incorporate CQ improvement into MC3 process.

16.2 Partner with Workforce Action to integrate CQ into workforce development strategies.

16.3 Develop a user-friendly CQ Assessment Instrument that reflects best practices and is suitable for the local context.

16.4 Establish a mechanism and schedule for the CQ assessment of Milwaukee County behavioral health providers.

16.5 Establish an inclusive CQ collaboration including advocates and providers representing culturally diverse populations.

RESPONSIBILITY

Action Team Involvement:
CQ Action Team

Partners:
Milwaukee County BHD Community Services Branch, Families Moving Forward, Pastors United, Mental Wellness Ministry, Hmong American Friendship Association, La Causa, Gerald Ignace Indian Health Center, and MC3

BHD Staff Partner:
Sue Gadacz

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
1	Improve consumer satisfaction and recovery outcomes by: ➢ Providing services that are welcoming, person-centered, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable ➢ Increasing the use of self-directed recovery action plans ➢ Completing the functional integration of MH/AODA service components of the Milwaukee County CARS Division ➢ Using person-centered experiences to inform system improvement	➢ MHSIP survey revision, supplemental questions developed for more welcoming and person-centered approach ➢ Improvement in all MHSIP domains from 2011 to 2013 on BHD Acute IP units; four of six domains above 70% ➢ Maintaining MHSIP scores above 75% in community services ➢ ACT/IDDT implementation at CARS Division & eight (8) community agencies ➢ Personal & Family Stories Workgroup	➢ General efforts to improve consumer experiences to achieve optimal MHSIP & Vital Voices scores ➢ Expand collection of consumer satisfaction data in more service settings throughout community ➢ Collecting and curating stories from consumers and families for quality improvement and public education ➢ IDDT implementation, enhance co-occurring capability, unified "front door" for MH and AODA
2	Promote stigma reduction in Milwaukee County through: ➢ Evidence-based stigma reduction presentations that include presentations by persons with lived experience ➢ Partnering with efforts led by NAMI, Rogers Memorial Hospital, and the Center for Urban Population Health Project Launch	➢ Stigma reduction curriculum developed involving consumer stories, information on services and recovery; public education sessions held for County Districts 5 & 10 ➢ Performances of NAMI's "Pieces" throughout Milwaukee County ➢ WISE online video library	➢ Additional public education sessions throughout the County in diverse settings, e.g., schools/universities, churches, parks, community centers
3	Improve the quality of the mental health workforce through: ➢ Implementation of workforce competencies aligned with person-centered care ➢ Improved mental health nursing recruitment and retention ➢ Improved recruitment and retention of psychiatrists ➢ Improved workforce diversity and cultural competency	➢ Nursing's Voice: Applied research on skills and attitudes of MH nurses and employers to develop plans for recruitment, retention; relationship-building with educators and MH nurse employers; continuing education and networking opportunities for RNs; internships for nursing students with interest in MH ➢ Over 500 individuals from 87 community agencies actively engaged in MC3 Steering Committee and Change Agent activities ➢ 28 community agencies completed NIATx change projects, four COMPASS Clinics since 2013; change projects shared on MC3 website	➢ Replication and adaptation of Nursing's Voice activities for other mental health professionals ➢ Implementation of person-centered workforce competencies as defined by SAMHSA, MC3, or other sources ➢ Promoting measurement and monitoring of workforce diversity within community agencies to ensure cultural diversity consistent with the population being served ➢ Collect data on recruitment and retention of psychiatrists, nursing staff

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
4	Expand the network of Certified Peer Specialists who are well trained, appropriately compensated, and effectively engaged with peers and whose services are eligible for Medicaid reimbursement by: ➢ Increasing the number Certified Peer Specialists ➢ Recruiting and training Certified Peer Specialists with bilingual (Spanish) capability; ➢ Increasing the number of programs that employ Certified Peer Specialists ➢ Establishing a peer-operated program ➢ Advocating for quality in the delivery of Certified Peer Specialist services	➢ 119 Certified Peer Specialists in Milwaukee County (August 2014), up from 40 in mid-2012 ➢ Established and maintained Peer Pipeline website (collaboration between County and MHA), providing information on training, continuing education, certification, and employment opportunities for CPS ➢ Training for Spanish-speaking CPS ➢ Two employer trainings on integrating peer support into service array, treatment teams ➢ Peer Specialists employed in TCM and CSP ➢ Aurora Psychiatric Hospital employing CPS	➢ Peer-run drop-in center contract to be issued in mid-2014 ➢ Explore engaging Certified Peer Specialists with additional provider organizations and in diverse settings ➢ Establish baseline and optimal goal (based on demand) for number of CPS employed in the community
5	Improve the coordination and flexibility of public and private funding committed to mental health services	➢ Community Recovery Services and Comprehensive Community Services (Medicaid psychosocial rehab benefits) approved, enrollment underway in CARS Division and community partners ➢ Public Policy Forum, BSG providing fiscal analysis and ACA preparation with BHD and CARS Division	➢ Apply fiscal analysis and ACA preparation assessment in strategic planning and annual budgeting ➢ Explore service expansion (e.g., CRS) opportunities based on analyses by HSRI and others
6	Establish a mechanism to publicly chart system quality indicators that reflect progress on Redesign SMART Goals	➢ Public data dashboard presented in January 2014 on County website, updated quarterly ➢ System mapping project in collaboration with IMPACT 2-1-1 highlighting service utilization trends by ZIP code, e.g., Ch. 51 commitments ➢ Personal & Family Stories Workgroup	➢ Research on service utilization with IMPACT 2-1-1 and other data ➢ Integrate Personal/Family Stories with Consumer Satisfaction & utilization assessments ➢ Quarterly updates to dashboard ➢ Outreach to private sector for data sharing and analysis ➢ Data repository for public/private system data, with unique PINs to ensure confidentiality and promote cooperation

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
7	Develop a structure for ongoing system improvement and oversight of the Mental Health Redesign process	➢ Mental Health Redesign and Implementation Task Force maintaining partnership among public/private stakeholders since July 2011, making public reports and monthly updates to Milwaukee County Board of Supervisors ➢ MC3 Steering Committee & Change Agents assessing co-occurring capabilities and conducting relevant change projects	➢ Adapt to changing oversight of public mental health services, and establish/affirm collective aims for sustaining quality improvement activities and structures, e.g., Quality Action Team
8	Improve crisis access and response to reduce Emergency Detentions (Chapter 51, Involuntary Commitment for Treatment)	➢ Implementation of NIATx system improvement technology to provide ongoing QI process ➢ EDs reduced overall and as a percentage of total PCS admissions from 2011 to 2014 (60.8% to 54.1%) ➢ Increase in person-centered crisis plans on file for BHD consumers (surpassed target) ➢ Expanded hours for mobile crisis services	➢ Assess all community crisis support services for broad perspective of available resources (e.g., mobile crisis calls and visits in community, unique crisis respite consumers, etc.) ➢ Categorize and gather data on different types of crisis events
9	Improve the flexible availability and continuity of community-based recovery supports	➢ Recovery Case Management (40 slots) added in April 2013, piloted by MMHA, to complement three existing levels of TCM ➢ Two additional caseloads (50 slots) of Level I Targeted Case Management contracted, maintained with Bell Therapy since April 2013 ➢ CRS and CCS approved and implemented ➢ Central Intake Units trained as Certified Application Counselors for ACA Marketplace	➢ Continue client enrollment in CCS and CRS benefits ➢ Ongoing assessment of demand for and availability of TCM, CRS, CCS, and CSP benefits
10	Improve the success of community transitions after psychiatric hospital admission	➢ Community Intervention Specialist (Housing Division) facilitating discharge planning and housing placements from public and private inpatient services since August 2013 ➢ Community Linkages and Stabilization Program (CLASP) aiding consumers transitioning from inpatient services to community-based care	➢ Establish definition of a successful or sustainable community transition ➢ Gather current, available data on successful community transitions ➢ Measure effectiveness of transition support services; expand or replicate as appropriate

Attachment 5 – SMART Goal Achievements and Opportunities

	Goal	Achievements	Ongoing & Future Opportunities
11	Improve the economic security of persons with mental illness by increasing utilization of disability-related benefits including SSI/SSDI and Medicaid	➢ Winged Victory provided SSA application assistance to 314 individuals in 2013, an increase of 45% from 2012 and 76% from 2011; approvals up 36% from 2012 to 2013	➢ Establish SOAR Collaborative ➢ Provide benefit counseling in club houses, day program providers, etc. ➢ Monitor ongoing enrollment of clients into public/private insurance plans to establish baseline and work toward 100% coverage
12	Increase engagement of individuals with mental illness in employment, education, or other vocational-related activities	➢ Implemented Individual Placement and Support (IPS) employment model ➢ Improvement in employment status of SAIL and WIser Choice consumers from intake to six-month follow-up in 2013 ➢ Presentation by SSA representative on benefits and work incentives in mid-2013	➢ Examine employment outcomes based on type of employment, e.g., compare performance of various employment models ➢ Review of WIser Choice GPRA data/outcomes
13	Improve access to, and retention in, recovery-oriented supportive housing for persons with mental illness who are homeless or inadequately/unsafely housed	➢ Increased supportive housing units in 2012, 2013, and 2014 by 28% (90 units), 10% (40 units), and 16% (73 units), respectively ➢ Pathways to Permanent Housing program opened in June 2013 ➢ Clarke Square neighborhood initiative providing housing & supportive services for youth aging out of foster care	➢ Maintain high rates of retention in supportive housing ➢ Increase capacity for Community Intervention Specialist Services to support Housing First model ➢ Involve crisis support resources to increase housing permanency ➢ Expand housing efforts to include consumers aging out of foster care
14	Improve criminal justice and mental health system collaboration to reduce inappropriate incarceration of people with mental illness by: ➢ Establishing a HIPAA-compliant data link between the County criminal justice system and Behavioral Health Division ➢ Supporting a continuum of criminal justice diversion services for persons with behavioral health needs	➢ Community Justice Council analysis of high utilizers in mental health & law enforcement ➢ Crisis Assessment Response Team (CART) reducing unnecessary conveyances to PCS through contracted partnership with MPD; 143 direct CART contacts (July 2013 through March 2014) with individuals in crisis	➢ Coordinate with Wraparound, foster care, BMCW ➢ Expand CIT to include MCSO, parole/probation ➢ Further coordination and development of criminal justice resources, e.g., IMPACT 2-1-1

	Goal	Achievements	Ongoing & Future Opportunities
15	Reduce acute hospital admissions through improved access to non-hospital crisis intervention and diversion services for people in mental health crisis	➢ BHD Adult Inpatient admissions down 48.4% from 2010 to 2014 ➢ Access Clinic served 6,310 individuals (2,214 new clients) in 2013, consistent with 2012 and up 46% from 2011 ➢ Implementation of NIATx process improvement technology to provide ongoing Quality Improvement process	➢ Catalog available crisis intervention supports (e.g., public, private, law enforcement, etc.) ➢ Enhance mechanisms to track and link consumers discharged from acute inpatient care with follow-up supports ➢ Analyze utilization data from mobile crisis calls, community visits, crisis respite use, etc., to complement data on reduced inpatient utilization
16	Improve the level of cultural intelligence (CQ) operating in all components of the behavioral health system by: ➢ Developing a CQ knowledge base ➢ Incorporating CQ standards into program standards, clinical policies & procedures ➢ Instituting workforce development strategies that promote CQ ➢ Developing a translator/interpreter network ➢ Establishing a CQ system improvement plan	➢ Cultural intelligence training curriculum adapted from corporate models into content targeted toward behavioral health and social service fields (with SMB Group) ➢ Conducted training of trainers in 2014 with representatives from Action Teams, CARS Division, and other partners ➢ Hosted expert presentation on personal and organizational CQ enhancement	➢ Develop a cultural intelligence inventory, and conduct pre- and post-testing ➢ Provide ongoing trainings for County and contracted providers on range of cultural intelligence issues ➢ Examine whether there are any changes in the cultural sensitivity item on the MHSIP

Attachment 6 – Cultural Intelligence Action Team

Overview of Cultural Intelligence Efforts in Milwaukee

The Milwaukee County Behavioral Health Division Redesign process was well underway when administrators invited former Contract Administrator Rochelle Landingham and contracted provider Shawn Green to a meeting on Redesign efforts. Both women had worked closely with the implementation of BHD's WIser Choice Program and were very familiar with the program as well as other department programs and service.

The BHD Administrators approached the local Coalition affiliate of the Federal Center of Substance Abuse Treatments do discus gaps for consumers of color in Milwaukee County. Expert advice and planning ensued and an invitation was given to Rochelle Landingham and Shawn Green to come to the Redesign Task Force.

At the meeting, the two were struck by the lack of diversity in the room for a group purposed to redesign a system that serves primarily people of color. Several discussions followed that meeting and the two women were offered the opportunity to meet with the expert consultants hired for the Redesign effort. The now emerging group utilized the consultant's to refine their ideas around addressing the absence of culture specific programming and opportunities for program participants.

The group worked to develop and present, to the Redesign Task Force, a request to expand the effort to include and address **Cultural Intelligence** by way of an additional goal as well as Action Team. The Cultural Intelligence (CQ) Center defines this as: "a person's capability to function effectively in situations characterized by cultural diversity. CQ is a critical capability that enhances employee, manager and organizational effectiveness. It also enhances interpersonal interactions in a wide range of social contexts." (http://www.culturalq.com)

Although Redesign Task Force efforts were well underway, Co-Chairs Sue Gadacz and Pete Carlson explored and ultimately introduced a motion to add a Cultural Intelligence Action Team. The request was vetted by the Task Force at-large and approved. Cultural Intelligence (CQ) became the 16th Goal of the Redesign Action Plan and the CQ Action Team (CQAT) began meeting monthly staring July 10, 2013. The CQAT identified five priorities, which are to:

1. Develop an annual CQAT Action Plan
2. Provide training and curriculum
3. Secure data capping (client type and type of service{s} utilized)
4. Insure peer/participant access and outcomes inclusive of strong partnerships
5. Execute program enhancements

The co-chairs actively recruited members of ethnic, disability and other under-represented groups. The Team continues to meet on the second Tuesday of each month at Westcare WI/Harambee, 335 West Wright Street in Milwaukee at noon.

CQ Forging Ahead

The Cultural Intelligence Action Team (CQAT), a component of the Milwaukee County Behavioral Health Division Redesign, has a vision **to increase and enhance the performance levels of direct care, administrative and other related service staff who work with, in or on behave of service participants in the many diverse communities and constituents in and around Milwaukee County.**

The overall goal of the CQAT is **to conceptualize the framework to expand and ensure that cultural intelligence endures throughout and beyond the Redesign efforts**. **This framework should instruct, equip, and offer care providers the tools to effectively interact with care recipients in culturally**

intelligent and appropriate manners as deemed by the care recipients. The desired result is that care providers understand how best to create and utilize strategies that respect and honor the cultural norms, behaviors, and habits of the persons and communities in which they serve/work.

As the system further engages diverse communities, Cultural Intelligence (CQ) serves as the cornerstone of our collective work with individuals, families and the community at-large. CQ provides the opportunity for partnership with and between representatives of the widest possible array of culturally diverse constituencies in Milwaukee and southeastern Wisconsin, to work collaboratively with people and families in service, leadership, provider partners, front line staff, and others to enhance outcomes.

Employing Cultural Capabilities

The Cultural Intelligence Center has identified four capabilities that are consistently constant in the behavior of individuals who are effective in culturally diverse situations. They are:

- **Drive**
- **Knowledge**
- **Strategy**
- **Action**

Having worked for and on behalf of BHD, the co-chairs have an up-close and realistic understanding of the necessity to redesign and correct system flaws. In a letter to legislators the two proposed that the new **Milwaukee County Mental Health Board**:

- Reflects the ethnic diversity of BHD's current and predicted service population
- Legislation includes narrative and measures to ensure that language and cultural-specific services are readily available to service-seekers, based on the demographics of those actively utilizing County/State sponsored, behavioral health services in Milwaukee County and
- Ensure that members of the proposed Board complete the Cultural Intelligence training

Executing **the Action Plan**, the CQAT recruited 25 people, who have been involved in the Redesign process, for the **inaugural Cultural Intelligence training** held on Tuesday, April 1, 2014. On October 29th we conducted the **Passport to Cultural Intelligence training** with 21 people. Each participant completed a CQ assessment and received their personalize analysis of the findings at the trainings.

We welcome the opportunity to talk with you about partnering as a/your human service/faith partner in this important work. We look forward to working with you and please contact us at:

Shawn Green
Shawngreen82@gmail.com
414-264-6700

Rochelle Landingham
rochelle.landingham@westcare.com
414-239-9359 ext. 80103

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: November 24, 2014

TO: Kimberly Walker, Chairperson – Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Clare O'Brien, Fiscal & Management Analyst, Department of Health and Human Services

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to enter into 2015 contracts with the State of Wisconsin for Social Services and Community Programs**

Issue

Sections 46.031 and 49.325 of the Wisconsin Statutes require counties to execute annual contracts with the State Departments of Health Services (DHS) and Children and Families (DCF) for "Social Services and Community Programs." The contracts, also referred to as Community Aids, provide State and Federal funding for county services to persons with mental illness, disabilities, substance abuse problems and juvenile delinquents and their families as mandated by State and/or Federal law.

The Director, Department of Health and Human Services (DHHS), is therefore requesting authorization to sign the 2015 contracts with DHS and DCF for the provision of social services and community programs mandated by state law. The Behavioral Health Division (BHD) cannot receive 2015 revenues from the State until these contracts are signed.

Background

State and Federal funds that are forwarded to the Behavioral Health Division (BHD) under the Social Services and Community Programs state contract, commonly referred to as "Community Aids" provide a significant funding source for the department. For 2015, at least $36 million is anticipated for BHD.

The state's Social Services and Community Programs contracts include various separate revenues used to fund the Department of Health and Human Services (DHHS) (including the Behavioral Health Division). Funding identified in this report pertains only to revenues associated with services within BHD.

At this time, DHHS has not received the actual 2015 "Community Aids" contract from the State. However, DHHS has received an advisory notification of 2015 allocations, and this has been utilized to identify the fiscal effect of the expected contract (allocations are posted at http://www.dhs.wisconsin.gov/sca/ and http://www.dcf.wi.gov/contractsgrants/social_human_services_contracts).

State Allocations and Fiscal Effect

Community Aids – Basic County Allocation (BCA)

The Basic County Allocation (BCA) is a type of block grant provided to counties that is not earmarked to serve a specific target population. Counties are able to determine how much funding to provide to each of the populations eligible to be served with these funds: persons with mental illness, developmental disabilities, physical disabilities, substance abuse problems and delinquent children.

The 2015 Budget includes $22,336,586 of BCA for BHD. This amount is consistent with the State allocation of BCA to Milwaukee County.

BHD Earmarked Revenue Sources

Behavioral Health Division

State earmarked funding for BHD supports services in the Wiser Choice fee-for-service network and the mental health purchase of service contracts within BHD's Community Services Branch. As shown in the table below, the 2015 Budget anticipates $15.8 million in revenue compared to the State's preliminary allocation of $13.6 million. The difference of $2.2 million reflects Substance Abuse Treatment TANF funding not yet issued for the last six months of 2015. The State only committed half of the grant to BHD effective January 1 to June 30, 2015 and the last six months of funding, or $2.2 million, will be determined by a Request for Proposals (RFP) process. The State periodically solicits proposals for its earmarked funding sources.

CSB will submit a response to the RFP and is hopeful it will be level funded for the last six months of the year for a total allocation of $4.4 million. A final decision on funding is anticipated prior to the end of the State's fiscal year which is June 30, 2015. Any additional funding would be issued through an amendment to the Social Services/Community Programs contract.

CY2015 State/County Social Services/Community Programs Contract				
Preliminary Revenue Notification Compared to the 2015 Budget				
		2015		State
		Preliminary		vs. DHHS/BHD
Basic County Allocation	**BHD Budget**	**State Notice**		**Budget**
DHS Community Aids	**$22,336,586**	**$22,336,586**		**$0**
Earmarked Revenues				
BHD Earmarked Revenues				
Community Options Program (COP)	$1,478,673	$1,478,673		$0
CSP Wait List	$84,519	$88,217		$3,698
Certified Mental Health Program	$337,499	$358,859		$21,360
IMD Regular Relocation	$5,891,687	$5,891,677		($10)
Mental Health Block Grant	$680,914	$685,914		$5,000
Substance Abuse Treatment TANF	$4,394,595	$2,197,298	[1]	($2,197,298)
AODA Block Grant	$2,431,021	$2,431,021		$0
IV Drug	$500,000	$500,000		$0
Subtotal BHD Earmarked Revenues	$15,798,908	$13,631,659		($2,167,250)
GRAND TOTAL Revenue	**$38,135,494**	**$35,968,245**		**($2,167,250)**

[1]The State Department of Health Services has issued a six-month (January 1 - June 30, 2015) contract with the Community Services Branch for the Substance Abuse Treatment TANF grant. A Request for Proposals (RFP) will be issued by DHS in early 2015 so that an award decision can be made in time for the last six months of 2015. CSB will submit a response to this RFP to secure ongoing funding. Once an award is made, the State will issue an amendment to the 2015 State/County contract.

Recommendation

It is recommended that the Mental Health Board authorize the Director, Department of Health and Human Services, to execute the 2015 Social Services and Community Programs contracts from the State Departments of Health Services and Children and Families, and any addenda to those contracts, in order for the County to obtain the State Community Aids revenue. The 2015 Social Services and Community Programs contracts provide total revenue of $35,968,245.

Fiscal Impact

A fiscal note form is attached.

Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Don Tyler, Director, DAS
Josh Fudge, Director, Office of Performance, Strategy & Budget
Matt Fortman, Fiscal & Management Analyst, DAS
Scott Manske, Comptroller's Office

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 11/24/14

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services, requesting authorization to enter into 2015 contracts with the State of Wisconsin for Social Services and Community Programs

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.

A. Authorization is requested to sign the 2015 Social Services and Community Programs contracts with the State Departments of Health Services and Children and Families. Approval will allow Milwaukee County to receive State revenue for county services to persons with mental illness, disabilities, substance abuse problems and juvenile delinquents and their families as mandated by State and/or Federal law.

B. The state's Social Services and Community Programs contracts include various separate revenues used to fund the Department of Health and Human Services (DHHS) (including the Behavioral Health Division). Funding identified in this report pertains only to revenues associated with services within BHD. Approval to sign the 2015 contracts will allow Milwaukee County to receive funds.

C. DHHS staff has compared revenues in the State Advisory Notification to revenues that were anticipated in the 2015 Budget. Total funding anticipated in the 2015 Budget is $38.1 million and the total funding issued at this time by the State is $35.9 million. The difference of $2.2 million reflects the last six months of funding for the Substance Abuse Treatment TANF grant. The July 1 to December 31, 2015 balance of funding for this grant will be determined through a Request for Proposals (RFP) process being undertaken by the State.

D. The fiscal note assumes that the Substance Abuse Treatment TANF grant is level funded by the State.

[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 Clare O'Brien, Fiscal & Management Analyst

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CDPB Staff Review? ☐ Yes ☐ No ☒ Not Required

BEHAVIORAL HEALTH DIVISION

NOVEMBER 2014

FISCAL REPORT

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BHD Combined

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KEY FISCAL ITEMS AS OF NOVEMBER 2014

Behavioral Health Division – Inpatient

- Clinical Staffing
- Adult Inpatient Bed Reduction
- Hilltop Downsizing
- State Plan Amendment Revenue
- WIMCR Revenue

CARSD – Community Access to Recovery Services Division

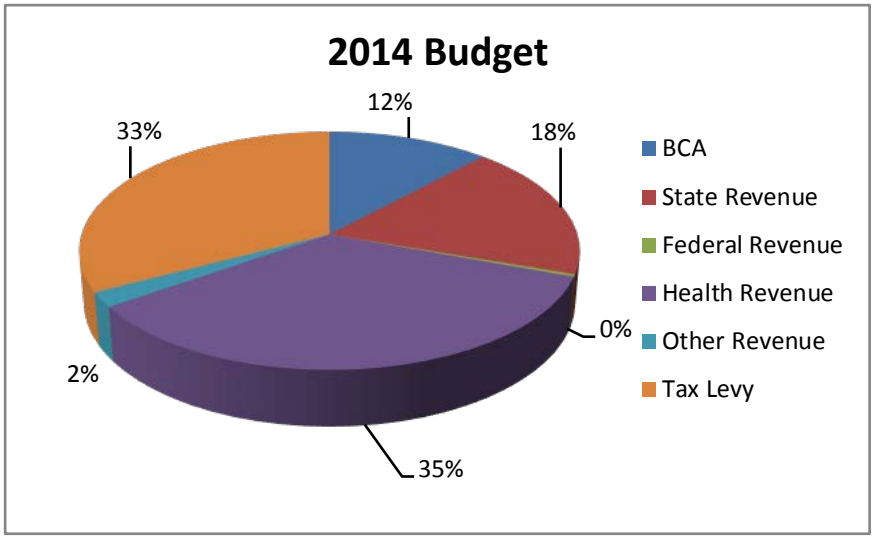
- CRS & CCS Billing Implementation

BHD - Combined Reporting
November Year to Date 2014 Fiscal Results
P & L Summary

		2013 Actual	2014 Budget	2014 Actual YTD	2014 Projection	Surplus/ (Deficit)
BHD Combined	**Revenue**	118,722,888	124,381,941	113,261,070	120,722,309	(3,659,632)
	Expense	179,245,135	184,785,420	152,962,295	178,864,665	5,920,755
	Tax Levy	60,522,247	60,403,479	39,701,225	58,142,356	2,261,123
BHD Inpatient	**Revenue**	33,704,918	33,109,314	32,465,542	34,843,471	1,734,157
	Expense	86,084,156	82,548,746	71,153,946	83,604,285	(1,055,539)
	Tax Levy	52,379,238	49,439,432	38,688,404	48,760,814	678,618
CARSD	**Revenue**	85,017,970	91,272,627	80,795,528	85,878,838	(5,393,789)
	Expense	93,160,979	102,236,674	81,808,349	95,260,380	6,976,294
	Tax Levy	8,143,009	10,964,047	1,012,821	9,381,542	1,582,505

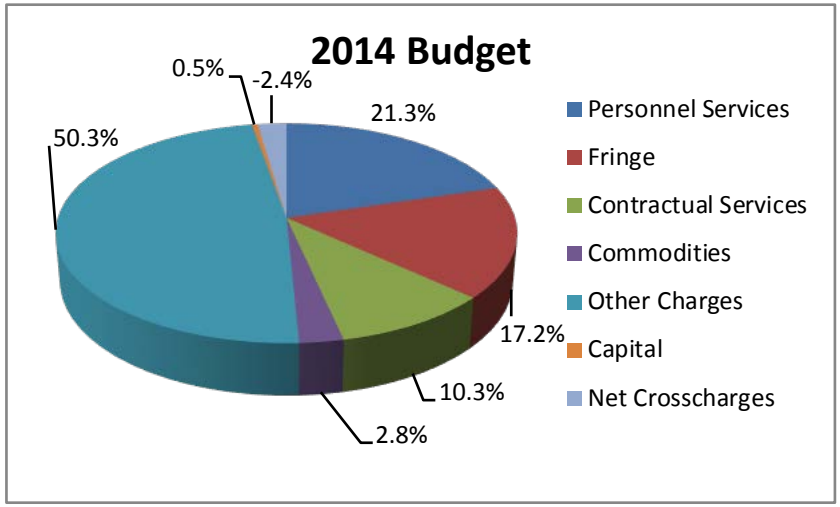
BHD - Combined Reporting
November YTD 2014 Fiscal Results
Revenue Summary

BHD COMBINED	2013 Actual	2014 Budget	2014 Actual YTD	2014 Projection	Surplus/ (Deficit)
BCA	22,357,608	22,016,586	22,016,595	22,016,586	0
State Revenue	34,504,888	33,929,039	28,901,884	33,029,336	(899,703)
Federal Revenue	962,530	649,915	519,177	587,500	(62,415)
Health Revenue (Patient)	57,949,363	64,038,034	58,866,183	61,767,973	(2,270,061)
Other Revenue	2,948,499	3,748,367	2,957,230	3,320,914	(427,453)
Sub-Total Revenue	118,722,888	124,381,941	113,261,069	120,722,309	(3,659,632)
Tax Levy	60,522,247	60,403,479	34,228,007	58,142,355	(2,261,124)
	179,245,135	184,785,420	147,489,076	178,864,664	(5,920,756)



BHD - Combined Reporting
November YTD 2014 Fiscal Results
Expenditure Summary

BHD COMBINED	2013 Actual	2014 Budget	2014 Actual YTD	2014 Projection	Surplus/ (Deficit)
Personnel Services	43,351,559	39,374,420	34,700,940	40,818,955	(1,444,535)
Fringe	29,407,717	31,791,161	28,896,757	32,326,690	(535,529)
Contractual Services	19,405,946	18,949,288	15,650,197	18,902,005	47,283
Commodities	5,458,214	5,257,511	2,858,806	4,218,767	1,038,744
Other Charges	85,251,528	92,978,253	70,062,247	86,364,960	6,613,293
Capital	721,330	883,468	533,089	813,251	70,217
Net Crosscharges	(4,351,159)	(4,448,681)	(5,212,960)	(4,579,964)	131,283
	179,245,135	184,785,420	147,489,077	178,864,664	5,920,756



BHD - Combined Reporting
November YTD 2014 Fiscal Results
Expenditure Summary
($ in Millions)

BHD COMBINED	2014 Budget	2014 Projection	Surplus/ (Deficit)	Surplus Explanation
Community Services	$ 22.4	$ 20.1	$ 2.3	Reflects $2.3M in Purchase of Service surplus due to executed contracts being less than budgeted appropriations.
AODA	$ 14.2	$ 13.6	$ 0.6	Reflects Fee for Service network for Detox, ATR & TANF etc. Impact of ACA reducing expenditures
WRAP	$ 53.2	$ 49.6	$ 3.6	Wrap Fee for Service $3.6 M due to youth enrollment lower than budgeted.
BHD Crisis	$ 3.2	$ 3.0	$ 0.2	Purchase of Service for crisis mobile, access clinics etc.
	$ 93.0	$ 86.3	$ 6.7	

2015 Projected Budget Surplus/(Deficit) Items

as of December 2014

Item	Explanation	Surplus/Deficit
Increase inpatient Medicaid Rate	After budget was completed BHD received notice from the State that the Medicaid rate for Adult inpatient and CAIS was increasing by $219 per day.	$690,000
Dietary Contract	During the budget process a RFP for dietary services was performed. Although the budget included assumptions of savings from the competitive bid process the savings were conservative in relation to the pricing in the executed contract	$700,000
Adult Inpatient Bed Reduction	As a result of staffing shortages beds available was reduced in the adult acute area. Current staffing patterns will not change as a result of the reduction, but there will be a reduction in revenue.	($2,000,000)
2014 Reserve	BHD is expected to surplus in 2014 by $2.3M. The reduction is largely due to higher reimbursement on claims and lower spending in CSB provider network	$2,300,000
Hilltop Phase Down Payments	Payments received from the State in 2015 for Hilltop clients located in the community in 2014	$380,000
Write Off %	Oct. YTD WO % are being recalculated. % needs to be compared to % in budget and variance determined.	$200,000
BHD Fringe Adjustment	Cost to increase fringe to levels comparable with all other county employees	($800,000)
Total		**$1,470,000**

2015 Budget Risk/Opportunities

as of December 2014

Item	Explanation	Surplus/Deficit
2015 Fringe Benefits	In 2015 the actual costs of associate health care claims will be recorded to BHD resulting in a budget surplus/deficit	TBD
TANF Grant	Budget assumed $4.4M, but BHD was notified that the grant would go out for competitive bid and received only $2.2 to fund through June.	TBD
Staffing Model Execution	A key component of the 2015 budget was addressing staffing shortages and OT challenges. Management execution of hiring and retaining staff to eliminate OT, and run beds at optimal levels is critical to meeting budget	TBD

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: December 1, 2014

TO: Kimberly Walker, Chairperson – Milwaukee County Mental Health Board

FROM: Patricia Schroeder, Administrator, Behavioral Health Division

SUBJECT: **Report from the Administrator, Behavioral Health Division, and Director, Department of Administrative Services, Providing an Update on the New Facility Administrative Committee**

Background

The Administrative Committee that will analyze the Behavioral Health Division (BHD) facility and plan for new space has been initiated. This group has the following membership:

Co-Chairs
Patricia Schroeder, Administrator, BHD
Teig Whaley-Smith, Director, Department of Administrative Services

Mental Health Board Representatives
Pete Carlson
Lyn Malofsky
Duncan Shrout

Other Members
John Schneider, Chief Medical Officer, BHD
James Kubicek, Deputy Administrator, Crisis and Acute Services, BHD
Susan Gadacz, Deputy Administrator, Community Services, BHD
Randy Oleszak, Fiscal Administrator, BHD
Jeanne Dorff, Deputy Administrator, Department of Health and Human Services (DHHS)
Raisa Kolton, Chief Of Staff, County Executive's Office
Tonya Simpson, Communications, DHHS
William Banach, Architecture, Engineering and Environmental Services, Facilities Management
David Cialdini, Economic Development

Meetings are being held weekly during the analysis process.

Discussion

The recommendation has been accepted by the group to use CBRE as a consultant in the analysis of the financial costs and requirements of the current and future facility. CBRE has been working with other projects within Milwaukee County as part of the County Facilities Project (CFP), which included the transition of City Campus. CBRE has performed effectively and efficiently in similar work within other County departments. Their experience with our buildings, processes, and leadership team will advance this project quickly. They also provided leadership with BHD in their analysis of facilities in 2007-2008, which will provide a basis for our current analysis. Part of their support will include help in creating a Request for Proposals to identify a consultant and partner to assist in the space planning analysis within this work.

An initial agreement has been endorsed by the Administrative Committee to get us started. A more comprehensive proposal will come to the Board at a next meeting.

Teig Whaley-Smith will provide a brief presentation on the direction of this work at the December 18, 2014, meeting. This presentation will include data on the value of the current BHD facility and land.

Respectfully Submitted,

Patricia Schroeder, Administrator
Milwaukee County Behavioral Health Division
Department of Health and Human Services

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: November 21, 2014

TO: Kimberly Walker, Chairperson – Milwaukee County Mental Health Board

FROM: Patricia Schroeder, Administrator, Behavioral Health Division

SUBJECT: **Report from the Administrator, Behavioral Health Division, providing a report on the establishment of a 501(c)(3) Corporation**

Background

The Milwaukee County Behavioral Health Division (BHD) is taking steps to establish a 501(c)(3) Corporation to receive research grants and charitable donations on behalf of BHD's mental health programs. Though BHD already has the capacity to receive grants and donations, most donors prefer that gifts be formally transmitted through a 501(c)(3). Such endeavors typically expand and enhance funding, and BHD is excited about this new venture.

Discussion

Three (3) members would serve on the 501(c)(3) Corporation Board for three (3) year terms: the BHD Administrator, serving ex-officio and as chair; the Mental Health Board (MHB) Chair or her designee; and an outside director with recognized expertise in philanthropy or mental health research funding, with appointment by the BHD Administrator.

BHD intends to have bylaws and related paperwork finalized by November 24, 2014, for consideration at the MHB's December 18, 2014, meeting. A contract has been tendered to the von Briesen law firm, whom the County previously engaged for similar work for the Transit and Family Care Departments. Unless subsequently approved, the maximum amount to be paid under this contract is $5,000.

Respectfully Submitted,

Patricia Schroeder, Administrator
Milwaukee County Behavioral Health Division
Department of Health and Human Services

Follow up to Board Information Request

I. Finance Committee Reports
   a. Quarterly Financials(2): **Suggested frequency quarterly**
   b. Program savings(16): **Suggested frequency quarterly**

II. Administrative Update
   a. Staffing levels(4): **Suggested frequency semi annually**
   b. Salary/Benefit Info for RNs and MDs(4)**Suggested frequency: annually**
   c. Long Term Care Closure(6):**Suggested frequency: quarterly in 2015**
   d. Joint Commission Progress(7): **Suggested frequency: quarterly**
   e. Progress on Strategic Plan: **Suggested frequency: quarterly until plan is adopted**

III. Community Access to Recovery Services
   a. Program Scope and Contracts(8)**Suggested frequency: annually**
   b. Northside Access Clinic(12)**Suggested frequency: one report**
   c. CCS(9)**Suggested frequency: semi annually**
   d. Substance Abuse Delivery System(14)**Suggested frequency: annually**
   e. Program evaluation/quality measures: **Suggested frequency: semiannually**
   f. CSP transition data: **Suggested frequency: quarterly in 2015**

IV. Quality Dashboard or Reports
   a. Re-admission rates(10)**Suggested frequency: quarterly**
   b. Inpatient census(5)**Suggested frequency: quarterly**
   c. Program utilization(11)**Suggested frequency: quarterly**
   d. Client Staff Injuries(17)**Suggested frequency: quarterly**
   e. Wait time for police at PCS(13)**Suggested frequency: quarterly**

V. Orientation to RFP/Contracting Process and how quality is measured(15)**One time presentation**

VI. Needing Clarification
   a. Psychiatric info(1)
   b. Arrest records(3)
   c. Board performance obligations for which Board is contractually bound: These are spelled out in the bill creating the Board. With further clarification of the request Corp Counsel might be able to make a presentation.

COUNTY OF MILWAUKEE
Behavioral Health Division Medical Staff Organization
Inter-Office Communication

DATE: November 20, 2014

TO: Kimberly R. Walker, JD, Chairperson, Milwaukee County Mental Health Board

FROM: Heather Martens, PsyD, President of the Medical Staff Organization
Prepared by Lora Dooley, Director of Medical Staff Services

SUBJECT: A Report from the President of the Medical Staff Organization Requesting Approval of the Behavioral Health Division Medical Staff Organization Bylaws

Background

Under Wisconsin and Federal regulatory requirements, the Medical Staff Organization must develop and adopt Bylaws. After adoption or amendment by the Medical Staff Organization, it is required that the proposed Bylaws be presented to the Governing Authority for action. Bylaws and amendments thereto become effective only upon Governing Authority approval. In accordance with Joint Commission standard MS.01.01.03 and CMS CoP §482.12(a)(4), neither the organized medical staff or the governing body may unilaterally amend the Medical Staff Bylaws.

Discussion

The following is a summary of the major changes proposed and adopted by the Behavioral Health Division Medical Staff Organization at their meeting of November 5, 2014:

SCOPE & REASON FOR CHANGE	
3.0 Article III - Appointment, Reappointment and Privileging	
3.5	Allied Health Professional - addition of licensed social workers and marriage/family therapists, in connection with Act 235 pilot (Treatment Director designee for initiation of emergency detentions)
3.6.2.1	Criminal Activities – (new addition) describes under what circumstances the medical staff may or must deny, modify or restrict membership and/or privileges
3.6.2.2	Administrative Denial – (new addition) describes under what circumstances the medical staff may deny an application
3.11	Reapplication After Adverse Action – (new addition) defines when an applicant may reapply for privileges impacted by an adverse action

3.12	Leave of Absence and Reappointment – (new addition) defines when leave of absence from the medical staff must be requested, the process for extending a leave, returning from leave and limitation(s) on length of leave, in conjunction with current appointment
3.13	Impaired Practitioners – (new addition) conforms with regulatory requirements that the medical staff and governing authority ensure practitioners' are able to safely exercise privileges
	5.0 Article V – Officers and Medical Administration
5.1	Officers – eligibility for two offices were revised to conform with current Wisconsin and CMS regulatory requirements that the leader of the Medical Staff Organization (President) must be either a physician, dentist or podiatrist. Due to succession issues, these criteria shall apply to both the Office of President and of Vice-President of the Medical Staff Organization.
5.1.3	Vice-President of Quality – (new addition) office may be held by any member of the active Medical Staff.
5.1.4	Members-At-Large – (new addition) there shall be two (2) elected seats to serve on the Medical Staff Executive Committee both to be held by psychologists.
5.3	Committees –the multidisciplinary medical staff committees will be re-designated as hospital committees (Pharmacy and Therapeutics, Institutional Review Board and Critical Incident). These committees shall all continue to report to the MEC and shall require the approval of the MEC on any recommendations impacting practitioners with privileges.
5.6	Medical Administrative Organization – responsibilities refined to remove employment related administrative functions and reflect only those that specifically relate to authority and responsibility as a medical staff organization "department chair."
	Appendix I – Correction Action
1.1	Initiation of Correction Action – revised in connection with applicant burden and what circumstance(s) affords no right to hearing or appeal
3.0	Suspensions – language modified to include hearing and appeal rights for summary suspensions lasting more than 14 days; additional causes for automatic suspension added related to DEA restrictions/ loss, Medicare/Medicaid sanctions or exclusions and when action is required under the Wisconsin Caregiver Law (DHS 12)
	Appendix II – Hearing and Appellate Review (Medical Staff)
1.1	Exclusionary criteria added related to applicants on temporary privileges
1.2	Hearing committee composition redefined (also under 4.1)
5.10	Right to legal counsel redefined

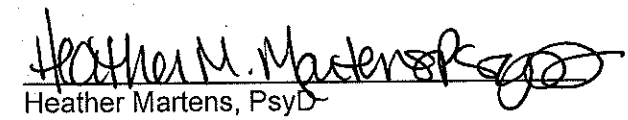
Appendix III - Fair Hearing and Appeal (Allied Health Professionals)

Allied Health professionals are not entitled to the same appellate rights under HCQIA, as Medical Staff. Therefore, a separate hearing and appeal process has been defined.

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve the Bylaws, as amended and adopted by the Medical Staff Organization at their meeting of November 5, 2014.

Respectfully Submitted,



Heather Martens, PsyD
President, BHD Medical Staff Organization

cc Patricia Schroeder, BHD Administrator
John Schneider, BHD Executive Medical Director
M. Kathleen Eilers, BHD/DHHS Transitional Liaison Designee
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, Senior Executive Assistant

Attachment
1 BHD Medical Staff Organization Bylaws, December 2014

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

BYLAWS
of the
MEDICAL STAFF ORGANIZATION

DECEMBER 2014

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MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
MEDICAL STAFF ORGANIZATION

BYLAWS

PREAMBLE

Whereas, the Milwaukee County Behavioral Health Division is organized under the laws of the County of Milwaukee and the State of Wisconsin and functions within the organizational framework established by the duly constituted authorities of the County of Milwaukee; and

Whereas, its purpose is to provide patient care, treatment, services, education, and research; and

Whereas, it is recognized that the Medical Staff Organization is self-governing in its responsibilities for overseeing quality medical and behavioral health care, treatment, and services provided by practitioners with privileges as well as for those providing education and research in the Milwaukee County Behavioral Health Division and within community sites; and

Whereas, the Medical Staff shall accept and discharge this responsibility subject to the Governing Authority of the Milwaukee County Behavioral Health Division; and

Whereas, the Milwaukee County Behavioral Health Division serves as a teaching resource for physicians and behavioral health professionals; and

Whereas, the cooperative efforts of the Medical Staff, the Administrative Staff and the Governing Authority are necessary to fulfill the obligations of the Behavioral Health Division to its patients and to the community;

Therefore, the Medical Staff of the Milwaukee County Behavioral Health Division hereby organize themselves in conformity with these Bylaws.

DEFINITIONS:

1. The term "Medical Staff" shall be interpreted to include licensed physicians (medical and osteopathic), licensed dentists, licensed podiatrists, and licensed psychologists. All "Medical Staff" shall have delineated clinical privileges and shall be eligible for membership in the Medical Staff Organization.

2. The term "Allied Health Professional" shall be interpreted to include licensed health care providers other than physicians, psychologists, dentists and podiatrists who are permitted by state law AND by the Hospital to provide patient care services within approved Hospital programs/services. Allied Health Professional Staff shall be categorized as independent or dependent and shall be permitted to practice with or without direction or supervision, based on the scope of his/her license, certification and/or registration and in conjunction with hospital approval and Medical Staff approval, when applicable. "Allied Health Professional" Staff shall not be eligible for membership in the Medical Staff Organization.

   A. Independent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, without the supervision or direction of a physician but in collaboration with a physician who is privileged and working with the same or very similar patient population and who is assigned to the same service or program. In accordance with these Bylaws and State and Federal standards, independent Allied Health Professional staff shall have delineated clinical privileges. Advanced Practice Nurses shall maintain a current collaboration agreement with a member of the Active or Affiliate staff.

   B. Dependent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, under the supervision or direction of a physician. It shall be determined by the Executive Medical Director or designee whether supervision shall be direct or indirect based on BHD scope of practice. In accordance with these Bylaws and State and Federal standards, dependent Allied Health Professional staff shall have delineated clinical privileges whenever such services and supplies are furnished as an incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

3. The term "Governing Authority" shall be interpreted to refer to the Milwaukee County Mental Health Board as created under Wisconsin Statute 15.195(9)

4. The term "Executive Committee" shall be interpreted to refer to the Executive Committee of the Medical Staff of the Milwaukee County Behavioral Health Division.

5. The term "Allied Staff" shall be interpreted to refer to clinical professional staff who provide service to patients under the direction of a member of the Medical Staff and do not have delineated clinical privileges. This group shall include but not be limited to registered nurses, social workers, occupational and music therapists, and non-licensed psychologists.

6. The term "Executive Medical Director" shall be interpreted to refer to the Executive Medical Director of the Milwaukee County Behavioral Health Division who shall serve as Chief Medical

Officer and have authority and responsibility for the overall medical and clinical management of the MCBHD.

7. The term "Administrator" shall be interpreted to refer to the Administrator of the Milwaukee County Behavioral Health Division and is equivalent to that of the position of Chief Executive Officer.

8. The term "Chief of Staff" shall be interpreted to refer to the President of the Medical Staff Organization.

9. The term "Chief Quality Officer" shall be interpreted to refer to the Deputy Administrator of the Milwaukee County Behavioral Health Division charged with overseeing clinical compliance.

1.0 ARTICLE I - NAME

The name of the organization shall be the "Medical Staff Organization of the Milwaukee County Behavioral Health Division (MCBHD)."

2.0 ARTICLE II - PURPOSE

The purpose of this organization shall be:

2.1 to ensure that all patients admitted to all programs of the MCBHD receive a uniform standard of quality patient care, treatment and services through participation in the following:

2.1.1 direction, review and evaluation of the quality of patient care through continuous hospital-wide and Medical Staff quality improvement monitoring activities;

2.1.2 ongoing monitoring of patient care practices;

2.1.3 delineation of clinical privileges for Medical Staff and Allied Health Professional Staff commensurate with individual credentials and demonstrated ability and judgment;

2.1.4 provision of continuing medical and professional education based on needs identified through monitoring and review, evaluation, and planning mechanisms; and

2.1.5 review of utilization of the MCBHD's resources to provide for the appropriate allocation to meet patient care needs;

2.2 to initiate and maintain Bylaws, Rules and Regulations and policies and procedures for self-governance of the Medical Staff, with at least biennial review of the Bylaws and Rules and Regulations. These reviews shall be more frequent, when necessary, to reflect the hospital's current practice;

2.3 to provide a means whereby issues may be discussed by the Medical Staff with the Executive Medical Director of MCBHD and the Governing Authority;

2.4 to promote educational programs and activities for staff and trainees; and

2.5 to promote programs in research, in order to advance knowledge and skills in the behavioral health sciences.

3.0 ARTICLE III - APPOINTMENT, REAPPOINTMENT AND PRIVILEGING

All new applicants seeking clinical privileges or current Medical Staff Members and Allied Health Professionals seeking amended clinical privileges shall be subject to the credentialing and privileging requirements in place, for privileges sought, at the time the initial privilege request or the privilege amendment is approved. Therefore, new applicants, current Medical Staff Members and Allied Health Professionals shall be held subject to any and all changes in credentialing and privileging requirements, for new privileges being sought, that are enacted during the period that the initial privilege request or privilege amendment is pending approval.

All credentialing and privileging requirements shall be as defined by these Bylaws. Methods for carrying out requirements shall be in accordance with Medical Staff policy and procedure.

3.1 Physician Qualifications. The applicant shall be a graduate of a recognized medical or osteopathic school and licensed to practice as a physician (medical or osteopathic) in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All physicians practicing within the hospital or its clinics shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. Applicants seeking tele-medicine privileges shall be licensed in the state of Wisconsin AND in the state from which the tele-service is provided, shall be privileged by the medical Staff but shall not be eligible for membership. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested.

3.2 Dentist Qualifications. The applicant shall be a graduate of a recognized dental school and licensed to practice dentistry in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All dentists shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested.

3.3 Podiatrist Qualifications. The applicant shall be a graduate of a recognized podiatric medical school and licensed to practice podiatry in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All podiatrists shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested.

3.4 Psychologist Qualifications. The applicant shall be a graduate of a recognized doctoral program in clinical or counseling psychology, licensed to practice psychology in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All psychologists who meet these qualifications shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal pre- or post-doctoral internship or fellowship training, commensurate to the privileges being requested.

3.5 Allied Health Professional Qualifications. The applicant shall be a graduate of a recognized master's degree program in their professional specialty and licensed, certified and/or registered to practice independently or dependently, as appropriate, in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All independent allied health professionals shall be privileged by the Medical Staff but shall not be eligible for membership in the Medical Staff Organization. Dependent allied health professionals shall be privileged when recommended by the Medical Staff and authorized by the Hospital. Allied health professional staff may include, but shall not be limited to, Advanced Practice Nurses (including Nurse Practitioners, Clinical Nurse Specialists and Nurse Midwives), Physician's Assistants, Optometrists, licensed Social Workers and Marriage

and Family Therapists authorized to participate in the Act 235 pilot. All applicants must demonstrate recent (within the last two years) practice experience or specialty training, commensurate to the privileges being requested.

3.6 Procedure for Appointment and/or Privileging.

3.6.1 Applicants for membership and/or privileges must meet the qualifications as specified above.

3.6.2 An applicant shall not be denied consideration for an appointment to the Medical Staff or for clinical privileges based on race, sex, age, disability, creed, color, sexual orientation, marital status, military service membership, arrest/conviction record (unless offense is substantially related to circumstances of position and/or licensed activity) or national origin.

3.6.2.1 Criminal Activities.

An applicant may have his or her application for membership and/or clinical privileges denied, modified or restricted and a member may have his or her Medical Staff membership or clinical privileges modified, restricted or revoked, when the individual has a conviction of, or a plea of guilty or no contest to any felony, or to any misdemeanor involving controlled substances; illegal drugs; Medicare, Medicaid, or insurance or health care fraud or abuse; violence against another; sexual misconduct; or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a healthcare program) operated or financed in whole or in part by any Federal, State or local government agency, even if not yet excluded, debarred, or otherwise declared ineligible.
(Reference Social Security Act Sec. 1128)

3.6.2.2 Administrative Denial.

The Medical Staff Office may, with the approval of the Executive Medical Director or Credentialing and Privileging Review Chairperson, deny any application for appointment or reappointment to the Medical Staff or Allied Health Professional Staff and/or application for clinical privileges, without further review, if it is determined that the applicant does not hold a valid Wisconsin medical/professional license and/or other registrations or certifications applicable to his/her practice and no application is pending; does not have adequate professional liability insurance, if required; is not eligible to receive payment from the Medicare or Medicaid programs or is currently excluded from any health care program funded in whole or in part by the federal government or by a state or local government; or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. Reference Wisconsin DHS 12: Caregiver Background Checks)

3.6.3 Applications for initial Medical Staff membership and/or clinical privileges shall be in writing, and the form shall include evidence of current licensure (including, registrations and/or certifications, as required), relevant training and experience (including all medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), current competence (including but not limited to names of peer

references, one of which shall be directed, a chronological list of all past and present hospital appointments and practice affiliations, military history, faculty or clinical teaching appointments, recent continuing education activities), and reasonable evidence of current ability to perform privileges requested (health status). The application form shall request information relating to involvement in any professional liability action, previously successful or currently pending challenges to or any voluntary or involuntary limitation or relinquishment of any licensure or registration, any limitation, reduction, or loss of medical or professional staff membership or clinical privileges at another hospital, whether voluntary or involuntary, whether ever reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan, whether they have any present or pending guilty or no contest pleas or convictions involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol. The application form shall request names of at least two (2) peers who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding applicant's current clinical ability, ethical character, and ability to work with others. Allied Health professional references may be provided by a physician when recent work activities do not include a direct contact/observation of performance by a peer. At least one peer reference must be from the same professional discipline as the applicant. These peer recommendations and all other documentation obtained in connection with the application shall become a part of the applicant's permanent record and shall be maintained by Medical Staff Services on behalf of the Credentialing and Privileging Review Committee and Medical Staff Organization. Applicants must consent to the inspection of records and documents related to the application. Applications shall include a request for specific clinical privileges. Allied Health Professional applications shall include approved written collaboration agreements, which include practice guidelines defining independent and/or dependent functions for which clinical privileges are being requested. Each applicant for Medical Staff membership and/or privileges shall be provided with a copy of and be oriented to the Bylaws, Rules and Regulations, and major policies of the Medical Staff, and shall agree in writing to abide by them.

3.6.4 Application for membership and/or privileges by physicians, dentists, podiatrists, psychologists, and allied health professionals shall be submitted to the Executive Medical Director or designee. The Executive Medical Director or designee shall be responsible for processing the application and obtaining all required and any additional supporting documentation. Application processing shall include the collection of at least two peer references and for verifying from the primary source or an equivalent primary source (i.e., AMA, AOA, ECFMG, ABMS, and/or FSMB) all required professional training (medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), required current professional licensure from the appropriate State Medical Board(s), DEA registration, and for querying the National Practitioner Data Bank (NPDB) and the Office of Inspector General List of Excluded Individuals and Entities (OIG-LEIE). Additional supporting documentation, including other hospital appointment and practice affiliation verifications, malpractice claims history verifications and recent continuing education may also be collected and used in the initial evaluation process. Before assigning initial clinical responsibilities, applicant identity is verified, criminal background check is completed and all applicable health screening requirements must be satisfied. Upon completion of the credentialing verification processes, the Executive Medical Director or designee shall transmit the application and all required and any supporting documentation to the Chief Psychologist (if applicable) and to the Service

Medical Director. The Chief Psychologist's recommendation, when applicable, shall be forwarded to the Service Medical Director by Medical Staff Services. The Service Medical Director's recommendation shall be forwarded to the Medical Staff Credentialing and Privileging Review Committee. Temporary privileges, for a period of not more than 120 days, may be granted to an applicant pending appointment and/or privileging after receiving a recommendation by the Credentialing and Privileging Review Committee or by the Chair acting on behalf of the Committee, provided the application is complete and meets all Category 1 application criteria. A Category 1 application means that all required verifications as established by the Medical Staff Credentialing and Privileging Review Committee are in place, applicant has no history of corrective action (hospital/licensing board), has a clean criminal background check, minimal or no malpractice history (1 or 2 dismissals and/or 1 or 2 settlements/payments of $30,000 or less or cases are older than 20 years), privilege requests are appropriate to training, and all references are good. No Medical Staff member shall be permitted to recommend approval of his/her own privileges or appointment.

3.6.5 The Credentialing and Privileging Review Committee shall review the application and supporting documentation, review and confirm the validity of the applicant's credentials and may conduct an interview with the applicant. Applicants shall be acted upon by this committee within 90 days upon application completion and verification of meeting all credentialing requirements, or reasonable attempts thereto, for all privileges requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application for appointment and/or request for clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation of acceptance or rejection to the Executive Committee. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The Executive Medical Director or Medical Staff Services, when designated shall notify the applicant of any areas of incompletion, question and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information within the next forty-five (45) days. Applicants who do not make reasonable attempts to resolve misstatements or omissions from the application or resolve doubts about qualifications, current abilities or credentials within forty-five (45) days, when additional information is requested by the Executive Medical Director or Medical Staff Services may, in the sole discretion of the Executive Medical Director, be deemed a voluntary withdrawal of the application due to incompleteness and shall not be subject to hearing rights under these Bylaws. If temporary privileges were granted pending completion of the application approval process, they will be deemed expired at this time.

3.6.6 The Executive Committee shall recommend to the Governing Authority that the application be accepted or rejected; and if accepted, provisional or full clinical privileges shall be granted. The Executive Committee, as represented by the Chairperson of the Credentialing and Privileging Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff appointment and/or clinical privileging.

3.6.7 Temporary Privileges.

The Administrator, or designee, acting on behalf of the Governing Authority and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the Governing Authority. Temporary privileges shall be granted by the Administrator or by one of the following authorized designees: the Executive Medical Director or the Chairperson of the Medical Staff Credentialing and Privileging Review Committee. No Medical Staff member shall be permitted to approve his/her own privileges.

3.6.7.1 Important Patient Care, Treatment or Service Need.

Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized Medical Staff verifies current licensure and current competence.

3.6.7.2 Clean Application Awaiting Approval (Category 1).

Temporary privileges may be granted for up to 120 calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the Medical Staff Executive Committee and approval by the Governing Authority. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the hospital: current licensure; education, training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required (when applicable); malpractice history; one positive reference specific to the applicant's competence from an appropriate medical peer; ability to perform the privileges requested; a query to the OIG-LEIE, and results from a query to the National Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1, expedited privileging consideration, as described in section 3.6.4 of these Bylaws.

3.6.7.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

3.6.7.4 Termination of temporary privileges: The Administrator, acting on behalf of the Governing Authority and after consultation with the President of the Medical

Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Executive Medical Director acting as the Administrator's designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

3.6.7.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II or Appendix III of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

3.6.8 Disaster privileges – Medical Staff Leadership, in collaboration with Hospital Leadership and the Governing Authority, has determined that disaster privileging shall not be utilized at the Behavioral Health Division (as a hospital specializing in psychiatric and behavioral care, instances would be too few where such volunteers would be required to come forward or would volunteer to come forward, to assist).

3.6.9 Telemedicine privileges - Licensed independent practitioners who are responsible for the care, treatment and/or services of an MCBHD patient via telemedicine link, including interpretive services, are subject to credentialing and privileging requirements and will be processed through one of the following mechanisms:

3.6.9.1 MCBHD shall fully privilege and credential the practitioner according to the processes described in sections 3.6.1 - 3.6.7 of these Bylaws; or

3.6.9.2 MCBHD may privilege practitioners using credentialing information from the distant site, if the distant site is a Joint Commission-accredited organization.

3.6.9.3 MCBHD may use the credentialing and privileging decision from the distant site if all of the following requirements are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization and has a direct contract/agreement with MCBHD to provide services;
2. The practitioner is privileged at the distant site for those services to be provided at MCBHD; and
3. MCBHD has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant

site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital.

3.6.10 An expedited Governing Authority approval process shall not be used.

3.7 Appointment and/or privileging. Medical Staff and Allied Health Professional appointment and/or clinical privileging shall be approved by the Governing Authority based on Medical Staff recommendations. Prior to a written decision of rejection, the Governing Authority shall meet with the President of the Medical Staff and the Chairperson of the Credentialing and Privileging Review Committee to review the recommendations and the concerns regarding the appointee's professional qualifications. The Credentialing and Privileging Review Committee Chairperson shall transmit the decision to the applicant. In cases of rejection, the applicant shall be informed and advised of his/her right to appeal in accordance with the provisions of Appendix II or Appendix III of these Bylaws. Medical Staff and Allied Health Professional appointment and/or privileging shall be for a period of no more than two (2) years. All initial appointments and privileges shall be subject to a provisional period of at least six (6) months and shall require a focused audit of practitioner performance prior to completion of the provisional privilege period. The decision to grant, limit or deny an initially requested privilege or existing privilege for renewal is communicated to the practitioner within 30 days of approval.

3.8 Reappointment and/or reprivileging. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for continued membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The applicant's failure to sustain this burden shall constitute cause for recommendation that the application for reappointment and/or privileges be denied. Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging shall be approved by the Governing Authority based on Medical Staff recommendations. Any significant misstatements in, falsifications in, or omissions from the reprivileging application shall constitute cause for the application to be deemed incomplete. The Executive Medical Director or Medical Staff Services shall notify the applicant of any areas of incompletion and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information prior to the Credentialing and Privileging Review Committee meeting at which the application is scheduled for review. Applicants who do not make reasonable attempts to resolve misstatements or omissions from the application or doubts about qualifications, current abilities or credentials, when requested, shall result in application being deemed incomplete and no further action shall be required. The Executive Committee, as represented by the Chairperson of the Credentialing and Privileging Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging. The recommendations of the Executive Committee shall be derived, in part, from the recommendations of the Credentialing and Privileging Review Committee, who will review and reappraise the individual based on information collected. Information collection shall include the required two-year NPDB query, re-verification of current professional licensure from the appropriate State Medical Board(s), and query of the OIG-LEIE. Additional information collection shall include statements regarding the applicant's current ability to perform privileges (health status), training and experience (continuing education specifically related to privileges being requested), and current competence (professional performance, judgment and clinical/technical skills as assessed by his/her supervisor and as indicated by the results of ongoing professional

practice evaluations and other Medical Staff monitors and peer review activities). A Medical Staff peer reference shall also be required, when the Service Medical Director or other supervisor is not a clinical peer. In the case of Allied Health Professionals, the physician collaborator shall also provide a reference or assessment of professional performance, judgment and clinical/technical skills, if s/he is not the supervisor. Applications for reappointment and/or reprivileging shall be acted upon prior to expiration of current appointment and/or privileges. Medical Staff and Allied Health Professional reappointment and/or reprivileging shall be for a period of no more than two (2) years.

All applicants seeking reappointment and/or reprivileging within the Active or Affiliate Medical Staff Category or Allied Health Professional Staff Category must have exercised all privileges held at least once every three months from date of last appointment (excepting applicants formally granted medical, family or other leave of absence or applicants who are assigned by the Executive Medical Director or his/her designee to provide vacation coverage on an as needed or seasonal basis) or s/he shall not be considered eligible for reappointment and/or reprivileging within those privilege areas that have not been utilized with sufficient frequency to allow for the required performance and current competency assessments. Applicants who do not utilize privileges held at least once every three months shall remain in good standing, as appropriate, upon expiration of such privileges. S/he shall remain eligible to reapply for appointment and/or such privileges should s/he so desire, and it is evident that s/he will be able to exercise such privileges with the required minimum frequency, and a current need and position vacancy in his/her specialty exists.

3.9 Clinical Privileges. All individuals permitted by law and by the MCBHD (as specified under sections 3.1 through 3.5 of these Bylaws) to provide patient care services independently, or dependently under the direction of a Medical Staff Member when privileging is recommended, shall have hospital specific delineated clinical privileges, whether or not they are members of the Medical Staff of the MCBHD. Physicians, Dentists, Podiatrists, Psychologists and Allied Health Professionals who are not staff members but who meet the above independent practice definition, may request privileges through the Medical Staff by submitting a written request to the Executive Medical Director or designee, who will review credentials and transmit the application to the appropriate Service Medical Director and to the Chief Psychologist, when applicable, and to the Credentialing and Privileging Review Committee.

3.9.1 The delineation of an individual's clinical privileges includes the limitations, if any, on the individual's privileges to treat patients or direct the course of treatment for the conditions for which the patient was admitted. Each patient cared for shall have a physical examination and/or medical history documented by a physician or authorized designee, such as an advanced practice nurse, privileged to perform such.

The physical examination shall include a thorough medical history and physical examination with all indicated laboratory examinations required to discover all structural, functional, systemic and metabolic disorders, and performance of a screening neurological exam. History shall include patient's past physical disorders, head trauma, accidents, substance dependence/abuse, exposure to toxic agents, tumors, infections, seizure or temporary loss of consciousness or headaches, and past surgeries. Screenings shall include a complete neurological exam, when indicated (i.e., system review indicates positive neurologic symptomatology); a record of mental status; the onset of illness and circumstances leading to admission; attitudes and behavior; an estimate of intellectual functioning, memory functioning and orientation; and an inventory of the patient's assets in a descriptive fashion. More than one practitioner may participate in the performance,

documenting and authentication of a history and physical for a single patient. The authenticating practitioner(s) shall be responsible for its content. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

If a physical examination was completed within 30 days of the patient's admission (or readmission), an update examination to document any changes in patient's condition is required within 24 hours after admission or re-admission. If the examining practitioner finds no change in the patient's condition since the history and physical was completed, s/he shall indicate in the patient's record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. However, any noted changes in the patient's condition must be documented in an update note and placed in the patient's record within 24 hours after admission [per DHS 124.14(3)(c)(2) and CMS 482.22(c)(5)(ii)].

3.9.2 Clinical privileges to dentists shall be limited to outpatient activities only and must be specifically defined. Each patient cared for by a dentist must have a physical examination entered into the medical record by a physician, certified nurse practitioner or physician's assistant staff member. The dentist shall perform the part of his or her patient's history and physical examination that relates to dentistry. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

3.9.3 Clinical privileges to podiatrists shall be limited to outpatient activities only and must be specifically defined. Each patient cared for by a podiatrist must have a physical examination entered into the medical record by a physician, certified nurse practitioner or physician's assistant staff member. The podiatrist shall perform the part of his or her patient's history and physical examination that relates to podiatry. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

3.9.4 Clinical privileges to allied health professionals must be specifically defined and shall be limited to activities within the individual's assigned service/program or to service provisions defined within a provider's service contract. Independent Allied Health Professional practice is permitted only in Hospital approved programs and services and must be in collaboration with the service(s)/program(s) attending physician(s). Certified nurse practitioners and physician's assistants may perform patient histories and physical examinations.

3.9.5 In an emergency, any Medical Staff member or Allied Health Professional who has clinical privileges is permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his or her Medical Staff status or clinical privileges, provided that the care provided is within the scope of the individual's license.

3.10 Revised Clinical Privileges. The Credentialing and Privileging Review Committee shall review all applications and supporting documentation to revise or amend current privileges. Applicants are required to submit documentation as to licensure (including certifications, registrations, as applicable), training and experience, current competence and ability to perform privileges requested. All requests to revise privileges shall require primary source (or equivalent primary source) verification of required training, primary source re-verification of required license(s),

registrations and/or certifications, a new NPDB query and OIG-LEIE query. Requests shall be acted upon by this committee within 90 days upon completion of the verification of the applicant's credentials and current ability to perform the privilege requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application and request for revised clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation of acceptance or rejection to the Executive Committee. All clinical privilege revisions shall be subject to a provisional period of at least six (6) months and shall require a focused audit demonstrating satisfactory practitioner performance prior to advancing from provisional to full privilege status.

3.11 Reapplication After Adverse Action.

3.11.1 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who did not exercise any of the hearing rights provided in Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were subject of the adverse action for a period of one (1) year from the date of the final adverse action.

3.11.2 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who exercised some or all of the hearing rights provided under Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.

3.12 Leave of Absence and Reappointment.

3.12.1 Any member of the active Medical Staff or Allied Health Professional who will be absent for a period of time exceeding twelve (12) weeks must provide written notification to the President of the Medical Staff and Executive Medical Director which may be done through Medical Staff Services as designee for both. Such notification shall state the start and, if known, anticipated end date of the leave and the reasons for the leave (e.g., military duty, additional training, family matters, or personal health). The Medical Staff Member or Allied Health Professional shall be responsible for arranging for coverage with his or her Service Medical Director during the leave. If the practitioner fails to return following the last day of the approved leave (including any extension granted up to the end of the current term of appointment), and does not reapply as described below, the practitioner shall be considered to have resigned his or her membership and/or clinical privileges and shall not be entitled to any hearing or appellate review. A request for appointment to the Medical Staff or Allied Health Professional Staff and clinical privileges subsequently received from a practitioner so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointment.

3.12.2 Upon timely return from leave of absence prior to expiration of the practitioner's then current appointment period, the practitioner shall be required to submit a written request for reinstatement to the Credentialing and Privileging Review Committee. The practitioner may be required to submit such additional information as may be relevant to his/her request for reinstatement, including interval status information. The Credentialing and Privileging Review Committee will review the request and submit their

recommendations to the Medical Staff Executive Committee. Thereafter, the process described for reappointment shall be followed.

3.12.3 A leave of absence may not extend beyond the term of the Medical Staff Member's or Allied Health Professional's current term of appointment. If the practitioner is not able to return from leave before his/her current appointment period and/or clinical privileges are set to expire but has submitted an application for reappointment and/or renewal of clinical privileges, action on the application will be deferred for up to two (2) years until the practitioner identifies, with reasonable certainty, the date of anticipated return from leave. Deferring the application due to continued leave of absence shall not give practitioners any rights to hearing or appeal. The practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The practitioner's membership and/or clinical privileges shall be considered expired between the time of expiration of the term in which the leave began and the date of reappointment.

3.13 Impaired Practitioners.

3.13.1 Because it is inevitable that from time to time, some Medical Staff Members and Allied Health Professionals will develop physical or mental conditions that may limit their ability to safely exercise the clinical privileges they have been granted, it shall be the responsibility of all Medical Staff and Allied Health Professionals to bring to the attention of the Executive Medical Director or his/her designee or the President of the Medical Staff, such conditions. Refer to Medical Staff Policy on Health and Welfare Ad Hoc Committee Responsibilities.

3.13.2 If, as a result of a practitioner's self-reporting of a condition, the Medical Staff Executive Committee recommends modification of status or privileges, the affected practitioner shall be notified, in writing, of the recommendation. The recommendation shall not be considered a professional review action, if the practitioner voluntarily accepts the recommendation. If the Medical Staff Executive Committee recommends modifications of appointment status or privileges due to the practitioner's condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the practitioner exercises the hearing rights under Appendix II or Appendix III.

3.14 Ethics and Ethical Relationships.

3.14.1 The Code of Ethics as adopted by the professional organizations of each member profession shall govern the professional conduct of the membership of the Medical Staff and all individuals privileged by the Medical Staff.

3.14.2 Medical Staff and Allied Health Professionals shall sign a statement prior to appointment and/or privileging indicating an understanding of the requirement to observe the ethical principles of their profession as well as those of the Milwaukee County Behavioral Health Division.

3.14.3 The Behavioral Health Division and Governing Authority shall take steps to protect and ensure the integrity of clinical decision making of all members of the Medical Staff and privileged Allied Health Professional Staff. Medical Staff and independent Allied Health

Professional clinical decisions shall be autonomous and based solely on identified needs of the patient, regardless of their ability to pay. Dependent Allied Health Professionals shall consult with and defer to their supervising physician or the unit/program/service attending physician regarding clinical decisions, as appropriate. Medical Staff and Allied Health Professional clinical decisions shall be protected from financial issues or influences such as compensation, incentives or financial risk. Ethical conflicts related to patient care decisions may be referred to the Ethics Committee.

4.0 ARTICLE IV – APPOINTMENT CATEGORIES

4.1 Active Medical Staff.

The active Medical Staff shall consist of fully licensed physicians and psychologists who are full or part-time employees of, or on contract with the Milwaukee County Behavioral Health Division who function as the primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team, including, where appropriate, emergency service care, consultation assignments, and supervisory assignments. Members of the active Medical Staff shall be eligible to vote, to hold office, and to serve on all Medical Staff committees. Those physicians or psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the active staff for a period recommended by the Credentialing and Privileging Review Committee.

4.2 Affiliate Medical Staff.

The affiliate Medical Staff shall consist of fully licensed physicians, dentists, podiatrists and psychologists who are hourly or part-time employees of, or on contract with the Milwaukee County Behavioral Health Division and do not function as a primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team. They shall be employed in a manner consistent with their professional preparation and qualifications within the overall plan of the Behavioral Health Division and be subject to the Bylaws and Rules and Regulations of the Medical Staff that are applicable to their profession. Members of the Affiliate Medical Staff shall not be eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff. Those physicians, dentists, podiatrists or psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the active Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

4.3 Consulting Medical Staff.

The consulting Medical Staff shall consist of fully licensed physicians, dentists, podiatrists and psychologists who may treat patients at the Behavioral Health Division, or who are only engaged in consultation with members of the Medical Staff such as for special cases or procedures, or to conduct research or for teaching and/or lecturing to medical students, psychiatric residents and fellows and/or psychology interns and fellows. The consulting Medical Staff will include those

physicians, dentists, podiatrists or psychologists who do not wish to accept a regular active appointment. Members of the consulting Medical Staff are not eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff. Appointment to the consulting Medical Staff may be with or without privileges.

4.4 Telemedicine Consulting Medical Staff.

The Telemedicine Consulting Medical Staff shall consist of fully licensed physicians who may treat patients at the Behavioral Health Division via an electronic link, but who are mainly engaged in consultation with members of the Medical Staff by providing radiological or cardiology interpretive services. Members of the Telemedicine Consulting Medical Staff shall not be eligible for Medical Staff membership and do not have the rights and privileges of a member of the Medical Staff to vote or to hold office or serve on committees.

4.5 Allied Health Professional Staff.

The allied health professional staff shall consist of fully licensed and certified Advanced Practice Nurses, Physician's Assistants, Optometrists or other licensed independent practitioners other than physicians, psychologists, dentists or podiatrists who are allied with the Medical Staff and who are permitted by law and by the hospital to practice independently or dependently. Allied health professional staff may be full or part-time employees, or employed by a Medical Staff Member on contract or independent contractors or employed by a Medical Service Contractor whose services have been authorized by Milwaukee County for the Milwaukee County Behavioral Health Division. Members of the allied health professional staff shall not be eligible for Medical Staff membership and do not have the rights and privileges of a member of the Medical Staff to vote or to hold office. Those allied health professionals who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the active or affiliate Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

4.6 Appointment Amendment.

A Medical Staff Member may, at any time, request modification of his/her staff category by submitting a written request. All Medical Staff appointments are subject to the eligibility criteria, as described in sections 4.1 through 4.4.

5.0 ARTICLE V - OFFICERS AND MEDICAL ADMINISTRATION

5.1 Officers and Members-At-Large

The officers of the Medical Staff shall be the President of the Medical Staff Organization, the Vice-President of the Medical Staff Organization and the Vice-President of Quality. The officers shall be elected biennially at a meeting of the Medical Staff Organization and shall hold office for the designated term or until a successor is elected. Each officer must be a member of the active Medical Staff. For the positions of President and Vice-President of the Medical Staff Organization,

the candidate must be either a physician, dentist or podiatrist. The Executive Medical Director and Chief Psychologist shall not be eligible to hold office.

There shall also be two (2) Members-At-Large positions. The qualifications for these positions are that each Member-At-Large must be a Member of the active Medical Staff and each must be a psychologist.

5.1.1 The President shall be elected for a two year term. S/he shall preside at meetings of the Medical Staff Organization and be Chairperson of the Executive Committee of the Medical Staff. S/he may delegate specific duties to the Vice-President of the Medical Staff Organization. The President may be re-elected to that office to succeed himself/herself for one additional term.

5.1.2 The Vice-president of the Medical Staff Organization shall be elected for a two year term. S/he shall act in the event of any absence of the President, and when acting in this capacity, s/he shall assume all the duties, responsibilities, and authority of the President. S/he shall be responsible for keeping complete minutes of all general Medical Staff Organization meetings, Executive Committee meetings and meetings on order of the President. S/he shall make recommendations to the Executive Committee concerning dues assessments, as necessary, and shall be accountable for all funds of the Medical Staff, and s/he shall report on receipts and disbursements of such funds. The Vice-President of the Medical Staff Organization may be re-elected to that office to succeed himself/herself for one additional term. In the event that the office of the President becomes permanently vacant, the Vice-President of the Medical Staff Organization shall succeed to the Presidency for the remainder of the term and a new Vice-President of the Medical Staff Organization shall be elected. In the event that a Vice-President of the Medical Staff Organization is unable to carry out his/her duties, a special election shall be held to fill his/her office.

5.1.3 The Vice-President of Quality shall be elected by special election in 2014 to serve for a three year term commencing January 1, 2015. Thereafter, this officer shall be elected for a two year term. S/he shall be responsible for oversight of quality processes throughout MCBHD and shall work closely with the Chief Medical Officer, Chief Quality Officer and Deputy Administrator on projects that improve quality and support the reduction of medical/healthcare errors and other factors that could contribute to unintended adverse patient outcomes. S/he shall serve on the Medical Staff Peer Review Committee for process oversight in an ex-officio capacity, without vote, serve on hospital administrative quality committees and make recommendations to the Executive Committee and Quality Council on such matters. The Vice-President of Quality may be re-elected to that office to succeed himself/herself. There shall be no restriction on the number of terms that s/he may serve. In the event that a Vice-President of Quality is unable to carry out his/her duties, a special election shall be held to fill his/her office.

5.1.4 The Members-At-Large positions are to represent the psychology community at the Medical Staff Executive Committee. There shall be two Members-At-Large selected by special election in 2014 with terms commencing January 1, 2015. One shall serve for a one year term and one shall serve for a two year term or until successors are elected. Thereafter, each Member-At-Large shall serve elected for a two-year term. There shall be no restriction on the number of terms that a Member-At-Large may serve. In the event that a Member-At-Large is unable to carry out his/her duties, a special election shall be

held to fill his/her seat on the Medical Staff Executive Committee. When only one nomination is put forth for a Member-At-Large position, the President of the Medical Staff may appoint that psychologist nominee to the vacant Member-At-Large position and shall communicate such appointment to the Medical Staff Organization.

5.2 Election and Removal of Officers and Members-At-Large.

5.2.1 Election of the President and the Vice-President of the Medical Staff Organization shall take place at the November meeting of the Medical Staff Organization that directly precedes the expiration of the term of the offices (even years). Office terms shall be for two years beginning January 1 (odd years).

Election of the initial Vice-President of Quality shall take place by special election in December 2014 for a three year term. Thereafter, the election shall take place at the November meeting (odd years) beginning in 2017 and office term shall then be for two years beginning January 1 (even years).

Elections of the initial Members-At-Large shall take place by special election in December 2014. Thereafter, there shall be one Member-At-Large election held each year at the November meeting of the Medical Staff Organization and each Member-At-Large term shall be for two-years. Election of the Members-At-Large shall be by the psychology members of the active Medical Staff.

Special elections shall be held within sixty days for elected positions vacant due to disability, ineligibility, or unavailability. Elections shall be by simple majority vote, including absentee ballots. Elections may be held at a regular or special meeting of the Medical Staff Organization or may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff.

5.2.2 In the event that an officer is unable to carry out his/her duties, and following a review by the Peer Review Committee, an officer may be removed from office by two-thirds majority vote of the Medical Staff as a whole. The removal of an officer shall be initiated by the joint recommendation of the Executive Medical Director or designee and Chief Psychologist or designee or on written request of any ten voting members of the Medical Staff.

In the event that a Member-At-Large is unable to carry out his/her duties, the procedure for removal of Executive Committee members in section 5.3.1 of these Bylaws shall be followed.

5.3 Committees of the Medical Staff.

The committees of the Medical Staff shall be the Executive, Credentialing and Privileging Review, and Medical Staff Peer Review. The President of the Medical Staff shall have the right upon taking office to appoint Chairpersons in collaboration with the Executive Medical Director and/or Chief Psychologist, as appropriate, and members unless specified otherwise in committee descriptions. The President of the Medical Staff and the Executive Medical Director shall be Ex-Officio members of all Medical Staff committees, as well as any special ad hoc committees, if not appointed as regular members. For purposes of conducting business, a membership quorum with a physician

majority must be present for all committees. If a quorum is not present, the chairperson may entertain a motion to recess, to fix the time to which to adjourn to allow selection of a new date and time, or to adjourn the meeting.

5.3.1 The Medical Staff Executive Committee.

The Medical Staff Executive Committee shall consist of the three elected officers of the Medical Staff, two psychologist Members-At-Large, the Chairperson of the Credentialing and Privileging Review Committee, the Chairpersons of the Medical Staff Peer Review Committee, the Executive Medical Director, the Service Medical Directors, and the Chief Psychologist. A majority of voting Medical Staff Executive Committee members shall be fully licensed physicians within the Active Staff. Selection and appointment of Medical Staff members, in addition to the aforementioned automatic appointments, may be made upon the joint recommendation by the Executive Medical Director, Chief Psychologist and Medical Staff President, subject to maintaining majority composition requirements, and shall be approved by the Committee. All members of the Medical Staff shall be eligible for membership on the Executive Committee. The Administrator, the Associate Administrator-Clinical Compliance, the Director of Nursing and the Director of Medical Staff Services shall attend each meeting on an ex-officio basis. The President of the Medical Staff shall chair the Medical Staff Executive Committee. The Medical Staff Executive Committee has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the Medical Staff process. Functions of the Medical Staff Executive Committee shall be as follows:

1. it shall be empowered to act for and represent the Medical Staff in the intervals between the general Medical Staff Organization Meetings. Such authority shall include the review, and recommendations for amendment of Medical Staff Bylaws and Rules and Regulations, the assessment of dues, and development, review, amendment and adoption of Medical Staff policies and procedures that form the system of rights, responsibilities, and accountabilities between the organized Medical Staff and the Governing Body and between the organized Medical Staff and its members;

2. it shall review and make Medical Staff committee appointments and Medical Staff committee chairperson appointments at the first meeting of each year, and at any other time it is deemed necessary;

3. it shall receive quarterly reports from the hospital-wide Quality Improvement Program and shall concern itself with programmatic, departmental and support service quality improvement activities as well as the results and corrective actions taken from such activities;

4. it shall concern itself with all matters affecting the delivery and quality of professional services and medical services in the hospital, the organization of the Medical Staff, and with reports and recommendations from the Credentialing and Privileging Review Committee, the Medical Staff Peer Review Committee, and any hospital committees or services that recommend actions that impact individuals with privileges;

5. it shall ensure Medical Staff representation and participation in any hospital deliberation affecting the discharge of Medical Staff responsibilities;

6. it shall ensure Medical Staff representation for the opportunity to participate and provide advice in any hospital leadership deliberation concerning the selection of medical services to be provided through a contractual arrangement (e.g., laboratory, radiological, pharmacy, rehabilitative, etc.) and in the selection of any medical or clinical staffing contractual arrangements [e.g., for dentists, podiatrists, physicians, psychiatrists, psychologists, advanced practice nurses, optometrists, physician's assistants or any other licensed independent practitioners (LIPs) or non-LIPs if privileges are required];

7. it shall provide liaison between the Medical Staff, the Executive Medical Director, and the Administrator of MCBHD as well as the Governing Authority;

8. it shall ensure that the Medical Staff is kept abreast of the accreditation/ regulatory compliance program and informed of the accreditation status of the hospital, and it shall direct the Medical Staff concerning its responsibilities in this area;

9. it shall coordinate the activities and policies governing the Medical Staff;

10. it shall communicate with the Allied Staff (defined in the Preamble of these Bylaws) through acceptable mechanisms as determined by their respective Clinical Discipline Heads and through mechanisms as determined by the appropriate Service Administrator for those Allied Staff who are not members of discipline departments;

11. it shall make recommendations directly to the Governing Authority for its approval, on matters relating to the following and other matters, as relevant:

    a. the structure of the Medical Staff;

    b. the participation of the Medical Staff in organization performance-improvement activities;

    c. the mechanisms used for evaluating individual professional practice;

    d. the mechanism used to review credentials and to delineate individual clinical privileges;

    e. recommendations of individuals for Medical Staff membership;

    f. recommendations for delineated clinical privileges for each eligible individual;

    g. the mechanism by which membership on the Medical Staff may be terminated;

    h. the mechanism by which clinical privileges may be terminated;

    i. the mechanism for fair hearing procedures; and

    j. other medical-administrative matters including sentinel events;

12. it shall take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff Members and Allied Health Professional Staff and shall request evaluation, by an appropriate body, in instances where there is doubt about an applicant's ability to perform privileges requested or privileges currently granted;

13. it shall review the Medical Staff Bylaws and Rules and Regulations at least every two years and make recommendations for revisions, as necessary, and shall review Medical Staff policies and procedures at least every three years and make revisions, as necessary;

    a. if the voting members of the Medical Staff Organization propose to adopt a rule, regulation or policy or an amendment thereto, they first communicate the proposal to the Medical Staff Executive Committee;

    b. if the Medical Staff Executive Committee proposes to adopt a rule, regulation or an amendment thereto, they first communicate the proposal to the Medical Staff;

    c. when the Medical Staff Executive Committee adopts a policy or an amendment thereto, they shall communicate this to the Medical Staff Organization;

    d. in cases of documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Staff Executive Committee may provisionally adopt and the Governing Body may provisionally approve an urgent amendment without prior notification of the Medical Staff. The Medical Staff shall be notified and have opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the Medical Staff Organization and the Medical Staff Executive Committee, the provisional amendment shall stand.

14. it shall receive and act on reports and recommendations from Medical Staff committees, hospital committees, clinical services, and assigned activity groups and make recommendations directly to the Governing Authority;

15. the Administrator or designee shall attend each Executive Committee Meeting on an ex-officio basis and may vote if s/he is a member of the Medical Staff;

16. it shall assure the provision of a single level of care to all patients, irrespective of the staff providing the care, by means of institution-wide and program specific standards of care, policies and procedures, monitors and corrective actions.

The Executive Committee shall meet as often as needed, but at least ten times per year, to represent the Medical Staff in the intervals between the general Medical Staff Organization meetings. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by two-thirds majority vote of the Executive Committee. The

removal of a member shall be initiated, with cause cited, by the joint recommendation of any two members of the Executive Committee.

5.3.2 The Credentialing and Privileging Review Committee.

The Credentialing and Privileging Review Committee shall consist of at least six members of the active Medical Staff to be comprised of a physician majority but with at least two psychologists. The Chairperson shall be a physician. The members and Chairperson shall be appointed by the President of the Medical Staff in collaboration with the Executive Medical Director and Chief Psychologist. The Director of Medical Staff Services shall attend each meeting on an ex-officio basis. This committee shall be responsible for establishing credentialing and privileging requirements for each profession, in conjunction with recommendations from the Service Medical Directors and the Chief Psychologist, when applicable, subject to Medical Staff Executive Committee and Governing Authority approval, and for evaluating and recommending all applicants for Medical Staff appointment, privileging, reappointment, reprivileging and privilege revisions to the Medical Staff Executive Committee and for conveying all recommendations of the Medical Staff Executive Committee to the Governing Authority for approval. It shall further be responsible for the delineation of privileges, recommending promotions to Active Staff and other changes in appointment or privileges and for making recommendations thereon to the Executive Committee of the Medical Staff. It shall review credentials, reports and references, as well as reports and records from Peer Review, Medical Records, Quality Management, and other Medical Staff committees, when appropriate, in order to formulate its decisions and recommendations.

This committee shall meet as often as needed, but at least quarterly, and shall report to the Medical Staff Executive Committee. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by request of the Chairperson to the Medical Staff President and Executive Medical Director and to the Chief Psychologist, as applicable.

5.3.3 Medical Staff Peer Review Committee.

There shall be a Medical Staff Peer Review Committee. A physician and a psychologist shall be selected to serve as Co-Chairpersons and shall be appointed by the President of the Medical Staff in collaboration with the Executive Medical Director and Chief Psychologist, as appropriate. The respective Chairpersons shall select three additional physicians and two additional psychologists from the active Medical Staff to serve as members. The Vice-President of Quality shall serve ex-officio, without vote. This committee shall be responsible for carrying out quality improvement activities including, but not limited to, the review of clinical performance of members of their discipline to assess compliance with discipline established standards of practice and codes of ethics, the review of Medical Staff monitors, compliance with established Medical Staff rules, regulations and policies, and initiation of corrective action, when indicated. This committee shall further be responsible for carrying out the same or similar review activities and initiation of corrective action, when indicated, for Allied Health Professional Staff. This committee may conduct a professional practice evaluation when questions arise through focused or ongoing professional practice evaluation activities, or through other mechanisms, regarding a practitioner's quality of care, treatment and service, professional competence, clinical judgment, ability to perform privileges held or

professional ethics, or when concerns regarding the provision of safe, high quality patient care are identified through clinical practice trends evidenced during the course of focused or ongoing professional practice evaluation or are triggered by single incident. In these instances, the committee shall assign one or more of its members to serve as peer investigator(s) for the specific practice concern. The Committee may consult with or seek assistance from other members of the Medical Staff or from an external source, in some circumstances, such as need for specialty review, when there are a limited number or no Medical Staff members within the required specialty or with the appropriate technical expertise on the Medical Staff or when the Medical Staff Peer Review Committee and/or Credentialing and Privileging Review Committee is/are unable to make a determination and requests an external opinion. Upon completion and committee discussion of the investigator(s) findings, the committee shall establish a monitoring plan, when appropriate, and set a time-limited duration. Whenever corrective action could result in consideration for reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee.

Ongoing professional review and required focused professional review activities associated with initial and provisional privileging may be delegated to members of the Medical Staff who are not members of this committee. All practitioners upon initial privilege approval or upon revised privilege approval shall be subject to a period of focused professional practice evaluation by his/her immediate supervisor or designee. Focused professional practice evaluation guidelines and evaluation monitors, for this purpose, shall be program or service specific and approved by the Medical Staff Peer Review Committee.

(Note: Per Wisconsin Stat. 146.37-Healthcare Services Review; civil immunity and 146.38-Healthcare Services Review; confidentiality of information and Title IV-Health Care Quality Improvement Act SEC 411 [42 U.S.C. sec 11111 et seq] Professional Review.

The Peer Review Committee shall meet as often as needed, but at least quarterly, and shall report in statistical or summary fashion only to the Medical Staff Executive Committee. All meetings of the Peer Review Committee shall be documented. Records of reviews, inquiries, proceedings and conclusions shall be maintained in accordance with State and Federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee at the discretion of the Co-chairpersons.

5.4 Committees (Other).

5.4.1 Joint Conference Committee.

The Joint Conference Committee shall consist of not more than two members of the Governing Authority one of whom must be an Officer, the Administrator, the Executive Medical Director, the President of the Medical Staff, the Vice-President of the Medical Staff Organization, the Vice-President of Quality, the Chief Psychologist and the Director of Nursing. This Committee shall be co-chaired by the President of the Medical Staff and a Governing Authority Officer.

This committee shall provide a direct avenue of communication between the MCBHD Medical Staff and the Governing Authority and shall be responsible for resolving issues and/or disputes between the two groups and to manage critical issues.

This committee shall meet at least semi-annually but may convene whenever deemed necessary by the Governing Authority, the Behavioral Health Division Administrator, the Executive Medical Director, or the MCBHD Medical Staff President.

5.4.2 Nominating Committee.

The Nominating Committee shall consist of three members of the active Medical Staff and shall include two physicians and one psychologist, selected by the Medical Staff at large at the May meeting of the Medical Staff Organization in the year when the biennial election of the President is scheduled (even years). The Nominating Committee shall serve as an ad hoc committee for a period of two years and shall reconvene, as necessary during the two year period for all other regularly scheduled elections or if should there be a need for a special election. Should there be a need to replace a member of the nominating committee, a new physician or psychologist, as appropriate, shall be selected by the Medical Staff at large at the next regular meeting of the Medical Staff Organization.

The Nominating Committee shall have the duty of preparing and presenting to the Medical Staff membership a slate of recommended candidates for the office(s) of the Medical Staff and the candidates for Member-At-Large at each meeting when an election is scheduled to take place or for any special election held. The Officers and Members-At-Large shall be nominated by any member of the active Medical Staff.

5.4.3 Ad Hoc Committees.

Ad Hoc Committees, as recommended by the Medical Staff Executive Committee, shall be formed through appointment by the President of the Medical Staff to address Medical Staff issues not within the responsibilities of the Medical Staff committees.

5.5 Medical Administrative Organization.

The Medical Administrative Organization shall include the positions of Executive Medical Director, the Service Medical Directors (Adult Inpatient, Child and Adolescent, Crisis, Community and Physical Care Services) and the Chief Psychologist.

All Medical Directors shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process. The Chief Psychologist shall be certified by an appropriate psychology board or affirmatively establish comparable competence through the credentialing process. All Medical Directors and the Chief Psychologist, as applicable to psychological services, shall be responsible or collaboratively responsible with Service Administrator(s) for the following, as appropriate to position and function within his/her MCBHD service:

1. all clinical related activities of his/her department;

2. administratively related activities of the department (service medical directors and clinical program directors shall be collaboratively responsible);

3. continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

4. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

5. recommending clinical privileges for each member of the department;

6. assessing and recommending to the Administrator and/or Governing Authority off-site sources for needed patient care, treatment and services not provided by the department or MCBHD;

7. integration of the department into the primary functions of the organization;

8. the coordination and integration of inter-departmental and intra-departmental services;

9. the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

10. recommending sufficient numbers of qualified and competent persons to provide care, treatment or service;

11. determining qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

12. the continuous assessment and improvement of the quality of care, treatment and services provided;

13. the maintenance of quality control programs, as appropriate;

14. the orientation and continuing education of all persons in the department; and

15. recommendations for space and other resources needed by the department.

5.5.1 Additional authority and responsibilities to the Medical Staff Organization shall be as follows:

1. serve as a voting member of the Medical Staff Executive Committee;

2. chair and/or serve on other Medical Staff committees, as appointed

3. be responsible for the Medical Staff Organization's adherence to State and Federal regulations as well as the monitoring and evaluation of required standards and shall work in conjunction with the Medical Staff Organization and MCBHD to facilitate compliance;

4. formulate recommendations for rules, policies and responsibilities reasonably necessary for proper discharge of Medical Staff and service responsibilities, subject to the approval of the Medical Staff Executive Committee and Governing Authority, when appropriate; and

5. request, through the President, that special meetings of the Medical Staff Organization be called, when deemed necessary for the proper clinical functioning of the MCBHD.

6.0 ARTICLE VI – MEETINGS

6.1 Regular Meetings and Agenda.

There shall be general meetings of the full Medical Staff Organization held at least quarterly. The agenda at each of these meetings shall be:

1. call to order;

2. reading of the minutes of the last regular meeting and of any special meetings held during the quarter and approval of said minutes;

3. unfinished business;

4. report from the Medical Staff Executive Committee regarding activities and actions including the results of Medical Staff and hospital quality management monitors and follow-up;

5. reports from chairpersons of other Medical Staff committees;

6. reports from branches, programs and services;

7. reports from the Administrator, Executive Medical Director and Associate Administrator-Clinical Compliance;

8. new Business; and

9. adjournment.

10. The last meeting of each calendar year shall be designated as the meeting at which election of officers and Members-At-Large shall occur in accordance with the office terms defined in section 5.1 of these Bylaws. Newly elected officers and Members-At-Large shall take office as of the first of the new year after the election. This item will be added to the agenda, as appropriate.

    Special elections may be held outside of a formal meeting in December 2014, in order to allow time to solicit nominations for the newly created office of Vice-President of Quality and the Members-At-Large to the Medical Staff Executive Committee.

6.2 Special Meetings and Agenda.

Special meetings of the Medical Staff Organization may be called at any time by the President, at the request of the Medical Staff Executive Committee, at the request of the Executive Medical Director, at the request of the Governing Authority and/or Administrator of MCBHD, or on written request of any ten voting members of the Medical Staff. Notification of a special meeting shall be published to the entire Medical Staff five days prior to the date set for the meeting.

The agenda at special meetings shall be limited to the reading of the notice calling the meeting, the transaction of only that business for which the meeting was called, and adjournment.

6.3 Attendance at Meetings.

Active Medical Staff - All Active Medical Staff who are assigned to a work week of 20 hours or more are required to attend 75% of the regularly scheduled quarterly meetings during each calendar year, unless excused by the President. Active Medical Staff who are assigned to a work week of less than 20 hours are required to attend at least one of the regularly scheduled quarterly meetings during each calendar year in order to maintain voting rights, unless excused by the President.

Affiliate Medical Staff - Affiliate Medical Staff may, but are not required to, attend meetings.

Consulting Medical Staff - Consulting Medical Staff may, but are not required to, attend meetings.

Allied Health Professional Staff - Allied Health Professional Staff may, but are not required to, attend meetings.

The Administrator, Director of Nursing, Associate Administrator-Clinical Compliance and Director of Medical Staff Services shall attend each meeting on an ex-officio basis.

Members of the Medical Staff, Allied Health Professional Staff and ex-officio attendees shall receive minutes from all regular and special meetings held

The President of the Medical Staff or his/her designee shall send a letter of reprimand to any Medical Staff Member not meeting the above requirements with copy of such letter placed in member's permanent record, with an additional copy sent to the Credentialing and Privileging Review Committee to be considered during the reappointment process.

6.4 Conduct of Meeting.

All meetings of the Medical Staff Organization and its Medical Staff committees shall be conducted according to the rules contained in "Robert's Rules of Order, Newly Revised" when they are appropriate and consistent with the Bylaws and Rules and Regulations of the Medical Staff.

7.0 ARTICLE VII - CORRECTIVE ACTION AND RIGHT OF APPEAL

7.1 Whenever the professional conduct or other activities of a Medical Staff Member are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective

action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Medical Staff appointment and/or privileges are detailed in Appendix I and Appendix II of these Bylaws.

Whenever the professional conduct or other activities of an Allied Health Professional are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Allied Health Professional appointment and/or privileges are detailed in Appendix I and Appendix III of these Bylaws.

8.0 ARTICLE VIII - HEARING AND APPELLATE REVIEW

8.1 Right to Hearing and to Appellate Review.

Whenever a Medical Staff Member or prospective Medical Staff Member is notified by the Credentialing and Privileging Review Committee of a recommendation that may adversely affect his/her Medical Staff appointment and/or clinical privileges, s/he shall be entitled to a hearing and appellate review, as outlined in Appendix II of these Bylaws.

Allied Health Professionals shall have a right to fair hearing but have no right to formal appellate review.

9.0 ARTICLE IX - RULES AND REGULATIONS

9.1 The Medical Staff Executive Committee shall adopt by a simple majority of quorum vote subject to physician majority of all voting members such Rules and Regulations as may be necessary for the proper conduct of its work. Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. Amendments shall be communicated, considered and acted upon in accordance with Section 5.3.1, subsection 13 of these Bylaws. Amendments so made shall become effective when approved by the Governing Authority.

10.0 ARTICLE X - BYLAWS

10.1 Amendments.

All voting members of the Medical Staff Organization shall be given written notice of any proposed amendment to these Bylaws at least ten days prior to the meeting at which a vote is scheduled to take place. The affirmative vote of two-thirds of the voting membership subject to physician majority shall be required for adoption of the proposed amendment(s). Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. An amendment vote may be held at a regular or special meeting of the Medical Staff Organization or may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff. Amendments so made shall become effective when approved by the Governing Authority.

Proposed amendments to these Bylaws may be originated by the Medical Staff Executive Committee or by a petition signed by ten or more members of the active Medical Staff.

10.2 Adoption.

These Bylaws, together with the appended Rules and Regulations, shall replace any previous Bylaws and Rules and Regulations. They shall, when adopted and approved, be equally binding on the Governing Authority, Medical Staff and privileged Allied Health Professional Staff.

11.0 ARTICLE XI - DUES

11.1 Authority.

Dues, as determined by the Executive Committee of the Medical Staff, may be assessed to voting members of the Medical Staff.

11.2 Assessment.

All members of the Medical Staff Organization holding appointment within the Active Staff Category (voting members) shall be required to pay dues within 45 days of receiving an assessment.

1. All new applicants who apply for and are formally appointed to the Active Staff on or before July 1 shall be required to pay dues during his/her initial appointment year, unless no dues are assessed for that year.

2. All new applicants who apply for and are formally appointed to the Active Staff after July 1 shall not be subject to a dues assessment until the following calendar year.

3. If a Medical Staff member is delinquent, payment of any outstanding dues assessment(s) must be made at time of application for reappointment.

11.3 Reporting.

In accordance with 5.0 Article V, Section 5.1.2, the Vice-president of the Medical Staff Organization shall be accountable for all funds of the Medical Staff. S/he shall report on receipts and disbursements of such funds to the Medical Staff Organization, at least annually. Dues accumulated within the treasury fund may be used for, but not limited to, the following purposes:

1. Bereavements
2. Birth/adoption of child by Medical Staff Member
3. Awards/Recognitions/Appreciations – Individual or Group
4. Scholarships/Education
5. Medical Staff Organization gatherings/functions
6. Other events/circumstances deemed to be appropriate

APPENDIX I

CORRECTIVE ACTION:

Section 1.0 General Procedures:

1.1 Initiation of Corrective Action.

Whenever the activities or professional conduct of a Medical Staff Member or Allied Health Professional deviates from the standards, are inconsistent with the aims of the Medical Staff or are disruptive to the operations of the hospital, corrective action against such Medical Staff Member or Allied Health Professional may be requested by an officer of the Medical Staff, the Executive Medical Director, a Service Medical Director or the Chief Psychologist, when applicable, or by the Administrator of MCBHD or Governing Authority. Applicants have the burden of producing adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. If an application is found to contain significant misstatements or omissions following appointment and/or privileging, this shall constitute cause for automatic relinquishment of membership and/or privileges with no right to hearing or appeal. All requests for corrective action shall be in writing, shall be made to the Peer Review Committee and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. Appropriate Civil Service procedures shall be followed, when indicated.

1.2 Reduction or Suspension of Clinical Privileges.

The Peer Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee. The Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.

1.3 Credentialing and Privileging Review Committee Interview:

Within ten (10) days after the Credentialing and Privileging Review Committee's receipt of Peer Review findings, the committee shall present a report to the Medical Staff Executive Committee. Prior to the presentation of such report, the Medical Staff Member or Allied Health Professional against whom corrective action has been requested shall have an opportunity for an interview with the Credentialing and Privileging Review Committee. At such interview, s/he shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing and shall be preliminary in nature. A

record of such interview shall be made by the Credentialing and Privileging Review Committee and included with its report to the Executive Committee.

1.4 Withdrawal of Initial Application for Medical Staff Appointment or Clinical Privileges:

A Medical Staff Member or Allied Health Professional may voluntarily withdraw his/her initial application for Medical Staff appointment or clinical privileges prior to a final action. Right to hearing and appellate review shall be forfeited at that time. Such withdrawals are generally not reportable to the National Practitioner Data Bank.

1.5 Withdrawal of Application for Renewal of Medical Staff Appointment or Clinical Privileges While Under Investigation:

A Medical Staff Member or Allied Health Professional who applies for renewal of Medical Staff appointment or clinical privileges and voluntarily withdraws that application while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or taking a professional review action, must be reported to the National Practitioner Data Bank.

Section 2.0 Medical Staff Executive Committee Authority:

2.1 The action of the Medical Staff Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend: a.) reduction, b.) suspension or c.) revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that a Medical Staff Member's membership be suspended or revoked. Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Appendix II (Hearing and Appellate Procedure: Medical Staff). Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion shall entitle the affected Allied Health Professional to the procedural rights provided in Appendix III (Fair Hearing and Appeal Procedure: Allied Health Professionals).

2.2 Responsibilities.

The President of the Medical Staff shall promptly notify the Administrator of MCBHD, in writing, of all requests for corrective action received by the Medical Staff Executive Committee and shall continue to keep the Administrator of MCBHD fully informed of all action taken. After the Medical Staff Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Appendix II or Appendix III of these Bylaws.

Section 3.0 Suspensions:

3.1 Summary.

Any one of the following--the President of the Medical Staff, the Executive Medical Director, the Chief Psychologist (limited to psychologists), the Administrator, the chairperson of the Credentialing and Privileging Review Committee, or the Governing Authority—shall each have the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition and amendment.

Circumstances which would lead to immediate summary suspensions would include inebriation while on duty, sexual misconduct with patients or other caregiver misconduct, conviction of a felony involving violence to others, or any other intentional act performed that endangers patient safety or is considered to be in clear violation of professional ethics.

3.2 Temporary.

A Medical Staff Member whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request that the Credentialing and Privileging Review Committee of the Medical Staff hold a hearing on the matter. The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within 30 days shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter under Appendix II of these Bylaws. The Credentialing and Privileging Review Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Credentialing and Privileging Review Committee does not recommend immediate termination of the summary suspension, the affected Medical Staff member shall be entitled to request an appellate review by the Governing Authority. The summary suspension, as sustained or as modified by the Credentialing and Privileging Review Committee, shall remain in effect pending a final decision by the Governing Authority.

An Allied Health Professional whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request a meeting on the matter before two physicians and one peer, appointed by the President. The failure of an Allied Health Professional to request a meeting from the President to which s/he is entitled by these Bylaws, within (30) days shall be deemed a waiver of his/her right to such a fair hearing and to any appeal to which s/he might otherwise have been entitled on the matter in under Appendix III of these Bylaws.

3.3 Automatic.

A temporary suspension in the form of a withdrawal of a Medical Staff Member's or Allied Health Professional's clinical privileges, effective until medical records are

completed, shall be imposed automatically seventy-two (72) hours after final warning of delinquency for failure to complete medical records within the time allotted by the hospital. Notification of such suspension to the Medical Staff Member or Allied Health Professional and appropriate hospital authorities shall be made by the Executive Medical Director or designee.

Action by the State Board of Examiners revoking or suspending a Medical Staff Member's or Allied Health Professional's license, or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain current professional licensure shall automatically suspend all of his/her hospital privileges.

Action by the federal Drug Enforcement Administration revoking or suspending a Medical Staff Member's or Allied Health Professional's registration or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain registration, when required, shall automatically suspend his/her prescriptive authority. Automatic suspension of all hospital privileges shall be considered whenever circumstances warrant.

Action by Medicare/Medicaid resulting in exclusion or suspension from participating in these programs or becoming subject to conviction or offense under DHS 12 Wisconsin Caregiver Laws shall automatically suspend all of his/her hospital privileges.

It shall be the duty of the President of the Medical Staff to cooperate with the Administrator of MCBHD in enforcing all automatic suspensions.

APPENDIX II

HEARING AND APPELLATE REVIEW: PROCEDURE (MEDICAL STAFF)

Section 1.0 Right to Hearing and to Appellate Review:

1.1 Whenever a Medical Staff Member or Medical Staff privilege applicant receives a notice of a recommendation by the Credentialing and Privileging Review Committee which, if approved by decisions of the Medical Staff Executive Committee and the Governing Authority, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges or is summarily suspended for a period of more than 14 days, s/he shall be entitled to a hearing before the Medical Staff Executive Committee. If the recommendation of the Medical Staff Executive Committee following such hearing is still adverse to the affected practitioner, s/he shall then be entitled to an appellate review by the Governing Authority before s/he makes a final decision on the matter.

Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II of these Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

1.2 When any Medical Staff Member receives notice of a decision by the Governing Authority that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges and such decision is not based on a prior adverse recommendation by the Credentialing and Privileging Review Committee of the Medical Staff, s/he shall be entitled to a hearing. Such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the active Medical Staff who are discipline peers appointed by the Chair of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee. If such a hearing does not result in a favorable recommendation, s/he shall be entitled to an appellate review by the Governing Authority, before a final decision on the matter is made.

1.3 All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Appendix II to assure that the affected practitioner is accorded all rights to which s/he is entitled.

The notice of hearing shall state in concise language the acts or omissions with which the Medical Staff Member is charged, a list of specific or representative medical records being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 2.0 Request for Hearing:

2.1 The President of the Medical Staff or his/her designee shall be responsible for giving prompt written notice, by certified mail (return receipt requested) or by hand delivery, of an adverse recommendation or decision to any affected Medical Staff Member who is entitled to a hearing or to an appellate review.

2.2 The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within thirty (30) days of receipt of the written notice by certified mail (return receipt requested) or by hand delivery, shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter.

2.3 When the waiver of hearing or appellate review relates to an adverse recommendation of the Credentialing and Privileging Review Committee of the Medical Staff or of a hearing committee appointed by the Medical Staff Executive Committee, the same shall thereupon become and remain effective against the staff member pending decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Authority, the same shall thereupon become and remain effective against the Medical Staff Member in the same manner as a final decision of the Governing Authority, provided for in Section 7.0 of this Appendix II. The President of the Medical Staff shall promptly notify the affected Medical Staff Member of this status by certified mail (return receipt requested) or by hand delivery.

Section 3.0 Notice of Hearing:

3.1 Within ten (10) days after receipt of a request for hearing from a Medical Staff Member , the Medical Staff Executive Committee or the Credentialing and Privileging Review Committee, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President of the Medical Staff, notify the Medical Staff Member of the time, place and date so scheduled, by certified mail (return receipt requested) or by hand delivery. The hearing date shall not be less than fifteen (15) days, nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Medical Staff Member who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than fifteen (15) days from the date of receipt of such staff member's request for hearing.

3.2 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the Administrator, in conjunction with the President of the Medical Staff, shall schedule the hearing and shall give written notice to the practitioner who requested the hearing. The notice shall include:

a) The time, place and date of the hearing;

b) A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the Medical Staff Executive Committee, (or Governing Authority), at the hearing;

c) The names of the hearing panel members and presiding officer or hearing officer, if known; and

d) A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to, in writing, by both parties.

Section 4.0 Composition of Hearing Committee:

4.1 When a hearing relates to an adverse recommendation of the Credentialing and Privileging Review Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the active Medical Staff who are discipline peers appointed by the Chairperson of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

4.2 When a hearing relates to an adverse decision of the Medical Staff Executive Committee that is contrary to the recommendation of the Credentialing and Privileging Review Committee, the Medical Staff President shall appoint a hearing committee of not less than three (3) individuals to conduct such hearing and shall designate one of the members of said committee as Chairperson. At least one representative from the Medical Staff shall be included on this committee.

Section 5.0 Conduct of Hearing:

5.1 There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

5.2 An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of minutes.

5.3 The presence of the Medical Staff Member for whom the hearing has been scheduled shall be required. A Medical Staff Member who fails without good cause to appear at

such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2.0 of this Appendix II and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 2.0 of this Appendix II.

5.4 Postponement of hearing beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponement shall only be for cause shown and at the sole discretion of the hearing committee.

5.5 The affected Medical Staff Member shall be entitled to be accompanied by and/or represented at the hearing by an attorney, a member of the Medical Staff in good standing or by a member of his/her local professional association.

5.6 The Chairperson of the hearing committee or his/her designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

5.7 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

5.8 The Credentialing and Privileging Review Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff Member to represent it at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses. The Medical Staff Executive Committee, when its action has prompted the hearing, shall appoint one of its members to represent the committee at the hearing, to present the facts in support of the adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected Medical Staff Member shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved a lack of any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

5.9 The affected Medical Staff Member shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the Medical Staff Member does not testify in his/her own behalf, s/he may be called and examined as if under cross-examination.

5.10 The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct.

Accordingly, both sides shall be entitled to be represented by counsel of their choosing, in connection with preparation for the hearing or for a possible appeal.

5.11 The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon conduct its deliberations outside the presence of the staff member for whom the hearing was convened.

5.12 Within five (5) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Credentialing and Privileging Review Committee or to the Medical Staff Executive Committee, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Credentialing and Privileging Review Committee or decision of the Medical Staff Executive Committee.

Section 6.0 Appeal to the Governing Authority:

6.1 Within seven (7) days after receipt of a notice by an affected Medical Staff Member of an adverse recommendation or decision made or adhered to after a hearing as above provided, s/he may, by

a. written notice to the Governing Authority, then

b. delivered through the President of the Medical Staff by certified mail (return receipt requested) or by hand delivery

c. request an appellate review by the Governing Authority.

Such written notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Medical Staff Member's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

6.2 If such appellate review is not requested within seven (7) days, the affected Medical Staff Member shall be deemed to have waived his/her right to the same and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 7.2 of this Appendix II.

6.3 Within ten (10) days after receipt of such notice of request for appellate review, the Governing Authority shall schedule a date for such review, including a time and place for oral argument if such has been requested and shall, through the President of the Medical Staff by written notice sent by certified mail (return receipt requested) or by hand delivery, notify the affected Medical Staff Member of the same. The date of the appellate review shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request for appellate review, except that

when the Medical Staff Member requesting the review is under a suspension which is currently in effect, such review shall be scheduled as soon as the arrangements can reasonably be made but not more than ten (10) days from the date of receipt of such notice.

6.4 The appellate review shall be conducted by the Governing Authority or by a duly appointed appellate review committee appointed by the Governing Authority of not less than three (3) members with one designated as Chairperson.

6.5 The affected Medical Staff Member shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. S/he shall have seven (7) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which s/he disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Authority through the President of the Medical Staff by certified mail (return receipt requested) or by hand delivery, at least five (5) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Credentialing and Privileging Review Committee of the Medical Staff. The President of the Medical Staff shall provide a copy thereof to the Medical Staff Member at least five (5) days prior to the date of such appellate review by certified mail (return receipt requested) or by hand delivery.

6.6 The Governing Authority or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to subparagraph 6.5 of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Medical Staff Member was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected Medical Staff Member shall be present at such appellate review, s/he shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The Credentialing and Privileging Review Committee or the Medical Staff Executive Committee, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

6.7 New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, may be introduced at the appellate review under unusual circumstances, and the Governing Authority or the committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.

6.8 If the appellate review is conducted by the Governing Authority, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Credentialing and Privileging Review Committee of the Medical Staff for further review

and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

6.9 If the appellate review is conducted by a committee appointed by the Governing Authority, such committee shall, within seven (7) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Authority affirm, modify or reverse its prior decision or refer the matter back to the Credentialing and Privileging Review Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Authority as above provided.

6.10 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6.0 have been completed or waived.

Section 7.0 Final Decision by the Governing Authority:

7.1 Within ten (10) days after the conclusion of the appellate review, the Governing Authority shall make his/her final decision in the matter and shall send notice thereof to the Credentialing and Privileging Review Committee and, through the President of the Medical Staff, to the affected Medical Staff Member, by certified mail (return receipt requested) or by hand delivery. This decision shall be immediately effective and final and shall not be subject to further hearing or appellate review. All final decision adverse actions shall be reported to the National Practitioner Data Bank.

7.2 Notwithstanding any other provision of these Bylaws, no Medical Staff Member shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MCBHD, or by a duly authorized committee appointed by the Governing Authority.

APPENDIX III

FAIR HEARING AND APPEAL: PROCEDURE (ALLIED HEALTH PROFESSIONALS)

Section 1.0 Right to Fair Hearing:

1.1 Allied Health Professional Staff are not entitled to the hearing and appeals procedures set forth in Appendix II of these Bylaws. In the event an Allied Health Professional receives notice of a recommendation by the Medical Staff Executive Committee that will adversely affect his/her exercise of clinical privileges, the Allied Health Professional and his/her supervising physician shall have the right to meet personally with two physicians and one peer assigned by the President of the Medical Staff to discuss the recommendation.

1.2 The Allied Health Professional and the supervising physician must request such a meeting, in writing, to the Administrator within ten (10) business days from the date of receipt of such notice. At the meeting, the Allied Health Professional and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing as specified for Medical Staff members and none of the procedural rules set forth in Appendix II of these Bylaws with respect to such hearings shall apply. The meeting shall take place as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the request for meeting unless an earlier date has been specifically agreed to, in writing, by both parties

1.3 Within five (5) days after the fair hearing meeting, findings from this review body will be forwarded to the affected Allied Health Professional, the Medical Staff Executive Committee and the Governing Authority.

Section 2.0 Right to Appeal:

2.1 The Allied Health Professional and the supervising physician may request an appeal, in writing, to the Administrator within ten (10) calendar days of receipt of the findings of the review body. The Administrator shall so notify the Governing Authority of the request.

2.2 Within ten (10) calendar days after receipt of such notice of request for appeal, the Governing Authority shall schedule a date for such review, including a time and place through the Administrator, who shall by written notice sent by certified mail (return receipt requested) or by hand delivery notify the affected Allied Health Professional and supervising physician of the same. The date of the appeal shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request.

2.3 Two members of the Governing Authority assigned by the Governing Authority Chair shall hear the appeal from the Allied Health Professional and the supervising physician. A representative from the Medical Staff leadership (Officer, Executive Medical Director

or Service Medical Director) may be present. The decision of the appeal body will be forwarded to the Governing Authority for final decision within five (5) days of hearing the appeal.

Section 3.0 Final Decision:

3.1 The Allied Health Professional and the supervising physician will be notified within ten (10) calendar days of the final decision of the Governing Authority.

3.2 Notwithstanding any other provision of these Bylaws, no Allied Health Professional shall be entitled as a right to more than one hearing and one appeal on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MCBHD, or by a duly authorized committee appointed by the Governing Authority.

BYLAWS
OF THE
MEDICAL STAFF ORGANIZATION
OF THE
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

Approved and Adopted by the Medical Staff Organization
of the Milwaukee County Behavioral Health Division
in accordance with existing Bylaws
November 5, 2014

Date _____ Heather Martens, PsyD, President of the Medical Staff
Milwaukee County Behavioral Health Division

And

Approved and Adopted by the Milwaukee County Mental Health Board as Governing Authority
of the Milwaukee County Behavioral Health Division
in accordance with existing Bylaws
December 2014

Date _____ Kimberly R. Walker, JD, Chairperson
Milwaukee County Mental Health Board

Reviewed and Supported by Hospital Administration

Date _____ John H. Schneider, MD, FAPA, Executive Medical Director
Milwaukee County Behavioral Health Division

Date _____ Patricia Schroeder, RN, MSN, MBA, FAAN, Administrator
Milwaukee County Behavioral Health Division

References: (REGULATORY PUBLICATION DATES BELOW TO BE UPDATED)

- Joint Commission CAMH, July 2014 Refreshed Core
- CMS Conditions of Participation, State Operations Manual - Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals *(Rev. 116, 06-06-14)*
- CMS Revised Guidance Related to New & Revised Hospital Governing Body and Medical Staff Regulations, Ref: S&C: 14-45-Hospital (9-15-14)
- CMS Subpart E—Requirements for Specialty Hospitals, Sec 482.60 – 482.62
- Wisconsin State Statutes: 15.195(9); 50.36; 146.37, 146.38
- Title IV-Health Care Quality Improvement Act SEC 411 [42 U.S.C.sec 11111 et seq] Professional Review
- "Robert's Rules of Order"
- Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment Medicaid Integrity Group, August 2010
- Social Security Act, Sec 1128
- Wisconsin Administrative Code, DHS 12 (Caregiver Background Checks) and DHS 124 (Hospitals)
- National Association of Medical Staff Services – Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals, February 2014

DATES REVISED:
(Previous revision dates not kept)

June, 1986
December,1989; Addenda July, 1990 and March, 1991
December 1991; Addenda April, 1992 and June, 1993
April 1994
July 1994
September 1994
November 1996
August 1997
November 1998
November 2000
January 2002
September 2002
September 2004
March 2008
October 2010
December 2011
May 2012
February 2013
November 2014

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COUNTY OF MILWAUKEE
Behavioral Health Division Medical Staff Organization
Inter-Office Communication

DATE: November 20, 2014

TO: Kimberly R. Walker, JD, Chairperson, Milwaukee County Mental Health Board

FROM: Heather Martens, PsyD, President of the Medical Staff Organization
Prepared by Lora Dooley, Director of Medical Staff Services

SUBJECT: **A Report from the President of the Medical Staff Organization Requesting Approval of Appointment and Privilege Recommendations Made by the Medical Staff Executive Committee**

Background

Under Wisconsin and Federal regulatory requirements, all physicians and all other practitioners authorized under scope of licensure and by the hospital to provide independent care to patients must be credentialed and privileged through the Medical Staff Organization. Accepting temporary privileges for an immediate or special patient care need, all appointments, reappointments and privileges for each physician and other practitioners must be approved by the Governing Body.

Discussion

From the President of the Medical Staff and Chair of Credentialing and Privileging Review presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C[1]:

A. New Appointment

B. Reappointments

C. Provisional Period Reviews / Status Changes

D. Notations Reporting (to be presented in **CLOSED SESSION** in accordance with protections afforded under Wisconsin Statute 146.38)

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve all appointments and privilege recommendations, as submitted by the Medical Staff Executive Committee.

Respectfully Submitted,

Heather Martens, PsyD
President, BHD Medical Staff Organization

cc Patricia Schroeder, BHD Administrator
John Schneider, BHD Executive Medical Director
Clarence Chou, MD, BHD Chairperson, Medical Staff Credentialing and Privileging Review
M. Kathleen Eilers, BHD/DHHS Transitional Liaison Designee
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, Senior Executive Assistant

Attachment
1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
NOVEMBER/DECEMBER 2014

The following credentials files were reviewed. Privilege recommendations/actions were made based on information related to qualifications, current competence and ability to perform privileges (health status). All requisite primary source verifications or queries were obtained and reviewed regarding professional training, professional licensure(s), registrations, National Practitioner Data Bank and OIG-List of Excluded Individuals and Entities & System Award Management. Decisions were further based on Service Chief (Medical Director and Chief Psychologist, when applicable) recommendations, peer recommendations when applicable, focused or ongoing (FPPE/OPPE) professional practice evaluation data, malpractice claims history and verification of good standing with other hospitals/practices. Notations reporting shall be presented at the Board Meeting in closed session.

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 5, 2014	MEDICAL STAFF EXECUITVE COMMITTEE NOVEMBER 20, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Amit Bhavan, MD	Psychiatric Officer; Medical Officer	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
Richard L'Amie, MSW	51.15 Treatment Director Designee (Act 235 Pilot)	Allied Health/ Provisional		Dr. Moisio recommends appointment & privileges, as requested	Committee recommends appointment to 5/1/16 and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
Yang Lo, MSW	51.15 Treatment Director Designee (Act 235 Pilot)	Allied Health/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends appointment to 5/1/16 and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
REAPPOINTMENT / REPRIVILEGING	**PRIVILEGE GROUP(S)**	**APPT CAT/ PRIV STATUS**	**NOTATIONS**	**SERVICE CHIEF(S) RECOMMENDATION**	**CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 5, 2014**	**MEDICAL STAFF EXECUITVE COMMITTEE NOVEMBER 20, 2014**	**GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)**
Anne Dunn, MSN	Advanced Practice Nurse-Psychiatric and Mental Health	Allied Health / Full		Dr. Schneider recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Tanya Heinrich, MD	General Psychiatry; General Medical Practice	Active / Full	MA	Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Cynthia Love, MD	General Psychiatry; Child Psychiatry; General Medical Practice	Active / Full		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Heather Martens, PsyD	General Psychology-Adult; Extended Psychology-Acute Adult Inpatient	Active / Full		Dr. Riggle and Dr. Khazi recommend appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Kemba McCain, MSN	Advanced Practice Nurse-Family Practice	Allied Health / Full		Dr. Puls recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
John Prestby, PhD	General Psychology-Adult	Active / Full	CB/HS/PR	Dr. Riggle and Dr. Schneider recommend appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Dawn Puls, MD	General Medical Practice	Active / Full		Dr. Schneider recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 5, 2014	MEDICAL STAFF EXECUITVE COMMITTEE NOVEMBER 20, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Robert Ruskiewicz, MD	General Psychiatry; General Medical Practice	Affiliate / Full		Dr. Schneider recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Shuba Samuel, MSN	Advanced Practice Nurse-Family Practice	Allied Health / Full		Dr. Puls recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Pamela Wolfe, MD	General Psychiatry; General Medical Practice	Active / Full	MA	Dr. Khazi recommends appointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
PROVISIONAL STATUS CHANGE REVIEWS	**PRIVILEGE GROUP(S)**	**CURRENT CATEGORY/ STATUS**	**NOTATIONS**	**SERVICE CHIEF RECOMMENDATION**	**CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 5, 2014**	**MEDICAL STAFF EXECUITVE COMMITTEE NOVEMBER 20, 2014**	**GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)**
Mohammed Rahemtulla, DO	Psychiatric Officer; Medical Officer	Affiliate/ Provisional		Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	

Clarence Chen (MDI)
CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE
(☐OR PHYSICIAN COMMITTEE MEMBER DESIGNEE)

11/20/14
DATE

PRESIDENT, MEDICAL STAFF ORGANIZATION
CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

11/20/14
DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

RECOMMENDATIONS OF THE MCBHD MEDICAL STAFF CREDENTIALING & PRIVILEGING REVIEW AND MEDICAL STAFF EXECUTIVE COMMITTEES WERE REVIEWED. ALL PRIVILEGE AND APPOINTMENTS ARE HEREBY GRANTED AND APPROVED, AS RECOMMENDED BY THE MEC, UNLESS OTHERWISE INDICATED ABOVE.

GOVERNING BOARD CHAIRPERSON

DATE APPROVED

MEDICAL STAFF GOVERNING DOCUMENTS AND POLICY/ PROCEDURE UPDATES	MEDICAL STAFF ACTION	GOVERNING BODY ACTION
MEDICAL STAFF ORGANIZATION BYLAWS – Amendments require approval of both the Medical Staff and the Governing Authority. Neither body may unilaterally amend the Medical Staff Bylaws.	ADOPTED BY THE MEDICAL STAFF ORGANIZATION AT THEIR MEETING OF NOVEMBER 5, 2014	GOVERNING BODY REVIEW AND RECOMMENDATION REQUIRED ☐_____AMENDMENTS APPROVED ☐_____ AMENDMENTS NOT APPROVED – Report detailing specific objections to be returned to MSO. Board Chairperson Initials Above Board Action