

Chairman: Kimberly Walker
Vice-Chairman: Peter Carlson
Secretary: Robert Chayer
Board Clerk: Jodi Mapp, 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, July 17, 2014 - 8:00 A.M.
 Milwaukee County Mental Health Complex Auditorium

MINUTES

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

SCHEDULED ITEMS:

1. Welcome and Introductions: County Executive Chris Abele, Representative Joe Sanfelippo, State Senator Leah Vukmir.

APPEARANCES:

County Executive Chris Able
 Senator Leah Vukmir, 5th Senate District
 Representative Joe Sanfelippo, 15th Assembly District

County Executive Able, Senator Vukmir, and Representative Sanfelippo provided opening remarks expressing their gratitude and thanks to the Board for their willingness to serve in such an important capacity. Also discussed was the challenging road taken to get to this point, and the charge and focus of this new Board, which is to improve the lives of citizens with mental illness that the Milwaukee County Behavioral Health Division serves.

The Board took no action regarding this item.

2. Introduction of Members and Staff.

APPEARANCES:

Hector Colon, Director, Department of Health and Human Services (DHHS)
 Patricia Schroeder, Administrator Designee, Behavioral Health Division (BHD), DHHS
 Kathie Eilers, Transitional Liaison Designee, BHD, DHHS
 John Schneider, Executive Medical Director, BHD, DHHS
 Susan Gadacz, Deputy Administrator, Community Access to Recovery Services Division, BHD, DHHS
 Jim Kubicek, Deputy Administrator, BHD, DHHS
 Paul Bargren, Corporation Counsel

SCHEDULED ITEMS (CONTINUED):

Behavioral Health Division staff and Mr. Bargren introduced themselves, summarized their background and experience, and stated what their respective roles are in conjunction with the Mental Health Board.

Board Members introduced themselves and briefly summarized their background and experience.

The Board took no action regarding this item.

3. Vision for the Mental Health System.

APPEARANCES:

County Executive Chris Able

Hector Colon, Director, Department of Health and Human Services (DHHS)

Mr. Colon stated that he is looking forward to working with the Mental Health Board on moving toward a service delivery model that is more person centered and recovery oriented. He shared the progress that has been made over the last several years highlighting reductions in clients utilizing the observation unit, in-care admissions, and emergency room visits; with an increase in people accessing community based services, Wraparound services, and the access clinic. Mr. Colon indicated the vision, ultimately, is to close the long-term care units, which will allow people to be truly integrated into society in the community of their choice with the proper support needed to be successful. It is also the goal to become Joint Commission Accredited.

County Executive Able stated that he has encouraged and supported collaboration with other areas within Milwaukee County, such as the Criminal Justice System, where there is an overlap in the population being served.

The Board took no action regarding this item.

4. Overview of BHD Branches.

APPEARANCES:

Patricia Schroeder, Administrator Designee, Behavioral Health Division (BHD),
Department of Health and Human Services (DHHS)

John Schneider, Executive Medical Director, BHD, DHHS

Jim Kubicek, Deputy Administrator, BHD, DHHS

Susan Gadacz, Deputy Administrator, Community Access to Recovery Services Division,
BHD, DHHS

Behavioral Health Division (BHD) management presented the Board with a PowerPoint presentation describing the overall operations of the Division.

Ms. Schroeder began by stating BHD's mission and vision and reviewed the core values. She concluded with BHD's commitment to excellence, continuous improvement, and the future direction of BHD.

SCHEDULED ITEMS (CONTINUED):

Dr. Schneider discussed the population being served (Chapter 51.50-dangerous and unwilling to accept treatment, indigent-uninsured patients, and voluntary patients) and the stigmas and stereotypes associated with mental health.

Mr. Kubicek discussed the Recovery Oriented System of Care, Acute Inpatient/Child and Adolescent Treatment Unit, and all other specialty units and their admission statistics. He provided information on the various rehabilitation centers and the quality improvement of the centers, Crisis Services, Psychiatric Crisis Services (PCS) admissions and emergency detentions, efforts to decrease emergency detentions, Access Clinic and Mental Health Outpatient Program (MHOP) improvements, the Community Linkages and Stabilization Program (CLASP), and the Community Consultation Team (CCT).

Ms. Gadacz discussed Wraparound Milwaukee, Community Access to Recovery services, Milwaukee Co-occurring Competency Cadre (MC3), Mental Health Redesign, and the Office of Consumer Affairs.

Ms. Schroeder indicated the PowerPoint presentation used will be provided to Board members.

Ms. Neubauer requested the Board be provided with information regarding BHD's workforce for a public versus private comparison.

Questions and comments ensued.

The Board took no action regarding this item.

***The Board took a break at 10:12 a.m. and reconvened at approximately 10:25 a.m.
The roll was taken and all Board Members were present.***

5. Differentiating governance from management.

APPEARANCE:

Katie Pritchard, PhD, IMPACT Planning Council

Ms. Pritchard presented a PowerPoint presentation to the Board on Traditional Board Responsibilities and Roles. She discussed how boards govern and staff manages; the board/management relationship and their various roles; provided tips on how to address confusion, tension, and difference of opinions; and reviewed seven characteristics of an effective board.

The Board took no action regarding this item.

SCHEDULED ITEMS (CONTINUED):

6. Review of Wisconsin Act 203.

APPEARANCES:

Paul Bargen, Corporation Counsel

Colleen Foley, Deputy, Corporation Counsel

Hector Colon, Director, Department of Health and Human Services (DHHS)

Eric Peterson, Government Affairs Liaison, Office of the County Executive

John Schneider, Executive Medical Director, Behavioral Health Division, DHHS

Ms. Foley described the Office of Corporation Counsel's role as it relates to the Behavioral Health Division (BHD), which includes probable cause hearings, emergency detentions, and final commitment and extension hearings.

Mr. Bargren provided the Board with a detailed explanation of Act 203. He reviewed mental health policy and function, jurisdiction over BHD and community programs and services, the Board's duties and powers, BHD personnel, BHD's budget, the Board's approval authority for BHD contracts and disbursements, and reporting requirements.

Bernestine Jeffers, Women's Alcohol and Other Drug Abuse (AODA) Treatment State Coordinator, Division of Mental Health and Substance Abuse Services, Bureau of Prevention Treatment and Recovery, State of Wisconsin Department of Health Services, appeared and spoke regarding this item.

Ms. Neubauer requested that the Board be provided with more information regarding the open meetings and open records laws.

Questions and comments ensued.

The Board took no action regarding this item.

The Board broke for lunch at 11:58 a.m. and reconvened at approximately 12:10 p.m. The roll was taken and all Board Members were present.

7. Review of draft by-laws.

APPEARANCES:

Kathie Eilers, Transitional Liaison Designee, Behavioral Health Division, Department of Health and Human Services (DHHS)

Eric Peterson, Government Affairs Liaison, Office of the County Executive

Hector Colon, Director, DHHS

Ms. Eilers reviewed each Article of the By-laws of the Milwaukee County Mental Health Board.

Mr. Peterson provided additional information on how the Board will address procurement issues, lobbying and lobbyists, and economic interests.

SCHEDULED ITEMS (CONTINUED):

Questions and comments ensued.

MOTION BY:(Neubauer) Lay Item #7 over to the August meeting.

MOTION 2ND BY: (Malofsky)

Ms. Neubauer later withdrew her motion to lay this item over, therefore no vote was taken.

MOTION BY: (Shrout) Amend and Approve the By-Laws, Article X, by changing it to read as follows: "An amendment of these By-Laws may be adopted by a two-thirds majority vote at any regular meeting of the Board providing the amendment has been submitted in writing at the previous regular meeting seven (7) calendar days prior to the next regular meeting." 8-0

MOTION 2ND BY: (Diamond)

AYES: Carlson, Chayer, Lutzow, Perez, Shrout, Walker, Wesley, and Zeiger - 8

NOES: Neubauer - 1

ABSTENTIONS: Malofsky - 1

A voice vote was taken on this item.

8. Review of BHD 2015 Budget.

APPEARANCES:

Hector Colon, Director, Department of Health and Human Services (DHHS)
Randy Oleszak, Fiscal Administrator, Behavioral Health Division (BHD), DHHS
Jim Kubicek, Deputy Administrator, BHD, DHHS
Susan Gadacz, Deputy Administrator, Community Access to Recovery Services Division, BHD, DHHS

Mr. Colon stated the newly enacted law dictates that the Behavioral Health Division must be kept at a tax levy between \$53 million and \$65 million. The total overall budget for the Behavioral Health Division (BHD) that is being presented to the Board has a \$62 million tax levy. The total overall budget for BHD is approximately \$183 million. There are other sources of revenue that come from areas such as patients and the state and federal government that combined with the tax levy, amounts to the overall total budget of \$183 million. This total is up slightly from last year's budget, which was approximately \$179 million.

Mr. Colon went on to discuss decreases in staff, the implementation of performance based budgeting, investing in evidenced-based programs, maximizing revenue, the expansion of quality assurance initiatives, the reduction of overhead due to downsizing and closure efforts, BHD relocation efforts, and the challenges that come along with this budget. He stated the budget continues to move toward a more person-centered, recovery-oriented, trauma informed, and sensitive approach in the delivery model; with the ultimate goal of less reliance on institutions, psychiatric inpatient admissions, and emergency room visits. It is also a priority to make sure the hospital is being operated consistent with Joint

SCHEDULED ITEMS (CONTINUED):

Commission Accreditation standards.

Questions and comments ensued.

The Chair indicated that at the next scheduled meeting, the Board will vote on adoption of the budget.

The Board took no action regarding this item.

9. Election of Board Officers.

APPEARANCE:

Eric Peterson, Government Affairs Liaison, Office of the County Executive

Mr. Shrout nominated Kimberly Walker for Chairman of the Milwaukee County Mental Health Board.

Ms. Walker accepted that nomination.

No other nominations for Chairman were made.

MOTION BY: *(Shrout) Vote Kimberly Walker for Chairman of the Milwaukee County Mental Health Board by acclamation and unanimous consent. 10-0*

MOTION 2ND BY: *(Neubauer)*

AYES: Carlson, Chayer, Lutzow, Malofsky, Neubauer, Perez, Shrout, Walker, Wesley, and Zeiger - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this office.

Immediately following the election of the Chair, Ms. Walker assumed her role as Chairman and facilitated the balance of the meeting.

Ms. Wesley nominated Mary Neubauer for Vice-Chairman of the Milwaukee County Mental Health Board.

Ms. Malofsky nominated Peter Carlson for Vice-Chairman of the Milwaukee County Mental Health Board.

Considering there were two nominations for the office of Vice-Chairman, the Chair, whose discretion the decision falls under, decided that a ballot vote would be appropriate. Ballots were distributed to the voting members of the Board and returned to the Chair once completed.

SCHEDULED ITEMS (CONTINUED):

Mr. Peterson indicated that because there were ten (10) voting members present, it would take six (6) votes to elect.

The Chair read each ballot aloud with Mr. Peterson and the Board Clerk tallying the votes. Mr. Carlson received seven (7) votes to Ms. Neubauer's three (3) votes. The Chair announced that the Vice-Chairman of the Milwaukee County Mental Health Board is Peter Carlson.

An anonymous ballot vote was taken on this office.

Mr. Shrout nominated Robert Chayer for Secretary of the Milwaukee County Mental Health Board.

Dr. Chayer accepted that nomination. No other nominations for Secretary were made.

MOTION BY: *(Shrout) Vote Robert Chayer for Secretary of the Milwaukee County Mental Health Board by acclamation and unanimous consent. 10-0*

AYES: Carlson, Chayer, Lutzow, Malofsky, Neubauer, Perez, Shrout, Walker, Wesley, and Zeiger - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this office.

10. Approval of By-laws and Member Expectations.

The Chair explained that the Board has before them, as it relates to member expectations, a document that provides the framework or a starting point for the Board to operate. If the Board adopts the member expectations at this point, the expectations can always be amended to what the Board ultimately decides those expectations should be.

Questions and comments ensued.

Mr. Zeiger requested that the Board be provided with the policies that relate to this item for review prior to the next meeting.

MOTION BY: *(Neubauer) Lay over adoption of the member expectations document to the next scheduled meeting. 10-0*

MOTION 2ND BY: *(Shrout)*

AYES: Carlson, Chayer, Lutzow, Malofsky, Neubauer, Perez, Shrout, Walker, Wesley, and Zeiger - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this item.

SCHEDULED ITEMS (CONTINUED):

11. Approval of appointments.

APPEARANCES:

Hector Colon, Director, Department of Health and Human Services (DHHS)
Jim Kubicek, Deputy Administrator, Behavioral Health Division (BHD), DHHS
Susan Gadacz, Deputy Administrator, Community Access to Recovery Services Division,
BHD, DHHS

Mr. Colon formally introduced both Ms. Schroeder and Ms. Eilers to the Board who each provided experience and background information on themselves.

Questions and comments ensued.

MOTION BY: *(Shrout) Approve the appointment of Ms. Schroeder. 10-0*

MOTION 2ND BY: *(Perez)*

AYES: Carlson, Chayer, Lutzow, Malofsky, Neubauer, Perez, Shrout,
Walker, Wesley, and Zeiger - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this appointment.

MOTION BY: *(Lutzow) Approve the appointment of Ms. Eilers. 10-0*

MOTION 2ND BY: *(Shrout)*

AYES: Carlson, Chayer, Lutzow, Malofsky, Neubauer, Perez, Shrout,
Walker, Wesley, and Zeiger - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this appointment.

12. Prioritization of information update/future agenda items

APPEARANCES:

Kathie Eilers, Transitional Liaison, Behavioral Health Division (BHD), Department of
Health and Human Services (DHHS)
John Schneider, Executive Medical Director, BHD, DHHS
Patricia Schroeder, Administrator, BHD, DHHS
Jim Kubicek, Deputy Administrator, BHD, DHHS

Ms. Eilers took the time to itemize the requests the Board made for information during the course of the meeting, which included WiSer Choice; the State audit; and workforce in terms of wage scale, disparity, recruitment strategy, and turnover. There will be contractual items that need to be approved and the budget will need to be adopted.

A number of requests for information were made by Board Members.

SCHEDULED ITEMS (CONTINUED):

The Chair suggested this item be scheduled again for the August meeting to establish what reports the Board will be interested in receiving and at what meeting cycle they will be addressed. BHD will provide the Board with a list of what would be considered standard reports.

The Chair directed all Board Members to create a separate email account related solely to the Mental Health Board and provide that email information to the Clerk, who then will create a contact list for distribution.

Questions and comments ensued.

The Board took no action regarding this item.

13. Set dates and times for future meetings.

APPEARANCES:

Kathie Eilers, Transitional Liaison, Behavioral Health Division, Department of Health and Human Services (DHHS)
Hector Colon, Director, DHHS
Eric Peterson, Government Affairs Liaison, Office of the County Executive

Ms. Eilers explained that August 28, 2014, would be the next regular scheduled meeting. The schedule is set up so that the meetings fall on the fourth Thursday of the month, except for December, every other month.

Questions and comments ensued.

Mr. Zeiger suggested that at some point, the Board discuss convening meetings at various locations throughout the community.

MOTION BY: (Shrout) **Approve the tentative schedule of Board meeting dates.**
10-0

MOTION 2ND BY: (Lutzow)

AYES: Carlson, Chayer, Lutzow, Malofsky, Neubauer, Perez, Shrout,
Walker, Wesley, and Zeiger - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this item.

Later during the course of the meeting, the following motion was made to reconsider this item.

MOTION BY: (Neubauer) **Reconsider Item #13.**

After continued discussion, no further action was taken on this item.

SCHEDULED ITEMS (CONTINUED):

14. Opportunity for tours of selected inpatient and community programs.

APPEARANCES:

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

Ms. Schroeder indicated that tours will be scheduled in the near future for Board Members and will be done in small groups.

Questions and comments ensued.

The Board took no action regarding this item.

15. Other items as approved for discussion by the Board; possible action on administrative or ministerial matters.

The Board took no action regarding this item.

16. State/County MOU.

APPEARANCE:

Susan Moeser, Fiscal Services Director, Behavioral Health Division, Department of Health and Human Services

See Board handout or posted documents for a full description of this item.

MOTION BY: (Lutzow) **Approve the State/County Memorandum of Agreement. 10-0**

MOTION 2ND BY: (Perez)

AYES: Carlson, Chayer, Lutzow, Malofsky, Perez, Shrout, Walker, Wesley, and Zeiger - 9

NOES: 0

ABSTENTIONS: Neubauer - 1

A voice vote was taken on this item.

17. Adjournment

MOTION BY: (Neubauer) **Adjourn. 10-0**

MOTION 2ND BY: (Perez)

AYES: Carlson, Chayer, Lutzow, Malofsky, Neubauer, Perez, Shrout, Walker, Wesley, and Zeiger - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this item.

SCHEDULED ITEMS (CONTINUED):

The aforementioned agenda items were not necessarily considered in agenda order.

STAFF PRESENT:

Hector Colon, Director, Department of Health and Human Services (DHHS)
Patricia Schroeder, Administrator, Behavioral Health Division (BHD), DHHS
Kathie Eilers, Transitional Liaison, BHD DHHS
John Schneider, Executive Medical Director, BHD, DHHS
Susan Gadacz, Deputy Administrator, Community Access to Recovery Services Division, BHD, DHHS
Jim Kubicek, Deputy Administrator, BHD, DHHS
Paul Bargren, Corporation Counsel
Colleen Foley, Deputy, Corporation Counsel
Eric Peterson, Government Affairs Liaison, Office of the County Executive
Randy Oleszak, Fiscal Administrator, BHD, DHHS
Susan Moeser, Fiscal Services Director, BHD, DHHS

Length of meeting: 8:10 a.m. to 2:50 p.m.

Adjourned,

Jodi Mapp

Board Clerk
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, August 28, 2014 @ 8:00 a.m.
All items for the agenda must be in the Board Clerk's possession by the end
of the business day on Thursday, August 14, 2014.**

The July 17, 2014, meeting minutes of the Milwaukee County Mental Health Board are hereby approved.



Dr. Robert Chayer, Secretary
Milwaukee County Mental Health Board

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

Budget Summary

Category	2013 Budget	2013 Actual	2014 Budget	2015 Budget	2015/2014 Variance
Expenditures					
Personnel Costs	\$75,737,832	\$72,759,275	\$71,051,105	\$67,990,831	(\$3,060,274)
Operation Costs	\$97,764,772	\$107,935,558	\$112,548,386	\$118,333,168	\$5,784,782
Debt & Depreciation					
Capital Outlay	\$446,875	\$480,701	\$642,839	\$476,502	(\$166,337)
Net Crosscharge/Abatement	(\$4,043,421)	(\$4,308,313)	(\$4,448,681)	(\$3,307,500)	\$1,141,181
Total Expenditures	\$169,906,458	\$176,867,221	\$179,793,649	\$183,493,001	\$3,699,353
Revenues					
Direct Revenue	\$59,012,384	\$60,897,862	\$65,786,401	\$67,414,058	\$1,627,657
Intergov Revenue	\$54,364,995	\$57,825,026	\$56,533,125	\$54,008,442	(\$2,524,683)
Total Revenues	\$113,377,379	\$118,722,888	\$122,319,526	\$121,422,500	(\$897,026)
Tax Levy	\$56,529,079	\$58,144,333	\$57,474,123	\$62,070,501	\$4,596,379
Personnel					
Full-Time Pos. (FTE)	801.03	747	670.49	584.26	(86.2)
Seas/Hourly/Pool Pos.	29.9	24.53	26	31	5
Overtime \$	\$3,114,576	\$3,620,640	\$2,695,080	\$1,188,504	(\$1,506,576)

Department Mission: The Milwaukee County Department of Health and Human Services – Behavioral Health Division will be a Center of Excellence for person-centered, high-quality best practices in collaboration with community partners.

Wisconsin Act 203: In April 2014, the Governor signed Wisconsin Act 203 (Wis. Stats 51.41) which effectively transferred all control of mental health functions from the Milwaukee County Board of Supervisors to a newly-created, 13-member Milwaukee County Mental Health Board (MCMHB). This legislation applies to the mental health programs and services that are contained within department 6300 and the new Community Access to Recovery Services Division (CARSD) which includes the Community Services Branch (CSB) and Wraparound Milwaukee. The MCMHB has primary responsibility for the treatment and care of Milwaukee County residents with mental illness, alcohol and other drug dependencies as well as the allocation of funds.

The legislation authorizes the MCMHB to propose a budget to the County Executive that includes the total amount of the budget, the community aids amount and a property tax levy amount. The dollar amount of the tax levy must be at least \$53 million but not more than \$65 million. Although the County Executive can adjust the tax levy requested by the MCMHB, the revised tax levy amount must remain within the \$53 million to \$65 million range unless agreed to by the MCMHB, County Executive and County Board. This range can also be adjusted if additional mental health programs and services are transferred to the oversight of the MCMHB. The tax levy

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

would then be increased by the amount of tax levy expended on the transferred programs and services in the prior fiscal year.

In addition, the County Treasurer is directed to hold "any moneys" that have not been expended or encumbered on mental health programs and services at the end of the fiscal year in a reserve fund. The reserve fund may be used at any time to cover deficits in the mental health budget. If the amount in the reserve exceeds \$10 million, the amount exceeding \$10 million may be used at any time for any mental health service or program.

Finally, MCMHB is responsible for funding a building reserve, transition liaison position and travel expenses for MCMHB members. Please refer to the 8200 – Management & Support Services section of the budget for further detail on these expenses.

Department Description: The Behavioral Health Division (BHD) consists of Management and Support Services, Adult Crisis Services, Adult and Child Acute Inpatient Services, Rehab Central Nursing Facility, Community Services Branch, and Wraparound Milwaukee. The Hilltop Nursing Facility will be closed in 2014.

In 2014, the Community Services Branch, Wraparound Milwaukee and Emergency Medical Services were transferred from department 6300 – Behavioral Health Division to department 8000 – Department of Health and Human Services. For 2015, the Community Services Branch and Wraparound Milwaukee are now transferred back to department 6300 as the Community Access to Recovery Services Division (CARSD). This structure is consistent with Wisconsin Act 203. For 2015, Emergency Medical Services remains in department 8000.

Overview: The 2015 Budget reflects an increase in expenditures of \$3,699,353, revenue reduction of \$897,026 for a net tax levy increase of \$4,596,379. This increase is largely the result of higher fringe benefit costs, expansion and retention of community based services as well as the development of a solid staffing model for the hospital. Though the passage of Wis. Stats 51.41 provides greater financial flexibility for BHD through the creation of a reserve to capture any surpluses BHD may realize, BHD must now assume greater financial independence.

In light of this new financial landscape, the 2015 Budget was constructed based on a critical review of all revenue streams, projected census figures as well as anticipated clinical staffing needs. Over the past few years, BHD has undergone tremendous change with the downsizings and ultimate closures of its Hilltop and Rehab Central long-term care facilities in 2014 and 2015, respectively. As a result, 2015 staffing models have been rebuilt to reflect one to one staff to patient ratios to consider higher acuity patients, reduction in overtime, staffing based on productive hours to ensure 24-hour coverage of shifts and a vacancy and turnover rate based on actual experience. This initiative results in increased personnel expense of approximately \$1.1 million.

Furthering efforts begun in 2011, the 2015 Budget seeks to transfer even more inpatient services to a community care setting in order to provide the maximum amount of freedom and the highest quality of life for individuals utilizing behavioral health services.

Rehab Central is budgeted to close November 1, 2015. This initiative is supported by new investments in community behavioral health services totaling over \$2 million to reflect Rehab Central Relocations and additional bed capacity. Additionally, Family Care Managed Care Organizations will continue to invest millions of dollars to provide high quality services to BHD clients to ensure a successful transition to the community. Overall, the investments made by the County with additional resources from State and Federal sources and Family Care will enhance services and increase the investment made in community-based mental health services.

All Milwaukee County behavioral health programming will move forward with a person-centered, recovery-oriented, trauma-informed and culturally sensitive approach to the people we serve with strong communication and coordination of services among the divisions.

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

Strategic Program Area 1: Management & Support Services

Strategic Outcome: High Quality, Responsive Services

What We Do: Activity Data			
Activity	2013 Actual	2014 Budget	2015 Budget
This program area does not have activity data.			

How We Do It: Program Budget Summary					
Category	2013 Budget	2013 Actual	2014 Budget	2015 Budget	2015/2014 Variance
Expenditures	\$1,292,227	\$1,277,300	\$1,987,920	\$2,593,071	\$605,151
Revenues	\$3,998,629	\$1,118,785	\$3,245,324	\$1,783,964	(\$1,461,360)
Tax Levy	(\$2,706,402)	\$158,515	(\$1,257,404)	\$809,107	\$2,066,511
FTE Positions	175.3	131.4	151.7	141.1	(10.6)

How Well We Do It: Performance Measures			
Performance Measure	2013 Actual	2014 Budget	2015 Budget
Overtime Costs / Personal Services Costs	4%	3%	2%
Revenue dollars / fiscal staff	\$4,750,735	\$4,217,915	\$4,081,429
Patient revenue collected / Billed revenue	44.7%	38.2%	43.3%

Strategic Implementation:

141.1 FTEs are provided for fiscal management, compliance, administration, patient accounts and admissions, management information systems, dietary and medical records, and environment of care for the entire facility.

In 2015, BHD continues to work toward Joint Commission (JC) accreditation to ensure a focus on the provision of quality services.

Due to the recent redesign efforts at BHD, including the complete closure of its long-term care facilities, Rehabilitation Center - Hilltop by the end of 2014 and Central by November 2015, BHD conducted an analysis of overhead needs. It is important to note that throughout the downsizing, the entire facility must be maintained to be in compliance with State and Federal standards even though parts of the building will be vacated.

As a result of the analysis, the following positions are abolished on the dates indicated below. The reductions reflect the annualized impact to FTEs while the savings shown in parentheses is the fiscal impact in 2015:

The following positions are abolished as of Jan.1 2015:

- 1.0 FTE Admin Spec – MH NR (\$63,172)
- 0.2 FTE BH Clinical Prog Dir Psychology (\$38,520)
- 1.0 FTE Clerical Asst 1 (\$59,632)
- 1.0 FTE Clothing Supply Clk 1 (\$53,306)
- 1.0 FTE Fiscal Asst 1 (\$49,792)

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

- 1.2 FTE Fiscal Asst 2 (\$71,757)
- 1.0 FTE Hosp Maint Wrkr MHC (\$62,902)
- 2.0 FTE Office Supp Asst 2 (\$95,484)
- 1.0 FTE Pharmacy Tech (\$57,752)
- 1.0 FTE Secretarial Asst (\$52,160)
- 0.5 FTE Staffing Assistant (\$28,794)
- 1.0 FTE Volunteer Coord Hrly (\$38,244)
- 1.0 FTE Admin Asst NR (\$60,598)
- 1.0 FTE Adv Prac Nurse Prescriber (\$104,750)
- 1.0 FTE BH Med Dir – Forensic Services (\$248,514)
- 1.0 FTE Clerical Spec MHD (\$66,356)
- 1.0 FTE Physician Quality Officer (\$173,312)
- 1.0 FTE Pol & Pro Coord Clin Compliance (\$87,440)
- 1.0 FTE Utilization Review Coord (\$115,480)

The following positions are abolished as of July 1, 2015:

- 1.0 FTE Materials Distrib Clerk (\$27,009)

The following positions are abolished as of Nov. 1, 2015:

- 0.2 FTE Hosp Maint Wrkr MHC (\$10,693)

The implementation of the Electronic Medical Records (EMR) system is targeted for completion in 2015. EMR funding is increased by \$245,571 to a total of \$2,171,000. This includes funding for hosting fees and maintenance for the new EMR system, support for the current IT system through the transition to the EMR, dedicated IMSD technical support and enhancement for the new system, project management consultation and other costs related to the new EMR.

A number of reductions have been made to outside contracts and other line accounts due to the long-term care closures. Based on actual spending and projections, dietary, security, and housekeeping are adjusted for an overall decrease of \$311,334 in tax levy. Engineering building maintenance and HOC Laundry crosscharges were reduced by \$293,473 combined, and utilities also decreased by \$336,604. Finally, services, commodities, capital equipment and major maintenance are reduced by \$202,709.

In terms of revenue adjustments to this area, Wisconsin Medicaid Cost Reporting (WIMCR) and State Plan Amendment revenues are reduced by a combined total of \$1,563,730, from \$4 million in 2014 to \$2,499,270 in 2015, to reflect actual experience. In 2012, BHD hired a consultant to review all elements of the Medicaid Cost Report and the Wisconsin Medicaid Cost Reporting (WIMCR) system to ensure Medicaid reimbursement from the State was maximized. However, budgeted revenues contained in the 2013 and 2014 Budgets were not fully realized.

BHD building space rental revenue decreased by \$270,236 and other miscellaneous revenue decreased by \$113,000.

Mental Health Board

Wisconsin Act 203 (Wis. Stats 51.41) requires BHD to earmark funding for the following items: 1) Transition Liaison to assist the Milwaukee County Mental Health Board (MCMHB) in the transition of oversight functions, 2) building reserve fund to address BHD's capital needs and 3) travel expenses for the MCMHB members. As a result, the budget includes a contracted Transition Liaison position at a cost of \$65,000, \$300,000 for a building reserve fund and \$25,000 for MCMHB travel expenses.

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Strategic Program Area 2: Adult Crisis Services

Strategic Outcome: Self-sufficiency

What We Do: Activity Data			
Activity	2013 Actual	2014 Budget	2015 Budget
Psychiatric Crisis Services			
Admissions	11,464	11,068	10,681
Access Clinic			
Number of Clients Served	6,978	6,576	6,576
Crisis Mobile			
Number of Mobiles Completed	1,716	1,642	1,806
Number of Mobiles Requested by Law Enforcement	291	370	463

How We Do It: Program Budget Summary					
Category	2013 Budget	2013 Actual	2014 Budget	2015 Budget	2015/2014 Var
Expenditures	\$20,200,965	\$20,470,356	\$21,155,153	\$24,595,439	\$3,440,285
Revenues	\$11,340,126	\$11,967,188	\$10,711,680	\$11,557,645	\$845,965
Tax Levy	\$8,860,839	\$8,503,168	\$10,443,473	\$13,037,794	\$2,594,320
FTE Positions	106.2	128.9	110	118	8

How Well We Do It: Performance Measures			
Performance Measure	2013 Actual	2014 Budget	2015 Budget
Percent of clients returning to PCS within 90 days	33%	27%	27%
Percent of Time on Waitlist Status	1%	5%	5%
Clients transferred to private facilities from PCS	16%	23%	23%

Strategic Implementation:

118 FTE's are provided to operate the Psychiatric Crisis Service Emergency Room, Access Clinic, Crisis Line, Crisis Mobile Team, and Crisis Stabilization Centers. In 2015, BHD will implement a new nurse staffing model to insure 24-hour coverage of shifts while accounting for the productive hours of employees excluding paid time off. Staff was also added for one to one coverage of patients as needed. To implement these staffing models, 9.2 FTEs of Nursing Asst 1 Mh and 2.0 FTEs of RNI were created with a corresponding decrease of 4.7 FTEs of overtime in the Adult Crisis Services Area.

The Adult Crisis Services remains committed to the reduction of admissions to PCS, particularly the reduction of involuntary admissions/emergency detentions (23 percent fewer emergency detentions from 2010 to 2013). These reductions are being achieved by the increased utilization of community-based crisis services such as the Crisis Mobile Team (35 percent increase in mobile assessments since 2008) and Crisis Assessment & Response Team (CART). Additionally, the Crisis Services is implementing ACT 235 legislation (emergency detention pilot program

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in Milwaukee County that enables Treatment Directors or Designees to complete emergency detentions only when involuntary care is required), which is meant to increase stabilization services in the community rather than admissions to PCS and hospitalization.

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Strategic Program Area 3: Inpatient Services (Adult and Children)

Strategic Outcome: Self-sufficiency

What We Do: Activity Data			
Activity	2013 Actual	2014 Budget	2015 Budget
Acute Adult Inpatient			
Average Daily Census	59	54	60
Number of Admissions	1,456	1,200	1,142
Number of Patient Days	21,363	20,000	21,900
Average Length of Stay (Days)	14.7	14	16.4
Child and Adolescent Inpatient Services			
Average Daily Census	8	6	11
Number of Admissions	829	1,250	1,005
Number of Patient Days	2,930	2,500	4,380
Average length of Stay (Days)	3.5	2	3.4

How We Do It: Program Budget Summary					
Category	2013 Budget	2013 Actual	2014 Budget	2015 Budget	2015/2014 Var
Expenditures	\$36,746,719	\$33,661,635	\$33,696,594	\$38,078,871	\$4,382,277
Revenues	\$10,718,143	\$11,585,066	\$10,968,733	\$14,606,010	\$3,637,277
Tax Levy	\$26,028,576	\$22,076,569	\$22,727,861	\$23,472,861	\$745,000
FTE Positions	187.3	202.1	183.7	202.8	19.1

How Well We Do It: Performance Measures			
Performance Measure	2013 Actual	2014 Budget	2015 Budget
Acute Adult Inpatient			
Percent of clients returning to Acute Adult within 90 days	24.4%	19%	17.5%
Patients Responding Positively to Satisfaction Survey	71.5%	72%	72.0%
Child and Adolescent Inpatient Services			
Percent of children who return to CAIS within 90 days	18.9%	17%	15.0%
Patients Responding Positively to Satisfaction Survey	78.4%	75%	75.0%

Strategic Implementation:

202.8 FTEs support the operation of Inpatient Services which provides four licensed psychiatric hospital units with three specialized programs for adults and one specialized unit for children and adolescents. In 2015, BHD will implement a new nurse staffing model to insure 24-hour coverage of shifts while accounting for the productive

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hours of employees excluding paid time off. Staff was also added for one to one coverage of patients as needed. To implement these staffing models, 19.6 FTEs of Nursing Asst 1 Mh and 2.2 FTEs of RNI were created with a corresponding decrease of 7.4 FTEs of overtime in the Acute Inpatient Services Area.

Average daily census projections for both the Child and Adult units were increased to reflect the trend in longer lengths of stay that coincide with an aggregate increase in acuity for BHD admissions. As more patients with less acuity are transferred to provider hospital systems; patients that are admitted to BHD require a longer period of time for their symptoms to stabilize.

Between 2012 and mid-year 2014, CAIS' 90-day readmission rate declined by 20.3 percent as its average length of stay increased from 2.2 days to 3.4 days, a 35 percent increase. This indicates a likelihood that increased length of stay has a positive impact on recidivism. This effort will be continued in 2015 and as a result, the average daily census projection increases to 11.

Future Acute Bed Reductions

For both the Adult and Child inpatient units, an ongoing review of census capacity will continue throughout 2015. Discussions with health systems will continue related to their ability to admit additional patients. This review will consist of a data driven analysis of available beds in the community and BHD. The analysis is focused on functional and clinical capacity of the various systems. A demand capacity analysis has been commissioned in 2014 that will further inform this decision. If capacity is found within the private health system network, additional bed reductions will occur over the course of 2015. These reductions may occur in the adult or child inpatient units, or both.

Impact of the ACA

As a result of the federal Affordable Care Act (ACA), previously uninsured individuals receiving services within BHD's Adult Acute unit are anticipated to receive health care coverage either through the State's expansion of Badger Care or enrollment in the private health care exchanges. As a result, the Budget assumes additional patient care revenue in Acute of \$250,000.

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Strategic Program Area 4: Inpatient Services - Nursing Facility Central

Strategic Outcome: Self-sufficiency

What We Do: Activity Data			
Activity	2013 Actual	2014 Budget	2015 Budget
Average Daily Census	56	56	14
Number of Admissions	3	0	0
Number of Patient Days	20,497	20,440	4,513

How We Do It: Program Budget Summary					
Category	2013 Budget	2013 Actual	2014 Budget	2015 Budget	2015/2014 Var
Expenditures	\$13,170,490	\$13,536,736	\$11,799,508	\$10,278,608	(\$1,520,900)
Revenues	\$3,638,335	\$3,248,717	\$3,200,613	\$1,522,678	(\$1,677,935)
Tax Levy	\$9,532,155	\$10,288,019	\$8,598,895	\$8,755,930	\$157,035
FTE Positions	83.5	73.9	75.5	50.3	(25.2)

Strategic Implementation:

Furthering an initiative that started in 2014, BHD will be closing the Rehabilitation Center-Central in 2015. One unit is scheduled for closure in 2014, followed by a second unit closure on July 1, 2015 and ultimately the final unit closure on November 1, 2015. The Division will work closely with Family Care and Service Access to Independent Living (SAIL) to secure community placements for all clients by November 1, 2015.

As a result of the downsizing and closure, the following positions are abolished on the dates indicated below. The personnel reductions lag the unit closures by one to two months to allow sufficient time to transition patients into the community. The reductions reflect the annualized impact to FTEs in 2015:

Positions abolished as of Jan 1, 2015 include:

- 1.0 FTE Clerical Asst 2
- 0.5 FTE Unit Clerk
- 0.5 BH Clinical Psychologist III (transferred to Acute Adult)

Positions abolished as of March 1, 2015 corresponding to the initial 2014 unit closure include:

- 13.1 FTE Nursing Asst 1 MH
- 1.3 FTE RN 1
- 1.0 FTE RN 2
- 1.0 FTE RN 2 – MDS
- 2.0 FTE Cert Occ Therapy Asst
- 0.25 FTE Occupational Therapist

Positions abolished as of September 1, 2015 corresponding to the July 1, 2015 unit closure include:

- 13.1 FTE Nursing Asst 1 MH
- 3.3 FTE Psych LPN MHC

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- .25 FTE BH Staff Psychiatrist
- 0.75 FTE Occupational Therapist
- 1.0 FTE Psych Soc Wkr

Positions abolished as of December 1, 2015 corresponding to the November 1, 2015 final unit closure include:

- 1.0 FTE Unit Clerk
- 14.8 FTE Nursing Asst 1 MH
- 3.3 FTE Psych LPN MHC
- 3.9 FTE RN 1
- 1.0 FTE RN 2 - MH
- 1.0 FTE Nursing Program Coordinator
- .50 FTE Adv Prac Nurse Prescriber
- .25 FTE BH Staff Psychiatrist
- 1.0 FTE Cert Occupational Therapy Asst
- 2.0 FTE Occupational Therapist
- 0.5 FTE Music Therapist
- 1.0 FTE Psych Soc Wkr

The downsizing and closure will result in an expenditure reduction of \$1,520,900 including personnel, dietary, pharmacy, security and other patient expenses. The savings are offset by a loss of (\$1,677,935) of patient revenue due to the declining census. The phased-in 2015 reductions result in a total annual reduction of 65.3 FTEs. The full impact of the savings will be realized in 2016.

Central Relocations

The Community Services Branch (CSB) will continue to work closely with BHD's Rehab Centers Central team to assist in moving clients from Central into appropriate community placements. To achieve this, CARSD has included partial year funding of \$2,326,200 for at least eight clients, some with very high acuity and in need of secure placements, to be relocated by July 1. This will lead to the permanent closure of Central. The request will be utilized for supported apartments, group home beds, adult family home placements, possible short term referrals to the State Institutions and additional clinical supports included, but not limited to, community living support skills, one-on-one, and two-on-one enhanced staffing patterns.

Since the community placements began in 2014, the individuals that will be placed in 2015 experience more challenges including emotional and behavioral health disorders, oftentimes complicated by aggression, cognitive delay, and/or medical conditions. For these individuals, enrollment in CRS or Community Options Program (COP) will be pursued. In addition, ongoing utilization reviews occur monthly for possible enrollment into Family Care.

These funds build upon the investment made in the 2014 Budget of \$793,174 which included additional contracted CSP slots, group home beds, and other supports such as adult family homes and other needed services.

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Strategic Program Area 5: Community Access to Recovery Services Division (CARSD)

Strategic Outcome: Self-sufficiency / Quality of Life

What We Do: Activity Data			
Activity	2013 Actual	2014 Budget	2015 Budget
<i>Adult Day Treatment</i>			
Number of Visits	3,888	3,888	3,888
<i>AODA – clients seen for:</i>			
Detoxification – All Levels	5,939	6,334	5,566
Outpatient Treatment	2,384	2,574	2,500
Medication Assisted Treatment	171	175	180
<i>Family Intervention Support Services</i>			
Number of Clients Served	869	550	800
<i>CATC Wraparound</i>			
Number of Clients Served	1,195	1,205	1,205
<i>Wraparound, Non-court ordered</i>			
Number of Clients Served	563	475	500
<i>Mobile Urgent Treatment</i>			
Number of Clients Seen	1,682	1,785	1,800

How We Do It: Program Budget Summary					
Category	2013 Budget	2013 Actual	2014 Budget	2015 Budget	2015/2014 Var
Expenditures	\$85,071,067	\$92,959,017	\$101,363,698	\$106,851,046	\$5,487,348
Revenues	\$77,050,672	\$85,017,970	\$91,110,212	\$91,656,203	\$545,991
Tax Levy	\$8,020,395	\$7,941,047	\$10,253,486	\$15,194,843	\$4,941,357
FTE Positions	130.5	115.8	135.1	103.18	(31.92)

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How Well We Do It: Performance Measures			
Performance Measure	2013 Actual	2014 Budget	2015 Budget
Provider agencies completed a NIATx change project	60%	60%	62%
Average Satisfaction Survey Score	78.5%	70%+	75%
Percent of outpatient clients screened for Medicaid and placed with a Medicaid certified agency	23%	23%	40%
Average Dollars expended per Community Support Program slot			
County-run (2013 Capacity of 337)	\$13,939	\$13,939	n/a
Non-County-run (2013 Capacity of 963)	\$3,723	\$3,832	\$4,418
Wraparound			
Average Daily Number of REACH enrollees	340	350	400
Family Satisfaction with Care Coordination (5.0 Scale)	4.72	4.50	4.60
Percent of Total Youth in Wraparound Programming Using Residential Treatment Care	19.0%	15.0%	17.0%

Strategic Implementation:

The 2014 Budget previously incorporated Wraparound Milwaukee and the Community Services Branch into the Department of Health and Human Services (Department 8000) as a separate division. With the passage of the Mental Health Bill (Wis Stats 51.41) in June of 2014, this division, now known as the Community Access to Recovery Services Division – CARSD, is transferred back to 6300 – Behavioral Health Division.

In 2015, Community Services Branch and Wraparound Milwaukee will continue their focus on providing community based mental health and substance use disorder services with a focus on assisting consumers in leading healthy, productive lives in the community. They will develop and manage a comprehensive, coordinated, community-based system that serves children, adolescents, and adults to provide the necessary continuum of care across the lifespan. Wraparound Milwaukee’s well established and award-winning processes for quality assurance and quality improvement will expand to the rest of the community services the County provides. There are clinical practices utilized in Wraparound Milwaukee that will be offered to adult consumers, such as care coordination and the one-person/one-plan approach, as a standard of care. CARSD will begin exploring financing structures that may be utilized under the Affordable Care Act to administer community based services.

The Psychiatric Inpatient Hospital, Emergency Room and Rehab Central will focus on providing safe, high quality and effective services, meeting all regulatory requirements for each service area and continue to transition clients to community placements through person-centered individualized plans.

Although each division will have its own identity to show its importance, focus and strategy; communication, continuity of care, coordination and operational efficiencies will continue and also be enhanced whenever possible. Both divisions will move forward with a person-centered, recovery oriented, trauma informed and culturally sensitive approach to the people they serve with strong communication and coordination of services among the divisions.

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Community Services Branch

Community Recovery Services

In 2014, the Community Services Branch (CSB) began the implementation of Community Recovery Services (CRS), a co-participation benefit for individuals with a severe and persistent mental illness that connects clients to necessary recovery services to promote independence. Services include supported employment, housing and the utilization of peers as providers. By the end of 2014, a total of 75 individuals are anticipated to be enrolled in CRS.

As part of the service array offered under CRS, CSB will contract for two, eight-bed Community Based Residential Facilities (CBRFs) at a cost of \$699,282 and leverage Medicaid revenue available under the program to offset 55 percent of the cost of providing these services. This results in a net tax levy of \$314,677.

Comprehensive Community Services

The budget reflects the implementation of the Comprehensive Community Services (CCS) Medicaid psychosocial rehabilitation benefit launched statewide in July 2014 as part of the State's 2013-2015 Mental Health Initiative. The program reimburses a county for both the non-federal (up to \$10 million statewide) and the federal share of the Medical Assistance allowable CCS costs if the county agrees to provide the benefit on a regional basis. Milwaukee County is considered its own region.

Milwaukee currently has Community Support Programs (CSP) as its only psychosocial rehabilitation benefit. Targeted Case Management (TCM) is also available to "targeted" populations. There is a very wide clinical gap between a CSP and a TCM; CCS is designed to fill that clinical gap. CCS offers the county the opportunity to strengthen the continuum of care where clients can be placed in levels of clinical care based on acuity vs. availability. CCS will be administered in a fee-for-service environment to offer more client choice of providers and timely access to services.

CCS is for persons with a mental health or substance use disorder and provides a flexible array of individualized community based psycho-social rehabilitation services delivered by clinical professionals to individuals in need of services across their lifespan. The flexible service array will assist an individual in achieving his/her maximum recovery potential.

The services to be provided are individualized to each person's need for rehabilitation as identified through a comprehensive assessment and an Individual Recovery Plan. CCS uses a wraparound model that is flexible, consumer directed, recovery oriented, strength and outcome based.

Initial implementation of CCS will be through utilization review of clients in existing services. Current TCM and CSP clients who could receive more clinically appropriate services in CCS will be offered participation in that benefit. In addition, those clients that are participating in Wiser Choice who could benefit from CCS will be offered participation as well. As a result, the program is anticipated to capture an additional \$500,000 in revenue for clients receiving TCM and CSP services.

Since CCS is a Medicaid entitlement, the CCS benefit must move to full implementation within one year of beginning the CCS Program. This means ensuring CCS is offered to children, adolescents, adults, and older adults that have either a mental health or substance use disorder who may be involved in DHHS and Department on Aging programs. For 2015, CCS is also being implemented in the Housing Division as part of a set of new initiatives. The Housing initiatives are anticipated to capture approximately \$450,000 in CCS revenue to offset their overall costs. Please refer to the budget narrative for Department 8000 – DHHS for more detail.

Central Relocations

The Community Services Branch (CSB) will continue to work closely with BHD's Rehab Centers Central team to assist in moving clients from Central into appropriate community placements. To achieve this, CARSD has included partial year funding of \$2,326,200 for at least eight clients, some with very high acuity and in need of

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secure placements, to be relocated by July 1. This will lead to the permanent closure of Central. The request will be utilized for supported apartments, group home beds, adult family home placements, possible short term referrals to the State Institutions and additional clinical supports included, but not limited to, community living support skills, one-on-one, and two-on-one enhanced staffing patterns. Since the community placements began in 2014, the individuals that will be placed in 2015 experience more challenges including emotional and behavioral health disorders, oftentimes complicated by aggression, cognitive delay, and/or medical conditions. For these individuals, enrollment in CRS or Community Options Program (COP) will be pursued. In addition, ongoing utilization reviews occur monthly for possible enrollment into Family Care.

These funds build upon the investment made in the 2014 Budget of \$793,174 which included additional contracted CSP slots, group home beds, and other supports such as adult family homes and other needed services.

Impact of the ACA

As a result of the federal Affordable Care Act (ACA), previously uninsured individuals within CSB's community-based system are anticipated to receive health care coverage either through the State's expansion of Badger Care or enrollment in the private health care exchanges. In preparation for the ACA, all of the CSB contracted Central Intake Units became Certified Application Counselor (CAC) organizations to enroll individuals into the marketplace. Medicaid and health insurance plans sold through the Exchange must provide mandated essential health benefits (EHB) that include coverage for mental health and substance abuse services. As a result, the Budget assumes 40 percent of CSB's current AODA population will achieve coverage through the ACA. This results in additional patient care revenue in CSB of \$250,000.

Access to Recovery (ATR) Grant

For the last ten years, Milwaukee County has received a federal discretionary grant called Access to Recovery (ATR) that has served as the financial structural support for the Wiser Choice voucher network for treatment and recovery support services for individuals with a substance use disorder. On an annual basis, 5,000 individuals receive services through Wiser Choice, 3,200 for clinical treatment services. CSB applied for a \$3 million grant extension of the original ATR which is scheduled to end in September 2014. Given the extreme competitive nature of the grant and the smaller pool of federal funds, Milwaukee County was not recommended for an ATR award.

In order to continue to serve its current population in need of substance use disorder treatment and recovery support services, the budget reflects a tax levy amount of \$1.5 million as a partial replacement for the loss of the ATR grant. This change reflects a reduction in expenditures of \$923,369, revenues of \$2,459,781 and tax levy increase of \$1,536,412.

Community Support Program Outsourcing

BHD is proposing to outsource the caseload currently covered by BHD's Community Support Program (CSP) – Downtown and Southside locations and have all 290 caseloads assumed by community providers through a purchase of service contract. The initiative will produce savings of \$559,132 including personnel, other expenditures and revenue reductions. This overall savings includes \$1,397,220 for the purchase of community slots, including continued implementation of the Assertive Community Treatment (ACT)/Integrated Dual Disorder Treatment (IDDT) models begun in 2014.

The Downtown CSP staff positions will be abolished as of December 1, 2014. Therefore, the full annualized savings is achieved in 2015. The Southside CSP staff positions will be abolished as of March 1, 2015 and as such, the FTE reductions reflect the annualized impact to FTEs while the savings shown in parentheses is the fiscal impact in 2015.

CSP - Downtown

- 1.0 FTE Office Supp Asst 2 (\$52,369)
- .50 FTE RN Pool (\$53,303)
- 2.0 FTE Comm Service Nurse (PR18N) (\$207,723)
- .50 FTE Adv Prac Nurse Prescriber-Pool (\$62,309)

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.50 FTE Adv Prac Nurse Prescriber (\$52,374)
.50 FTE BH Staff Psychiatrist (\$115,724)
4.0 FTE Cert Occ Therapy Asst (\$250,456)
6.0 FTE Occupational Therapist (\$554,014)
1.0 FTE Comm Supp Prog Coord (\$105,104)
3.0 FTE Psych Soc Wkr (\$226,556)
1.0 FTE Psych Soc Wkr CSP (\$81,610)

CSP - Southside

1.0 FTE Office Supp Asst 2 (\$39,621)
1.0 FTE Clerical Asst 1 (\$42,356)
.50 FTE RN Pool (\$38,025)
2.0 FTE Comm Service Nurse (PR18N) (\$162,615)
.50 FTE Adv Prac Nurse Prescriber-Pool (\$45,500)
.50 FTE Adv Prac Nurse Prescriber (\$43,468)
.75 FTE BH Staff Psychiatrist (\$153,837)
5.0 FTE Cert Occ Therapy Asst (\$256,661)
8.0 FTE Occupational Therapist (\$609,452)
1.0 FTE Comm Supp Prog Coord (\$87,236)
4.0 FTE Psych Soc Wkr (\$274,634)
1.0 FTE Psych Soc Wkr CSP (\$70,230)

These reductions result in a total annual reduction of 45 FTE.

Quality Assurance & Care Coordinator Initiatives

The budget supports the creation of five FTE Care Coordinators and one FTE Integrated Services Manager to create a care coordination unit in CARSD. The care coordinators will serve this function for clients in Community Options Program (COP) services. In addition, these positions will provide reach-in and reentry function for the Central clients relocating into the community and offer care coordination services for the clients that are identified as heavy utilizers of PCS services or those on the Community Justice Council's list of heavy PCS users and connected to the criminal justice system. As part of this initiative, the following positions are created:

5.0 FTE Care Coordinator \$455,490
1.0 FTE Integrated Services Manager \$105,102

Quality Assurance Support

The budget also reflects the creation of two Quality Assurance Specialist – AODA positions to monitor and oversee the increased demand for services and the implementation of new Medicaid benefits of Community Recovery Services and Comprehensive Community Services at a cost of \$113,620.

Wraparound Milwaukee

The Wraparound Milwaukee Program, as a special managed care or HMO model, delivers behavioral health and supportive services to children with severe emotional and mental health needs and their families.

Wrap & REACH Enrollment

Based on 2014 actual enrollment, the budget anticipates a reduction in enrollment of 200 youth, from 1,300 to 1,100, compared to the 2014 Budget. This reflects a reduction of \$5,439,400 in expenditures, \$4,631,525 in revenue for a net tax levy savings of \$807,875.

Professional Foster Care Home

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The budget establishes a professional foster care home initiative for adolescent girls who have histories of severe emotional problems and often run away from home and other facilities. The program is aimed at girls for whom a group home or residential treatment environment has been unsuccessful. The professional foster care home offers a more structured home environment with a dedicated and highly-trained foster parent. The foster parent must receive intensive training, hold a college degree as well as achieve State licensure. The rate for providing these services is \$195 per day compared to \$205 for a group home or \$311 for a residential treatment facility.

Wrap Position Changes

The budget also abolishes the following vacant positions:

2.0 FTE Community Service Nurse (\$168,544)

1.0 FTE Admin Coordinator SSI (abolish upon vacancy) (\$80,304)

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Behavioral Health Division Positions				
Title Code	2014 Budget	2015 Budget	2015/2014 Variance	Explanation
Adm Asst NR				
Accountant 2	1.0	1.0	-	
Accountant 3	1.0	1.0	-	
Accountant 4-NR	1.0	1.0	-	
Accts Rec Supv-Billing	1.0	1.0	-	
Adm Asst	2.0	2.0	-	
Adm Asst NR	2.0	1.0	(1.0)	Abolish
Adm Coord BH	12.0	12.0	-	
Adm Coord CATC	1.0	1.0	-	
Adm Coord SSI	1.0	-	(1.0)	Abolish upon vacancy
Admin Spec - MH NR	3.0	2.0	(1.0)	Abolish
Adv Prac Nurse Prescriber-Pool	10.5	9.6	(0.9)	Abolish
Adv Prac Nurse Prescriber	8.0	5.5	(2.5)	Unfund 1.0 Acute, Abolish 0.92 CSP's, Abolish 0.54 LT Care
Analyst Human Services Program		1.0	1.0	2014 Action
Asst Hosp Admtr 1	1.0	1.0	-	
Asst Program Administrator	2.0	2.0	-	
BH Clinical ProgDir Psychology	12.0	13.0	1.0	Create
BH Clinical Psychologist I	1.0	1.0	-	
BH Clinical Psychologist III	8.0	7.5	(0.5)	Abolish
BH Emer Serv Clinician	14.0	14.0	-	
BH Emer Serv Clinich RN	6.5	6.5	-	
BH House Physician 3	2.3	2.0	(0.3)	Abolish
BH House Physician 3 Hrly		2.0	2.0	Create 2.0 Hourly
BH Med Dir - Acute Services		1.0	1.0	Create
BH Med Dir - Adult	1.0	1.0	-	
BH Med Dir - Crisis Services	1.0	1.0	-	
BH Med Dir - Forensic Services	1.0	-	(1.0)	Abolish
BH Med Prog Director - CATC	2.5	2.5	-	
BH Staff Psychiatrist	18.3	13.3	(5.0)	Unfund 1.0/Abolish 4.0
BH Staff Psychiatrist Hourly	0.2	4.0	3.8	Create 4 Hourly
BHD Seasonal Worker		1.2	1.2	Create 4 seasonals
Care Coordinator		5.0	5.0	Create
Care Coordinator Wraparound	2.0	2.0	-	
Cert Occ Therapy Asst	14.3	2.1	(12.2)	Abolish
Clerical Asst 1	17.0	15.2	(1.8)	Abolish
Clerical Asst 1 Hr	0.7	0.8	0.1	Create
Clerical Asst 2	3.9	2.0	(1.9)	Abolish
Clerical Spec MHD	8.0	7.0	(1.0)	Abolish

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

Title Code	2014 Budget	2015 Budget	2015/2014 Variance	Explanation
Clin Safety and Risk Mgt Nurse	1.0	1.0	-	
Clinical Prog Dir Psy Hourly	0.1	0.1	-	
Clinical Psychologist 1- hrly	0.1	0.1	-	
Clinical Psychologist 3 Hourly	0.1	0.1	-	
Clothing Supply Clk 1	1.0	-	(1.0)	Abolish
Clothing Supply Clk 2	2.0	2.0	-	
Comm Service Nurse	6.0	0.3	(5.7)	Abolish
Comm Support Prog Coord	2.0	0.2	(1.8)	Abolish
Community Service Manager	1.0	1.0	-	
Contract Serv Coord	1.0	1.0	-	
Coordinator Grant Program		1.0	1.0	2014 Action
Coordinator Health Prevention	1.0	1.0	-	
Devlpmtl Disability Spec	1.0	1.0	-	
Dietitian 1	2.0	2.0	-	
Dietitian Supervisor	1.0	1.0	-	
Director BH Medical - QA	1.0	-	(1.0)	Abolish
Disribution Assistant	1.0	1.0	-	
ED Services Prog Coord	1.0	1.0	-	
Emergency Mgmt & Supply Coord		1.0	1.0	Create
EnvironmentalSvc Administrator	1.0	1.0	-	
Exdir1-Acuteinptsvsdir	1.0	1.0	-	
Exdir1-Deputy Prog Admin CATC	1.0	1.0	-	
Exdir1-Fiscal Servs Dir	1.0	1.0	-	
Exdir1-Psychcrisissvdi	1.0	1.0	-	
Exdir1-SAIL-Oper Coord	1.0	1.0	-	
Exdir2-Assoc Admin of Nursing	1.0	1.0	-	
Exdir2-Assoc Dir Clin Compl	1.0	1.0	-	
Exdir2-Assocmhadmtr Fis	1.0	1.0	-	
Exdir2-Assthospadm2-Mhc	2.0	2.0	-	
Exdir2-Dep Admin BHD	1.0	1.0	-	
Exdir2-Prog Admnr Catc	1.0	1.0	-	
ExDir3ChiefPsychologist -BHD	1.0	1.0	-	
Exdir3-Mh Administrator	1.0	1.0	-	
Executive Assistant MH	1.0	-	(1.0)	Abolish
Fiscal And Budget Mgr Chp	1.0	1.0	-	
Fiscal Asst 1	1.0	-	(1.0)	Abolish
Fiscal Asst 2	13.0	11.8	(1.3)	Abolish 1.5/Incr 0.5 to 0.75
Fiscal Mgt Analyst 3	1.0	1.0	-	
Fiscal Spec	7.0	7.0	-	
Hosp Maint Wrkr MHC	11.0	9.8	(1.2)	Abolish
House Physician 2 Hrly	4.0	4.0	-	
Housekeeper 1 Nr	2.0	2.0	-	

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

Title Code	2014 Budget	2015 Budget	2015/2014 Variance	Explanation
Human Ser Wkr	3.0	3.0	-	
Human Ser Wkr Child Welfare	1.0	1.0	-	
Infect Contrl Practitnr	1.0	1.0	-	
Integrated Service Coor	4.0	4.0	-	
Integrated Service Coor NR	1.0	1.0	-	
Integrated Svs Manager Supv		1.0	1.0	Create
Manager Clinical Program	1.0	1.0	-	
Materials Distrib Clerk	1.0	0.5	(0.5)	Abolish 1.0 7/1/15
Mechanical Mtce Supt	1.0	1.0	-	
Mechanical Utility Engr	1.0	1.0	-	
Med Rec Adm Mhc	1.0	1.0	-	
Med Rec Coord (BHD)	2.0	2.0	-	
Medexdir - Med Dir Psych		1.0	1.0	Create
Medical Service Manager	1.0	1.0	-	
Music Therapist	3.5	3.5	-	
Nursing Adm Coord-PR 29M	1.0	1.0	-	
Nursing Adm Coord-PR 29MN	1.0	1.0	-	
Nursing Asst 1 Mh	134.9	128.5	(6.4)	Abolish 35.3 LT Care/Create 28.8 Adult, Child, PCS
Nursing Asst MH Pool	6.0	5.0	(1.0)	Abolish
Nursing Prog Coord	8.8	7.9	(0.9)	Abolish 0.9 Long Term Care
Occ Therapist Pool	0.5	0.5	-	
Occupational Therapist	27.8	13.7	(14.1)	Abolish
Office Supp Asst 2	20.5	16.7	(3.8)	Abolish
Operating and Mtce Supv	1.0	1.0	-	
Pharmacy Tech	1.0	-	(1.0)	Abolish
Placemt Resources Mgr	1.0	1.0	-	
Pol&Pro Coord Clin Compliance	1.0	-	(1.0)	Abolish
Prog Analyst MH	4.0	4.0	-	
Prog Coord - AODA	1.0	1.0	-	
Prog Coord - CATC	2.0	2.0	-	
Prog Coord - Safety Svs	2.0	2.0	-	
Program Evaluator	1.0	1.0	-	
Psych Crisis Srvs Coord	2.0	2.0	-	
Psych LPN MHC	11.6	5.2	(6.4)	Abolish 6.4
Psych Soc Wkr	26.0	18.8	(7.2)	Abolish
Psych Soc Wkr CSP	2.0	0.2	(1.8)	Abolish
Psych Soc Wkr Pool	1.5	1.5	-	
Psychiatric Soc Wkr Mgr	1.0	1.0	-	
Psychology Postdoc Fellow	2.0	2.0	-	
Qual Assur Client Rights	1.0	1.0	-	
Qual Assur Coord	4.0	4.0	-	
Qual Assur Spec AODA	3.0	5.0	2.0	Create
Qual Assur Tech Wrap Around	1.0	1.0	-	

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

Title Code	2014 Budget	2015 Budget	2015/2014 Variance	Explanation
Qual Imprvt and Risk Coord	1.0	1.0	-	
Qual Imprvt Coord	1.0	1.0	-	
Qual Imprvt Coord BHD	1.0	1.0	-	
Qual Mangmt Admin Asst	1.0	1.0	-	
Quality Assurance Specialist	1.0	1.0	-	
-RC-Disribution Assistant	1.0	1.0	-	
Rehab Services Supervisor	1.0	1.0	-	
Rehabilitation Coordinator	1.0	1.0	-	
RN 1	89.8	87.5	(2.3)	Abolish 6.5 LT Care/Create 4.2 Adult,Child,PCS
RN 2	1.0	-	(1.0)	Abolish
RN 2 - MDS	1.0	0.2	(0.8)	Abolish
RN 2 - MH	11.5	6.1	(5.4)	Abolish
RN 2 - Staff Development	3.0	3.0	-	
RN 2 - Utiliz Review	6.5	6.5	-	
RN 2 - Wraparound	2.0	2.0	-	
RN 3 MH	6.0	6.0	-	
RN 3 MH Pool	1.0	1.0	-	
RN Pool	1.7	0.8	(0.9)	Abolish
Secretarial Asst	4.0	3.0	(1.0)	Abolish
Secretary	4.0	4.0	-	
Senior Executive Assistant MHB	-	1.0	1.0	Create
Sewing Mach Oper 2	1.0	1.0	-	
Spirituality Integ Cooed-hrly	0.5	0.5	-	
Staffing Assistant	4.5	4.0	(0.5)	Abolish
Stores Clerk 1	2.0	2.0	-	
Unit Clerk	17.8	16.4	(1.3)	Abolish
Utilization Review Coor	1.0	-	(1.0)	Abolish 1.0
Volunteer Coord-Hrly	1.0	-	(1.0)	Abolish
Subtotal Positions	696.7	615.4	(81.4)	
Overtime	50.0	21.3	(28.7)	
Salary Adjustment	5.0	3.2	(1.8)	
Shift Differential	6.2	4.6	(1.6)	
Special Premium	2.3	2.2	(0.1)	
Vacancy & Turnover	(58.8)	(40.4)	18.4	
Subtotal Other	4.7	(9.1)	(13.8)	
Grand Total	701.4	606.2	(95.2)	

*2014 Actions identified in these tables indicate mid-year 2014 actions approved by the County Board.

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
 FUND: General – 0077

EXPENDABLE TRUST ACCOUNTS

The following are expendable trust accounts, which may be utilized only for purposes which are legally mandated or where a formal trust relationship exists. The expenditures from these organizational units are limited to the purpose specifically designated by the donor. These trusts are not included as part of the BHD operating budget.

Org Unit	Description of Expendable Trust	Projected Balances as of 12/31/13
878	MHD - Research Fund	\$217,724
	Referred to as the Frieda Brunn Mental Health Research Fund. This fund was created in 1970 for the purpose of supporting mental health research. Expenditure recommendations from the fund are made by the Research Committee at BHD.	
	Expenditure	Revenue
	\$25,000	\$25,000
879	MHD - Patient Activities and Special Events	\$89,364
	This fund is comprised of various trusts which stipulate the expenditures should be made to provide for patient activities and special events.	
	Expenditure	Revenue
	\$10,100	\$10,100

Legacy Health Care and Pension Expenditures				
2013 Budget	2013 Actual	2014 Budget	2015 Budget	2015/2014 Variance
\$15,334,428	\$16,659,312	\$17,463,489	\$18,896,026	\$1,432,537

BUDGET TESTIMONY

#1

From: lucas seelow <ljseelow@gmail.com>
Sent: Friday, August 15, 2014 6:37 PM
To: Eilers, Kathleen
Subject: Closure of Milwaukee County CSP

Hello Mary Eilers,

I'm writing to you as a concerned citizen and a Milwaukee County employee on behalf of the proposed budget in relation to closing down the Downtown and Southside CSPs. I've been employed with the Program since March 2014 and have seen first hand how we have changed the individual's life and have made our community a safer and more desirable place to visit and live. I'm proud to say that I work for such a program with support from the community, co-workers, and individuals we serve.

The purpose of my email to the board is due to some possible concerns that have arisen with the proposed idea of our closure.

*The serving of the long term relationships with the clients at S-CSP and D-CSP, some of which have been in the programs for 20+ years. The average length of stay for a client is 15 years.

* Concerns about the accuracy of the protected money that will be saved by the closure of the County run CSPs.

*Timing of closure of the county run CSPs would results in 1/4 of all CSP clients throughout Milwaukee County being relocated.

*At the same time, new CSP services will be required for those being discharged from Long Term Care and Hilltop.

*Having a Milwaukee County CSP would remain a valuable safety net, particularly for client's without benefits.

*Southside CSP has bilingual Latino staff with over 35 years combined experience and are conveniently located in the near Southside Community to serve the clients that live here.

Could you please distribute this affirmation to the other board members to be reviewed before the voting of the budget on Aug. 28th.

Thank you for your time and consideration.

Sincerely,
Lucas J. Seelow, MS/OTR

WISCONSIN ADVOCACY PROJECT INC.

August 17, 2014

Milwaukee County Mental Health Board

Dear Members

Please find attached my testimony concerning the BHD proposed 2015 budget. You will notice that the format used is that of asking questions. That is due to confusion on my part whether this is the DHHS proposal to the County Executive or the actual budget being put forth by the Abele administration. In any case I would hope that you would hope that you would ask these questions and request written answers from the administration.

I would also urge the Board to insist on holding at least one public hearing on the budget at which it hears oral testimony from the public. Contrary to Planning Council presentation, the Milwaukee County Mental Health Board is not just any nonprofit agency Board. Rather it is a publically appointed Board with the responsibility of overseeing millions of dollars of public resources. As such I would urge the members of the Board and the Board as whole to establish a conduit to the public in which citizens could provide insight, and provide information outside of the formal administrative channel which has been established. Perhaps the easiest way to accomplish this is for members to be provided with a Milwaukee County email account which is listed along with member's names on the BHD website. It is imperative that as you make major policy decisions you are exposed to and can have a dialog with public that is not wholly dependent on the administration.

Thank you

Joseph Volk
Wisconsin Advocacy Project

- 1) There is a difference of \$1,095,966 in total expenditures and total revenues plus total levy on the budget summary page (p. 1) compared to the program areas listed in the budget (see breakout below). Please explain the difference.

Program Area	Total Expenditure	Total Revenues	Tax Levy	Revenues + Levy
Management/Support	\$ 2,593,071	\$ 1,783,964	\$ 809,107	\$ 2,593,071
Adult Crisis	\$ 24,595,439	\$ 11,557,645	\$ 13,037,794	\$ 24,595,439
Acute Inpatient	\$ 38,078,871	\$ 14,606,010	\$ 23,472,861	\$ 38,078,871
Rehab Central	\$ 10,278,608	\$ 1,522,678	\$ 8,755,930	\$ 10,278,608
CARSD	\$ 106,851,046	\$ 91,656,203	\$ 15,194,843	\$ 106,851,046
Subtotal	\$ 182,397,035	\$ 121,126,500	\$ 61,270,535	\$ 182,397,035
P.1 Budget Summary	\$ 183,493,001	\$ 121,422,500	\$ 62,070,501	\$ 183,493,001
Difference between subtotal and summary	\$ 1,095,966	\$ 296,000	\$ 799,966	\$ 1,095,966

- 2) The 2014 budget (Unit No. 1950) states: "Generally, legacy costs are allocated based on a 3-year average of FTE by department. Because of the allocation method for legacy costs, each department has a different rate for legacy healthcare and legacy pension costs." How will the legacy costs be allocated with the passage of Act 203? Is BHD now responsible for all legacy costs of former BHD employees whose positions are lost due to downsizing/privatizing, or will those costs continue to be allocated as a rolling average across all County departments?
- 3) The position list identifies a new position being created titled "Senior Executive Assistant MHB" (p. 20). This position is not listed in the narrative, yet the narrative identifies a contracted position of \$65,000 for Transition Liaison (p. 4). Is this the same position?
- 4) \$2,326,200 is identified for at least eight clients to move to the community for six months. Annualized, this is \$581,550 per client to reside in the community. What is the cost per client on an annualized basis to reside at Central?
- 5) The budget states that CCS is a psychosocial rehabilitation Medicaid entitlement that must move to full implementation within one year of starting. What was the start date? What is the Department's estimate of children, adolescents, adults and older adults that will be eligible for this benefit who is not currently receiving County services?
- 6) Since CCS is a psychosocial rehabilitation benefit administered by BHD, is it the opinion of the Milwaukee County Mental Health Board that departmental programs outside of BHD that utilize CCS should be transferred to the jurisdiction of the Board since it appears to pertain to mental health or be highly integrated with mental health, as identified in Act 203? If not, who will provide oversight of services rendered by other County departments, including WIMCR cost reconciliation and any future Medicaid audits?
- 7) Compared to the 2014 Adopted budget, the numbers served in Strategic Program Area 5 (p. 11) are identical under the 2013 actual number served and 2013 budget number to be served for the first 4 rows. Is the proposed 2015 budget using 2013 actual numbers, or budgeted numbers? How do AODA outpatient numbers increase in 2015 over 2014 since the narrative identifies the loss of ATR funding?
- 8) In the 2015 budget a significant amount of new dollars are allocated to "crisis community services". What is the increase in non-crisis community services, how many new clients would be served and in what non crisis program areas?

BUDGET TESTIMONY

#3

From: David Eisner [eisner.local594@yahoo.com]
Sent: Sunday, August 17, 2014 6:31 PM
To: Eilers, Kathleen
Cc: bmccamish@afscme.org; deisner@afscme48.org; eisner.local594@yahoo.com
Subject: 2015 Behavioral Health Division (BHD) Budget Testimony

Date: August 17, 2014

To: Milwaukee County Mental Health Board

From: Boyd McCamish, Executive Director, District Council 48
David Eisner, Lobbyist, District Council 48

Re: 2015 Behavioral Health Division(BHD)Budget Testimony

AFSCME, District Council 48 represents workers at the Milwaukee County Behavioral Health Division.

This memo describes our concerns about the ongoing resident relocation 2015 Budget proposal initiatives and includes some policy recommendations for your consideration.

AFSCME has traditionally represented Wisconsin workers at institutions as varied as nursing homes, mental health facilities, the state centers for the developmentally disabled as well as correctional institutions. We have also represented workers in non-institutional long term care settings-public and private.

Many of the employees are single mothers and women of color who hold family-supporting jobs. The downsizing of BHD will affect literally hundreds of working families in Milwaukee County.

Many BHD employees have been employed at BHD for a long time. They are "human infrastructure" of BHD. Their longevity provides some predictability for the clients, a critical ingredient in dealing with people with severe behavioral issues. In our experience, the same cannot be said for community settings or private agencies where turnover is high, compensation is inadequate, oversight is scant and accountability is lacking. These are serious shortcomings for policy makers who are deciding the fate of individuals with severe mental illness and behavioral challenges.

For these reasons, District Council 48 is requesting the Mental Health Board reject BHD Administration's proposal to outsource the caseload currently covered by BHD's Community Support Program (CSP)-Downtown and Southside locations.

AFSCME has literally decades of experience with federal, state and local government decisions involving the downsizing of institutions. We have learned some things along the way. Here is a list of our "best practices" recommendations for Milwaukee

County Mental Health Board policy makers:

1. Ensure that any placement made from BHD be a "voluntary placement". Define "voluntary placement" as a placement made with the explicit written approval and consent of the resident, or his or her responsible family member or guardian.
2. Ensure that all relocation plans developed for individuals relocated from BHD be developed in consultation with professional and direct care staff at BHD.
3. Require BHD Administration to provide to residents, responsible family members or guardians of individuals relocated from BHD information on the appeals and grievance processes.
4. Require BHD Administration to submit an annual report to the Mental Health Board on the status of all individuals that were placed in the community from BHD since 2011. Specify that the report should include the following:
 - a) An assessment of the impact of the relocations on the health status of individuals who have been relocated within the previous year; which could be measured by assessing the person's weight, changes in the medication regimen, hospitalizations, re-commitment to a psychiatric facility, success/failure in day treatment programs
 - b) A listing of every setting where relocated residents currently reside and all other settings where they have lived since they left BHD in order to monitor the ongoing well-being of individuals relocated from BHD
 - c) Information on the involvement of guardians or family members of residents who have been relocated
 - d) Information on the cause of death of individuals who were relocated that have passed away
 - e) Information on whether individuals committed crimes or were jailed or imprisoned since they were relocated

Many of these ideas are not new, but they are rarely considered in public policy debates involving initiatives to move clients from institutions to less restrictive settings. We borrowed some of these suggestions from a law that AFSCME helped craft several years ago-2005 ACT 386, when the legislature was debating the downsizing of nursing homes and state centers for the developmentally disabled.

Please feel free to contact us at (414) 344-6868, or at the above listed email addresses if you have any questions. Thank you for your consideration in these matters.

Boyd McCamish
Executive Director
AFSCME, District Council 48

David Eisner
Lobbyist
AFSCME, District Council 48



The Milwaukee Mental Health Task Force is committed to being a leader in identifying issues faced by all people affected by mental illness, facilitating improvements in mental health services, giving consumers and families a strong voice, reducing stigma, and implementing recovery principles.

Date: August 17, 2014

Re: Testimony on 2015 Milwaukee County Behavioral Health Division Requested Budget

From: Mary Neubauer, Milwaukee Mental Health Task Force Co-chair, Maryneubauermcmhb@gmail.com
 Martina Gollin Graves, Milwaukee Mental Health Task Force Co-chair, Martina@mhawisconsin.org
 Barbara Beckert, Milwaukee Mental Health Task Force Coordinator, barbara.beckert@drwi.org

To: Kimberly Walker, Chair - Milwaukee County Mental Health Board
 Members of the Milwaukee County Mental Health Board

We are writing to you on behalf of the Milwaukee Mental Health Task Force to share initial analysis of the 2015 Behavioral Health Division (BHD) Budget Request and our 2015 budget recommendations for your consideration.

As you may know, the Milwaukee Mental Health Task Force was formed in 2004, in response to a crisis in inpatient psychiatric services that exposed major gaps in Milwaukee's system of mental health care. It includes over 40 organizations who work collaboratively to identify issues faced by people affected by mental illness, facilitate improvements in services, give consumers and families a strong voice, reduce stigma, and implement recovery principles. The Task Force works collaboratively with the Make It Work Coalition to provide analysis and education on state and county budgets, as well as other policy issues. Last week, our coalitions hosted a briefing on the *2015 County Budget Department Requests as Submitted to the County Executive*. We are in the process of developing our budget paper and securing answers to a number of questions. The analysis and recommendations provided in this document may evolve, as additional information is secured.

The Milwaukee County Mental Health Board (MCMHB) was established with the mission of advancing a community-based, person-centered, recovery-oriented system that seeks to protect the personal liberties of individuals living with mental illnesses. The Milwaukee County budget is a key vehicle for achieving this system transformation, including full inclusion of people with mental illness and other disabilities in the community, and shifting services and supports from overreliance on institutional and crisis care to increased access to high quality community supports. Achieving system transformation is not easy and will require very significant expansion of community services and supports including housing, benefits counseling, employment services, outpatient services, case management, peer run services, and more. If we are to see a dramatic reduction in the nearly 11,000 people a year seen at the county's psychiatric emergency room, more community capacity building and bold action are needed.

Wisconsin Act 203 identifies a range for tax levy that must be included in the Behavioral Health Division budget. The Departmental request states: "The legislation authorizes the MCMHB to propose a budget to the County Executive that includes the total amount of the budget, the community aids amount and a property tax levy amount. The dollar amount of the tax levy must be at least \$53 million but not more than \$65 million." The Division request identifies a proposed tax levy amount of \$62 million, leaving \$3 million of levy available and on the table for mental health services. Given the stated intent of Act 203 to shift services to the community, we believe it would be prudent to utilize the full amount of levy authorized under the Act to expand and enhance community services, including case management and outpatient. Investment of these dollars in 2015 will also greatly assist with the transition to new community initiatives such as Comprehensive Community Services (CCS) while simultaneously reducing the impact of the loss of \$3.5 million in Federal grants expiring this year. Fully financing community services in 2015 could be expected to yield a greater return on investment in future years as the County becomes adept at leveraging CCS and Community Recovery Services (CRS), which will ultimately allow the Division more flexibility to manage the levy amount within the stated range of Act 203.

We also encourage the MCMHB to hold a public hearing on the 2015 BHD budget, as the BHD budget will no longer be included in the scope of the Milwaukee County Board of Supervisors Public Hearing. This is a very important opportunity for dialogue with community members regarding their frontline experiences and perspectives, and we believe it is vital to ensuring a transparent and substantive oversight role.

Thank you for your consideration of this analysis and recommendations, and your service to the community. Please feel free to contact us to follow up – we welcome the opportunity for dialogue.

BEHAVIORAL HEALTH DIVISION COMMUNITY ACCESS TO RECOVERY SERVICES DIVISION (CARSD)

Expansion of Community Services is vital to achieving the “community-based, person-centered, recovery-oriented system” mandated in Act 203. Investing in expanded access to community services is a top priority.

Community Access to Recovery Services Division 2015 Budget Highlights

- **Wiser Choice ATR (Access to Recovery) Grant.** The County will lose approximately 30% of funding for AODA services with the end of federal ATR funding. That funding of approximately \$3.6 million in grants will lapse at the end of September. Given the reduced funding, it seems likely that significantly fewer people will be served. The budget request includes \$1.5 million to partially fill the hole caused by the loss of this funding. *Note: Other SAMHSA grants to Milwaukee County community providers also expire in September. All told, Milwaukee will see \$5M in SAMHSA funds come to an end in less than 3 months.*
- \$2,326,200 is allocated to serve at least eight clients from Rehab Central and develop community services and supports for these clients.
- Tax levy of \$314,677 is allocated to develop two eight bed housing options. *Note: Staff have indicated these may be group homes/CBRFs or other smaller settings such as supported apartments.*
- Outsource the two county Community Support Programs (CSP). *Question: How much will be saved by outsourcing CSPs; two figures are cited on page 14. Will dollars saved be invested to serve more people and expand access?*
- **Care Coordination:** The budget supports the creation of five FTE Care Coordinators and one FTE Integrated Services Manager to create a care coordination unit. The care coordinators will serve this function for clients in Community Options Program (COP) services. In addition, these positions will provide reach-in and reentry function for the Central clients relocating into the community and offer care coordination services for the clients that are identified as heavy utilizers of PCS services or those on the Community Justice Council's list of heavy PCS users and connected to the criminal justice system.
- **Implementation of Comprehensive Community Services.** Funding for the CCS benefit is state and federal funding – not county funding. However, staff support from Milwaukee County is provided to implement and coordinate CCS. The budget reflects the creation of two Quality Assurance Specialists – AODA positions to monitor and oversee the increased demand for services and the implementation of the new Medicaid benefits of Community Recovery Services and Comprehensive Community Services at a cost of \$113,620.

Recommendations for Community Access to Recovery Services Budget

Support the BHD Community Services Budget Request including the following:

- Allocation of \$1.5 million to restore funding for AODA services. This will partially replace the loss of \$3.6 million in federal funds. *Note: It would be helpful if the Mental Health Board could receive an analysis of on the expected decrease in the number of people served, or other service reductions expected given this significant loss of funding. A larger allocation may be needed.*
- Allocation of \$2,326,200 to develop and fund community services and placements for at least eight Central clients. *Note: The timeline for closing Central and Hilltop must be aligned with development of individualized community capacity for these residents. The timeline for closing must have some flexibility to allow for needed development of community capacity.*
- Creation of Care Coordination Unit and related staff, and Quality Assurance staff for community programs. Staff support is needed to implement and coordinate new Medicaid benefits.
- Development of additional residential capacity as funded in the budget, with a priority given to smaller less institutional settings.

(continued)

Recommendations for Additional Community Investments

We ask the Mental Health Board to consider advancing this additional community investment:

Expand Peer Run Services. Peer run services are an evidence-based practice which can promote recovery for those providing the service, as well those receiving services. The HSRI Report noted that Milwaukee County has lagged behind in provision of peer run services and urged that it be a priority to develop additional peer run services and to expand those currently in existence.

- Establish a North Side Peer Run Drop In Center (\$278,000). The County currently funds a South Side Peer Run Drop In Center, as well as Our Space, which offers a range of programming options, also located on the South Side. Equitable access is needed on the North Side and should be a high priority given the significant number of individuals seen at PCS who live on the North Side. *Note: See also the recommendation for funding of Warmline in the Adult Crisis Services budget.*

Questions about Community Access to Recovery Services budget

Obtain more information about the following:

- How will dollars saved from privatizing the two county CSPs be used? We urge that savings be dedicated to expanding community services and serving more people.
- The budget should include a breakout for numbers served in Targeted case Management (TCM), Community Support Program (CSP), and group homes for 2013, 2014, and 2015 as provided for other community programs. Are there waiting lists, formal or informal, for any of these programs?
- CCS is supported by state and federal funds. Is CCS expected to save money in other programs (CSP or TCM, for example) funded by Milwaukee County? If so, how will the funds saved be allocated?

BEHAVIORAL HEALTH DIVISION – ADULT CRISIS SERVICES

Adult Crisis Services 2015 Budget Highlights

Includes Psychiatric Crisis Service Emergency Room, Access Clinic, Crisis Line, Crisis Mobile Team, and Crisis Stabilization Centers

- There are some staffing changes and increases: “In 2015, BHD will implement a new nurse staffing model to insure 24-hour coverage of shifts while accounting for the productive hours of employees excluding paid time off. Staff was also added for one to one coverage of patients as needed. To implement these staffing models, 9.2 FTEs of Nursing Asst 1 Mh and 2.0 FTEs of RNI were created with a corresponding decrease of 4.7 FTEs of overtime in the Adult Crisis Services Area.
- The budget projects a modest decrease in admissions at PCS from 11,068 to 10,681.
- The budget projects an increase in the number of crisis mobiles from 1,642 to 1,806.
- The projected number of clients served at the Access Clinic remains the same for 2015: 6,576. This may decline given that the Access Clinics serve only uninsured and Milwaukee County has seen an increase in the number of people insured due to both BadgerCare and access to insurance through the marketplace.
- The budget projects that there will be fewer emergency detentions as a result of ACT 235 legislation (emergency detention pilot program in Milwaukee County that enables Treatment Directors or Designees to complete emergency detentions only when involuntary care is required), which is meant to increase use of stabilization services in the community and decrease admissions to PCS and hospitalization.

Recommendations for Additional Investment in Adult Crisis Services Budget

We ask the Mental Health Board to consider advancing these additional investments in Crisis Services:

- Establish a North Side Access Clinic (\$250,000). The Access Clinics have been very successful in increasing access to outpatient services for uninsured individuals. Access clinics are located at the Complex and on the south side. A high percentage of those using BHD services are from the north side of Milwaukee; however, most expansion of community services has been on the South side including the south side Access Clinic, the south side Peer Run Drop in Center, and the Pathways to Permanent Housing established in the 2013 and 2014 budget. We urge you to address the significant unmet needs on the north side, and to allocate funding for a North Side Access Clinic, as well as the Peer Run Drop in Center mentioned earlier in this document. Equitable access is needed on the North Side and should be a high priority given the significant use of emergency services in this area and the need to provide diversion.
- Allocate \$25,000 to support Warmline, Inc., Milwaukee's longest running peer run program. As noted earlier in this paper, the HSRI report made the case for expansion of peer run services in Milwaukee. Warmline is a non-crisis support line run by and for people living with mental illness. It has been in operation for nearly 14 years, and has received over 70,000 calls for support during this time. Warmline is open from 7:00 PM to 11:00 PM on Sunday, Monday, Tuesday, Wednesday, Friday and Saturday and all holidays - times when most other services and providers are not available. La Linea de apoyo, the newly established Spanish WARMLINE is now open Saturday and Sunday from 7 – 10 PM. Warmline services divert people from ER's and PCS, and reduce calls to case managers, as well as to the Milwaukee County Crisis Line. Based on the outstanding results from Warmline and the proven track record of success, we recommend allocating \$25,000 to help Warmline sustain current operations; funding is needed to support staff costs related to new requirements from the state.
- Add a Certified Peer Specialist to the Crisis Mobile Team, as an additional resource to support and engage individuals experiencing a mental health crisis.
- Evaluate the new 24 hour coverage model for mobile crisis to determine if the allocated resources are successful in meeting the goal of providing 24 hour coverage.

BEHAVIORAL HEALTH DIVISION – INPATIENT AND LONG TERM CARE

Inpatient and Long Term Care 2015 Budget Highlights

- New staffing model: “In 2015, BHD will implement a new nurse staffing model to insure 24-hour coverage of shifts while accounting for the productive hours of employees excluding paid time off. Staff was also added for one to one coverage of patients as needed.”
- Central scheduled to close by November 2015.
- Hilltop is scheduled to be closed by the end of 2014.
- Inpatient beds are maintained at current levels, pending results of the inpatient capacity study and continuing dialogue with other providers.

Recommendations for BHD Inpatient and Long Term Care Services Budget

- Support the new nursing staffing model, pending additional information and clarification: *Isn't 24 hour coverage of shifts current practice? The budget language seems to suggest it is not.*
- The MHTF continues to support closure of Central and Hilltop with the provisions that closure should only occur when each resident has a quality community placement that they and/or their guardian have approved and that provides individualized, recovery oriented, comprehensive services and supports. The timeline for closure needs to be person centered and allow for flexibility given the need for significant development of community capacity by BHD and Managed Care Organizations (MCOs). We hope this development will be expedited to support the closure timeline. However, the timeline for facility closure must be flexible if capacity development and placements take longer than expected.
- We support continued efforts to develop more inpatient capacity with the private hospitals and more community diversion services, including contracting, – as an alternative to county inpatient services. Following the release of the capacity study in September, we will further assess recommendations regarding inpatient beds at the Complex.
- A plan is also needed for serving others individuals who need intensive support moving forward, who are not eligible for Family Care and would have been referred to Rehab Central in the past.

Questions about BHD Inpatient and Long Term Care Services Budget

- The 2015 budget has significant increased expenditures for inpatient services (approximately \$5 million increase for inpatient). Given the commitment to downsizing inpatient and expanding community services why is there such a significant increase for the inpatient services?
- Revenue is projected to increase by \$3.6 million – what is the source. The only new revenue mentioned is ACA of \$250,000.
- Is the creation of 19.6 FTE of Nursing Asst (p. 8) and 2.2 FTE RNs expected to eliminate the reported current practice of heavy reliance on mandatory overtime?

ADDITIONAL CONCERNS

The Milwaukee Mental Health Task Force has also developed recommendations to address the life and death of Dontre Hamilton, a young man who lost his life in Red Arrow Park in April 2014, as a consequence of his contact with an officer of the Milwaukee Police Department. Some of these recommendations have budget implications. We will also share those recommendations separately with the Mental Health Board.

BEHAVIORAL HEALTH DIVISION

2ND QUARTER 2014

FISCAL REPORT

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BHD Combined

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KEY FISCAL ITEMS AS OF JUNE 2014

Behavioral Health Division – Inpatient

- Clinical Staffing
- Overtime
- State Plan Amendment Revenue
- Hilltop Downsizing

CARSD – Community Access to Recovery Services Division

- CRS Billing
- WRAP Crisis Revenue
- CCS Billing Implementation

BHD - Combined Reporting Q2 2014 Fiscal Results P & L Summary

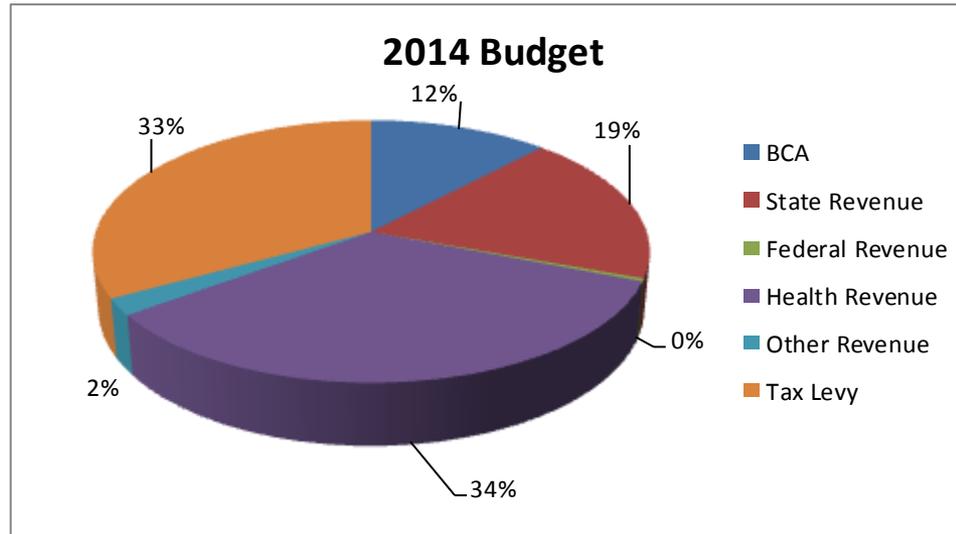
		2013	2014	2014	2014
		Actual	Budget	Actual YTD	Projection
BHD Combined	Revenue	118,722,888	122,481,941	57,588,107	120,076,863
	Expense	<u>179,245,135</u>	<u>182,885,420</u>	<u>77,144,745</u>	<u>180,174,995</u>
	Tax Levy	<u><u>60,522,247</u></u>	<u><u>60,403,479</u></u>	<u><u>19,556,638</u></u>	<u><u>60,098,132</u></u>
BHD Inpatient	Revenue	33,704,918	31,209,314	17,330,859	33,907,547
	Expense	<u>86,084,156</u>	<u>80,648,746</u>	<u>37,865,017</u>	<u>83,963,541</u>
	Tax Levy	<u><u>52,379,238</u></u>	<u><u>49,439,432</u></u>	<u><u>20,534,158</u></u>	<u><u>50,055,994</u></u>
CARSD	Revenue	85,017,970	91,272,627	40,257,248	86,169,316
	Expense	<u>93,160,979</u>	<u>102,236,674</u>	<u>39,279,728</u>	<u>96,211,454</u>
	Tax Levy	<u><u>8,143,009</u></u>	<u><u>10,964,047</u></u>	<u><u>(977,520)</u></u>	<u><u>10,042,138</u></u>

BHD - Combined Reporting

Q2 2014 Fiscal Results

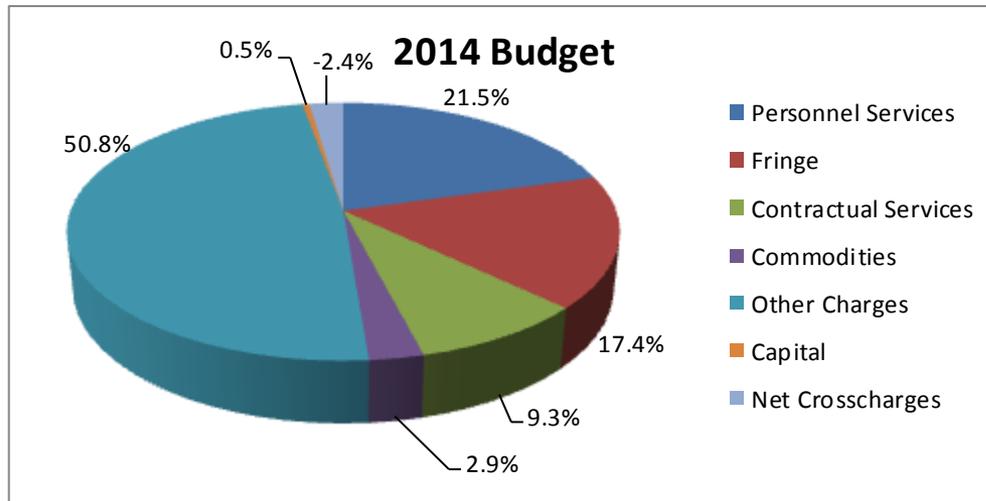
Revenue Summary

BHD COMBINED	2013 Actual	2014 Budget	2014 Actual YTD	2014 Projection
BCA	22,357,608	22,016,586	12,843,012	22,016,586
State Revenue	34,504,888	33,929,039	15,620,257	32,802,337
Federal Revenue	962,530	649,915	139,087	587,500
Health Revenue	57,949,363	62,138,034	28,013,457	62,227,220
Other Revenue	2,948,499	3,748,367	972,292	2,443,220
Sub-Total Revenue	<u>118,722,888</u>	<u>122,481,941</u>	<u>57,588,105</u>	<u>120,076,863</u>
Tax Levy	<u>60,522,247</u>	<u>60,403,479</u>	<u>19,556,638</u>	<u>60,098,132</u>
	<u><u>179,245,135</u></u>	<u><u>182,885,420</u></u>	<u><u>77,144,743</u></u>	<u><u>180,174,995</u></u>



BHD - Combined Reporting Q2 2014 Fiscal Results Expenditure Summary

BHD COMBINED	2013 Actual	2014 Budget	2014 Actual YTD	2014 Projection
Personnel Services	43,351,559	39,374,420	20,111,200	41,313,128
Fringe	29,407,717	31,791,161	14,559,428	31,791,161
Contractual Services	19,405,946	17,049,288	8,014,776	18,437,593
Commodities	5,458,214	5,257,511	1,569,842	4,773,495
Other Charges	85,251,528	92,978,253	34,856,800	87,676,072
Capital	721,330	883,468	193,315	593,090
Net Crosscharges	(4,351,159)	(4,448,681)	(2,160,616)	(4,409,544)
	<u>179,245,135</u>	<u>182,885,420</u>	<u>77,144,745</u>	<u>180,174,995</u>



BHD - Combined Reporting

Non Controllable Expenses – Legacy and Cross Charge

	2013 Actual	2014 Budget	2015 Budget
External OH Crosscharges	\$ 7,339,122	\$ 5,928,427	\$ 7,546,171
Legacy Healthcare	\$10,614,733	\$ 9,194,584	\$11,121,978
Legacy Pension	\$ 6,028,886	\$ 5,137,553	\$ 7,774,048
Total Expenses	<u>\$23,982,741</u>	<u>\$20,260,564</u>	<u>\$26,442,197</u>
FTE Count	610.4	536.1	584.3
Cost Per FTE	<u>\$ 39,290</u>	<u>\$ 37,793</u>	<u>\$ 45,254</u>
2015 Increase in Non-Controllable Per FTE			<u><u>\$ 7,462</u></u>

BHD - Combined Reporting

Q2 2014 Fiscal Results

FTE and Overtime

<u>BHD - Combined</u>		<u>2013</u> <u>Actual</u>	<u>2014</u> <u>Budget</u>	<u>2014</u> <u>June YTD</u>
FTE	Inpatient	603	577	575
	CARSD	105	124	110
	Total	<u>708</u>	<u>701</u>	<u>685</u>

OVERTIME - Inpatient *

	Jan	Feb	Mar	April	May	June
Overtime Hours	9,474	8,843	9,370	8,646	8,687	8,107
Overtime Dollars	\$303,409	\$255,761	\$274,080	\$256,210	\$258,064	\$261,418

* YTD CARSD Overtime is immaterial.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: August 28, 2014

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

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Randy Oleszak, Fiscal Director, Department of Health and Human Services

SUBJECT: **A report from the Director, Department of Health and Human Services, requesting authorization to increase expenditure authority and offsetting revenue to reflect projected services actuals in the Behavioral Health Division**

Issue

BHD is currently projecting a deficit of about \$1.9 million in its services accounts specifically in the areas of temporary help services, food, housekeeping and licensed bed fees charged by the State of Wisconsin. This deficit is primarily due to the slower than expected closure of Rehabilitation Center-Hilltop which is projected to result in revenues and expenditures in excess of the 2014 Adopted Budget.

BHD's 2014 Adopted Budget assumed the number of licensed beds on Hilltop would be reduced from 48 to 24 by May 1, 2014 with an ultimate closure of the remaining 24 licensed beds by November 1, 2014. As of Aug. 1, 2014, Hilltop has a census of 35 residents which puts it behind its budget targets.

Available funding to support the increase in expenditures will be derived from patient care revenue for Hilltop residents as well as the receipt of one-time Disproportionate Share Hospital revenue provided by the State. Therefore, approval of this appropriation transfer request as shown below results in a zero tax levy impact.

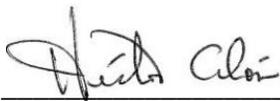
Service Description	Increase
Housekeeping	\$100,000
Temporary Help	\$650,000
State Bed Fees	\$350,000
Food	\$700,000
Equipment Rental	\$100,000
Total Expense	\$1,900,000
Patient Revenue	\$1,100,000
Other Revenue	\$800,000
Total Revenue	\$1,900,000
Net Tax Levy	\$0

Although there is no tax levy impact to this transfer, the adjustment is required to increase the expenditure authority within BHD so that outside services contracts can be paid.

Recommendation

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to increase expenditures and revenues within BHD's 2014 Adopted Budget as detailed above.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Héctor Colón", written over a horizontal line.

Héctor Colón, Director
Department of Health and Human Services

cc: Patricia Schroeder, BHD Administrator
Kathleen Eilers, BHD Consultant
Jodi Mapp, Senior Executive Assistant, BHD
Josh Fudge, Fiscal and Budget Administrator
Scott Manske, Comptroller
Matt Fortman, DAS Fiscal & Management Analyst

**COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION**

Date: August 12, 2014
To: Milwaukee County Mental Health Board Chair, Kimberly Walker
From: Frederick J. Bau, Department of Human Resources--Labor Relations
RE: Adoption of the 2014 Memorandum of Agreement between Milwaukee County and the Federation of Nurses and Health Professionals for Milwaukee County Mental Health Board Bargaining Unit Positions in Certain Organizational Units

Milwaukee County has reached an understanding with the bargaining team for the Federation of Nurses and Health Professionals (FNHP) that establishes a Memorandum of Agreement (MOA) for 2014 for Milwaukee County Mental Health Board (MCMHB) bargaining unit positions in certain organizational units. The County has also negotiated a 2014 MOA with the FNHP for bargaining unit positions in non-MCMHB organizational units that has been approved by the Milwaukee County Board and County Executive. Terms of the non-MCMHB MOA are the same as the MCMHB MOA.

I am requesting that this item be placed on the August 28, 2014, agenda for the MCMHB meeting as an action item.

The following documents are attached for the Board's review:

- 1) The Tentative Agreement between the County and the Union;
- 2) A Union notification that the MOA was ratified by the membership;
- 3) A Fiscal Impact Statement that has been prepared by the Office of the Comptroller.

If you have any questions, please call me at 223-1932.

cc: Raisa Koltun, Interim Chief of Staff, Office of the County Executive
Scott Manske, Comptroller
Jerome Heer, Director, Audit Division
Don Tyler, Director, Department of Administrative Services
Kerry Mitchell, Chief Human Resources Officer
Paul Bargren, Corporation Counsel
Patricia Schroeder, Administrator, Behavioral Health Division
Kathleen Eilers, Transitional Liaison, Behavioral Health Division
Jodi Mapp, Senior Executive Assistant to Administrator, Behavioral Health Division
Luis Padilla, Employee Relations Director

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7-24-14
JW

**2014
AGREEMENT
BETWEEN
COUNTY OF MILWAUKEE
AND
FEDERATION OF NURSES AND HEALTH PROFESSIONALS
LOCAL 5001, AFT, AFL-CIO**

**MILWAUKEE COUNTY
LABOR RELATIONS
COURTHOUSE, ROOM 210
901 NORTH NINTH STREET
MILWAUKEE, WISCONSIN 53233
414-278-4852**

TA
7-24-14
JW

2014
Federation of Nurses and Health Professionals
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2014
AGREEMENT
BETWEEN
COUNTY OF MILWAUKEE
AND
FEDERATION OF NURSES AND HEALTH PROFESSIONALS
LOCAL 5001, AFT, AFL-CIO

This Agreement made and entered into by and between the County of Milwaukee, a municipal body corporate, as municipal employer, hereinafter referred to as "County" and the Federation of Nurses and Health Professionals, as representatives of employees who are employed by the County of Milwaukee hereinafter referred to as "Federation". **The County is a party to this Agreement by virtue of the power granted to the Milwaukee County Mental Health Board under Wis. Stat. 51.41 (10).**

WITNESSETH

In consideration of the mutual covenants herein contained, the parties hereto do hereby mutually agree as follows:

PART 1

1.01 RECOGNITION

The County of Milwaukee agrees to recognize and herewith does recognize the Federation of Nurses and Health Professionals, Local 5001, AFT, AFL-CIO, as the exclusive collective bargaining agent on behalf of bargaining unit classifications, in accordance with the certification of the Wisconsin Employment Relations Commission as amended, made pursuant to Subchapter IV, Chapter 111.70, Wisconsin Statutes.

1.02 BARGAINING UNIT DEFINED

(1) Whenever the term "employee" is used in this Agreement, it shall mean and include bargaining unit nurses of Milwaukee County in **Organizational Units 6323, 6325, 6332,**

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1 6334, 6336, 6363, 6364, 6373, 6383, 6443, 6445, 6446, 8703, 8704, 8713 and 8751 in the
2 following classifications: Registered Nurse I, Registered Nurse II, Registered Nurse II
3 Utilization Review, Registered Nurse II (Mental Health), Registered Nurse II Staff
4 Development, Advance Practice Nurse Prescriber, Clinical Nurse Specialist, Community
5 Service Nurse, EMS Instructor, RNII Adult Services Division, RNII Department on
6 Aging, Infection Control Practitioner, RN I (Pool), Clinical Safety and Risk Management
7 Nurse, Advance Practice Nurse Prescriber (Pool), Forensic Chemist, Occupational
8 Therapist, Occupational Therapist (Pool), Music Therapist and Behavioral Health
9 Emergency Service Clinician.

10 (2) When classifications are created which have not been certified by the Wisconsin
11 Employment Relations Commission to any bargaining unit, the employer shall notify the
12 Federation within 30 days of the creation of such classifications and send the copies of
13 the job descriptions of same. Upon request of the Federation, the parties shall meet and
14 attempt to enter into a stipulation of agreement regarding the inclusion or exclusion of the
15 classifications. If the parties reach an agreement, they shall jointly notify the Wisconsin
16 Employment Relations Commission of the agreement and request the Commission to
17 certify the classification(s) as being represented by the Federation. If the parties fail to
18 reach an agreement, either party may petition the Commission for a determination under
19 Chapter 111.70.
20

21 1.04 DURATION OF AGREEMENT

- 22 (1) The provisions of this Agreement shall become effective January 1, 2014, unless otherwise
23 herein provided. Unless otherwise modified or extended by mutual agreement of the
24 parties, this Agreement shall expire on December 31, 2014. If during the term of this
25 Agreement the State Legislature modifies the educational requirements for the licensure of
26 Registered Nurses, the County agrees to meet with the Federation for the singular purpose
27 of negotiating the impact of such legislative action on wages, hours and conditions of
28 employment.
- 29 (2) The initial bargaining proposals of the County and the Federation for a successor agreement
30 shall be exchanged at a time mutually agreeable to the parties. Thereafter, negotiations shall
31 be carried on in an expeditious manner and shall continue until all bargainable issues
32 between the parties have been resolved.
33

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PART 2

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2.01 WAGES

(1) Effective Pay Period 10, 2014, (April 13, 2014), the wages of bargaining unit employees shall be increased by one percent (1%).

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This Agreement shall remain in full force and effect until replaced by a subsequent Agreement.

Dated at Milwaukee, Wisconsin, this _____ day of _____, 2014.

(Three copies of this instrument are being executed, all with the same force and effect as though each were an original.)

FEDERATION OF NURSES
AND HEALTH PROFESSIONALS
LOCAL 5001, AFT, AFL-CIO

COUNTY OF MILWAUKEE
a municipal body corporate

BY _____
Candice Owley
President, WFNHP

BY _____
Chris Abele, County Executive

BY _____
Jeff Weber
President, Local 5001

BY _____
Joseph J. Czarnecki, County Clerk

BY _____
Paul Bargren, Corporation Counsel

BY _____
Scott Manske, Comptroller

IN PRESENCE OF

IN PRESENCE OF

Susan Schwegel
Chief Steward, Local 5001

Frederick J. Bau,
Labor Relations

Approved for Execution

Mark A. Grady
Deputy Corporation Counsel



Wisconsin Federation
of Nurses & Health
Professionals AFT, AFL-CIO

A Union of Professionals

9620 West Greenfield Ave.
West Allis, WI 53214-2601
T: 414/475-6065
800/828-2256
F: 414/475-5722
www.wfnhp.org

June 25, 2014

Frederick J. Bau
Senior Labor Relations Specialist
Milwaukee County Labor Relations
901 N 9th Street, Room 210
Milwaukee, WI 53222

Dear Mr. Bau,

This letter is inform you that on May 15, 2014, the members of the Milwaukee County Chapter of Wisconsin Federation of Nurses and Health Professionals, Local 5001, AFT, AFL-CIO, voted to ratify the 2014 tentative agreement between the County and the Union.

Please let the union office know if you need any further details.

Sincerely,

Jeff Weber, RN
WFNHP Local 5001 President
Milwaukee County Chapter President

Candice Owley, RN
WFNHP President

- Local 5001*
DynaCare Laboratories
Milwaukee County
St. Francis Hospital
- Local 5011*
Sheboygan City
Professionals
Sheboygan County
Health Care Centers
Sheboygan County
Divisions of Public Health &
Community Programs
- Local 5012*
Memorial Hospital of
Burlington
- Local 5024*
Dodge County Public
Health & Human Services
- Local 5032*
Clement J Zablocki Veterans
Administration Medical
Center
- Local 5033*
Langlade Memorial Hospital
- Local 5034*
Eagle River Memorial
Hospital
- Local 5035*
Middle River Health &
Rehabilitation Center
- Local 5037*
Wood County Health
Department
- Local 5038*
West Allis Health
Department
- Local 5039*
Ridgewood Care Center
- Local 5040*
Cumberland Memorial
Hospital
- Local 5061*
Brookside Care Center
Kenosha County Division of
Health
- Local 5068*
Manitowoc County Health
Department
- Local 5084*
Columbia County
Department of Health &
Human Services

MILWAUKEE COUNTY
LABOR RELATIONS

2014 JUN 26 PM 5: 24

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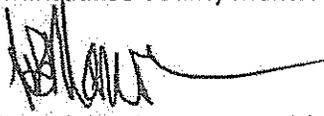
An affiliate of the
American Federation
of Teachers, AFL-CIO



COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE: August 4, 2014

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

FROM: Scott B. Manske, Comptroller 

SUBJECT: Fiscal Impact – 2014 Collective Bargaining Agreement with the Federation of Nurses and Health Professionals Local 5001, AFT, AFL-CIO

Under Wisconsin Employment Relations Commission (WERC) rules and Statute Statute, non-public safety bargaining units are only allowed to negotiate for base wage increases on an annual basis. The start of the bargaining year for the Federation of Nurses and Health Professionals Local 5001, AFT, AFL-CIO (FNHP) was January 1, 2014. The last day of their previously negotiated contract was December 31, 2013. The bargaining unit was recertified, according to the Milwaukee County Department of Labor Relations.

2014 Base Wage Limit

Using rules provided by WERC, a calculation was made to provide the maximum base wage increase allowable for 2014 for this bargaining unit. The calculation was based on the members of the bargaining unit in the pay period that was 180 days prior to the expiration date of the most recent collective bargaining agreement. The pay period used was Pay Period 15 2013 (ending July 6, 2013). At that time, the bargaining unit had 214 members who were actively employed.¹ The annual wages of the members were calculated based upon their existing wage rates and were then multiplied by the CPI applicable to bargaining years beginning on January 1, 2014 or 1.66 percent. This became the maximum base wage increase allowable for purposes of bargaining or \$153,761.²

2014 Wage Increase and Base Wage Compliance

Based upon the proposed agreement with the bargaining unit, the base wage rates will increase by 1.0 percent effective with Pay Period 10 (beginning April 13, 2014). The determination of compliance with Base Wage Limit uses the proposed 1.0 percent increase for the portion of the calendar year which the increase is in effect. As a result, the base wage increase will result in a total salary lift for 2014 of \$60,564 for the bargaining unit, which is within the maximum base wage increase allowable. Calculation of the maximum base wage increase for the bargaining unit was made in accordance with the WERC rules. No provision was made for any litigation that may have occurred subsequent to the issuance of those rules, and we have no knowledge of any such litigation. Representatives of Labor Relations,

¹ For purposes of this fiscal note, the FNHP bargaining unit consists of all represented employees only under control of the Milwaukee County Mental Health Board.

² The FNHP bargaining unit had 214 total authorized positions as of July 6, 2013 (authorized positions having the definition provided by WERC "...those positions in the bargaining unit that are filled"). However, 39 of these employees were pool or hourly positions. These employees have been excluded for purposes of calculating the maximum base wage increase and total salary lift due to language within the WERC rule ERC 90.03(3) which states to multiply the hourly base wage rate by the annual number of regularly scheduled hours for each authorized position when determining maximum base wage increases. Since these positions do not have regularly scheduled hours, they have been excluded.

Corporation Counsel, Department of Administrative Services, Office of the Comptroller and outside legal counsel have discussed and agreed to the definition, negotiation, and calculation of base wages.

Impact of 2014 Wage Increase on 2014 Budget and 2015 Budget

Based upon the proposed agreement with the bargaining unit, the base wage rates will increase by 1.0 percent effective with Pay Period 10 (beginning April 13, 2014). The cost of the wage increase for 2014, using the contract effective date, would be as follows:

Salary Increase	\$ 60,564
FICA	\$ 4,633
Pension - County Portion	\$ 6,178
Pension - Employee Contribution	\$ (3,089)
Net Cost	\$ 68,286

The 2014 Adopted Budget included an appropriation for the 1.0 percent wage increase for the bargaining unit, with a similar effective date and therefore, there is no resulting budgetary impact based on the proposed agreement for the current year. Since this wage increase inflates the base wage of these employees it would therefore impact each subsequent year budget. The budget impact on 2015, assuming the same pension percentages, would be as follows:

Salary Increase	\$ 92,627
FICA	\$ 7,086
Pension - County Portion	\$ 9,448
Pension - Employee Contribution	\$ (4,724)
Net Cost	\$ 104,437

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: August 28, 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: **A report from the Director, Department of Health and Human Services, requesting authorization to retroactively increase the purchase of service contract with Community Advocates for the Milwaukee County Substance Abuse Prevention Coalition and Stay Strong Milwaukee in the Behavioral Health Division**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health 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. Per Wis. Stat. 51.41(10), the Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase the existing purchase of service contract with Community Advocates for a universal substance abuse prevention strategy funded by a federal Substance Abuse Prevention and Treatment Block Grant award of \$71,700 from the Bureau of Milwaukee Child Welfare.

Discussion

Milwaukee County Substance Abuse Prevention Coalition

Community Advocates administers and staffs the work of the Milwaukee County Substance Abuse Prevention (MCSAP) Coalition. 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. The mission of MCSAP is to improve the quality of lives in our community by preventing the harmful consequences of substance use and abuse among youth, families and the larger community.

Community Advocates also administers and staffs the work of Stay Strong Milwaukee. Stay Strong Milwaukee partners with local agencies to promote alcohol and drug abuse (AODA) prevention activities in Milwaukee County.

Given the experience of Community Advocates administering the MCSAP Coalition work, Stay Strong Milwaukee activities and prevention programming, BHD is proposing to partner to

provide additional programming and media messaging to prevent substance use and abuse especially among youth and families.

The requested increase of \$71,700 aligns the scope of work and the annual collection of data related to the National Outcome Measurement System/Government Performance and Results Act (NOMS/GPRA). In addition, BHD is required to report the number of evidence-based programs, policies and practices implemented and the number of people reached by the prevention strategies used. Community Advocates possesses the linkages through the coalition and Stay Strong Milwaukee program to deliver a preventative intervention and report the outcomes of the universal prevention strategies.

The \$71,700 in funds awarded through the federal Substance Abuse Prevention and Treatment Block Grant will be used for two purposes: 1) to provide additional evidence-based substance abuse prevention programming targeting high-risk parents and youth in the amount of \$26,700; and 2) to provide universal substance abuse preventative interventions targeting marijuana, prescription drug misuse and heroin use through public service announcements and other evidence-based universal strategies in the amount of \$45,000.

Fiscal Effect

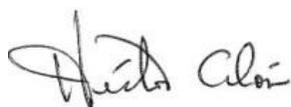
The contract increase is 100 percent funded through the federal grant and has no tax levy impact. A fiscal note form is attached.

BHD continues to oversee this contract to ensure Community Advocates adheres to the performance measures and contract administration requirements and oversight currently included in all purchase of service contracts with the Department of Health and Human Services.

Recommendation

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to retroactively increase the existing purchase of service contract by \$71,700 beginning September 1, 2014 for a total contract allocation of \$571,700 with Community Advocates for the Milwaukee County Substance Abuse Prevention Coalition and Stay Strong Milwaukee for the time period of January 1, 2014 through December 31, 2014.

Respectfully Submitted,



Héctor Colón, Director
Department of Health and Human Services

cc: Patricia Schroeder, BHD Administrator
Kathleen Eilers, BHD Consultant
Jodi Mapp, Senior Executive Assistant, BHD

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 8/28/14

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: A report from the Director, Department of Health and Human Services, requesting authorization to retroactively increase the purchase of service contract with Community Advocates for the Milwaukee County Substance Abuse Prevention Coalition and Stay Strong Milwaukee in the Behavioral Health Division

FISCAL EFFECT:

- | | |
|--|--|
| <input type="checkbox"/> No Direct County Fiscal Impact
<input type="checkbox"/> Existing Staff Time Required
<input checked="" type="checkbox"/> Increase Operating Expenditures
(If checked, check one of two boxes below)
<input type="checkbox"/> Absorbed Within Agency's Budget
<input type="checkbox"/> Not Absorbed Within Agency's Budget
<input type="checkbox"/> Decrease Operating Expenditures
<input checked="" type="checkbox"/> Increase Operating Revenues
<input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures
<input type="checkbox"/> Decrease Capital Expenditures
<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> 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.

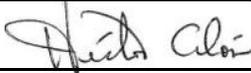
	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	\$71,700	0
	Revenue	\$71,700	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

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

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
- B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated.¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
- C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
- D. Describe any assumptions or interpretations that were utilized to provide the information on this form.
- A. Approval of the request would permit BHD to retroactively amend an existing purchase of service contract with Community Advocates to administer \$71,700 in federal Substance Abuse Prevention and Treatment Block Grant funds awarded by the State's Bureau of Milwaukee Child Welfare. The term of the amendment would be January 1, 2014 to December 31, 2014.
- B. The recommended amendment would increase the contract by \$71,700 to \$571,700.
- C. There is no tax levy impact associated with approval of this request as the contract increase is 100 percent funded through the federal grant.
- D. No assumptions are made.

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

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: August 28, 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 Jim Kubicek, Deputy Administrator, Behavioral Health Division

SUBJECT: **A report from the Director, Department of Health and Human Services, requesting authorization to execute a contract with Rogers Memorial Hospital, Inc. for indigent hospital admissions**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health 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. Per Wis. Stat. 51.41(10), the Director of the Department of Health and Human Services (DHHS) is requesting authorization to establish a contractual relationship with Rogers Memorial Hospital, Inc. (Rogers).

Background

The proposed fee-for-service contract will specifically target patients who present at Psychiatric Crisis Services (PCS) that require admission to an inpatient facility and do not have insurance. This contract will primarily be used as a census management tool when the Behavioral Health Division (BHD) begins to approach capacity.

Currently, BHD transfers approximately 1,300 individuals annually to the private health systems. Up to this point, each of these individuals was required to have a payor source. Under this agreement, BHD can begin to transfer individuals that are indigent and BHD becomes the payor.

This agreement will only apply to direct transfers from BHD to Rogers.

At this time, this agreement reflects an amount not-to-exceed of \$500,000 and is effective July 14, 2014 to July 14, 2015. Additional funding must be reviewed and/or approved by the Milwaukee County Mental Health Board.

BHD's 2014 Adopted Budget included \$890,000 in funding to support the cost of care for individuals placed at one of the State institutions. It is projected there will be a surplus of about \$245,000 in this account to cover the cost of the contract in 2014. The remaining cost of the contract would be covered by funds included in the 2015 Budget. The 2015 portion of the contract is contingent upon approval of BHD's 2015 Budget.

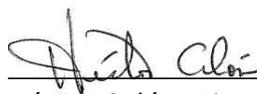
Rogers agrees to comply with all policies and procedures related to documentation of services provided as a condition for billing for the service. Rogers will maintain records and financial statements as required by state and Federal laws, rules, and regulations. Rogers will also retain all the documentation necessary to demonstrate the date, time, duration, location, intervention, summary of the activity engaged in and patient's response to the service provided.

Rogers further agrees not to disclose any confidential material or information connected with BHD or transferred patients.

Recommendation

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to execute an indigent care fee-for-service contract with Rogers Memorial Hospital, Inc. in an amount not-to-exceed \$500,000 beginning July 14, 2014 through July 14, 2015.

Respectfully Submitted,



Héctor Colón, Director

Department of Health and Human Services

cc: Patricia Schroeder, BHD Administrator
Kathleen Eilers, BHD Consultant
Jodi Mapp, Senior Executive Assistant, BHD
Jim Kubicek, Deputy Administrator, BHD

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 8/28/14

Original Fiscal Note

Substitute Fiscal Note

SUBJECT: A report from the Director, Department of Health and Human Services, requesting authorization to execute a contract with Rogers Memorial Hospital, Inc. for indigent hospital admissions

FISCAL EFFECT:

- | | |
|--|--|
| <input type="checkbox"/> No Direct County Fiscal Impact
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(If checked, check one of two boxes below)
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<input type="checkbox"/> Increase Capital Revenues
<input type="checkbox"/> Decrease Capital Revenues
<input type="checkbox"/> 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		

DESCRIPTION OF FISCAL EFFECT

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

- A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
 - B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. ¹ If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
 - C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
 - D. Describe any assumptions or interpretations that were utilized to provide the information on this form.
-
- A. Approval of the request would permit BHD to execute a fee-for-service contract with Rogers Memorial Hospital, Inc. beginning July 14, 2014 through July 14, 2015. The contract would pay for the care of uninsured individuals who are transferred from BHD to Rogers for inpatient admission.
 - B. The recommended contract reflects a total not-to-exceed amount of \$500,000.
 - C. There is no tax levy impact associated with approval of this request as the cost of the contract is being covered by a projected surplus in funds budgeted for patient transfers to State institutions. BHD's 2014 Adopted Budget includes \$890,000 for care at State institutions and a surplus of \$245,000 is anticipated. The remaining funding of \$255,000 is included in the 2015 proposed budget and is contingent upon approval of BHD's 2015 Budget.
 - D. No assumptions are made.

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

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
INTER-OFFICE COMMUNICATION**

DATE: August 18, 2014
TO: Kimberly R. Walker, JD, Chairperson, Milwaukee County Mental Health Board
FROM: Heather Martens, PsyD, President of the Medical Staff Organization
SUBJECT: MEDICAL STAFF EXECUTIVE COMMITTEE REPORT TO THE BOARD

The Milwaukee County Mental Health Board will play an integral role in Medical Staff Governance. In accordance with regulatory requirements, the Board may expect the Medical Staff to present, at each Board meeting, their recommendations on applications for Medical Staff and Allied Health Professional privileging and appointment for Board action. In addition, when changes are recommended to Medical Staff Bylaws and Rules and Regulations, those changes shall also require Board action. Neither the Medical Staff or the Board may unilaterally amend these documents. In accordance with Joint Commission standard MS.01.01.01, EP9, authority to implement and amend Medical Staff policies is delegated to the Medical Staff Executive Committee (MEC) under current Medical Staff Organization Bylaws [Section 5.3.1 (13) (c)]. Therefore, policies and procedures shall be presented as informational only unless Board members direct otherwise.

As a first introduction to the Medical Staff Organization of the Behavioral Health Division, orientation materials describing regulatory requirements pertaining to the relationship between the Board, Hospital Administration and Medical Staff Leadership and Governance functions have been prepared for you. Additional information pertaining to medical staff affairs or concerns will be made available whenever needed or requested.

I. ORIENTATION TO THE MEDICAL STAFF ORGANIZATION

From the Executive Medical Director, President of the Medical Staff, Chair of Credentialing and Privileging and Director of Medical Staff Services presenting orientation information:

- A. Medical Staff Leadership and Governance
- B. Capabilities of a Psychiatric Hospital
- C. Overview: Credentialing, Privileging, Appointment, Peer Review and Corrective Action

MEDICAL STAFF REPORT TO THE BOARD

August 18, 2014

Page 2

II. CREDENTIALING AND PRIVILEGING REPORT

From the President of the Medical Staff and Chair of Credentialing and Privileging Review presenting recommendations for appointments and/or privileges:

- A. New Appointment(s)
- B. Reappointments
- C. Provisional Reviews / Status Changes
- D. Leave of Absence
- E. Notations Reporting (to be presented at meeting)

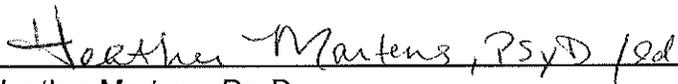
III. BYLAWS, RULES/REGULATIONS, POLICIES/PROCEDURES

From the President of the Medical Staff presenting policy/procedure updates, as INFORMATIONAL ONLY unless otherwise directed by the Board:

- A. Categorization of Applications for Appointment and/or Privileges (New)
- B. Approved Drug List (Formulary) Policy (New)
- C. Specialty Board Certification/Board Equivalency of Medical Managers (revised)
- D. Continuing Education Requirements – Medical Staff and Privileged Allied Health Professionals (revised)
- E. Abbreviations - Medical Record 2014 (revised in connection with EHR)

Prepared by: Lora M. Dooley, Director of Medical Staff Services

Recommended and Approved by:



Heather Martens, PsyD

President of the BHD Medical Staff Organization

cc Patricia Schroeder, BHD Administrator
John Schneider, BHD Executive Medical Director

Attachments

- 1 Medical Staff Leadership and Governance
- 2 Overview: Credentialing, Privileging, Appointment, Peer Review & Corrective Action
- 3 Medical Staff Credentialing Report & Medical Executive Committee Recommendations
- 4 Categorization of Applications for Appointment and/or Privileges
- 5 Approved Drug List (Formulary) Policy
- 6 MS 3.1.2.5-Specialty Board Certification/Board Equivalency of Medical Managers
- 7 MS 4.0.1-Continuing Education Requirements-Medical Staff and Privileged Allied Health Professionals
- 8 Abbreviations – Medical Record 2014

Medical Staff Leadership & Governance

Specialty Hospital Capabilities

Presentation to the Governing Board

June 12, 2014

John Schneider MD FAPA
Milwaukee County Behavioral Health Division
Executive Medical Director

Leadership and Governance

Basis of relationship between the
Medical Staff Organization and Governing Board

1) Wisconsin DHS 124: Hospitals

- 124.05 Governing Body
- 124.12 Medical Staff

2) 42 CFR 482

- So called Medicare Conditions of Participation

3) The Joint Commission

- Leadership Standards

Whom do we listen to on leadership?

"Leadership in Healthcare Organizations: A Guide to Joint Commission (TJC) Leadership Standards."

A Governance Institute White Paper.
Winter 2009

Paul M. Schyve, M.D.

Leaders and Systems

Good leadership is important for the success of any organization.

But...

- Who are the "leaders" in healthcare organizations?
- What is "good leadership" in healthcare organizations?
- What is the "success" that healthcare organizations seek?

Leaders and Systems -2

Prior to 1994 in TJC Standards:

Management
Governance
Medical Staff
Nursing Services

Each had their "own" chapter of standards.

...As if, the good performance of each unit would assure the success of the organization.

Leaders and Systems -3

TJC sought expert advice from nation's leading healthcare management, clinical practice and academic practice to review this approach...

Unanimous feedback and advice:

STOP thinking of a healthcare organization as a conglomerate of units, think of it as a **SYSTEM**.

Leaders and Systems -4

Contextualize Leadership into the Mission and Goals:

Primary goal is to provide high-quality, safe care to those who seek its help.

Secondary goals to be financially sustainable, provide community service, function as an ethical business and others.

Leaders and Systems -5

So...

No longer is the focus on the performance of each group of leaders.

But rather on **how the leaders in the organization work together to achieve those goals.**

Leaders and Systems – The Who

Part One:

Who are the “leaders” and “groups of leaders?”

- The Governing Body
- Chief Executive Officer (CEO) and other senior managers (“C-Suite”)

Leaders and Systems – The Who -2

Part Deux: The But...

Healthcare Organizations and certainly Hospitals, have a third leadership group:

- Leaders of the physicians and other licensed independent practitioners (LIPs).

Leaders and Systems – The Who -3

Part Deux: The Why...

Healthcare decision about diagnoses and treatment are made by LIPs.

LIPs can ONLY be clinically supervised by other LIPs.

Clinical decisions drive most of the use of resources and affect the organizations ability to achieve its primary goal of high-quality and safe care.

Leaders and Systems – The Who -4

Part Duex: Thus, Therefore and Ergo:

To fail to adequately incorporate into the organization's leadership LIPs leaders to evaluate and establish direction for the clinical care and decision making of the organizations LIPs, is to create a FUNDAMENTAL GAP in the leadership's capability to achieve the organization's goals for safety, quality, finical sustainability, community service and ethical behavior.

Leaders and Systems – The Who -5

TJC Standards for Leadership address THREE groups:

- The Governing Body
- The CEO and other senior managers
- The leaders of the LIPs (The Medical Managers and the Medical Staff Organization Leadership)

Leaders Working Together

Team Characteristics:

- Shared Vision and goal
- Shared Plan to achieve the goal
- Clarity about each member's role
- Each member's individual competence
- Understanding other members strengths and weaknesses
- Effective Communication
- Monitoring of members' functions
- Backing Each Other Up
- Mutual Trust

Leaders Working Together -2

There is little ambiguity in law or in TJC Standards as to where the ultimate responsibility and authority lie with respect to safety and quality of care, it is with the Governing Body.

However, as the board is not a LIP, it cannot clinically supervise patient care decisions. Consequently, to effectively fulfill its accountability for the safety and quality of care, the board MUST work collaboratively with the medical staff leaders to that goal.

Leaders Working Together -3

Leaders are all aligned with the mission and goals related to the quality and safety of care

Leaders share the goal of meeting the needs of the population served

Leaders provide knowledge and skills

Leaders manage conflicts between groups in their decision making

Leaders demonstrate mutual respect and civility with the goal of building trust

Behavioral Health Division Medical Staff Organization

Overview: Credentialing, Privileging,
Appointment, Peer Review & Corrective Action

What is Credentialing?

Joint Commission

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization.

Credentialing involves the collection, verification and assessment of information regarding three critical parameters

- Current licensure
- Education and relevant training
- Experience, ability and current competence to perform the requested privilege(s)

Why Perform Credentialing?

The most important reasons to credential are:

- ▶ **Patient Safety** – The number one concern
- ▶ **Risk Management** – If the provider has problems that would have been revealed by credentialing, but credentialing was not performed, the hospital may be liable
- ▶ **Required by accrediting and regulatory agencies**

Who Gets Credentialed ?

(Joint Commission)

Any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision. Such individuals must operate within the scope of his or her license consistent with individually granted clinical privileges

How is Credentialing Performed?

For Hospitals, the Process is Established within the Following Medical Staff Governing Documents:

- ▶ Bylaws
- ▶ Rules and Regulations
- ▶ Policies and Procedures

The Scope of the Process Includes:

- ▶ Criteria / Policy Development
- ▶ Application Process
- ▶ Verification Process – Information Gathering
- ▶ Review/Recommendation/Action
- ▶ Proctoring/Provisional Period
- ▶ Recredentialing/Reappraisal (must be done at least every 2 years)
- ▶ Other (amendments, discipline, leave of absence)

Credentialing Application Content and Verification Scope

Best Practice Elements:

1. Proof of Identity
2. Education and Training
3. Military Service
4. Professional Licensure
5. DEA Registration (Federal & State)
6. Board Certification
7. Affiliation and Work History
8. Criminal Background Check
9. Sanctions Disclosure
10. Health Status
11. National Practitioner Data Bank (NPDB)
12. Malpractice Insurance
13. Professional References

(Adopted in May 2014 by National Association of Medical Staff Services)

Credentialing is the Process of Assessing the Application Quality

WHAT TO LOOK FOR

- › Application is Complete
- › Disclosure Questions are answered affirmatively
- › References are positive
- › Relevant training is complete
- › Previous affiliations are verifiable
- › Privileges requested correlate with training and experience
- › Applicant has the ability to perform the privileges requested (*there is no indication of physical, cognitive or substance abuse impairment that could impact performance of a privilege*)
- › Red Flags/Potential Concerns

WHAT ARE SOME EXAMPLES OF RED FLAGS ?

- › History of disciplinary actions by hospitals, organizations, societies or state medical/professional boards
- › Past or present investigative proceedings
- › Malpractice claims history includes 3 or more incidents / liability coverage canceled
- › References fail to respond or recommend with reservation
- › Reports of problems in the applicant's professional practice
- › Unexplained time gaps of greater than 30 days, since medical school/professional school completion
- › Failure to maintain current CME/CE requirements
- › Discrepancies in information between application, CV and verifications
- › Missing information/unanswered questions
- › Frequent moves / job changes

What is Privileging ?

- › Privileging is the process whereby the specific scope and content of independent patient care services are authorized for a practitioner by a health care organization based on evaluation of the individual's credentials and performance.
 - Meets the criteria for "core" privileges (basic competencies acquired in the accredited training program for the specialty)
 - Meets the criteria for "special request" privileges (additional training, volume of procedures performed annually, acceptable peer review outcomes)
 - Assuring that the practitioner is only permitted to request and be granted privileges that can be safely exercised at the hospital (equipped and staffed to support the procedure)
 - Privileges must be requested, evaluated and granted no less than once every 24 months. Unsupported petitions for special request privileges are not granted
 - Newly granted privileges are subject to provisional period and focused professional practice evaluation (FPPE) – proctoring

What is Appointment ?

Appointment (membership) is what determines a medical staff member's rights, responsibilities and functions in medical staff committees, leadership and governance. Membership categories determine the political rights a practitioner has as a member of the Medical Staff including, but not limited to, hold office, vote, constitute a quorum, amend Bylaws, hold a meeting with the MEC, recall an election.

Criteria for Appointment (Membership)

- ▶ Internal
 - Criteria for membership categories are determined by the Medical Staff and approved by the Governing Body.
- ▶ External
 - Requirements are set by forces outside the organization
 - Accrediting and certifying bodies
 - State and Federal laws and regulations

Responsibilities / Accountabilities

All of the following bodies are accountable for making informed decisions and for being able to defend the bases for those decisions. Applicants have the burden of proof that they meet all established criteria and for satisfying any questions or concerns that may arise during the credentialing process. Applications are not considered complete until all questions/concerns have been answered to the satisfaction of the Medical Staff. Most issues are resolved by the time the application reaches the MEC.

Credentials Committee

- ▶ Reviews practitioners specific credentialing information and department evaluations and makes recommendations to MEC related to individual privileges and medical staff membership
- ▶ Develops, reviews or recommends policies and procedures related to credentialing processes

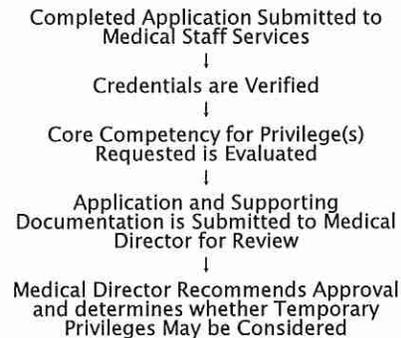
Medical Executive Committee (MEC)

- ▶ Makes recommendations directly to the Governing Body regarding:
 - The process used to review credentials and delineated privileges
 - The delineation of privileges for each practitioner
 - Medical Staff membership appointments

Governing Body

- ▶ Takes action on recommendations submitted by MEC
 - The final decision to grant or deny appointment and/or privileges lies with the Governing Body

Credentialing



Appointment & Privileging



Corporate Negligence

- ▶ Hospitals have liability under the doctrine of corporate negligence for inadequate credentialing, privileging and/or peer review. Hospitals, along with their medical staffs, must exercise reasonable care to assure that practitioners on the medical staff are competent and qualified to exercise their clinical privileges.
- ▶ If a hospital knows *or should have known* that a practitioner is not qualified and competent, and if the practitioner injures a patient through an act of negligence, the hospital could face liability.

Example of Corporate Negligence in Wisconsin

Johnson v. Misericordia Community Hospital (1981):

The patient in this case was injured by a surgeon who failed to disclose on his medical staff application that he had several pending malpractice cases, and falsified his application by lying about the status of his privileges at other hospitals in the community. The hospital gave the physician temporary privileges, made him Chief of Staff, and allowed him to sign off on his own medical staff application. Had they performed due diligence, they would have learned that the physician had restricted privileges at several hospitals and was not allowed to perform surgery independently. The court ruled that if the hospital had exercised reasonable due diligence, it would have discovered the adverse information. Therefore, the hospital was exposed to liability for any patient harm subsequently caused by this physician.

On-going Professional Practice Evaluation

- ▶ What is OPPE?
 - Joint Commission required activity
 - Routine monitoring of current competency for Medical Staff members (MD, DO, DDS, DPM, Psychologists) and Advanced Practice Professionals (NP, APNP)
 - What types of data is used in OPPE?
 - Generic Screens and Clinical Pertinence Assessments
 - Seclusion/Restraint data
 - Drug usage data
 - Patient satisfaction survey data (when available)
 - Other relevant data as determined by the Medical Staff

Peer Review – What is it?

- ▶ The review/evaluation of health care services in order to improve quality of care and avoid improper utilization of services
- ▶ A fair, credible, consistent and efficient process of evaluating performance based on rules, rates and case review, performance thresholds & expectations
- ▶ Measuring performance against expectations and providing feedback when improvement is needed as well as when quality of care is deemed exemplary
- ▶ Focused on education & improvement, not on finding fault

Peer Review Tools

- ▶ When peer review demonstrates a need for improved practitioner performance:
 - Detailed performance improvement plans with specific goals and time frames for completion
 - Observation & proctoring
 - Mentoring
 - Focused continuing medical education requirements
 - Regular feed back on performance

Comprehensive Framework

- ▶ American Council on Graduate Medical Education (ACGME) developed a set of general competencies for teaching programs
- ▶ Medical Staff organizations have adopted the same general competencies as a comprehensive framework for peer review and ongoing professional practice evaluation

Patient Care and Medical Knowledge

- ▶ **Patient Care** – practitioners must be able to provide patient care that is compassionate, appropriate and effective. Practitioners are expected to:
 - Gather information
 - Synthesize material
 - Partner with patients & families
- ▶ **Medical /Clinical Knowledge** – practitioners must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, and apply this knowledge to patient care.
 - Acquire knowledge
 - Analyze knowledge
 - Apply knowledge

Interpersonal & Communication Skills and Professionalism

- ▶ **Interpersonal & Communication Skills** – practitioners must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, families and members of the health care team. Practitioners are expected to:
 - Communicate effectively across a broad range of socioeconomic and cultural backgrounds
 - Communicate effectively with physicians, other health care professionals, and health related agencies
 - Work effectively as a member or leader of a health care team
 - Act in a consultative role to other health care professionals
 - Maintain comprehensive, timely and accurate medical records
- ▶ **Professionalism** – practitioners must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Practitioners are expected to demonstrate:
 - Compassion, integrity, and respect for others
 - Responsiveness to patient needs that supersedes self-interest
 - Respect for patient privacy and autonomy
 - Sensitivity and responsiveness to a diverse patient population, including diversity in gender, age, culture, race, religion, disabilities and sexual orientation

Practice-Based Learning and Improvement / Systems-Based Practice

- ▶ **Practice-based Learning and Improvement** – Practitioners must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence and life-long learning. Practitioners are expected to meet the following objectives:
 - Identify strengths, deficiencies, and limits of one's knowledge and expertise
 - Set learning and improvement goals & meet learning goals
 - Systematically analyze practice using quality improvement methods
 - Locate and assimilate evidence from scientific studies related to patient's health problems
 - Use information technology to optimize patient care
 - Participate in the education of patients, families, students and other health care professionals
- ▶ **Systems-based Practice** – Practitioners must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Practitioners are expected to:
 - Work effectively in various health care delivery settings and systems relevant to their clinical specialty
 - Coordinate patient care within the health care system relevant to their clinical specialty
 - Incorporate considerations of cost awareness and risk benefit analysis in patient care as appropriate
 - Advocate for quality care and optimal patient care
 - Work effectively in teams to enhance patient safety and improve the quality of patient care
 - Participate in identifying system errors and implementing system solutions

Corrective Action

- ▶ When reasonable efforts to improve, correct or remediate fail, or when the practitioner refuses to engage in meaningful improvement, the Medical Staff, through its Medical Executive Committee, will initiate corrective action in accordance with the Medical Staff Bylaws.

Corrective Action Requiring MEC Approval

- ▶ The following corrective actions may be taken by the Medical Executive Committee, are not reportable to the National Practitioner Data Bank, and do not entitle the practitioner to due process rights:
 - A warning
 - A letter of reprimand
 - A monitoring agreement
 - Suspension of 30 days or less
 - Probation

Corrective Action Requiring MEC and Board Approval

- ▶ The following corrective actions recommended by the Medical Executive Committee entitle the practitioner to due process rights, must be reported to the National Practitioner Data Bank, and requires Governing Board approval:
 - Reduction or limitation of clinical privileges
 - Revocation of Medical Staff membership and clinical privileges
 - Imposition of mandatory consultation requirement

Corrective Action by the Governing Board

- ▶ If the Board takes a corrective action entitling the practitioner to due process rights that was not specifically recommended by the MEC, the Board shall first refer the matter back to the MEC for consideration.
- ▶ If the MEC does not modify its original recommendation, the Board may modify the action of the MEC, but must assure that due process rights are granted the practitioner before the corrective action is finalized.

Due Process Rights & Federal Law

The Health Care Quality Improvement Act of 1986 (HCQIA) established:

- The National Practitioner Data Bank, and all requirements to report and query
- Immunity from civil money damages for participants in peer review (excluding damages related to civil rights actions)
- Definition of "professional review action" as an action or recommendation by a professional review body which is taken or made during a professional review activity based on competence or professional conduct which affects or may affect a physician's clinical privileges or membership
- Adequate notice and hearing/appeal procedures for physicians who are the subject of reportable professional review actions.
- Individual state peer review statutes further address requirements and protections for medical staff participants and hospitals (Wisconsin 146.37 and 146.38)

Questions?

Contacts

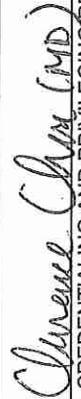
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PROVISIONAL STATUS REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE AUGUST 7, 2014	MEDICAL STAFF EXECUTIVE COMMITTEE AUGUST 14, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Robert Clark, MD	General Psychiatry; General Medical Practice	Active / Provisional	SC M#, PR	Dr. Khazi recommends appointment & privileges, as requested	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.	
AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	REQUESTED / RECOMMENDED CHANGE	NOTATIONS	APPOINTMENT IN ACCORDANCE WITH MEDICAL STAFF BYLAWS	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE AUGUST 7, 2014	MEDICAL STAFF EXECUTIVE COMMITTEE AUGUST 14, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Anna Berg, MD	Affiliate/ Psychiatric Officer; Medical Officer Practice	Affiliate/ General Psychiatry, General Medical Practice		Dr. Thrasher recommends change in status and privileges, as requested	Committee recommends amending privileges, as requested, for a 6 month provisional period	Recommends amending privileging as per C&PR Committee.	
OTHER	LICENSING BOARD ACTION	CURRENT CATEGORY/ STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE AUGUST 7, 2014	MEDICAL STAFF EXECUTIVE COMMITTEE AUGUST 14, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Graig Aders, MD	Board Order Stipulation Entered into - Issued 7/16/14	Affiliate	L	Dr. Thrasher and Dr. Schneider reviewed and recommend no action regarding privileges.	Committee notes and recommends no action.		

MEDICAL STAFF GOVERNING DOCUMENTS AND POLICY/PROCEDURE UPDATES	COMMITTEE ACTIONS	GOVERNING BODY ACTIONS
Abbreviations - Medical Record (2014) (Revised)	7/15/14: Expedited approval by Executive Medical Director, 8/14/14 Affirmed by MEC	Informational only unless Board Members object.
Approved Drug List (Formulary) Policy (NEW)	7/3/2014: Expedited approval by Executive Medical Director in connection with Plan of Correction (Acute Inpatient); 07/10/14-Approval affirmed by MEC	Informational only unless Board Members object.
Categorization of Applications for Appointment and/or Privileges (New)	8/7/14: Approved by Credentials Committee; 8/14/14- approved by MEC	Informational only unless Board Members object.
Specialty Board Certification/Board Equivalency of Medical Managers (Rev)	8/7/14: Approved by Credentials Committee; 8/14/14- approved by MEC	Informational only unless Board Members object.
Continuing Education Requirements - Medical Staff and Privileged Allied Health Professionals (Rev)	8/7/14: Approved by Credentials Committee; 8/14/14- approved by MEC	Informational only unless Board Members object.
BOARD COMMENTS/OBJECTIONS:		
<p style="text-align: center;">  CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE </p> <p style="text-align: center;"> 8/19/14 DATE </p> <p style="text-align: center;">  PRESIDENT, MEDICAL STAFF ORGANIZATION CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE (MEL Desjardes) 8/20/14 DATE </p>		

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 MEC, UNLESS OTHERWISE INDICATED ABOVE. MEDICAL STAFF POLICIES/PROCEDURES ARE APPROVED AS PRESENTED, UNLESS OTHERWISE NOTED.

GOVERNING BOARD CHAIRPERSON _____ DATE APPROVED _____

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
MEDICAL STAFF ORGANIZATION

CATEGORIZATION OF APPLICATIONS FOR APPOINTMENT AND/OR PRIVILEGES
MEDICAL STAFF & ALLIED HEALTH PROFESSIONALS

NEW APPLICANTS		REAPPOINTMENT APPLICANTS
CATEGORY 1	<p>ALL OF THE FOLLOWING MUST APPLY:</p> <ul style="list-style-type: none"> - No history of corrective action (hospital/licensing board) - Clean Criminal Background Check - Minimal or no malpractice claims history <ul style="list-style-type: none"> Dismissal from 1 or 2 claims and/or 1 or 2 settlements/payments of \$30,000 or less and/or Cases older than 20 years - Privilege requests are appropriate to specialty training - Good references 	<p>ALL OF THE FOLLOWING MUST APPLY:</p> <ul style="list-style-type: none"> - No history of corrective action (hospital/licensing board) - Criminal Background Check reveals no new Category 2 findings since last appointment - Minimal or no malpractice claims history <ul style="list-style-type: none"> Dismissal from 1 or 2 claims and/or 1 or 2 settlements/payments of \$30,000 or less and/or Cases older than 20 years - Privilege requests are appropriate to specialty training - Good Service Chief/Supervisor recommendation
CATEGORY 2	<p>NO HISTORY OF CORRECTIVE ACTION BUT ONE OR MORE OF THE FOLLOWING APPLY:</p> <ul style="list-style-type: none"> - Criminal Background Check findings unrelated to Caregiver Law Offenses - Malpractice claims history <ul style="list-style-type: none"> 3 or more dismissed claims and/or 1 or 2 settlements/payments at or under \$500,000 and/or 1 or 2 open claims pending - Unusual privilege requests 	<p>NO HISTORY OF CORRECTIVE ACTION BUT ONE OR MORE OF THE FOLLOWING APPLY:</p> <ul style="list-style-type: none"> - Criminal Background Check reveals new non-felony or non-DUI findings unrelated to Caregiver Law Offenses, since last appointment - Malpractice claims history <ul style="list-style-type: none"> 3 or more dismissed claims and/or 1 or 2 settlements/payments at or under \$500,000 and/or 1 or 2 open claims pending - Unusual privilege requests
CATEGORY 3	<p>IF ONE OR MORE OF THE FOLLOWING APPLY:</p> <ul style="list-style-type: none"> - History of corrective action (hospital/licensing board) - Criminal Background Check findings related to Caregiver Law offenses and/or offenses or conviction for driving under the influence (DUI) and/or a federal felony conviction - Malpractice Claims History <ul style="list-style-type: none"> 3 or more malpractice claims within the last 20 years (open or closed resulting in settlements or payments) - References revealed adverse or potentially adverse information 	<p>IF ONE OR MORE OF THE FOLLOWING APPLY:</p> <ul style="list-style-type: none"> - History of corrective action (hospital/licensing board) - Criminal Background Check findings related to Caregiver Law offenses and/or offenses or conviction for driving under the influence (DUI) and/or a federal felony conviction - Malpractice Claims History <ul style="list-style-type: none"> 3 or more malpractice claims within the last 20 years (open or closed resulting in settlements or payments) - Adverse Service Chief/Supervisor or peer recommendation
TEMPORARY PRIVILEGES	<p>DOES NOT APPLY.</p>	
PRIVILEGE AMENDMENTS	<p>Notations reporting to follow reappointment criteria.</p>	
REVIEWED/APPROVED:	<p>Medical Staff Services 07/29/2014</p>	<p>Medical Staff Executive Committee 08/14/2014</p>
	<p>Credentialing and Privileging Review Committee 08/07/2014</p>	<p>Governing Board</p>

POLICY & PROCEDURE MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION	<u>DATE ISSUED:</u> 07/03/14	<u>SUBJECT:</u> APPROVED DRUG LIST (FORMULARY) POLICY		
	<u>DATE REVIEWED* / REVISED:</u>	<u>SECTION:</u> 3.5 Medications Alpha - F	<u>POLICY NUMBER:</u> MS 3.5.1	<u>PAGE(S)</u> 1 of 2
MEDICAL STAFF				

I. REQUESTS FOR ADDING A NEW MEDICATION TO THE APPROVED DRUG LIST (FORMULARY):

- A. Prescribing Medical Staff Members may submit a formal request, in writing, to the Pharmacy and Therapeutics Committee (pre made or pre filled out documentation from pharmaceutical companies are not allowed).
- B. Pharmacy and Therapeutics Committee will review newly FDA approved medications quarterly.

II. ANNUAL REVIEW OF APPROVED DRUG LIST:

- A. Annually, in the first quarter, the Pharmacy and Therapeutics Committee will review the following list and make recommendations to the Medical Staff Executive Committee no later than the March meeting:
 - 1. Inpatient approved drug list.
 - 2. Stocked drug list for contingency located in Crisis Service Pyxis.
 - 3. Stocked drug list for back-up contingency located in Long-Term Care.
- B. Following initial review and prior to the report to Medical Staff Executive Committee, the Pharmacy and Therapeutics Committee will solicit additional input from the Medical Staff at large.

III. PROCESS FOR REVIEW OF NEW DRUGS AND DRUGS TO BE ADDED TO THE LIST:

- A. Pharmacy and Therapeutics Committee will assign a physician and pharmacist to complete the drug review.
- B. Review team will complete a review listing:
 - 1. Clinical Indication based on FDA Labeling and Current Use.
 - 2. Efficacy, toxicity and pharmacokinetics.
 - 3. Equivalence.
 - 4. Risk of adverse drug reactions.
 - 5. Risk of potential errors.
 - 6. Acquisitions and storage cost with cost/revenue impact.
- C. Review team will complete summary recommendations for review at Pharmacy and Therapeutics Committee meeting.
- D. For medications reviewed and approved, the Pharmacy and Therapeutics Committee will develop proper use guidelines, including:
 - 1. Indications, relative contraindications and absolute contraindications.
 - 2. Safety parameters for dosing, side effect monitoring, drug-drug interactions, laboratory monitoring, teratogenicity, lethality in overdose, withdrawal risk and potential for medication variances.
 - 3. Dietary, age or other restrictions on use.
 - 4. Cost, preparation/formulations and cost-effective dosing strategies.

POLICY & PROCEDURE	DATE: 07/03/14	SUBJECT: APPROVED DRUG LIST (FORMULARY) POLICY	PAGE(S) NUMBER 2 of 2
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E. Pharmacy and Therapeutics Committee development of education plan including:

1. Determine if placement on institutional similar sounding name and high-risk medication lists is warranted.
2. Pharmacy and Therapeutics Committee and Department of Nursing jointly sponsored in-service by the Prescriber and Pharmacist that completed drug review.
3. Publish proper use and references in MCBHD newsletters.
4. Review and acquisition of patient education materials.

HISTORY OF POLICY:	DATES REVIEWED / APPROVED
REVIEWS / REVISIONS:	07/14 Newly Issued.
CURRENT POLICY	
REVIEWS: Developed by Chair, Pharmacy & Therapeutics Committee	
APPROVAL:	
_____ John H. Schneider, MD, FAPA Executive Medical Director	07/03/14 Expedited Approval *
_____ Medical Staff Executive Committee Heather Martens, PsyD, President	07/10/14
Governing Board	

*Expedited review and approval was made by action of the Executive Medical Director in accordance with MCBHD MSO Bylaws, section 5.6, subsection 5.6.1(12).

This policy shall be scheduled for review by the full Medical Staff Executive Committee at the next scheduled meeting wherein policy approval shall be reaffirmed or recommended for modification, if deemed necessary. Evidence of such review and action shall be documented in the minutes of said meeting.

POLICY & PROCEDURE MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION DEPARTMENT: MEDICAL STAFF (Credentialing & Privileging Review) Applies to: <input checked="" type="checkbox"/> Behavioral Health Division – All Hospital & Clinic Services <input checked="" type="checkbox"/> Community Access to Recovery Services – All Health Care Services	DATE ISSUED 01/23/92	SECTION: 3.1 General Professional Responsibility	POLICY # MS 3.1.2.4	PAGE 1 of 1
	DATE REVIEWED*/REVISED 08/2014	SUBJECT SPECIALTY BOARD CERTIFICATION / BOARD EQUIVALENCY OF MEDICAL MANAGERS		

POLICY: It is the policy of the Milwaukee County Behavioral Health Division that all Medical Staff members in management positions shall be Board Certified by the appropriate specialty board(s) or shall demonstrate and document equivalent experience, training and/or testing as part of his/her credentials.

Only certifications that are made by American Boards of Medical Specialties, the American Board of Professional Psychology, the American Board of Podiatric Medicine, and the American Boards of Dental Specialties shall be recognized by the Behavioral Health Division Medical Staff.

- PROCEDURE:**
- At the time of initial appointment to a management position, the Credentialing and Privileging Review Committee shall ask each appropriate Medical Staff Manager to complete the Specialty Board Equivalence Worksheet, if not Board Certified in the applicable specialty.
 - Specialty Board Certification or its equivalence (as documented on the worksheet) shall be considered by the Committee as a necessary component for privileging and reprivileging of all Medical Staff members in medical management positions.
 - As part of its deliberations, the Credentialing and Privileging Review Committee shall determine whether or not the information provided on the worksheet constitutes specialty board equivalence.
 - Failure to complete and return the equivalence worksheet shall result in a delay of the applicant's receipt of privileges under Category IV - Medical Staff Management.

- ATTACHMENTS:**
- 1 - Specialty Board Equivalency Worksheet – Physicians
 - 2 - Specialty Board Equivalency Worksheet – Psychologists

HISTORY OF POLICY:	DATES REVIEWED / APPROVED
REVIEWS* / REVISIONS:	10/27/94*; 10/23/97; 10/26/00*; 03/14/07; 8/2014
CURRENT POLICY	
REVIEWS:	
Medical Staff Services	07/21/14
Executive Medical Director	08/07/14
Credentialing and Privileging Review Committee	08/07/14
APPROVALS:	
Medical Staff Executive Committee Heather Martens, PsyD, President	08/14/14
Governing Board	

H:\CENTADM\WPDATA\POLICIES\3124-Board Cert

SPECIALTY BOARD EQUIVALENCE WORKSHEET - PSYCHOLOGISTS

Psychologist Name

Working Title

The Behavioral Health Division requires that all Medical Staff members appointed to management positions be Board Certified by the appropriate specialty board, or that s/he demonstrate specialty board equivalence at the time of appointment/reappointment.

As the Credentialing and Privileging Review Committee finds no documentation of specialty board certification among your credentials, you are asked as part of your appointment/reappointment to complete and return this worksheet:

1. Are you currently on the National Register: Yes No

If No, are you eligible for registration: Yes No

2. Additional relevant education, training, management certification (list schools, extended workshops and dates, if appropriate):

3. Additional relevant work experience in special area(s) of expertise (e.g. child, adolescent, forensic, geropsychiatry, neuropsychology, etc.):

4. Additional relevant work experience in professional/medical staff leadership and management:

Signature

Date

POLICY & PROCEDURE MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION	DATE ISSUED 12/21/00	SECTION: 4.0 Continuing Education	POLICY # MS 4.0.1	PAGE 1 of 4
DEPARTMENT: MEDICAL STAFF (Credentialing & Privileging Review) Applies to: <input checked="" type="checkbox"/> Behavioral Health Division – All Hospital & Clinic Services <input checked="" type="checkbox"/> Community Access to Recovery Services – All Health Care Services	DATE REVIEWED/REVISED 08/2014	SUBJECT CONTINUING EDUCATION REQUIREMENTS – MEDICAL STAFF AND PRIVILEGED ALLIED HEALTH PROFESSIONALS		

POLICY: It is the policy of the Medical Staff Organization of the Milwaukee County Behavioral Health Division, in accordance with regulatory standards, to require members of the Medical Staff and privileged Allied Health Professionals to provide proof of current competence to perform all privileges requested at time of appointment and/or privileging and at time of reappointment and/or reprivileging and to make recommendations for privileging based, in part, on continuing education data.

PURPOSE: To assure that all members of the Medical Staff and all privileged Allied Health Professionals participate in continuing education activities that are specifically related to privileges requested and any special populations regularly served.

To assure that all members of the Medical Staff and all privileged Allied Health Professionals maintain current competence within their practice specialty(s), including pharmacology when applicable, and special populations who are regularly served, by participating in sufficient and relevant continuing education activities.

PROCEDURES:

All members of the Medical Staff and all privileged Allied Health Professionals shall report continuing education activities, in writing, to the Medical Staff Office for inclusion in credentials files for consideration in decisions about initial, renewal or revision of individual clinical privileges. All members of the Medical Staff and all privileged Allied Health Professionals shall comply with the minimum continuing education requirements established by the Medical Staff which may be the same as, or in addition to, requirements established by the Wisconsin Department of Safety and Professional Services. Failure to comply with established continuing education requirements shall be grounds for consideration to limit, restrict or deny applicable privileges. Continuing education documentation shall not substitute for internship, residency, fellowship, preceptorship or any other formal graduate or post-graduate training, when required.

I. GENERAL PRIVILEGE GROUP (PRACTICE SPECIALTY)

Minimum CME/CEU reporting shall be as required by Wisconsin Department of Safety and Professional Services and as recommended by the Credentialing and Privileging Review Committee of the MCBHD Medical Staff Organization. See Attachment for the minimum State mandated requirements, periods for completion and special requirements or methods for earning and claiming credit. In addition to State requirements, the Behavioral Health Division shall require the following:

- A. **PHYSICIANS** – At least 50% of the State required minimum shall be earned within the physician's primary practice specialty
 - 1. For Active and Affiliate Staff, at least 5 hours of continuing education, per year, is required pertaining to special populations or services provided as part of regular program/service assignment, when applicable (e.g. treatment of children, adolescents, geriatrics, developmentally disabled, addiction, crisis response, forensics, etc.).
 - 2. Psychiatrists – At least 4 hours of Category I continuing education, per year, in psychopharmacology shall be required.

POLICY & PROCEDURE	DATE 08/2014	SUBJECT CONTINUING EDUCATION REQUIREMENTS – MEDICAL STAFF AND PRIVILEGED ALLIED HEALTH PROFESSIONALS	PAGE 2 of 4
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3. Physicians seeking appointment/reappointment as a Psychiatric Officer of the Day who are presently in a psychiatry residency or sub-specialty psychiatry fellowship program shall be considered to be in compliance with the continuing education requirement.
 4. Physicians seeking appointment/reappointment as a Medical Officer of the Day who are presently in a medical residency or medical sub-specialty fellowship program shall be considered to be in compliance with the continuing education requirement.
 5. The Wisconsin Department of Safety and Professional Services deems three months of post-graduate medical training to be equivalent to 30 hours of Category I CME.
 6. Board Certified physicians complying with maintenance of certification (MOC) requirements shall be considered to satisfy applicable privilege group CME requirements.
- B. PSYCHOLOGISTS - In accordance with the State Board requirements, BHD shall require a minimum of 40 hours per license period relevant to the professional practice of psychology.
1. For Active and Affiliate Staff, at least 5 hours of continuing education, per year, is required pertaining to special populations or services provided as part of regular program/service assignment, when applicable (e.g. treatment or assessment relating to children, adolescents, geriatrics, developmental disabilities, addictions, crisis response, forensics, etc.).
 2. While the Psychology Licensing Board does not require newly licensed psychologists to complete CE during the initial period of licensure, newly licensed psychologists appointed to the Medical Staff shall be required to complete not less than 20 hours of CE during his/her initial appointment period.
- C. DENTISTS - While the Dentistry Licensing Board does not require newly licensed dentists to complete CE during the initial period of licensure, newly licensed dentists appointed to the Medical Staff shall be required to complete not less than 15 hours of CE during his/her initial appointment period.
- D. PODIATRISTS - At least 50% of the State required minimum shall be specific to podiatric care.
- E. ALLIED HEALTH PROFESSIONALS
1. Nurse Practitioners/Clinical Nurse Specialists - 30 hours every 2 calendar years; with at least 15 hours specific to practice certification specialty(s) shall be required.
 - a. At least 8 hours per year in pharmacology specific to ANCC (or other approved certification) specialty shall be required, as per Licensing Board requirements.
 2. Other AHP Categories - 30 hours every 2 year licensing period shall be required; with at least 15 hours specific to practice specialty unless Licensing Board requires more.

POLICY & PROCEDURE	DATE	SUBJECT	PAGE
	08/2014	CONTINUING EDUCATION REQUIREMENTS – MEDICAL STAFF AND PRIVILEGED ALLIED HEALTH PROFESSIONALS	3 of 4

II. EXTENDED PSYCHOLOGY WITH INPATIENT ATTENDING RESPONSIBILITIES

- A. Psychologists requesting initial privileges to function as an Acute Inpatient or Crisis Observation attending shall be required to demonstrate competency to perform attending duties, at time of application.
1. Five (5) hours of continuing education within two years of privilege request relevant to clinical assignment and inpatient or crisis management, as applicable, shall be required, at time of application (e.g., crisis response, risk assessment, diagnosis/treatment of mental health disorders, etc.); AND
 2. Five (5) hours of continuing education within two years of privilege request pertaining to legal issues in mental health law related to clinical responsibilities shall be required (e.g., *issues related to Wisconsin Mental Health Law and treatment of non-voluntary patients, etc.*)
- B. For reappointment, attending psychologists must demonstrate continued current competency through ongoing professional practice evaluation processes. Based on OPPE, the Credentialing and Privileging Review Committee may require specific continuing education for an attending psychologist, when deemed appropriate.

III. BOARD/SPECIALTY CERTIFICATION

Board Certification is not required for any Medical Staff privilege category but recent certification or participating in maintenance of certification (MOC) may be submitted as evidence of current competence for a privilege group. Allied Health Professionals shall be required to maintain all appropriate certifications to their practice specialty(s).

- A. Board Certification, if recent (within the last two years), may be used to establish initial competence for General Privileges Groups requested, in conjunction with appropriate training verifications in lieu of providing CME/CEU documents. Privileging decisions shall not be based on Board Certification alone.
- B. Only certifications that are made by American Boards of Medical Specialties, the American Board of Professional Psychology, the American Board of Podiatric Medicine, and the American Boards of Dental Specialties shall be recognized by the Behavioral Health Division Medical Staff.
- B. Only certifications made by the American Nurses Credentialing Center, the National Certification Board for Nurse Practitioner Specialties and Nurses or the National Certification Corporation in Obstetric/Gynecology or Women's Health shall be recognized for Nurse Practitioners and Clinical Nurse Specialists privileged through the Behavioral Health Division Medical Staff.

IV. SPECIAL PROCEDURES

Special procedures are generally not utilized within the normal realm of practice at BHD. Special procedures may include, but are not limited to, Electro-convulsive therapy, Sodium Amytal Interviews, BTP Interventions with Painful/Aversive Stimuli.

- A. If it is determined that use of a special procedure would benefit a patient, a Medical Staff Member may be granted the privilege on a temporary basis, following consultation with the patient's treatment team and service/program Medical Director.
- B. The Medical Staff Member shall provide evidence of current and substantial competence to perform the specific privilege requested in the form of recent Certification (within the last 2 years) and/or substantial CME/CEU documentation, as applicable.

POLICY & PROCEDURE	DATE 08/2014	SUBJECT CONTINUING EDUCATION REQUIREMENTS – MEDICAL STAFF AND PRIVILEGED ALLIED HEALTH PROFESSIONALS	PAGE 4 of 4
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- C. Privileges shall only be considered if the applicant will be utilizing the procedure within a BHD service and appropriate consents have been obtained from the patient/responsible party and State, when applicable.
- D. Special Privileges are not necessary, not required and cannot be considered if the procedure is to be performed at a site other than BHD (e.g., at Froedtert Memorial Lutheran Hospital, Children’s Hospital of Wisconsin, MCW/FMLH Clinics, etc.)
- E. Special privileges shall be considered only when the Behavioral Health Division has the equipment and resources necessary to support the procedure.

V. REPORTING CME/CE INFORMATION

- A. Initial Application: All Medical Staff and Allied Health Professionals shall be required to provide CME/CE documentation as part of his/her initial application. Recent formal post-graduate training may count toward CME/CE requirements, in accordance with what the applicable Professional Licensing Board allows.
- B. Reappointment/Reprivileging: Evidence of satisfaction of the minimum CME/CEU requirements must be submitted for each licensing period. Medical Staff and Allied Health Professionals that choose not to submit CME/CE documentation to the Medical Staff Office as credits are earned, are required to provide evidence of completion of the State requirements as well as any BHD specific requirements at time of reappointment/reprivileging.
- C. Privilege Amendments: CME/CE documentation shall be reported to support a request to amend privileges, when applicable.
- D. Acceptable Forms of Documentation: CME/CE reporting shall be by submission of copies of CME/CE certificates or in the form of a CME/CE tracker or other evidence of course completion. Information provided must include course title, course date, credits earned and the name of the accredited sponsor.

ATTACHMENT – Minimum State Mandated Continuing Education Requirements by Specific Professional Licensing Board and Provider Type

REFERENCES: Wisconsin Department of Safety and Professional Services;
Joint Commission MS 12.01.01, EP4 and EP5

HISTORY OF POLICY:	DATES REVIEWED / APPROVED
REVIEWS / REVISIONS:	06/08/05; 03/14/07; 08/2014
CURRENT POLICY	
REVIEWS: Medical Staff Services	07/29/2014
Executive Medical Director	08/07/2014
Credentialing and Privileging Review Committee	08/07/2014
APPROVALS:	
Medical Staff Executive Committee Heather Martens, PsyD, President	08/14/2014
Governing Board	

ATTACHMENT - MS 4.0.1

<i>Provider Type</i>	<i>CME/CE Period</i>	<i>Minimum Requirements Per Licensing Period</i>	<i>Special Requirements / Methods for Earning Credits</i>	<i>License Renewal</i>
Physicians	1/1 even to 12/31 odd	30 hours		MD - 10/31 odd DO - 2/28 even
Dentists	10/1 odd to 9/30 odd	30 hours	A minimum of 25 credit hours of instruction must be in clinical dentistry or clinical medicine. CPR and AED must be current to practice dentistry. *Continuing education requirements do not apply to the biennium in which a license is first issued.	9/30 odd
Podiatrists	11/1 even to 10/31 even	50 hours	Must be approved by APMA, AMA, AOA or accreditation council for continuing medical education (ACCME).	10/31 odd
Psychologists	10/1 odd to 9/30 odd	40 hours	CE credits can also be obtained by authoring professional books or papers (up to 20 hours), the first time of teaching a course, seminar, or workshop (up to 20 hours) or taking and completing graduate courses (up to 20 hours). *Continuing education requirements do not apply to the biennium in which the license was first issued.	9/30 odd
Advanced Practice Nurses	10/1 even – 9/30 even	8 hours / year	Completion of at least eight (8) contact hours per year in pharmacology/therapeutics relevant to the advanced practice nurse prescriber's area of practice.	9/30 odd
Professional Counselor	3/1 odd to 2/28 odd	30 hours	A minimum of 15 credit hours in professional counselor continuing education programs must be through NRCA, ARCA, WRCA, NBCC, ACA, WCA, CRCC or a college or university that is accredited by CACREP. Four of those 15 credit hours must be in professional counselor ethics and professional boundaries. The remainder of the 30 credit hours may be obtained through the APA Committee for the Approval of Continuing Education, through programs recognized by the Social Work Section or through programs recognized by the Marriage and Family Therapy Section of the Wisconsin Administrative Code. Additional credits may be given for other activities including, but not limited to, teaching academic courses, publishing professional books, and presenting at national conferences. *continuing education is not required to renew your license the first time.	2/28 odd
Marriage and Family Therapist	3/1 odd to 2/28 odd	30 hours	A minimum of 15 credit hours must be obtained through AAMFT, WAMFT, COAMFTE or relevant programs offered by an accredited college or university. Four of those 15 credit hours must be in marriage and family therapy ethics and professional boundaries. The remainder of the 30 credit hours may be obtained through the APA Committee for the Approval of Continuing Education, through programs recognized by the Social Work Section or through programs recognized by the Professional Counselor Section of the Wisconsin Administrative Code. Additional credits may be given for other activities including, but not limited to, teaching academic courses, publishing professional books, and presenting at national conferences. *Continuing education requirement does not apply to biennium when license was first issued.	2/28 odd

<i>Provider Type</i>	<i>CME/CE Period</i>	<i>Minimum Requirements Per Licensing Period</i>	<i>Special Requirements / Methods for Earning Credits</i>	<i>License Renewal</i>
Social Worker – Advanced Practice	3/1 odd to 2/28 odd	30 hours	<p>Four of the hours must be in social work ethics and professional boundaries in the first full biennium after they are licensed.</p> <p>Additional credits may be given for other activities including, but not limited to, teaching academic courses, publishing professional books, and presenting at national conferences.</p> <p>*Continuing education requirement does not apply to the biennium when license was first issued.</p>	2/28 odd
Social Worker – Licensed Clinical	3/1 odd – 2/28 odd	30 hours	<p>Four of the hours must be in social work ethics and professional boundaries in the first full biennium after they are licensed.</p> <p>Additional credits may be given for other activities including, but not limited to, teaching academic courses, publishing professional books, and presenting at national conferences.</p> <p>*Continuing education requirement does not apply to the biennium when license was first issued.</p>	2/28 odd

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Dev. 6/2/2014



BEHAVIORAL HEALTH DIVISION

Abbreviations

2014

STATEMENT

Please remember that both the Centers for Medicare and Medicare Services (CMS) and JCAHO recommend limiting the use of symbols and abbreviations to *only* those that are easily understood and universally used. Symbols and abbreviations are linked to increased medical errors, especially when not understood or misinterpreted by the reader.

JCAHO recommends abbreviations may *never* be used as a final diagnosis.

New this edition includes a Do Not Use Abbreviation List, as required by JCAHO.

OFFICIAL DO NOT USE LIST

U,u	Write "Unit"
IU	Write "International Unit"
Q.D., QD,	Write "daily"
q.d., qd,	Write "daily"
Q.O.D.,QOD	Write "every other day"
q.o.d., qod	Write "every other day"
X.O mg	Write X mg
.Xmg	Write 0.X mg
M _{SO} ₄ or MgSO ₄	Write "morphine sulfate" or magnesium "Sulfate"

A

A&O	Alert and oriented
AV	Audio/visual
AA	Alcoholics Anonymous
ADA	American Dietetic Association
A/H or AH	Auditory Hallucinations
AIDS	Acquired Immunodeficiency Syndrome
AIMS	Abnormal Involuntary Movement Scale
AODA	Alcohol and Other Drug Abuse
ASAP	as soon as possible
AV/H	Audio visual hallucinations

B

BMI	body mass index
BPRS	Brief Psychiatric Rating Scale

C

CAD	Coronary Artery Disease
CAT	Computerized Axial Tomography
CBC	Complete Blood Count
CHF	Congestive Heart Failure
CMI	Chronic Mental Illness
CNA	Certified Nursing Assistant
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebral vascular accident
CXR	chest x-ray

D

DD	Developmentally Disabled
DSM-IV	Diagnostic and Statistical Manual - 4th Edition
DVT	Deep Venous Thrombosis
DWI	Driving While Intoxicated

E

ECT	Electroconvulsive Therapy
ED	Emergency Detention
EEG	electroencephalogram
EKG	electrocardiogram
EPS	Extrapyramidal Symptoms
ETOH	alcohol (ethanol)

F

FLR Full leather restraint

G

GAF Global Assessment of Functioning
GED General Equivalency Diploma
GERD Gastroesophageal Reflux Disorder
GI Gastrointestinal
GU Genitourinary
GYN Gynecology

H

H&P History and Physical
HEENT Head, Eyes, Ears, Nose, Throat
H/I or HI Homicidal Ideation
HIV Human Immunodeficiency Virus
HPI History of Present Illness
HSV Herpes Simplex Virus
HTN hypertension

I

IBS Irritable Bowel Syndrome
IBW Ideal Body Weight
ID Intellectual Disability
IM Intramuscular
INR International Normalized Ratio
IQ Intelligence Quotient
IUD Intrauterine device

J

K

KELS Kohlman Evaluation of Living Skills

L

LBP	low back pain
LE	Lower Extremity
LFT	Liver function test
LOS	Length of Stay
LP	Lumbar puncture
LSD	Lysergic Acid Diethylamide
LSH	Luteinizing Stimulating Hormone

M

mg	milligram
MI	Myocardial Infarction
ml	millileter
mm	millimeter
MMPI	Minnesota Multiphasic Personality Inventory
MRI	Magnetic Resonance Imagery
MS	Multiple Sclerosis
MSE	Mental Status Exam
MUTT	Mobile Urgent Treatment Team

N

NG	Nasogastric
NKA	No Known Allergies
NKDA	No Known Drug Allergies
NMS	Neuroleptic Malignant Syndrome
NPO	Nothing by Mouth
NSAID	Nonsteroidal anti-inflammatory drug

O

O2	Oxygen
OBS	observation

P

PAP	Papanicolaou Smear
PERLA	Pupils Equal, React to Light and Accomodation
PMH	Past Medical History
po	by Mouth
PERLA	Pupils Equal, React to Light and Accomodation

Q

R

S

S&R	Seclusion and Restraint
SI	Suicidal Ideation
SIB	Self Injurious behavior
SLE	Systemic Lupus Erythematosus
SNF	Skilled Nursing Facility
SOS	Suicide Observation Status
SSD	Social Security Disability
SSI	Social Security Income
STAT	immediately

T

T3	Triiodothyronine Uptake
T4	Thyroxine
TB	Tuberculosis
TD	Tardive Dyskinesia
TDA	Treatment Director's Affidavit
TIA	Transient Ischemic Attack
TM	Tympanic Membrane
TMJ	Temporal Mandibular Joint
TSH	Thyroid Stimulating Hormone
TT	Tetanus Toxoid

U

UA	urinalysis
URI	Upper Respiratory Infection

V

VH	visual hallucinations
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vaccine Abbreviations

DTP	Diphtheria Tetanus Pertusis
MMR	Measles, Mumps, Rubella

W

WBC	White Blood Cell Count
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X

Y

Z

Approved By:

John Schneider, MD 07/15/2014

John Schneider, MD, FAPA, Executive Medical Director Date

Medical Staff Executive Committee 08/14/2014

Governing Board