

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

**SPECIAL MEETING  
MILWAUKEE COUNTY MENTAL HEALTH BOARD**

**Tuesday, September 23, 2014 - 10:00 A.M.**  
**Milwaukee County Mental Health Complex Auditorium**

**MINUTES**

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

**SCHEDULED ITEMS:**

- 1. Approval of the minutes from the August 28, 2014, Milwaukee County Mental Health Board meeting.

The minutes from the August 28, 2014, meeting were reviewed.

**MOTION BY:** *(Shrout) Approve the minutes from the August 28, 2014, Milwaukee County Mental Health Board meeting. 11-0*

**MOTION 2<sup>ND</sup> BY:** *(Perez)*

**AYES:** Carlson, Chayer, Lutzow, Malofsky, Miller, Neubauer, Perez, Shrout, Walker, Wesley, and Zeiger - 11

**NOES:** 0

**ABSTENTIONS:** 0

**A voice vote was taken on this item.**

- 2. A Presentation titled "Analysis of Adult Bed Capacity for the Milwaukee County Behavioral Health System" presented by the Public Policy Forum.

**APPEARANCES:**

Hector Colon, Director, Department of Health and Human Services (DHHS)  
Patricia Schroeder, Administrator, Behavioral Health Division, DHHS

The PowerPoint was presented by:  
Rob Henken, President, Public Policy Forum  
David Hughes, Vice President, Human Services Research Institute  
Kevin Martone, Executive Director, Technical Assistance Collaborative

## **SCHEDULED ITEMS (CONTINUED):**

Mr. Henken provided background information regarding the origins of the project and report referencing the 2010 study of the behavioral health system. He stated this report is the result of an amendment to the 2014 Milwaukee County Budget that authorized this study. For those not familiar, Mr. Henken explained the Public Policy Forum is a private, non-profit, independent research organization dedicated to enhancing the quality of public policy decision-making in a non-partisan and objective format. He clarified that while policy is their main expertise, they are not experts in mental health. Therefore, they recruited the assistance of national mental health experts from the Human Services Research Institute and the Technical Assistance Collaborative.

Mr. Hughes and Mr. Martone presented an overview of the report by describing a recovery oriented and community focused mental health care system and what that entails in a national context. They discussed data collection, the methods used to gather information, and their findings; stakeholder perspectives, factors that influence inpatient admissions and demand, and access to community-based services. Statistics were provided as they related to acuity bed availability, inpatient admissions by payer source, psychiatric crisis services admissions and emergency detentions, mobile contacts diverted from inpatient, and access clinic admissions.

In closing, recommendations were provided as well as scenarios in which the appropriate number of acute inpatient beds would be available to those needing this level of care.

Questions and comments ensued.

The following people registered to speak regarding this item and posed questions and comments:

Serge Blasberg, National Alliance for the Mentally Ill of Greater Milwaukee  
Dennis Purtell, State Public Defender's Office  
Meg Kissinger, Milwaukee Journal Sentinel

The following people submitted written commentary for consideration:  
Barbara Beckert, Disabilities Rights Wisconsin

***The Board took no action regarding this item.***

### 3. Adjournment.

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

**MOTION 2<sup>ND</sup> BY:** (Malofsky)

**AYES:** Carlson, Chayer, Lutzow, Malofsky, Miller, Neubauer, Perez, Shrout, Walker, Wesley, and Zeiger - 11

**NOES:** 0

**ABSTENTIONS:** 0

**SCHEDULED ITEMS (CONTINUED):**

**STAFF APPEARANCES:**

Hector Colon, Director, Department of Health and Human Services (DHHS)  
Patricia Schroeder, Administrator, Behavioral Health Division, DHHS

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

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

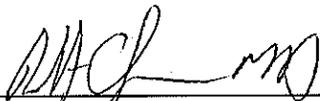
Adjourned,

***Jodi Mapp***

Senior Executive Assistant  
Milwaukee County Mental Health Board

**DEADLINE FOR THE MILWAUKEE COUNTY MENTAL HEALTH BOARD:  
The next regular meeting for the Milwaukee County Mental Health Board is  
Thursday, October 23, 2014 @ 8:00 a.m.**

The September 23, 2014, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled meeting of the Milwaukee County Mental Health Board.



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Dr. Robert Chayer, Secretary  
Milwaukee County Mental Health Board

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
Inter-Office Communication

2

**DATE:** October 23, 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 Randy Oleszak, Fiscal Director, Department of Health and Human Services*

**SUBJECT:** **A report from the Director, Department of Health and Human Services, providing a summary comparison of the County Executive’s 2015 Budget to the budget adopted by the Mental Health Board**

**Background**

The Behavioral Health Division’s 2015 Requested Budget was submitted to the County Executive on July 15. The Milwaukee County Mental Health Board (MHB) approved this version of the 2015 budget at its August meeting. On October 1, the County Executive issued his 2015 Recommended Budget for all Milwaukee County departments, including BHD.

Though the County Executive’s version of BHD’s budget included the policies and programs adopted by the MHB, changes were made to fringe benefits, employee compensation and internal service costs. This report identifies the major changes contained in the County’s Executive’s version.

**Discussion**

Wisconsin Statutes 51.41 authorizes the MHB to propose an annual budget to the County Executive for BHD. The County Executive may include a tax levy amount that is different than the tax levy amount proposed by the MHB but the tax levy amount cannot be less than \$53 million or more than \$65 million.

BHD’s original requested budget contained a tax levy of \$62,070,501 compared to \$59,099,341 in the County Executive’s Budget. This reflects a total decrease in tax levy of \$2,971,160. Total expenditures were reduced by nearly \$3.9 million primarily due to updated actuarial projections for countywide pension costs, the elimination of pay increases for employees and increases for employee health care contributions. In addition, revenues were reduced by \$900,000 as a result of reduced fringe benefit costs.

A summary of the changes is detailed below:

<b>Major Changes - 2015 Request Compared to Recommended</b>			
<b>Expenditure Adjustments</b>	<b>2015 Request</b>	<b>2015 County Executive</b>	<b>Change</b>
2% COLA Elimination	\$505,499	\$0	(\$505,499)
Employee Merit Award Elimination	\$616,016	\$0	(\$616,016)
<b>Subtotal Employee Compensation Changes</b>	<b>\$1,121,515</b>	<b>\$0</b>	<b>(\$1,121,515)</b>
Employee Health Care (includes premium increase)	\$8,144,280	\$7,298,690	(\$845,590)
Employee Pension	\$3,249,008	\$3,656,317	\$407,309
Legacy Health Care	\$11,121,978	\$8,474,419	(\$2,647,559)
Legacy Pension	\$7,774,048	\$7,225,794	(\$548,254)
<b>Subtotal Fringe Benefit Changes</b>	<b>\$30,289,314</b>	<b>\$26,655,220</b>	<b>(\$3,634,094)</b>
Medical Malpractice Claims		\$400,000	\$400,000
Community Consult. Team Contract Moved from DSD to BHD	\$5,598,669	\$5,753,213	\$154,544
Building Reserve Increase	\$408,000	\$508,000	\$100,000
Crosscharges/Abatements	(\$3,307,500)	(\$3,103,856)	\$203,644
<b>Total Expenditure Adjustments</b>	<b>\$34,109,998</b>	<b>\$30,212,577</b>	<b>(\$3,897,421)</b>
<b>Revenue Adjustments</b>			
Revenue Adjustments due to Fringe Reduction	\$121,422,500	\$120,496,239	(\$926,261)
<b>Total Tax Levy Change</b>			<b>(\$2,971,160)</b>

**Recommendation**

This report is informational only. No action is required by the Mental Health Board.

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

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
Inter-Office Communication

**DATE:** October 23, 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 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 establish an administrative fund transfer policy in the Behavioral Health Division**

Issue

As mentioned previously at the August meeting of the Mental Health Board, BHD is seeking to create a policy that would authorize BHD to process appropriation transfers administratively.

Background

Wisconsin Statutes 51.41 authorizes the Milwaukee County Mental Health Board (MHB) to propose an annual budget to the County Executive for the Behavioral Health Division (BHD). Once this budget is approved by the County Executive, the budget provides the total spending authority for BHD for one calendar year. This budget reflects total expenditures, revenues and property tax levy required for the operation of programs and services within BHD.

Throughout the course of the year, certain adjustments to the budget may be necessary to better reflect BHD’s actual experience. In most cases, these adjustments, or appropriation transfers, would increase or decrease BHD’s expenditures and revenues compared to its base budget while maintaining the same tax levy as established in the original budget.

BHD is requesting approval to implement these adjustments administratively assuming there is no tax levy impact to BHD’s overall budget. Attachment 1 details the proposed administrative transfer policy and approval process.

Recommendation

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to authorize the use of administrative fund transfers as detailed in Attachment 1.

Respectfully Submitted,



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Héctor Colón, Director  
Department of Health and Human Services

Attachments (2)

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

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## BHD FUND TRANSFER PROCESS

### Overview

Wisconsin Statutes 51.41 authorizes the Milwaukee County Mental Health Board (MHB) to propose an annual budget to the County Executive for the Behavioral Health Division (BHD). Once this budget is approved by the County Executive, the budget provides the total spending authority for BHD for one calendar year. This budget reflects total expenditures, revenues and property tax levy required for the operation of programs and services within BHD.

Throughout the course of the year, certain adjustments to the budget may be necessary to better reflect BHD's actual experience. In most cases, these adjustments, or appropriation transfers, would increase or decrease BHD's expenditures and revenues compared to its base budget while maintaining the same tax levy as established in the original budget.

### Policy

*Administrative Only Fund Transfer.* BHD may transfer funds between accounts within its budget if such accounts have established appropriations. An administrative transfer cannot increase the department's total property tax levy originally established in the calendar year budget for BHD.

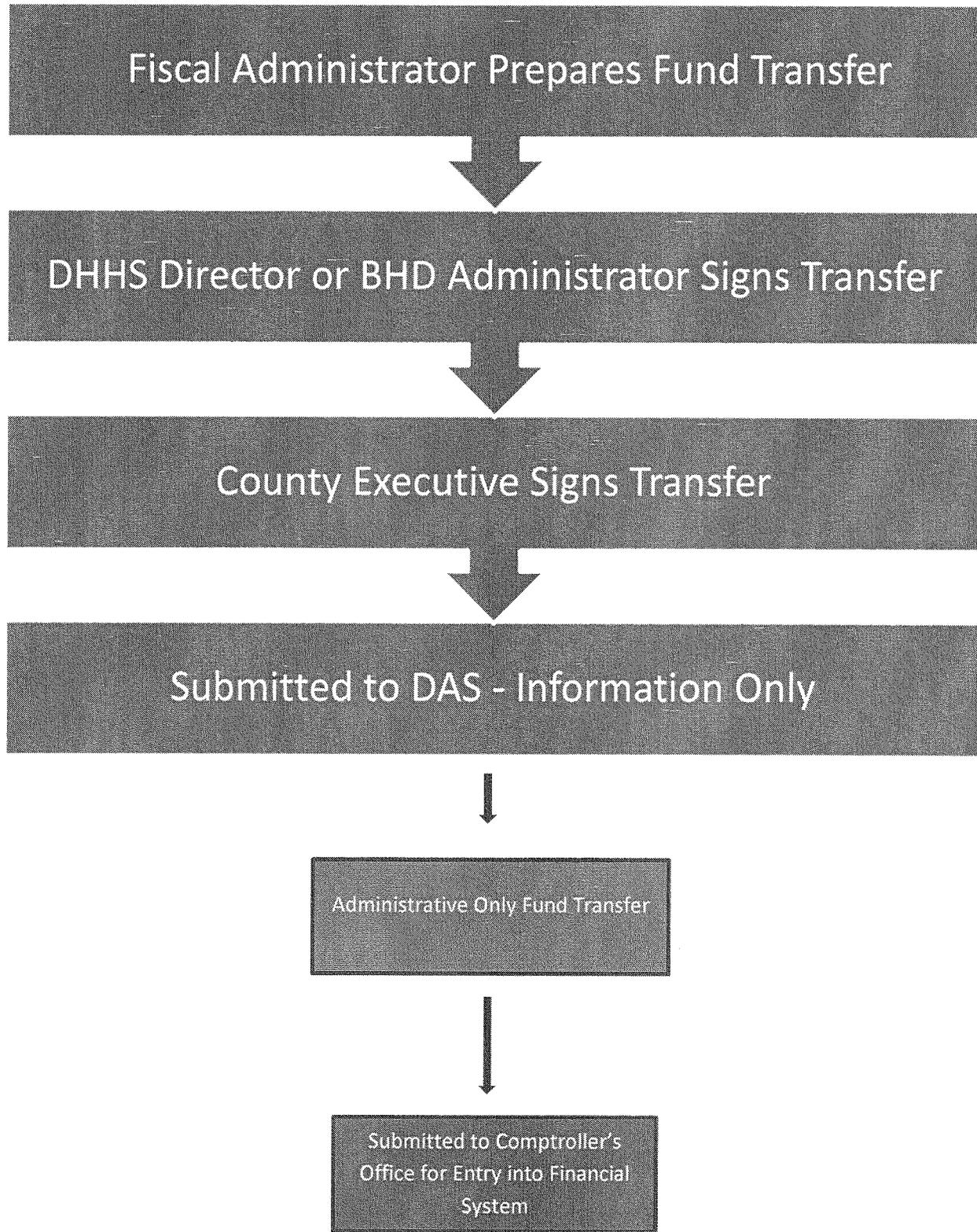
This type of transfer would adjust all account series as necessary (5000 – Personal Services, 6000 – Services, 7000 – Commodities, 8000 – Other Charges, 8500 – Capital Equipment and 9700/9800 – Crosscharges & Abatements) and all revenue accounts provided that there is no tax levy change as a result of the transfer. This type of transfer would not require MHB approval. Please see section titled "Process" below for the review and approval process.

On a quarterly basis, the BHD Fiscal Administrator will provide an informational report notifying the MHB as to any administrative fund transfers that may have occurred during the previous quarter.

### Process

A request for an appropriation transfer within the Behavioral Health Division shall be prepared by the BHD Fiscal Administrator on the appropriation fund transfer form (Schedule A). The form shall contain an explanation and justification for the transfer as well as identify the organizational units and accounts affected. Once complete, the BHD Administrator or DHHS Director will sign the fund transfer and submit it to the County Executive for signature. The form is then submitted to the Department of Administrative Services (DAS) for information only and DAS submits it to the Comptroller's Office for entry into the county's financial system.

Please refer to the flow chart below for a summary of the approval process.



APPROPRIATION TRANSFER REQUEST

FISCAL YEAR DEPT. NO.  
6300

SCHEDULE A

1699 R4E MILWAUKEE COUNTY

DEPARTMENT NAME

Behavioral Health Division

Were Appropriations Requested Below Denied For The Current Budget?

No

No

Line No.	ACCOUNT DISTRIBUTION							OBJECT CODE DESCRIPTION	Transfer Request	DOA Account Modification
	Fund	Agency	Org. Unit	Revenue/Obj	Activity	Project				
TO (Credit)										

TO TOTALS (Credit) \$ - \$ -

FROM (Debit)										

FROM TOTALS (Debit) \$ - \$ -

EXPLANATION

		TRANSFER NO.
IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH ADDITIONAL PAGES.		
DATE	SIGNATURE	TITLE
		Director, DHHS or BHD Administrator
		Milwaukee County Executive

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
Inter-Office Communication

**4**

**DATE:** October 23, 2014

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

**FROM:** Patricia Schroeder, Administrator, Behavioral Health Division  
*Approved by Héctor Colón, Director, Department of Health and Human Services*  
*Prepared by: Dennis Buesing, Administrator, DHHS Contract Services*

**SUBJECT:** **Report from the Director, Department of Health and Human Services, requesting authorization to enter into a three-year, non-professional services contract with Aramark Corporation to provide food services for the Behavioral Health Division**

**Issue**

The Director, Department of Health and Human Services (DHHS), is requesting authorization for the Behavioral Health Division (BHD) to enter into a three-year, non-professional services contract with Aramark Corporation to provide food services beginning December 1, 2014.

**Background**

BHD food service functions have been outsourced to a non-governmental organization since 2009. The contract with the incumbent vendor expires on December 31, 2014. DHHS issued an RFP for food services in August of 2014. DHHS has completed the RFP process and is recommending that the contract be awarded to Aramark Corporation.

**Discussion**

DHHS issued a joint RFP for Food Services with DHHS Delinquency and Court Services Division (DCSD) Juvenile Justice Center (JJC) and the House of Correction (HOC) on August 11, 2014 with a proposal submission date of September 9, 2014. Four companies attended the pre-proposal conference on August 15, 2014. Three organizations submitted proposals. The RFP review panel consisted of representatives from BHD, DHHS Management Services Division, the Department on Aging and HOC staff who reviewed and scored each of the three proposals.

Proposals for BHD, JJC, and HOC were all evaluated and scored separately and will result in three separate contracts. After the review and scoring process was concluded, the panel identified two finalist whose scores, per the published criteria, were in a competitive range. At

that point, per the RFP guidelines, a “best and final offer” for cost only was solicited from the two finalists.

The proposer with the lowest cost was Aramark Corporation, and per the terms of the RFP, Aramark is being recommended for the BHD food service contract.

Aramark is a privately held fortune 500 company headquartered in Philadelphia, Pennsylvania with regional offices in Downers Grove, Illinois. It is the 23<sup>rd</sup> largest employer on the Fortune 500 list. In business since 1936, Aramark has a staff with extensive food service experience in 22 countries. Aramark offers a full array of food services to education, healthcare, senior meals, corrections and sports and recreation industries.

A three-year contract with an option for two additional one-year terms is recommended. The 2014 - 2015 contract will begin December 1, 2014, and the total contract will not exceed five years. The 2014 - 2015 (13 month) contract amount is recommended at a maximum amount of \$1,362,000, including labor, food, transportation and other commodities. There will be one month of overlap between the existing vendor and Aramark to provide for a smooth transition beginning in January 2015.

This contract will relocate BHD food preparation from the BHD food preparation building on Watertown Plank Road to the HOC food preparation kitchen in Franklin and will result in a lower overall food preparation cost. The contract is based on a per meal cost. Therefore, depending upon the average daily census, the new contract reflects anticipated savings of between \$531,000 and \$847,000, a reduction of between 28 percent and 45 percent, compared to the proposed 2015 budget of \$1,892,962.

Aramark will have an equivalent of approximately 13.15 FTEs dedicated to BHD. They will offer an average hourly wage of \$14.03 with a minimum hourly wage of \$11.50.

### **Fiscal Effect**

Funds for these services have already been identified in the 2015 budget and this contract would have no additional tax levy impact beyond what has been allocated in the Department's 2015 budget.

### **Recommendation**

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to execute a non-professional services contract with Aramark Corporation starting December 1, 2014 to December 31, 2017 for \$1,362,000 with subsequent years (2016 and forward) to be renegotiated per RFP limitations and guidelines.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Hector Colon", written in a cursive style.

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Héctor Colón, Director  
Department of Health and Human Services

cc: County Executive Chris Abele  
Raisa Koltun, County Executive's Office  
Jodi Mapp, BHD Senior Executive Assistant  
Matt Fortman, Fiscal & Management Analyst, DAS

## MILWAUKEE COUNTY FISCAL NOTE FORM

**DATE:** 10/23/14

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report from the Director, Department of Health and Human Services, requesting authorization to enter into a three-year, non-professional services contract with Aramark Corporation to provide food services for the Behavioral Health Division

**FISCAL EFFECT:**

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> No Direct County Fiscal Impact<br><input type="checkbox"/> Existing Staff Time Required<br><input type="checkbox"/> Increase Operating Expenditures<br>(If checked, check one of two boxes below)<br><input type="checkbox"/> Absorbed Within Agency's Budget<br><input type="checkbox"/> Not Absorbed Within Agency's Budget<br><input type="checkbox"/> Decrease Operating Expenditures<br><input type="checkbox"/> Increase Operating Revenues<br><input type="checkbox"/> Decrease Operating Revenues | <input type="checkbox"/> Increase Capital Expenditures<br><input type="checkbox"/> Decrease Capital Expenditures<br><input type="checkbox"/> Increase Capital Revenues<br><input type="checkbox"/> Decrease Capital Revenues<br><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
<b>Operating Budget</b>	Expenditure	0	\$1,362,000
	Revenue	0	0
	Net Cost	0	\$1,362,000
<b>Capital Improvement Budget</b>	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.<sup>1</sup> 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 authorize the execution of a contract for food services effective December 1, 2014 to December 31, 2017. BHD has completed a Request for Proposals (RFP) process and is recommending that the contract be awarded to Aramark.
- B. The transition to the new vendor will begin in December 2014. The overlap in vendors is not anticipated to result in additional cost. Aramark will only charge a very nominal administrative fee during the transition. For 2015, the total contract amount, including labor, food, and supplies is a maximum of \$1,362,000.
- C. The total 2015 budget for food service is \$1,892,962. Therefore, savings of at least \$531,000 are anticipated under this new contract. The savings could be as high as \$847,000 depending upon the average daily census.
- E. The fiscal note assumes expenditures will not exceed the amounts authorized.

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

<sup>1</sup> 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:** October 23, 2014

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

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

**SUBJECT:** **Report from the Director, Department of Health and Human Services, requesting authorization to amend purchase of services contracts with Project Access, Inc., Outreach Community Health Centers, Transitional Living Services, and Milwaukee Mental Health Associates**

**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 (MHB). Per the statute, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase existing purchase of services contracts with Project Access, Inc., Outreach Community Health Centers, Transitional Living Services and Milwaukee Mental Health Associates.

**Discussion**

The 2015 Behavioral Health Division's Budget which was approved by the MHB at its August meeting included the outsourcing of both the Downtown and Southside county-operated Community Support Programs (CSP) to private agencies. The Downtown location is scheduled to close December 1, 2014. To begin the transition of clients from this location to the contracted agencies, BHD is requesting authority to increase existing CSP contracts with the following four contracted providers: 1) Project Access, Inc. 2) Outreach Community Health Centers 3) Transitional Living Services and 4) Milwaukee Mental Health Associates. These agencies hold state certification to provide CSP services.

BHD is requesting the purchase of 11 caseloads at a 1:10 ratio with the four agencies to ensure adequate placement for 110 clients requiring care in the community for November and December of 2014. A contract covering services for these clients for 2015 will be brought forward to the MHB in December.

The transition for the Southside location is set to begin January 1, 2015 with the closure of the county operated program to occur on March 1. A contract covering services for these clients in 2015 will be brought forward to the MHB in December.

BHD will continue to oversee these contracts to ensure that all agencies follow DHS 63, adhere to the performance measures, contract administration requirements and maintain oversight currently included in all purchase of services contracts within DHHS.

**Fiscal Effect**

The annual per client cost of care in a CSP is calculated at \$4,818. The table below reflects the adjusted contracts for each agency.

Agency	# of Caseloads	Current Contract	Amendment	Total Adjusted Contract
Project Access	30	\$671,239	\$24,090	\$695,329
Outreach Community Health Centers	30	\$380,502	\$24,090	\$404,592
Transitional Living Services	30	\$966,590	\$24,090	\$990,680
Milwaukee Mental Health Associates	20	\$644,947	\$16,060	\$661,007
<b>Subtotal</b>	<b>110</b>	<b>\$2,663,278</b>	<b>\$88,330</b>	<b>\$2,751,608</b>

Included within the cost is the use of the evidence based practice of Assertive Community Treatment/Integrated Dual Disorder Treatment (ACT/IDDT) as a standard of care.

A fiscal note form is attached.

**Recommendation**

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to increase existing purchase of services contracts with Project Access, Inc., by \$24,090; Outreach Community Health Centers by \$24,090; Transitional Living Services by \$24,090 and Milwaukee Mental Health Associates by \$16,060 for CSP expansion. The contracts cover the transition of clients from the Downtown CSP for the time period of November 1, 2014 through December 31, 2014.

Respectfully Submitted,

  
\_\_\_\_\_  
Héctor Colón, Director

Department of Health and Human Services

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

**MILWAUKEE COUNTY FISCAL NOTE FORM**

**DATE:** 10/23/14

Original Fiscal Note

Substitute Fiscal Note

**SUBJECT:** Report from the Director, Department of Health and Human Services, requesting authorization to amend purchase of services contracts with Project Access, Inc., Outreach Community Health Centers, Transitional Living Services, and Milwaukee Mental Health Associates

**FISCAL EFFECT:**

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

*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.*

	<b>Expenditure or Revenue Category</b>	<b>Current Year</b>	<b>Subsequent Year</b>
<b>Operating Budget</b>	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
<b>Capital Improvement Budget</b>	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.<sup>1</sup> 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 amend existing purchase of services contracts for the Community Support Program (CSP) with Project Access, Outreach Community Health Centers, Transitional Living Services and Milwaukee Mental Health Associates. The contracts would absorb 110 cases from the County operated Downtown CSP which is slated to close December 1, 2014. The term of the amendments would be November 1 to December 31, 2014. The effective date of the amendments would allow for one month of overlap with County staff and contracted staff in order to provide for a smooth transition of clients.
  - B. The total cost of the amendments being recommended is \$88,330.
  - C. There is no tax levy impact associated with approval of this request. The amendments to the contracts can be absorbed within the Downtown CSP budget. This area is projecting a salary and commodities surplus of about \$100,000 for 2014 due to position vacancies and lower drug costs.
  - D. No assumptions are made.

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

Authorized Signature 

Did DAS-Fiscal Staff Review?  Yes  No

<sup>1</sup> 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.

Did CDPB Staff Review?

Yes

No

Not Required

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** October 9, 2014

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

**FROM:** Kathie Eilers, Transitional Liaison, Behavioral Health Division  
*Approved by Patricia Schroeder, Administrator, Behavioral Health Division*

**SUBJECT:** **Report from the Transitional Liaison, Behavioral Health Division, requesting an Amendment to Article V of the Bylaws that refer to Special Meetings**

**Issue**

According to the Bylaws of the Milwaukee County Mental Health Board, Special Meetings can only be called for by the majority of the voting members of the Board.

**Recommendation**

It is recommended that the Milwaukee County Mental Health Board Bylaws, Article V, be amended to read "Special Meetings are those which are called for **by the Chair** or by the majority of the voting members of the Board."

Respectfully Submitted,



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

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** October 9, 2014

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

**FROM:** Mary Neubauer, Member, Milwaukee County Mental Health Board

**SUBJECT: Report from Board Member, requesting an Amendment to Article VIII of the Bylaws that refer to Committees with the intent of creating a Finance Committee**

According to the Bylaws of the Milwaukee County Mental Health Board, "the Board may create ad-hoc committees to prepare recommendations on matters for the Board's consideration. Ad-hoc committees will be charged with specific issues or tasks to address and confine their work to those issues or tasks and shall be discharged upon the final report of the committee to the Board. The Board Chair shall appoint an odd number of voting members of the Board to the ad-hoc committee and name the chair and secretary for the committee. Non-voting members of the Board may be appointed as non-voting members of the committee. No action of an ad-hoc committee shall become the action of the Board without an affirmative vote of the Board.

**Recommendation**

It is recommended that the Milwaukee County Mental Health Board Bylaws, Article VIII, be amended to read and include the following:

There is created a Finance Committee appointed by the Chairperson. The Committee shall consist of five (5) members who have expertise in the areas of budgets and finance. The purpose of the Committee is to review quarterly financial statements and the divisional budget to make sure resources are spent in accordance with budget targets and the mission of the Division. The Finance Committee will report on the results of their analysis and any recommendations to the full Mental Health Board. The Committee will meet quarterly but may meet more often during budget preparation time.

**COUNTY OF MILWAUKEE  
Behavioral Health Division  
Administration Inter-Office  
Communication**

**DATE:** October 23, 2014

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

**FROM:** Héctor Colón, Director, Department of Health and Human Services  
*Prepared by Patricia Schroeder, Administrator, Behavioral Health Division*

**SUBJECT:** **Report from the Director, Department of Health & Human Services, requesting Milwaukee County Mental Health Board support of and participation in an administrative committee to plan a new Behavioral Health Division facility**

**Discussion**

The Milwaukee County Behavioral Health Division (BHD) was built in 1978. It is a four story, multilevel facility originally built to house 300 beds. The facility totals about 591,000 square feet, currently less than 400,000 are in use. The cost of maintaining the facility in 2013 was \$10.5 million. Costly upgrades and maintenance have been deferred, and the facility is not sustainable for the future in its current condition. As we move away from an outdated institutional system of care, it is also important that we ensure our facility is updated and is in line with our goal of creating less restrictive, community based and more person-centered treatment options.

Several analyses and studies over the past 10 years have recommended that BHD consolidate space or relocate into a new, more efficient, code compliant space. At this time, BHD is going through a major transition, and it is not yet clear what its space needs will be. Most recently, a study by the Public Policy Forum and the Health Services Research Institute (HSRI) suggested that at this time, 54 - 60 high acuity beds are needed to adequately serve the community.

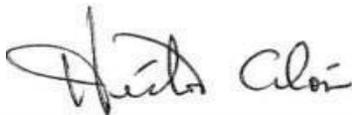
While many high acuity patients have traditionally come to BHD, several private hospitals in the community have committed to building capacity to contribute to taking care of this population. Given this, it is anticipated that the projected number of beds needed at BHD will decrease over the next several years.

BHD Administration would like to begin the process of identifying its space needs and finding a more efficient and appropriate space for its programs and services. The first step in this process is forming an administrative New Facility Committee. This Committee would use previous and forthcoming reports and audits, and work with experts to determine exactly what the space and operational needs are for the individuals we serve and our staff, and how to best move forward with finding or creating a new facility. The Committee will consider all possible models of mental health care provision in its review, including leasing of space for inpatient care, contracting out for inpatient care, developing its own new space, or other.

**Recommendation**

It is recommended that the Milwaukee County Mental Health Board support and designate two board members to participate in an administrative committee to plan a new BHD facility.

Respectfully Submitted,



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Héctor Colón, Director  
Department of Health and Human Services

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

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** October 9, 2014

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

**FROM:** Patricia Schroeder, Administrator, Behavioral Health Division

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

**Background**

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

**Discussion**

Expansion of Services in the Community

1. Crisis Mobile Team Expansion

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

2. New Access Clinic Location

A new south side Access Clinic is opening on 8th and Greenfield in October. This walk-in center will be available five days a week, 24 hours per week, providing outpatient mental health services including assessment, referral to services needed, psychiatric services when needed, prescriber support, and peer specialists. This Clinic site is in the LaCausa Community Enrichment Center, which also provides space for our Community Linkages and Stabilization Program (CLASP), Targeted Case Management (TCM), and Peer Recovery Center.

3. CART-- Crisis Assessment Response Team Expansion

A second Crisis Assessment Response Team, made up of a single mobile team clinician and a single police officer partnered in the community, is tracking to be added this year. The primary objective is to respond to emergency detention calls to provide service and attempt to stabilize individuals with their own natural supports/resources or assist them in obtaining voluntary treatment. This team would be located at MPD Avenues West Substation, 2020 West Wells Street.

4. Implementation of Comprehensive Community Services (CCS)

Comprehensive Community Services is a state and federally funded Medicaid benefit that is a recovery oriented, integrated behavioral health program for adults with severe mental illness or substance use disorders and children with severe emotional disturbance or substance use disorders. CCS provides a coordinated and comprehensive array of community based recovery services, treatment, and psychosocial rehabilitation services to address client needs.

This program was approved in September 2014, and implementation is well underway. Enrollment in CCS began at the end of September.

Long Term Care Transitions

5. Hilltop and Rehab Central

The work to transition residents of the two long-term care areas at BHD into community living has been moving forward for the past two years. Every other week, representatives from BHD; the state; and advocacy groups; including Disability Rights Wisconsin and others, meet to discuss each individual resident and clarify their personal needs for safe, effective, and supportive care living in a least restrictive environment. In 2012, there were approximately 70 residents of Hilltop with a set of units for those with chronic mental illness and developmental disabilities and about 70 residents of Rehab Central with a set of units for those with serious and persistent mental illness. Hilltop is scheduled to close at the end of 2014. Rehab Central is scheduled to close in 2015.

Progress to Date

At the time of writing, Hilltop has 29 residents, with 9 others scheduled for transition to the community in October, and most of the others scheduled for transition into the community by year end. Rehab Central has 31 residents, with 2 others scheduled to transition in October. We are ahead of schedule in this transitioning. Work is underway, in partnership with the Human Resources Department, in transitioning the clinical staff from these areas into other available positions at BHD as appropriate. At this time, there may be several individuals who will experience layoffs due to limits of job openings.

## Organizational Initiatives

### 6. Joint Commission Accreditation Process

Actions are underway to prepare for Joint Commission review and accreditation in 2015. A mock survey process was conducted by consultants in mid-August, and action plans are moving forward across the organization. A facility analysis is scheduled for the end of October to identify gaps in the environment of care standards compliance. A number of facility issues have already been identified, which will need to be addressed to achieve accreditation.

### 7. Implementation of a New Employee Handbook

The creation of the Mental Health Board created the opportunity of revising expectations for employee performance. A new handbook was created in partnership between the Human Resources Department and BHD leaders, and new policies were developed in support of these expectations. Changes were made in dress code, attendance, and corrective action policies to name a few. Managers and staff have been educated on new expectations through multiple in-person and online sessions. The expectations went "live" on October 5th.

### 8. Electronic Health Record (EHR) Implementation

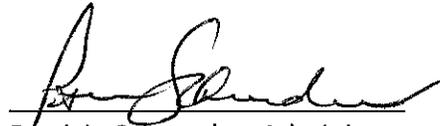
The EHR--Avatar, a part of Netsmart, has been in the implementation process for about 18 months. Phases I and II are substantially implemented with need to complete several significant components including treatment planning and the medication related modules. Phase III moves the implementation more deeply into community based settings. This work is running behind schedule. A project management consultant contracted through the Information Management Services Division (IMSD) is completing an analysis to clarify and validate progress and recommendations regarding the next steps and ongoing infrastructure support.

### 9. Communications

A plan is being developed to support internal and external communications for BHD. Internally, one aspect of communications with all employees has included monthly Town Hall meetings on the second Thursday of each month and offered three times a day (7:15 a.m., 1:45 p.m., and 3:30p.m.) for people working different hours. These meetings have been open and candid providing information on activities, issues, and directions of the organization. Time is held for questions and discussion. Attendance for these sessions has grown each month, with each session having about 30-40 attendees. Leaders are working in partnership with the Director of Communications on creating and expanding this plan.

There is very positive energy and a significant amount of work and change across the Behavioral Health Division. It is a privilege to be a part of it.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read 'Patricia Schroeder', written over a horizontal line.

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



# Milwaukee County

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

**DATE:** October 23, 2014

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

**THRU:** Hector Colon MS, OT, Director, Department of Health and Human Services  
Patricia Schroeder RN, MSN, MBA, FAAN, Administrator, Behavioral Health Division

**FROM:** Jennifer Bergersen MSW, Chief Quality Officer, Behavioral Health Division  
John Schneider MD, FAPA, Chief Medical Officer, Behavioral Health Division

**SUBJECT: 3-2014 Quarterly Quality Report: Summary**

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## PREAMBLE

This report is broken down into subsections for ease of reading. While it is ideal to read the report in its entirety, the reality is many readers will want to examine or re-examine what is most important to them abstracted from the other sections, these headings should facilitate this. First, there is this *Preamble* describing the organization and subsections of the report. Second, there is the *Background* that lists the vision and context of the current report. Third, there is the *Overview* of the Quality report and supporting documents that is intended to anchor expectations of what and how the report was constructed including a number of important provisos and limitations to the data and analysis. Fourth and finally, there is a broad based *Current Initiatives* section that highlights a number of recent and ongoing quality activities.

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## BACKGROUND

The Milwaukee County Behavioral Health Division (BHD) is continuing our transformative journey to be a center for behavioral health excellence. We continue with a focus on improving the client/patient experience, as well as providing high-quality, safe behavioral health care. To achieve this vision, we plan continued increases in community based services and less reliance on facility based care such as inpatient. BHD has a unique combination of processes, people, and resources working together with an extensive community based provider network of public and private health care partners.

SUBJECT: 3-2014 Quarterly Quality Report: Summary

The leadership and staff at BHD are committed to person-centered, quality care in collaboration with community partners. Leadership at BHD continues to monitor quality indicator data in order to identify opportunities to leverage data driven, healthcare benchmarked, action aimed continuous quality improvement (CQI) activities. Programs and service teams throughout BHD have individual CQI initiatives and projects in support of the Division Quality Plan underway. In addition, these projects support and extend the Milwaukee County's Mental Health Redesign initiatives. Moreover, they fully support our values and goals to be nationally accredited and regulatory compliant while providing safe, cost-effective, person-centered and evidence based healthcare.

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## OVERVIEW

We view this report, and in particular this inaugural edition, as an opportunity to engage in an ongoing dialog about the four underlying principles of quality, namely our joint organizational and functional definition of quality, methodologies to ensure accountability at all levels, articulation and differentiation of responsibilities between leadership and quality committees and the key role of engaging our caregivers and the medical staff.

In this inaugural edition of our Quarterly Quality Report there are a number of companion documents. There is the *Process Description of our Key Performance Indicator (KPI) Dashboard* that describes the methodologies and data sets included in the current version of the quality scorecard. Next, there is the *Narrative Summary of our Current Scores*, this is a text based rendition of KPI Dashboard noting our current scores, color-coded status grades and broad action steps in our noted areas for improvement. In addition, there is the *Description of Oversight Activities*, here we describe our internal organizational structure and processes including committees and oversight activities involved in quality review and improvement following regulatory and licensing reviews and/or critical negative outcomes. Each of these is enclosed as an appendix to this document.

A cautionary note on the limits of this report is in order, to better align the intent of the authors with the expectations of our readers. Our quality report and the dashboard or Key Performance Indicators are intended to allow the Executive Team to succinctly articulate to the Board of Directors our current performance and areas we are actively improving on. The intent is to keep the Board apprised of performance to the degree needed for governance, thus it is by design a high level summary document and necessarily lacks some granular detail. In addition, as the current year ends and we continue our strategic planning cycle, and moreover, in anticipation of our release in December of our 2015-2016 Quality Plan, it is noted that a number of the current indicators, the measures used for the indicator and their targets/goals plan to be changed and/or further refined. Therefore, we declaratively reiterate this is a

SUBJECT: 3-2014 Quarterly Quality Report: Summary

sample, dare we say, draft version. Finally, we request constructive criticism, feedback and commentary so as the Executive Team further refines our strategic planning and Quality Plan we can ensure that we have cooperatively engaged and included the desire, guidance and thoughtfulness of our Governing Board.

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### CURRENT INITIATIVES

There are a number of recent initiatives and projects that deserve special highlighting as they are cardinal to our ongoing journey to excellence and exemplify our continued efforts to embed quality principles in all we do. To further engage our caregivers and staff, and with the initiation of the Milwaukee County Mental Health Board, BHD has introduced a new employee handbook and are increasing our efforts and investments in leadership development and education as we believe this is central to further strengthening our care teams and quality. In addition, BHD continues to work on new approaches to quality leveraging technology. In particular to ensure accountability and responsibility we are working on staffing data tracking, staff performance assessments and our continued implementation of an Electronic Health Record. We hope that the transition to new technology will allow us to reengineer and reenergize these activities with more end user flexibility and access to data to staff at all levels.

Moreover, there are a number of ongoing and existing initiatives that have been championed during prior redesign iterations that are worth highlighting. As part of the Mental Health Redesign quality activities a “Personal Stories” initiative is underway to provide unique educational opportunities for further healthcare workforce development. To anchor the important work our staff are engaged in, we believe humanizing our patients is critical to motivating change and quality efforts. We are also participating in a LEAN re-engineering project as a joint exercise between Milwaukee County and the University of Wisconsin – Milwaukee. We will re-engineer a Human Resources process, such as hiring, and another multi-division process such as contracting to incorporate the philosophy of improved quality and efficiency while improving costs.

All of our activities, in addition to focusing on improved patient experience, outcome and cost efficacy, are aimed at furthering our pursuit of Joint Commission Accreditation. We continue to target mid-year 2015 for accreditation readiness and submission to the Joint Commission for our initial survey. In support of this timeline, our work continues with consultants to update our roadmap and ongoing improvement steps. We have scheduled at the end of October, further review of Emergency Management preparedness and Environment of Care compliance. In this context and with our recent facility event we are beginning preliminary investigation and review of our facility’s physical building and developing initial next steps in planning.

**COUNTY OF MILWAUKEE**  
**Behavioral Health Administration**  
**Inter-Office Communication**

**DATE:** October 23, 2014

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

**THRU:** Hector Colon MS, OT, Director, Department of Health and Human Services  
Patricia Schroeder RN, MSN, MBA, FAAN, Administrator, Behavioral Health Division

**FROM:** Jennifer Bergersen MSW, Chief Quality Officer, Behavioral Health Division  
John Schneider MD, FAPA, Chief Medical Officer, Behavioral Health Division

**SUBJECT:** **3-2014 Quarterly Quality Report – Process Description KPI Dashboard**

Attached is the Behavioral Health Division's (BHD) sample snap shot, balanced scorecard with data elements from various services across the division that leadership believes to be some of our Key Performance Indicators. For each entry you will note the program area that owns the measure, the name of the indicator metric/measure, the current goal/target, current state score for the metric/measure, and a graded status indicator with color shading to denote progress toward the goal or benchmark. Measures are included in the following programs/areas: Community Access to Recovery Services (CARS), Psychiatric Crisis Service (PCS), Acute Adult Inpatient, Child and Adolescent Inpatient Service (CAIS), Rehab Center – Hilltop (Hilltop), Rehab Center – Central (Central), Human Resources (HR) and BHD Financial.

The indicators chosen are based upon a number of criteria. They include current budgeting process outcome goals imbedded in approved budgets, BHD and DHHS strategic planning goals, Mental Health Redesign quality activities and currently required publicly reported data. Current goals and targets are imbedded in those documents or based upon the national average of the publicly reported data. Narrative discussion about indicator current state scores and high level commentary of improvement plans for red and yellow status indicators is provided in the companion document, the narrative summary of our current grades.

Two data sets require further introduction for understanding. Namely our Customer Satisfaction Data, the Mental Health Statistics Improvement Program (MHSIP) surveys and our publicly reported data, the Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures.

The MHSIP is evidence based, validated patient/client survey instrument developed in the late 1990s by the Human Services Research Institute (HSRI) in Massachusetts with a grant support from the Substance Abuse and Mental Health Services Administration (SAMHSA). It measures a number of critical domains and outcomes as self-reported by patient/clients including: Access, Quality, Outcomes, Overall Satisfaction and Participation in Treatment Planning. Seven additional items ask respondents to rate other aspects of services received including treatment options, medications, cultural sensitivity and staff. National norms and comparisons, in addition to our own internal historical data (back to 2003) are available for benchmarking.

The HBIPS core measure initiative is a major national leadership effort to improve quality, safety, and performance of hospital-based inpatient psychiatric services through the collaboration of hospitals, physicians, and consumers. It is part of Center for Medicare and Medicaid Services (CMS) certification and The Joint Commission accreditation process. HBIPS has is a set of standardization of measures, data specifications, and definitions to help hospitals compare their performance within hospital-based psychiatric services to that of their peers. These measures are also part of the National Quality Core Measures of Performance that are being used by CMS are part of its pay-for-performance initiatives. As with the MHSIP, HBIPS has national norms and benchmarks. Our own data set dates back to 2013, prior to the mandatory 2014 reporting start date.

Of note, related to our HR indicators, we are very early in development of measurement and data gathering, and thus at the current time are unable to list more complete data other than naming the indicators. As part of our 2015-2016 Quality Plan we anticipate having fully validated assessment, monitoring and evaluation mechanisms in place and will begin official reporting and benchmarking in the first quarter of 2015.

**COUNTY OF MILWAUKEE**  
**Behavioral Health Administration**  
**Inter-Office Communication**

**DATE:** October 23, 2014

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

**THRU:** Hector Colon MS, OT, Director, Department of Health and Human Services  
Patricia Schroeder RN, MSN, MBA, FAAN, Administrator, Behavioral Health Division

**FROM:** Jennifer Bergersen MSW, Chief Quality Officer, Behavioral Health Division  
John Schneider MD, FAPA, Chief Medical Officer, Behavioral Health Division

**SUBJECT:** **3-2014 Quarterly Quality Report – Narrative Summary of Current Scores**

BHD Leadership presents here a narrative summary of the current scores noted on our 3<sup>rd</sup> Quarter, 2014, Quality Report. As noted in the Quality Report Summary and in the companion document, Process Description KPI Dashboard, this version is a model or draft, with planned revision based upon input from the board. Moreover, it is also noted the report represents a sample of a snap shot, balanced scorecard with data elements from various services across the division that leadership believes to be some of our Key Performance Indicators. It is imperative to note, this is not intended to be, nor does it represent, all our measures tracked or an exhaustive list of every quality improvement initiative BHD currently has underway.

For each entry you will note the program area that owns the measure, the name of the indicator metric/measure, the goal/target, current-state score for the metric/measure, and a graded status indicator with color shading to denote progress toward the goal or benchmark. In this document we list, in narrative form the scores and progress to our targets. For indicators whose measure has a yellow or red status indicator, a bulleted list of ongoing improvement steps, by program area are noted.

**Community Access to Recovery Services (CARS):** For the period noted, the CARS Branch notes 446 supported housing units and good/green progress, the 2015 goal tentatively targets 572. Engagement in employment and employment related activities for both the mental health (SAIL) and substance abuse (Wiser Choice) service lines report yellow status with 10% and 36% respectively. Patient/Client customer satisfaction scores indicate green level status with a 78% positive response rating. Finally, Milwaukee County has a robust 119 Certified Peer Specialists. CARS Leadership is actively undertaking the following improvement steps:

- Implementing evidence based practices to increase the number of patients/clients engaged in employment and employment related activities.
- Two models will be used including pursuing Supported Employment through Individual Placement and Support (IPS) and the Clubhouse Employment Model for those seeking competitive employment.
- Two of CARS newly implemented service lines, Comprehensive Community Services (CCS) and Children's Rehabilitative Services (CRS) are expected to positively impact the employment, education or other vocational-related activities indicators as they both have employment as an element of their service array.

**Psychiatric Crisis Service (PCS):** Based on BHD historical data and year to date projections, the Psychiatric Crisis Service (PCS) all source visits (admissions) and Emergency Detentions in particular show green status with 10,750 and 5,842 respectively. Waitlist utilization also show green status with 32% and 8% respectively. Repeat PCS visits (90 day recidivism) and percentage of patients/clients transferred to community provider hospitals/units from PCS shows yellow status with a score of 10%.

- Partial year implementation of third-shift transfer coordinator limited 2014 year-to-date performance compared to full year modeling, thus 2015 is anticipated to be better.
- Continued work with community partner hospitals to define acuity levels and exclusion criterion are expected to better define and help identify transferable patients.
- Further review and refinement of targets related to recidivism and patients transferred to the community is expected as part of annual strategic planning based on analysis of the recently reported Human Services Research Institute (HSRI) Analysis of Adult Bed Capacity.

**Acute Adult Inpatient Service:** Admission and other utilization measures including mean length of stay (mLOS) and mean daily census (mDC) show green performance with scores of 1,154, 15.0 and 55.7 respectively. While improved overtime, 90 day recidivism rate continues with yellow performance at 17.4%. Global Customer Satisfaction based on our Mental Health Statistics Improvement Program (MHSIP) surveys shows yellow performance at 69%. Our Hospital Based Inpatient Psychiatric Services (HBIPS) scores show green level performance in 5 of the 6 domains, with red level performance on HBIPS 2, Hours of Physical Restraint Rate. Note Improvement steps will be reported jointly for Acute Adult Inpatient Service and the Child and Adolescent Inpatient Service.

**Child and Adolescent Inpatient Service (CAIS):** Utilization scores in admissions, mLOS and mDC show green performance with 955, 3.4 and 8.4 respectively. 90 day readmission rates and customer satisfaction show yellow performance with scores of 21% and 71% respectively. Note Improvement steps will be reported jointly for Acute Adult Inpatient Service and the Child and Adolescent Inpatient Service.

#### **HBIPS 2 – Hours of Physical Restraint Rate (Adult only)**

- Analysis of unit-by-unit data to understand if Intensive Treatment Unit patient mix is contributory to data skew.
- Reviewed and Revised the Policy “Agitation & Risk for Violent Behavior: Identification & Management of Individuals at Risk and Use of the Broset Violence Checklist (BVC)” – specific to the Intensive Treatment Unit (ITU).
- Reviewed pharmacologic therapy for the treatment of acute agitation.
- Clinical leaders provided education and team building activities in the identification and response to patient agitation.
- Treatment/Care Team weekly review of prospective seclusion and restraint quality management data.

#### **Consumer Satisfaction**

- Review survey process and protocol to improve/maximize survey response rate.
- BHD Food Service contract revision with incorporated enhanced quality requirements.
- Expanded role and responsibility of Client Rights Specialist.

- Ongoing analysis of Environment Domain to develop staged redesign of therapeutic environment and activities.

**Readmission Rates**

- Review indicator/measure and consider using Center for Medicare/Medicaid Services (CMS) and American Health Care Association (AHCA) industry standard of 30 days.
- Conduct systematic root cause analysis of high hospital utilization.
- Conduct evidence based review of readmissions to determine current best practice opportunities.
- Develop and implement specific improvement plan informed by root cause analysis and current past practices.

**Rehab Center – Hilltop:** Utilization and closure plan status indicators for admissions, discharges, unit census and percent of closure complete all show green. However, the indicator for Present Closure Complete is noted to be yellow as the closure project is not yet complete.

- BHD continues to work collaboratively with the State of Wisconsin, advocates, MCO's, residents and guardians to secure safe and secure community based placements for the remaining residents on Hilltop. Currently there are 29 residents that remain on the Units.
- It is projected that approximately half of those residents will be discharged by the end of October, with the balance being discharged by the end of November.
- BHD had hoped to be farther along in the process by this time however members of the relocation committee remain optimistic that the goal of all residents being successfully discharged by November will be met.

**Rehab Center – Central:** Utilization and closure plan status indicators for admissions, discharges, unit census and percent of closure complete all show green. However, the indicator for Present Closure Complete is noted to be yellow as the closure project is not yet complete. In particular, given that the closure target for Rehab Center – Central is before or by fourth quarter 2015, it appears we are currently proceeding at an acceptable rate.

**Human Resources (HR):** As noted in the companion document, Process Description KPI Dashboard, we are very early in development of measurement and data gathering for our HR indicators and thus, at the current time are unable to list more complete data other than naming the indicators. Further, as part of our 2015-2018 Quality Plan we anticipate having fully validated assessment, monitoring and evaluation mechanisms in place and will begin official reporting and benchmarking in the first quarter of 2015.

**Financial:** Budgeted revenue, expense and tax levy are noted. Until further strategic planning and alignment of budget-planning cycles to better optimize business practices, status indicators are difficult to implement. It is expected that defined stepwise goals to achieve this will be part of the next strategic plan.



## Milwaukee County Behavioral Health Division Key Performance Indicator (KPI) Dashboard

Program	Indicator	2015 Target	2014	Status
Community Access To Recovery Services	Supportive Housing Units	572	446	Green
	Engagement of individuals with mental illness in employment, education, or other vocational-related activities (SAIL)	11%	10%	Yellow
	Engagement of individuals with mental illness in employment, education, or other vocational-related activities (Wiser Choice)	38%	36%	Yellow
	Percent of clients responding positively to satisfaction survey	80%	78%	Green
	Certified Peer Specialists in Milwaukee County	143	119	Green
Psychiatric Crisis Service (PCS)	Admissions	10,000	10,750	Green
	Emergency Detentions	5,400	5,842	Green
	Percent of clients returning to PCS within 90 days	27%	32%	Yellow
	Percent of time on waitlist status	5%	8%	Green
	Percent of clients transferred to private inpatient psychiatric hospitals/units from PCS	20%	11%	Green
Acute Adult Inpatient Service	Admissions	1,125	1,154	Green
	Mean Length of Stay (days)	16.4	15.0	Green
	Mean Daily Census	52.0	55.7	Green
	Percent of clients returning to Acute Adult within 90 days	16.0	17.4	Yellow
	Percent of patients responding positively to satisfaction survey	74%	69%	Yellow
	HBIPS - 2 Hours of Physical Restraint Rate	3.0	4.0	Red
	HBIPS - 3 Hours of Locked Seclusion Rate	0.32	0.4	Green
	HBIPS - 4 Patients discharged on multiple antipsychotic medications	10%	13%	Green
	HBIPS - 5 Patients discharged on multiple antipsychotic medications with appropriate justification	98%	95%	Green
	HBIPS - 6 Patients discharged with a continuing care plan	100%	100%	Green
HBIPS - 7 Post discharge continuing care plan transmitted to next level of care provider	100%	100%	Green	
Child / Adolescent Inpatient Service (CAIS)	Admissions	950	955	Green
	Mean Length of Stay (days)	3.4	3.4	Green
	Mean Daily Census	8.8	8.4	Green
	Percent of children returning to CAIS within 90 days	20%	21%	Yellow
	Percent of patients responding positively to satisfaction survey	74%	71%	Yellow
Rehab Center Hilltop	Admissions	0	0	Green
	Discharges	29	20	Green
	Unit Census	0	29	Green
	Percent of closure completion	100%	45%	Yellow
	For clients placed in the community, percent of clients returning to BHD for an inpatient admission	6%	9%	Green
Rehab Center Central	Admissions	0	0	Green
	Discharges	31	18	Green
	Unit Census	0	31	Green
	Percent of closure completion	100%	47%	Green
	For clients placed in the community, percent of clients returning to BHD for an inpatient admission	6%	9%	Green
Human Resources	Position Fill Rate			
	Position Turn-over Rate			
	Overtime Utilization			
	Mandate Utilization			
Financial	Revenue	\$121.0	\$119.0	
	Expense	\$179.6	\$178.5	
	Tax Levy	\$59.0	\$59.0	

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

**DATE:** September 26, 2014

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

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

**SUBJECT:** **A Report from the President of the Medical Staff Organization requesting decision from the Board concerning implementation of Medicare CoP §482.12(a)(10) which requires the Board to directly consult with the Leader of the Medical Staff not less than semi-annually**

**Issue**

*Requirement for Direct Consultation Between the Governing Board and Medical Staff Leader*

Recent changes were made to Medicare Conditions of Participation that added §482.12(a)(10) which requires the Governing Board or a subcommittee thereof to consult with the Leader of the Medical Staff at least two times per calendar year or fiscal year.

**Discussion**

In accordance with Medicare CoP §482.22(b)(3), there must be an individual member of the hospital's medical staff who is assigned responsibility for the organization and conduct of the medical staff (for purposes of this guidance, the "leader" of the medical staff). Behavioral Health Division Organization Bylaws define the leader, for this purpose, as the President of the Medical Staff. §482.12(a)(10) has been newly created and requires that the governing body consult with this individual, or with someone the leader of the medical staff has designated. Consultations are to take place not less than semi-annually.

For this purpose, "direct consultation" means that the governing body, or a subcommittee of the governing body, meets with the leader(s) of the medical staff(s), or his/her designee(s) either face-to-face or via a telecommunications system permitting immediate, synchronous communication. (79 FR 27113, May 12, 2014).

It is up to the governing body as to whether the leader of the medical staff must make the designation in writing when he or she chooses to designate another individual for these periodic consultations, or whether the leader of the medical staff may make informal, ad hoc designations. It is also up to the governing body as to whether it wishes to establish minimum advance notice of a designation from the leader of the medical staff to the governing body.

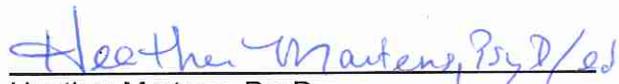
**Recommendation**

It is recommended that the Milwaukee County Mental Health Board authorize the Medical Staff President to notify the Board, in writing not less than two weeks prior to a scheduled "direct consultation," when he or she chooses to designate another individual(s) for these periodic consultations.

Secondly, the Medical Staff Organization is requesting that the Mental Health Board determine the manner in which it wishes to implement the "direct consultation" requirement, whether through meetings with the Board, as a whole, or by subcommittee.

Upon determination by the Board, the consultation requirements shall be incorporated within the BHD Medical Staff Bylaws. As neither the Medical Staff or the Board may unilaterally amend the Medical Staff Bylaws, the revised governing documents shall be presented to the Medical Staff for adoption and then returned to the Board for final approval.

Respectfully Submitted,



Heather Martens, PsyD  
President, BHD Medical Staff Organization

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

**Attachment**

- 1 Except from CMS Revised Guidelines Related to New & Revised Hospital Governing Body and Medical Staff Regulations (Ref: S&C: 14-45-Hospital)

*§482.12(a)(10) Consult directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or his or her designee. At a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the hospital. For a multi-hospital system using a single governing body, the single multi-hospital system governing body must consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements of this paragraph (a).*

#### **Interpretive Guidelines §482.12(a)(10)**

*In accordance with §482.22(b)(3), there must be an individual member of the hospital's medical staff who is assigned responsibility for the organization and conduct of the medical staff (for purposes of this guidance, the "leader" of the medical staff).*

*§482.12(a)(10) requires that the governing body consult with this individual, or with someone the leader of the medical staff has designated.*

*"Direct consultation" means that the governing body, or a subcommittee of the governing body, meets with the leader(s) of the medical staff(s), or his/her designee(s) either face-to-face or via a telecommunications system permitting immediate, synchronous communication. (79 FR 27113, May 12, 2014)*

*This regulation does not preclude a hospital from having a member of the medical staff serve as a member of the hospital's governing body. However, membership on the governing body by a medical staff member is not sufficient per se to satisfy the requirement for periodic consultation. In such a situation the hospital meets the consultation requirement only if the medical staff member serving on the governing body is the leader of the medical staff, or his or her designee, and only if such membership includes meeting with the board periodically throughout the fiscal or calendar year and discussing matters related to the quality of medical care provided to patients of the hospital. If there were a change in the medical staff leadership or his/her designee, and the bylaws governing terms and conditions of governing body membership did not allow for substitution of the new leader of the medical staff (or his or her designee) on the governing body, then the governing body would be expected to engage in direct consultation with the new leader of the medical staff, or his or her designee.*

*It should be noted that if a hospital chooses to have the leader of the medical staff, or his or her designee, serve on the governing body, there is nothing in the regulation which prohibits the hospital from also including other medical staff members on the governing body in addition to the leader of the medical staff, or his or her designee.*

*In the case of a multi-hospital system that has one single governing body, the governing body must consult with each separately certified hospital's medical staff leader, or his/her designee. The consultations do not have to be separate. For example, the system governing body could periodically have a meeting that includes the leader of the medical*

*staff, or his/her designee, from each hospital within the system, so long as there is discussion of matters related to the quality of medical care provided to the patients of each hospital.*

*If the medical staff members at separately certified hospitals in a multi-hospital system and the hospital system's governing body also have opted to have a unified medical staff (see guidance for §482.22(b)(4)) for some or all of the hospitals in the system, then the governing body must consult with the leader of the unified medical staff or his/her designee. In this case, the leader of the unified medical staff, or the designee, as applicable, is expected to be aware of the concerns/views of members of the medical staff practicing at each separately certified hospital using the unified medical staff.*

*It is up to the governing body as to whether the leader of the medical staff must make the designation in writing when he or she chooses to designate another individual for these periodic consultations, or whether the leader of the medical staff may make informal, ad hoc designations. It is also up to the governing body as to whether it wishes to establish minimum advance notice of a designation from the leader of the medical staff to the governing body.*

*The requirement for the governing body to consult periodically throughout the year leaves some flexibility for the governing body to determine how often during the year its consultations with the leader of the medical staff or designee would occur, but it is expected that consultations occur at least twice during either a calendar or fiscal year. ("Fiscal year" refers to the Medicare cost-reporting year for the hospital; in the case of a hospital system with multiple, separately certified hospitals that have one single governing body and a unified medical staff, it is possible that individual hospitals have separate fiscal years. In this case, it would be more practical for the governing body to use a calendar year basis for determining the frequency of consultation.)*

*The governing body is expected to determine the number of consultations needed based on various factors specific to the hospital, or to each of the hospitals within a multi-hospital system. These factors include, but are not limited to, the scope and complexity of hospital services offered, specific patient populations served by a hospital, and any issues of patient safety and quality of care that a hospital's quality assessment and performance improvement program might periodically identify as needing the attention of the governing body in consultation with its medical staff. The hospital must also provide evidence that the governing body is appropriately responsive to any periodic and/or urgent requests from the leader of the medical staff or designee for timely consultation on issues regarding the quality of medical care provided to patients of the hospital. (79 FR 27112, May 12, 2014).*

*The "year" referenced in the regulation may be either the calendar year or the hospital's fiscal year, as identified on its Medicare cost report. It is up to the hospital which approach it will take, but it must document the approach selected and consistently apply it. For example, if a hospital chooses to use the calendar year, and had only one*

*consultation during a calendar year, it could not then point out that it had had two meetings during the time period covered by its fiscal year.*

*The required consultation must include discussion of matters related to the quality of medical care provided to the hospital's patients, or, in the case of a hospital system with one single governing body and a unified medical staff, the quality of medical care provided to each separately certified hospital's patients.*

*The hospital's governing body must adopt policies and procedures addressing how it implements the requirement for periodic, direct consultation with the leader of the medical staff, or the designee. The hospital must have evidence that the required consultations do take place, such as meeting agendas and lists of attendees, or minutes taken of the discussion, including who was present, etc., and that matters related to the quality of medical care provided to patients of the hospital were discussed.*

#### **Survey Procedures §482.12(a)(10)**

- *Ask the hospital's CEO how the hospital complies with the requirement for periodic consultations by the governing body with the leader of the hospital's medical staff, or the leader's designee. Can the CEO provide evidence that such consultations have occurred, e.g., meeting agendas and lists of attendees, meeting minutes, etc.*
- *Ask the CEO whether the hospital tracks these consultations by the calendar year or its fiscal year; ask to see a copy of the policy that establishes this.*
  - *Is there evidence that the consultations were "direct?"*
  - *Is there evidence that the governing body met with the medical staff leader or designee at least twice during the previous year?*
  - *Is there evidence that the discussion concerned matters related to the quality of medical care in the hospital?*
- *Ask the leader of the hospital's medical staff, or his/her designee, whether he or she has had meetings with either the whole governing body or a subcommittee of it to discuss the quality of medical care in the hospital.*
  - *Has the leader/designee ever requested a meeting in addition to those regularly scheduled, to discuss a matter of urgent concern to the medical staff? If yes, did the governing body respond by setting up a meeting?*
  - *If the hospital shares a unified medical staff with other separately certified hospitals in a multi-hospital system, the interview with the leader of the medical staff, or designee, may have to be conducted by telephone. Ask the leader/designee how he/she gathers information about the concerns/views of*

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

**DATE:** September 26, 2014

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

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

**SUBJECT:** **A Report from the President of the Medical Staff Organization requesting Approval of Appointment and Privilege Recommendations made by the Medical Staff Executive Committee**

**Background**

Under Wisconsin and Federal regulatory requirements, all physicians and all other practitioners authorized under scope of licensure and by the hospital to provide independent care to patients must be credentialed and privileged through the Medical Staff Organization. Accepting temporary privileges for an immediate or special patient care need, all appointments, reappointments and privileges for each physician and other practitioners must be approved by the Governing Body.

**Discussion**

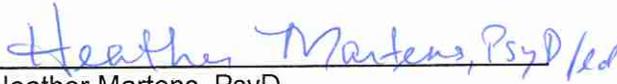
From the President of the Medical Staff and Chair of Credentialing and Privileging Review presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C<sup>1</sup>:

- A. New Appointment(s)
- B. Reappointments – None this period
- C. Provisional Reviews / Status Changes
- D. Notations Reporting (to be presented in **CLOSED SESSION** in accordance with protections afforded under Wisconsin Statute 146.38)

**Recommendation**

It is recommended that the Milwaukee County Mental Health Board approve all appointments and privilege recommendations, as submitted by the Medical Staff Executive Committee.

Respectfully Submitted,

  
Heather Martens, PsyD  
President, BHD Medical Staff Organization

cc Patricia Schroeder, BHD Administrator  
John Schneider, BHD Executive Medical Director  
Clarence Chou, MD, BHD Chairperson, Medical Staff Credentialing and Privileging Review  
M. Kathleen Eilers, BHD Consultant  
Lora Dooley, BHD Director of Medical Staff Services  
Jodi Mapp, Senior Executive Assistant

**Attachment**

1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
GOVERNING BODY REPORT  
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS  
OCTOBER 2014**

The following credentials files were reviewed. Privilege recommendations/actions were made based on information related to qualifications, current competence and ability to perform privileges (health status). All requisite primary source verifications or queries were obtained and reviewed regarding professional training, professional licensure(s), registrations, National Practitioner Data Bank and OIG-List of Excluded Individuals and Entities & System Award Management. Decisions were further based on Service Chief recommendations, and as applicable, peer recommendations, focused or ongoing (FPPE/OPPE) professional practice evaluation data, malpractice claims history and verification of good standing with other hospitals/practices. Notations reporting shall be presented at the Board Meeting in closed session.

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 11, 2014	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 18, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Oswald Bwechwa, MSW	51.15 Treatment Director Designee (Act 235 Pilot)	Allied Health/ Provisional		Dr. Moiso recommends appointment & privileges, as requested	Committee recommends appointment to 5/1/16 and provisional privileges for a minimum period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
Julie Lubbers, MSW	51.15 Treatment Director Designee (Act 235 Pilot)	Allied Health/ Provisional		Dr. Moiso recommends appointment & privileges, as requested	Committee recommends appointment to 5/1/16 and provisional privileges for a minimum period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
Michael Maletis, MSW	51.15 Treatment Director Designee (Act 235 Pilot)	Allied Health/ Provisional		Dr. Moiso recommends appointment & privileges, as requested	Committee recommends appointment to 5/1/16 and provisional privileges for a minimum period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
Jody Schmidt, MSW	51.15 Treatment Director Designee (Act 235 Pilot)	Allied Health/ Provisional	PR	Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends appointment to 5/1/16 and provisional privileges for a minimum period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
PROVISIONAL STATUS REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE AUGUST 7, 2014	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 18, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Christina Girgis, MD	General Psychiatry; General Medical Practice	Affiliate/ Provisional		Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Michelle Heaton, DO	Psychiatric Officer; Medical Officer	Affiliate/ Provisional		Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Elizabeth Lampe, MD	Psychiatric Officer; Medical Officer	Affiliate/ Provisional		Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Kimberly Sanders, MD	Psychiatric Officer; Medical Officer	Affiliate/ Provisional		Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Due to changes in the Committee's meeting schedule in connection with the new Board, the above provisional assessments were completed early. However, since a September meeting was later added, recommendations were held until this report to correlate with completion of the six month provisional privilege period minimum.							
PROVISIONAL STATUS REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 11, 2014	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 18, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
John Schneider, MD	General Psychiatry; General Medical Practice	Active/ Provisional	CB	Dr. Khazi recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	REQUESTED / RECOMMENDED CHANGE	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 11, 2014	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 18, 2014	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Reono Bertagnolli, MD	Consulting Telemedicine/X-Ray Interpretation	Add Ultrasound Interpretation		Dr. Puls recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for remainder of current biennium. Waive provisional period due to having held these privileges in immediate prior appointment with BHD.	Recommends amending privileging as per C&PR Committee.	
Michael Hinz, MD	Consulting Telemedicine/X-Ray Interpretation	Add Ultrasound Interpretation		Dr. Puls recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for remainder of current biennium. Waive provisional period due to having held these privileges in immediate prior appointment with BHD.	Recommends amending privileging as per C&PR Committee.	

MEDICAL STAFF GOVERNING DOCUMENTS AND POLICY/PROCEDURE UPDATES	COMMITTEE ACTIONS	GOVERNING BODY ACTIONS
BOARD COMMENTS / MODIFICATIONS / OBJECTIONS:		

Clarence Chen  
CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE

9/18/14  
DATE

Stephen M. Martens  
PRESIDENT, MEDICAL STAFF ORGANIZATION  
CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

9/18/14  
DATE

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.

\_\_\_\_\_  
GOVERNING BOARD CHAIRPERSON

\_\_\_\_\_  
DATE APPROVED