

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

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, October 22, 2015 - 8:00 A.M.
Milwaukee County Mental Health Complex Auditorium

MINUTES

PRESENT: Peter Carlson, Robert Chayer, Ronald Diamond, Rochelle Landingham, Jon Lehrmann, Thomas, Lutzow, Jeffrey Miller, *Mary Neubauer, Maria Perez, Duncan Shroul, Kimberly Walker, and Brenda Wesley

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

SCHEDULED ITEMS:

1. Welcome.

Madame Chair opened the meeting by greeting Board Members and the audience.

- Resignation of Lyn Malofsky/Board Vacancies

APPEARANCE:

Collen Foley, Deputy, Corporation Counsel

Chairwoman Walker stated at the August Board meeting, Ms. Malofsky indicated she was relocating to Madison, Wisconsin. After discussions with Corporation Counsel, it was determined that even with Ms. Malofsky's willingness to continue to serve on the Board, it would not be possible because her specific seat requires that you be a Milwaukee County resident.

Ms. Foley explained this particular vacancy on the Board is covered under Wis. Stat. 51.41(1d)(b)3, which states it must be a representative of the community who is a consumer of mental health services and who is recommended by the Milwaukee County Board of Supervisors. The process for filling this vacancy was explained in detail and has been in process for several weeks.

The Board took no action regarding this informational item.

SCHEDULED ITEMS (CONTINUED):

2.	<p>Approval of the Minutes from the August 27, 2015, Milwaukee County Mental Health Board Meeting.</p> <p>The minutes from the August 27, 2015, meeting were reviewed.</p> <p>Questions and comments ensued.</p> <p>MOTION BY: (Perez) Approve the Minutes from the August 27, 2015, Milwaukee County Mental Health Board Meeting. 8-0-1</p> <p>MOTION 2ND BY: (Lutzow)</p> <p>AYES: Carlson, Chayer, Landingham, Lutzow, Miller, Perez, Shrout, and Walker - 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: Wesley - 1</p> <p>EXCUSED: Neubauer – 1</p> <p style="text-align: center;">A voice vote was taken on this item.</p>
3.	<p>Acute Services Request for Proposals Update.</p> <p>APPEARANCES: Patricia Schroeder, Administrator, Behavioral Health Division (BHD), Department of Health and Human Services (DHHS) Colleen Foley, Deputy, Corporation Counsel Dr. John Schneider, Chief Medical Officer, BHD, DHHS</p> <p>Ms. Schroeder stated BHD is undergoing a transformational process based on the mental health redesign initiative. The vision created was community-based services rooted in a commitment to the values of the person-centered, recovery-oriented, trauma-informed, culturally intelligent model in the least restrictive environment.</p> <p>Several studies emerged over the last year evaluating BHD operations, the main focus being acute care services, with consistent recommendations encouraging the exploration of other models for delivery of acute care services, inclusive of privatization and/or partnerships.</p> <p>On July 15, 2015, the Request for Proposals (RFP) was posted for operating acute services. The interested providers have a visible image focused on forensic services and less evidence of therapeutic model experience. Administrators and the RFP panel recommended suspending the RFP. Options on moving forward were presented, including exploration of a local partnership and exploration of additional national entity partnerships.</p>

SCHEDULED ITEMS (CONTINUED):

<p>MOTION BY: <i>(Shrout) Form One Committee Made up of Four Board Members, Three Voting and One Non-Voting, and Three Behavioral Health Division Staff Members to Explore a Local Public/Private Partnership, as well as a National Single Source Partnership. 3-6-1</i></p> <p>MOTION 2ND BY: <i>(Lutzow)</i></p> <p>AYES: Lutzow, Shrout, and Walker - 3</p> <p>NOES: Chayer, Landingham, Miller, Neubauer, Perez, and Wesley - 6</p> <p>ABSTENTIONS: Carlson - 1</p> <p style="text-align: center;">The Motion Failed.</p>
<p>MOTION BY: <i>(Shrout) Form One Committee Made up of Four Board Members, Three Voting and One Non-Voting, and Three Behavioral Health Division Staff Members to Explore a Local Public/Private Partnership, as well as a National Single Source Partnership with a Request that Vice-Chairman Carlson and Board Member Lehrmann Have Discussions with Private Sector Hospitals and Report Those Discussions Back to the Newly Formed Committee. 4-5-1</i></p> <p>MOTION 2ND BY: <i>(Lutzow)</i></p> <p>AYES: Lutzow, Perez, Shrout, and Walker - 4</p> <p>NOES: Chayer, Landingham, Miller, Neubauer, and Wesley - 5</p> <p>ABSTENTIONS: Carlson - 1</p> <p style="text-align: center;">The Motion Failed.</p>
<p>MOTION BY: <i>(Neubauer) Form Two Committees, Both Made up of Three Voting and Potentially One Non-Voting Board Members, and Three Behavioral Health Division Staff Members, with One Committee Exploring a Local Public/Private Partnership and One Committee Exploring a National Single Source Partnership, Naming a Chairman and Secretary to Each. 7-2-1</i></p> <p>MOTION 2ND BY: <i>(Landingham)</i></p> <p>AYES: Chayer, Landingham, Lutzow, Miller, Neubauer, Perez, and Wesley - 7</p> <p>NOES: Shrout and Walker - 2</p> <p>ABSTENTIONS: Carlson - 1</p> <p style="text-align: center;">Voice votes were taken on this item.</p>

SCHEDULED ITEMS (CONTINUED):

4.	<p>Electronic Medical Record/Avatar Overview.</p> <p>APPEARANCES: Laurie Panella, Chief Information Officer, Information Management Services Division, Department of Administrative Services Alicia Modjeska, Chief Administrative Officer, Behavioral Health Division, Department of Health and Human Services</p> <p>Ms. Panella provided an overview of the project by summarizing the timeline, milestones, challenges, and costs associated with the implementation of the Electronic Medical Record System. She discussed the live training for community providers and explained upgrades that improve the patient experience and streamlines the process.</p> <p>Ms. Modjeska provided a pharmacy update detailing the various changes, enhancements, and upgrades to the system.</p> <p><i>The Board took no action regarding this informational item.</i></p>
5.	<p>Post Prosecutory Conversions from Criminal Justice System Update.</p> <p>APPEARANCE: Colleen Foley, Deputy, Corporation Counsel</p> <p>Ms. Foley stated criminal conversions pose very serious challenges for the Behavioral Health Division (BHD) in terms of safety of patients and staff. She reviewed statutes related to Discharge Civil Proceedings and Competency Proceedings and 2013-2015 BHD criminal conversion admissions. There is increasing severity of the nature of the crimes committed and the acuity of illness of individuals that are starting to come through these conversions, and per statute, BHD is compelled to admit these individuals.</p> <p>Questions and comments ensued.</p> <p>Chairwoman Walker requested that Ms. Schroeder reach out to the State to plan and schedule their attendance at a regularly scheduled meeting of the Board, preferably the February 2016 meeting and that this occur annually.</p> <p><i>The Board took no action regarding this informational item.</i></p>
6.	<p>Administrative Update.</p> <p>APPEARANCES: Patricia Schroeder, Administrator, Behavioral Health Division (BHD), Department of Health and Human Services (DHHS) Amy Lorenz, Director, Community Access to Recovery Services (CARS), BHD, DHHS</p>

SCHEDULED ITEMS (CONTINUED):

	<p>Ms. Schroeder provided highlights of key activities and issues related to Behavioral Health Division (BHD) operations. She discussed the temporary inpatient bed hold related to psychiatry staffing, BHD's new communications team, the Division's organizational chart, Comprehensive Community Services and Community Recovery Services updates, safety audit, the Public Policy Forum report on Outpatient Behavioral Health Capacity, and planning for the North Side Community Based "Place."</p> <p>Board Member Lutzow requested a report on feedback from the Deloitte December 2014 findings be brought before the Board at the December meeting.</p> <p>Questions and comments ensued.</p> <ul style="list-style-type: none">• Request for Resource <p>Ms. Schroeder indicated research on employee engagement and creating a positive work environment often cite the impact of food or an occasional treat in supporting staff. While modestly supporting employees with these gestures, expenses are being paid by leaders and sometimes employees themselves. Support of employee engagement is critical to retention.</p> <p>MOTION BY: (Shrout) Approve the Annual Stipend of \$5,000 to Support Employee Engagement Efforts/Expenses. 10-0</p> <p>MOTION 2ND BY: (Miller)</p> <p>AYES: Carlson, Chayer, Landingham, Lutzow, Miller, Neubauer, Perez, Shrout, Walker, and Wesley - 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p style="text-align: center;">A voice vote was taken on this item.</p>
7.	<p>Combined Community Services Board Update.</p> <p>Board Member Shrout provided background information on the Combined Community Services Board (CCSB) citing its creation, charge, and responsibilities, including oversight of providers and services, budgeting, and program planning evaluation. He went on to state in 2014, the Disability Services Division hired the Human Services Research Institute and the Public Policy Forum to identify a means of improving services for Milwaukee County citizens and residents with intellectual developmental disabilities. A series of recommendations were developed to address system challenges. CCSB will be closely monitoring the following recommendations: 1) investment in self advocacy, 2) assure system transparency, 3) investment in peer support and contribution, and 4) provide direction and oversight.</p> <p>Questions and comments ensued.</p> <p>The Board took no action regarding this informational item.</p>

SCHEDULED ITEMS (CONTINUED):

8.	<p>Mental Health Board Sub-Committees Update.</p> <ul style="list-style-type: none">• Finance Committee <p>APPEARANCE: Randy Oleszak, Chief Financial Officer, Behavioral Health Division, Department of Health and Human Services</p> <p>Vice-Chair Carlson stated the Finance Committee addressed Act 203's reporting requirement due March of 2016, which states the Mental Health Board needs to put together a report for the County Board of Supervisors related to alternative revenue opportunities. A proposal was brought forth to contract with Deloitte, and the Finance Committee recommended the Board approve that contract for preparation of the report. The Finance Committee also discussed BHD's two trust funds. One is related to patient activities, and one is related to research. Both trust funds go back anywhere between thirty and forty years.</p> <p>Mr. Oleszak provided an update on the State Budget.</p> <p>Questions and comments ensued.</p> <ul style="list-style-type: none">• Quality Committee <p>Dr. Chayer discussed staffing changes, goals and objectives, the dashboard, Joint Commission, closed loop medication, Hilltop closure, BHD's involvement in Zero Suicide, and the safety on BHD's campus.</p> <p>Board Member Landingham indicated that MC3 is interested in presenting to the Quality Committee.</p> <p>Questions and comments ensued.</p> <p><i>The Board took no action regarding this informational item.</i></p>
9.	<p>Fiscal Update.</p> <p>APPEARANCE: Randy Oleszak, Chief Financial Officer, Behavioral Health Division, Department of Health and Human Services</p> <ul style="list-style-type: none">• 2015 Fiscal Results• 2016 Budget Update• 2016 Budget Timeline and Changes

SCHEDULED ITEMS (CONTINUED):

Mr. Oleszak provided an overview of the Second Quarter June 2015 Fiscal Report detailing 2015 risks and opportunities in the areas of inpatient and Community Access to Recovery Services along with annual 2015 projections. Items highlighted for 2015 that have the most financial importance include Rehab Central closure, adult inpatient bed reduction, State plan amendment revenue, fringe surplus, community based residential facility completion, community billing implementation, Alcohol and Other Drug Abuse (AODA) surplus, Comprehensive Community Services expansion, value-based contracting, Family Care expansion, and WIMCR.

Initiatives in the 2015-2017 State Budget that may or may not have an impact on the Behavioral Health Division (BHD) were identified as future changes related to emergency detentions, changes to Badger Care for childless adults, disproportionate share hospital, State mental health allocation, and residential substance abuse services. This initial assessment of potential changes is based on staff interpretation, so additional information is needed in order to ascertain the full impact on BHD.

The BHD Budget approved by the Mental Health Board was forwarded to the County Budget Office who made changes in an effort to balance the County Budget as a whole. Mr. Oleszak explained those changes, which included a change in compensation to employees, a one-time bonus to employees, an increase to pension costs, and an increase in cross charges. The timeline for the budget process was detailed. The Budget also altered the budget amendment recommended by the Board for third-shift staffing at both Crisis Resource Centers (CRC) to \$150,000, which supports third shift staffing of a clinician only at the North Side CRC at this time.

- Act 203 March 2016 Reporting Requirement and Contract Approval with Deloitte

Mr. Oleszak stated a requirement within Act 203 states a study is to be conducted on alternate funding sources and programs and other funding models with a report of the results of the study due to the Milwaukee County Board of Supervisors and the County Executive on March 1, 2016. Discussions were held with Deloitte to complete the study. Because of Deloitte's experience, it is being proposed that the BHD enter into a single source agreement to complete the research study and report.

MOTION BY: (Miller) Approve the Deloitte Contract. 10-0

MOTION 2ND BY: (Carlson)

AYES: Carlson, Chayer, Landingham, Lutzow, Miller, Neubauer, Perez, ShROUT, Walker, and Wesley - 10

NOES: 0

ABSTENTIONS: 0

A voice vote was taken on this item.

SCHEDULED ITEMS (CONTINUED):

Pursuant to Wisconsin Statutes Section 19.85(1)(c), the Board may adjourn into Closed Session for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as they relate to the following matter(s):

10. Medical Executive Report and Credentialing and Privileging Recommendations.

APPEARANCE:

Dr. Clarence Chou, President, Medical Staff Organization, Behavioral Health Division, Department of Health and Human Services

MOTION BY: *(Carlson) Adjourn into closed session under the provisions of Wisconsin Statutes Section 19.85(1)(c) for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as it relates to Item #10. At the conclusion of the Closed Session, the Board may reconvene in open session to take whatever action(s) it may deem necessary on the aforesaid item. 8-0*

MOTION 2ND BY: *(Lutzow)*

AYES: Carlson, Chayer, Landingham, Lutzow, Neubauer, Perez, Walker, and Wesley - 8

NOES: 0

ABSTENTIONS: 0

EXCUSED: Miller and Shrout - 2

A voice vote was taken on this item.

The Committee convened into Closed Session at 11:30 a.m. and reconvened back into open session at approximately 11:35 a.m. The roll was taken, and all Board Members were present except for Board Member Shrout, who was excused.

MOTION BY: *(Neubauer) Approve the Medical Staff Credentialing Report and Executive Committee Recommendations. 9-0*

MOTION 2ND BY: *(Perez)*

AYES: Carlson, Chayer, Landingham, Lutzow, Miller, Neubauer, Perez, Walker, and Wesley - 9

NOES: 0

ABSTENTIONS: 0

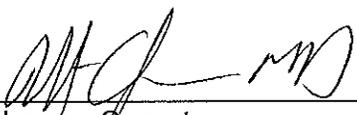
EXCUSED: Shrout - 1

A voice vote was taken on this item.

SCHEDULED ITEMS (CONTINUED):

11.	<p>Adjournment.</p> <p>MOTION BY: (Neubauer) Adjourn. 9-0 MOTION 2ND BY: (Carlson) AYES: Carlson, Chayer, Landingham, Lutzow, Miller, Neubauer, Perez, Walker, and Wesley - 9 NOES: 0 ABSTENTIONS: 0 EXCUSED: Shrout - 1</p> <p style="text-align: center;">A voice vote was taken on this item.</p>
<p>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.</p> <p>Length of meeting: 8:08 a.m. to 11:38 a.m.</p> <p>Adjourned,</p> <p>Jodi Mapp Senior Executive Assistant Milwaukee County Mental Health Board</p>	
<p>The next meeting for the Milwaukee County Mental Health Board will be on Thursday, February 25, 2016, @ 8:00 a.m.</p>	

The October 22, 2015, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled meeting of the Milwaukee County Mental Health Board.



Dr. Robert Chayer, Secretary
Milwaukee County Mental Health Board

Milwaukee County Outpatient Behavioral Health Capacity Assessment

FINAL REPORT
October 27, 2015

Prepared by:

Human Services Research Institute
Technical Assistance Collaborative
Public Policy Forum

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Executive Summary

Introduction

The Milwaukee County Outpatient Capacity Analysis (OCA) is the third report issued jointly by the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC), and the Public Policy Forum (PPF) related to the ongoing initiative by public and private sector stakeholders to redesign the mental health care delivery system in Milwaukee County. The first report analyzed system strengths and weaknesses and offered recommendations to improve system performance, and the second focused on adult inpatient bed capacity. In this report, we focus on behavioral health services that are provided outside of inpatient settings. The OCA was commissioned by the Milwaukee Health Care Partnership and was funded by a diverse array of organizations, including the Partnership, local health care and managed care entities, the State of Wisconsin, and local foundations.

The types of outpatient services inventoried in this report are clinical services and programs that are considered essential for a comprehensive system of care, especially for low-income populations. Additionally, these services are assumed to be related to demand for inpatient care. When available as part of a community-based behavioral health system, they may effectively function as an alternative to inpatient and emergency treatment.

Whereas inpatient services and the County-funded behavioral health system have relatively clearly defined boundaries, outpatient services are much more diverse and diffuse, and are delivered through a complex array of organizations and practitioners with multiple funding sources. As a result, data on outpatient services are fragmentary, complex, and incomplete. To best characterize this de facto system, this report presents a multidimensional overview of supply and demand, providing estimates of treated and untreated prevalence, measures of utilization, and an assessment of gaps and barriers to access. It concludes with a broad range of recommendations. While these recommendations emphasize the leadership role of the Milwaukee County Behavioral Health Division (BHD), they also incorporate the functions of a wide network of stakeholders.

Data sources

Corresponding to the complexity of the array of outpatient services, information presented in this report was collected from a variety of sources. Qualitative information relating to the availability and accessibility of outpatient services was obtained through a review of documents and previous reports and through interviews with stakeholders (including BHD administrators, inpatient hospital discharge planners, and administrators and staff of community programs, clinics, and agencies). Quantitative analysis draws upon two sources. The first is Medicaid claims data from July 2010 through September 2014, obtained by request from the Wisconsin Department of Health Services (DHS). These files consisted of all claims for Medicaid enrollees with a behavioral health diagnosis registered in Milwaukee County. The second source is utilization data for services funded by Milwaukee County BHD for adults and children/adolescents. Reflecting the fragmentary nature of outpatient services utilization data, missing from this report is information about the uninsured population as a whole, which was unavailable for the study (though some uninsured individuals are included in BHD utilization data).

Semi-structured interviews were conducted with a broad base of stakeholder representatives, including key DHS and BHD staff, discharge planners from BHD and local hospitals, providers of mental health and substance use services, providers of primary care (FQHCs) and other safety-net

services, as well as representatives from academia and Medicaid managed healthcare plans. Our researchers also held a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders to navigate the health care and social service systems. Additionally, to further explore issues of access identified by stakeholders, we conducted a simulated patient or “secret shopper” campaign, where our researchers posed as individuals seeking outpatient behavioral health treatment for Medicaid enrollees. Our aim was to determine whether new clients were being accepted, whether providers accepted patients insured via Medicaid, and how quickly a new client might be seen.

Assessing supply and demand: Prevalence, provider capacity, service utilization and accessibility

Prevalence: We were able to approximate a treated prevalence rate for the Medicaid population using claims data to calculate the penetration rate (that is, the percentage of Medicaid enrollees receiving behavioral health services on a quarterly basis for the period from July 2010 through September 2014). These data indicate that while overall Medicaid enrollment increased steadily through the period—rising from about 275,000 to 315,000, or approximately 15%—the number of adults and children/adolescents receiving mental health and substance abuse services remained about the same in all categories, resulting in a net decline in the penetration rate. This suggests that the service capacity for Medicaid enrollment has not kept pace with the need; this could be the result of a lag in the response of supply to demand (in which case penetration rates may rise over time) or because of some form of market failure whereby increased demand does not prompt a corresponding increase in supply (for example, because Medicaid rates are too low to prompt expansion, in which case rates will not rise).

With respect to the general population, a recent report from DHS, entitled *Wisconsin Mental Health and Substance Abuse Needs Assessment*,¹ presents the following prevalence estimates of treated and untreated behavioral health disorders for Milwaukee County and the state:

- Number of adults with any mental illness: 135,895
- Number of adults with serious mental illness: 32,901
- Number of children with any mental illness: 34,969
- Number of children with serious emotional disturbance: 18,317
- Statewide, about 49% with any mental illness (50% of adults and 46% of children) did not access services
- The statewide treated prevalence rate for substance abuse is estimated to be about 23%

Provider capacity: Outpatient capacity in terms of provider supply may be represented in two ways: as an inventory of the total of behavioral health service providers in Milwaukee County who might potentially serve the population in question; and as provider volume (that is, the number of people actually served by various outpatient providers, which we call the “de facto” behavioral health system). An inventory may draw from lists maintained by licensing and regulatory agencies, although the complexity and fragmentation of outpatient behavioral services and the diversity of provider types presents a challenge for this approach. A list of licensed mental health and/or substance abuse outpatient provider agencies, drawn primarily from DHS records but supplemented by a few other sources, identifies 373 entities, including multiple sites operated by a single organization, that are eligible to serve Medicaid enrollees. These represent a complex array

¹ Available at <https://www.dhs.wisconsin.gov/publications/p0/p00613.pdf>

of organizational characteristics, including public and private ownership, for-profit and nonprofit, faith-based, hospital-affiliated and nonaffiliated, mental health and substance abuse combined or one or the other only.

Provider Volume: A simple count of facilities provides only a limited picture of overall capacity. Another approach to measuring capacity is by provider volume. In contrast to the formal “system” represented by the list of provider organizations and individual clinicians licensed to practice in Milwaukee County, the analysis of provider volume identifies who actually provides how much service to residents of the county, thereby representing the de facto behavioral health system.

For this purpose, we analyzed Medicaid claims by Medicaid provider type for the period of January through September 2014. This time frame was selected as being the most current available and reflecting the effects of Medicaid expansion. The methodology for analyzing claims is described in Appendix 1.

Providers serving Medicaid-enrolled Milwaukee County residents, Jan.-Sept. 2014

	Number of providers	Number of people served	Providers serving <10	Number people served by <10 providers
Mental health/substance abuse clinics	209	26,418 ¹	110	319
Mental health/substance abuse – individual non-prescribing clinicians	300	2,929	210	666
Hospital outpatient	138	16,533	114	251
Physician – independent group practices	272	31,112	168	428
Physician – health care system group practices	16	2,125	5	25
Physician – no affiliation identified	226	3,154	184	411
Nurse practitioner – affiliated with organizations	9	306	3	17
Nurse practitioner – no affiliation identified	20	49	18	49
Federally qualified health center	15	3,150	10	32
Institutions for Mental Diseases – outpatient	8	2,459	4	8
Laboratory (drug screening)	21	2,445	13	38
Narcotic services	7	1,301	5	11
Day treatment	17	479	8	41
Health Check ¹	3	219	2	8
Health Check Other ¹	20	444	13	36
Crisis	11	1,611	11	10

¹ Wisconsin’s terms for Early Periodic Screening Diagnosis and Treatment, including behavioral health.

There are several features of the information in this table that have implications for policy considerations related to outpatient capacity. First, these claims represent only Medicaid enrollees registered in Milwaukee County, yet the number of providers far exceeds the number located within the county, demonstrating that a considerable number of Milwaukee County Medicaid enrollees travel outside the boundaries of Milwaukee County in order to receive behavioral health services. This has several possible alternative interpretations for policy purposes. On the one hand, it may indicate a shortage of providers in Milwaukee County or barriers to accessing services there. Alternatively, it may simply indicate that the de facto service system is regional in nature.

A second notable feature is the large number of providers that serve very small numbers of consumers, in many cases only one or two during the period from January to September 2014. Conversely, a handful of large organizations serve a preponderance of individuals: the top three highest-volume providers together accounted for 40% of the total volume. The implication of this in a policy context is that the provider “system” is in fact bifurcated into two segments: a few large-volume providers and many smaller providers. On the one hand, this poses a challenge to integration and continuity of care. A more positive inference, however, is that these low volume providers may represent untapped potential for capacity expansion. If the reason they serve few Medicaid patients is due not to reluctance, but because they are in some sense outside the referral mainstream, then there may be potential for increasing capacity through efforts to integrate them more directly into an overall system, for example through more aggressive outreach by case managers and inpatient discharge planners.

We also analyzed BHD data for a variety of outpatient services provided directly or under contract by the County over the five-year period.

Utilization

Whereas provider volume represents capacity at the organizational level, the analysis of utilization (the number of consumers using services), via Medicaid claims as well as BHD data, considers services at the consumer level. It looks at who gets what and where, and whether these patterns change over time.

Medicaid Utilization

Based on Medicaid claims data, utilization appeared fairly stable for all provider types throughout the study period (July 2010 to September 2014). Utilization of outpatient services provided by hospitals and, in smaller numbers, by institutions for mental disease (IMDs), was fairly consistent throughout the period. By comparison, utilization numbers for services provided in licensed mental health and substance abuse clinics were much larger; these too were fairly consistent—though there was some variation, possibly due to seasonal differences. Services provided by nurse practitioners varied somewhat unpredictably, but represented relatively small numbers throughout the period. Given the widely noted problems with access to child psychiatrists in Milwaukee County, nurse practitioners may be an area for further exploration as an opportunity to increase capacity through physician extenders. Billing for children by federally qualified health centers (FQHCs) increased gradually across the period, suggesting an increasing capacity for providing behavioral health services, although there are some anomalous variations.

BHD Utilization

Data were collected for utilization of BHD adult and child mental health and substance services annually from 2011 through 2014 as shown in the following tables. Additionally, for adult services, wait times from referral to admission for services were reported. Adult mental health services

reported are those accessed through BHD's Service Access to Independent Living (SAIL) program. Substance abuse services are those accessed through the Wisconsin Supports Everyone's Recovery (Wiser) Choice program. Child and adolescent behavioral health services are those provided through Wraparound Milwaukee.

Generally, the number of persons admitted in all categories is quite consistent over the four-year period, with a slight drop off in 2014 for a few categories of service. Increasing wait times for admission to adult mental health services (nearly quadrupling over the four-year period) provides evidence of mounting strain on capacity and is consistent with feedback obtained from stakeholders about difficulties with access. BHD administrators attribute this trend to the significant increase in the number of requests, which nearly doubled over the period, and simultaneous decreases in provider capacity due to a variety of factors such as contract changes in 2014. BHD reports having initiated a number of measures to address this increased demand, with the expectation that wait times will be reduced. Preliminary data through August 2015 indicates a lag of about 60 days—still considerably more than 2011-2013, but a downward trend from 2014. Data on wait times for child and adolescent services were not available for this report.

Adult Mental Health Services (SAIL): Number admitted annually and median number of days between referral and admission
 (Note: TCM = Targeted Case Management; CSP = Community Support Program; CBRF = Community Based Residential Treatment)

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission						
TCM	224	17	265	28	315	49	379	67
CSP	78	22.5	102	31	115	52	141	80
CBRF	5	27	9	27	8	32.5	15	75
Day Treatment	38	15	24	16.5	39	24	44	29

Adult Substance Abuse Services (Wiser Choice): Number admitted annually and median number of days between referral and admission

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission						
Outpatient	1511	7.0	1148	6.0	1179	3.0	868	2.0
Day Treatment	310	6.0	224	4.0	212	3.0	198	1.0
Transitional Residential	529	7.0	329	5.0	206	4.0	312	3.0
Medically Monitored Residential	21	14.0	6	22.5	5	30.0	10	3.0
Methadone	9	25.0	14	17.5	20	0.5	81	5.0
Employment	18	7.0	179	7.0	177	6.0	126	11.0
School/Training	53	2.0	78	5.0	48	4.5	85	8.0
Housing	9	8.0	21	8.0	16	5.0	16	2.0

Child and Adolescent Mental Health and Substance Abuse Services (Wraparound Milwaukee) Units of Service and Number Served by Category of Service 2011-2014

Service Type	Unit Type	2011		2012		2013		2014	
		Units	Persons	Units	Persons	Units	Persons	Units	Persons
AODA	¼ Hour	4,172	178	3,774	150	5,162	186	5,304	181
Day Treatment	Daily	2,161	53	2,697	65	2,380	54	1,318	29
Outpatient	Hourly	37,195	1,146	42,727	1,227	47,339	1,346	46,598	1,280
Psychiatric Review/Meds	Session	3,483	906	4,521	1,046	4,758	1,097	3,847	1,031

Stakeholder interviews

To obtain “the story behind the data” and, in particular, to identify issues of access and service gaps, we conducted face-to-face and telephone interviews with dozens of community, County, and State stakeholders. We also conducted a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders navigate the health care and social service systems.

While there was some variation in response among the stakeholders interviewed, the following emerged as consistent themes related to gaps in services and barriers to accessing outpatient behavioral health care in Milwaukee County.

- **Fragmentation:** Although, individually, many providers deliver high-quality care, services take place in “silos,” resulting in problems with access, integration, and continuity of care.
- **BHD service access:** Assessment and referral processing by the Service Access to Independent Living (SAIL) program resulted in service access bottlenecks for persons with serious mental illness.
- **Dual diagnosis treatment:** Difficulties remain in terms of access to the Wiser Choice Alcohol and Other Drug Abuse (AODA) program, with continuing bifurcation and duplication of mental health and AODA services despite past efforts to develop integrated treatment. (BHD comments that this bottleneck is primarily attributable to capacity limitations with contracted providers rather than delays in processing referrals.)
- **Managed care organizations:** Variation in managed care organization policies, procedures, and operational protocols creates confusion for members and providers. There were also questions about the availability of providers.
- **Role of FQHCs:** The potential but as yet underdeveloped role of FQHCs in providing behavioral health services was noted, as was a lack of integration with BHD and other behavioral health providers.
- **Case management:** Stakeholders expressed frustration and concern over the lack of readily accessible case management. (Again, BHD identifies this as a provider capacity issue.)
- **Medicaid reimbursement rates:** Stakeholders identified the low Medicaid rates for services as one of the most significant barriers to behavioral health care, with several discharge planners asserting that only a handful of providers would accept Medicaid enrollees.
- **Psychiatrist and advanced practice nurse shortages:** Barriers particularly to psychotropic medication treatment, especially for children, were widely noted, with representatives of provider organizations commenting on the challenges of recruiting and retention.
- **Primary Care Practitioners:** PCPs are a resource for treating individuals with less serious disorders, but most are reluctant to treat children, older adults, and adults with more complex behavioral health conditions, particularly with respect to prescribing psychotropic medications.
- **Telemedicine:** While several stakeholders acknowledged that telemedicine is a reimbursable service approach under Wisconsin Medicaid, only one provider was identified as offering the service.

- **Navigation and transportation:** Individuals and families who do not qualify for intensive services, including case management, find it difficult to access services within a fragmented system on their own. Stakeholders also reported a lack of convenient and accessible public transportation options as a significant barrier to care.

It should be noted that information gained from stakeholder interviews, while generally credible, constitutes anecdotal evidence that varies in consistency and in the extent to which it is supported by other types of evidence. For example, the apparent inconsistency between anecdotal accounts by discharge planners on the one hand, and the evidence from claims data and the simulated patient investigation on the other, may be explained by differences in patient types. The patients being referred by inpatient discharge planners generally represent higher levels of severity and acuity, which fewer providers may be willing to accept.

Simulated patient (“Secret Shopper”) study

To further test the findings obtained from stakeholder interviews, we used a method recommended by policy makers and employed by some state Medicaid agencies. Using this method, researchers posed as potential new patients and called a subset of providers to request new-patient appointments for a mental health disorder. The goal was to obtain information about a) whether new patients were being accepted; b) whether Medicaid was accepted; and c) the length of time to the first appointment.

In general, results supported the anecdotal evidence from stakeholders about barriers to access, particularly with respect to psychiatrists (especially child psychiatrists). A notable result was the difficulty in even being able to contact a considerable proportion of providers.

Summary and recommendations

Milwaukee County's plan to outsource inpatient and emergency care provides BHD the opportunity to focus its resources and energy to ensuring the provision of high-quality community-based care, including mental health outpatient, intensive outpatient, and day treatment services. BHD can lead this effort by:

- Continuing to engage community stakeholders in promoting a vision for a transformed system of care
- Refining and expanding its strategic plan to include clearly articulated goals, objectives, action steps, and timelines for achieving the vision
- Providing tools and resources to support the envisioned change
- Creating performance and outcome measures to incent and assess change
- Identifying and addressing potential concerns as they emerge, to prevent disruption in progress
- Working with providers and other stakeholders to establish accountability for achieving specific strategic plan objectives

The following recommendations include actions and strategies that have been promoted successfully in other locales. BHD ideally would pursue these recommendations in coordination with other stakeholders to increase capacity and accessibility of outpatient behavioral services. These are discussed in more detail in the main body of the report.

- Improve BHD and private provider intake processes.
- Coordinate with FQHCs in the outpatient behavioral health system.

- Use knowledge and experience gained from initiatives involving complex populations, such as those with HIV/AIDS, to support the development of Medicaid Health Homes, including Behavioral Health Homes.
- Continue to expand Medicaid-Covered Services, notably Comprehensive Community Services (CCS) implemented in 2014.
- Foster a collaborative approach to recruiting and retaining behavioral health practitioners, especially psychiatrists and extenders.
- Increase the use of health information technology, notably the Wisconsin Statewide Health Information Network (WISHIN) (BHD notes that it has recently implemented an electronic health record system that it uses to track utilization of community-based services.)
- Expand the use of telepsychiatry.
- Build on the success of the Medical College of Wisconsin's Child Psychiatric Consultation (CPC) program and adopt a similar program for adults.
- Strengthen linkages to the Medical College of Wisconsin/University of Wisconsin-Madison's Psychiatric Residency Programs.
- Promote access to Wisconsin's Primary Care & Psychiatry Shortage Grant Program.
- Recruit and incentivize providers of medication-assisted treatment.
- Work with the state to increase Medicaid rates for behavioral health outpatient service.
- Engage Medicaid managed care organizations in addressing gaps in outpatient care.
- For each of the above recommendations, develop an action plan specifying key implementers/facilitators, other stakeholder participants, actions steps, and performance metrics.

Conclusion

The provider inventory, analysis of service utilization, and feedback from stakeholders in this phase of Milwaukee County's system redesign initiative all highlight the variety of challenges that BHD and the broader community are facing as they seek to expand community-based services, improve quality, control costs, and support recovery. These are challenges that most county-based behavioral health systems face—that is, issues of fragmentation, complexity of provider types, a rapidly changing policy environment, multiple levels of governance, and limited resources.

The bottom-line conclusion generated from this analysis of outpatient behavioral health capacity for low-income populations in Milwaukee County is a nuanced one. A key question is whether the extent of unmet need would best be reduced by a simple increase in the supply of providers, or by addressing inefficiencies and barriers to access among the array of providers currently in place. Our various data sources indicate that both are significant factors and both need to be addressed.

Moreover, as indicated in our recommendations, the most effective approach is when both factors are addressed together. An example is the shortage of child psychiatrists. There is certainly a need for more child psychiatrists, as there is throughout the nation; however, there are also possibilities for improving access and coordination of care with those in place. While various initiatives to attract psychiatrists to Milwaukee County are currently under way, a more immediately effective response to the problem may be the Child Psychiatric Consultation program, a public/private/academic/philanthropic collaboration that extends the availability of existing resources to address a local shortage.

Our analysis also indicates that stakeholder perspectives and other forms of anecdotal evidence are important for identifying areas of concern and flagging issues requiring attention, but they should not be relied on as the sole basis for remedial action. This is not to say that these sources are not reliable, but rather that the complexity of the array of outpatient behavioral health services limits the capacity to understand the full nature and scope of any feature when viewed from a single perspective.

Consequently, it is critical that the fragmentation and discontinuity of behavioral health services be addressed by establishment of comprehensive and well-integrated data systems that will provide for overall monitoring of system performance and identification of opportunities for improvement. Several of our recommendations focus on the potential benefits of increased data sharing and health information technology generally.

Finally, the analysis of Medicaid claims indicates that while enrollment was increasing during the past two years, utilization was generally declining—not only in terms of percentage, but also in counts of people served. This important finding suggests some shrinkage of capacity beginning around 2013, though to different degrees depending on the provider type. There are several possible explanations for this decrease, the most likely of which is a decreased willingness by providers to accept patients with Medicaid insurance. Assuming this explanation is accurate, stakeholders need to consider and implement strategies to address it, including potential changes to contracts between the State and managed care entities, and higher Medicaid reimbursement rates.

How the various issues of provider shortage and lack of system integration that affect capacity and accessibility are addressed and who should take the lead initiative in doing so depends on the issue; the general thrust of our recommendations, however, is that BHD, on the basis of its defined mission and statutory authority, is in the best position to define the vision and the goals for this effort and to lead in the monitoring of its progress. Ultimately, success will be determined not only by how well BHD performs in this role, but also by how well the State, private health systems, and the diverse array of other stakeholders in the community work with BHD and together as necessary partners.

Section 1

Introduction: Milwaukee County Outpatient Capacity Analysis

1.1 Purpose

The Milwaukee County Outpatient Capacity Analysis is the third report issued jointly by the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC), and the Public Policy Forum (PPF) related to the ongoing initiative by public and private sector stakeholders to redesign the mental health care delivery system in Milwaukee County. The purpose of the Outpatient Capacity Analysis is to provide an overview of availability, capacity, and accessibility of outpatient behavioral health clinical services for the low-income population of Milwaukee County.

The first report, released in October 2010, provided a comprehensive analysis of system strengths and weaknesses and an extensive set of recommendations designed to improve system performance.² Then, in September 2014, the three organizations released a report analyzing adult mental health inpatient bed capacity in Milwaukee County.³ The purpose of that analysis was to assess the total number, type, and distribution of inpatient beds that County stakeholders would need to retain, develop, and/or reconfigure to meet future need in the community.

While this analysis of outpatient capacity is a natural extension of the previous activities, it differs in several important ways. Inpatient services have clearly defined boundaries, a small set of easily identified providers, a fairly clear definition of the need for treatment, and relatively comprehensive data systems. In contrast, outpatient behavioral health services are much more diverse and diffuse, made up of what economist Nancy Wolff characterizes as “socially complex service interventions with permeable boundaries.”⁴ A wide variety of services are delivered through a complex array of organizations and individual practitioners who are loosely coordinated at best, and are frequently in competition with one another. In addition, these providers and practitioners vary widely in terms of mission, type of ownership, incentives, size, staffing characteristics, target populations, and scope of activities. Therefore, an analysis of outpatient capacity is more complex and nuanced than simply enumerating facilities and available client slots and comparing these with some projection of need.

The task of assessing outpatient capacity also differs from that for inpatient services in that there are no comprehensive and integrated data systems comparable to those available for inpatient services. Consequently, our analysis necessarily draws upon diverse sources of information: Medicaid claims, Milwaukee County Behavioral Health Division (BHD) service utilization data, stakeholder interviews, and simulated patient “secret shopper” calls, as described in Appendix 1: Data Sources and Methods. Drawing on this diversity of data sources, the result is a multi-dimensional representation of outpatient behavioral health services including need (prevalence), demand (service utilization) and supply (provider inventory).

² The report can be accessed at <http://publicpolicyforum.org/sites/default/files/HSRIMentalHealthReport.pdf>.

³ The report can be accessed at <http://publicpolicyforum.org/sites/default/files/MilwaukeeInpatientCapacity.pdf>.

⁴ Wolff, N. (2000). Using Randomized Controlled Trials to Evaluate Socially Complex Services: Problems, Challenges and Recommendations. *Journal of Mental Health Policy and Economics*, 3, 97-109

Finally, it should be noted that this report differs from the previous two reports produced by HSRI, TAC, and PPF in that the scope is not limited to adults and to mental health. Instead, this report also covers the outpatient system for children/adolescents and for substance abuse services.

The limited extent to which outpatient services are coordinated and integrated—in most of the United States as well as in Milwaukee County—makes it difficult to provide a definitive judgment about the extent to which unmet need is caused by a shortage of providers, various barriers to access, or inefficiency of the overall system. We do offer such judgments where they seem to be supported by the data; the overall result, however, is not a simple equation of need and demand, but rather a multi-dimensional overview of the various sources and amounts of treatment provided for low-income residents of Milwaukee County with mental health and substance abuse disorders.

These three limiting factors—provider shortages, barriers to access, and system inefficiencies—are, as noted, characteristic of behavioral health services throughout the United States. They have been addressed in some locales using various strategies that offer lessons for Milwaukee County. Additionally, stakeholders interviewed for this project offered many insights and recommendations for addressing these issues. Drawing upon these national and local sources, the report concludes with a set of recommendations for ways in which improvements in all three areas may be achieved.

1.2 Contributors and acknowledgements

The Milwaukee-based PPF served as the local consultant and fiscal agent for the project, which was funded by several private sector behavioral health system stakeholders, the Wisconsin Department of Health Services (DHS), and local foundations. A full list of financial contributors can be found in Appendix 1. HSRI and TAC served as co-researchers. HSRI and TAC are nationally recognized consulting firms that have extensive experience in providing technical assistance on mental health and related issues to government agencies, national associations, and direct service providers. As in earlier projects conducted by HSRI, TAC, and PPF, a Project Advisory Group (composed of officials from BHD and DHS as well as representatives from private behavioral health provider organizations) was actively involved, assisting the researchers in understanding factors that influence outpatient capacity and need in Milwaukee County.

1.3 Background

The first phase of the initiative by Milwaukee County to redesign its mental health system began in 2008, after wide discussions—in several forums and meetings involving advocates, administrators, consumers, and providers—of challenges for the County’s mental health care delivery system and following local media coverage of related issues.

In October 2008, the Milwaukee Health Care Partnership, the Medical Society of Milwaukee County, the Faye McBeath Foundation, and the Greater Milwaukee Foundation agreed to fund a proposal developed by the Public Policy Forum to conduct planning for this effort. That project was designed to lay the groundwork for an overarching system improvement effort, exploring how other states and counties carried out similar system transformation efforts and containing a detailed plan for a comprehensive planning effort in Milwaukee County. PPF then contracted with HSRI and TAC to conduct a study as the basis for this planning initiative. The resulting report, entitled *Transforming the Adult Mental Health Delivery System in Milwaukee County*, outlined a set of 10 recommendations:

1. Downsize and redistribute inpatient capacity.
2. Involve private health systems in a more active role.
3. Reorganize crisis services and expand alternatives.

4. Reduce emergency detentions.
5. Reorganize and expand community-based services.
6. Promote a recovery-oriented system through person-centered approaches and peer supports.
7. Enhance and emphasize housing supports.
8. Ensure cultural competency.
9. Ensure trauma-informed care.
10. Enhance quality assessment and improvement programs.

Following this report, in April 2011, the Milwaukee County Board of Supervisors passed a resolution supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign and Implementation Task Force (Redesign Task Force) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities. The Redesign Task Force first convened in July 2011, establishing a charter and delegating Action Teams to prioritize recommendations for system enhancements within key areas. The Action Teams presented their prioritized recommendations in early 2012 and received feedback and guidance from consultants from HSRI. The implementation activities were then framed within SMART goals (Specific, Measurable, Attainable, Relevant, and Timebound), which were approved by the County Board in March 2013. These goals became the work plan through 2014, guided by several action teams composed of public and private sector stakeholders.

In conjunction with early implementation of redesign strategies, PPF, HSRI, and TAC were commissioned to conduct an analysis of mental health inpatient bed capacity in the county. The resulting report, *Analysis of Adult Bed Capacity*, was published in September 2014 and contained a set of recommendations relating to the appropriate number and types of beds to meet the county's needs, the expansion of community-based services, and the role of private hospitals in meeting the need for beds.

In parallel with the inpatient bed capacity analysis, the Public Policy Forum was commissioned by the County to conduct an analysis to assess the fiscal impacts of the mental health redesign activities to date and the projected impact of the fully implemented redesign. The resulting report, *Fiscal Analysis of Mental Health Redesign in Milwaukee County*, published in March 2015,⁵ provided a detailed analysis of BHD's spending and revenue performance for the 2010-2013 timeframe in the areas of emergency, inpatient, long-term care, and community-based adult mental health services. The report also included financial projections for 2017 under various adult inpatient bed scenarios to determine the amount of funds saved from inpatient reductions that could be redirected toward community-based services.

1.4 The Outpatient Capacity Analysis scope of work

As discussed in the preceding reports on inpatient capacity, there is no standard accepted formula for “right sizing” behavioral health systems—that is, for determining the proper balance between inpatient and outpatient capacity or the appropriate mix of different types of outpatient services. Any such judgment depends on how need is defined, how the array of services is configured, and how the population is affected by multiple factors specific to the local community (such as

⁵ Report can be accessed at <http://publicpolicyforum.org/sites/default/files/FiscalAnalysisMentalHealthRedesign.pdf>.

demographics, social supports, stressors, etc.). The scope of any such analysis, therefore, will depend on the specific goals, purposes, and questions of interest.

The scope of this project is limited primarily to analysis of access, capacity, and utilization of the outpatient behavioral health (mental health and substance abuse) clinical services for low-income residents of Milwaukee County. Included in the analysis are behavioral health care services provided in the general health care sector (e.g., primary care clinics) to the extent these can be identified. The analysis is designed to address systemic issues involving service access and delivery while specifically excluding consideration of treatment philosophies and frameworks/specifics of clinical practice.

Population: While the analysis considered outpatient capacity in Milwaukee County for the general population, the focus of the report is on the capacity available to serve low-income residents who are eligible for Medicaid or who possess no insurance coverage. This target population included the entire age spectrum—children and adolescents, transition-age youth, adults, and the elderly—where feasible.

Providers: Two provider types are included in the analysis differentiated by ownership status—private (either for-profit or nonprofit) and County—with separate data sources. The first type consists of licensed Medicaid providers: mental health and substance abuse clinics, primary hospital outpatient clinics, primary care clinics (including Federally Qualified Health Centers, or FQHCs), and individual clinicians, in group or individual private practice. All of these are assessed using Medicaid claims data. The second provider type is Milwaukee County BHD, assessed using a separate data system maintained by the County.

Services and Programs: In general, the types of outpatient services inventoried are clinical services and programs, funded either by Medicaid or the County, that are considered essential for a comprehensive system of care and that may be assumed, based on expert opinion and research, to be related to demand for inpatient care—for example, psychotherapy, psychopharmacology, psychiatric day treatment, and substance abuse treatment, typically provided by licensed clinicians (psychiatrists and general practice physicians, physician assistants, advanced practice nurses, psychologists, and social workers as well as other licensed counselors). The scope therefore focuses on those clinical services that, when available as part of the community-based behavioral health system, effectively function as an alternative to inpatient treatment.

Services included in the analysis that are funded by Medicaid are identified by CPT codes, listed in Appendix 1: Data and Methods. Services funded by the County are listed below.

1.5 BHD mental health and substance abuse services

BHD funds a broad array of community-based mental health services for adults, ranging from case management to outpatient psychiatric care to community-based crisis respite. The “front door” to many of the County’s community adult mental health and substance abuse services is Community Access to Recovery Services (CARS), a County-funded and County-staffed unit that conducts needs assessments and refers clients to appropriate services. A detailed description of BHD services is provided in Section 5.

1.6 National examples of downsizing initiatives

Transforming mental health service systems from institutional to community-based care is a national trend with proven success in many states. Iowa, Pennsylvania, New York, and Massachusetts are examples of states that have successfully closed government-operated psychiatric beds/institutions. In addition, several states are involved in active *Olmstead*-related mental health settlement agreements or investigations; these include Arizona, Connecticut, Delaware, Georgia, Illinois, Kentucky, Mississippi, New Hampshire, New Jersey, North Carolina, and Oregon.

The ability for states to successfully close publicly owned hospital beds is based in part on timely planning and the availability of readily accessible community resources. For example, Pennsylvania's success at closing hospital beds has been associated with the availability of funding for community infrastructure development and programs start-up *prior* to bed closures. Iowa's state agency recently discharged 62 people with significant community-service needs from state hospitals; it credits the success of this effort to its partnership with a team of representatives from multiple agencies that advocate for transitioning mental health patients. State government and advocacy partners, with input from family members and guardians, coordinated efforts to ensure quality placements. Discharge planning for the Iowa Mental Health Institutions included a thoughtful, systematic plan that took place over several months.⁶

1.7 Milwaukee County's statutory role in providing outpatient behavioral health services

Milwaukee County's role in providing and/or administering care and treatment to children and adults with mental health and substance abuse disorders traditionally has been guided by Chapter 51.42 of the Wisconsin Statutes. That section assigns to the county board of supervisors in each county "primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services."⁷

Wisconsin Act 203, adopted by the Wisconsin Legislature and Governor in April 2014, changed that framework in Milwaukee County by creating the Milwaukee County Mental Health Board (MHB) to take over from the Milwaukee County Board of Supervisors the mental health and substance abuse-related responsibilities outlined in Section 51.42. The MHB is made up of 11 individuals with expertise or experience in various facets of mental health services and administration. Members were appointed in June 2014, and the Board held its initial meeting in July 2014.

In addition to "oversee(ing) the provision of mental health programs and services in Milwaukee County," the MHB has administrative control over BHD's budget and personnel. That includes the programs and services provided by the division at the Mental Health Complex as well as the services administered by its community services branch. The MHB also is charged with approving BHD's annual budget, though the legislation stipulates that the property tax levy contained in the budget must be between \$53 million and \$65 million, unless a higher or lower amount is agreed to by the MHB, county executive, and county board.

⁶ "With Mental Health Institutes Closed, Patients Served Elsewhere in Iowa," Erin Murphy, *Sioux City Journal*, July 12, 2015

⁷ <http://docs.legis.wisconsin.gov/statutes/statutes/51.pdf>

Both before and after the adoption of Act 203 and the creation of the MHB, questions have been raised about the extent of Milwaukee County's statutory *mandate* to ensure the provision of a robust array of community-based behavioral health services to county residents.⁸ There is little legal ambiguity about the County's mandate to ensure the provision of *emergency* behavioral health care and treatment: As noted above, Chapter 51.42 clearly states that the County must ensure that persons who need immediate emergency services receive them, and Chapter 51.15 specifies that the County must provide a place where persons taken into custody by law enforcement under an "emergency detention" can be detained, evaluated, diagnosed, and treated.⁹

However, when it comes to the community-based clinical services that are the subject of this analysis, the legal picture is murkier. Although the statutes place primary responsibility with the MHB for securing mental health and substance services for residents who need them, the statutes also limit that responsibility "to the programs, services and resources...that the (MHB) is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds."¹⁰

This limitation—combined with other sections of the statutes that detail the responsibilities of counties in the human services realm—traditionally has led to an interpretation by Milwaukee County officials that their foremost responsibility is to provide behavioral health services for those who are deemed indigent and have no alternative means of accessing and/or paying for them. County officials traditionally have asserted that they do have the legal ability to restrict non-emergency services for those not deemed indigent, and to establish waiting lists if necessary to ensure that expenditures do not exceed available resources. They also have recognized, however, that their failure to provide for the delivery of a broad continuum of community-based mental health and substance abuse services could harm them financially by creating a greater need for the emergency services they are mandated to provide.

Act 203 also provided additional clarity with regard to the types of services Milwaukee County is to offer. The Act states that the MHB must "mak(e) a commitment to all of the following:

1. Maintaining community-based, person-centered, recovery-oriented, mental health systems
2. Maximizing comprehensive community-based services
3. Prioritizing access to community-based services and reducing reliance on institutional and inpatient care
4. Protecting the personal liberty of individuals experiencing mental illness so that they may be treated in the least restrictive environment to the greatest extent possible
5. Providing early intervention to minimize the length and depth of psychotic and other mental health episodes
6. Diverting people experiencing mental illness from the corrections system when appropriate
7. Maximizing use of mobile crisis units and crisis intervention training"

However, in light of the Statutes' acknowledgement that the County's mandate with regard to behavioral health services is limited by available resources, there is no clear answer for those

⁸ The statutes are exceedingly clear that Milwaukee County does not have to be a provider of behavioral health services; where it is responsible for providing services, it may either provide those services itself or contract for their provision.

⁹ Memorandum from Paul Bargren, Milwaukee County Corporation Counsel, and Colleen Foley, Deputy Corporation Counsel to BHD Administrator Pat Schroeder dated June 3, 2015.

¹⁰ Ibid

seeking to determine the exact scope and nature of the non-emergency behavioral health services that Milwaukee County *must* provide for county residents.

1.8 Current status of the Mental Health Complex

As the Mental Health Redesign process has progressed in Milwaukee County, BHD has succeeded in reducing the patient census at the Mental Health Complex and reducing the number of admissions at its emergency room facility, which is referred to as the Psychiatric Crisis Service (PCS). Specifically, adult inpatient capacity at the County's Mental Health Complex decreased by 31% from 2010 to 2013 while PCS admissions dropped by 15%. In addition, the County recently closed one of its 72-bed long-term care facilities and plans to complete the closure of its second facility by the end of 2015. To its credit, BHD has established partnerships with community providers and other stakeholders to implement these long-term care closures.

Based on the decline in patient census at the Mental Health Complex between 2010 through 2013, BHD should have realized significant reductions in expenditures for those services. However, as described in the recent *Fiscal Analysis of Mental Health Redesign in Milwaukee County* report by PPF, total expenditures in those service areas decreased by only 4%.¹¹ This lack of realized savings is critical as it significantly diminishes the amount of funding available to reinvest in the expansion of community-based treatment services and supports. A comprehensive array of *readily accessible* outpatient services and supports is essential for alleviating the demand for inpatient services.

In addition, as described in the *Analysis of Adult Bed Capacity* report, issued in September 2014,¹² admissions to private inpatient psychiatric beds increased during the same time that BHD admissions decreased. The implications of this shift are relevant for outpatient service capacity. The private hospitals are required to provide aftercare within 30 days of discharge for BadgerCare Plus and SSI Medicaid HMO enrollees. As the number of enrollees admitted to private psychiatric hospitals increases, the need for these hospitals to provide timely aftercare also increases.

An additional source of uncertainty about continuity of care, at least in the short term, is the County's recently announced intent to outsource management of its remaining inpatient beds and PCS and divest itself of the Mental Health Complex. Closing the Mental Health Complex is consistent with longstanding recommendations from multiple sources, including the Mental Health Redesign Initiative and the HSRI/TAC/PPF reports. However, this huge change to the service delivery paradigm in Milwaukee County could have impacts on outpatient capacity that are difficult to predict at this time.

¹¹ *Fiscal Analysis of Mental Health Redesign in Milwaukee County*, Public Policy Forum, March 2015.

¹² *Analysis of Adult Bed Capacity for Milwaukee County Behavioral Health System*, prepared by the Human Services Research Institute, Technical Assistance Collaborative and Public Policy Forum, September 2014.

Section 2

Outpatient Service Need—Treated and Untreated Prevalence

This report addresses both the supply and the demand side of behavioral health in Milwaukee County. Epidemiologists describe the demand side of the equation in terms of treated and untreated prevalence. Section 5 on utilization addresses treated prevalence using consumer-level data to describe need in terms of the types of services that are received and the numbers of people who receive them. Sections 6 and 7 provide qualitative information on the need side in the form of stakeholder perspectives and a simulated patient study that explores questions of unmet need. Here, we briefly review information on the overall prevalence of behavioral health conditions in Milwaukee County.

2.1 Prevalence and planning

Prevalence is the proportion of a population with an illness or condition. In a general sense, it may be considered as a measure of need, with the gap between treated and untreated illness representing unmet need. For purposes of practical planning, however, there are a number of factors that should be taken into consideration to supplement the raw count of untreated populations. The relationship between the overall prevalence of a condition, the number of persons who have been diagnosed with the condition, and the number who have received treatment for it can vary in complex ways depending on the nature of the condition, the population, and the treatment system.

Many people with mental disorders never receive a mental health diagnosis or obtain treatment. For example, a 2005 survey of adults in California indicated that about 25% reported a need for mental health services in the past year but only about 10% actually used any services.¹³

The magnitude of the difference in the proportions of these three groups (overall prevalence, treated prevalence, and untreated prevalence) may vary depending on a variety of factors. Overall prevalence may vary depending on population characteristics such as rural or urban; however, unlike many other health conditions, the prevalence of mental health disorders has been shown to be relatively stable over time. The introduction of more effective diagnostic tools or more extensive screening, for example, reduces the difference between overall and diagnosed prevalence. Likewise, differences between diagnosed and treated disorders are influenced by system capacity and access. For most planning purposes, therefore, it is not advisable to consider only one of these measures of prevalence in isolation. Moreover, the gap between overall prevalence and treated prevalence as a measure of unmet need, though important to recognize, is usually so large that it has little utility except for long-range planning, as the resources necessary to close the gap are beyond any practical scale.

Accordingly, rather than suggesting a specific metric or formula for what would be required to address unmet need, we discuss overall prevalence and treated prevalence (as represented by utilization and penetration, discussed in Section 5) independently. This allows us to consider what each factor may contribute to future planning efforts that would involve specific actions to reduce

¹³ An, R., & Sturm, R. (2010). Self-Reported Unmet Need for Mental Health Care After California's Parity Legislation. *Psychiatric Services*, 61(9), 861.

the gap between treated and untreated behavioral health conditions for Milwaukee County residents.

The unmet need for behavioral health care in Milwaukee County has been well documented in numerous reports that draw from epidemiological data, surveys, and stakeholder interviews. The Substance Abuse and Mental Health Services Administration (SAMHSA) regularly publishes reports that provide national estimates for the prevalence of treated and untreated mental health and substance abuse disorders of various kinds. With appropriate adjustments for local population characteristics, these estimates may serve as a general indication of prevalence in Milwaukee County. The epidemiological studies that are the basis of the SAMHSA reports are, of course, the product of a complex science that makes use of a variety of sophisticated methodological tools. It is not within the scope of this project to aim for the level of precision that is possible with the use of these tools; instead, the goal here is to provide a general yardstick for the extent of treated and untreated mental illness and substance abuse in the county as context for the discussion of outpatient service availability and need.

The most recent of the SAMHSA reports, with data from 2012, is the source for the estimates presented here.¹⁴

2.1.1 National prevalence estimates applied to Milwaukee County

According to SAMHSA, 4.2% of U.S. adults (an estimated 10.0 million individuals) reported having serious mental illness (SMI) within the year prior to being surveyed. However, this rate varies considerably according to sociodemographic characteristics. The rate for individuals whose incomes are less than 100% of the federal poverty level is 7.7%; the rate among individuals who are above the federal poverty level is less than half that, at 3.6%.¹⁵

The following estimates apply 2011 national epidemiological data to 2013 Milwaukee County demographic data. This allows for use of the most current population characteristics at the expense of some loss of precision that might result from changes in prevalence in the period from 2011 to 2013. This is likely to be minimal for mental health disorders, which have been found to be fairly consistent over extended periods of time. Rates for substance use disorders may be more variable, but the extent of change in a two-year period is unlikely to be extreme for present purposes.

Based on 2013 census data, the adult population (20 years and older) of Milwaukee County was 681,038. Exhibit 1 displays the national rates for mental illness and substance abuse in 2011, along with corresponding estimates for Milwaukee County.

Exhibit 1. Estimated Prevalence of Behavioral Health Disorder in Milwaukee County

	National Rate, 2011	Estimate for Milwaukee County, Based on 2013 Population Count
Any mental illness	18%	122,586
Mental illness causing serious functional impairment	4%	27,241
Substance abuse disorder	8%	54,483

¹⁴ Substance Abuse and Mental Health Services Administration. (2013). Behavioral Health, United States, 2012. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁵ SAMHSA, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health*, 2013.

2.1.2 Overall prevalence of behavioral health disorder in Milwaukee County

Prevalence levels for many conditions, including behavioral health disorders, may vary considerably from one local area to another; however, obtaining fine-grained epidemiological data at the local level is difficult due to the intensive resource requirements of high-quality methods, such as diagnostic interviews with adequate sample sizes. Consequently, there is usually a tradeoff between national and state-level estimates, which have more detailed information about conditions but less about local circumstances; and more local studies, which are more limited in the information they provide due to resource constraints. For Milwaukee County, however, several studies are available that provide a fair balance between these two considerations: the Wisconsin Mental Health and Substance Abuse Needs Assessment,¹⁶ produced by the Wisconsin Department of Health Services in 2014; and the Milwaukee County Health Care Partnership Community Health Needs Assessment,¹⁷ which consists of three data sources: a community health survey, key informant interviews, and analysis of secondary data compiled from local, state and national sources.

Some relevant statistics for Milwaukee County from the DHS report are:

- Number of adults with any mental illness (AMI): 135,895
- Number of adults with serious mental illness (SMI): 32,901
- Number of children with AMI: 34,969
- Number of children with serious emotional disturbance 18,317
- About 49% with any mental illness (50% of adults and 46% of children) did not access services
- The statewide treated prevalence rate for substance abuse is estimated to be about 23%
- About 34% of AMI adults and 50% of AMI children were served with public (Medicaid and County) funds
- Milwaukee's inner city had among the highest number of psychiatrists needed to significantly reduce shortage

Interested readers are encouraged to review these reports for additional data on Milwaukee County service needs.

¹⁶ Available at <https://www.dhs.wisconsin.gov/publications/p0/p00613.pdf>

¹⁷ Available at <http://mkehcp.org>

Section 3

Outpatient Service Supply: Private and County Services

3.1 Provider inventory: Capacity as volume of services

3.1.1 The behavioral health system

The purpose of this section is to describe where low-income residents of Milwaukee County can and do obtain treatment for behavioral health disorders. In that sense, it provides a representation of the Milwaukee County outpatient behavioral health system. As noted throughout this report, however, reference to the collective sources of behavioral health services as a “system” is something of a misnomer. In actuality, people with behavioral health needs obtain treatment, services, and support from a wide variety of sources that differ along many dimensions:

- Organizational characteristics (size, governance, complexity)
- Ownership (public, nonprofit, private for-profit, faith-based, etc.)
- Revenues (public and private insurance, government support, grants, donations, etc.)
- Mission (general population, low-income, special populations such as specific ethnic groups or persons with AIDS)
- Scope of services provided (general health care as well as behavioral health care, counseling only, psychopharmacology, psychosocial support programs, etc.)

A particular challenge is the diversity of settings, especially as these include the general health care sector (e.g., primary care clinics) as well as specialty mental health and substance abuse providers. It is important to remember, therefore, that the term “service system” refers to a conceptual construct more than an organizational structure.

Given these circumstances, this inventory of behavioral health providers in Milwaukee County addresses the question of capacity at two levels of complexity. The first level is to provide a listing of specialty behavioral health service providers in the county. A list compiled from a variety of sources, but primarily the Wisconsin Department of Health Services, is provided in Appendix 4 and summarized below. Other such lists and directories are readily available; rather than replicate them here, we provide a summary description and information on where they may be obtained. The second level is a multidimensional representation of the array of services incorporating need, demand, and supply.

3.2 Provider directories

The following are sources of information about behavioral health providers in Milwaukee County:

- The Wisconsin Department of Health Services provides lists of licensed mental health and substance abuse clinicians by county at <https://www.dhs.wisconsin.gov>. According to these lists, Milwaukee County has 124 licensed mental health clinicians and 95 licensed substance abuse clinicians.
- List of Wisconsin individuals certified for third-party billing for mental health treatment: PDF document not organized by county at <https://www.dhs.wisconsin.gov/guide/individual-third-party.pdf>.

- There is also a PDF document entitled Community Mental Health Program Certification Directory by County, City, and Provider Name that lists both licensed mental health and substance abuse facilities. It is available at <https://www.dhs.wisconsin.gov/guide/mh-directory.pdf>. This document identifies 125 separate facilities, many having more than one branch in the county.
- Appendix 4 presents a list of licensed mental health and substance abuse clinics compiled from DHS provider lists and other sources, including the Wraparound provider directory and SAMHSA treatment locator database at <https://findtreatment.samhsa.gov/>. This list, which includes branch offices, consists of 374 facilities.
- Milwaukee LGBT Community Center has an online directory of mental health and substance abuse treatment resources (including psychotherapists, substance abuse programs, and support groups) at <http://www.mkelgbt.org/>.
- Mental Health America of Wisconsin maintains an online directory of mental health and substance treatment programs and therapists (exclusive of psychiatrists) at www.mhawisconsin.org.
- The Milwaukee Health Care Partnership has published a set of directories of area safety-net providers and federally qualified health centers at <http://mkehcp.org>.
- The Milwaukee County BHD website contains a directory of the Wiser Choice provider network at http://county.milwaukee.gov/ImageLibrary/Groups/Everyone/SAIL_AODA/WiserChoice_Prov_Directory_2012.pdf.
- Licensure of psychiatrists, physician assistants, psychologists and advanced practice nurses are listed separately with the Wisconsin Department of Safety and Professional Services. These lists are provided for a fee and were not available for this report.

Lists and directories do not provide a full picture of where and how behavioral health services are actually delivered. To provide this additional level of detail, we draw upon two sources of information: an analysis of Medicaid claims data, presented in Section 5, and a simulated patient (secret shopper) study described in Section 7.

Section 4

Provider Volume as a Measure of Capacity

The purpose of this section is to address the issue of outpatient capacity by presenting an overview of the providers from whom Medicaid enrollees obtain behavioral health services. The intent is to present the relative volume of people served across different provider types as a snapshot of the de facto outpatient behavioral health system serving low-income people. As a result, this section is complementary to the section on utilization, which reports on the number and percentage of the Medicaid population receiving various kinds of behavioral health services. It is important to note, therefore, that the unit of analysis in this section is *providers* as opposed to *consumers*. That is, the numbers presented here should be interpreted as the volume of clientele among providers and not the number of individuals receiving services, which is presented in Section 5.

An analysis of this type necessarily entails a considerable number of inferences and assumptions that should be kept in mind when reviewing the results. Most of these relate to the use of Medicaid claims data as a source of information about the structure and function of health and behavioral health systems. Though researchers and policy makers frequently draw upon Medicaid and Medicare claims data for these purposes, it is important to keep in mind that these data systems are designed mainly for accounting. Consequently, their structure consists of codes for diverse types of services, provider organizations, and clinician specialty differentiated not by function, but by allowed reimbursement rate. To make the jump from a system of reimbursement rates to a system of services, therefore, requires a set of complex algorithms, the nature of which requires a variety of decisions that have implications for how the characteristics of the system are represented by the results. These issues and the algorithms used in this analysis are described in more detail in Appendix 1: Data and Methods.

Another point to note: the data reported here represent outpatient capacity in the sense of actual as opposed to potential volume. Hypothetically, any provider may have the capacity to serve a higher volume than the actual number. To measure the extent of potential or unused capacity, if any exists in the system, would require information obtained through other means—provider surveys, for example—and not through Medicaid claims.

4.1 Provider volume by billing provider type (January–September 2014)

The period from January to September 2014 was selected to represent a snapshot of the system at a point in time that was long enough to insure that the distribution of service recipients across programs was representative of the system as a whole. As the most recent available data, it represents the current state of the behavioral health system as accurately as possible, particularly with respect to the impact of the Affordable Care Act. One tradeoff in this choice is the possibility that these data may be an undercount of the numbers of people served due to lag times in submitting claims, a likelihood that is suggested by a drop-off identified in the analysis of utilization. We feel this is an acceptable tradeoff given that this section focuses on relative volume of different provider types rather than trends in the numbers of individuals served, which is provided in Section 5.

The analysis identifies the total number of people treated by each provider type as a measure of the relative capacity of different components of the behavioral health system in Milwaukee County. It is important to note that the numbers in this section do not represent unduplicated counts of

individual consumers (unduplicated counts are presented in the analysis of penetration rates in Section 5). In terms of organizational capacity, it is irrelevant whether a person served is unique in the system or is also receiving services elsewhere. Billing provider type was chosen as the single Medicaid identifier that most closely represents the structure of the behavioral health system as it is usually considered within a policy context. An alternative choice might have been ‘place of service’ code; we decided against this option, however, as it was less descriptive of the behavioral health system (corresponding more generally to locations where general health care is provided) and because a large number of records were missing a place of service code.

Exhibit 2 presents a general overview of the number of providers by type and the numbers served by each provider type. As discussed above, these counts are based on the Medicaid claims field “provider billing type.” The categories in this field include both type of organization (e.g., clinic) and type of medical professional (e.g., physician). The rationale and limitations of using the provider billing type field to characterize outpatient capacity is discussed in more detail in Appendix 1.¹⁸

In terms of the provider array serving Milwaukee County, several characteristics with implications for policy and planning are immediately evident from the table.

First, the number of providers far exceeds those located in Milwaukee County. For example, although Milwaukee County has only four FQHCs, there are 15 represented in the claims. (According to the list on the Wisconsin DHS website at <https://www.dhs.wisconsin.gov/forwardhealth/fqhc.pdf>, there are 42 FQHCs in the state.) It is evident that many Medicaid enrollees registered in Milwaukee County receive services from providers located outside of the county.

A second notable feature is that many providers—both organizations or agencies and individual clinicians—serve very small numbers of Medicaid enrollees, in many cases only one or two during the period from January to September 2014. This feature is represented in the two columns on the right-hand side of the table, which indicate the number of providers that served fewer than 10 individuals and the total number of individuals served by these providers. Conversely, a handful of large organizations serve a preponderance of individuals: the top three highest-volume providers together accounted for 40% of the total volume.

The implication of this in a policy context is that the provider “system” is in fact bifurcated into two segments: one that consists of a handful of large organizations located within Milwaukee County that serve a preponderance of individuals; and another of provider organizations, many outside of the county, that are quite numerous (representing almost one-half of the hospitals and one-third of the Mental Health/Substance Abuse clinics) but serve a smaller proportion of the population. On the one hand this poses a challenge to integration and continuity of care. On the other hand, however, if the reason that providers have low volume is that they are in some sense outside the referral mainstream, then there may be potential for increasing capacity through efforts to integrate them more directly into an overall system (e.g., through more aggressive outreach by case managers and inpatient discharge planners).

¹⁸ It also is important to note that in the tables and charts in this section, providers are cited based on Medicaid provider identification numbers. Those identification numbers may not correspond to providers who are actually delivering the service. For example, St. Luke's Medical Center is cited as an outpatient provider, but the actual outpatient services may be delivered elsewhere in the Aurora Medical Group system.

Exhibit 2. Providers¹ serving Medicaid-enrolled Milwaukee County residents, Jan.-Sept. 2014

	Number of providers	Number of people served	Providers serving <10	Number people served by <10 providers
Mental health/substance abuse clinics	209	26,418 ²	110	319
Mental health/substance abuse – individual non-prescribing clinicians	300	2,929	210	666
Hospital outpatient	138	16,533	114	251
Physician – independent group practices	272	31,112	168	428
Physician ³ – health care system group practices	16	2,125	5	25
Physician ³ – no affiliation identified	226	3,154	184	411
Nurse practitioner – affiliated with organizations	9	306	3	17
Nurse practitioner – no affiliation identified	20	49 ⁴	18	49
Federally qualified health center	15	3,150	10	32
Institutions for mental diseases – outpatient	8	2,459	4	8
Laboratory (drug screening)	21	2,445	13	38
Narcotic services	7	1,301	5	11
Day treatment	17	479	8	41
Health Check ⁵	3	219	2	8
Health Check Other ⁶	20	444	13	36
Crisis	11	1,611	11	10

1. As indicated by Medicaid billing provider type (see Appendix 1 for explanation)

2. Includes 200 people in group therapy, 189 at Sixteenth Street

3. Includes all sub-specialties

4. Excludes a single nurse practitioner in Ozaukee County serving 149 people

5. Early Periodic Screening and Diagnostic Treatment

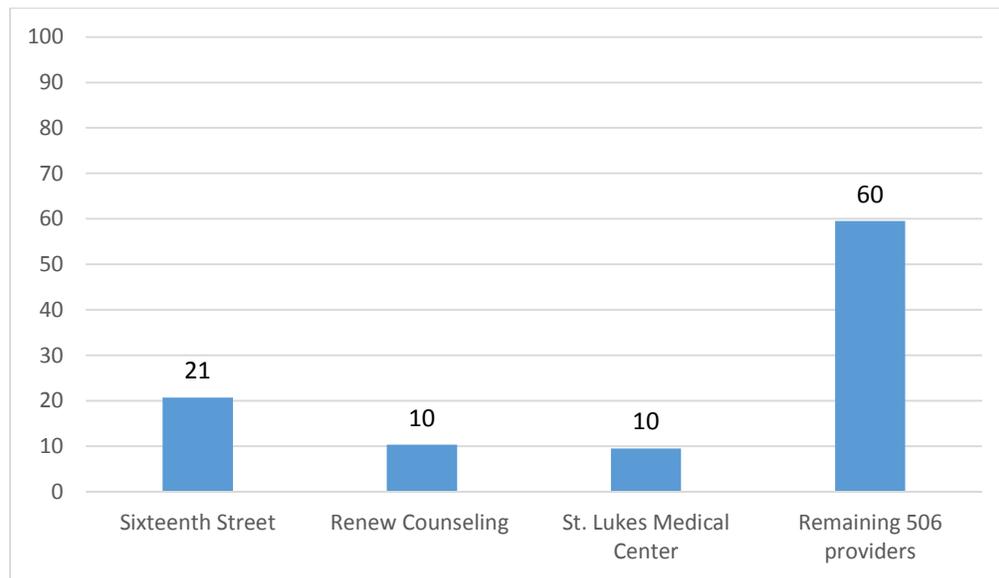
6. Includes covered mental health services for children

The largest individual organizations by volume in two categories, mental health/substance abuse clinics and hospital outpatient clinics, are discussed in greater detail below.

4.1.1 Mental health and substance abuse clinics

There were 509 separate organizations or individuals in the “mental health and substance abuse” provider type (the type with the highest number of members) that provided behavioral health services to Milwaukee County Medicaid enrollees between January and September of 2014. The distribution in the volume of services provided was highly skewed, with an average of 57 persons per provider but a median of only four. Approximately one-quarter of these submitted claims for only one person during this period. The top three highest-volume providers together accounted for 40% of the total volume.

Exhibit 3. Percentage of Total Persons Served (n=34,906) by Mental Health/Substance Abuse Billing Providers, January-September 2014: Top 3 by Volume vs. All Others*



* As noted above, while St. Luke's Medical Center is cited as an outpatient provider per Medicaid claims data, actual outpatient services may be delivered elsewhere in the Aurora Medical Group system.

The top 100 providers by volume (listed in Appendix 3 by numbers served) accounted for slightly more than 90% of the total (32,403) served by agencies.

4.1.2 Hospital outpatient services

Although 139 hospital outpatient clinics provided services to Milwaukee County Medicaid enrollees in the measurement period, the volume was highly concentrated: only 25 served at least 10 people (Exhibit 4), accounting for 99% of the total. Of those, the top eight accounted for 91% of the total.

Exhibit 4. Hospital Outpatient Serving at Least 10 People

Clinic	Number Served
WHEATON FRANCISCAN INC - ST JOSEPH	3385
FROEDTERT HOSPITAL	2174
COLUMBIA ST MARYS HOSPITAL	2140
AURORA ST LUKES MEDICAL CTR	1865
CHILDRENS HOSPITAL OF WISCONSIN INC	1724
WHEATON FRANCISCAN HEALTHCARE ST FRANCIS INC	1538
AURORA HEALTH CARE METRO INC	1484
AURORA WEST ALLIS MEDICAL CE	696
WHEATON FRANCISCAN WI HEART HOSPITAL AND MIDWEST S	279
WHEATON FRANCISCAN INC ELMBROOK	217
COMMUNITY MEMORIAL HOSPITAL	207
ST MARYS HOSPITAL OZAUKEE	125
WHEATON FRANCISCAN HEALTHCARE	122
WHEATON FRANCISCAN HEALTHCARE FRANKLIN, INC.	118
WAUKESHA MEMORIAL HOSPITAL INC	86
UNITED HOSPITAL SYSTEM INC	27
ST JOSEPHS COMMUNITY HOSP	18
AURORA MEDICAL CENTER GRAFTON	16
ST ELIZABETH HOSPITAL INC	14
ST MARYS HOSPITAL	13
ST AGNES HOSPITAL	11
ST VINCENT HOSPITAL	11
MERITER HOSPITAL INC	10
ST MARYS HOSP MED CENTER	10

4.2 Conclusion

In the period covered by this analysis (January to September 2014), an unduplicated count of 66,993 child and adult Medicaid enrollees residing in Milwaukee County received behavioral health services from 1,381 unique billing providers. It is important to remember that the total number by provider type does not equal the number receiving services because individuals may have received services from multiple provider types—that is, these are not unduplicated counts. Rather, they are intended to demonstrate the volume of services for each provider in terms of number of people served.

It should be noted also that not all of these providers are located in Milwaukee County. The list represents any provider of services to a Milwaukee resident. Thus, the list represents outpatient capacity for Milwaukee County in the sense of *where people actually obtain services* (the de facto service system for Milwaukee County) rather than providers exclusively located in Milwaukee. This aspect of the data is discussed in more detail in subsequent sections of this report.

Section 5

Outpatient Service Use: Penetration and Utilization

This section addresses the demand side of the equation in terms of treated prevalence, using consumer-level data to describe need in terms of the types of services that are received and the numbers of people who receive them. Data from Medicaid claims are presented first, followed by information on services funded and/or provided by Milwaukee County.

5.1 Medicaid claims data

Utilization rates and the numerator for penetration rates were constructed using claims data provided by the Wisconsin DHS. The denominator for penetration rates (total Medicaid enrollment) was obtained from the Wisconsin ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal>. We were unable to access data on behavioral health service utilization by the uninsured population for this analysis.

5.2 Methods

Medicaid claims data for the period from July 2010 through March 2014 were analyzed to determine utilization—number of adults and children receiving mental health and substance abuse services. Types of services were identified using algorithms combining CPT procedure codes and diagnostic codes. (These algorithms are presented in Appendix 1.) Counts of services are provided at quarterly intervals. As noted above, Medicaid claims systems, designed to account for reimbursement based on fee schedules for various combinations of provider and service types, do not necessarily correspond to the structure of behavioral health systems as considered for policy and planning purposes. Thus, the Medicaid data field “billing provider type” used to differentiate among components of the service system combines codes for types of organizations (e.g., clinics) and for certain clinical professions (e.g., physicians). As a consequence, there is some unavoidable ambiguity in distinguishing between services that are provided by an individual practitioner in a private practice or in an organizational setting such as a clinic. These issues are discussed in more detail in Appendix 1.

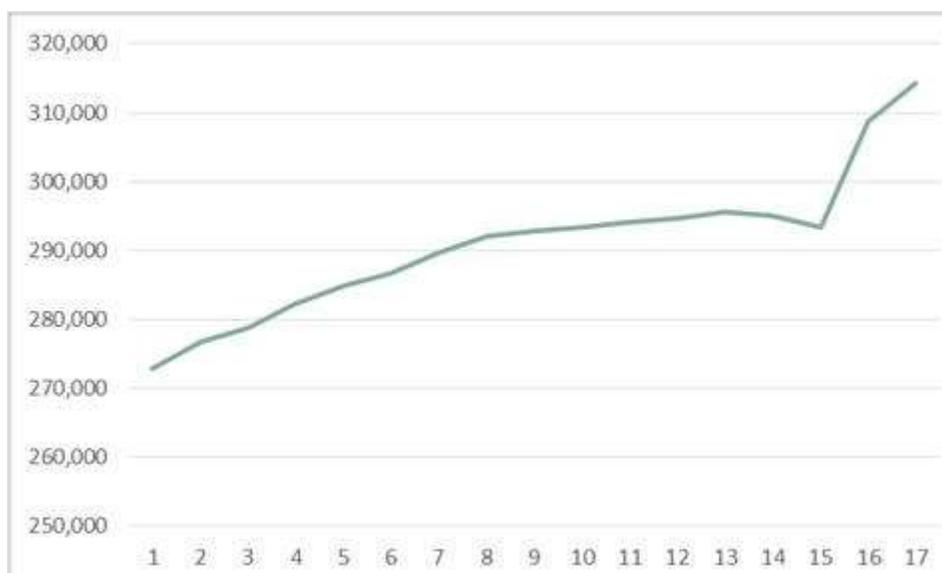
5.3 Results

5.3.1 Service penetration

Penetration refers to the proportion of the eligible population that receives a service, represented as a percentage. Exhibit 5 presents total Medicaid enrollment of Milwaukee County (children/adolescents and adults) on a quarterly basis (average for the three months in the quarter), which serves as the denominator for the treated prevalence statistics that follow. (Data tables for the following graphs are presented in Appendix 2.)

It can be seen that Medicaid enrollment increased steadily over the period of 17 quarters between July 2010 and September 2014, for a net increase of about 61,000 people across the period.

Exhibit 5. Milwaukee County Total Medicaid Enrollment, July 2010 – September 2014



Exhibits 6-9 present percentages of child/adolescent and adult Medicaid enrollees receiving mental health and substance abuse services (as indicated by diagnosis and procedure codes) on a quarterly basis. It is evident that for all categories, the percentage of Medicaid enrollees receiving services gradually increased for about eight consecutive quarters and then began to decline midway through the period of analysis, around July-September 2012. Later, in Exhibits 10 through 17, we show actual patient counts for various Medicaid-funded services.

Given that penetration rates are a function of combined utilization and total enrollment, changes in penetration rates may be due to increased enrollment, decreased utilization, or both. With respect to service capacity, increased enrollment alone with no change in utilization would indicate that capacity has not shrunk, but that it also has not responded to the increased need represented by the expanded enrollment.

The utilization data presented in Exhibits 10 through 20, which generally show relatively flat trend lines in the number of people receiving services, therefore suggest that capacity did not shrink during this period, but neither did it increase in response to increased Medicaid enrollment. (One exception may be Milwaukee County's Wraparound Milwaukee program for children and adolescents; according to Wraparound Milwaukee administrators, Wraparound enrollment recently has increased at a faster pace than total Medicaid enrollment, but we could not verify that assertion with the data provided.)

A definitive explanation for the failure of most services to expand capacity in line with increases in Medicaid enrollment cannot be determined from these data alone, but there are several possible explanations. The simplest explanation is that service use was affected by some policy change, such as more limited benefits for recent enrollees. However, the benefit package for those eligible for the Medicaid expansion that went into effect in April 2014 was not thus restricted. Another possibility is that the more recent enrollees who are responsible for the increase in Medicaid rolls during this period, including the Medicaid expansion population of childless adults with incomes less than 100% of the Federal Poverty Level, differ from their predecessors in having less need for behavioral health services. This would be a plausible explanation if more recent enrollees were known to be a

substantively different population, for example as a result of an expansion in eligibility; however, this was not the case in Wisconsin for that particular point in time.

A more likely explanation is that the system as a whole may have reached some maximum level of capacity. If that were the case, then there might be an expectation based on simple laws of supply and demand that the capacity would expand in response to the increase in potential clients. That this did not occur in the remaining eight quarters of the analysis period, however, may again have several possible explanations. For example, there may be a natural lag in provider response to increased demand; it seems unlikely, however, that any lag would be as much as the two-year period indicated by the data.

It is most likely that this finding can be attributed to one of the various widely-recognized types of health care market failures which subvert the laws of supply and demand. It may be that the low reimbursement rates for Medicaid relative to other payment sources create a disincentive for providers to change the payer mix by accepting more Medicaid clients. This possibility is supported by our findings from stakeholder interviews and a simulated patient investigation (reported in Sections 6 and 7, respectively). Another possibility is that providers' ability to expand capacity is constrained by workforce shortages, as widely reported by stakeholders. Although definitive explanations may require further investigation, these possibilities are addressed in various ways by many of the recommendations at the conclusion of this report.

Exhibit 6. Percentage of adult Medicaid enrollees receiving mental health services, by quarter (July 2010 through Sep 2014)

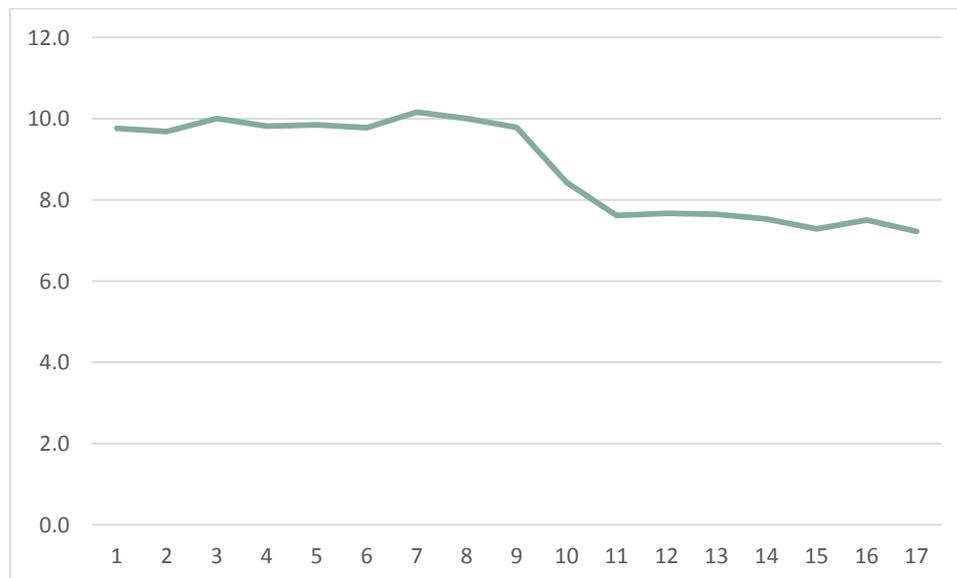


Exhibit 7. Percentage of child/adolescent Medicaid enrollees receiving mental health services, by quarter

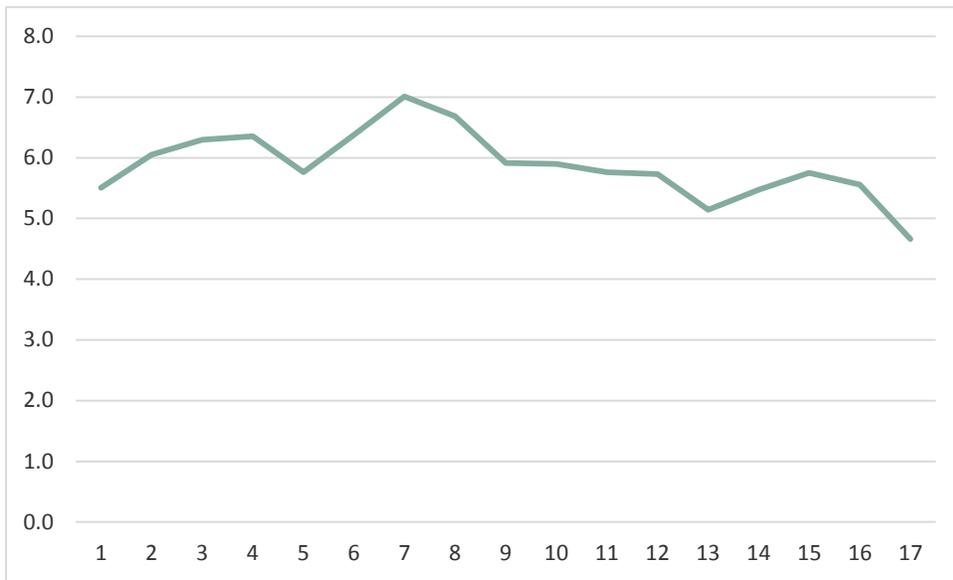


Exhibit 8. Percentage of adult Medicaid enrollees receiving substance abuse services, by quarter

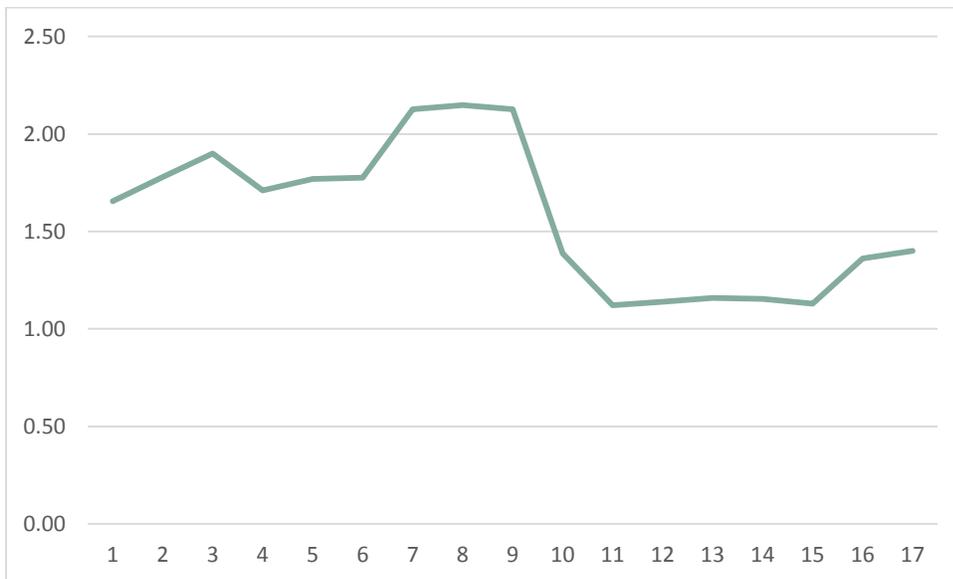
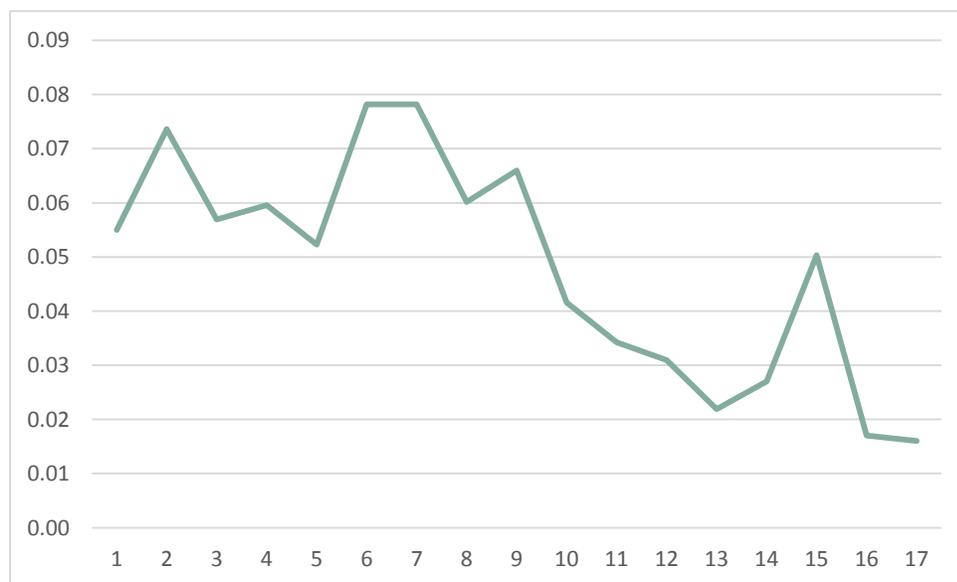


Exhibit 9. Percentage of child/adolescent Medicaid enrollees receiving substance abuse services, by quarter



While direct comparison with Medicaid penetration rates reported in other sources is difficult because of differences in methods, program characteristics, enrollee populations, etc., the rates for Milwaukee County appear to be roughly in line with those reported in other studies. For example, in a study of fee-for-service Medicaid enrollees in 13 states in 2003, 11.7% of Medicaid beneficiaries were identified as using inpatient and/or outpatient mental health or substance abuse services (10.9% and 0.7% used each of these services, respectively), with substantial variation across age and eligibility groups.¹⁹

5.3.2 Utilization by Medicaid provider type

Exhibits 10 through 13 display the numbers of children/adolescents and adults receiving mental health and substance abuse services each quarter from July 2010 through September 2014, by billing provider type.

As shown in Exhibit 10, billing for children by FQHCs gradually increased over the period, suggesting an increasing capacity for providing behavioral health services, although there are some anomalous variations.

Numbers for narcotic treatment for children and adults in Exhibits 10 and 11 are very small as these represent only persons who were given a primary diagnosis of mental illness. A preponderance of people using this service are given a substance abuse diagnosis, as indicated in Exhibits 12 and 13.

Outpatient services provided in hospitals and, in smaller numbers, in institutions for mental disease (IMDs), are fairly consistent throughout the period. That also is the case for the much larger

¹⁹ Ireys, H. T., Barrett, A. L., Buck, J. A., Croghan, T. W., Au, M., & Teich, J. L. (2010). Medicaid beneficiaries using mental health or substance abuse services in fee-for-service plans in 13 states, 2003. *Psychiatr Serv*, 61(9), 871-877. doi: 10.1176/appi.ps.61.9.871

numbers for services provided in licensed Mental Health and Substance Abuse clinics—though there is some variation, possibly due to seasonal differences. Services provided by nurse practitioners vary somewhat unpredictably, but are relatively small numbers throughout the period. Given the widely noted problems with access to child psychiatrists in Milwaukee County, this may be an area for further exploration as an opportunity to increase capacity through physician extenders.

Because the supply of psychiatrists is a critical capacity issue in Milwaukee County, in Exhibits 14 through 17 we specifically break down the numbers of people receiving mental health and substance abuse services provided by psychiatrists, identified by a specialty billing code within the Physician and Physician Group billing types. Based on the estimate of approximately 18,000 children with serious emotional disturbance in Milwaukee County presented in Wisconsin Mental Health and Substance Abuse Needs Assessment described above (Section 2.1.2), the figure of approximately 1,500 children and adolescents served by psychiatrists (Exhibit 14) appears to verify this gap in the service system cited by many stakeholders.

It should be noted, however, that an exception to the general gap in psychiatric services for children is the success of Wraparound Milwaukee in developing and maintaining an extensive provider network with a comprehensive range of services, such that the gap in service needs for children with serious emotional disturbance is significantly less in Milwaukee County compared to most other areas in the country. Even with the critical shortage of child psychiatrists, Wraparound Milwaukee has access to four psychiatrists, making it possible for any child enrolled in Wraparound to be seen by a psychiatrist if needed according to Wraparound administrators.

NOTE: Data for Physicians, Physician Assistants and Advanced Practice Nurses from the final quarter in 2012 to the end of the measurement period appeared to be incomplete for reasons that are unclear, but possibly related to changes in coding for medication management services mandated by the Centers for Medicare and Medicaid Services (CMS) beginning in 2013. Our procedure code algorithms were designed to capture that change, but data anomalies persisted. Accordingly, we have imputed values for those quarters, based on the average for all preceding quarters.

Exhibit 10. Child/Adolescent Mental Health Services Utilization by Medicaid Provider Type

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep												
Mental Health/Substance Abuse	3873	4053	4297	4496	4145	4565	4991	4978	4414	4738	4418	4383	3835	3772	3932	4037	3594
Hospital Outpatient	521	558	588	654	625	688	730	614	618	689	712	671	508	632	715	505	469
Physician¹	2258	2428	2687	2662	2266	2583	3141	2707	2334	2562	2562	2562	2562	2562	2562	2562	2562
Physician Group	801	1123	1134	1155	1119	1324	1424	1379	1206	1767	2319	2359	2122	2327	2448	2303	1858
Nurse Practitioner	57	61	55	55	58	57	84	84	72	65	65	65	65	65	65	65	65
Physician Assistant¹	15	12	15	12	9	18	18	14	8	13	13	13	13	13	13	13	13
Federally Qualified Health Center	62	199	133	111	109	134	121	105	104	171	193	167	165	214	292	263	180
Institution for Mental Disease	25	44	32	47	74	68	95	79	62	38	30	42	27	61	72	20	14
Crisis Intervention	5	1	5	3	4	6	8	8	4	3	3	3	1	5	7	9	6
Therapy Group		1		4	2	3	6	4	6	2	3	14	5	3	15	1	1

¹Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 11. Adult Mental Health Services Utilization by Medicaid Provider Type

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept												
Mental Health/Substance Abuse	9096	8970	9160	9101	9282	9229	9740	9756	9581	9047	8255	8334	8159	7768	7669	8776	8727
Hospital Outpatient	974	978	1150	1268	1231	1265	1373	1160	1174	1077	1087	1130	1031	1011	602	480	490
Physician¹	4422	4441	5123	5188	5361	5406	5770	5323	5063	5121	5121	5121	5121	5121	5121	5121	5121
Physician Group	2157	2400	2459	2433	2408	2232	2423	2508	2522	2538	3057	3223	3325	3429	3296	3563	3418
Nurse Practitioner¹	264	264	283	307	450	486	550	631	540	463	463	463	463	463	463	463	463
Physician Assistant¹	68	57	65	75	85	102	105	88	71	80	80	80	80	80	80	80	80
Federally Qualified Health Center	313	410	302	278	315	485	494	420	329	202	269	230	256	244	344	423	398
Institution for Mental Disease	53	51	27	39	63	62	63	60	61	28	31	24	13	29	22	10	10
Narcotic Treatment²	20	11	5	3	2	4	3	1	1	1							
Crisis Intervention	1077	1072	1086	1100	1091	1097	1101	1100	1102	1085	1075	1093	1091	1085	1091	1132	1132
Therapy Group	1	3	11	6	6	7	9	6	12	4	16	18	13	2	7	32	1

¹ Green shaded cells imputed (average of preceding quarters) due to missing data

²Numbers represent only persons receiving a primary diagnosis of mental illness (vs. substance abuse)

Exhibit 12. Child/Adolescent Substance Abuse Services Utilization by Medicaid Provider Type¹

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept												
Mental Health/Substance Abuse	25	26	26	1	27	38	39	36	42	19	17	13	12	10	18	9	6
Hospital Outpatient	1	5	6	4	4	3	5	2		2	1				1	1	
Physician²	25	34	26	30	25	36	30	23	29	29	29	29	29	29	29	29	29
Physician Group	13	19	15	14		12	22	9	14	16	19	19	6	20	39	7	11
Federally Qualified Health Center		1			1	1	1	1		1		1	1			1	
Institution for Mental Disease	7	7	4	27	1	1	2	2	1	1	1		1	1		1	1
Narcotic Treatment	3	1			1				1	4	4	3	3	1	1	1	3

¹Nurse practitioner and physician assistant omitted, few than 3 per quarter

²Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 13. Adult Substance Abuse Services Utilization by Medicaid Provider Type

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept												
Mental Health/Substance Abuse	516	438	467	477	552	596	726	719	724	610	504	480	467	436	481	592	638
Hospital Outpatient	69	97	101	80	98	93	105	74	72	76	75	80	62	66	54	50	57
Physician¹	953	1067	1196	1080	1118	1141	1513	1445	1392	1212	1212	1212	1212	1212	1212	1212	1212
Physician Group	510	688	775	677	684	669	804	857	796	597	646	695	645	699	627	762	644
Nurse Practitioner¹	109	115	136	108	202	170	226	255	222	159	159	159	159	159	159	159	159
Physician Assistant¹	16	14	27	17	26	24	32	34	32	23	23	23	23	23	23	23	23
Federally Qualified Health Center	73	88	59	57	67	51	54	66	81	30	18	15	39	25	46	130	89
Institution for Mental Disease	54	62	34	41	70	83	73	59	44	38	26	23	27	28	21	22	19
Narcotic Treatment	548	543	548	547	540	515	534	560	597	615	626	671	705	728	723	963	1100
Case Management	2	2	2	1	1			2		5	5	5	5	4	4	6	5
Crisis Intervention	69	97	101	80	98	93	105	74	72	76	75	80	62	66	54	50	57
Therapy Group			2	1						1		4	1			6	1

¹Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 14. Child/Adolescent Mental Health Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept												
Individual¹	1142	1176	1305	1313	1165	1342	1540	1397	1241	1291	1291	1291	1291	1291	1291	1291	1291
Group	58	87	100	100	99	110	134	139	112	150	243	308	305	320	367	328	225

¹Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 15. Adult Medicaid Mental Health Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept												
Individual¹	2638	2687	3189	3332	3460	3536	3615	3399	3242	3233	3233	3233	3233	3233	3233	3233	3233
Group	355	375	362	405	407	302	255	319	383	499	571	537	617	637	587	487	410

¹Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 16. Child/Adolescent Medicaid Substance Abuse Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept												
Individual¹	14	14	12	8	8	5	9	9	10	10	10	10	10	10	10	10	10
Group		2	3	2	1	1		1	1	1	1	7	1	2	1	2	1

¹Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 17. Adult Medicaid Substance Use Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept												
Individual¹	197	217	233	227	264	227	263	209	205	227	227	227	227	227	227	227	227
Group	24	29	29	21	28	17	20	20	22	38	41	57	66	71	78	65	57

¹Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibits 18-20 present total numbers served by combined provider types. (Mental health services for both age groups and total are combined. Substance abuse services for the two age groups are presented separately due to differences in scale.) It should be noted that these are not unduplicated counts; that is, some individuals may receive services from more than one provider type in a quarter. As discussed above, the relatively flat trend lines demonstrate that outpatient service capacity has remained relatively stable and did not expand in response to the increase in Medicaid enrollment during the same period.

Exhibit 18. Adult, Child-Adolescent, and Total Medicaid Mental Health Service Utilization, Combined Provider Types

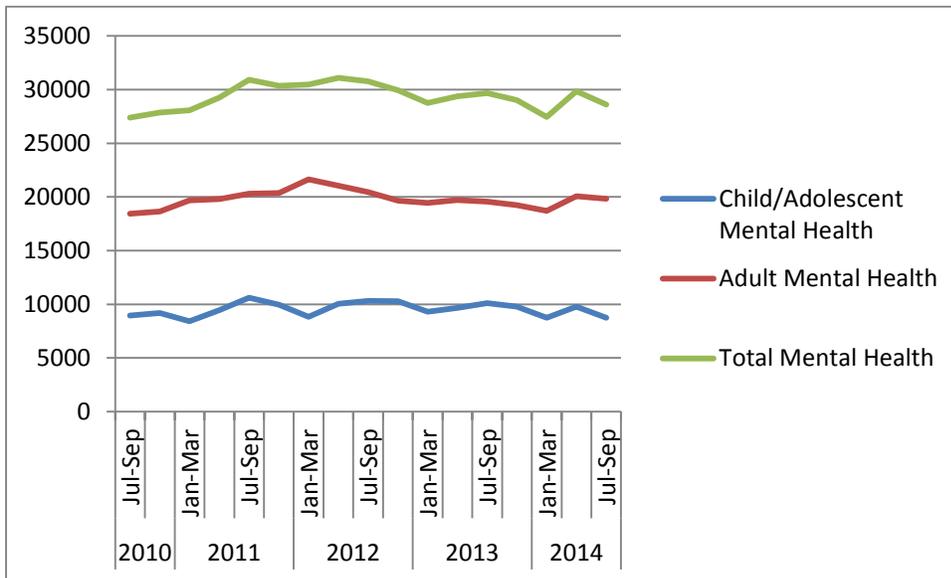


Exhibit 19. Adult Medicaid Substance Abuse Service Utilization, Combined Provider Types

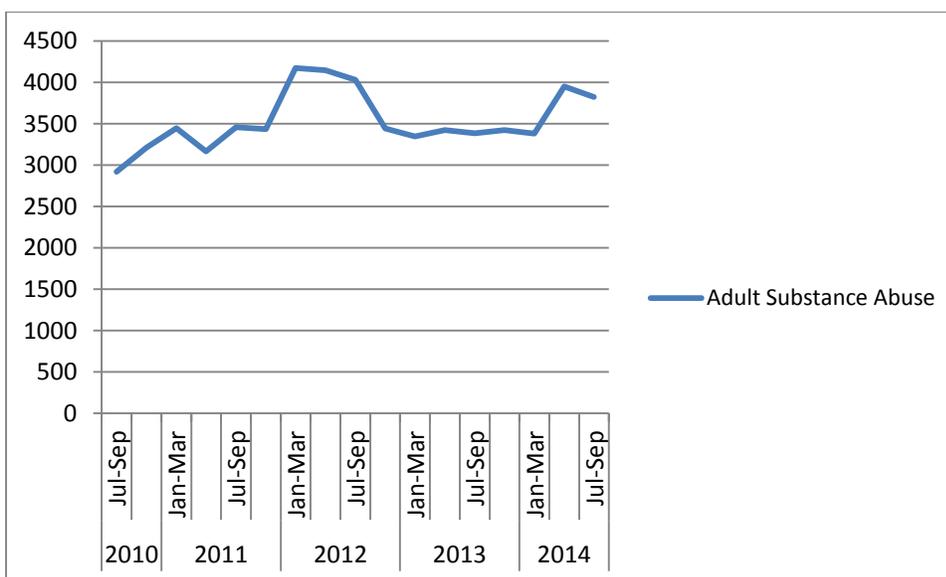
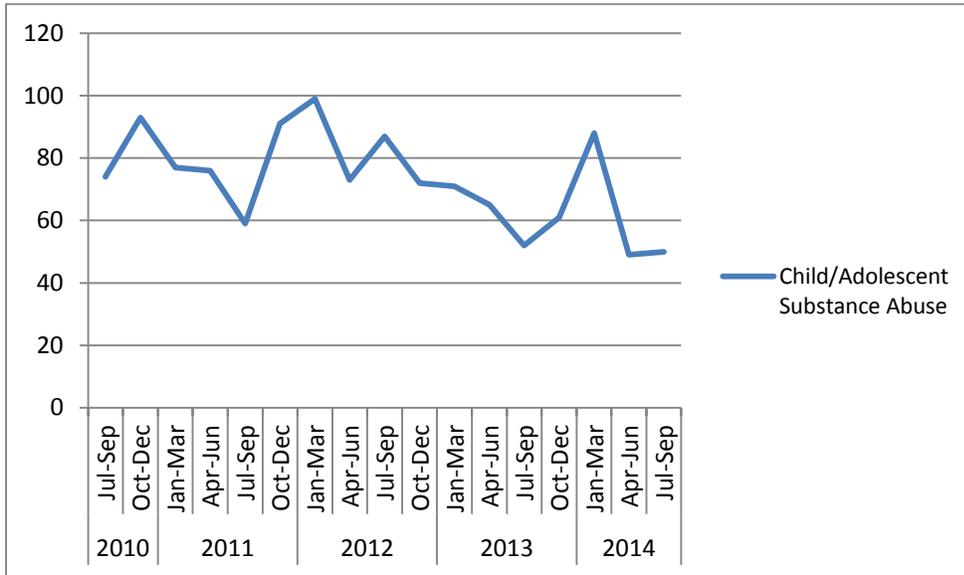


Exhibit 20. Child Medicaid Substance Abuse Service Utilization, Combined Provider Types



5.3.2.1 Medicaid service utilization summary

Because there is no standard formula to determine the “right” size or configuration of a behavioral health system, and because the array of providers serving Milwaukee County residents is so diffuse, the analysis of penetration, utilization, and volume does not readily lend itself to judgments about where there may be gaps that should be addressed, whether there is an imbalance of various types of services, etc. The stakeholder interviews provide more nuanced and reliable feedback of this kind, as indicated in the Recommendations section at the end of this report.

What these data do provide is context in the form of a general representation of the array of services and providers in Milwaukee County and an overview of who is providing how much of what kind of services—that is, the de facto behavioral health outpatient service system. Accordingly, several observations may be made:

- There is a **great deal of diversity in the type and size of providers**—from very large health care systems, to small clinics serving specialized populations, to individual clinicians or small private group practices. While this diversity presents challenges for monitoring performance and building system integrity, it does offer the benefit of flexibility, increasing the possibility for matching individual client needs with provider capabilities. To take advantage of that potential, however, some means of coordination is required, as addressed in the Recommendations section.
- A very **considerable proportion of these providers serve only a handful of people each**. These do constitute a segment of the "system's" capacity, though they account for a low volume of services. On the one hand, this suggests the possibility of barriers to access—that qualified Medicaid providers are limiting the number of Medicaid recipients in their practice—but it may also represent underutilized resources that could be leveraged to expand access.
- While it was not feasible to map the location of all providers, it is **evident that many of them, particularly in the low-volume group, are located outside Milwaukee County**. This may have a variety of implications that could be explored. It may indicate that for the Medicaid population, the county is a somewhat arbitrary boundary and that the de facto service system is in fact more regional, or it may indicate that the supply of providers within the county is inadequate.
- These alternative explanations, along with other possibilities, lead to a third observation—that the **challenges and limitations of using claims and county encounter data** demonstrate the need for a more robust, comprehensive, and integrated health information data system for effective planning and policy making.

5.3.3 BHD service utilization

BHD administers or provides a wide variety of community-based mental health services for adults through its Community Access to Recovery Services (CARS) branch, which consists of two programs, one for mental health and the other for substance abuse services. The Service Access to Independent Living (SAIL) program serves adults with mental illness by assessing individual needs and facilitating access to appropriate community services and supports. Wisconsin Supports Everyone's Recovery (WIsler) Choice is the County's public alcohol and drug treatment and recovery service system. WIsler Choice is open to County residents ages 18-59 with a history of alcohol or drug use, with priority given to families with children and pregnant women (regardless

of age). Individuals access the Wiser Choice system by visiting one of the County's Central Intake Units (CIUs).

The summary below provides brief descriptions of each of the major community-based adult mental health services funded and/or provided by BHD that can be categorized as “clinical outpatient services” per the scope of this report.

5.3.3.1 BHD Mental Health Services

- **Outpatient services** are clinic-based services, such as medication management and one-on-one or group therapy. The County traditionally has contracted with two providers for outpatient services: the Medical College of Wisconsin and Outreach Community Health Centers. However, BHD and the Medical College will be ending their contractual relationship at the end of 2015 and may instead convert to a fee-for-service relationship. In addition, the County runs a drop-in Access Clinic at the Mental Health Complex that is staffed by County personnel. The County Access Clinic is not strictly comparable to the other two outpatient settings, as it provides assessment and referral services in addition to outpatient treatment. Among these referrals are those to agencies participating in the MHOP (Mental Health Outpatient, see below) program, which provides outpatient therapy on a fee-for-service basis, in contrast to contracted outpatient providers. The Access Clinic has been described as an urgent care setting for individuals with ongoing mental health concerns. It is limited to uninsured indigent individuals, while clients with some form of insurance (including Medicaid) are referred to the other two outpatient providers.
- **The Community Support Program (CSP)** offers comprehensive case management that also involves intense clinical treatment. The County staffed two CSPs and contracted for additional CSP services with six community providers until this year, when the remaining County CSPs were eliminated and the County began contracting for all CSP services.
- **Community Recovery Services (CRS)** is a mental health benefit created in the 2009-11 state budget that offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients. CRS focuses on assessment, development of an individualized plan of care, and support for the consumer in his or her plan of care. An individual can participate in CRS and other programs such as CSP at the same time, maximizing his or her opportunity for recovery and independence. The program began at the start of 2014.
- **Comprehensive Community Services (CCS)** is a new Medicaid benefit that, according to the State, seeks to reduce inpatient admissions by strengthening the array of county resources in early intervention and treatment. CCS also provides services for those with co-occurring mental health and substance use disorders, as well as for those with substance use disorders alone. CCS funds a wide array of services, including medication management, psychotherapy, employment training, and life skills training. In its initial implementation, CCS expenses will be fully funded by the federal and state governments. BHD began its CCS program in August 2014.
- **MHOP** is a non-residential treatment service totaling less than 12 hours of counseling per patient per week, which provides a variety of evaluation, diagnostic, crisis, and treatment services. Services include medication management, individual counseling, and intervention and may include group and family therapy and referral to other services that may occur over an extended period. There are six providers of Mental Health Outpatient services in the CARS network. Outpatient services were provided to 476 individuals in 2014.

- **Day Treatment** is intensive treatment for individuals 18 years of age and older who have complex and co-occurring disorders, provided in a community milieu Monday through Friday, with 24-hour crisis interventions available through links to the Milwaukee County Crisis Line. CARS psychologists facilitate 60 treatment groups per week – via the Dialectical Behavior Therapy Treatment Team and the Recovery and Stabilization Treatment Team – plus monthly recovery planning conferences with clients, their families, and other involved providers. The capacity of the program is 22 to 28 clients, based on acuity and risk concerns. There were 59 clients served in 2014.

5.3.3.2 BHD Addiction Services

- **Outpatient** is a non-residential treatment service totaling less than 12 hours of counseling per patient per week, which provides a variety of evaluation, diagnostic, crisis and treatment services relating to substance abuse to ameliorate negative symptoms and restore effective functioning. Services include individual counseling and intervention and may include group and family therapy and referral to non-substance abuse services that may occur over an extended period. There are 33 providers of Outpatient services in the CARS network. Outpatient services were provided to 2,628 individuals in 2014.
- **Day Treatment** is a medically monitored and non-residential substance abuse treatment service which consists of regularly scheduled sessions of various modalities, such as individual and group counseling and case management, provided under the supervision of a physician. Services are provided in a scheduled number of sessions per day and week, with each patient receiving a minimum of 12 hours of counseling per week. There are 15 providers of Day Treatment services in the CARS network. There were 309 individuals engaged in Day Treatment services in 2014.
- **Medication Assisted Treatment (MAT)** in Milwaukee County has expanded in terms of providers, types of clients served, and additional services provided to the population. Vivitrol providers for both the insured and uninsured populations in the CARS network expanded in 2014, while CARS also continued to work closely with contracted Methadone clinics. As of February 2015, all clients presenting to a CIU are now assessed to determine if they meet MAT criteria and are given information about the different choices. There are three providers of MAT in the CARS network. There were 279 individuals who received MAT in 2014.

BHD also provides a range of support (psychosocial) services – e.g., case management, recovery support, and residential programs – that are outside of our focus on core outpatient clinical services.

As an approximation of the gap between available capacity and demand for major SAIL-authorized services, Exhibit 21 presents the number of new SAIL admissions for the 2011-2014 timeframe and the median number of days from the initial request for services to admission. The list of services includes not only CSP and Day Treatment (described above), but also Targeted Case Management (TCM) and Community-Based Residential Facilities (CBRFs), despite the fact that those services do not meet the definition of "clinical" services used in this report. We include those services here simply as an illustration of service volumes and wait times for the primary services accessed through SAIL. Also, the table does not include persons who declined or were deemed inappropriate for services. It should be noted that SAIL does not ordinarily refer clients to outpatient care except insofar as outpatient therapy occurs as a part of a broader service package (as with CSP), and nearly all requests to SAIL are for individuals already receiving some form of psychiatric care.

Exhibit 21. SAIL New Admissions and Median Number of Days From Request To Admission

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission						
TCM	224	17	265	28	315	49	379	67
CSP	78	22.5	102	31	115	52	141	80
CBRF	5	27	9	27	8	32.5	15	75
Day Treatment	38	15	24	16.5	39	24	44	29

The bottlenecks in obtaining CSP services described by stakeholders are evident in the near quadrupling of the number of days between request and admission from 2011 to 2014. BHD officials attribute this trend to the significant increase in the number of requests, which nearly doubled over the period. As noted above, BHD has initiated a number of measures to address this increased demand, with the expectation that wait times will be reduced. Preliminary data through August 2015 indicate a lag of about 60 days—still considerably more than 2011-2013, but a downward trend from the previous year.

Exhibit 22 presents the number of admission and mean days from request to admission to BHD's substance abuse services, also known as Wiser Choice, excluding admissions to detoxification and the Intoxicated Driver Program, and no-shows. In contrast to wait times for SAIL services, wait times have declined significantly for most Wiser Choice service categories over the past four years, with the exception of employment and school/training services. The data also indicate a relatively sharp decrease in the number of admissions to outpatient and day treatment over the 2011-2014 timeframe.

Exhibit 22. Wiser Choice Median Days from CIU Screen to Admission

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission						
Outpatient	1511	7.0	1148	6.0	1179	3.0	868	2.0
Day Treatment	310	6.0	224	4.0	212	3.0	198	1.0
Transitional Residential	529	7.0	329	5.0	206	4.0	312	3.0
Medically Monitored Residential	21	14.0	6	22.5	5	30.0	10	3.0
Methadone	9	25.0	14	17.5	20	0.5	81	5.0
Employment	18	7.0	179	7.0	177	6.0	126	11.0
School/ Training	53	2.0	78	5.0	48	4.5	85	8.0
Housing	9	8.0	21	8.0	16	5.0	16	2.0

Exhibit 23 presents trends for units of service and number of children served by Wraparound Milwaukee. Except for a slight decline in 2014 from the previous year, both units of service and numbers of persons served generally increased during the period. (Data on wait times for admission were not available for this report).

Exhibit 23. Wraparound Milwaukee Units of Service and Number Served by Category of Service 2011-2014

Service Type	Unit Type	2011		2012		2013		2014	
		Units	Persons	Units	Persons	Units	Persons	Units	Persons
AODA	¼ Hour	4,172	178	3,774	150	5,162	186	5,304	181
Day Treatment	Daily	2,161	53	2,697	65	2,380	54	1,318	29
Outpatient	Hourly	37,195	1,146	42,727	1,227	47,339	1,346	46,598	1,280
Psychiatric Review/Meds	Session	3,483	906	4,521	1,046	4,758	1,097	3,847	1,031

As the above tables demonstrate, the number of adults receiving mental health services and children receiving mental health and substance abuse services through BHD was fairly consistent over the four-year period, with a slight decline in some categories in 2014. The increased wait times for adult mental health services, however, indicates some strain on capacity of those services, though preliminary data for 2015 reported by BHD suggest that is being alleviated to some extent. The sharp decline in admissions for most categories of substance abuse services, with the exception of methadone treatment, also may indicate that there are capacity constraints. These trends should be monitored closely.

Section 6

Outpatient Capacity and Access: Stakeholder Perspectives

While the review of documents and multiple sources of data were essential to gaining an understanding of behavioral health service provision and utilization in Milwaukee County, input from individuals who participate in and experience the system is another essential source of information. We conducted face-to-face and telephone interviews with dozens of community, County, and State stakeholders. These individuals were identified by suggestions from the study advisory group, our experience gleaned from our previous work on Milwaukee County behavioral health issues, and suggestions from interviewees themselves.

Between March and June 2015, interviews were conducted with a broad base of stakeholder representatives, including key Wisconsin Department of Health Services and County BHD staff, discharge planners from BHD and local hospitals, representatives of mental health and substance use provider organizations, FQHCs and other safety-net providers, academia, and Medicaid managed healthcare plans. We also conducted a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders navigate the health care and social service systems.

6.1 Results

While there was some variation in response among the stakeholders interviewed, consistent themes emerged. The following issues were perceived by most as gaps in care or barriers to accessing outpatient behavioral health care in Milwaukee County.

6.1.1 System fragmentation

Stakeholders consistently described services in Milwaukee County to be cumbersome to access and 'siloed'. Persons interviewed often described individuals and agencies that are "doing good things," but absent communication with, or connection to, the rest of the behavioral health system.

6.1.1.1 BHD

As noted above, adults in Milwaukee County with serious mental health disorders who require long-term community support must receive an assessment and/or referral to a variety of services through Service Access to Independent Living (SAIL). "Qualified mental health providers" may also conduct an assessment but are required to submit a completed referral form for services to SAIL for approval and authorization. While SAIL is justifiably intended to provide uniform application of eligibility criteria for services, we heard from multiple stakeholders that SAIL is not as responsive as desired when individuals have an immediate need to access care. (BHD suggests this perception may in fact be related to the inability of individuals to be enrolled immediately and notes having studied the referral process with the goal of decreasing wait times and improving access to services.)

The Wiser Choice Alcohol and Other Drug Abuse (AODA) program is Milwaukee County's public alcohol and drug treatment and recovery service system for individuals not enrolled in an HMO. Individuals who want or need access to the Wiser Choice system must visit a County-contracted Central Intake Units (CIU) to be assessed and determined eligible for services. Stakeholders noted

the need for improvement in this intake system, with some suggesting that the system creates redundancy by requiring individuals who have been assessed as needing treatment by qualified treatment professionals to travel to a CIU for approval. BHD notes that the CIUs have a comprehensive screen that determines an individual's needs – and what level of service is required to meet those needs – based upon evidence-based screening tools and assessments, and that this comprehensive assessment also is necessary to compile data required by funding sources.

Access to treatment for co-occurring mental health and substance use disorders also was described as limited. In spite of efforts to provide integrated treatment, stakeholders asserted that the mental health and AODA systems and services continue to operate separately with redundant processes for accessing services. (BHD notes that CARS has recently implemented an electronic health record system that provides a uniform intake assessment process – this system may not have been in place or may have been very newly implemented at the time we conducted our stakeholder interviews.)

6.1.1.2 Medicaid Managed Care

Most Medicaid recipients must enroll with a Managed Care Organization (MCO). There are eight MCOs serving Milwaukee County. Stakeholders reported that while all MCOs are bound by the same DHS contractual requirements, there are differences in their policies, procedures, and operational protocols—differences that lead to confusion for members and providers. In addition, stakeholders commented that the published MCO provider networks are misleading in that listed providers often have little capacity to accept new patients within required timeframes and there are questions about the extent to which DHS holds MCOs accountable for contractual network adequacy requirements.

6.1.1.3 FQHCs

FQHCs play a vital and growing role in meeting the needs of Milwaukee County residents with varying degrees of behavioral health needs, serving as a safety net for the uninsured and underinsured. However, behavioral health capacity among most FQHCs is limited to clinical services such as evaluation, therapy, and medication management, with no direct access to longer-term treatment and the psychosocial services and supports provided by BHD. FQHCs also reported little interaction or communication with BHD. The Centers appear to be operating parallel to, not as a part of, the behavioral health system.

6.1.2 Access to case management

Stakeholders expressed frustration and concern over the lack of readily accessible case management. Case management is often part of a “service bundle” available for individuals with the most serious and chronic conditions. Stakeholders reported that individuals are maintained on caseloads far longer than intended, providing few openings for new referrals. The high degree of fragmentation in the behavioral health system makes it especially challenging for individuals and families to access the services and supports they need absent case management and case coordination.

6.1.3 Access barriers due to Medicaid reimbursement rates

In addition to the physical inconvenience of Medicaid provider geographic locations (noted by stakeholders and indicated by the number of providers outside Milwaukee County), stakeholders identified the low Medicaid rates for services as one of the most significant barriers to behavioral health care, with several discharge planners asserting that there were only four mental health agencies in Milwaukee County that readily accepted Medicaid recipients for services. The limited

number of providers accepting Medicaid recipients was said to result in lengthy wait times for outpatient treatment, including access to medications, which contributes to increased demands on emergency departments and readmissions to inpatient psychiatric beds. The apparent inconsistency between these anecdotal accounts by discharge planners on the one hand, and the evidence from claims data and the simulated patient investigation (discussed in the next section) on the other, may be explained by differences in patient types. The patients being referred by inpatient discharge planners generally represent higher levels of severity and acuity, which fewer providers may be willing to accept.

6.1.4 Shortage of psychiatrists (children, older adults, complex conditions)

All providers and payers identified the lack of access to psychiatrists as a barrier to care in Milwaukee County. While the shortage of psychiatry is a national problem, the designation of one third of Milwaukee County as a Mental Health Professional Shortage Area further underscores the seriousness of the problem.

The Milwaukee County FQHCs have had some success in obtaining psychiatric capacity; however, directors reported lengthy recruitment efforts, challenges due to salary expectations, and problems with retention. One center reported a three-year effort to attract and hire a psychiatrist. Also, the FQHCs appear to be competing with each other and the rest of the provider agencies in Milwaukee for psychiatrists and advanced practice registered nurses (APRNs).

Primary care practitioners are serving as a resource for treating individuals with less serious disorders, but most are not comfortable treating children, older adults, and adults with more complex behavioral health conditions, particularly with respect to prescribing psychotropic medications. Telepsychiatry is a means by which primary care practitioners can access consultation from a child psychiatrist for assistance in diagnosing and treating patients presenting with mental health needs, thereby enhancing their skills and comfort level with treating children and adolescents. Early identification and treatment of mental health and substance use disorders is key to preventing further progression of the conditions. The Child Psychiatry Consultation Initiative discussed in Section 8 is one program that has helped in ameliorating this problem by enhancing the behavioral health competencies of primary care providers.

6.1.5 Use of alternative psychiatric practitioners

Some private providers and FQHCs reported interest in the use of physician assistants and APRNs with psychiatric specialty to help address the shortage of psychiatrists. The scope of practice for PAs and APRNs includes the provision of diagnoses, treatment recommendations, and the prescription of non-controlled substances for the treatment of psychiatric and substance use disorders, thereby providing relief for the demand for psychiatric appointments. This may be a limited solution, however, as agencies that have attempted to recruit APRN's and PA's reported that they are also in short supply in Wisconsin and can therefore command higher salaries than their agencies are able to afford.

6.1.6 Use of telemedicine

While several stakeholders acknowledged that telemedicine is a reimbursable service approach under Wisconsin Medicaid, only one provider was identified as offering the service. Stakeholders did not speak highly of the approach, indicating that the agency offering telepsychiatry was relying on psychiatrists from another country to deliver the service.

6.1.7 Navigation and transportation

As described earlier in this section, stakeholders consistently described services in Milwaukee County to be cumbersome to access and ‘siloeed’. Individuals and families who do not qualify for intensive services, including case management, may not know what services are available, if they are eligible to receive the services, and how to access them. Professionals within the system expressed difficulty with accessing services for their patients. Public transportation was reported by stakeholders to be a significant barrier to care. Currently, BHD provides services at the Mental Health Complex, which is neither centrally located nor easily accessible by transit for most of the population. This situation should be improved significantly with the planned addition by BHD of facilities in the northern and southern parts of Milwaukee County.

Section 7

Outpatient Capacity and Access: Simulated Patient (Secret Shopper) Investigation

To supplement the quantitative data and stakeholder interviews described previously, we also employed a method for investigating access to Medicaid programs recommended by the U.S. Department of Health & Human Services. The method is known as simulated patient (or "secret shopper"²⁰), and it is employed in a variety of studies for that purpose.^{21,22}

Under this approach, staff from HSRI represented themselves as individuals seeking outpatient behavioral health treatment to confirm whether new clients were being accepted, whether providers accepted patients whose source of insurance was Medicaid, and the length of wait time to the first appointment. Callers used a standardized script that was reviewed by three experienced clinicians to ensure that there was no content that might trigger a crisis-type response or indicate a highly acute need for care. Callers did not actually schedule an appointment once the required information was obtained.

From the Medicaid claims data and provider inventory lists, a sample of providers was randomly selected from five categories: clinics (licensed as mental health/substance abuse or hospital outpatient), FQHCs, psychiatrists, specialty child psychiatrists, and private practice clinicians (primarily social workers and psychologists). The clinic category was further divided into two subcategories. The first, "billing clinics," included those who had served significant numbers of Medicaid clients in 2014, as described in Section 4. The second, "non-billing clinics," included those having served few or none. Clinics in the group that billed in 2014 included some outside Milwaukee County; those in the non-billing group all were located in Milwaukee County.

A total of 249 organizations or individuals were targeted for calls: 77 billing clinics, 51 non-billing clinics, 3 FQHCs, 28 psychiatrists, 11 child psychiatrists, and 79 private practice clinicians. As shown in Exhibit 28, callers succeeded in contacting a total of 142 (57%) after making at least three calls. The inability to reach nearly half the targeted providers after three calls may indicate problems with access, although it should be noted that this issue arose most prominently with regard to private practitioners (of whom 30 of the 79 could not be reached). In contrast, our callers were able to contact all of the billing clinics.

Most of the billing clinics and all of the private practice clinicians were accepting new referrals. Only about half the non-billing clinics, on the other hand, were accepting new patients, and about the same proportion were accepting Medicaid. This may cast doubt on the possibility (discussed in Section 4) that providers with little or no Medicaid billing may represent underutilized capacity.

²⁰ Department of Health and Human Services Office of Inspector General. (2014a). Access to care: provider availability in Medicaid managed care. Washington DC.

Department of Health and Human Services Office of Inspector General. (2014b). State standards for access to care. Washington DC.

²¹ Polsky, D., Richards, M., Basseyn, S., Wissoker, D., Kenney, G. M., Zuckerman, S., & Rhodes, K. V. (2015). Appointment availability after increases in Medicaid payments for primary care. *N Engl J Med*, 372(6), 537-545. doi: 10.1056/NEJMsa1413299

²² Tipirneni, R., Rhodes, K. V., Hayward, R. A., Lichtenstein, R. L., Reamer, E. N., & Davis, M. M. (2015). Primary Care Appointment Availability For New Medicaid Patients Increased After Medicaid Expansion In Michigan. *Health Aff (Millwood)*, 34(8), 1399-1406. doi: 10.1377/hlthaff.2014.1425

Whether or not this is the case should be determined by efforts by discharge planners and other stakeholders to engage these organizations, as discussed in the Recommendations section.

The fact that only about 70% of the clinics that were represented in the 2014 billing data indicate they are accepting Medicaid is somewhat anomalous, as claims data indicate they did accept patients with Medicaid in 2014. The discrepancy may be explained in part by the number for whom information could not be obtained, although nine did indicate they were not accepting Medicaid. This suggests the possibility of more restricted access in the past year.

Wait times (days to first appointment) ranged considerably for all categories, but the average was lowest for private practice. The extreme range, even for the billing clinics, is noteworthy, suggesting that capacity varies on a case by case basis, but the median (representing 29 clinics) of only 10 days suggests that access and capacity may be less constrained than perceived by many stakeholders. For clinics, the longer wait times for non-billing clinics is again evidence weighing against the possibility that these providers represent potential for increasing capacity, though this merits further exploration. For psychiatrists, it was not possible for the most part to obtain a definite wait time, as most required that a new patient first identify a primary care provider before an appointment was offered. Informally, a number of those contacted indicated that wait times, once a PCP referral was obtained, would be considerable—“around 6 months,” for example—a clear illustration of the shortage of psychiatrists, especially for children.

(Other reasons that some providers in all categories did not provide an estimated wait time was a requirement to first supply a Medicaid enrollee number or to submit medical records.)

Exhibit 24. Simulated Patient (Secret shopper) results: provider type, accepting new patient and Medicaid insurance, and time to appointment

Provider type	Accept new patients	% accept new patients	Accept Medicaid	% Accept Medicaid	Days to Appointment
Billing Clinic/ Practice (contacted 58)	54	93	41 (7 unknown)	71	Mean 15 Median 10 Range 1-60
Non-billing Clinic/Practice (contacted 27)	14	52	13	48	Mean 37 Median 30 Range 5-75
Psychiatrist (contacted 18)	13	72	10 (5 unknown)	56	PCP required
Child psychiatrist (contacted 8)	7	88	8	100	6-12 months PCP required
Private practice (contacted 31)	31	100	24	77	Mean 11 Median 7 Range 1-49

These results suggest that more providers may be accepting new Medicaid patients than some key informants have perceived, although the availability of psychiatrists is clearly limited. Also, the inability of callers to contact a considerable number of private practice providers indicates that accessibility would be an issue if these providers do, in fact, represent untapped capacity. The number of providers who failed to return calls is indicative of the barriers to access encountered by individuals seeking to obtain behavioral health services.

Section 8

Summary and Recommendations: Seizing the Opportunity to Guide and Support System Transformation

The provider inventory, analysis of service access and utilization, and feedback from stakeholders all highlight the variety of challenges that BHD and the broader community are facing as they seek to redesign the system to expand community-based services, improve quality, control costs, and support recovery. For the most part, these are challenges that are common to behavioral health systems in most localities—that is, issues of fragmentation, complexity of provider types, a rapidly changing policy environment, multiple levels of governance, and limited resources.

These issues appear to contribute to the current disarray of outpatient behavioral services in Milwaukee County. Perhaps a result of BHD’s historical role as a predominant service provider, the agency has operated more in the role of providing direct service than in the role of establishing direction for a county-based behavioral health system. In reality, there are multiple sub-systems delivering behavioral health care in Milwaukee County, such as the BHD system for the uninsured, the Medicaid managed care system, the primary care system, the system of FQHCs – all serving individuals with behavioral health needs.

There is little coordination or communication among providers and agencies in these systems, which may or may not serve the same populations. These systems function independently from, if not in competition with, each other. Yet, individuals in need of services rarely need services from only one sub-system. Changes can and often do occur in Medicaid eligibility, covered benefits, enrollment in managed care plans and/or insurance coverage, resulting in the need for a more comprehensive and coordinated “touch” with the behavioral health system at large. The absence of such a cohesive system results in disconnected and bifurcated care.

The likely outsourcing of the management of County-run inpatient and emergency room services at the Mental Health Complex provides BHD the opportunity to refocus its resources and energy on coordinating and defining standards of quality and accessibility for the provision of community-based care, including mental health outpatient, intensive outpatient, and day treatment services. A change in expectations for service delivery may not be intuitive for providers or payers, and often requires education and re-training. BHD can facilitate that effort by:

- Enhancing its recently developed strategic plan with clearly articulated goals, objectives, action steps, and timelines geared toward achieving the vision
- Providing tools and resources to support the envisioned change
- Creating performance and outcome measures to incentivize and assess change
- Identifying and addressing potential concerns as they emerge, to prevent disruption in progress
- Working with providers and other stakeholders to establish accountability for achieving specific strategic plan objectives

BHD has had success in the past with directing and supporting the infusion of the evidence-based practice of “trauma-informed care” into treatment services in Milwaukee County. Similarly, the agency now has the opportunity to promote expectations for access to and the delivery of outpatient mental health and substance use disorder services.

The existence of this array of challenges does not mean the County and its stakeholder partners are not making progress along the path set out at the beginning of the redesign initiative. Yet, drawing on successful strategies that have emerged and continue to emerge across the country, we offer a variety of recommendations that could improve access to outpatient behavioral health services and the quality of the care they offer. Putting most of these recommendations into effect would require not only that BHD provide leadership in quality assurance and facilitator functions, but also that other stakeholders in the Milwaukee County behavioral health system, including the State of Wisconsin, assume specific responsibilities and accountabilities.

8.1 Adopt processes and policies that improve access to outpatient care

8.1.1 Coordinate and communicate behavioral health outpatient services capacity

Our data findings suggest that lack of access to outpatient behavioral health services may not be as much a function of lack of capacity as much as identification, navigation, and allocation of the capacity that exists. A recommended first step is to reach out to providers/agencies serving only a small number of individual members of the “public system” to determine their interest in and willingness to serve additional clients, as well as reasons they may not be interested in expanding services to these members. If available capacity is identified, then the information should be communicated throughout the county, to be accessed for individuals in need regardless of payer source. If barriers or concerns to expanding capacity to uninsured or Medicaid-funded consumers are identified, the payers will then know what actions will need to be taken to address these concerns, such as resolving inadequate rates or cumbersome intake processes.

Milwaukee residents also may benefit from enhanced support to access the services they need. While IMPACT provides information about services and supports, individuals in need of behavioral health services may need an additional “touch” to assist in accessing those services. While full-blown case management may not be necessary, “service connectors” or “system navigators” may be a worthy investment to assure individuals are able to access the care they need before their situation reaches a longer-term or crisis stage.

8.1.2 Leverage and promote federal initiatives

Disseminating information about, and facilitating implementation of, evidence-based practices and emerging funding strategies could be a valuable role for BHD. An example of a federal initiative that BHD may wish to leverage and promote at the local level is the implementation of Coordinated Specialty Care (CSC) programs, a set of core services delivered as team-based care that has proven to be effective in mitigating the effects of psychotic disorders on youth and young adults when implemented early in the onset of the disorders. Individuals who experience a first episode of psychosis may be served by BHD, Medicaid, or private insurance. By taking the lead in disseminating information about the impact of CSC to all service providers and payers, BHD efforts may have a measurable impact on reducing debilitation and further decompensation. For other providers, we recommend that all payers examine their policies and identify payment options for evidence-based approaches related to the early identification of psychotic disorders and options for recommended treatment for first episodes of psychosis, including team-based care, recovery-oriented psychotherapy, family psychoeducation, supported employment and supported education, pharmacotherapy, care coordination, and case management.

8.1.3 Improve intake processes

Many states and communities have departed from narrow points of entry into services, maximizing the opportunity to identify and engage individuals in need of services wherever they may be encountered. In county-administered service systems, the county is responsible for insuring that limited resources are used to support individuals “most in need” or who meet eligibility criteria. However, this can be accomplished by overseeing and monitoring data and performance rather than serving as the direct gate-keeper, as BHD currently does.

We heard repeatedly from stakeholders (including both consumers and providers) that BHD's intake processes for SAIL and Wiser Choice are in need of improvement. BHD has noted that bottlenecks and delays did occur with regard to SAIL in 2014 due a record number of requests for services (including a number of clients previously served in BHD's long-term care units), staff vacancies, insufficient contracted TCM and CSP capacity to meet demand, and discontinuation of two BHD-operated CSP programs. BHD has recognized these issues and taken a number of remedial actions that already have resulted in improvements. Moreover, Comprehensive Community Services has been expanding, offering another alternative for community services in addition to the existing ones.

We commend BHD's recent progress, though it is not possible for us to determine whether that progress is sufficient to meet the concerns repeatedly raised by stakeholders. We recommend continued close monitoring by BHD, including collection and dissemination of performance data to stakeholders.

8.1.4 Private provider intake policies

As described by the discharge planners we interviewed, provider policies that require an individual to keep a certain number of therapy appointments or to change therapists in order to see a psychiatrist are impeding access to outpatient care. This may be especially true for individuals with serious mental health and substance use disorders, who struggle with keeping appointments and navigating system requirements without direct support or assistance from a case manager or peer specialist. Providers have legitimate reasons to maximize outpatient clinic productivity; employing or contracting for professional staff, particularly psychiatrists, is costly, and the loss of revenue from missed appointments can be a significant drain on provider budgets. However, there are alternative strategies to decrease missed outpatient appointments, including:

- Outreach to case managers and care coordinators to assist clients in keeping appointments
- Appointment reminders, such as text messages and phone calls a day before the scheduled appointment
- Tracking missed appointments to identify trends or patterns
- Over-booking appointments, based on the trending information
- Maintaining some level of “same-day” capacity. The longer patients have to wait to get appointments, the more likely they are to not keep the appointment. While, according to the National Council for Behavioral Health, a same-day appointment has a 10% chance of not being kept, almost 25% of patients with *next-day* appointments cancel or simply do not show up. Offering same-day access improves operational efficiencies, avoids revenue loss, and allows clinicians to spend more time engaging patients in treatment.²³

²³ National Council for Behavioral Health, *Same Day Access to Behavioral Health Services*

In the event that individuals contact a provider agency but cannot be given an intake appointment, a warm hand-off, whereby the provider contacted connects the individual in need of service with another agency that may be able to serve them, can increase the likelihood that the individual will obtain an appointment and not drop out of service altogether. This may be a challenge to implement, however, in a complex service system where an individual may have multiple care managers. Consequently, this approach may depend on prior implementation of some of the other recommendations for enhancing system integration.

8.1.5 Increase the use of health information technology

The Wisconsin Statewide Health Information Network (WISHIN) has launched WISHIN Pulse—a health information exchange technology that gives health care providers secure access to their patients’ medical information across systems and locations. While it is unlikely that all providers will use the same electronic health record, WISHIN Pulse creates a HIPAA-compliant *community* health record that provides an aggregated summary view of a patient’s health information from all providers who have seen the individual. Rather than making treatment decisions based on only the information obtained by a treating provider or agency, the technology enhances clinical decision making by allowing community providers to “communicate, collaborate, and coordinate patient care” with timely access to all available treatment information.

Health providers and payers across the country are exploring opportunities to access and share health care information in real time. WISHIN Pulse technology would allow BHD staff and contracted outpatient and community service providers to upload delivered services to the WISHIN Pulse platform. BHD staff and contracted providers would benefit from learning about the availability of information via WISHIN and from training on how to access the information. Sharing behavioral health clinical information via this secure technology should contribute to more effective and efficient outpatient service delivery and better outcomes for recipients.

While WISHIN supports information exchange among providers, it is not clear that the technology supports information sharing among behavioral health care payers, such as the Medicaid MCOs. Individuals with serious behavioral health conditions often experience changes in eligibility and plan enrollment, leaving plans to manage and coordinate care with gaps in information about services a member may have received. The Milwaukee County behavioral health system would benefit from the ability not only to share information among providers, but to do so among payers as well. We recommend exploration of the ability for WISHIN Pulse to interface with the Medicaid MCOs’ information systems.

8.2 Strategies to increase outpatient service capacity

8.2.1 Recognize and embrace FQHCs and similar health centers as participants in the outpatient behavioral health system

Outpatient service capacity is expanding outside of traditional behavioral health provider agencies in Milwaukee County. Individuals receiving primary health care at the Sixteenth Street Community Health Center (CHC), Progressive CHC, Outreach CHC, Milwaukee Health Services, and at similar community-based health centers like the Gerald L. Ignace Indian Health Center, Inc., now have greater access to behavioral health treatment. Embracing expansion of health centers offers important benefits for the residents and the behavioral health system in Milwaukee.

One of the primary benefits of expanding behavioral health service capacity in the FQHCs is the opportunity to integrate behavioral health care with comprehensive patient-centered medical homes for low-income individuals. The benefits of integrated care are well-established; individuals

with behavioral health conditions experience high rates of serious health conditions such as diabetes, heart failure, and hypertension, but they often are unwilling or unable to access consistent primary care. In addition, a high percentage of individuals presenting at emergency departments with acute medical symptoms often are suffering with undiagnosed and/or untreated anxiety, depression, substance use, and other behavioral health disorders.

The Primary Care Access Study, commissioned by the Milwaukee Health Care Partnership in 2008, found that people without access to primary care were more apt to use emergency department services when they needed care. For a 12-month period between 2006 and 2007, the Partnership study found that about 47% of all emergency visits (170,142 visits) were avoidable, and could have been addressed in a primary care medical home. Approximately 100,000 of these so-called “primary care treatable” visits were made by low-income Medicaid enrollees and uninsured individuals. According to the study, emergency department care is more than five times as costly as primary care.²⁴

FQHCs and similar health centers serve as patient-centered medical homes (PCMHs), providing integrated medical, behavioral, dental, and vision care, as well as care coordination. By identifying mental health disorders and providing treatment earlier in their progression, this approach means that individuals are less likely to deteriorate and require services from the more formalized behavioral health system. In addition, the Centers report that stigma is not as big a concern for individuals seeking mental health treatment at their locations; patients view the treatment as similar to seeing the doctor for primary care visits. This is particularly important for certain racial and ethnic groups whose cultures do not embrace Western medicine’s approach to mental health treatment.

Our discussions with FQHC leaders indicated that while efforts are being made to expand the behavioral health capacity of FQHCs in Milwaukee County so they can effectively integrate behavioral health into the PCMH model, several challenges exist, including a lack of clinicians and poor coordination with BHD. Concerted efforts to address those issues by public and private stakeholders would help to alleviate the stress on BHD and reduce the overutilization of unnecessary and costly ED visits for behavioral health-related issues. Recommendations for increasing access to behavioral health clinicians are provided further below.

A second benefit of FQHCs is that Wisconsin, like many other states, reimburses Medicaid outpatient procedures at FQHCs using a prospective payment system. Under this system, health centers receive a fixed, per-visit payment for any visit by a patient with Medicaid, regardless of the length or intensity of the visit. Prospective payment reimbursement (PPS) differs from Medicaid fee-for-service (FFS) reimbursement in two important ways. First, the per-visit rate for the Medicaid PPS is specific to the individual health center location. Second, beginning in FY2002 and each year thereafter, the per-visit rate is based on the previous year's rate, adjusted by the Medicare Economic Index (MEI) for primary care and *any change in the FQHC's scope of services*.²⁵ Unlike the Medicaid FFS rates, which are set well-below the amount needed to cover costs and are rarely increased, PPS rates allow FQHCs to cover their costs and to subsidize care for the uninsured.

8.2.2 Medicaid health homes

The Affordable Care Act provides states the opportunity to improve care coordination and care management for Medicaid beneficiaries with complex needs through health homes. Health homes integrate physical and behavioral health care and long-term services and supports for high-need,

²⁴ <http://mkehcp.org/access-2/primary-care/>

²⁵ <http://www.nachc.com/medicaid-prospective-payment-system.cfm>

high-cost Medicaid populations with the goal of improving health care quality and reducing costs. In addition to improving the quality of care and reducing fragmentation of care, states can receive enhanced federal financial participation (90%) for the first eight quarters of health home implementation.²⁶ To be eligible for a Medicaid health home, an individual must have two chronic conditions, have one chronic condition and be at risk for another, or have a serious mental illness.

The goal of the Medicaid health home state plan option is to promote access to and coordination of care. Health homes may be: (1) physically located in primary care or behavioral health providers' offices; (2) created "virtually," with a designated point of accountability for holistic services with intensive care coordination; or (3) located in other settings that suit beneficiaries' needs. Providers use person-centered care planning and coordination/integration of services to reduce fragmentation of care. Health homes must provide six core services, based on person-centered plans of care, linked as appropriate and feasible by health information technology:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care and follow-up;
- Individual and family support; and
- Referral to community and social support services.

According to the Center for Health Care Strategies,²⁷ early adopters of Medicaid health homes have learned important lessons about designing and implementing health homes for individuals with complex care needs. Lessons which seem highly relevant for behavioral health services in Milwaukee County include:

- The knowledge and experience working with complex populations should be used to guide design of the health home services, aligning payment models with policy goals to advance payment modernization;
- Health home providers need support to achieve culture change; and
- Health home providers need to invest in access to real-time data to support effective care coordination.

8.2.2.1 Wisconsin's Health Home SPA for Persons with HIV/AIDS

Wisconsin is in its third year of implementation of Health Homes for individuals with HIV/AIDS in Brown, Kenosha, Milwaukee, and Dane Counties. The AIDS Resource Center of Wisconsin (ARCW) has adopted the AIDS/HIV medical home model to improve the quality of care it provides, attain better health outcomes, and reduce costs. ARCW provides direct health care services, including medical, dental, and behavioral health visits, as well as care management and connection to social services.

ARCW uses an electronic health record (EHR) to track medical care and social services. Each patient has a dedicated primary care provider and can also access oral health and behavioral health care at the Center. ARCW focuses on both the physical and social determinants of health. Onsite at ARCW, patients can meet with pharmacists, legal experts, and social service providers and access services such as medication management, housing support, food pantries, and case management.

²⁶ Center for Health Care Strategies, Fact Sheet, August 2015.

²⁷ Ibid

Since implementing the medical home, ARCW has seen improvements in outcomes. Currently, 76% of ARCW patients on HIV medication have an undetectable viral load; the national average is about 25%.²⁸

8.2.2.2 TLS High Acuity Behavioral Health Medical Home

Transitional Living Services (TLS) is proposing to serve as a behavioral health patient-centered medical home (BH PCMH), integrating primary medical care and care coordination into its behavioral health practice. While integrating behavioral health services into PCMHs works well for individuals with low to moderate behavioral health conditions, individuals with more severe and chronic conditions are more likely to trust their care to the behavioral health provider with whom they have an established relationship. According to SAMHSA, patients enrolled in integrated care experience a decrease in emergency department and inpatient services use, a decrease in overall health costs, and improvement in health outcomes.²⁹ Practitioners in the Whole Health Group (the BH PCMH brand) promote full clinical integration with service recipients participating in the development of a patient-centered plan written in conjunction with their assigned care manager. In addition, practitioners will be expected to consistently share information, assessments and clinical data supporting continuous coordinated care. Both the ARCW and TLS initiatives can serve as models for other providers in Milwaukee County.

8.2.3 Fully implement Medicaid-covered services

The outpatient behavioral health system would benefit from an even more intensive effort by BHD to fully implement all available services, particularly services for which DHS is providing a full or substantial match of Federal funds with little or no cost to the County. For example, Comprehensive Community Services (CCS) provides a comprehensive service array for individuals that need more intensive service than Targeted Case Management but not as intense as the Community Support Program. However, BHD has faced obstacles in its efforts to rapidly implement CCS. As a result, individuals needing more than Targeted Case Management who do not qualify for the Community Support Program may not be receiving all the services and supports they need. Additionally, some stakeholders suggested that individuals who could be stepped down from the Community Support Program remain in that program longer than necessary, resulting in a lack of openings for others who need that level and intensity of services.

In addition, while Community Recovery Services (CRS), which are more psychosocial in nature, were not a focus of this study, it appears that these services also may be underdeveloped in Milwaukee County. CRS entails community living support, supported employment, and peer support services authorized via Wisconsin's Medicaid State Plan Amendment. These services are intended to facilitate each recipient's recovery by augmenting clinical services and case management with outcome-based services that are individualized based on the needs identified through a comprehensive assessment and a person-centered planning process. Individuals working towards recovery through receipt of CRS are less likely to need intensive treatment services and interventions. Access to CRS would likely alleviate some demand on outpatient clinical services and it would be beneficial for BHD to intensify its efforts to enroll more individuals in this program, as well. Similar to CCS, DHS currently is providing the matching Federal funds with no cost to the County.

²⁸ <http://www.hrsa.gov/healthit/healthitgranteespotlight/hivmedicalhome2013/index.html>

²⁹ [http://www.integration.samhsa.gov/research#integrated care](http://www.integration.samhsa.gov/research#integrated%20care)

Many states and communities across the country are refinancing the delivery of services to maximize Medicaid revenue. State and local funding is stretched to the limit, while demand for services continues to increase. We understand that BHD's 2016 budget proposes to expand CCS with the goal of enrolling 560 individuals by the end of 2016. We recommend that BHD continue its efforts to work with DHS to resolve barriers to implementation of Medicaid reimbursable services (such as CCS and CRS). Maximizing Federal Medicaid revenues would be a helpful solution for freeing up resources that could be used to cover non-Medicaid-eligible adults and to pay for additional services that contribute to positive healthcare outcomes, such as stable and affordable housing. In addition, we support BHD's proposal to add additional staff (which will be 100% cost-reimbursable) to enhance implementation of Medicaid maximization efforts.

8.2.4 Facilitate collaborative workforce recruitment and retention strategies

Behavioral health providers and primary care organizations potentially would benefit from a collaborative approach to recruiting and retaining behavioral health practitioners, thereby increasing outpatient service capacity. Currently, BHD, provider agencies, and health systems compete with each other for staff. By sharing and integrating recruitment efforts and pooling resources, agencies may be able to cast a wider net and attract more behavioral health professionals to work in Milwaukee County, and reduce competition within the county for the limited candidates who are available.

The Medical College of Wisconsin (MCW) and University of Wisconsin-Madison (UW-Madison) take in about 17 new psychiatry residents each year. Starting in July 2017, MCW will take an additional seven residents. BHD should explore existing connections to the universities to ensure that the county has maximum participation with the psychiatric residency programs and to encourage expansion of community residency programs.

In addition, the Primary Care & Psychiatry Shortage Grant Program encourages primary care physicians and psychiatrists to locate in medically underserved areas of Wisconsin by providing service-based financial assistance to state residents who have graduated from a Wisconsin medical school and completed a medical residency training program (with a primary care or psychiatry emphasis) in Wisconsin. After meeting these eligibility criteria, physicians may begin claiming the financial assistance if they then go on to practice primary care medicine or psychiatry (including child psychiatry) in a medically underserved area of the state. The program is funded with a one-time, \$2 million appropriation, of which \$1 million is directed to psychiatrists. An estimated 17 psychiatrists may receive annual grant payments over a three-year period.³⁰ Given that one-third of Milwaukee County is designated as a MH-HPSA, psychiatrists who agree to practice in that part of the county would qualify for this assistance.

We recommend a collaborative effort among BHD and private providers to identify needed human resources, and to facilitate access to Wisconsin's psychiatric resource support. While BHD is moving away from being a direct provider of services, its potential new focus on ensuring coordination among service providers and access to high-quality care would dictate that it also provide leadership in issues related to the behavioral health workforce in Milwaukee County, such as coordination of efforts to increase recruitment of APNs.

³⁰ <http://www.wafp.org/Advocacy/primary-care-psychiatry-shortage-grant-program.html>

8.3 Increase access to psychiatric capacity

Stakeholders consistently reported lengthy waits for outpatient psychiatric appointments, especially for children and for older adults; for example, discharge planners reported six-month wait times for psychiatric appointments for older adults with Medicare coverage. It remains unclear to what extent the solution would be simply to increase the number of psychiatrists in Milwaukee County, versus increasing the effectiveness and efficiency of existing capacity. Regardless, there are strategies, both nationally recognized and local, that would increase access to psychiatry in Milwaukee County, including the following.

8.3.1 Expand the use of telepsychiatry

Telepsychiatry is a nationally recognized approach to increasing access to psychiatric care. A literature review was conducted, based on findings published from 60 scholarly sources within the past 12 years, to assess the use of telepsychiatry in the United States.³¹ The review concluded that telepsychiatry was effective in treating individuals with a variety of mental health conditions. The review determined that treatment delivered using telemedicine was comparable to face-to-face service delivery and that most persons receiving telepsychiatry were satisfied with their level of care.³² Given that Wisconsin Medicaid covers the approach, we would highly recommend the pursuit of expanded use of telemedicine in Milwaukee County.

8.3.2 Build on the success of the Medical College of Wisconsin's Child Psychiatric Consultation (CPC) program and adopt a similar program for adults

The Child Psychiatric Consultation program is increasing access to psychiatric capacity by expanding the scope of behavioral health diagnostic and treatment practice for children and building primary care practitioners' behavioral health competencies. The CPC program provides pediatricians and family practice physicians a formal process to call or email an on-call psychiatrist for advice and expertise on how to diagnose and/or treat a child who presents with signs or symptoms of a behavioral health disorder. The psychiatrist responds within 15 minutes to a phone call, and within at least 24 hours to an email. Since the program began in February, 24 clinics with 145 providers in Milwaukee County have signed up. Access to timely consultation with a child psychiatrist allows the PCP to provide prompt treatment for the child as opposed to placing the child on a several-month waiting list to see a specialist. Early identification and treatment of mental health disorders in children/adolescents can prevent progression to more serious, lifelong disabilities. The CPC Program began as a pilot supported through funding from the Charles E. Kubly Foundation for two years before it received \$1 million in state funding.

Similarly, "Grand rounds," or case consultations led by psychiatrists with groups of primary care providers, have proven effective for treating adults with behavioral health needs. An example is Project ECHO out of New Mexico.³³ Although originally developed to address shortages of medical specialists, the approach has been successfully adapted to shoring up PCPs' expertise in diagnosing and treating behavioral health disorders.

³¹ <http://perspectives.ahima.org/telepsychiatry-in-the-21st-century-transforming-healthcare-with-technology/#.VczT0md3vIU>

³² <http://perspectives.ahima.org/telepsychiatry-in-the-21st-century-transforming-healthcare-with-technology/#.VczT0md3vIU>

³³ <http://echo.unm.edu/about-echo/>

8.4 Address gaps in substance use disorder treatment

8.4.1 Recruit and incentivize providers of medication assisted treatment

Medication assisted treatment (MAT) is the use of medications in combination with counseling and other behavioral therapies to provide treatment for substance use disorders. The medication used includes methadone, buprenorphine (Subutex®), buprenorphine and naloxone (Suboxone®), and naltrexone (Vivitrol®). MAT is a Chapter 51 identified service that Milwaukee County is responsible to provide within available resources. Discharge planners reported difficulty with assisting patients in accessing MAT, particularly Suboxone. In addition, many stakeholders reported that physicians in Milwaukee often require cash payment for buprenorphine, a practice that prohibits access for individuals with limited income, including pregnant females.

Research shows that medication-assisted treatment is an effective way to manage substance abuse and help individuals return to productive lives.³⁴ MAT also has been identified by the Milwaukee Lifecourse Initiative for Healthy Families' project on Infant Mortality Reduction as a treatment to improve birth outcomes for pregnant women suffering from addiction. State and federally certified Opioid Treatment Programs are the only organizations authorized to provide methadone maintenance treatment. However, physicians who have completed a federally required training program and acquired a necessary Drug Enforcement Agency identification number are able to start in-office treatment and provide prescriptions for buprenorphine, Suboxone and Vivitrol, thereby reducing stress on the formalized SUD outpatient service system.

We recommend that BHD collaborate with the Milwaukee County Chapter of the Wisconsin Medical Society and health care partners to promote greater access to buprenorphine and Suboxone in Milwaukee. Providers should adopt strategies to enhance monitoring of compliance with use as prescribed to detect diversion and abuse. We recommend a targeted expansion of practitioners who will treat Medicaid recipients and persons with limited income.

8.5 Enhance cooperation between Milwaukee County and the State

The Wisconsin Department of Health Services can be instrumental in facilitating implementation of several of the recommendations. Given the degree to which state Medicaid agencies fund behavioral services, nationally and in Milwaukee County, it is essential that DHS be an active partner in efforts to enhance access to outpatient services for low-income individuals in Milwaukee County.

8.5.1 Increase Medicaid rates for behavioral health outpatient services

A recent report by the Wisconsin Hospital Association cites Kaiser Family Foundation data that indicate Medicaid spending overall for services to adults in Wisconsin is the sixth lowest in the nation, and the overall spend for services to children is *the* lowest in the nation.³⁵ Interviewees for this study consistently confirmed that the low rates for Medicaid reimbursement for behavioral health services were a barrier to provider participation. Any effort to increase the number of behavioral health providers willing to serve Medicaid recipients must contemplate this issue.

While low outpatient rates may appear to maintain or reduce costs to the Medicaid program, they may in fact increase costs overall. For example, the lack of adequate outpatient, intensive outpatient, and partial-hospital program capacity was identified as contributing to increased

³⁴ <https://www.dhs.wisconsin.gov/aoda/methadone.htm>

³⁵ "Medicaid and Hospitals & Health Systems: The Wisconsin Story," B. Potter, May 5, 2015.

utilization of inpatient and emergency department services—which are reimbursed at much higher rates than outpatient treatment options. By increasing outpatient rates, DHS likely could increase outpatient service capacity and reduce demand for more costly high-end services.

8.5.2 Engage Medicaid managed care organizations in addressing gaps in outpatient care

We recommend that DHS assess the adequacy of its contract language for behavioral health services, considering the use of ‘requirements’ versus ‘suggestions’ for the MCOs to enhance the Department’s ability to monitor and enforce compliance. Also, consistent with CMS’ proposed rule for Medicaid Managed Care,³⁶ the contracts should contain operational standards for network adequacy, access to care, and the provision of care coordination. Finally, DHS should assess if contract monitoring activity is sufficient to ensure MCOs are complying with contract requirements.

Results from the Simulated Patient Intake Request calls indicated that:

- 23.4% of providers contacted did not respond to three phone calls requesting an appointment
- Only 61% of the providers contacted were accepting new Medicaid patients
- 6.1% of providers had closed their offices or moved to another location

Any of these results could decrease the likelihood that an individual needing outpatient services would get access to such care. Given that the MCOs also are responsible for more costly levels of care, this information presents an opportunity for planning to further assess the adequacy of their provider networks. DHS’ contract includes a Pay for Performance program, withholding a percentage of the capitation payment (2.5% for 2015) to be earned back by the MCO.³⁷ MCOs are able to earn this withhold back by meeting quality performance targets for a specific set of measures (as described in the HMO P4P Guide for FY2015). The Hospital Access measure contains indicators relevant for outpatient services: readmission to an inpatient setting within 30 days from discharge and a mental health follow-up visit within 30 days of discharge from an inpatient setting.³⁸ The MCOs should work with their network providers to identify and address issues that impact their ability to meet these performance targets, and to develop and implement solutions.

In addition, each MCO is required to develop and implement program initiatives to address the specific clinical needs of its enrolled population served under its DHS contract. These priority areas may include clinical and non-clinical Performance Improvement Projects, which present another opportunity for MCOs to influence the array and delivery of outpatient services in the county.

MCOs participating in Medicaid managed care throughout the country have been effective in expanding behavioral health provider networks in order to meet access standards and improve care for their members. Strategies employed by these plans that could also be effective in Milwaukee County include:

- Targeting rate increases to address particular service needs, such as for psychiatrists and day treatment services. MCOs are not bound by Medicaid fee-for-service rates and can attract additional providers for their networks with higher rates.

³⁶ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-12965.pdf>

³⁷ <https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.spage>

³⁸ Measurement Year (MY) 2015 Hospital Pay-for-Performance Guide, April 2014.

- Reducing administrative requirements and streamlining authorization processes to reduce administrative burden for providers.
- Providing financial incentives to cover start-up costs for, and to promote the use of, telepsychiatry.
- Providing reimbursement for recovery supports and services, including stable housing. There is a growing body of research which indicates that while these supports may not be identified as health care or clinical services, they are proven to be effective in reducing the need for more intensive treatment interventions and enhancing the positive outcomes of more traditional behavioral and primary health care.

8.5.3 Develop processes for addressing each recommendation of the *Outpatient Capacity Analysis* report

Most of the recommendations above will require action by multiple stakeholders in Milwaukee County's system of behavioral health services. For this to occur, we recommend that BHD organize an outpatient services work group with other key stakeholders identified in this report (including DHS) that would be tasked with identifying a primary implementer/coordinator for each recommendation deemed worthy of pursuit, as well as developing action steps, performance metrics, assigned responsibilities, and performance monitoring procedures. It is not within our capacity to determine which party should fulfill the implementer/coordinator role for each recommendation, but Exhibit 25 provides an example of what this process might yield for each.

Exhibit 25. Action Plan for Addressing OCA Report Recommendation

Recommendation	Key Implementer	Action Steps	Performance Metrics
Coordinate and communicate behavioral health outpatient services capacity: identify and allocate existing capacity	BHD	<ul style="list-style-type: none"> • Identify low-volume Medicaid providers • Assess willingness and capability to increase number of Medicaid clients • Develop process for communicating availability throughout the system 	<ul style="list-style-type: none"> • Number of Medicaid providers identified, contacted • Number indicating willingness to accept Medicaid referrals • Number of referral sources receiving information • Number of new referrals made

8.6 Conclusion

The bottom-line conclusion generated from this analysis of outpatient behavioral health capacity for low-income populations in Milwaukee County is a nuanced one, as there is no clear determination as to whether the extent of unmet need would best be reduced by a simple increase in the supply of providers, or by addressing inefficiencies and barriers to access among the array of providers currently in place. Our various data sources indicate that both are significant factors and both need to be addressed.

Moreover, as indicated in our recommendations, the most effective approach is when both factors are addressed together. An example is the shortage of child psychiatrists. There certainly is a need for more child psychiatrists in Milwaukee County, as there is throughout the nation, but there also are proven possibilities for improving access and coordination of care with those in place. While various initiatives to attract psychiatrists to Milwaukee County are currently underway, a more immediately effective response may be the Child Psychiatric Consultation program, a collaboration

of public/private/academic/philanthropic entities that extends the availability of existing resources to address a local shortage.

While data limitations preclude our ability to make definitive determinations as to the causes and effects of outpatient access challenges, several salient points are suggested from the data:

- **Stakeholder perspectives and other forms of anecdotal evidence are important for identifying areas of concern and flagging issues requiring attention, but they should not be relied upon as the sole basis for remedial action.** This is not to say that these sources are not reliable, but rather that the complexity of the array of outpatient behavioral health services limits the capacity to understand the full nature and scope of any feature when viewed from a single perspective.
- **Corresponding to the fragmentation and discontinuity of the behavioral health services is a lack of comprehensive and well-integrated data systems that would provide for overall monitoring of system performance and identification of opportunities for improvement.** Several of our recommendations focus on the potential benefits of increased data sharing and health information technology generally. Implementing enhanced data systems and data sharing requires an investment of resources and a commitment to cooperation among the full spectrum of stakeholders. This is where BHD can play a prominent role – both as an assembler of resources and as a promoter of cooperation.
- **Services for the Medicaid population are characterized by a handful of high-volume provider organizations and a much larger number of various types of organizations and individual clinicians that serve a small number of clients, with a minimal amount of coordination among this range of providers.** Given this variability and loose structure, it is possible that improvements in communication and coordination could positively impact capacity just as much as an increase in provider supply. For example, small-volume providers may represent untapped potential for capacity expansion, and better communication to discharge planners regarding open slots among larger providers could prove similarly beneficial. This is another area in which BHD could take the lead – as the entity that ensures stakeholders have access to updated lists of providers and that a system is in place to share information regarding provider capacity to serve Medicaid recipients.
- **The analysis of Medicaid claims indicates that there was some shrinkage of capacity beginning around 2013, though to different degrees depending on the provider type.** There are several possible explanations for this decrease, the most likely of which is a decreased willingness to accept patients with Medicaid insurance. This finding should produce an intensified effort by the Wisconsin Department of Health Services – as well as the managed care organizations with whom it contracts – to understand the extent to which insufficient reimbursement rates are the primary contributor, and/or what might be done to alter this paradigm irrespective of rate increases.

How the various issues of provider shortage and lack of system integration that affect capacity and accessibility are addressed and who should take the lead initiative in doing so depends on the issue; the general thrust of our recommendations, however, is that BHD, on the basis of its defined mission and statutory authority, is in the best position to define the vision and the goals for this effort and to lead the monitoring of its progress. Ultimately, success will be determined not only by how well BHD performs in this role, but also by how well the State, private health systems, and the diverse array of other stakeholders in the community work with BHD and together as necessary partners.

Appendix 1: Project Funders, Data Sources, and Methods

The following organizations contributed funding for the Milwaukee County Outpatient Capacity Analysis:

Milwaukee Health Care Partnership
Greater Milwaukee Foundation
Charles E. Kubly Foundation
Wisconsin Department of Health Services
Rogers Memorial Hospital
United Way of Greater Milwaukee & Waukesha County
Anthem
Children's Community Health Plan
iCare
Managed Health Services
TLS Behavioral Health
UnitedHealthcare

Data Sources

Information presented in this report was collected from a variety of sources. Qualitative information relating to the availability and accessibility of outpatient services was obtained by a review of documents and previous reports and through interviews with stakeholders (including BHD administrators, inpatient hospital discharge planners, and administrators and staff of community programs, clinics, and agencies). Quantitative analysis primarily utilized Medicaid claims data from July 2010 through September 2014, obtained by request from the Wisconsin Department of Health Services. These files consisted of all claims for Medicaid enrollees with a behavioral health diagnosis who were registered in Milwaukee County.

Stakeholder Interviews

Semi-structured interviews were conducted with a broad base of stakeholder representatives, including the following:

- Wisconsin Department of Health Services and Milwaukee County Behavioral Health Division staff
- Discharge planners from BHD and local hospitals
- BHD community services team
- Consumers and advocates
- Staff of provider organizations including mental health and substance abuse clinics and hospital outpatient clinics
- Medicaid HMOs
- Federally Qualified Health Centers (FQHCs)
- Community-based service providers

Consumer Focus Group/Secret Shopper Study

Our researchers also held a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders navigate the health care and social service systems. To triangulate with anecdotal evidence provided by stakeholders regarding access to services, we conducted a simulated patient or “secret shopper” study, where our researchers posed as individuals seeking outpatient behavioral health treatment. The aim of this exercise was to determine the extent to which providers were accepting new clients, whether they were accepting Medicaid insurance, and the length of wait time to a first appointment.

County Behavioral Health Data

Milwaukee County BHD provided service utilization data for all County-funded behavioral health services from 2011 through 2014. Data on selected services (particularly those representing clinical services, consistent with the overall focus of this report) are presented in Section 5.3.3.

Medicaid Claims

Medicaid claims data for the period from July 2010 through September 2014 were analyzed to determine penetration (the percentage of the total number of Medicaid enrollees that used behavioral health services in a given quarter), utilization (number of people receiving various types of services), and volume (number of people served by various types of providers). Claims data were provided by Wisconsin DHS; Medicaid enrollment counts, for the penetration rate denominator, were obtained from the Wisconsin ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal>.

METHODS

The following provides details of the various aspects of the Medicaid claims data analysis, including challenges and limitations.

Services: The types of services included in the analysis of penetration and utilization are clinical services and programs—for example, psychotherapy, psychopharmacology, psychiatric day treatment, and substance abuse treatment, typically provided by licensed clinicians (psychiatrists and general practice physicians, physician assistants, advanced practice nurses, psychologists, and social workers, as well as other licensed counselors). The scope therefore incorporates those clinical services that, when available as part of the community-based behavioral health system, effectively function as an alternative to inpatient treatment. Consistent with standard practices in health care services research using Medicaid or Medicare claims, specific services were identified using algorithms combining codes from the Current Procedural Terminology (CPT) and the Diagnostic and Statistical Manual of Mental Disorders 5th addition (DSM-V). These algorithms are presented in the table below. Some CPT codes are unique to behavioral health (e.g., “psychotherapy”) and therefore require no accompanying DSM code, whereas others, such as “office visit,” may be for treatment of a wide variety of health conditions; therefore, to identify, for example, treatment of depression in a primary care clinic, an accompanying behavioral health diagnosis is necessary.

Providers: The type of provider was identified using codes in the field “billing provider type.” The list of codes used in the analysis is presented in Exhibit 26. This approach presents certain challenges and imposes certain limitations as follows.

Limitations and challenges of using Medicaid claims to represent a behavioral health system:

Though researchers and policy makers frequently draw upon Medicaid and Medicare claims data for the purpose of analyzing various functions of health care systems, it is important to keep in mind that these data systems are designed for a quite different purpose: as accounting systems for tracking payments made at various reimbursement rates determined by complex combinations of service and provider type. Accordingly, the structure of Medicaid claims files consists of codes for diverse types of services, provider organizations, and clinician specialty differentiated not by function, but by allowed reimbursement rate—corresponding only partially to the structure of health and behavioral health systems as they are usually considered in a policy context.

This is less of a challenge when the unit of analysis is at the level of the individual patient rather than the provider. Constructing a file with records of specific services provided to individual patients, perhaps characterized by particular diagnostic groupings, is relatively straightforward. Grouping providers in some way that corresponds to policy discussions, however, entails a considerable number of inferences and compromises that should be kept in mind when reviewing the results.

A particular challenge in classifying provider types using claims data is how to represent the multi-level relationship between organizations and individual practitioners that is typical of behavioral health and general health care systems, whereby practitioners may be either nested within organizations or functioning more or less autonomously (private practice). For the purposes of this analysis, we have chosen to use the Medicaid claims field of “billing provider” as the closest approximation of how the structure and functions of the behavioral health system are usually considered within a policy context. (An alternative choice might have been Place of Service code; we decided against this option, however, as it was less descriptive of the behavioral health system, corresponding more generally to locations where general health care is provided, and because a large number of records were missing a place of service code.)

Consequently, there is a certain amount of unavoidable ambiguity, notably in the ability to distinguish between services that are provided by an individual practitioner in a private practice or services provided in an organizational setting such as a clinic. Thus, while the overall volume of services provided is accurate (these are unduplicated counts) the proportion by different components of the system is imprecise to some degree.

CPT/DSM V Algorithms for Penetration, Utilization and Provider Volume Analysis

Analyses consisted of counts of people served monthly (aggregated into quarters) broken out first by: 1) billing provider type and, in the case of three provider types, by additional billing provider specialty (yellow highlight in the table below); 2) child versus adult; and 3) diagnostic group (mental health vs. substance abuse) as indicated by ICD-9 code: mental health ICD-9 290-302 and 306 to 316, substance abuse 303-305.³⁹

For some provider types it is necessary to select out behavioral health services (exclude general medical care) by using a combination of the following procedure (CPT) and ICD-9 codes: CPT codes 99201-99215 or 90801-90899 in combination with the aforementioned ICD codes for mental health and substance abuse. For other providers this selection is unnecessary as all services are behavioral health. Exhibit 29 presents these configurations.

³⁹ For ICD code descriptions, see <http://www.icd9data.com>

Change in medication management codes used by psychiatrists in 2013

A change in CPT coding in 2013 had a significant effect on behavioral health that may explain some anomalies in the data reported here. Prior to 2013, psychiatrists used code 90862 for medication management. Beginning in 2013, this was eliminated and psychiatrists were instead required to use evaluation and management (E/M) codes for pharmacologic management for a patient. The purpose of this was to establish concordance between psychiatrists and other physicians. We attempted to accommodate this change by incorporating E/M codes into the algorithm, but the sharp drop-off in identified services suggests that this does not adequately reflect the change in coding.

Exhibit 26. Algorithms used to identify provider type and service

Billing Provider Type		Procedure (CPT) and Diagnosis (ICD) combination
1	Hospital	CPT 99201-99215 AND CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
9	Nurse practitioner	CPT 99201-99215 AND CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
10	Physician assistant	CPT 99201-99215 AND CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
11	Mental Health and Substance Abuse Services	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
17	Therapy Group / Group	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
21	Case Management	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
31	Physician	CPT 99201-99215 AND CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
	Specialty 339 (Psychiatrist)	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
33	Physician Group	CPT 99201-99215 AND CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
	Specialty 339 (Psychiatrist)	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
52	Narcotic Treatment Service	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
58	Institution for Mental Disease 740 Specialty Mental Health	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
75	Federally Qualified Health Center (FQHC)	CPT 99201-99215 AND CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)

80	Crisis Intervention/CCS/CSP	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) OR ICD-9 303-305 (substance abuse)
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Appendix 2: Penetration Rate Data Tables

Exhibit 27 is the data table for the penetration rate graphs presented in Section 5. It presents figures for total enrollment quarterly during the measurement period (July 2010-September 2014). Exhibit 28 presents penetration rates for mental health services for adults and children. Exhibit 29 presents penetration rates for substance abuse services for adults and children. These data are discussed in Section 5.

Exhibit 27. Adult and Child Total Medicaid Enrollment, July 2010 – September 2014

	2010 Jul-Sep	2010 Oct-Dec	2011 Jan-Mar	2011 Apr-Jun	2011 Jul-Sep	2011 Oct-Dec	2012 Jan-Mar	2012 Apr-Jun	2012 Jul-Sep
child	114,578	115,515	115,914	117,493	118,583	118,983	120,197	121,326	122,803
adult	158,357	161,207	162,885	164,792	166,198	167,712	169,400	170,794	170,038
total	272,934	276,722	278,799	282,285	284,780	286,695	289,597	292,121	292,841
	2012 Oct-Dec	2013 Jan-Mar	2013 Apr-Jun	2013 Jul-Sep	2013 Oct-Dec	2014 Jan-Mar	2014 Apr-Jun	2014 Jul-Sep	
child	122,631	122,760	122,705	123,169	122,100	121,208	123,562	125,082	
adult	170,653	171,374	171,881	172,373	172,980	172,121	185,104	189,236	
total	293,284	294,134	294,586	295,542	295,080	293,329	308,666	314,318	

Exhibit 28. Penetration rates for mental health services, by quarter

	Jan-Mar		Apr-Jun		July-Sep		Oct-Dec	
	n	%	n	%	n	%	n	%
2010								
child					6,307	5.5	6,987	6.0
adult					15,462	9.8	15,610	9.7
2011								
child	7,297	6.3	7,464	6.4	6,833	5.8	7,583	6.4
adult	16,298	10.0	16,182	9.8	16,373	9.9	16,402	9.8
2012								
child	8,426	7.0	8,110	6.7	7,260	5.9	7,233	5.9
adult	17,216	10.2	17,093	10.0	16,642	9.8	14,392	8.4
2013								
child	7,072	5.8	7,034	5.7	6,338	5.1	6,682	5.5
adult	13,046	7.6	13,182	7.7	13,177	7.6	13,021	7.5
2014								
child	6,970	5.8	6,865	5.6	5,831	4.7		
adult	12,536	7.3	13,900	7.5	13,677	7.2		

Exhibit 29. Penetration rates for substance abuse services, by quarter

	Jan-Mar		Apr-Jun		July-Sep		Oct-Dec	
	n	%	n	%	n	%	n	%
2010								
child					63	0.05	85	0.07
adult					2,622	1.66	2,869	1.78
2011								
child	66	0.06	70	0.06	62	0.05	93	0.08
adult	3,095	1.90	2,818	1.71	2,941	1.77	2,979	1.78
2012								
child	94	0.08	73	0.06	81	0.07	51	0.04
adult	3,602	2.13	3,668	2.15	3,616	2.13	2,368	1.39
2013								
child	42	0.03	38	0.03	27	0.02	33	0.03
adult	1,922	1.12	1,957	1.14	1,997	1.16	1,995	1.15
2014								
child	61	0.05	21	0.02	20	0.02		
adult	1,943	1.13	2,520	1.36	2,649	1.40		

Appendix 3: Top 100 Providers by Volume

Exhibit 30, on the following pages, presents the top 100 provider organizations by volume (numbers served). The billing provider type “mental health and substance use clinic” accounted for slightly over 90% of the total (or 32,403) served by agencies. This count excludes 2,503 persons for whom services were billed by individual clinicians using the mental health/substance abuse billing provider type. Most of these practitioners were likely on the staff of a clinic, but some may have been in private practice. For a discussion of the difference between organizations and individual practitioners, see Appendix 1: Data and Methods.

Exhibit 30. Top 100 agencies by volume (of total 207) with numbers served (32,087 served in total)

Agency	Number Served	Agency	Number Served
SIXTEENTH STREET COMMUNITY	7213	BEHAVIORAL MEDICINE CENTER	226
RENEW COUNSELING SERVICES	3600	WILLOWGLEN ACADEMY OUTPATIENT CLINIC	213
ST LUKES MEDICAL CENTER OUTPATIENT BEHAVIORAL HEALTH	3320	MILWAUKEE HEALTH SERVICE SYSTEMS	211
OUTREACH COMMUNITY HEALTH CENTERS	1523	ST LUKES SOUTH SHORE	209
ACACIA MENTAL HEALTH CLINIC LLC	1421	AIDS RESOURCE CENTER OF WI	206
MCW DEPARTMENT OF PSYCHIATRY	945	THE BRIDGE HEALTH CLINICS & RESEARCH CENTERS, INC.	199
SHOREHAVEN BEHAVIORAL HEALTH	942	COLUMBIA ST MARYS BEHAVIORAL MEDICINE	198
BEHAVIORAL HEALTH SERVICES	864	FROEDTERT PHYSICIAN PARTNERS	192
HORIZON HEALTHCARE, INC	686	CHILDREN'S HOSPITAL OF WISCONSIN	184
SEBASTIAN FAMILY PSYCHOLOGY PRACTICE LLC	641	FOKUS FAMILY SERVICES LLC	183
MILWAUKEE HEALTH SERVICE SYS	394	ACHIEVEMENTASSOCIATESLTD	181
REACH INC COMPREHENSIVE MENTAL HEALTH CLINIC	386	PROFESSIONAL SERVICES GROUP INC	180
ROGERS MEMORIAL HOSPITA	382	CHILD ADOLESCENT FAMILY&	179
AMERICAN BEHAVIORAL CLINICS	379	AMRI COUNSELING SERVICES LLC	163
TLS BEHAVIORAL HEALTH	371	FAMILY OPTIONS COUNSELING LLC	151
CHILDRENS SERVICE SOCIETY OF WISCONSIN	325	AURORA PSYCHIATRIC HOSPITAL	147
CORNERSTONE COUNSELINGSERVIC	303	LA CAUSA INC	145
APPLIED THERAPIES AND WELLNESS CENTER SC	277	PSYCARE MILWAUKEE LLC	144
WISCONSIN COMMUNITY SERVICES	271	COMPREHENSIVE CLINICAL & CONSULTING SERVICES INC	142
MILWAUKEE COUNTY MENTALHEALT	252	STRESS MANAGEMENT & MENTAL HEALTH CLINICS	140
ALTERNATIVESIN PSYCHOLOGICA	244	AURORA BAYCARE	128
AURORA FAMILY SERVICE INC	242	NORTH SHORE PSYCHOTHERAPY ASSOC III	125
FORWARD CHOICES LLC	242	RELEVANCE COUNSELING SERVICES	124
JEWISH FAMILY SERVICES INC	236	DISCOVERY & RECOVERY CLINIC	122

AGENCY	NUMBER SERVED	AGENCY	NUMBER SERVED
GATEWAY TO CHANGE	102	PSYCHIATRIC SERVICES	41
OMNI ENRICHMENT INC	102	ADKINS COUNSELING SERVICES LLC	40
CATHOLIC CHARITIES	100	ELMBROOK FAMILY COUNSELING CENTER	39
PENFIELD CHILDREN'S CENTER	96	MEDINA'S WAY	39
AURORA MEDICAL GROUP INC	95	AURORA BEHAVIORAL HEALTH	38
THE BRIDGE HEALTH CLINICS & RESEARCH CENTERS, INC	93	TURCOTT MEDICAL AND PSYCH ASSOCIATES	38
META HOUSE INC	89	M & S CLINICAL SERVICES INC	35
NORTHSHORE CLINIC & CONSULTANTS	89	PATHWAYS COUNSELING CENTER	30
HORIZON HEALTHCARE INC	80	THE POWER OF CHANGE INC	30
AURORA MEDICAL GROUP BEHAVIO	78	FAMILY SERVICE OF WAUKESHA	26
CHRISTIAN FAMILY COUNSELING	77	WAUKESHA COUNTY HEALTH&	26
MINDSTAR COUNSELING LLC	73	CENTER FOR QUALITY COMMUNITY LIFE, INC.	25
TOTTY AND ASSOCIATES	73	ASSOCIATED WOMEN PSYCHOTHERAPISTS	24
GRO FAMILY SERVICES	71	CAREER YOUTH DEVELOPMENT	24
SHORE COUNSELING & CONSULTING	68	ANNE HUEBNER & ASSOCIATES LLC	23
WI EARLY AUTISM PROJECT	62	EMPATHETIC COUNSELING SERVICES INC	19
HEALTH PSYCHOLOGY ASSOCIATES	61	HARVEST CONSULTING COMPANY, LLC	18
LIGHTHOUSE CLINIC LLC	60	LIFE SPAN PSYCHOLOGICAL SERVICES LLC	17
BEHRENS PSYCHOTHERAPY SERVICES, LLC	59	GENESIS MILWAUKEE OUTPATIENT CLINIC	16
GUEST HOUSE COUNSELING CLINIC	56	CURRENT INITIATIVES COUNSELING SERVICE LLC	15
NEERAJ AGRAWAL CLINIC LTD	56	ANGELS COUNSELING & THERAPY SERVICE	14
LUTHERAN COUNSELING & FAMILY	55	RAWHIDE YOUTH & FAMILY COUNSELING SERVICES	13
WEST GROVE CLINIC LLC	55	WORD OF HOPE MINISTRIES, INC.	13
CHRISTIAN LIFE COUNSELING	54	SHECAR SUBSTANCE ABUSE MENTAL HEALTH OUTPATIENT TR	12
EBB TIDE THERAPY	51	FAMILY DEVELOPMENT CENTER	11
RAVENSWOOD CLINIC INC	44	THE COUNSELING CENTER OF MILWAUKEE INC	11

Appendix 4: Milwaukee County Mental Health and Substance Abuse Clinics and Wraparound Vendors

The following is a list of mental health and substance abuse clinics licensed by DHS, supplemented by sources indicated by the following color coding.

Yellow highlight: list provided by DHS but not DHS online provider list
Purple highlight: In SAMHSA Behavioral Health Treatment Facility database but not DHS online provider list
Green highlight: In Wraparound Provider list but not DHS online provider list, excluding some vendor types e.g. transportation and group homes
Non-highlighted: Complete DHS provider list
Columns MH and SA indicate Mental Health and/or Substance Abuse as identified by DHS. WA indicates Wraparound provider

Provider Organization	Street	MH	SA	WA
16TH STREET BEHAVIORAL HEALTH CENTER	1032 S. 16TH STREET	x		
2ND CENTURY	2187 S 85TH STREET		x	
A STRONG FOUNDATION COUNSELING SERVICES, LLC	4447 N OAKLAND AVENUE	x	x	
ACACIA MENTAL HEALTH CLINIC, LLC	5228 W FOND DU LAC AVE	x	x	
ACACIA MENTAL HEALTH CLINIC, LLC	2931 S KINNICKINNIC AVENUE			
ACACIA MENTAL HEALTH CLINIC, LLC	1840 N FARWELL, #306D			
ACACIA MENTAL HEALTH CLINIC, LLC	6040 WEST LISBON AVE STE #102			
ACHIEVEMENT ASSOCIATES, LTD.	11040 WEST BLUEMOUND RD	x	x	
ACS CLINICAL SERVICE, LLC - MILWAUKEE BRANCH	2266 N PROSPECT AVE SUITES 204 & 520			
ADKINS COUNSELING SERVICES	6001 W CENTER STREET #105	x	x	x
AFFILIATED WELLNESS GROUP	4650 N PORT WASHINGTON RD			
AJA COUNSELING CENTER				
AIDS RESOURCE CENTER OF WISCONSIN	820 N. PLANKINTON AVENUE	x	x	
ALLIANCE INDIVIDUAL & FAMILY SERVICES LLC	5600 WEST BROWN DEER RD #216	x		x
ALLIED MENTAL HEALTH & REHABILITATION CNLCS	4425 W WOOLWORTH AVENUE			
ALTERNATIVES IN PSYCH CONSULT	5757 WEST OKLAHOMA AVE		x	x
ALTERNATIVES IN PSYCHOLOGICAL CONSULTATION, S.C.	10045 W LISBON AVENUE, #221	x		

Provider Organization	Street	MH	SA	WA
ALTERNATIVES IN PSYCHOLOGICAL CONSULTATION, SC	10045 W LISBON AVENUE			
AMERICAN BEHAVIORAL CLINICS-BLUEMOUND #1	10424 W BLUEMOUND ROAD			
AMERICAN BEHAVIORAL CLINICS-BLUEMOUND #2	9720 W BLUEMOUND ROAD			
AMERICAN BEHAVIORAL CLINICS-LAYTON	7330 W LAYTON AVENUE			
AMRI COUNSELING SERVICES, LLC	4001 WEST CAPITOL DRIVE	x	x	
ANGELS COUNSELING & THERAPY SERVICE	10701 WEST NORTH AVE STE #205	x		x
ANU FAMILY SERVICES, INC.				
APPLIED THERAPIES AND WELLNESS CENTER SC	1033 N MAYFAIR ROAD, #305	x	x	
ARC MILWAUKEE WOMEN'S PROGRAM	1022 W MADISON STREET			
ARO COUNSELING CENTERS, INC	6815 W CAPITOL DRIVE			
ASSOCIATED MENTAL HEALTH CONSULTANTS, INC.				
ASSOCIATED THERAPIES	8989 N. PT. WASHINGTON RD #220	x		
AUDUBON TECHNOLOGY & COMMUNICATION CENTER	3300 SOUTH 39TH STREET			
AURORA BEHAVIORAL HEALTH - FRANKLIN	9200 W. LOOMIS ROAD, #217	x	x	
AURORA BEHAVIORAL HEALTH - NORTH SHORE	6980 N. PORT WASHINGTON, #202	x	x	
AURORA BEHAVIORAL HEALTH CENTER WAUWATOSA	1220 DEWEY AVENUE	x		
AURORA BEHAVIORAL HEALTH CENTER - SINAI	1020 N 12TH ST 4TH FLOOR	x		
AURORA BEHAVIORAL HEALTH CENTER - WOMEN'S PAVILION	2424 S 90TH STREET SUITE 502	x		
AURORA BEHAVIORAL HEALTH CENTER-LAKESHORE	3611 CHICAGO AVE		x	
AURORA FAMILY SERVICE, INC.	3200 W HIGHLAND BOULEVARD	x		x
AURORA HEALTH CARE METRO, INC. DBA AURORA ST. LUKE'S SOUTH SHORE	5900 S. LAKE DRIVE	x		
AURORA PSYCHIATRIC HOSPITAL INC	1220 DEWEY AVENUE	x	x	
AURORA PSYCHIATRIC HOSPITAL CHEMICAL DEPENDENCY SERVICES	1220 DEWEY AVENUE			
AURORA BEHAVIORAL HEALTH CENTER AURORA WEST ALLIS POT	2424 SOUTH 90TH STREET			
BEHAVIORAL CONSULTANTS, INC.				
BEHRENS PSYCHOTHERAPY SERVICES, LLC	2321 E CAPITOL DRIVE, #400	x		
BELL THERAPY - SOUTH 68TH STREET	2858 SOUTH 68TH STREET	x		
BELL THERAPY COMMUNITY SUPPORT PROGRAM SOUTH	4420 SOUTH 108TH STREET	x		
BELL THERAPY, INC	5555 N 51ST STREET			
BELL THERAPY, INC. - DAY ONE	4065 N. 35TH STREET	x		
BELL THERAPY, INC. COMMUNITY SUPPORT PROGRAM - NORTH	4929 W. FOND DU LAC AVENUE	x		

Provider Organization	Street	MH	SA	WA
BELL THERAPY, INC. - C.S.P. SOUTH (WILLOWGLEN)				
BELWOOD LTD./BELL THERAPY	5151 W SILVER SPRING, W WING B25	x		
BENEDICT CENTER WOMEN'S HARM REDUCTION PROGRAM	135 W WELLS STREET, #700		x	
BRACY PSYCHOLOGICAL SERVICE & STRESS MGM INSTITUT				
CAREER YOUTH DEVELOPMENT, INC.	2603 N. MARTIN LUTHER KING DR.	x	x	
CARMELITE HOME FOR BOYS	1214 KAVANAUGH PLACE			x
CATHOLIC CHARITIES OF THE ARCHDIOCESE OF MILWAUKEE, INC.	2021 N. 60TH STREET	x		
CEDAR CREEK FAMILY COUNSELING, INC.	9910 WEST LAYTON AVE SUITE 2	x	x	
CENTER FOR QUALITY COMMUNITY LIFE, INC. (CQCL)	6830 W VILLARD AVENUE, #300	x	x	
CHAI POINT	1400 NORTH PROSPECT AVENUE			
CHILD, ADOLESCENT, FAMILY & MARRIAGE THERAPY ASSOCIATES	230 W WELLS ST, STE 630	x		
CHILDREN'S HOSPITAL OF MILWAUKEE	1020 N. 12TH STREET, 5TH FLOOR	x		
CHILDREN'S HOSPITAL OF WISCONSIN	9000 W. WISCONSIN AVENUE	x		x
CHILDREN'S SERVICE SOCIETY OF WISCONSIN	620 S 76TH SREET, #120	x		x
CHILDYNAMICS, LLC	11904 W. NORTH AVENUE, #110	x		x
CHILEDA INSTITUTE, INC.				
CHRISTIAN FAMILY COUNSELING-RISEN SAVIOR	9505 BROWN DEER RD			
CHRISTIAN FAMILY COUNSELING	1214 SOUTH 8TH STREET			
CHRISTIAN FAMILY COUNSELING	2345 NORTH 25TH STREET			
CHRISTIAN FAMILY COUNSELING	9555 SOUTH HOWELL AVENUE SUITE 750			
CLEMENT J ZABLOCKI VAMC MENTAL HEALTH DIVISION	5000 WEST NATIONAL AVENUE			
CITY TRANSFORMATION CLINIC NORTH	1442 NORTH FARWELL AVENUE, SUITE 300		x	
COLUMBIA ST. MARY'S BEHAVIORAL MEDICINE - MILWAUKEE	2323 N LAKE DRIVE, 7TH FLOOR	x	x	
COLUMBIA WEST CLINIC	10950 W CAPITOL DRIVE			
COMPREHENSIVE CLINICAL & CONSULTING SERVICES, INC.	7161 N. PORT WASHINGTON RD	x		
COMPREHENSIVE CLINICAL & CONSULTING SVS	4131 W LOOMIS RD SUITE 240			
CORNERSTONE COUNSELING SERVICES, INC	5007 S HOWELL AVENUE, SUITE 350			
CORNERSTONE COUNSELING SERVICES, INC.	10850 W PARK PLACE, #100			
CORNERSTONE COUNSELING SERVICES, INC.	4811 S 76TH STREET			
CORNERSTONE COUNSELING SERVICES, INC.	5555 N PORT WASHINGTON ROAD, #200			
CORNERSTONE COUNSELING SERVICES	16535 WEST BLUEMOUND ROAD			

Provider Organization	Street	MH	SA	WA
COUNSELING AND TRANSITION CENTER		x		
CLINICARE CORPORATION MILWAUKEE ACADEMY	9501 WATERTOWN PLANK ROAD			
CREATIVE CONSULTING & COUNSELING SEVICES	2728 N PROSPECT			
CREATIVE FAMILY SERVICE	6040 WEST LISBON AVENUE, SUITE 206	x	x	
CRISIS RESOURCE CENTER	5409 W VILLARD AVE			
CRISIS RESOURCE CENTER	2057 S 14TH STREET			
CURRENT INITIATIVES COUNSELING SERVICE LLC	6815 WEST CAPITOL DR SUITE 207	x	x	x
DAY ONE - SILVER SPRING CENTER	5555 NORTH 51ST BLVD	x		
D AND S HEALING CENTER	310 EAST BUFFALO STREET			
DIANNE FRANCES MFA MS LPC	10520 WEST BLUEMOND ROAD			
DISCOVERY AND RECOVERY CLINIC INC	4402 SOUTH 68TH STREET	x		
DLO PARTNERS LLC DBA BRIGHTSIDE MENTAL HEALTH	3073 S CHASE AVE	x		
DOMINION BEHAVIORAL HEALTH SERVICES, LLC				
EAU CLAIRE ACADEMY				
EBB TIDE THERAPY	2821 N 4TH STREET RM 144	x	x	
EMPATHETIC COUNSELING SERVICES INC.	5501 W BURLEIGH ST	x	x	
EMPATHETIC COUNSELING SERVICES SOUTH	551 WEST HISTORIC MITCHELL ST			
EULOPIA FAMILY SERVICES, INC.				
EXODUS FAMILY SERVICES, LLC				
EXPRESS YOURSELF MILWAUKEE, INC.				
FAMILY AND CHILDREN'S CENTER, INC.				
FAMILY CRISIS COUNSELING				
FAMILY COUNSELING CENTER LLC	8112 WEST BLUEMOUND ROAD			
FAMILY OPTIONS COUNSELING, LLC	3015 N 114TH STREET	x		x
FAMILY WORKS PROGRAMS, INC.				
FOKUS FAMILY SERVICES	2821 N. 4TH STREET, #139	x	x	
FOREVER FREE SUBSTANCE ABUSE & MENTAL HEALTH TREATMENT CENTER	724 S LAYTON BLVD			
FORWARD CHOICES LLC	6040 W LISBON AVENUE, #103	x		x
GATEWAY FAMILY HEALTH CENTER	801 S 70TH STREET			
GATEWAY FAMILY HEALTH CENTER	801 S 70TH STREET			
GATEWAY TO CHANGE	2319 W. CAPITOL DRIVE	x	x	

Provider Organization	Street	MH	SA	WA
GENESIS BEHAVIORAL SERVICES, INC. MEN'S AODA RESIDENTIAL	2436 N. 50TH STREET		x	
GENESIS DETOXIFICATION CENTER	2835 N 32ND STREET		x	
GENESIS MILWAUKEE OUTPATIENT CLINIC	230 W WELLS STREET, #312	x	x	
GENESIS WOMEN'S RESIDENTIAL PROGRAM	5427 W. VILLARD STREET		x	
GERALD L IGNACE INDIAN HEALTH CENTER	1711 SOUTH 11TH STREET	x		
GREAT LAKES BEHAVIORAL HEALTH	10201 WEST LINCOLN AVE			
GREENSQUARE DEVELOPMENTAL SPECIALISTS	7300 SOUTH 13TH STREET	x		
GREENSQUARE DEVELOPMENTAL SPECIALISTS	6791 N GREEN BAY ROAD			
GRO FAMILY SERVICES	6400 WEST CAPITOL DRIVE	x	x	
GUEST HOUSE COUNSELING CLINIC	1216 N. 13TH STREET	x	x	
HEALTH PSYCHOLOGY ASSOCIATES	5007 S HOWELL, #350			
HALE-RICHLIN CENTER FOR PSYCHIATRY (THE)				
HARMONY SOCIAL SERVICES CPA, INC.				
HARPER HOUSE-NEHEMIAH PROJECT				
HEALTH PSYCHOLOGY ASSOCIATES, SC	5555 N PORT WASHINGTON DR SUITE 200	x		
HIGHLAND COMMONS	6700 WEST BELOIT RD			
HOPE FORTIS SCHOOL	3601 N PORT WASHINGTON ROAD			
HOPE PRIMA SCHOOL	2345 N 25TH STREET			
HORIZON HEALTHCARE	5408 W BURLEIGH ST			
HORIZON HEALTHCARE INC	4650 S HOWELL AVENUE	x	x	
HORIZON HEALTHCARE, INC	5408 W BURLEIGH ST			
HOUSE OF JABEZ, LLC				
HOUSE OF LOVE II				
HUMAN DEVELOPMENT CENTER, INC.				
ICF CONSULTANTS, INC.				
IMPACT, ALCOHOL & OTHER DRUG ABUSE SERVICE	3970 NORTH OAKLAND AVE			
IMPACT, ALCOHOL AND OTHER DRUG ABUSE SERVICE, INC	6737 W WASHINGTON STREET, #2225		x	
INTEGRATED DEVELOPMENT SERVICES	217 W. DUNWOOD ROAD			
INTEGRITY FAMILY SERVICES, LLC				
JEWISH FAMILY SERVICES	1300 N. JACKSON STREET	x		
JEWISH FAMILY SVS - BAYSHORE	5800 N BAYSHORE DRIVE			

Provider Organization	Street	MH	SA	WA
JEWISH FAMILY SVS - BRADLEY CROSSING	4375 WEST BRADLEY ROAD			
JEWISH FAMILY SVS BROWN DEER ELEMENTARY	5757 WEST DEAN ROAD			
JEWISH FAMILY SVS CENTRAL CITY CYBERSCHOOL	4301 NORTH 44TH ST			
JEWISH FAMILY SVS NATIVITY JESUIT MIDDLE SCHOOL	1515 SOUTH 15TH STREET			
JEWISH FAMILY SVS-BROWN DEER MIDDLE/HIGH SCHOOL	8060 NORTH 60TH STREET			
JEWISH FAMILY SVS-NORTH POINT LIGHTHOUSE CHARTER	4200 WEST DOUGLAS AVENUE			
JEWISH HOME AND CARE CENTER, INC.	1414 NORTH PROSPECT AVENUE			
JUSTICE POINT	821 WEST STATE STREET, ROOM 417			
KIDS DISCOVER SUCCESS THERAPEUTICS, LLC				
KIDS IN TRANSITION, INC	2821 NORTH 4TH STREET STE #208		x	
LA CAUSA COMMUNITY ENRICHMENT CENTER	804 W GREENFIELD AVE			
LA CAUSA, INC SOCIAL SERVICES	1212 SOUTH 70TH STREET, SUITE 115A			
LA CAUSA, INC.	1212 S 70TH ST #115A	x	x	x
LAD LAKE CROSSROADS TO INDEPENDENCE GH				
LAD LAKE -ST. ROSE STAGES				
LAD LAKE, INC.				
LAD LAKE-ST. ROSE				
LAKESHORE CLINIC LTD/ROBERT DRIES PHD	8112 W BLUEMOUND RD			
LAKESHORE CLINIC, LTD.	3510 N OAKLAND AVENUE, #206			
LCFS-ST JOHN LUTHERAN CHURCH	4850 S LAKE DRIVE			
LIFE CHANGING MINISTRIES INC.	7315 NORTH TEUTONIA AVENUE		x	
LIFE-SPAN PSYCHOLOGICAL SERVICES, LLC	2266 N PROSPECT AVENUE, #503			
LIGHTHOUSE CLINIC	11803 W NORTH AVENUE, #207			
LIGHTHOUSE CLINIC, LLC	2524 E WEBSTER PLACE, #203	x		
LOCKETT ENTERPRISE BEHAVIORAL HEALTH SERVICES	230 W WELLS STREET, SUITE 214	x	x	
LOVE AND CARE COMMUNITY CENTER LLC	3975 NORTH 68TH STREET SUITE #205	x		
LUTHERAN COUNSELING AND FAMILY SERVICES OF WISCONSIN	3800 N. MAYFAIR ROAD	x	x	x
LUTHERAN COUNSELING & FAMILY SERVICES OF WI				
LUTHERAN SOCIAL SERVICES-HOMME HOME Y&F PROGRAMS				
M & S CLINICAL SERVICES, INC.	2821 NORTH 4TH ST #516	x	x	
MAPLEGROVE TREATMENT CENTER	1455 97TH STREET	x		

Provider Organization	Street	MH	SA	WA
MARQUETTE NEIGHBORHOOD HEALTH CENTER	1834 W WISCONSIN AVENUE, #100			
MARTIN LUTHER KING-HERITAGE HEALTH CENTER	2555 N MARTIN LUTHER KING JR DRIVE			
MATT TALBOT RECOVERY CENTER	2613 W. NORTH AVENUE		x	
MATT TALBOT RECOVERY SERVICES, INC (FIRST STEP COMMUNITY RECOVERY CENTER)	2835 N 32ND STREET			
MATTERS OF THE SPIRIT, LLC	6815 WEST CAPITOL DRIVE, SUITE 112			
MCFI DBA TLS BEHAVIORAL HEALTH	1040 S 70TH STREET			
MCW DEPARTMENT OF PSYCHIATRY CLINICS AT TOSA	1155 N MAYFAIR ROAD	x	x	
MD THERAPY	6815 W CAPITOL DRIVE, #208	x	x	x
MENTAL HEALTH AMERICA OF WISCONSIN				
MEDINA'S WAY	6815 WEST CAPITAL DRIVE #202	x		
MEDINAS WAY 2	1101-1107 WEST NATIONAL AVE			
META HOUSE, INC (SHOREWOOD CAMPUS) AKA META III	3924-26 N. MARYLAND AVENUE		x	
META HOUSE, INC (SOUTH CAMPUS) AKA RIVERWEST	2618 N. BREMEN STREET		x	
META HOUSE, INC.	2625 N WEIL STREET	x	x	
META HOUSE, INC. (NORTH CAMPUS)	2626 N. BREMEN STREET	x	x	
MILWAUKEE ACADEMY	9501 WATERTOWN PLANK ROAD			
MILWAUKEE ACADEMY/CLINICARE				
MILWAUKEE CENTER FOR INDEPENDENCE	2020 W WELLS STREET			x
MILWAUKEE CENTER FOR INDEPENDENCE DBA TLS BEHAVIORAL HEALTH	1040 S. 70TH STREET	x		
MILWAUKEE CENTER FOR INDEPENDENCE DBA TLS BEHAVIORAL HEALTH	1040 S. 70TH STREET	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION	9455 WATERTOWN PLANK ROAD	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIV PSYCHIATRIC CRISIS SERVS/ADMISSION CTR	9499 WEST WATERTOWN PLANK ROAD			
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIV WRAPAROUND MILWAUKEE	9201 WEST WATERTOWN PLANK ROAD			
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION - SOUTHSIDE CSP	1201 WEST MITCHELL STREET	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION MOBILE URGENT TREATMENT TEAM	9201 WATERTOWN PLANK ROAD	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION-DOWNTOWN CSP	1220 WEST VLIET ST SUITE #304	x		
MILWAUKEE COUNTY COMPREHENSIVE COMMUNITY SERVICES PROGRAM	9201 WEST WATERTOWN PLANK ROAD			
MILWAUKEE HEALTH SERVICE SYSTEMS DBA RIVER'S SHORE CLINIC	3707 N RICHARDS STREET		x	
MILWAUKEE HEALTH SERVICE SYSTEMS II	4800 S 10TH STREET #1		x	
MILWAUKEE HEALTH SERVICES, INC. DBA BEHAVIORAL HEALTH SERVICES CENTER	8200 W SILVER SPRING DRIVE	x		

Provider Organization	Street	MH	SA	WA
MILWAUKEE HEALTH SERVICES, INC.	140 N. HINE AVENUE			
MILWAUKEE MENTAL HEALTH ASSOCIATES		X	X	
MILWAUKEE MENTAL HEALTH ASSOCIATES COMMUNITY SUPPORT PROGRAM	4957 W FOND DU LAC AVENUE	X		
MINDSTAR COUNSELING, LLC	6114 W CAPITOL DRIVE, SUITE 102	X		X
MT. CASTLE TRANSITIONAL LIVING SERVICES				
MULTI-CULTURAL COUNSELING SERVICES II INC, DBA RENEW COUNSELING SERVICES	6815 W CAPITOL DR SUITE #105	X	X	
MWCCA BEHAVIORAL HEALTH CLINIC	728 NORTH JAMES LOVELL ST	X	X	
NAKODA COGNITIVE BEHAVIORAL SERVS LLC	204 EAST CAPITOL DRIVE			
NERVIG, MARY				
NEW BEGINNINGS MENTAL HEALTH CLINIC, LLC	6754 W БЕЛОIT RD	X		
NEW CHOICES, LLC	3565 N MARTIN LUTHER KING DR	X	X	X
NEW CONCEPT SELF DEV. CTR/CSS				
NEW HORIZON CENTER CRISIS/MENTORING SERVICES, LLC				
NEW LEAF THERAPIES LLC	4465 N OAKLAND AVE STE 400 D	X		X
NEW LIFE COUNSELING & FAMILY SOCIAL SERVICE AGENCY, INC.	2811 W NORTH AVE			
NEW LIFE COUNSELING & FAMILY SOCIAL SERVICE AGENCY, INC.	1442 N FARWELL, SUITE 300			
NEW PROSPECTS COUNSELING SERVICES	1219 NORTH CASS STREET			
NEXDAY	3333 SOUTH HOWELL AVE			
NORRIS ADOLESCENT CENTER				
NORTH SHORE PSYCHOTHERAPY ASSOCIATES	5800 N BAYSHORE DRIVE #A250	X		X
NORTHERN CROSSING BEHAVIORAL HEALTH SERVICES LLC	5303 WEST NORTH AVENUE			
NORTHSHORE CLINIC & CONSULTANTS	207 E BUFFALO STREET, #510			
NORTHSHORE CLINIC & CONSULTANTS	2363 S 102ND STREET, #203			
NORTHSORE CLINIC & CONSULTANTS INC	207 E BUFFALO STREET #300			
NORTHWEST PASSAGE LTD.				
OCONOMOWOC DEVELOPMENTAL TRAINING CTR. OF WI LLC				
OLIVER WENDALL HOLMES SCHOOL	2463 NORTH BUFFUM STREET			
OMNI ENRICHMENT, INC.	3020 W. VLIET STREET	X	X	
OUTREACH COMMUNITY HEALTH CENTER	711 W CAPITOL DRIVE		X	
OUTREACH COMMUNITY HEALTH CENTER, INC. RECOVERY CSP	711 W. CAPITOL DRIVE	X		
OUTREACH COMMUNITY HEALTH CENTERS INC	210 W CAPITOL DRIVE	X		

Provider Organization	Street	MH	SA	WA
OUTREACH COMMUNITY HEALTH CENTERS, INC	711 W CAPITOL DRIVE			
PARADIGM ENRICHMENT SERVICES, INC.	6110 WEST CAPITOL DRIVE MILWAUKEE	x	x	
PARK WEST SOCIAL & PSYCHOTHERAPY SERVICES INC	2772 N MARTIN LUTHER KING DRIVE #102	x		x
PARKWAY CLINIC	2906 S 20TH STREET			
PASTORAL COUNSELING SERVICE OF THE GREATER MILWAUKEE AREA	2825 N MAYFAIR ROAD SUITE 101	x		
PATHFINDERS MILWAUKEE, INC	4200 N HOLTON STREET, #400	x		x
PATHFINDERS FOR RUNAWAYS	1614 EAST KANE PLACE			
PATHWAYS COUNSELING CENTER				
PENFIELD CHILDREN'S CENTER	833 N 26TH STREET	x		x
PERFORMANCE ENHANCEMENT HEALTH SERVICES, SC	8800 SOUTH 102ND ST #103	x	x	
POSITIVE OUTLOOK CLINICAL SERVICES LLC	4345 NORTH 60TH STREET	x	x	x
PRO MARK CLINIC	4380 N RICHARDS STREET			
PROFESSIONAL READJUSTMENT OUTREACH CONSULTANT GROUP	4222 WEST CAPITOL DRIVE STE LL	x	x	
PROFESSIONAL SERVICES GROUP, INC.	1126 S 70TH STREET			x
PROJECT ACCESS, INC. CSP	823 S 60TH STREET	x		
PROJECT EXCEL-CCC (WCS)				
PSYCARE-MILWAUKEE LLC	633 W. WISCONSIN AVENUE, #1810	x		x
PSYCHIATRIC CONSULTANTS & THERAPISTS, SC	1220 DEWEY AVENUE			
PSYCHOLOGICAL AND COUNSELING SERVICES	7300 S 13TH STREET, #201			
QAM - QUALITY ADDICTION MANAGEMENT	1610 MILLER PARKWAY		x	
QUAD/GRAPHICS	555 S 108TH STREET			
RAVENSWOOD CLINIC	2266 N. PROSPECT AVENUE, #326	x	x	
RAWHIDE YOUTH & FAMILY COUNSELING SVS	5555 N PORT WASHINGTON RD STE 207			x
REACH, INC. COMPREHENSIVE MENTAL HEALTH CLINIC	4550 W BRADLEY ROAD	x	x	x
RELEVANCE COUNSELING SERVICES	3635 W OKLAHOMA AVENUE	x		
RENEW COUNSELING SERVICES	1225 W. MITCHELL STREET, #223	x	x	
REVIVE YOUTH AND FAMILY CENTER I				
REVIVE YOUTH AND FAMILY CENTER II				
RIGHT TURN II				
RIGHT TURN, INC.				
ROGERS MEMORIAL HOSPITAL	2448 SOUTH 102ND ST RM #200	x	x	

Provider Organization	Street	MH	SA	WA
ROGERS MEMORIAL HOSPITAL - CHILD & ADOLESCENT DAY TREATMENT	4555 W SCHROEDER DRIVE	x	x	
ROGERS MEMORIAL HOSPITAL - MILWAUKEE	11101 W. LINCOLN AVENUE	x	x	
ROOTS COUNSELING SERVICES	1863 N FARWELL AVE		x	
RUNNING REBELS COMMUNITY ORGANIZATION				
SANKOFA BEHAVIORAL & COMMUNITY HEALTH	500 W SILVER SPRING DR. SUITE K-200			
SEBASTIAN FAMILY PSYCHOLOGY	2745 W LAYTON AVE, STE 203			
SEBASTIAN FAMILY PSYCHOLOGY PRACTICE, LLC	1720 W FLORIST AVENUE, #125	x	x	x
SHECAR SUBSTANCE ABUSE/MENTAL HEALTH OUTPATIENT TREATMENT CENTER, LLC	2821 N 4TH STREET, #305	x	x	x
SHERRY, KENNETH E., PH.D./FIRST STEP CLINIC, INC.				
SHORE COUNSELING & CONSULTING CLINIC	6110 N PORT WASHINGTON ROAD	x		
SHORE COUNSELING & CONSULTING CLINIC	700 WEST VIRGINIA ST			
SHORE COUNSELING AND CONSULTING CLINIC	2600 N MAYFAIR ROAD, #650			
SHOREHAVEN BEHAVIORAL HEALTH INC	2727 W CLEVELAND AVE	x	x	x
SHOREHAVEN BEHAVIORAL HEALTH INC	4370 SOUTH 76TH STREET			
SHOREHAVEN BEHAVIORAL HEALTH, INC	3900 W BROWN DEER ROAD #200			
SIXTEENTH STREET COMMUNITY HEALTH CENTERS, INC.				
SOCIAL DEVELOPMENT COMMISSION YOUTH & FAMILY DEVELOPMENT PROGRAM	4041 N. RICHARDS STREET	x	x	x
SOUTHEAST CAMPUS	3333 S HOWELL AVENUE			
SAINT A	8901 WEST CAPITOL DRIVE			x
ST CHARLES - FAMILY DEVELOP CTR	151 S 84TH STREET			
ST CHARLES YOUTH & FAMILY SERVICES, INC	4757 N 76TH STREET			x
SAINT FRANCIS HOSPITAL OHIO BUILDING	3267 SOUTH 16TH STREET			
ST MARCUS SCHOOL	2215 N. PALMER STREET			
ST PETER LUTHERAN SCHOOL	1214 S 8TH STREET			
ST. CHARLES YOUTH & FAMILY SERVICES - FAMILY DEVELOPMENT CENTER	4757 N. 76TH STREET	x	x	
ST. LUKE'S MEDICAL CENTER OUTPATIENT BEHAVIORAL HEALTH CLINIC	2900 W OKLAHOMA AVENUE	x	x	
SAINT LUKES SOUTH SHORE BEHAVIORAL HEALTH	5900 SOUTH LAKE DRIVE			
ST. ROSE YOUTH & FAMILY CENTER	3801 N. 88TH STREET	x	x	x
SILVER SPRING PSYCHOTHERAPY ASSOCIATES	5215 NORTH IRONWOOD ROAD			
SOUTHWEST KEY PROGRAMS, INC.				
SOLUTIONS BEHAVIORAL HEALTH GROUP	10702 WEST BURLEIGH STREET			

Provider Organization	Street	MH	SA	WA
SPAHN CLINICAL SERVICES STAGES- ST. ROSE				
STRESS MANAGEMENT & MENTAL HEALTH CLINICS	5225 N. IRONWOOD LANE, #102	x		
STRESS MANAGEMENT AND MENTAL HEALTH CLINICS	10201 W LINCOLN AVENUE, #308	x		
TEEN CHALLENGE WISCONSIN ROBBY DAWSON HOME FOR WOMEN	727 NORTH 31ST STREET			
THE BRIDGE HEALTH CLINICS & RESEARCH CENTERS	611 WEST NATIONAL AVE #400	x	x	x
THE BRIDGE HEALTH CLINICS @ COMMUNITY ADVOCATES	728 NORTH JAMES LOVELL ST		x	
THE HUMAN DEVELOPMENT CENTER, INC.	6833 WEST FOND DU LAC AVE	x		
THE KELLEY CLINIC	1216 N. PROSPECT AVENUE	x		
THE POWER OF CHANGE INC BEHAVIORAL SERVICES	2821 N 4TH STREET SUITE 145	x	x	
THE REDI CLINIC - A DIVISION OF PATHWAY CLINIC, SC	2300 N MAYFAIR ROAD, #425	x		
THRIVE TREATMENT SERVICES, LLC TOMORROW'S FUTURE PHASE II				
TOTTY AND ASSOCIATES	7251 W NORTH AVENUE	x		x
TRANSFORMATIONSERVICES	835 N 23RD STREET, #212		x	
TRILLIUM CARE GROUP LLC	4811 S 76TH ST, #309			
TURCOTT MEDICAL AND PSYCHIATRIC ASSOCIATES	2600 N. MAYFAIR ROAD, #785	x		
UNITED COMMUNITY CENTER	604 W SCOTT STREET	x	x	
UNITED COMMUNITY CENTER	1100 S 6TH STREET, 3RD FLOOR		x	
UNITED COMMUNITY CENTER ART	1100 S 6TH STREET, 3RD FLOOR			
UNITED COMMUNITY CENTER LATINAS UNIDAS	1123 SOUTH 6TH STREET		x	
UNITED HANDS ACROSS THE CITY 'KEEPING DREAMS ALIVE', INC	2140 SOUTH 19TH STREET	x	x	
VALENTIN CLINIC	1220 DEWEY AVENUE	x	x	
V.I.C. LIVING CENTER, LLC WAKE UP PROGRAM, LLC WAUWATOSA THERAPIES, LLC				
WATER TOWER VIEW	3983 S PRAIRIE HILL LANE			
WCS-MILWAUKEE COUNTY DAY REPORTING CENTER	1673 S 9TH ST, BASEMENT		x	
WEST GROVE CLINIC	10012 WEST CAPITOL DRIVE #101	x	x	
WEST GROVE CLINIC LLC	11121 W NORTH AVENUE, #220			
WESTCARE WISCONSIN, INC.	335 WEST WRIGHT STREET		x	

Provider Organization	Street	MH	SA	WA
WHEATON FRAN BEHAV HEALTH - ST. FRANCIS	5650 N GREEN BAY AVENUE, #200			
WHEATON FRANCISAN BEHAVIORAL HEALTH - FRANKLIN	9969 S 27TH STREET			
WHEATON FRANCISCAN BEHAVIORAL HEALTH ST. FRANCIS HOSPITAL	3237 S 16TH STREET #200	x	x	
WHEATON FRANCISCAN BEHAVIORAL HEALTH - ST. JOSEPH REGIONAL MEDICAL CENTER	5000 W CHAMBERS ST #P210	x	x	
WILLOWGLEN ACADEMY	5555 NORTH 51ST BLVD			
WILLOWGLEN ACADEMY - CSP NORTH	4941 W FOND DU LAC AVE			
WILLOWGLEN ACADEMY - DAY ONE EAST	6414 W. FOND DU LAC AVE			
WILLOWGLEN ACADEMY OUTPATIENT CLINIC	4065 NORTH 35TH STREET STE # N100	x	x	
WILLOWGLEN COMMUNITY CARE				
WISCONSIN COMMUNITY SERVICES	3732 W WISCONSIN AVE. SUITE 200			
WISCONSIN COMMUNITY SERVICES OUTPATIENT MENTAL HEALTH PROGRAM	3734 W. WISCONSIN AVENUE	x		
WISCONSIN COMMUNITY SERVICES THE JOSHUA GLOVER CENTER	2105 N. BOOTH STREET		x	
WISCONSIN COMMUNITY SERVICES THURGOOD MARSHALL HOUSE	1914 N. 6TH STREET		x	
WISCONSIN COMMUNITY SERVICES UNLIMITED POTENTIALS	230 W. WELLS STREET, #500	x	x	
WISCONSIN COMMUNITY SERVICES-COMMUNITY SUPPORT PROGRAM	3734 W. WISCONSIN AVENUE	x		
WLCFS-CHRISTIAN FAMILY COUNSELING	9555 S HOWELL AVENUE, #750			
WORD OF HOPE MINISTRIES ATODA PROGRAM	2677 N 40TH STREET		x	

Chairperson: Peter Carlson
Senior Executive Assistant: Jodi Mapp, 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD FINANCE COMMITTEE

Thursday, December 3, 2015 - 1:30 P.M.
 Milwaukee Mental Health Complex
 Conference Room 1045

MINUTES

SCHEDULED ITEMS:

1.	<p>Chief Financial Officer Administrative Update.</p> <p>Highlights were provided on key financial activities and issues related to Behavioral Health Division (BHD) operations. Topics presented include financial projections, the Wisconsin Medicaid Cost Report (WIMCR) Audit, fringe surplus, capital improvements central services allocations, ICD10 Diagnosis Codes, Community Recovery Services billing, Comprehensive Community Services billing, provider payment, and emergency detention grant funding.</p>
2.	<p>Contract Process Overview.</p> <p>The existing contract process requires significant revision to be performance-based and value-based purchasing oriented. Internal discussions culminated in a decision to overhaul/redesign the entire process, including creating a contract report card for all providers. The contract report card will include compliance requirements and a menu of key performance measures/indicators; some of which are process, some are structure, and some are outcomes based. Planning is underway regarding how to integrate quality, patient experience, and grievance information into contracts to build a robust system of data that can be evaluated on an on-going basis. The redesign also includes internal restructuring that dedicates staff strictly to reviewing and monitoring contracts, including announced and unannounced visits. The intent is to ensure accountability, quality services are being provided, and fiscal viability.</p>
3.	<p>2016 Purchase of Service Contracts.</p> <p>An overview was provided detailing the various program contracts for Adult Mental Health and Alcohol and Other Drug Abuse (AODA); Community Based Crisis Services, which included the Community Linkages and Stabilization Program (CLASP), Access Clinic – South, the Crisis Mobile Team, Crisis Stabilization, the Crisis Resource Center (CRC), and the Community Consultation Team; Mental Health Services; and Substance Abuse Services.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>Wraparound Milwaukee contract allocations for 2016 vary slightly from 2015. Contracts for care coordination and other services that support the operation of the Wraparound Milwaukee Program; Reaching, Engaging, and Assisting Children and Families (REACH); Family Intervention and Support Services (FISS); Project O-YEAH (Young Emerging Adult Heroes); and the Mobile Urgent Treatment Team (MUTT). All remaining services are purchased on a fee-for-service basis through agencies participating in the Wraparound Milwaukee Provider Network.</p> <p>Contract performance data are tracked by conducting agency reviews twice a year, with financial incentives and disincentives built in and agency improvement plans required. This information is included with Requests for Proposals to ensure the evaluating committee can make the proper decision as to which agencies' contracts will be renewed. Contracted agencies have gone from eight to six due to performance indicators and for better quality control.</p> <p>The Finance Committee unanimously agreed to recommend approval to the full Board.</p>
4.	<p>2016 Professional Services Contracts.</p> <p>Professional services contracts focus on facility-based programming, supports functions that are critical to patient care, and are necessary to maintain hospital and crisis services licensure. Background information was provided on services the contracted agencies provide, which include cleaning, laboratory, and pharmacy.</p> <p>The Finance Committee unanimously agreed to recommend approval to the full Board.</p>
5.	<p>2016 Social Services Contract.</p> <p>2016 contracts with the State Department of Health and Human Services and Children and Families with the State are mandated by state law. Authorization is needed to receive Community Aids Basic County allocation reimbursement that is included in the Behavioral Health Division (BHD) Budget. The funding identified pertains only to revenues associated with services within BHD.</p> <p>The Finance Committee unanimously agreed to recommend approval to the full Board.</p>
6.	<p>2015-2016 Housing Homelessness Initiative Contract.</p> <p>In April, the Mental Health Board approved money to fund the ending chronic homelessness initiative in the Housing Division of the Department of Health and Human Services. The funds have yet to be transferred. Discussions with the Comptroller resulted in a more structured process around initiating fund transfers. Per the Comptroller, Corporation Counsel developed a Memorandum of Understanding (MOU) between the Housing Division and the Behavioral Health Division. The MOU will provide the dollar amount of funds to be transferred, as well as the scope of work the funds will support.</p>

Finance Committee Item 1

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: November 13, 2015

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

FROM: Randy Oleszak, Chief Financial Officer, Behavioral Health Division

SUBJECT: Report from the Chief Financial Officer, Behavioral Health Division, providing a Financial Update

Background

The purpose of this report is to highlight key financial activities or issues related to the Milwaukee County Behavioral Health Division (BHD) since the previous Finance Committee meeting.

Discussion

1. Financial Projections

As of October 31, 2015 BHD is projecting a surplus of \$3.2 million, which is consistent with projections presented to the finance committee in September.

BHD is projecting an inpatient surplus of \$2.5 million. The surplus is largely due to lower spending in pharmacy, dietary, and personnel costs as well as increased revenue resulting from improved write off percentages due to larger amount of billable services.

BHD is projecting a surplus of \$.7 million in Community Services. The surplus is primarily related to reduced pharmacy spending at outpatient mental health clinics and surpluses in AODA resulting from increases in clients with payors.

2. WIMCR Audit

A review of the 2013 Wisconsin Medicaid Cost Report (WIMCR) is being conducted by Public Consulting Group. The review has largely focused on legacy costs, contract agency overhead, and BHD overhead, including overhead allocated to BHD from County. Specific audit findings have not yet been discussed with BHD and any potential financial impact is not known at this time.

3. Fringe Surplus

In November the Comptroller of Milwaukee County presented to the Milwaukee County Finance Personnel & Audit Committee a projected overall net County fringe surplus of \$15 million. However, it was also reported that 2015 pension contributions, which were based on actuarial assumptions at the time the 2015 budget was compiled, were understated by approximately \$19 million. Subsequently, the Comptroller received County Board approval to utilize \$10 million of the projected fringe surplus to pay down the pension contribution deficit. Utilization of the anticipated remaining \$5 million fringe surplus is being determined.

4. Capital Improvements

Deferred maintenance to the Charles Landis Hospital poses a significant risk to the financial viability of the Behavioral Health Division. An assessment completed in 2007 by VFA indicated \$12.1 million and \$13.8 million in currently critical and potentially critical deferred maintenance items, respectively. The report also identified additional items of \$5.4 million and \$49.5 million classified as necessary but not yet critical and recommended. In total \$80.7 million in deferred maintenance costs were identified.

During the County 2016 Budget process, BHD submitted a five year request for capital improvements of \$24.7 million starting in 2017. Since the request if effective in 2017 the request was not taken up for approval by the board and an approved mid-term capital budget does not currently exist for BHD

On October 31st a portion of the roof at the hospital was damaged with estimated cost to repair of \$350,000. The County does have insurance but with a very high \$1.5 million deductible. At this time there a discussions to determine BHDs' financial obligation related to capital improvement items. In addition it should be noted that maintenance issues can have negative consequences on both patient safety and continuity of services.

5. Central Services Allocations

On an annual basis the County allocates indirect costs to County departments based on an estimate. Subsequently, the estimated costs are compared to actuals and an adjustment is recorded to charge actual cost. As a result \$375,000 of additional central service cost is being allocated to BHD than planned.

Community Billing and Provider Payments

6. ICD10 Diagnosis Codes

Utilization of ICD10 diagnosis codes became effective October 1, 2015. This was the same date as the transition to Avatar for Community Services' providers and a high volume of claims were submitted from providers using old diagnosis codes resulting in non-billable claims. BHD has been collaborating with the provider community and has received updated ICD10 codes for most services. BHD is acquiring the assistance of four data entry specialist to assist in correcting the coding by mid-December.

7. Community Recovery Services (CRS) Billing

Billing for CRS from November 2014 has not been completed. Initially billing for the period of November 2014 – January 2015 was submitted, however, based on discussion with the State Clinical Division, which oversees CRS, a decision was made to pull back the claims to ensure a perceived 100% compliance standard. State communication at the time indicated that less than 100% compliance would result in recoupment of all claims. Since that time BHD has implemented detailed audit and review procedures to ensure proper provider billing. All CRS back billing is expected to be completed by the end of November 2015.

8. Comprehensive Community Services (CCS) Billing

Due to the complexities of CCS billing, the timing of CCS expansion, and the transition of the Community Services billing system (CMHC) to Avatar a strategic decision was made to not program CCS billing in CMHC and delay billing until the implementation of Avatar. As a result CCS services for the period of January 2015 – September 30, 2015 have not yet been billed. Temporary data entry specialist are being hired and it is anticipated that billing for this period will be completed by year end. Effective October 1, 2015 CCS services are directly coded into Avatar and billed as part of the standard monthly billing cycle.

9. Provider Payment

On October 1, 2015 Community Service billing was transitioned to Avatar. During post implementation testing and review it was noted that provider payment volumes and dollars were lower than historical averages. BHD along with our community partners have been working diligently to provide timely and accurate payments post implementation. However, system configuration and provider adoption issues still exist and are in the process of being rectified.

Emergency Detention – Grant Funding

10. A total of \$1.5 million one-time statewide funding is available from July 2015 – June 2016 to assist counties become compliant with Wisconsin Act 55 which mandates that before an emergency detention can be approved, a crisis assessment on the individual by a mental health professional must occur.

The specific requirements of this grant as it relates to Act 55 did not take into consideration the exceptions that are mandated by law and statute for Milwaukee County, namely Chapter 51 and Act 235, which is specific pilot that enables Treatment Director designees to complete emergency detentions with law enforcement. Therefore, BHD did not apply for this grant.

It should be noted that BHD has collaborated with the Department of Aging and the Ch. 55 Coalition to make a recommendation and submission for grant funding to increase crisis capacity for individuals with dementia.

Respectfully Submitted,



Randy Oleszak, Chief Financial Officer
Milwaukee County Behavioral Health Division
Department of Health and Human Services



Milwaukee County Behavioral Health Division
2015 Key Performance Measure (KPM) Dashboard

Quality Committee Item

Program	Measure	2015 (1)	2015 Status (2)	2015 Target	Benchmark Source	Formula
Community Access To Recovery Services	Number Served - AODA	6,080	Green	5,529	BHD (3)	Unduplicated count of clients served in AODA programs
	Number Served - Mental Health	5,097	Green	4,663	BHD (3)	Unduplicated count of clients served in Mental Health programs
	Comprehensive Community Service (CCS) Enrollees	236	Green	236	BHD (3)	Count of clients enrolled in the Comprehensive Community Service program
	Reduction in past 6 months psychiatric bed days, admission to six months after admission	52%	Red	64.0%	BHD (3)	Change in the total number of psychiatric bed days from six months before the admission to six months prior to the first follow-up
	Reduction in past 30 days alcohol or drug use, admission to six months after admission	85%	Green	79.0%	BHD (3)	Change in the proportion of clients with any self-reported days of drug use 30 days prior to the initial enrollment interview to the proportion with drug use in 30 days prior to the follow-up interview six months later
	Reduction in homeless or in shelters, admission to six months after admission	79%	Yellow	82.0%	BHD (3)	Change in the total number of homeless/shelter days from the six months before the admission to the six months prior to the first follow-up
	Increase in employment (full or part time-competitive), admission to six months after admission	41%	Red	54.0%	BHD (3)	Change in client's employment status from six months before the admission to the six months prior to the first follow-up
	Percent of clients returning to Detox within 30 days	24%	Red	18.0%	BHD (3)	Percent of detox admissions occurring within 30 days of client's prior discharge from the program
Wraparound	Families served in Wraparound HMO (unduplicated count)	2,648	Green	2,650	BHD (3)	Families served in Wraparound HMO (unduplicated count)
	Average level of Family Satisfaction (Rating scale of 1-5)	4.7	Green	> = 4.0	BHD (3)	Average level of Family Satisfaction (Rating scale of 1-5)
	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	68%	Green	> = 75%	BHD (3)	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)
	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.3	Green	> = 3.0	BHD (3)	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)
	Percentage of youth who have achieved permanency at disenrollment	72%	Green	> = 70%	BHD (3)	Percentage of youth who have achieved permanency at disenrollment
	Percentage of Informal Supports on a Child and Family Team	43%	Green	> = 50%	BHD (3)	Percentage of Informal Supports on a Child and Family Team
Crisis Service	Admissions	10,562	Green	10,500	BHD (3)	PCS patient admissions
	Emergency Detentions	5,558	Green	5,400	BHD (3)	PCS admissions where patient had a legal status of "Emergency Detention"
	Percent of patients returning to PCS within 3 days	8%	Green	8%	BHD (3)	Percent of patient admissions occurring within 3 days of patient's prior discharge from the program
	Percent of patients returning to PCS within 30 days	25%	Yellow	20%	CMS (5)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	Percent of time on waitlist status	20%	Red	10%	BHD (3)	PCS hours on Waitlist Status / Total hours in time period x 100
Acute Adult Inpatient Service	Admissions	1,002	Green	1,125	BHD (3)	Acute Adult Inpatient Service patient admissions
	Mean Daily Census	48.7	Green	52.0	BHD (3)	Sum of the midnight census for the time period / Days in time period
	Percent of patients returning to Acute Adult within 30 days	12%	Yellow	7%	NRI (4)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	Percent of patients responding positively to satisfaction survey	72%	Yellow	74%	NRI (4)	Percent of patients selecting "Agree" or "Strongly Agree" to survey items
	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	55%	Red	65%	BHD (3)	Percent of patients selecting "Agree" or "Strongly Agree" to survey item
	HBIPS 1 - Admission screen for violence risk, substance abuse, trauma history, & patient strengths	95%	Green	95%	BHD (3)	Percent of patients screened for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths
	HBIPS 2 - Hours of Physical Restraint Rate	9.0	Red	0.72	CMS (5)	Total number of hours patients were in physical restraint per 1,000 inpatient hours
	HBIPS 3 - Hours of Locked Seclusion Rate	0.41	Yellow	0.31	CMS (5)	Total number of hours patients were in locked seclusion per 1,000 inpatient hours
	HBIPS 4 - Patients discharged on multiple antipsychotic medications	16%	Yellow	10%	CMS (5)	Percent of patients discharged on 2 or more antipsychotic medications
	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96%	Green	30%	CMS (5)	Percent of patients discharged on 2 or more antipsychotic medications with documented justification
	HBIPS 6 - Patients discharged with a continuing care plan	10%	Red	75%	CMS (5)	Percent of patients for whom the post discharge continuing care plan is created and contains the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations
	HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	10%	Red	68%	CMS (5)	Percent of patients for whom the post discharge continuing care plan was transmitted to the next level of care
Child / Adolescent Inpatient Service (CAIS)	Admissions	1,066	Green	1,100	BHD (3)	CAIS patient admissions
	Mean Daily Census	10.8	Green	11.0	BHD (3)	Sum of the midnight census for the time period / Days in time period
	Percent of patients returning to CAIS within 30 days	16%	Red	11%	BHD (3)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	Percent of patients responding positively to satisfaction survey	69%	Yellow	74%	BHD (3)	Percent of patients selecting "Agree" or "Strongly Agree" to survey items
	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	73%	Yellow	80%	BHD (3)	Percent of patients selecting "Agree" or "Strongly Agree" to survey item
	HBIPS 1 - Admission screen for violence risk, substance abuse, trauma history, & patient strengths	95%	Green	95%	BHD (3)	Percent of patients screened for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths
	HBIPS 2 - Hours of Physical Restraint Rate	5.6	Red	0.23	CMS (5)	Total number of hours patients were in physical restraint per 1,000 inpatient hours
	HBIPS 3 - Hours of Locked Seclusion Rate	0.80	Red	0.30	CMS (5)	Total number of hours patients were in locked seclusion per 1,000 inpatient hours
	HBIPS 4 - Patients discharged on multiple antipsychotic medications	3%	Green	3%	CMS (5)	Percent of patients discharged on 2 or more antipsychotic medications
	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96%	Green	36%	CMS (5)	Percent of patients discharged on 2 or more antipsychotic medications with documented justification
	HBIPS 6 - Patients discharged with a continuing care plan	10%	Red	88%	CMS (5)	Percent of patients for whom the post discharge continuing care plan is created and contains the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations
	HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	10%	Red	81%	CMS (5)	Percent of patients for whom the post discharge continuing care plan was transmitted to the next level of care
Financial	Total BHD Revenue (millions)	\$120.5	Yellow	\$120.5		
	Total BHD Expenditure (millions)	\$179.6	Yellow	\$179.6		

Notes:
 (1) 2015 estimates are based on annualized 2015 mid-year data
 (2) 2015 Status color definitions: Red (below 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)
 (3) Performance measure target was set using historical BHD trends
 (4) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages
 (5) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages

MHSIP
Consumer
Satisfaction
Survey

Mid-Year

2015

Prepared By:
Quality
Improvement
Department

Created 10/6/15

Introduction

The survey of Acute Adult Inpatient consumers is intended to obtain consumers' perceptions of services received during their inpatient episode of care. The survey is an ongoing performance improvement project that utilizes the information obtained to identify performance improvement initiatives for inpatient treatment. Consumers' perceptions of inpatient services are obtained regarding:

- Outcomes attained
- The environment in which services were provided
- Participation in treatment planning and discharge
- Protection of rights
- Being treated with dignity
- Empowerment
- Additional aspects of services received including cultural sensitivity, treatment choices, and medications

Method

At the time of discharge, unit social workers present the survey to all consumers and emphasize that the BHD values consumer input to the evaluation of services provided in its programs. They also explain to consumers that survey participation is voluntary, and assure consumers that analyses of the information obtained is summarized and does not identify any individual's responses. Individuals with multiple inpatient episodes are provided opportunities to respond to the survey after each inpatient stay.

Instrument

The MHSIP Inpatient Consumer Survey (2001) contains a total of 28 items. Twenty-one items are designed to measure six domains: *Outcome, Dignity, Rights, Participation, Environment and Empowerment*. Seven additional items ask respondents to rate other aspects of services received including treatment options, medications, cultural sensitivity, and staff. Respondents indicate their level of agreement/disagreement with statements about the inpatient mental health services they have received utilizing a 5-point scale: strongly agree – agree – neutral – disagree – strongly disagree. Respondents may also record an item as not applicable.

Additional survey items are completed to provide basic demographic and descriptive information: age, gender, marital status, ethnicity, length of stay, and legal status. Respondents may choose to provide written comments on the survey form about their responses or about areas not covered by the questionnaire. The following lists the consumer survey items.

NRI/MHSIP Inpatient Consumer Survey (2001)

Outcome Domain:

- I am better able to deal with crisis.
- My symptoms are not bothering me as much.
- I do better in social situations.
- I deal more effectively with daily problems.

Dignity Domain:

- I was treated with dignity and respect.
- Staff here believe that I can grow, change and recover.
- I felt comfortable asking questions about my treatment and medications.
- I was encouraged to use self-help/support groups.

Rights Domain:

- I felt free to complain without fear of retaliation.
- I felt safe to refuse medication or treatment during my hospital stay.
- My complaints and grievances were addressed.

Participation Domain:

- I participated in planning my discharge.
- Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.
- I had the opportunity to talk with my doctor or therapist from the community prior to discharge.

Environment Domain:

- The surroundings and atmosphere at the hospital helped me get better.
- I felt I had enough privacy in the hospital.
- I felt safe while in the hospital.
- The hospital environment was clean and comfortable.

Empowerment Domain:

- I had a choice of treatment options.
- My contact with my doctor was helpful.
- My contact with nurses and therapists was helpful.

Other survey items:

- The medications I am taking help me control symptoms that used to bother me.
- I was given information about how to manage my medication side effects.
- My other medical conditions were treated.
- I felt this hospital stay was necessary.
- Staff were sensitive to my cultural background.
- My family and/or friends were able to visit me.
- If I had a choice of hospitals, I would still choose this one.

Results

The following presents the results of the Inpatient MHSIP Consumer survey completed by consumers of the Acute Adult Inpatient Service in 2015. Data from 2012 – 2014 administrations of the survey are also presented in selected tables of this report to allow for comparisons.

The following are *general guidelines* for interpreting the inpatient consumer survey results based on eight years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:

- Percentages less than 70% can be considered ‘relatively low’ and below 60% can be considered ‘poor’
- Percentages in the 70 - 79% range can be considered ‘good’ or ‘expected’
- Percentages in the 80 - 89% range can be considered ‘high’
- Percentages 90% and above can be considered ‘exceptional’

Response Rate

Completed surveys were obtained at discharge from **56%** of the 743 consumers discharged from the Acute Adult Inpatient service in 2015 YTD (1/1/15-10/5/15). For the past 2 years, the Acute Adult Inpatient service MHSIP survey response rate has been below the target response rate of 40%.

Table 1 presents data on response rate by unit and the total BHD Acute Adult Inpatient Service for 2013 - 2015.

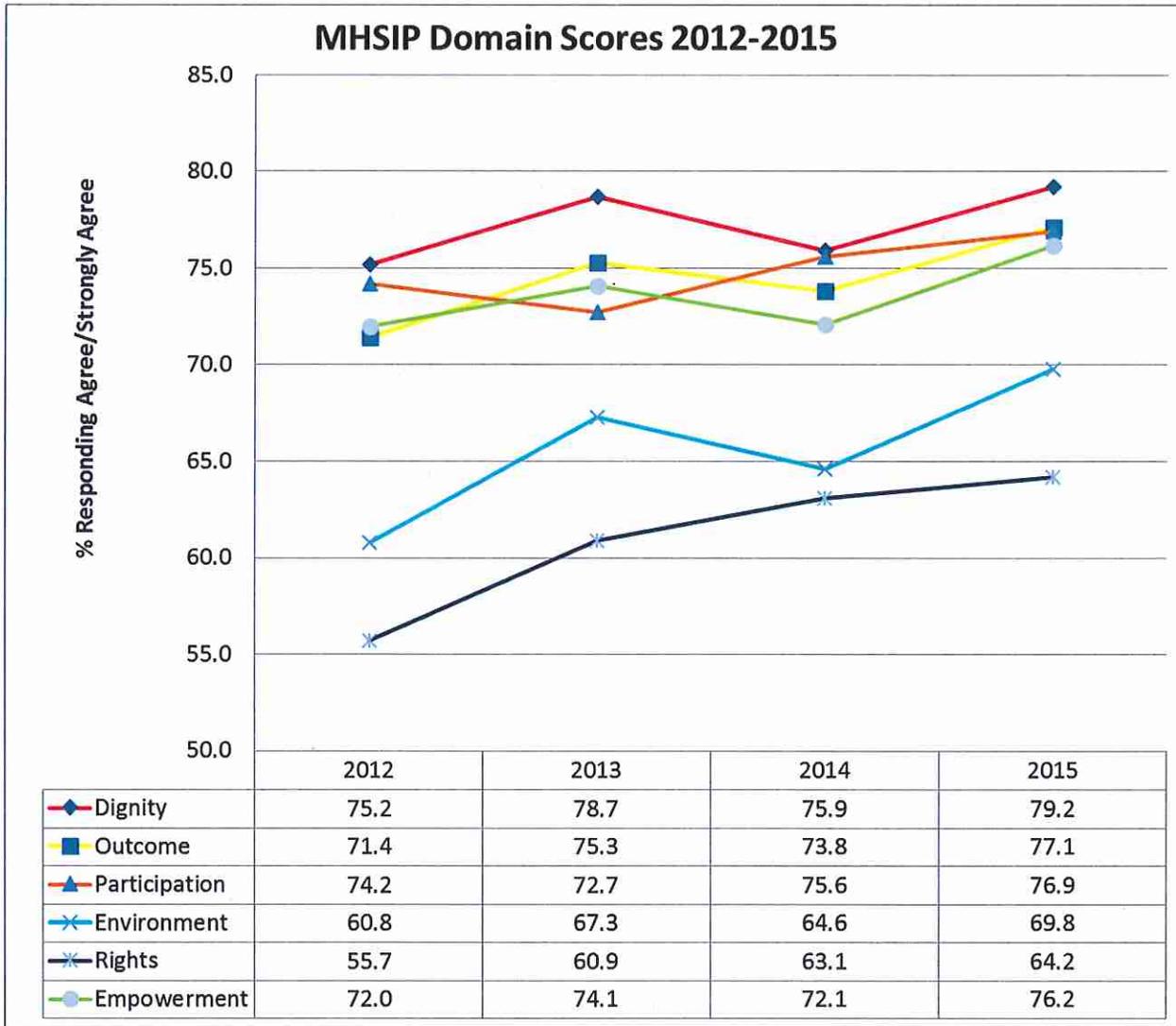
Table 1. Inpatient MHSIP Consumer Survey - Response Rate by Unit						
Unit	2013		2014		2015 YTD	
	Completed Surveys	Response Rate	Completed Surveys	Response Rate	Completed Surveys	Response Rate
43A - ITU	141	35.3	48	19.6	58	27.5
43B - ATU	246	43.0	143	29.7	271	79.7
43C - WTU	100	21.1	94	25.7	84	43.8
Total	487	33.7	285	26.1	413	55.6

Acute Adult Inpatient Service

Table 2 presents Acute Adult Inpatient Service’s consumer positive (agree/strongly agree) responses for 2012 – 2015 YTD. In 2015, the results revealed “Good” response rates for 5 of the 6 domains: 79% for Dignity, 77% for Outcome, 77% for Participation, 76% for Empowerment, and 70% for Environment. Relatively low response rates were obtained for patient Rights 64%.

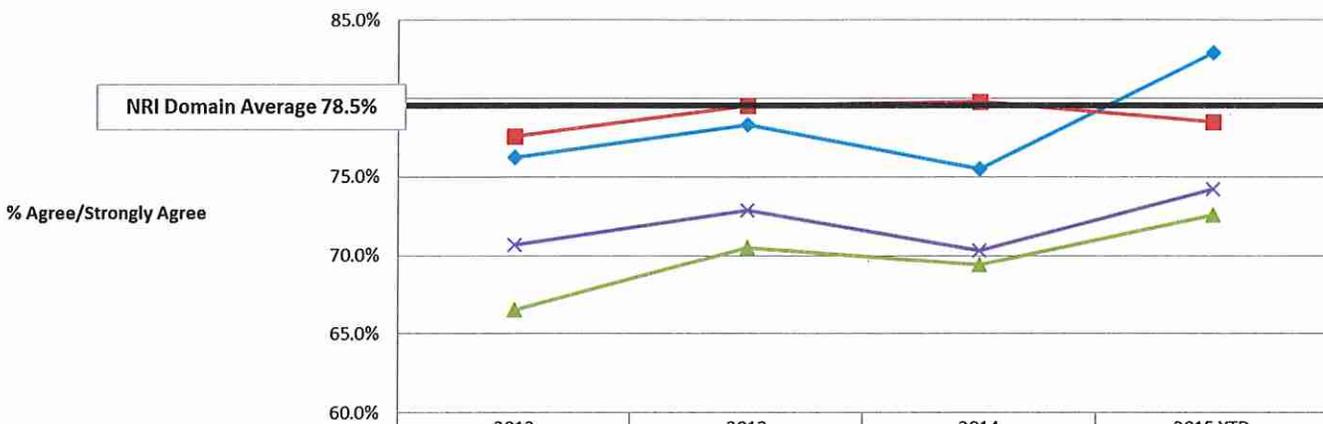
Table 2. Inpatient MHSIP Consumer Survey - All Units				
Domains	Agree/Strongly Agree Response %			
	2012	2013	2014	2015 YTD
Dignity	75.2%	78.7%	75.9%	79.2%
Outcome	71.4%	75.3%	73.8%	77.1%
Participation	74.2%	72.7%	75.6%	76.9%
Environment	60.8%	67.3%	64.6%	69.8%
Rights	55.7%	60.9%	63.1%	64.2%
Empowerment	72.0%	74.1%	72.1%	76.2%
Additional Questions				
My family and/or friends were able to visit me.	81.8%	79.0%	78.8%	78.7%
The Medications I am taking help me control my symptoms that used to bother me.	72.3%	73.2%	74.8%	77.2%
My other medical conditions were treated.	65.8%	72.4%	66.3%	68.1%
Staff were sensitive to my cultural background.	64.2%	61.9%	63.8%	68.7%
I felt this hospital stay was necessary.	66.7%	66.0%	68.4%	67.6%
I was given information about how to manage my medication side effects.	64.8%	64.7%	63.3%	71.9%
If I had a choice of hospitals, I would still choose this one.	58.1%	60.3%	55.3%	63.2%
Surveys Completed	484	487	285	413

The following graph presents Acute Adult Inpatient Service's 2012-2015 positive (agree/strongly agree) Domain scores.



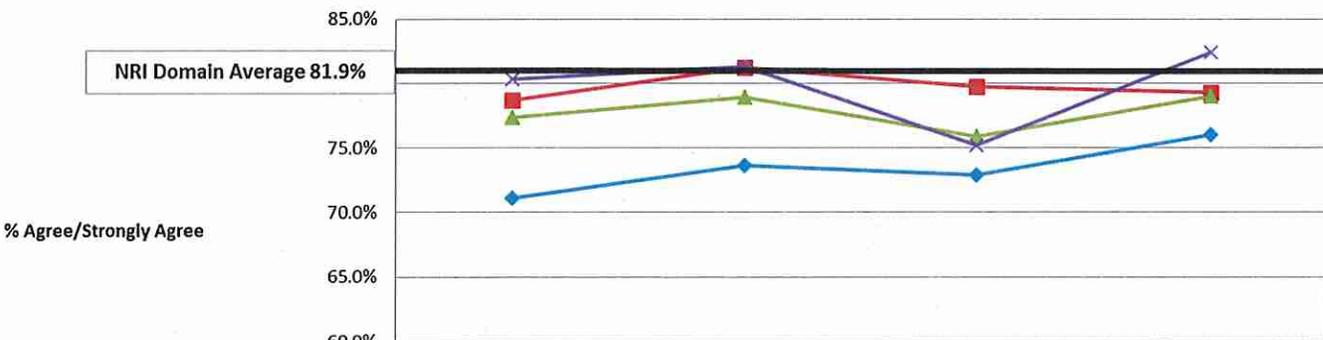
The following graphs present Acute Adult Inpatient Service's 2010-2014 positive (agree/strongly agree) survey item scores and NRI's domain average.

2010 - 2015 MHSIP Survey - Outcomes Domain



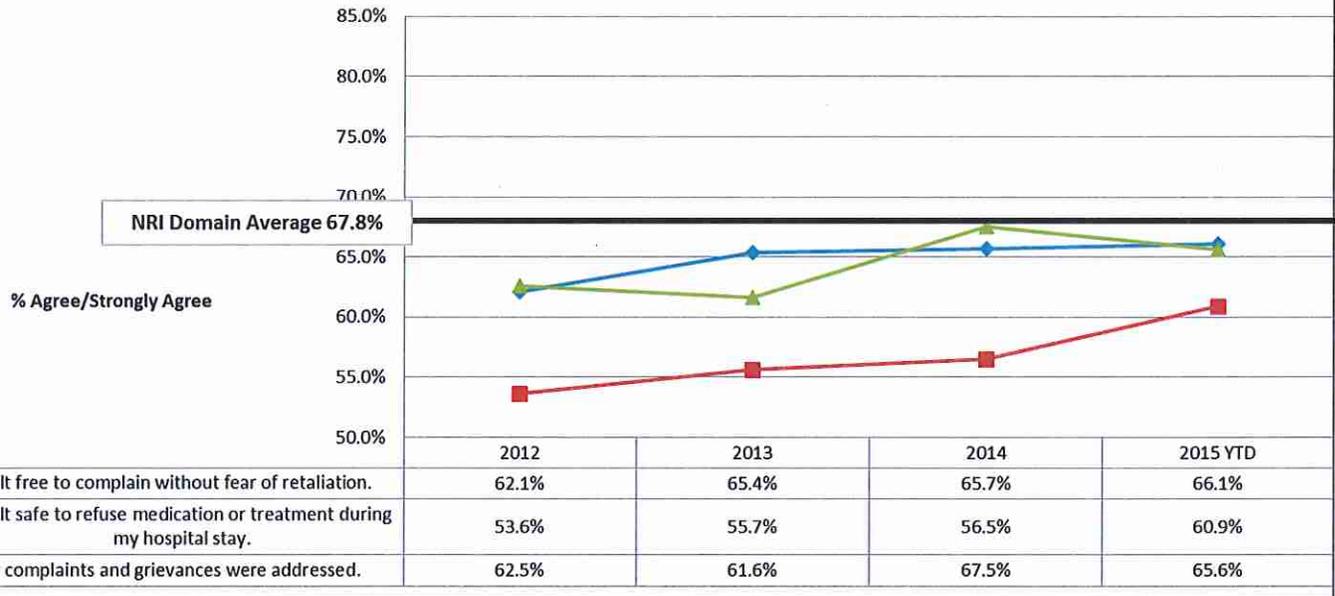
	2012	2013	2014	2015 YTD
I am better able to deal with crisis.	76.2%	78.3%	75.5%	82.9%
My symptoms are not bothering me as much.	77.6%	79.5%	79.8%	78.5%
I do better in social situations.	66.5%	70.5%	69.4%	72.6%
I deal more effectively with daily problems.	70.7%	72.9%	70.3%	74.2%

2010 - 2015 MHSIP Survey - Dignity Domain

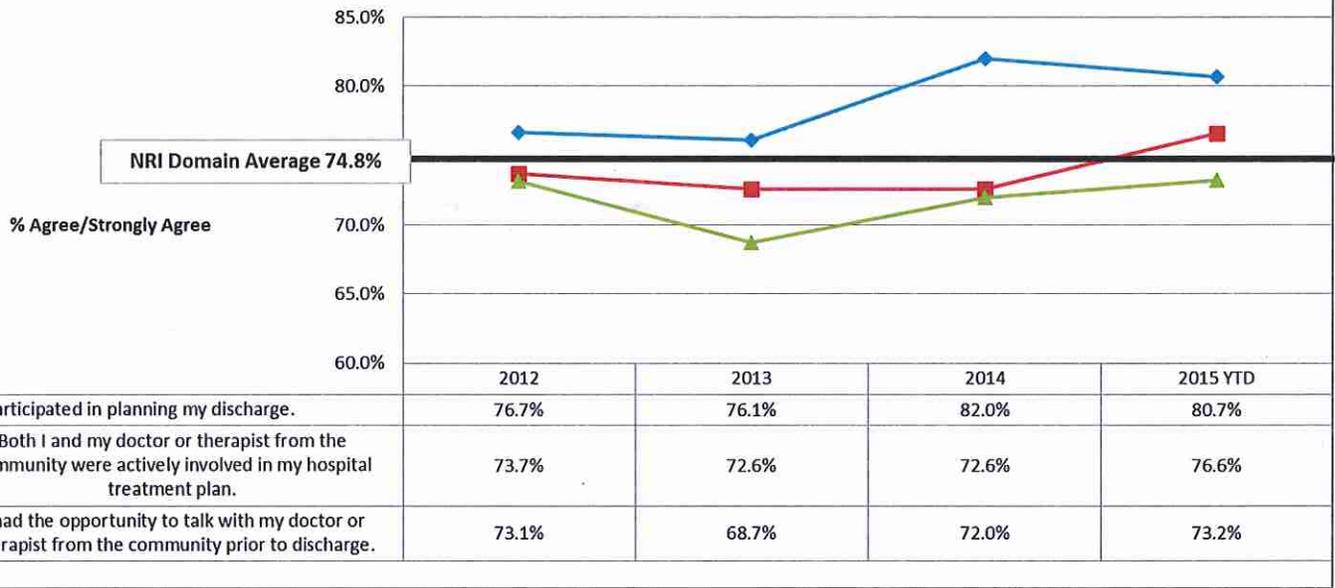


	2012	2013	2014	2015 YTD
I was treated with dignity and respect.	71.1%	73.7%	72.9%	76.0%
Staff here believe that I can grow, change and recover.	78.7%	81.2%	79.7%	79.3%
I felt comfortable asking questions about my treatment and medications.	77.4%	78.9%	75.9%	79.0%
I was encouraged to use self-help/support groups.	80.3%	81.3%	75.2%	82.4%

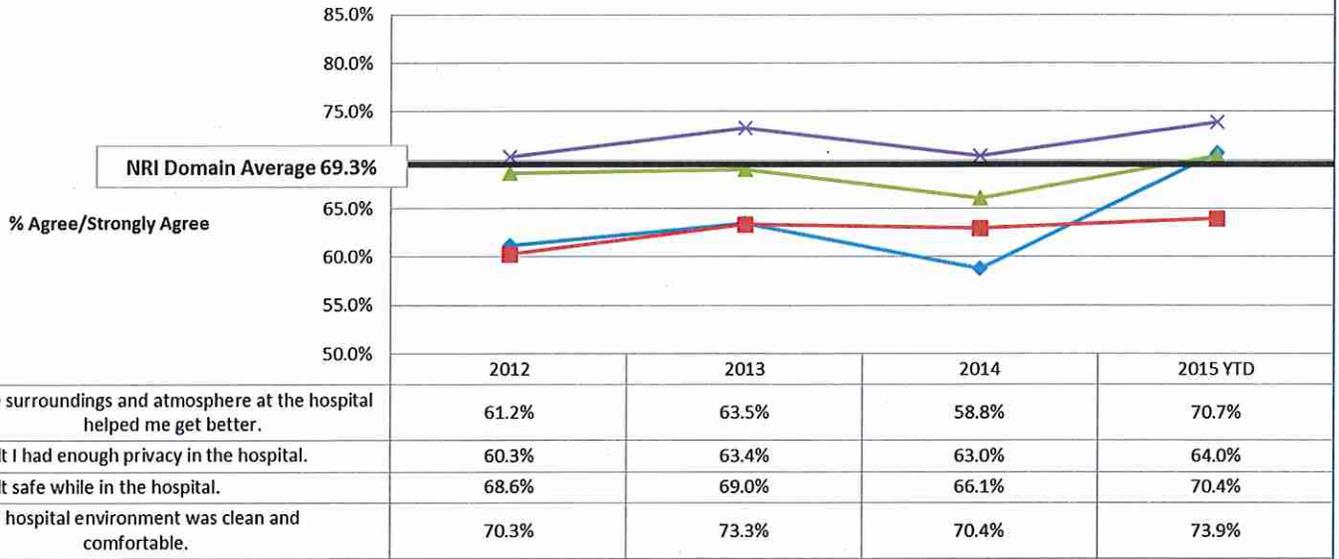
2010 - 2015 MHSIP Survey - Rights Domain



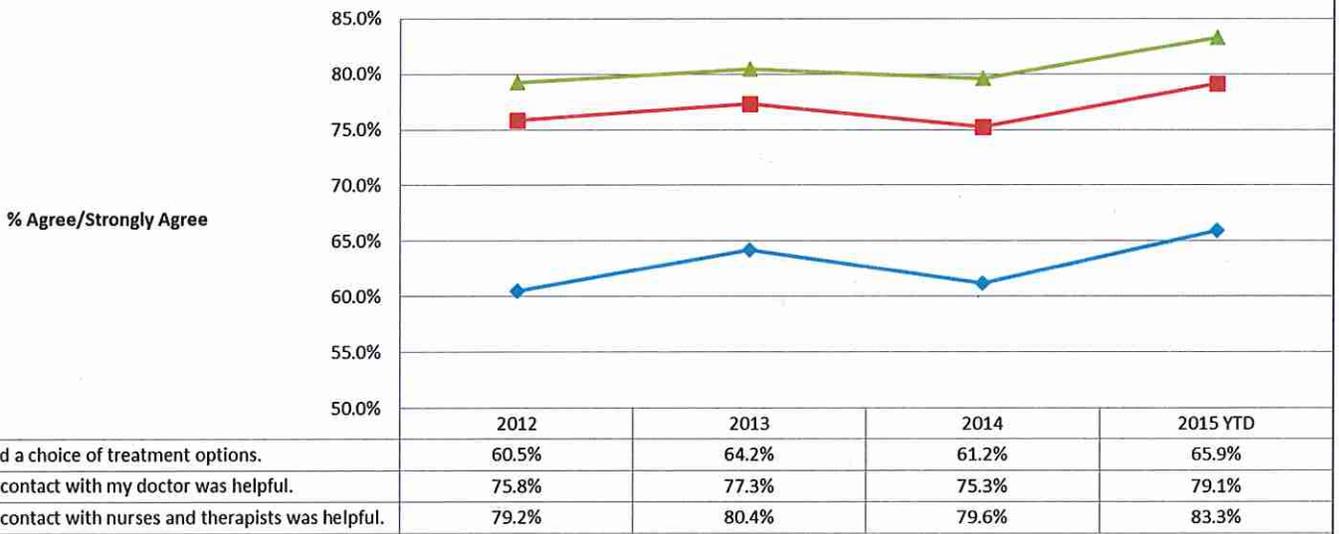
2010 - 2015 MHSIP Survey - Participation Domain



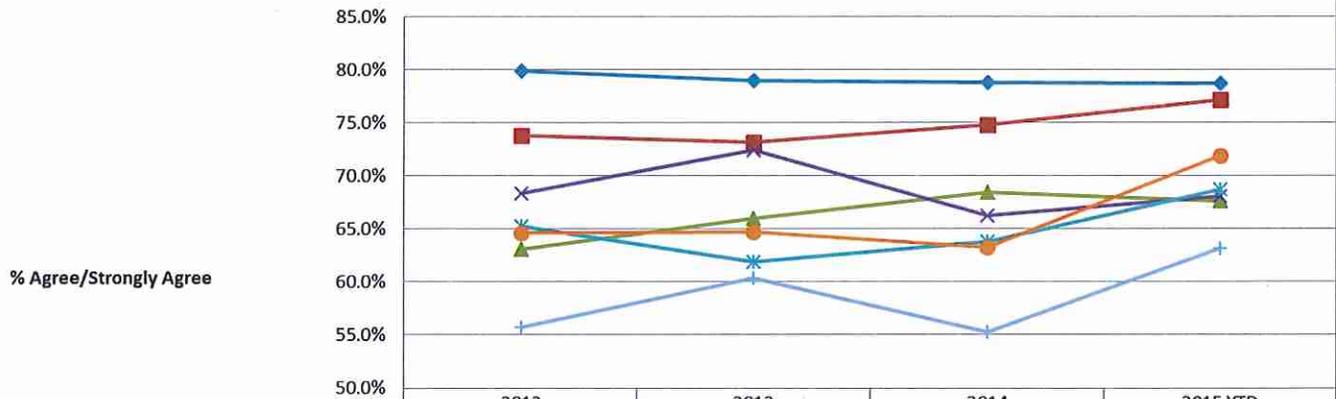
2010 - 2015 MHSIP Survey - Environment Domain



2010 - 2015 MHSIP Survey - Empowerment Domain



2010 - 2015 MHSIP Survey - Other Items



	2012	2013	2014	2015 YTD
◆ My family and/or friends were able to visit me.	79.9%	79.0%	78.8%	78.7%
■ The medications I am taking help me control symptoms that used to bother me.	73.8%	73.2%	74.8%	77.2%
▲ I felt this hospital stay was necessary.	63.1%	66.0%	68.4%	67.6%
✕ My other medical conditions were treated.	68.4%	72.4%	66.3%	68.1%
✱ Staff were sensitive to my cultural background.	65.3%	61.9%	63.8%	68.7%
● I was given information about how to manage my medication side effects.	64.6%	64.7%	63.3%	71.9%
⊕ If I had a choice of hospitals, I would still choose this one.	55.7%	60.3%	55.3%	63.2%

The NRI published national public rates from approximately 70 state inpatient psychiatric facilities that include MHSIP data as part of its Behavioral Healthcare Performance Measurement System. Due to possible differences in organizational and patient population characteristics, these aggregate data may not appropriately compare to BHD data.

Table 3. BHD Inpatient MHSIP Agree/Strongly Agree Domain Response Scores Comparison to NRI National Average

Domains	National Average	2015 BHD	BHD/National Avg Variance
Dignity	81.9%	79.2%	-2.7%
Outcome	78.5%	77.1%	-1.4%
Participation	74.8%	76.9%	2.1%
Environment	69.3%	69.8%	0.5%
Rights	67.8%	64.2%	-3.6%
Empowerment	Not Reported	76.2%	-

Table 4 presents 2015 survey results for domain and additional items by each Acute Adult Inpatient Unit. The following summarizes these comparisons and should be interpreted as a *general* measure of a unit's performance based on consumers' perceptions of their inpatient stay:

Table 4. 2015 YTD Inpatient MHSIP Consumer Survey - By Unit			
Domains	Agree/Strongly Agree Response		
	43A	43B	43C
Dignity	76.9%	80.0%	78.0%
Outcome	81.2%	74.8%	81.7%
Participation	75.0%	77.4%	76.6%
Environment	77.1%	68.1%	69.7%
Rights	69.6%	62.9%	64.6%
Empowerment	79.3%	75.0%	78.1%
Additional Questions			
My family and/or friends were able to visit me.	84.6%	74.8%	87.5%
The Medications I am taking help me control my symptoms that used to bother me.	83.9%	74.8%	80.2%
My other medical conditions were treated.	71.4%	68.6%	64.6%
Staff were sensitive to my cultural background	71.7%	66.9%	72.2%
I felt this hospital stay was necessary	70.2%	64.4%	76.3%
I was given information about how to manage my medication side effects	69.1%	74.0%	67.1%
If I had a choice of hospitals, I would still choose this one.	82.1%	61.4%	54.7%
Surveys Completed	58	271	84

Appendix

The comments below were written on surveys administered in 2015.

43A - Positive Comments

1. Even though my stay was involuntary I felt it helped me to adjust back to the community.
2. I really enjoyed the compassion of the medical staff. Security was top-notch and humble at the same time. The medicine, along with the good - prepared food, helped me cope during these trying times.
3. My stay on the unit 43A was helpful to me at this time in my life, sharp and focused for when I return to the public outside facility. Thanks for all of your help!
4. Good services
5. I want to personally thank the hospital and all workers who assisted me in my recovery. I love this hospital and the work they do even the security guards.

43A - Negative Comments

1. The doctors do not treat the patients in a respectful manner.

43B - Positive Comments

1. Dr. Singh and Dr. Holcom were very nice to me and the stay was short. And I appreciated everything they have done for me.
2. Excellent care, thank you deeply.
3. Great place to be for help!
4. Thank you deeply, love u all forever
5. Thank you!
6. The only concern when I was here better communication from the nurses I felt sometimes the staff was not treated fairly.
7. This hospital has what's necessary to achieve goal but an upgrade in food, community events and freedom will make it heaven!!
8. This place was helpful in my treatment plan and future.
9. During this stay I was treated for the most part with respect. The peer support specialist was of the utmost kindness thoughtfulness and respect. Doctors were respectful.
10. Everybody was great. Thanks so much for helping me out. Everybody so did.
11. Good stay
12. I appreciate everything that has been done to help me while I was here. I appreciate all the encouragement and musical encouragement in every way necessary.
13. Everybody was great thank so much for helping me out.
14. It was good.
15. Thank you for the help I needed during my stay.

43B - Negative Comments

1. Food here is horrible. Staff here needs to be nice and better available to others. Hospital is always cold my stay here has been very unwelcomed. Patient here some are very dangerous to others security needs to be on call more often.
2. Maintenance and cleaning not kept up on. CNA staff do not help meet my dietary needs - nurse often doesn't come out to talk with me regarding my requests, or tells me I must have family bring items that kitchen would have.
3. Most nurses were rude until they found out that I know and have a good relationship with their boss Katie. Food was garbage/ate rarely during my stay.
4. Some of the staff was disrespectful, while others were respectful. I felt forced to take the PM Meds. I felt if I didn't take the meds I'd be held here longer than if did.
5. The nurses should be nicer helpful and do more where able instead of saying see your own nurse.

43C - Positive Comments

1. I love Dr. Burroughs so much.
2. Todd is a great OT teacher
3. I feel this stay was very helpful to get myself stabilize on my meds. 3 thumbs up to mental health staff.
4. I felt that the doctors and nurses did a good job and although at time they were a little tough on us, I feel that was very necessary in order to keep the patients safe. I appreciate all the help they gave me. I am so happy to have had such a wonderful staff here that really care about their patients. Love and god bless, miss Jane will miss you all!
5. Ms. Karen was the best. Mr. Todd was fun. Ms. Michelle was wonderful. Food of choice would be nice or being able to buy snacks.
6. The staff here are helpful and hardworking. I didn't initially want to be here but I am grateful for this stay and believe it changed me for the better.
7. Thanks for everything. Fix all dietary issues - organic, gluten-free, high protein, etc.

43C - Negative Comments

1. Some of the C.N.A.'s rude...however I understand the amount of stress they are under. At certain times, depending upon the other patients I have at time not felt safe. Some of the behaviors were so severe and erratic. My social workers Christina went above and beyond in helping me also. I felt it was a miracle in how they helped me get better and I also think I have been hooked up to some very good community resources. I am not happy with daily programming. On the wall is listed all of these therapeutic programming that is supposed to be happening and most of it was not. (with the exception of Michele the music therapist and Joanne who did OT). Over the weekends we would have one OT session on Sat. and one on Sunday and that was all. I was referred to day hospital and that treatment was/is top-notch. Thank you for saving my life.
2. The food was horrible, didn't eat anything the entire time here.
3. Somewhat disappointed with MD's and medication prescribed.

CAIS Youth Survey

Mid-Year Report

2015

The CAIS Youth Survey collects demographic data about the age, gender, and race/ethnicity of respondents in addition to obtaining their opinions about the services received during the inpatient stay. In completing the youth survey, respondents indicate their level of agreement / disagreement with statements utilizing a 5-point scale: strongly agree- agree- neutral- disagree- strongly disagree. The CAIS Youth Survey contains 21 items measuring five aspects of the mental health services provided in the program:

- Access to Services
- Appropriateness of Treatment
- Participation in Treatment
- Cultural Sensitivity/ Respectful Treatment
- Outcomes

Prepared By:
Quality
Improvement
Department

Created 9/16/15

Method

Youth served in CAIS were requested to participate in the CAIS Youth Survey prior to discharge. Staff administering the survey explained that the Milwaukee County Behavioral Health Division values their input in the evaluation of the CAIS program, and would use the information to help improve the program. The patients filled out the surveys understanding that it was voluntary, confidential and anonymous. Additionally, staff determined whether assistance was needed to complete the survey (e.g. reading comprehension, following instructions, etc.). Assistance was provided as necessary, while maintaining the confidentiality of the responses.

Results

Responses were obtained from 395 of the 591 youth discharged from CAIS, yielding BHD's highest response rate ever **66.8%**.

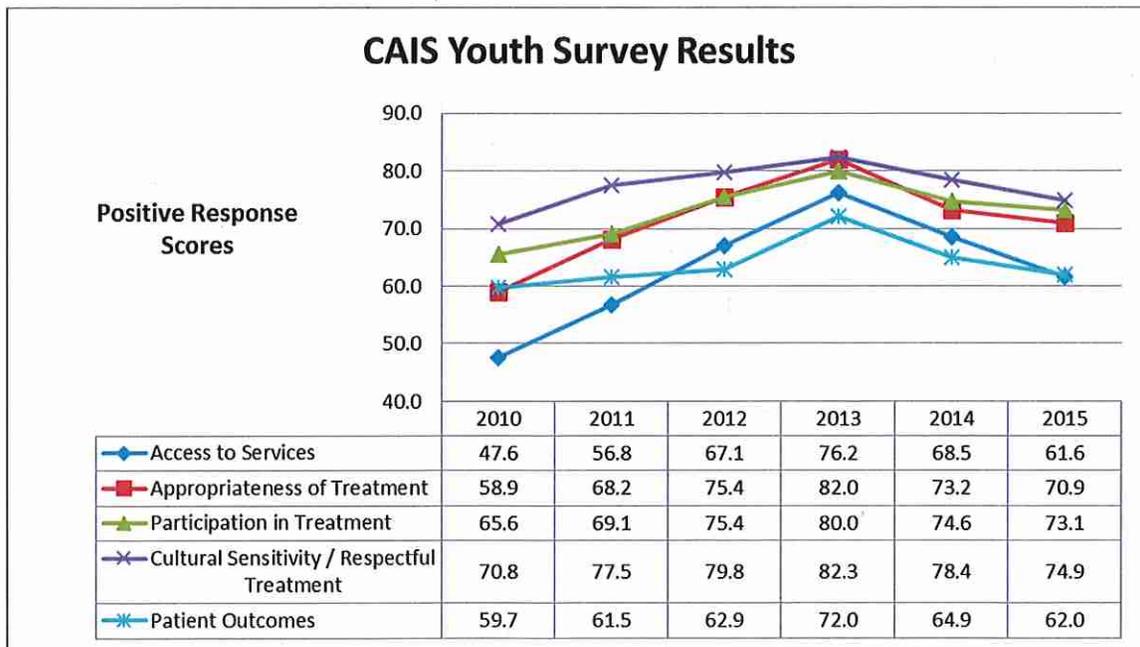
The survey results for 2015 revealed a decline in all five domain categories when compared to the 2014 results.

Demographics

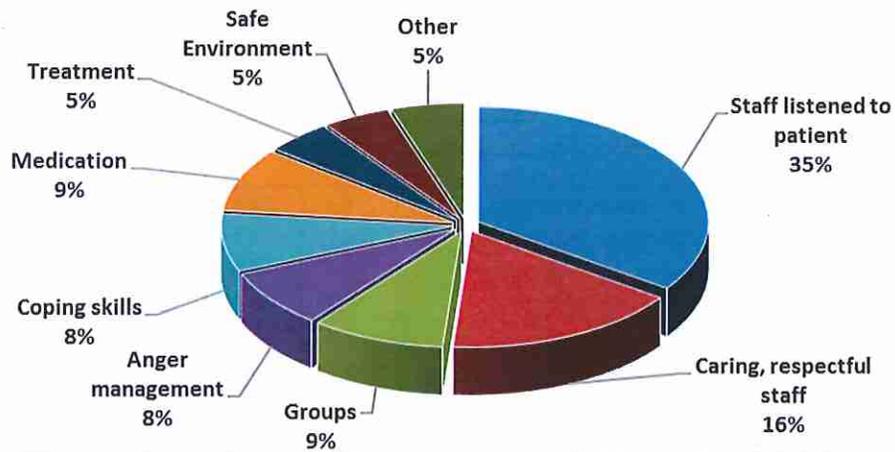
Of the 395 respondents, 38% were male and 62% were female. Their average age was 14.3 years. The ethnicity of respondents was 47% African American, 40% Caucasian, 6% Hispanic/Latino, 3% Asian, and 3% American Indian.

Table 1. 2012-2015 CAIS Youth Survey - Positive Response Rate Summary

Survey Item	2012	2013	2014	2015	2014/2015
	N = 261	N = 112	N = 327	N = 395	Variance
The location of services was convenient	62.8	73.4	62.0	58.1	-3.9
Services were available at times that were convenient for me	71.3	78.9	75.0	65.0	-10.0
Total Access to Services	67.1	76.2	68.5	61.6	-7.0
Overall, I am satisfied with the services I received	74.3	80.4	72.8	71.6	-1.2
The people helping me stuck with me no matter what	74.2	84.8	75.5	71.3	-4.2
I felt I had someone to talk to when I was troubled	76.8	80.4	74.9	71.3	-3.6
I received the services that were right for me	76.2	83.8	72.6	71.3	-1.3
I got the help I wanted	76.4	82.9	71.0	69.5	-1.5
I got as much help as I needed	74.2	79.8	72.6	70.6	-2.0
Total Appropriateness of Treatment	75.4	82.0	73.2	70.9	-2.3
I helped to choose my services	68.5	70.3	64.6	64.2	-0.4
I helped to choose my treatment goals	81.3	87.5	79.8	76.5	-3.3
I participated in my own treatment	76.4	82.1	79.4	78.7	-0.7
Total Participation in Treatment	75.4	80.0	74.6	73.1	-1.5
Staff treated me with respect	84.7	85.7	73.6	71.1	-2.5
Staff respected my family's religious/spiritual beliefs	76.4	75.9	78.5	77.7	-0.8
Staff spoke with me in a way that I understood	82.7	85.6	84.4	80.6	-3.8
Staff were sensitive to my cultural/ethnic background	75.2	82.0	77.0	70.2	-6.8
Total Cultural Sensitivity / Respectful Treatment	79.8	82.3	78.4	74.9	-3.5
As a result of the services I received:					
I am better at handling daily life	65.9	78.4	69.6	67.0	-2.6
I get along better with family members	60.2	69.4	57.1	59.3	2.2
I get along better with friends and other people	73.0	78.0	75.7	68.5	-7.2
I am doing better in school and/or work	54.8	62.7	59.4	55.0	-4.4
I am better able to cope when things go wrong	66.8	74.5	69.1	61.4	-7.7
I am satisfied with my family life right now	56.4	69.1	58.6	60.7	2.1
Total Outcomes	62.9	72.0	64.9	62.0	-2.9



Comments regarding "Most Helpful Things you Received During Your Stay" n=236



Category	Comments "Most Helpful Things You Received During Your Stay"
Anger Management	Anger management
	Anger management talks.
	Controlling my anger.
	Help with my anger.
	Helped with my anger.
	Helping and teaching me to stay calm.
	How to keep calm.
	How to not get mad and flip out.
	I learned to better control my anger.
	My anger and how to cope with it.
	My anger (x2).
	They help me a little to control my anger.
	They help me to calm myself down.
	They help me when I get mad.
	They help me with my anger and they gave me way to control it.
	They helped me with my anger and I learned stuff in school.
To control my anger.	
Working on my anger.	
Caring, Respectful Staff	All the staff I needed.
	As much help as I can get.
	Being respected by staff and kids and got back on my meds.
	Friendly staff and medication.
	Friends helping with my issues.
	Having to meet nice staff and got meds.
	Help from my favorite Jessica.
	Help from nurse.
	Help that's needed.
	How they treated me with respect.
	I got help.
Jessica and Jasmin most wonderful help! Sense of humor!	

Caring, Respectful Staff	Learning how to deal with stress and not to worry to much.
	Nurses, drawing and sleep.
	People giving me respect.
	Respect.
	Seeing the doctors and getting the help I needed.
	Some nice people.
	That people understood my problems and helped me with it.
	That whenever something is wrong they treated me with the help I needed.
	The attention.
	The CNAs (x2)
	The constant checking on me by the doctors.
	The kindness and calmness of the overall stay.
	The nice staff.
	The nurses and workers.
	The people I met.
	The people trying to help me.
	The people who I could relate to and cheer up.
	The people.
	The respect of the staff
	The respect that the staff gave me.
	The staff were great and understanding.
	The staff were helpful.
	The staff.
The support. Workers were nice and understanding.	
They was there for me.	
Well, I had to participate so I did and everyone treated me with respect and I liked it.	
Coping	Being helped with all of my problems and working through coping skills.
	Coming up with ideas to cope.
	Coping skills learning.
	Coping skills (x3)
	Coping with stress.
	Help with coping.
	How to cope with others.
	I learned how to get along with family better.
	I learned that doing art is a great way for me to cope.
	I was able to cope with my emotions.
	That I could stay calm when things happen.
	The most helpful things to me were breathing techniques, walking away, and also learning to ignore people who are a nuisance.

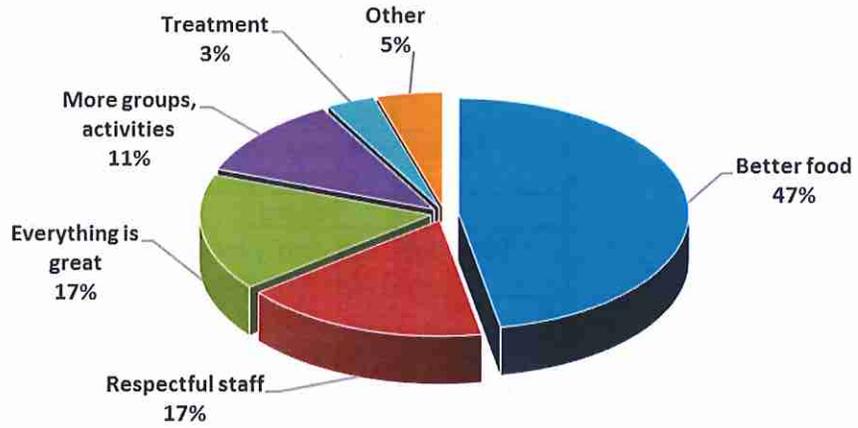
Coping	The relaxation.
	They help me stay calm.
	They helped me with the problems I had with other people here.
	Using coping skills.
	When nurse Gabriel taught me ways to deal with things.
Groups	Art and someone to talk to.
	Art class, music class.
	Art therapy
	Art therapy / someone to talk to.
	Being able to express myself in a artistic manner.
	Going to music group.
	Going to the groups and being able to cope with staff and peers.
	Group therapy.
	Groups
	I learned that I can use art as a tool.
	Music therapy and being social.
	O.T. (x2)
	O.T. group and snack time.
	O.T. therapy and the people who talk to me.
	OT and talking to my friends.
	OT Group was really fun.
	School / OT / Mr. Gabe RN.
	The group activities.
	The group treat we went to.
	Therapy and o.t. group.
When I got to go to OT I was expressing some feelings and what was going on.	
Medication	Being calm.
	Change in meds.
	Getting meds.
	Help with my meds.
	I got onto medication.
	Medications
	Medicine
	Medicine and other children that go through similar problems.
	Medicine change (x2)
	My meds.
	Receiving new medication.
	Taking medicine
	The change with my medicine.
	The doctor changing my meds that was very helpful.
	The fix of medication.
	The medication help me improve and I got a lot of help.
	The medicine to help me at night and talking to other people who understood me a little.
The medicine.	

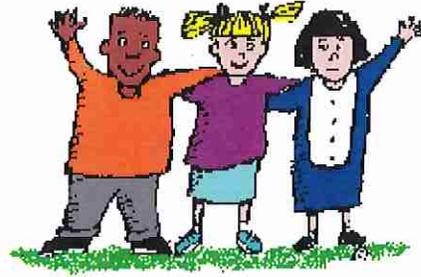
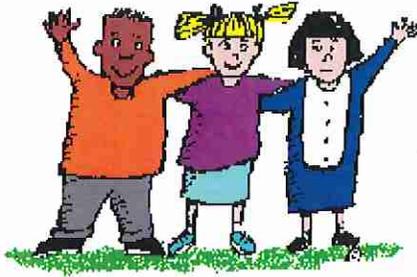
Medication	The most helpful thing to me was the new medicines because it calmed me down and makes me think before I do something.
	The pills were a little helpful and they work...school helps me to...but I need to go.
Other	I've learned a lot thank you.
	Food and water
	Food.
	Hearing stories of other kids and being more grateful.
	How to relate with my parents.
	I feel better now.
	I learned that everybody needs help.
	Snacks.
	That I have a bright future a head of me.
	That there's more thing in life to live for.
	The most helpful thing were the... The food and the music therapy
	When I got some more food.
Safe environment	Being able to think and be relaxed to think about everything.
	Being away from home.
	Getting a break from the outside to teach me something.
	Help me being safe and respect to others.
	Rest.
	Sleep (x3)
	Staying safe.
	That I will be watched and helped whenever I needed anything.
The beds were comfortable.	
Staff listed to patient	A lot of talking.
	Advice from staff and doctors.
	Being able to talk my problems out and not having the staff or anyone judge me.
	Being able to talk to people who actually listen to me.
	Being able to talk to someone and open up about my issues/stressors.
	Being social and sharing my troubles with people that understand.
	By talking to me and not to do wrong
	Getting the chance to talk to many people.
	Getting to know others.
	Getting to talk to someone.
	Having my doctors to talk to.
	Having people to talk to all of the time instead of feeling alone and isolated.
	Having someone to talk to and respected me-Pat and others.
	Having someone to talk to.
	Having someone to talk to.
I can talk to people.	

Staff listed to patient	I got to talk about my problems and I got along with everybody even with the kids.
	I got to talk to people.
	I got to talk to some people when helped.
	I had someone to talk to.
	I had staff and kids to talk to.
	I received a lot of help people talked to me and helped me when I needed it.
	I received good advices.
	I received good talks from staff/residents during my stay.
	I received positive communication from staff and peers.
	I talked to the staff about my situation and they told me things that I would never forget.
	I was able to finally talk about my feelings and learn how to start coping with them.
	I was able to talk things out.
	Insight and good pep talks.
	It helped me open up more and not isolating.
	Jessica and Terry and Matthew taking time to listen.
	My ability to converse freely with my one on one.
	My mom being there and me opening up.
	People to talk to really helped me relax and think about what happened.
	People to talk to. (x3)
	People who actually listened and gave me advice.
	People who understood me.
	Someone to talk to and they listened.
	Someone to talk to.
	Someone to vent to.
	Staff talking and understand.
	Staff talking to me and respecting me.
	Support, help, good service, good staff and people to talk to.
	Talk.
	Talked to people about my problems.
	Talking things over.
	Talking to doctors and social workers.
	Talking to me nicely.
	Talking to my doctors and making sure I was okay.
Talking to people.	
Talking to someone.	
Talking to staff and doctors and o.t and school and music.	
Talking to staff and drawing and talking to others.	
Talking to the doctors and nurses.	

Staff listed to patient	Talking to the doctors and social workers and receiving medication.
	Talking to the doctors/social workers.
	Talking to the pastor.
	Talking with nurse Gabe.
	Talking with staff about my problems, keeping my mind off of stuff during the day.
	Talking with staff.
	Talking with the doctor about my problems.
	Talking.
	Talks with staff, family members and wraparound team.
	Talks.
	That I always had somebody to talk to.
	That I knew the staff really cared and whenever I needed to talk they would be there.
	That they talked to me and opened up.
	The doctors and OT group and talking to people that understand what I was talking about.
	The fact that I had other people to talk to.
	The most helpful things here in this program is that I got to communicate with people.
	The most helpful things I received were talking with my team of nurses, social workers and doctors.
	The staff talking to me, and helping me get anger over
	The talks people had with me.
	They talked to me and changed my medicine.
	They tried talking to me about things and help me out.
	They understand things that am going through.
	They were there when I needed to talk (staff).
	To have someone to talk to.
Well one thing that was helpful for me was I had one nurse that could really talk to.	
When I need someone to talk to.	
Treatment	Connections with therapy and social workers.
	Getting a better control with my anxiety.
	Knowing I'm getting help with therapy.
	The help is needed and actual therapy.
	Treatment. (x4)
	Therapy. I think it get to the root of how I was feeling.
	They had the best treatment to me they helped me throughout my entire visit.
They help me in a good way.	

Comments regarding "What would improve the program here" n=238





CAIS YOUTH SURVEY

Please help CAIS be a better program by answering the following questions. Your answers are confidential.
 Directions: Put a cross (X) in the box that best describes your answer. Thank you!

Today's Date: ____ / ____ / ____

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. Overall, I am satisfied with the services I received.					
2. I helped to choose my services.					
3. I helped to choose my treatment goals.					
4. The people helping me stuck with me no matter what.					
5. I felt I had someone to talk to when I was troubled.					
6. I participated in my own treatment.					
7. I received services that were right for me.					
8. The location of CAIS was convenient.					
9. Services were available at convenient times for me.					
10. I got the help I wanted.					
11. I got as much help as I needed.					
12. Staff treated me with respect.					
13. Staff respected my family's religious/spiritual beliefs.					
14. Staff spoke with me in a way that I understood.					
15. Staff were sensitive to my cultural/ethnic background.					
As a result of the CAIS program:	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
16. I am better at handling daily life.					
17. I get along better with family members.					
18. I get along better with friends and other people.					
19. I am doing better in school and/or work.					

20. I am better able to cope when things go wrong.					
21. I am satisfied with my family life right now.					

22. What were the most helpful things you received during your stay in the program? _____

23. What would improve the program here? _____

24. Other comments: _____

Please answer the following questions to let us know a little about you.

Race / Ethnicity (mark with an X the category that applies to you):

- American Indian/Alaskan Native White (Caucasian)
- Black (African American) Asian/Pacific Islander
- Spanish/Hispanic/Latino Other

Age: _____ years old

Gender (mark with X): Male Female



2010-2015 BHD Citations by State of WI Dept of Quality Assurance (DQA)



2010-2015 BHD Citations by State of WI Department of Quality Assurance (DQA)					
Year	BHD Program			Total	%
	Inpatient Services	Rehab Services	Community Services		
2010	92	11	0	103	30.3
2011	11	12	0	23	6.8
2012	10	13	1	24	7.1
2013	97	66	0	163	47.9
2014	6	8	1	15	4.4
2015	0	9	3	12	3.5
Total	216	119	5	340	100.0

Quality Committee Item 3

I. Joint Commission Mock Survey Follow-up

An Executive Summary was prepared by Critical Management Solutions and shared with BHD management. The survey which took place on August 18-19, 2015, was intended to assess compliance with standards and elements that the organization had been identified as being non-compliant with in the 2014 mock survey. The survey summary included a spreadsheet with each standard and element color-coded to indicate current state of compliance as follows:

Green= Complete; Standards compliance has been achieved

Yellow= Making steady progress; on target to be completed

Red= Little or no progress

The summary also included a bulleted list of nine areas where the organization is recognized as having made considerable progress. These areas include:

- Safety of medication ordering in Avatar
- Staff genuinely appear to be better qualified and more confident
- Narcotic inventory control
- Medication temperature monitoring
- Critical Test Reporting
- Nursing assessments
- Nutritional screening process
- Timely initiation of treatment plans
- Medication storage in Day Treatment

Areas identified as requiring continued attention will be addressed as described in the sections below.

II. Assessment

The consultants have assured that "should BHD fully resolve all of the issues identified" in the report "and sustain that performance, the likelihood of the organization meeting the criteria for Joint Commission accreditation is quite high."¹

III. Goal

To prepare for survey application to the Joint Commission in December, 2015. All areas addressed in the Mock Survey report must be resolved by 12/01/2015.

IV. Plan of Action

QI has completed a tracking document including the 2014 and 2015 recommendations, assignments actions, and current status reporting columns. The standards and elements have been assigned to an administrative sponsor. The administrative sponsor has high-level and ultimate responsibility for completion of the element and changing the status to green. The sponsor assigns project leads to ensure completion of the work by appropriate staff.

It was also noted that several items had been identified in 2014 but surveyors reported that they did not have an opportunity to re-assess. These elements are also assigned.

¹Critical Management Solutions, Joint Commission Mock Survey Follow-Up Report Milwaukee County Behavioral Health, September 2, 2015, p2.

QI will meet on a weekly or every other week with each sponsor to assess progress, determine roadblocks and update status report.

V. Process Improvement Cycle

Corrective action plans and areas identified for potential improvement will be addressed per the quality improvement program. BHD QI has a systematic quality improvement process which has been reviewed with the QI committee and the entire organization through meetings, presentations and newsletter articles. Recently, Plan-Do-Study-Act (PDSA) and Rapid-cycle improvement concepts were covered and some of the projects will be presented later in this report.

The following performance improvement cycle will be utilized in the development of project and departmental activities:

Plan: Identification of goals; defining an aim statement

Do: Carry out the change; test, collect data

Study: Compare to baseline

Act: What was learned and define next steps- Adopt/Adapt/Abandon

VI. Assessing and Reporting the Process Outcomes

Process improvement cycle results are measured and reported in a systematic and high-level manner at BHD. Collected data is assessed utilizing quality benchmarks and Key Performance Measures (KPMs) from all program areas. KPM targets are set utilizing national benchmarks and internal history and trends. KPMs include utilization, clinical, financial, and satisfaction metrics, to provide a balanced dashboard report. Each process improvement project is implemented with the goal of improving the overall Key Performance Measures which define the care and services provided at BHD.

Quality Committee Item 4

KPM Dashboard Update

Community Access to Recovery Services

October 2015

Identified Issue:

To increase employment (full or part-time competitive) six months after admission into services from 41% to 54% for CARS clients.

CARS has identified continued support and expansion of the Individual Placement and Supports (IPS) employment model as one strategy towards an increase in client employment.

Background:

The Behavioral Health Division Community Access to Recovery Services (CARS) Department recognizes the important role employment and education play in an individual's recovery. As a result, CARS began piloting the integration of the Individual Placement and Supports (IPS) evidence-based model of supported employment into several of its treatment teams starting in 2014. The IPS supported employment model is a well-researched approach that has proven to increase competitive employment rates and successful participation in education programs. The model is driven by a fidelity scale and routinely subject to State fidelity reviews to ensure that participating programs are meeting the standards and expectations outlined within the model.

Analysis:

There are currently three (3) IPS pilots (two within Comprehensive Community Services (CCS) teams and one Community Support Program (CSP) team) in operation with a total of 38 consumers being serviced within IPS. Since August of 2015, The IPS teams have experienced a total of eight employment starts and one consumer enrolled in an education program.

Additionally, fidelity reviews are scheduled for one CCS team and the CSP team in December of 2015. The other CCS team will have a fidelity review at the end of January 2016.

Goal:

The goal will be to expand IPS services in 2016 to double (38 to 76 participants) the number of individuals being served within this model. The expected goal will be to have a minimum of 5-7 clients employed or enrolled in education programs per month.

Action:

CARS Service Manager, Tamara Layne, is coordinating efforts with the State of Wisconsin to schedule IPS trainings in the spring of 2016. This training is needed to prepare for the building of IPS into two additional CCS teams. It is with this expansion into two additional teams that additional clients will be able to be served within the IPS model to achieve full or part-time competitive employment.

COMMUNICATION WORKGROUP

Historical Perspective: A SWOT analysis of the nursing department performed by nursing administration revealed multiple opportunities for improvement in current processes and practices. Similar issues were grouped together and workgroups were formed to address several areas including teamwork, communication, education needs, recruitment and retention and staff scheduling. The focus of this workgroup is that of communication as trends regarding poor communication by and between nursing staff members had been identified. In addition to those concerns noted by nurse managers, customers including providers and vendors have identified the need for improved communication by staff when reporting on patient conditions, answering the telephone and during on unit conversations and meetings. After identifying and prioritizing needs, the workgroup decided to target reporting of patient condition by nurses to physicians and to develop a communication for this purpose.

Aim: To improve overall communication between nursing staff members

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Development of a communication tool based on current communication format expectations (SBAR) to be used by nurses when phoning a physician about a patient's status.	Lauren Hubbard/ Angela Post	August, 2015	All nursing units (including PCS/OBS)

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Initial setup of a standardized format for all workgroups	Linda Oczus	July, 2015	Initial meeting
Formation of small workgroup to establish priorities.	Lauren Hubbard/ Angela Post	July, 2015	Informally
DON presence at first workgroup meeting to guide process, set expectations and administer a communication tool to all team members for cohesion amongst the members	Linda Oczus	July, 2015	Initial meeting

COMMUNICATION WORKGROUP

Review of SWOT analysis findings as it pertained to communication needs	Linda Oczus	July, 2015	Initial meeting
Prioritization of findings to identify initial project	Workgroup	July, 2015	Initial meeting
Illicit feedback from nurses and providers regarding what the tool to be developed should contain	Workgroup	August, 2015	Informally and via email
Draft version of communication form developed and reviewed with nurses/nurse managers/providers for feedback	Workgroup	August, 2015	Informally and via email
Education to staff regarding expectations and use of the form	Nurse managers	September, 2015	Unit meetings
Auditing by nurse managers of use of the form	Nurse managers	September, 2015	On units
Revise form if needed	Workgroup	October, 2015	Workgroup

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
The expected outcome is that this form will be used for all physician communications and that all information regarding the patient's status is communicated during the initial phone conversation rather than multiple phone calls being needed as per past practice (due to nurses not being prepared)	Report by physicians that the nurse was prepared when making the initial call Report forms are turned in to nurse managers for auditing purposes Audits will reveal at least 90% of the form will be completed

COMMUNICATION WORKGROUP

Do

The communication tool was completed and distributed to staff in September, 2015. To date, only one unit is using the form on an inconsistent basis. Nurses cite knowing what information to tell a physician and do not see the need for the tool. Physician's report no change in practice.

Study

The trial of the use of the form began at the end of September and continues to the end of October. Thus far, use has been minimal which is below expected results.

Act

Physicians have been requested to inform the nurse to use the communication tool if they receive a call and the nurse is unprepared with the necessary information. Nurse managers will re-educate the nurses of the need to use the form as a patient safety tool and solicit feedback regarding their lack of desire to use the form.

**Empowering Families Choice
Performance Improvement Project Proposal
Wraparound Milwaukee
2015**

Rationale for Study:

Since Wraparound Milwaukee's inception 20 years ago, the importance of family voice & choice has evolved from family choice to a more defined family driven approach. Comparing the differences, there has been a shift from parent satisfaction to parent empowerment; from family inclusion, to increased capacity to make informed choices; from consideration of the family perspective to the families as primary decision makers (Marshall, 2012).

There is evidence from a family focus group, feedback from the Family/Provider Advisory Committee, responses to a question related to choice on the one month family satisfaction survey and the level of overall usage of the Provider Resource Guide that there is a need to improve families perception and knowledge as the primary decision makers within the Child & Family Team.

In order to increase feelings of empowerment for families earlier in the Wraparound experience which in turn will accelerate the restorative progression, a greater deliberative process of choice has been developed. Therefore, this study addresses both the growth in knowledge and information about service options in the community that results in an increased capacity for families to make informed choices which in turn results in greater feelings of empowerment in directing the renewed health of the child and family.

Study Questions:

1. The provision of enhanced/specific information about the Wraparound Provider Network and the Wraparound *Provider Resource Guide* increases (usage) access of the Resource Guide by families by 100% (from 18 to 36 individuals).
2. Families feel more empowered to make provider choices (increase of 10% over baseline) after accessing the Wraparound Provider Network Resource Guide

Research Design:

For Study Question #1

1. Collect baseline data of usage of the *Provider Resource Guide* online.
2. Redesign the *Provider Resource Guide* so that access is more direct and the descriptive information answers the family's questions about the credentials and characteristics of providers.
3. Raise awareness, Improve knowledge of how to access *Provider Resource Guide* and increase access options.
 - a. Enhanced and more deliberate presentation at family orientation
 - b. Create & distribute a brochure
 - c. Clarification of Care Coordinator role in discussing options and teaching families how to access the Guide.

- d. Develop a Resource Guide Phone App
 - e. Disseminate information through Families United
2. Collect Post- *intervention* usage of Resource Guide.

For Study Question #2

1. Pre-test using a Family Empowerment Survey
2. Access to an enhanced *Provider Resource Guide*, which allow families to assess the characteristics of a provider that are important to them
3. Posttest using a Family Empowerment Survey

Quality Committee Item 5

Quality Education Report/Update

Education and staff development are expanding in a number of ways across the continuum of the Behavioral Health Division. This list provides examples of the types of education currently underway.

New Employees:

- Hiring and Candidate Screening and Selection
- New Employee Orientation and Onboarding

Current Employees:

- Investment in Leadership Development
- Rapid Cycle Quality Improvement Education via Quality Improvement Team
- BHD Bi-Monthly News Letter to Promote Performance Improvement and Shared Success
- Curriculum Development and Training for Administrative Support Team
- Continuing Education by Physicians for Clinical Staff – On-site
- Support External Education Opportunities for Employees
- Annual House-Wide Education and Training for all Employees
 - Based on annual requirements and internal quality data
- Educational Modules are Uploaded into Health Stream for Ease of Access
- Health Information Technology Training
 - Electronic Medical Record and PYXIS System etc.
- Individual and Group Education for Specific Needs – Re-Education
- Education and Certification for MANDT training; Recertification Improvement Indicated

Community Education

- Family and Community Education and Support
- Family Advisory Council

Quality Committee Item 6

Health Information Technology/Audit

- Medical Records Director/Team is auditing the content of Electronic Health Care assessments and re-assessments for patients receiving care. To include:
 - History of behavioral health issue and treatment
 - Current mental status examination
 - History and Physical completion and timeliness
 - Psychosocial assessments
 - Psychiatric evaluation
 - Psychological assessments
 - Timing and Dating
 - Progress Notes
 - Patient Demographics
 - Summary List of medical diagnosis and conditions
 - Concise discharge summaries
 - Verbal Orders

- Physicians are provided a weekly record of feedback

- Medical Records reviews all coding for billing with feedback to physicians

- Utilization Review Nurse Team have initiated open record review for clinical documentation, compliance, and medical necessity with communication to physicians.

- Initiation of Clinical Audits by various subject matter experts

- Recommendations:
 - Implement the Problem List in Avatar
 - Create standard templates for Discharge Summary, Psychiatric Assessment and Progress Notes – and create a widget for ease of review.
 - Review of closed medical record audits to focus on compliance, quality, accuracy and timely completeness of records
 - Robust plan to review community provider network documentation in the EHR - initiation of phase 3

Quality Committe Item 7

Leadership: Role in Safety and Quality

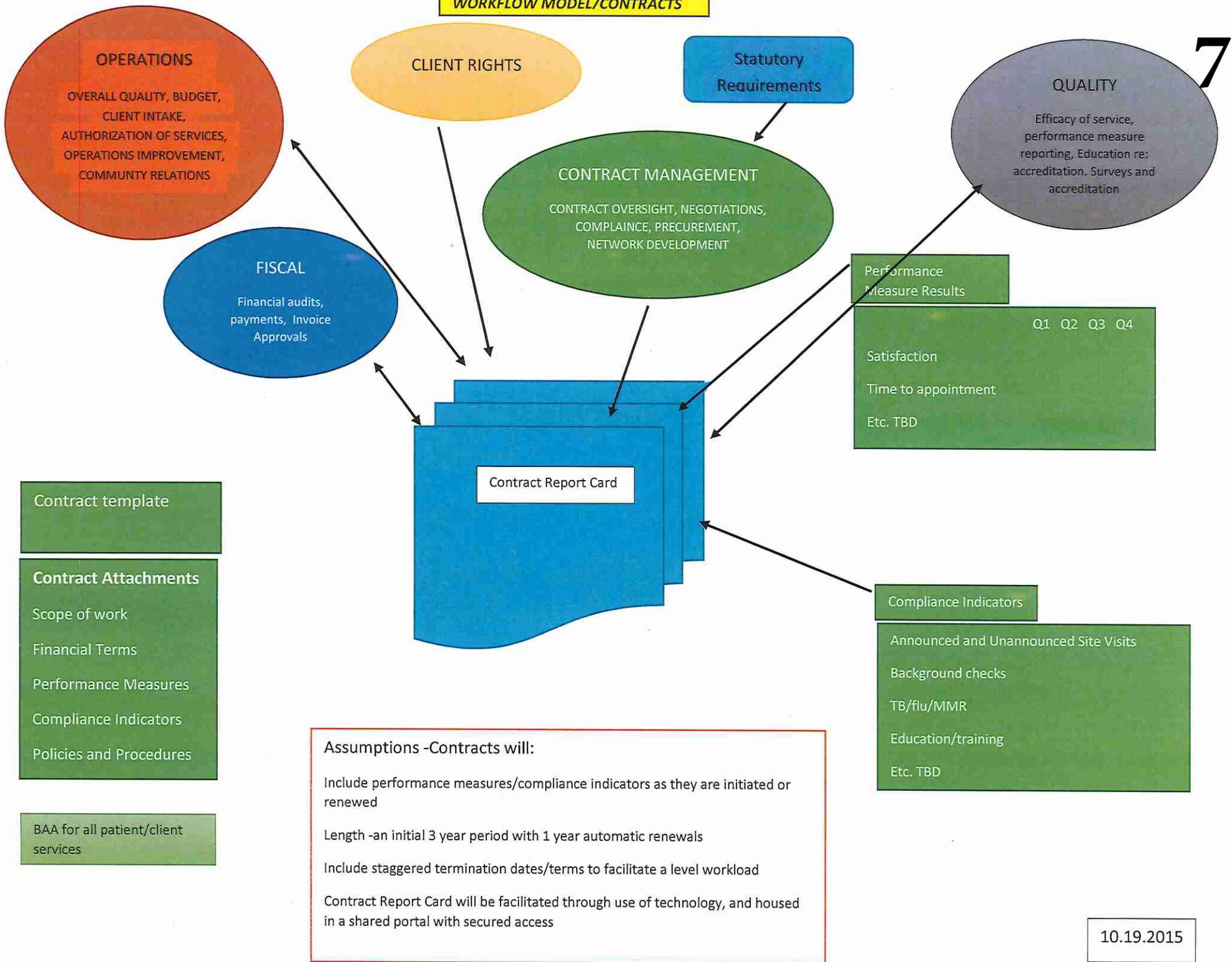
Joint Commission Standards

- The primary responsibility of leaders is to provide for the safety and quality of care, treatment and services.
- The Governing Body, senior managers and leaders of the organized medical staff are to address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment, and services.
- Leaders including the Governing Body are to evaluate how well they both plan and support planning, and how well they manage change and process improvement.
- The organization is to manage conflict between leadership groups to protect the quality and safety of care.
- Leaders are to monitor contracted services by communicating the expectations in writing to the provider of the contracted services.
- Organizational leaders are to provide the Governing Board with written reports of system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.
- Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

➤ Recommendations to Governing Board and Organizational Leaders:

- Develop and implement a conflict of interest and confidentiality policy.
- Develop and implement a conflict resolution process.
- Develop, collect and analyze data to measure contract performance expectations.
- Provide an annual report provided to Governing Board with system or process failures and performance improvement activities.
- Complete an organizational culture of safety survey
- Complete a Governing Board self-assessment

WORKFLOW MODEL/CONTRACTS



COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: December 7, 2015

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 Amy Lorenz, Deputy Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to execute 2016 purchase of service contracts with a value in excess of \$100,000 for the Behavioral Health Division for the provision of adult and child mental health services and substance use disorder services**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least \$100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS to execute mental health and substance use contracts for 2016.

Background

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

Discussion

Adult Mental Health and Alcohol and Other Drug Abuse (AODA) Overview

In 2016, significant focus will be placed on expanding the Comprehensive Community Services (CCS) benefit. It is anticipated that CCS will become the largest most populous level of care within the county as it serves Medicaid beneficiaries who experience either a mental health or substance use disorder. CARS will continue its emphasis on strengthening our welcoming, co-occurring capability and moving the service model to a recovery oriented system of care. Our partnerships with the Bureau of Milwaukee Child Welfare and our court diversion programs are a high priority. Family intactness, early intervention, and engagement will be key areas within our child welfare partnership. In addition, ensuring that Family Drug Treatment Court receives the necessary resources related to recovery, such as housing assistance and evidence based employment approaches that will be coordinated through the Division of Housing and

employment agencies that are using the supported employment model. Pursuing the creation of a preferred provider network of care for Adult Drug Treatment Court and our Mental Health Court pilot will be completed with the goal of improving quality of care and performance outcomes. CARS will continue the partnership on all levels with the Division of Housing. Lastly, CARS will be pursuing a new evidence-based model of care that addresses first episode psychoses for youth, developed in partnership with Wraparound Milwaukee.

Community Based Crisis Services

Community Linkages and Stabilization Program (CLASP)

CLASP provides post-hospitalization extended support and treatment designed to support an individual's recovery, increase ability to function independently in the community, and reduce incidents of emergency room contacts and re-hospitalizations through individual support from Certified Peer Specialists under the supervision of a clinical coordinator. CLASP provides a safe, welcoming, and recovery-oriented environment, and all services are delivered in a person-centered, trauma-informed, culturally competent, and recovery oriented focus of care. We recommend a contract with La Causa, Inc., for \$500,000 to continue providing CLASP services in 2016. This increase of \$95,286 over the 2015 contract amount is a part of new initiative to provide prevention services within the community by providing follow-up with patients within 24 hours of discharge. This will decrease risk of harm to ensure patients connect with and transition to outpatient services.

Access Clinic – South

The Access Clinic is a walk-in, no appointment location for individuals without insurance to be seen by a prescriber and have linkages for mental health outpatient services as necessary. The goals of the Access Clinic are: (1) to provide timely clinical assessments and crisis interventions for individuals experiencing mental illness and co-occurring conditions, including substance use disorders; (2) to employ and adequately train qualified clinicians to ensure appropriate determinations of levels of care, i.e., therapy, medication evaluation, or both; and (3) to make referrals and schedule appointments for consumers to access appropriate health services in the community based on assessed needs and consumer choices. We recommend a contract with La Causa, Inc., not to exceed \$429,194 to continue operating this Access Clinic in 2016.

Crisis Mobile Team

We recommend a \$200,000 contract with La Causa, Inc., to continue for third-shift mobile crisis response services.

Crisis Stabilization

The crisis stabilization homes serve adults who live with a mental illness or co-occurring disorder and are in need of further stabilization after an inpatient hospitalization. It is also warranted for individuals who are awaiting a residential placement and require the need for structure and support to ensure a smooth transition into the residential placement. Crisis stabilization may also provide temporary accommodation for people with mental health needs during a crisis or

when they need longer term stabilization from living at home. We recommend a contract with Bell Therapy to continue operating two crisis stabilization homes, one at \$279,135 annually and the other at \$298,000 annually. We recommend a contract with Whole Health Clinical Group (formerly known as Transitional Living Service) to continue operating one crisis stabilization home for \$250,000 annually.

Crisis Resource Center (CRC)

CRC serves adults who reside in Milwaukee County who live with a mental illness and are in need of crisis intervention and/or short term stabilization rather than hospitalization. CRC serves adults with mental illness and may include individuals with a co-occurring substance use disorder who are experiencing psychiatric crises. It is a safe, welcoming, and recovery-oriented environment for people in need of stabilization and peer support to prevent hospitalization. Whole Health Clinical Group (fmr. TLS) operates two CRCs in the county; a north side location with an annual contract of \$650,000. This includes an additional \$150,000 over the 2015 amount in order to establish third-shift coverage at the north side CRC. A south side location with an annual contract of \$250,000.

Community Consultation Team (CCT)

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

Mental Health Purchase of Service

Community Support Programs

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

Annual contract amounts are listed below as well as anticipated Medicaid payments to providers as BHD will bill Medicaid on behalf of providers in 2016.

BHD Community Support Programs			
Agency	Purchase of Service Contract	Est. Medicaid Billing	Total Payments (Contract + Medicaid)
Bell Therapy North & South	\$1,767,472	\$1,997,575	\$3,765,047
Milwaukee Mental Health Association	\$885,847	\$977,430	\$1,863,277
Outreach Community Health Center	\$669,582	\$829,172	\$1,498,754
Project Access, Inc.	\$912,139	\$1,013,248	\$1,925,387
Whole Health Clinical Group (TLS)	\$1,207,580	\$1,695,387	\$2,902,967
Wisconsin Community Services	\$986,758	\$1,413,827	\$2,400,585
Total	\$6,429,378	\$7,926,639	\$14,356,017

Targeted Case Management for Mental Health & Substance Use Disorders

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

Annual contract amounts are listed below as well as anticipated Medicaid payments to providers as BHD will bill Medicaid on behalf of providers in 2016.

BHD Targeted Case Management			
Agency	Purchase of Service Contract	Est. Medicaid Billing	Total Payments (Contract + Medicaid)
Alternatives in Psychological Consultation	\$557,610	\$508,671	\$1,066,281
Bell Therapy	\$150,000	\$43,426	\$193,426
Horizon Healthcare, Inc.	\$348,505	\$164,760	\$513,265
La Causa, Inc.	\$301,194	\$49,134	\$350,328
Milwaukee Mental Health Associates	\$263,723	\$290,313	\$554,036
Outreach Community Health Center	\$456,703	\$134,892	\$591,595
Whole Health Clinical Group (formerly TLS)	\$685,002	\$201,348	\$886,350
Wisconsin Community Services	\$1,215,418	\$204,861	\$1,420,279
Total	\$3,978,155	\$1,597,405	\$5,575,560

Outpatient Mental Health Clinics

Outreach Community Health Center provides outpatient mental health counseling services to uninsured individuals who are seen at the Access Clinic and require immediate short term mental health counseling and prescribing services. Outreach Community Health Center receives \$597,732.

Clubhouse Model

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

Drop-in Center

Psychosocial drop-in centers provide a casual environment for education, recreation, socialization, pre-vocational activities, and occupational therapy opportunities for individuals with severe and persistent mental illness and/or co-occurring disorders. The drop-in center model is based on a concept of membership and utilizes peer support as a central tenet. Our Space, Inc., provides individuals with a mechanism of social connectedness so that they may further their own recovery. Our Space receives \$250,962 annually for this purpose.

Office of Consumer Affairs

Horizon Healthcare supports the operation of the Office of Consumer Affairs. This includes a dedicated Certified Peer Specialist (CPS) in a supervisory capacity, as well as the hiring and supervision of 12 CPS who are employed in the four adult acute inpatient units, day treatment program, the BHD Observation Unit, and/or the crisis stabilization homes of BHD. Office of Consumer Affairs also provides a mechanism for the reimbursement for consumer participation in accordance with the BHD Consumer Reimbursement Policy. This is solely for the reimbursement of BHD sponsored activities with prior authorization. Horizon Healthcare receives \$240,000 annually for these activities.

Peer Run Recovery Center

The peer run recovery center – similar to the Drop-In Center – provides a low-pressure environment for education, recreation, socialization, pre-vocational activities, and occupational therapy opportunities for individuals experiencing severe and persistent mental illness and/or co-occurring disorders. A key element of the peer-run concept is the active engagement of members in the planning, direction, and evaluation of recovery center activities. Membership is voluntary, and members decide upon their own level of participation but are strongly encouraged to take initiative and exercise leadership in the management and day-to-day operations. LaCausa Inc. receives \$278,000 annually for this activity.

Consumer Satisfaction Evaluation and Advocacy

Vital Voices is the evaluation entity for the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey. This survey was developed for use in the public mental hygiene system and is now widely used by state and local governments in both substance abuse and mental health programs. The MHSIP survey assesses four areas of consumer perceptions: overall satisfaction; access to services; quality and appropriateness of services; and consumer reported outcomes. MHSIP is used to evaluate both mental health and substance abuse services in the CARS and for the Comprehensive Community Services benefit and assists in determining continuous quality improvement efforts for the upcoming year. Vital Voices also administers the Recovery Oriented System Indicator (ROSI). The ROSI assesses the recovery orientation of community mental health system for adults with serious and prolonged psychiatric disorders. Vital Voices receives \$175,961 annually for these services.

Benefits Advocacy

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

Information and Referral

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

IMPACT 211 Line

IMPACT 2-1-1 is a central access point for people in need. During times of personal crisis or community disaster, the free, confidential helpline and online resource directory make it easy for residents to get connected to information and assistance. CARS contracts with IMPACT for \$100,000 annually for this service.

Community-Based Residential Facility

Matt Talbot Recovery Center (a subsidiary of Horizon Healthcare, Inc.) operates two CBRFs providing long-term care residential and therapy services for up to five clients (referred by BHD) at each facility. These services may include: assistance with activities of daily living; nursing care; psychiatric assessment and monitoring; medication monitoring and management; recreation; transportation for medical appointments, shopping and social activities; family involvement; peer support; job skills training and job search; and other related services required by the client to live in the facility. The facilities maintain CBRF certification and are ADA-accessible. Each client is assigned a Case Manager on a one-to-one basis. The goal of the CBRF facility and services is to enable each client to live in the least restrictive environment in a community-based setting,

enabling the clients to realize their full potential. Horizon Healthcare receives \$2,196,557 annually to operate these facilities.

Substance Abuse Purchase of Service

Community Advocates

Community Advocates provides the administration and staff support for the work of the Milwaukee Coalition of Substance Abuse Prevention (MCSAP). This 40-member coalition is comprised of Milwaukee County citizens, substance abuse service professionals and individuals who are familiar with the consequences of alcohol and other drug abuse. Utilizing the Strategic Prevention Framework (SPF) as its model, Community Advocates will also subcontract via a competitive request for proposal, with agencies and coalitions to address population level prevention strategies. Community Advocates will receive funding at \$592,649 annually to continue these prevention activities.

AIDS Resource Center of Wisconsin (ARCW)

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

Meta House

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

Families Moving Forward

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

United Community Center (UCC) – Familias Sanas

United Community Center, in partnership with the Sixteenth Street Community Health Center, will strengthen their bilingual and bicultural service delivery. An annual allocation of \$45,000 will be used to implement the findings of the needs assessment.

Mental Health America – Suicide Prevention

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

Detoxification Services

CARS ensures medically monitored and ambulatory detoxification services for immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs. An assessment is conducted to determine whether a risk exists based on the individual's level of intoxication and whether a risk exists for severe withdrawal symptoms or seizures, based on the amount, frequency, chronicity, and recency of discontinuation or significant reduction in alcohol or other drug use. We recommend a contract with First Step Recovery Center (a subsidiary of Horizon Healthcare, Inc.) for \$2,572,145 to continue providing these services in 2016.

Central Intake Unit – Wiser Choice

The Central Intake Unit (CIU) is the front door for Wiser Choice, and is the first point of contact for individuals seeking treatment or recovery support services for a substance use disorder. The CIU's determine eligibility and administer a comprehensive assessment, establish a clinical level of care for placement at a treatment facility, and gather evaluative information. When individuals are found eligible, a referral is made to the treatment provider of choice selected by the service recipient. Treatment is provided by an extensive network of agencies on a fee-for-service basis. There are four agencies that provide Central Intake Unit (CIU) services for Wiser Choice: M&S Clinical Services at \$547,700 annually, IMPACT at \$509,412 annually, Wisconsin Community Services at \$315,512 and JusticePoint at \$45,000 annually.

Training and Technical Assistance Coordination

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

Faith Partnership Network

The Faith Partnership Network provides training and technical assistance to the non-secular providers within the Wiser Choice network. There is a focus on Medicaid certification and credentialing necessary for service provision within the ACA, the use of evidence-based

strategies, linkages with the Substance Abuse and Mental Health Services Administration, and the focus on service that are based in cultural intelligence. Faith Partnership Network receives \$51,000 annually.

Wraparound Milwaukee Overview

Overall contract allocations for 2016 in BHD's Child and Adolescent Community Services Branch will vary only slightly from 2015. BHD will again contract with a number of community agencies for care coordination and other services that support the operation of the Wraparound Milwaukee Program, REACH (Reaching, Engaging and Assisting Children and Families), FISS (Family Intervention and Support Services), Project O-YEAH (Young Emerging Adult Heroes), and MUTT (Mobile Urgent Treatment Team). As a special, 1915a Managed Care program under Medicaid, all remaining services are purchased on a fee-for-service basis through agencies participating in the Wraparound Milwaukee Provider Network. Individual Purchase of Service contract allocations being recommended are listed in this report.

Care Coordination Services

Care Coordination is a key service in Wraparound as they are the staff who facilitate the child and family team, help the family develop and then document the individual treatment plans (Plans of Care), coordinate the provision of mental health and other services to the youth and family, and provide reports to and testify at Children's Court. For administrative and programmatic efficiencies, in 2015, Wraparound Milwaukee decided to reduce the number of care coordination agencies it contracted with from eight to six agencies. Based on the results of the 2015 Request for Proposals process, the agencies contracted with were: AJA Counseling Center, Alternatives in Psychological Consultation, LaCausa, Inc., SaintA, St. Charles Youth and Family Services, and Willowglen Community Care. Those six agencies remain providers of care coordination for 2016. La Causa's contract is increased by \$175,200 over the 2015 amount due to anticipated increase in referrals.

For the voluntary REACH program, a separate RFP was issued and the four agencies with the highest RFP scores were selected to provide these services. Those four agencies are: LaCausa, Inc., Alternatives in Psychological Consultation, AJA Counseling Center, and SaintA. Those agencies also remain providers of care coordination. La Causa's contract is increased by \$143,850 over the 2015 amount due to anticipated increase in referrals.

Project O-YEAH provides care coordination services to youth and young adults, age 17-26, who have serious emotional and mental health needs and are usually transitioning out of foster care or other out-of-home care. In 2015, St. Charles Youth and Family Service and LaCausa, Inc. were awarded contracts via the RFP process.

The total number of youth and families projected to be served in 2016 is 1,700 families with an average projected daily enrollment of 1,100 families across regular, court-ordered Wraparound, REACH and Project O-YEAH.

Screening and assessment contracts are increased with AJA Counseling Center (\$75,000), Alternatives in Psychological Consultation (\$50,000), and SaintA's (\$75,000) over 2015 amounts due to an anticipated increase in referrals for these services.

The six agencies providing care coordination services, including screening and assessment services, are:

Care Coordination Agency	Service Type	2016 Proposed Contract
AJA Counseling Center	Regular Care Coordination	\$1,168,000
	REACH	\$ 722,700
	Screening/Assessment	<u>\$ 150,000</u>
		\$2,040,700
Alternatives in Psychological Consultation	Regular Care Coordination	\$1,168,000
	REACH	\$ 642,400
	Screening/Assessment	<u>\$ 100,000</u>
		\$1,910,400
LaCausa, Inc.	Regular Care Coordination	\$1,927,200
	REACH	\$1,107,450
	Project O-YEAH	\$ 303,862
	Screening/Assessment	<u>\$ 300,000</u>
	\$3,638,512	
SaintA	Regular Care Coordination	\$1,051,200
	REACH	\$ 803,300
	Screening/Assessment	<u>\$ 150,000</u>
		\$2,004,500
St. Charles Youth and Family Services	Regular Care Coordination	\$1,168,000
	Project O-YEAH	\$ 405,150
	Screening/Assessment	<u>\$ 160,000</u>
		\$1,733,150
Willowglen Community Care	Regular Care Coordination	\$1,168,000
	Screening/Assessment	<u>\$ 150,000</u>
		\$1,318,000
Care Coordination Total:		\$12,645,262

Support Services for Wraparound Milwaukee

For 2016, BHD recommends continuing an agreement with the Wisconsin Council on Children and Families to arrange for; program evaluation, staff training, management information and IT, and other technical support necessary to maintain the Medicaid Capitation contract with DHS.

This will assure continued approval by the Center for Medicare/Medicaid Service (CMS) for Wraparound Milwaukee’s 1915a status.

We also propose to contract again with Families United of Milwaukee for advocacy and educational support for families served by Wraparound Milwaukee. Families United was selected through the RFP process and was the sole bidder on this program in 2015. This minority-owned and operated agency continues to represent and advocate for families of youth with serious mental and behavioral needs. It also provides educational advocacy to help enrolled youth obtain an Individual Education Plan (IEP), achieve appropriate school placements, and reduce unnecessary residential and day treatment services. Families United staff consist of a full time Program Director, three educational advocates and utilization of stipends for additional parent involvement on committees, workgroups and training events.

Fiscal intermediary services through the Milwaukee Center for Independence (MCFI) allow the purchase of services from relatives and other natural supports for youth. Families can identify relatives or close friends who are available to provide supportive services such as transportation or respite but who would be unable to do so without financial assistance. The family ‘hires’ the provider, and MCFI serves as the fiscal intermediary with the provider.

Support Services for Wraparound	Service Type	2016 Proposed Contract
Wisconsin Council on Children and Families	Program Evaluation, Training Technical Assistance and IT Support	\$ 649,623
Families United of Milwaukee	Family and Educational Advocacy	\$ 525,000
Milwaukee Center for Independence	Fiscal Intermediary	\$ 25,000
Support Services for Wraparound Total:		\$1,199,623

Mobile Urgent Treatment Services

The Mobile Urgent Treatment Team provides crisis intervention services on a 24 hour basis to families enrolled in the Wraparound Milwaukee Program. In addition, this team provides services to any family in Milwaukee County with a child who is having a mental health crisis. Team members go to where the crisis is occurring, assess the situation, and work with the youth and family to determine the safest, least restrictive options to address the crisis, as well as provide support and referrals for continued services as needed. The Mobile Urgent Treatment Team (MUTT) will serve an estimated 1,800 families in 2016.

The Bureau of Milwaukee Child Welfare will again fully fund a dedicated MUTT team to work specifically with youth in foster care and their foster parents. This team has been effective at

reducing the incidence of failed foster placements through the provision of 24/7 crisis intervention services to foster families who are experiencing a mental health or behavioral crisis with a child in their care.

To support BHD's professional team of county psychologists and psychiatric social workers assigned to the MUTT program, St. Charles Youth and Family Services will provide up to ten crisis support workers for MUTT to ensure 24 hour, seven day per week coverage. St. Charles was the only agency to submit a bid to provide these services for the 2015-16 RFP period.

St. Charles is providing additional child psychiatrist coverage for the medication clinics and psychiatric consultation for Wraparound Milwaukee. It was chosen through the last RFP process to provide an eight bed crisis group home called Haven House for boys placed through the MUTT team and Wraparound Program.

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

New Initiatives

In 2015, the City of Milwaukee Health Department contracted with BHD-Wraparound Milwaukee to fund two MUTT staff positions for a MUTT Trauma Team to work directly with Police Officers in District 7. The Police Officers identify youth who are exposed to traumatic events during the course of a police response. With the consent of the family, the Officers may refer a youth to the MUTT Trauma team, who call the family to arrange a follow up visit and provide support/services as needed. MUTT staff then communicate with the referring Officers to 'close the loop' and let the Officers know that contact has been made.

Wraparound Milwaukee, in partnership with the Medical College of Wisconsin, also was awarded an OJJDP (Office of Juvenile Justice and Delinquency Prevention) grant of \$156,039 to enhance the provision of services to child victims of sexual exploitation and/or domestic sex trafficking. These funds were used to develop a curriculum for training specialized mentors to work with these youth on an intensive basis for up to one year. In April of 2015, the Youth Living Out Loud (YLOL) program officially began serving youth, with 32 youth currently enrolled in the service. The target over the 3 years of this grant is to serve up to 60 youth.

Journey House

In 2015, Wraparound Milwaukee began contracting with Journey House for six apartments to be used by young adults in the O-YEAH program. While living in this housing, young adults will receive support to help ensure a successful transition to adulthood. Young adults will receive peer support, mental health services, daily living support and other individualized services as

needed. Wraparound Milwaukee will assist young adults in this transition by subsidizing their rent payments during the first year on their own. For the first six months, Wraparound will pay the full cost of rent, with the young adult covering other expenses such as utilities. In months seven through ten, the young adult will pay 50% of the rent, and starting in month 11 the young adult will be responsible for 100% of the rent.

Agency Providing Support Services	Service Type	2016 Proposed Contract
St. Charles Youth and Family Services	Crisis Group Home (Haven House)	\$ 475,000
	Mobile Crisis and other Clinical Services	\$1,235,873
	Resource Center/Peer Specialists	\$ 250,000
Journey House	O-YEAH Housing support	\$ <u>43,752</u>
MUTT Support Services Total:		\$2,004,625

Family Intervention and Support Services (FISS)

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

The assessment services component of FISS is targeted to conduct about 800 assessments in 2016 as well as serve over 200 families in the case management component. FISS targets adolescents who are experiencing parent-child conflicts manifesting in school truancy, chronic running away from home, and other issues of uncontrollability. FISS is a voluntary, early intervention alternative for parents who can receive a range of mental health and support services as an alternative to filing a formal CHIPS petition. FISS is fully funded by the Bureau of Milwaukee Child Welfare.

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

Agency Providing FISS Program Services	Service Type	2016 Proposed Contract
St. Charles Youth and Family Services	FISS Assessment and Case Management	\$ 416,876
FISS Support Services Total:		\$ 416,876

Fiscal Effect

The total amount recommended in 2016 purchase of service contracts for the Community Access to Recovery Services (CARS) is \$39,473,993. This amount reflects a total of \$23,251,359 for the Community Services Branch and \$16,222,634 for Wraparound. Additionally, BHD anticipates paying \$9,524,044 to TCM and CSP providers related to BHD now billing Medicaid on their behalf. The total cost of these contracts are contained in BHD's 2015 Budget. There is a schedule attached detailing all contracts discussed in this report.

Respectfully Submitted:



Héctor Colón, Director
Department of Health and Human Services

Contract Agency	Program Description	2015	2016	2016/2015 Var
Community Services Branch				
Alternatives in Psych Consultation	TCM	\$ 507,610	\$ 507,610	\$ -
	AODA-TCM	\$ 50,000	\$ 50,000	\$ -
	Total	\$ 557,610	\$ 557,610	\$ -
AIDS Resource Center of WI	AODA Prevention	\$ 96,213	\$ 96,213	\$ -
	Total	\$ 96,213	\$ 96,213	\$ -
Bell Therapy (Phoenix)	CSP North	\$ 1,675,996	\$ 1,675,996	\$ -
	CSP South	\$ 91,476	\$ 91,476	\$ -
	Respite Stablization Existing	\$ 279,135	\$ 279,135	\$ -
	Respite Stablization 2012	\$ 298,000	\$ 298,000	\$ -
	TCM	\$ 150,000	\$ 150,000	\$ -
Total	\$ 2,494,607	\$ 2,494,607	\$ -	
Community Advocates	CRC		0	0
	Protective Payee		0	0
	HUD Shelter+Care		0	0
Community Advocates	AODA Prevention	\$ 592,649	\$ 592,649	\$ -
	BMCW Prevention		0	0
Total	\$ 592,649	\$ 592,649	\$ -	
Dungarvin	Community Consultation Services	\$ 154,544	\$ 154,544	\$ -
	Total	\$ 154,544	\$ 154,544	\$ -
Faith Partnership Network	Wiser Resource Center	\$ 51,000	\$ 51,000	\$ -
	Total	\$ 51,000	\$ 51,000	\$ -
Genesis	Detoxification	\$ -	\$ -	\$ -
	Total	\$ -	\$ -	\$ -
Grand Avenue Club	Club House	\$ 200,000	\$ 200,000	\$ -
	WRAP		0	0
Total	\$ 200,000	\$ 200,000	\$ -	
Horizon Healthcare	TCM	\$ 348,505	\$ 348,505	\$ -
	Consumer Affairs	\$ 240,000	\$ 240,000	\$ -
	Total	\$ 588,505	\$ 588,505	\$ -
IMPACT	CIU	\$ 509,412	\$ 509,412	\$ -
	211 Line	\$ 100,000	\$ 100,000	\$ -
	Total	\$ 609,412	\$ 609,412	\$ -
JusticePoint	CIU/Drug Court	\$ 45,000	\$ 45,000	\$ -
	Total	\$ 45,000	\$ 45,000	\$ -
LaCausa	CLASP	\$ 404,714	\$ 500,000	\$ 95,286
	TCM	\$ 201,194	\$ 201,194	\$ -
	AODA-TCM	\$ 100,000	\$ 100,000	\$ -
	3rd Shift Crisis Mobile	\$ 200,000	\$ 200,000	\$ -
	PeerRun Recovery Cnt	\$ 278,000	\$ 278,000	\$ -
	SS Access Clinic	\$ 429,194	\$ 429,194	\$ -
Total	\$ 1,613,102	\$ 1,708,388	\$ 95,286	
Medical College of Wisconsin	Outpatient MH	\$ 697,771	\$ -	\$ (697,771)
	Total	\$ 697,771	\$ -	\$ (697,771)
M&S Clinical Services	CIU	\$ 547,700	\$ 547,700	\$ -
	Families Moving Forward	\$ 150,000	\$ 150,000	\$ -
	Total	\$ 697,700	\$ 697,700	\$ -
Mental Health America	Info/Referral	\$ 44,000	\$ 44,000	\$ -
	Crisis Grant		\$ -	\$ -
	Suicide Prevention	\$ 40,000	\$ 40,000	\$ -
	Total	\$ 84,000	\$ 84,000	\$ -
Meta House	Child Care			
	AODA Prevention	\$ 50,000	\$ 50,000	\$ -
Total	\$ 50,000	\$ 50,000	\$ -	

Milwaukee Mental Health Associates	CSP	\$	885,847	\$	885,847	\$	-
	TCM	\$	213,723	\$	213,723	\$	-
	Recovery Case Management	\$	50,000	\$	50,000	\$	-
	Total	\$	1,149,570	\$	1,149,570	\$	-
Matt Talbot Recovery Center	Detoxification	\$	2,572,145	\$	2,572,145	\$	-
	2 CBRFs	\$	1,098,278.50	\$	2,196,557	\$	1,098,279
	Total	\$	3,670,424	\$	4,768,702	\$	1,098,279
Milwaukee Police Department	Crisis Mobile	\$	187,500	\$	-	\$	(187,500)
	Total	\$	187,500	\$	-	\$	(187,500)
Outreach Community Health Center	CSP	\$	669,582	\$	669,582	\$	-
	TCM	\$	456,703	\$	456,703	\$	-
	Outpatient MH	\$	597,732	\$	597,732	\$	-
	Total	\$	1,724,017	\$	1,724,017	\$	-
Our Space, Inc.	Drop-in Center	\$	250,962	\$	250,962	\$	-
	Total	\$	250,962	\$	250,962	\$	-
Project Access, Inc.	CSP	\$	912,139	\$	912,139	\$	-
	Total	\$	912,139	\$	912,139	\$	-
St. Charles Youth & Family	Training & Consultation	\$	403,126	\$	403,126	\$	-
	Total	\$	403,126	\$	403,126	\$	-
Sixteenth Street Clinic	Outpatient Capacity Bldg	\$	100,000	\$	-	\$	(100,000)
	Total	\$	100,000	\$	-	\$	(100,000)
Whole Health Clinical Group (formerly TLS)	CSP	\$	1,207,580	\$	1,207,580	\$	-
	TCM	\$	685,002	\$	685,002	\$	-
	Benefits Advocacy/WVP	\$	331,984	\$	331,984	\$	-
	CRC	\$	250,000	\$	250,000	\$	-
	Northside CRC	\$	500,000	\$	650,000	\$	150,000
	Respite Stabilization	\$	250,000	\$	250,000	\$	-
Total	\$	3,224,566	\$	3,374,566	\$	150,000	
United Community Center	Familias Sanas	\$	45,000	\$	45,000	\$	-
	Total	\$	45,000	\$	45,000	\$	-
					0	0	
					0	0	
					0	0	
					0	0	
Vital Voices	MHSIP - MH	\$	121,025	\$	136,025	\$	15,000
	MHSIP- AODA	\$	39,936	\$	39,936	\$	-
	Total	\$	160,961	\$	175,961	\$	15,000
Wisconsin Community Services	CSP	\$	986,758	\$	986,758	\$	-
	TCM/Level II	\$	1,115,418	\$	1,115,418	\$	-
	TCM/Level I	\$	100,000	\$	100,000	\$	-
	CIU/CJ Population	\$	315,512	\$	315,512	\$	-
	Total	\$	2,517,688	\$	2,517,688	\$	-
CSB Total			\$ 22,878,066	\$ 23,251,359	\$ 373,294		

Contract Agency	Program Description	2015	2016	2016/2015 Var
Wraparound Milwaukee Contracts				
AJA Counseling Center	Regular Care Coordination	\$ 1,168,000	\$ 1,168,000	\$ -
	REACH	\$ 722,700	\$ 722,700	\$ -
	Screening/Assessment	\$ 75,000	\$ 150,000	\$ 75,000
	Total	\$ 1,965,700	\$ 2,040,700	\$ 75,000
Alternatives in Psychological Consultation	Regular Care Coordination	\$ 1,168,000	\$ 1,168,000	\$ -
	REACH	\$ 642,400	\$ 642,400	\$ -
	Screening/Assessment	\$ 50,000	\$ 100,000	\$ 50,000
	Total	\$ 1,860,400	\$ 1,910,400	\$ 50,000

Aurora Family Services	Regular Care Coordination			\$	-
		Total	\$		\$
Families United in Milwaukee	Family & Educational Advocacy	\$	525,000	\$	525,000
		Total	\$	525,000	\$
Journey House	OYEAH enrollee housing	\$	23,320	\$	43,752
		Total	\$	23,320	\$
LaCausa, Inc.	Regular Care Coordination	\$	1,752,000	\$	1,927,200
	REACH	\$	963,600	\$	1,107,450
	Project O-YEAH	\$	303,862	\$	303,862
	Screening/Assessment	\$	300,000	\$	300,000
		Total	\$	3,319,462	\$
Milwaukee Center for Independence	Fiscal Intermediary	\$	25,000	\$	25,000
		Total	\$	25,000	\$
SaintA	Regular Care Coordination	\$	1,051,200	\$	1,051,200
	REACH	\$	803,300	\$	803,300
	Screening/Assessment	\$	75,000	\$	150,000
		Total	\$	1,929,500	\$
St. Charles Youth and Family Services	Regular Care Coordination	\$	1,168,000	\$	1,168,000
	Project O-YEAH	\$	405,150	\$	405,150
	Screening/Assessment	\$	160,000	\$	160,000
	HTI Transitional Specialist				
	Crisis Group Home	\$	475,000	\$	475,000
	Mobile Crisis & Other Clinical Service	\$	1,235,873	\$	1,235,873
	Resource Center/Peer Specialists	\$	250,000	\$	250,000
	FISS Assessment & Case Manageme	\$	416,876	\$	416,876
		Total	\$	4,110,899	\$
Willowglen Community Care	Regular Care Coordination	\$	1,168,000	\$	1,168,000
	Screening/Assessment	\$	150,000	\$	150,000
		Total	\$	1,318,000	\$
Wisconsin Council on Children and Families	Program Eval, Training, TA & IT	\$	649,623	\$	649,623
		Total	\$	649,623	\$
Wraparound Total			\$ 15,703,584	\$ 16,222,634	\$ 519,050

\$ 39,473,993

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: November 10, 2016

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

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

SUBJECT: **Report from the Director, Department of Health and Human Services,
Requesting Authorization to Enter into 2016 Professional Services Contracts for
the Behavioral Health Division (BHD)**

Issue

Wisconsin Statutes 51.41(10) requires Milwaukee County Mental Health Board approval for professional services contracts with a value of \$100,000 or greater. Per the statute, the Director, Department of Health and Human Services (DHHS), is requesting authorization for BHD to enter into a variety of professional services contracts for 2016.

Background

BHD uses professional services contracts to support various essential staff activities, including pharmacy services, supportive medical services, and medical program planning. These contracts support functions that are critical to patient care and necessary to maintain hospital, nursing home, and crisis services licensures and comply with Medicare conditions of participation. A discussion of all new or renewed 2016 professional services contract recommendations follows.

Clean Power

Cleaning services for BHD are currently provided by Clean Power under a month-to-month contract at a rate not to exceed \$109,768 per month (or \$1,316,136 annually) in 2016.

Dynacare Laboratories

Dynacare Laboratories provides laboratory services at BHD under a 5-year agreement set to expire December 31, 2015. BHD is recommending approval to execute a month-to-month contract for 2016 not to exceed \$50,000 annually.

LocumTenens.com LLC

LocumTenens.com LLC provides psychiatrist healthcare providers on a temporary basis to BHD under a one-year agreement. Services include sourcing, screening, and presenting psychiatrist candidates for the purpose of fulfilling essential inpatient coverage needs due to vacancies. BHD is recommending approval to execute an amendment to the existing agreement for 2016 at a rate not to exceed \$394,950 annually.

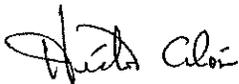
Recommendation

It is recommended that the Milwaukee County Mental Health Board authorize the Director, DHHS, or his designee, to execute the professional services agreements for 2016 identified in this report and for the amounts enumerated in the table below.

Vendor Name	Description of Service	Start Date	End Date	Annual Contract Amount
Clean Power	Cleaning Services	Monthly		\$1,316,136
Dynacare Laboratories	Laboratory Services	Monthly		\$50,000
Locum Tenens	Psychiatrist Temp Staff	1/1/2016	12/31/2016	\$394,950
			Total	\$ 1,761,086

Fiscal Effect

The 2016 Budget contains sufficient appropriations to support the total amount of \$1,761,086 recommended for these contracts.



Héctor Colón, Director
Department of Health and Human Services

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: November 23, 2015

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 Matt Fortman, Financial Analyst, Department of Health and Human Services

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to enter into 2016 contracts with the State of Wisconsin for Social Services and Community Programs**

Issue

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

The Director, Department of Health and Human Services (DHHS), is therefore requesting authorization to sign the 2016 contracts with DHS and DCF for the provision of Social Services and Community Programs mandated by state law.

Background

State and Federal funds that are forwarded to the Behavioral Health Division (BHD) under the Social Services and Community Programs state contract – commonly referred to as Community Aids – provide a significant funding source for the department, with at least at least \$38 million anticipated for BHD in 2016.

The State's Social Services and Community Programs contracts include various separate revenues used to fund DHHS, including BHD. Funding identified in this report pertains only to revenues associated with services within BHD.

At this time, DHHS has received the final 2016 Community Aids contract allocations from the State. Allocations are posted at the websites below:

- <http://www.dhs.wisconsin.gov/sca/>
- [http://www.dcf.wi.gov/contractsgrants/social human services contracts](http://www.dcf.wi.gov/contractsgrants/social_human_services_contracts)

State Allocations and Fiscal Effect

Community Aids – Basic County Allocation (BCA)

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

The 2016 Budget includes \$22,336,586 of BCA for BHD. This amount is consistent with the State allocation of BCA to Milwaukee County.

BHD Earmarked Revenue Sources

Community Mental Health

The 2015-2017 State budget consolidates several mental health grant programs into a new community mental health allocation. The bill combines mental health institutional relocation programs and psychosocial rehabilitation programs into a new community aids program for community mental health services.

Substance Abuse Grants

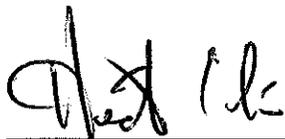
BHD is currently in the process of applying for renewal of the Substance Abuse Treatment TANF grant and AODA Block Grant. BHD anticipates that the amounts awarded will be unchanged from previous year.

**CY 2016 State/County Social Services/Community Program
Final Revenue Allocation Compared to the 2016 Budget**

	2016 BHD Budget	2016 Final State Allocation	State Notice vs. 2016 BHD Budget
Basic County Allocation			
DHS Community Aids	22,336,586	22,336,586	-
Earmarked Revenues			
Community Options Program*	1,478,673	-	(1,478,673)
CSP Waitlist	88,220	-	(88,220)
Certified Mental Health Program	358,860	-	(358,860)
IMD Regular Relocation	5,891,687	-	(5,891,687)
Community Mental Health	-	7,780,317	7,780,317
Mental Health Block Grant	640,910	685,914	45,004
Substance Abuse Treatment TANF	4,394,595	4,394,595	-
AODA Block Grant	2,431,021	2,431,021	-
IV Drug	500,000	500,000	-
Subtotal BHD earmarked Revenues	15,783,966	15,791,847	7,881
 Grand Total Revenue	 38,120,552	 38,128,433	 7,881

Recommendation

It is recommended that the Mental Health Board authorize the Director, Department of Health and Human Services, to execute the 2016 Social Services and Community Programs contracts from the State Departments of Health Services and Children and Families, and any addenda to those contracts, in order for the County to obtain the State Community Aids revenue. The 2016 Social Services and Community Programs contracts provide total revenue of \$38,128,433.



Héctor Colón, Director
Department of Health and Human Services

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

Date: December 1, 2015

To: Kimberly Walker, Chairperson - Mental Health Board

From: Hector Colon, Director, Department of Health and Human Services
Patricia Schroeder, Administrator, Behavioral Health Division
Laurie Panella, CIO, Information Management Services Division
Prepared by Matt Krueger, IMSD Project Manager

Subject: **Request for Authorization to Use Funds in 2015**

Request

The Director of the Department of Health and Human Services (DHHS), the Administrator of the Behavioral Health Division (BHD) and the Director of the Information Management Services Division (IMSD) are requesting authorization to spend an amount not to exceed \$664,000 on contracted professional services in order to continue the optimization of the Electronic Medical Records (EMR) system and provide help desk support across BHD.

Background

Capital Project WO444 - Electronic Medical Records System was adopted in the 2010 Capital Improvements Budget. The Joxel Group (TJG) was competitively awarded the professional services contract to facilitate and lead the EMR initiative. In part, these monies are being used to wrap up the Joxel engagement and expand the engagement with Netsmart. The remaining monies are devoted to a BHD site based IT support/service desk.

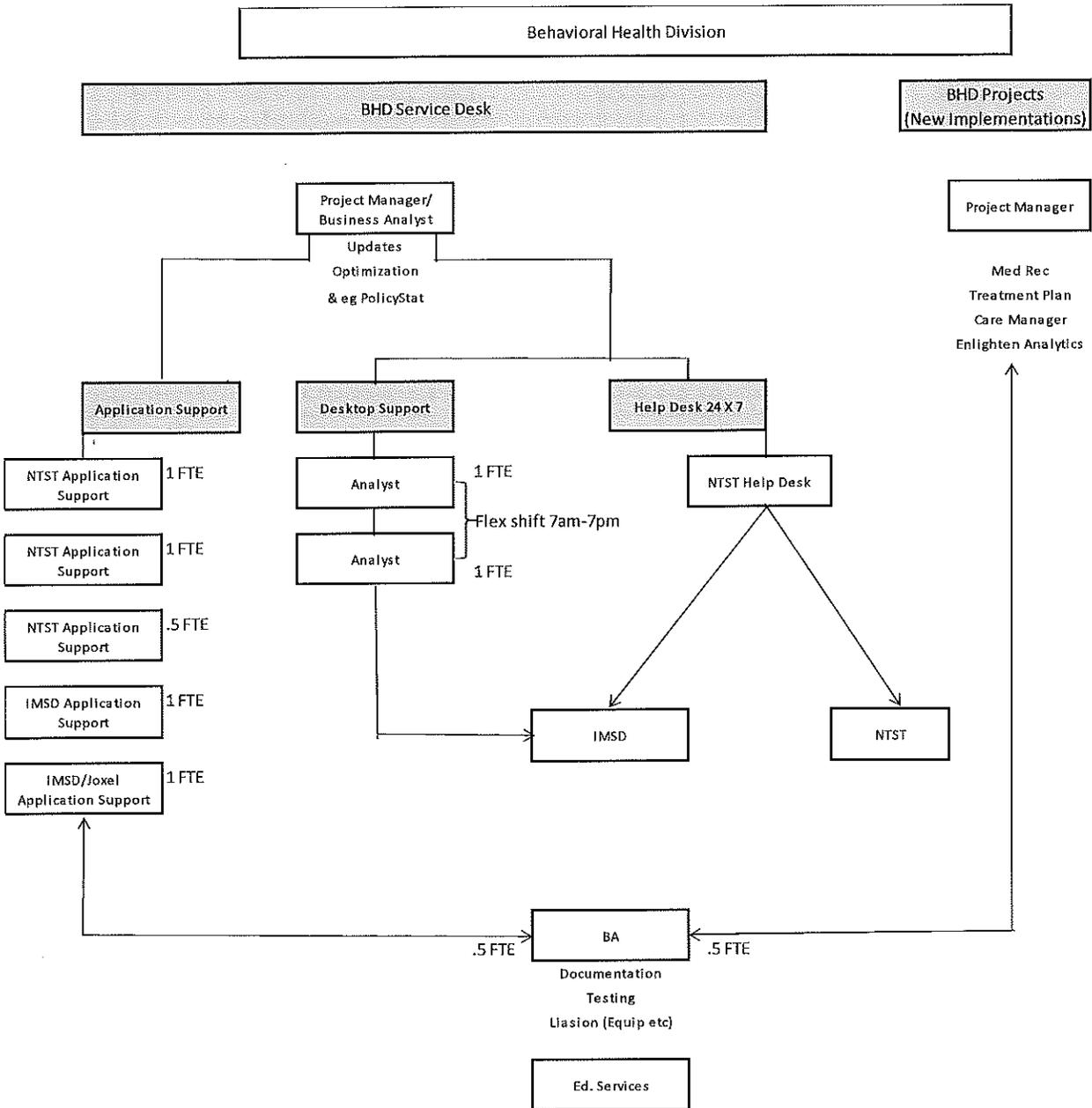
Current State

A combination of Joxel, Netsmart and IMSD resources are being utilized to provide IT support across BHD. Services include: Avatar support, desktop support and on-call services 24X7. Joxel, in combination with Netsmart, is primarily responsible for providing optimization services for Avatar.

Next Steps

As soon as practicable, BHD plans to deploy a site based IT support/service desk for the enterprise: Inpatient, Outpatient and Community, which would consist of Application Support, Desktop Support, Help Desk and pathways for escalation.

This new model will be structured as follows:



Application Support: The Application Support specialists will assist with optimizing functionality of the software insuring adherence to best practices workflow and configuration. Netsmart will be contributing 2.5 FTEs to this role. In addition, IMSD will be providing an additional resource for a total of 3.5 FTEs. Joxel resources will be phased out over time.

Desktop Support: The Desktop Support specialist is available to assist users at their desk site, and also assist with equipment deployment/issues. While much of the support can be provided remotely, BHD will house one FTE on-site to assist with issues noted above.

Help Desk. Netsmart has proposed a 24X7X365 Tier 1 Help Desk model. This would provide the BHD community with one telephone number to call for all IT-related needs regardless of where the issue originates.

In addition, a separate Project Manager would be assigned to implement new projects (Medication Reconciliation, Treatment Plan, Care Manager and Enlighten Analytics).

In early 2016, BHD plans to accelerate the replacement of Joxel resources.

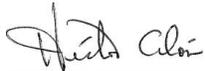
Fiscal Impact

In order to implement the plan above, DHHS, BHD and IMSD are requesting the authority to use an additional \$664,000 in 2015. These requested funds were not included in the 2015 BHD Budget.

Recommendation

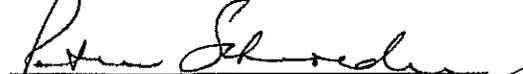
The Director of the Department of Health and Human Services, the Administrator of the Behavioral Health Division and the Director of the Information Management Services Division, respectfully request approval to encumber the aforementioned funds in order to execute the Service Desk plan as noted.

Approved By:



Hector Colon, Director
Department of Health and
Human Services

Approved By:



Patricia Schroeder, Administrator
Behavioral Health Division

Approved By:

Laurie Panella, CIO
IMSD

Raisa Koltun, Chief of Staff, County Executive's Office

Teig Whaley-Smith, Director, Department of Administrative Services

Jeanne Dorff, Deputy Director, Department of Health and Human Services

Randy Oleszak, Fiscal Administrator, DHHS/BHD

Alicia Modjeska, Chief Administrative Officer - BHD

Jodi Mapp, Senior Executive Administrative Assistant - BHD

Clare O'Brien, Fiscal and Budget Manager, DAS Central Business Office

Sushil Pillai, The Joxel Group, LLC

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

DATE: December 7, 2015

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

FROM: Patricia Schroeder, Administrator, Behavioral Health Division

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

Background

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

Discussion

1. Psychiatry Staffing in Acute Services Update – Dr. John Schneider

As was reported at the October Mental Health Board meeting, changes in psychiatry staffing levels have resulted in an inpatient bed hold to 50 adults, despite our budgeted 60 bed goal.

Within the past 6 months, we have had one retirement and two resignations of full-time psychiatrists. In addition, we have had two psychologists retire. In addition, we have two psychiatrists who have retired and are working hourly to support our staffing. These positions also need recruitment.

Given the needs of our high acuity population, we are in the process of expanding the physician practice model for care and staffing, while still embracing the current medical staff model, which includes psychiatrists, psychologists, and advanced practice nurses.

Through recruitment efforts that had occurred throughout the year, we have hired one full-time and one half-time psychiatrist. We will be using locums tenens to fill in the other needs.

Strategies that are being used include:

- Recruitment efforts for new psychiatrist graduates regionally
- Evaluation of the salary structure and compensation
- Ongoing use of recruiter agencies to assist in psychiatrist recruitment
- Support for retention efforts of full-time, part-time, and hourly psychiatrists.

2. Comprehensive Community Services (CCS) Update – Amy Lorenz

Enrollment – As of December 17, 2015, we have 195 clients enrolled in CCS and another 25 who are referred to agencies within the enrollment process. We remain on track to meet the target of serving 238 individuals by the end of the year.

Ancillary Provider Network - Now that we have implemented the electronic record across our community base, we are in the process of adding about 12 new providers of ancillary services to the network to support choice for consumers.

CCS for Youth - We have been working with the Disability Services Division (DSD) to move forward with plans to serve youth in the system. DSD will be working to become a branch office and will provide the screening and assessment, as well as service facilitation for the youth in their programs. We are working to develop CCS for the youth provider network with existing CCS providers. We hope to enroll our first youth in January 2016.

CCS for the Elderly - We have met with Milwaukee County Family Care and will be doing education with their teams about CCS.

Statement of Deficiency - Our corrective action plan was accepted by DQA. We have been working on improvements needed to include:

- Uniformity of forms, chart composition, etc., throughout the system. Our QA teams are following up with site visits to monitor progress.
- Recovery Advisory Committee. A small team has implemented solutions to these issues. We are recruiting additional consumers and will be in full compliance in January 2016.
- Enrollment Process. We continue to work on changing the process, with every other week involvement of Technical Assistance from DMHSAS.

Rumor Control - There was a rumor that we were turning people away from CCS application, stating we would not enroll for five months. That is simply not true.

3. Northside Place Planning Update

See **Attachment A.**

4. Findings Cited in the Deloitte "State Audit" of December 2014

See **Attachment B.**

5. Location of Future Meetings of the Mental Health Board

The meeting of the Mental Health Board of December 17, 2015, will be the last Mental Health Board meeting held in the Behavioral Health Division's 9201 building.

A number of other locations were scouted in consideration of future standing Mental Health Board Meeting locations. One of the locations that we toured is called the Sojourner Family Peace Center, which is located on the corner of 6th and Walnut Streets. This newly built facility houses the Inspiration Conference Room. This space is beautiful, size appropriate and has audio/visual (AV) capabilities, both of which are needed for the Board meetings. This location has ample, free parking and is open 24 hours. The 24/7 availability will also prove to be beneficial for early set ups and evening meetings.

The other meeting space option is the Tom Brophy Conference Room at the Community Advocates/Legal Aid Society Building, which is located in downtown Milwaukee on James Lovell Street and Wisconsin Avenue. This space is the appropriate size and meets all of our AV needs. They are more than willing to accommodate our a.m. and sometimes p.m. meeting schedule. Parking is available, however, the free parking lot has a limited number of spaces that are used by staff and customers. There are near-by parking lots that could be utilized for meeting events but are not free.

See **Attachment C.**

A decision for future meeting locations will need to be made by the Board.

6. Facility Repairs at the Behavioral Health Division (BHD) – Roof

On October 31, 2015, weather related issues caused a leak in the roof, along with damage to a room in the 9455 Building at BHD. While there is insurance for part of this damage, the deductible on the policy requires significant payment.

A policy within Milwaukee County calls for cost sharing of any County service within a County facility. The change in governance to the Mental Health Board requires a clear

understanding of BHD's current and future obligation for facility repairs until we are out of this space.

While this current expense is limited, the issue of paying for repairs in the BHD building going forward is significant and precedent setting. Discussions are proceeding within the County.

An opinion from Corporation Counsel has been requested.

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

A New Model for the Front Door to Community Based Behavioral Health Services Northside "Place" -- An Overview

Overview

Milwaukee County committed to creating a community based model for behavioral health services in 2010. This followed a report from the Public Policy Forum demonstrating the opportunity for this community to shift its use of resources from primarily acute care to prevention, early detection and ongoing support of those with chronic mental illness and substance use. One challenge frequently cited is the complexity and fragmentation of the existing mental health system, and the difficulty of individuals in accessing or understanding the potential services and how to find them. The current "front door" to Milwaukee County Behavioral Health services is the Psychiatric Emergency Department at the Behavioral Health Division. This is not by design, but rather by tradition. Once inside the system and the building, it is easier to get assessed and connected to other County supported behavioral health and disability services.

As part of the transformation of Milwaukee County's mental healthcare system, Milwaukee County has invested more than \$15 million in new and enhanced community based mental health services and, with its Mental Health Board, committed to privatizing acute care. Acute care services to be privatized include a psychiatric emergency department, observation beds, acute beds for adults, acute beds for children and adolescents, and a different building in which to operate. The current facility will continue to operate until new, alternative services for acute care are available and functioning. The transition to purchasing, rather than providing, acute services will shift the Behavioral Health Division from being primarily a provider of services to primarily a purchaser of services. This major system change reflects the national trend in strengthening community services and supports the rights of individuals with mental disabilities to live and receive care in the community in the least restrictive setting. These transitions require significant change in organizational structure and functions, many of which are currently underway.

A New Front Door

The privatizing of acute care services (including the psychiatric emergency department) and the impending move away from the existing BHD building provide an opportunity to reimagine the "front door" for mental health support in Milwaukee County, moving the delivery and coordination of community based service into the community and closer to the people/ geographic areas served. To realize this, two community based sites will be developed for mental health services ---one on the north side of Milwaukee and one on the south side of Milwaukee. The north side site is expected to open in late 2016, the south side site is expected to open in late 2017.

Initial Concepts Guiding Development

The initial expectations guiding the planning process included the following elements:

- The sites would be open 24 hours a day and 7 days a week.

- The sites would include clinician staff of several disciplines including certified peer specialists.
- The sites could support individuals with information for themselves or others, assessment and referral to other supports with a warm handoff.
- The sites would NOT be an emergency department, an acute care/hospital facility, a shelter or overnight facility with sleeping accommodations for crisis support.

The north side and the south side places will not be mirror images related to services. Some services will be at both sites, some will only be provided at a single site, based on need and other accessible services in those parts of the community.

The following existing services are targeted for transition to the north side and south side places:

- Mobile Crisis Teams
- Access clinics (unscheduled appointments to see a medication prescriber or talk with a counselor)
- Crisis line services
- Day Treatment programs and Intensive Outpatient Program services will be located at one of the two sites---likely at the south side site.
- Recommended a relationship be established with a nearby pharmacy to support access to medications.

Process for Input and Development

Development of these concepts has included several stages. Literature was reviewed, and a variety of discussions with others in behavioral health fields and in the community were held.

Initial descriptions of what such a community center might be were drafted, and discussions were set with multiple stakeholders for input. These "listening sessions" included a number of groups.

- BHD internal groups such as executives and managers, staff at Town Hall meetings, certified peer specialists, patients, community services staff, Wraparound Milwaukee staff, Family Council.
- External stakeholder groups which included the community at large, several advocate groups including the Mental Health Task Force Steering Committee and Pastors United in Milwaukee, Mental Health Board members, clients of mental health services that reflected multiple ethnic or racial backgrounds, administrators of other inpatient psychiatric settings in Milwaukee, Crisis Intervention Training (CIT) police officers, Crisis Assessment and Recovery Training (CART) teams, medical directors of other hospital emergency departments, case managers and discharge planners from private hospitals and their emergency departments.

All groups were asked "Question 1: what services and supports should be located at this place?," "Question 2: how should the place look and feel?" and "Question 3: what should it be called?"

Question 1: Services and Supports

All groups completed a written survey that listed 32 possible functions and services, asking them to rank the value of including those in a north side or south side place with the goal of creating an easier, less fragmented approach to support. Data were calculated for use. Those identified with highest frequency included:

- Crisis Mobile Team Dispatch for Adults and Children
- Substance Abuse Services and Referrals
- Peer Support Services
- Medication/prescriber and Counseling Clinic – walk in access clinic model
- Resources to support for Trauma and or Abuse Advocacy
- Housing Information and Resources
- Family Support and Advocacy Services such as NAMI, DRW, etc
- Referrals for therapy and ongoing support and treatment
- Benefit Applications and Assistance
- Interpreter Services
- Education and Information about Mental health, substance use, services available
- Outreach services station – moving beyond the walls to visibility and support in the community
- Access to primary care for providers who understand behavioral health issues was also supported.

All groups encouraged that there be “no wrong door” concept to support anyone who visited. Warm handoffs and assistance in accessing appointments and other services should be provided and supported in a new way.

Question 2: Look and feel

Participants described a welcoming environment that was clean, comfortable, and not institutional. The term “welcoming” was used over and over, with individuals that “greeted you” and “made you feel valued” and “heard”. Participants recommended against TVs playing in the lobby like a doctor’s office.

They suggested a north side of Milwaukee location in general, on a bus line, with good parking. Great lighting was suggested. Security was encouraged, with recommendations that it be subtle and not intimidating.

The issue of child care came up many times, suggesting a space where children could come with parents. There was also suggestion that when parents were talking with staff, they needed privacy, but the ability to still see/watch their children.

Transportation both to and from this place was highly emphasized.

Question 3: Name of site

Many names were suggested including Front Door, Home, Caring related themes, etc.

Some suggested what NOT to call it, including Milwaukee County Behavioral Health Division, “mental” anything, Center, Hub, etc.

No single best name was identified.

Size, Space and Location

Decisions regarding size of a facility, space considerations, and location are under consideration. The first steps required are to determine the services and workflows in the space. Zimmerman architects are currently engaged in space planning. A workgroup will be chartered to clarify space planning.

We anticipate leasing an existing building, once the necessary size is identified.

Staffing and Leadership

The leadership structure for the community sites will begin with a Director of Community Centers. This person will serve as the face of these centers, providing leadership to planning of both sites, work flow mapping, project management on the build, hiring or initial staff, engagement of partners in services, etc.

A role description has been developed, and is being evaluated by compensation, in readiness for posting. This position will report to Amy Lorenz, Deputy Community Services.

A manager will oversee 24/7 onsite services and staffing at each center. Staffing recommendations remain in development

Next Steps

Planning and development continue. It is anticipated that greater detail will be brought to the Mental Health Board, as well as other community groups, in February.

Attachment B

Responses to Findings Regarding the Milwaukee County Behavioral Health Division in the State Audit, Completed by Deloitte, December 2014.

The twelve Findings listed below were described in the Audit completed by the State of Wisconsin, Report on Mental Health Service Delivery in Milwaukee County, completed by Deloitte Consulting. And reported in December 2014. The comments to follow each Finding reflect the progress to date in strategic movement by the Behavioral Health Division.

Findings:

Finding 1: BHD has developed a standard data set to measure the quality of care of inpatient services delivered at the Complex. There is a significant opportunity to enhance the collection and reporting of quality and cost outcomes data that would allow BHD to measure itself against comparable facilities and agencies. Joint Commission Accreditation, specifically alignment with the Hospital-Based Inpatient Psychiatric Services (HBIPS) will accomplish this.

The quality and performance improvement model, processes, and data reporting is evolving. We are fully committed to being a data driven, high performing, and transparent health care system. Part of enhancing our capacity for data collection, analysis and use resides in the implementation of our electronic health record, which now influences services and outcomes across our continuum of services.

While we have clearly progressed in our approaches to measuring and improving performance with our EHR, we recognize the challenges of old technology used in our financial, human resource, time and attendance, and electronic health record systems. Virtually all of those systems are currently under evaluation, with several moving into new applications. Access to accurate data is the bedrock of this work.

BHD has been collecting and reporting the Hospital-Based Inpatient Psychiatric Services (HBIPS) data set since mid-2012. These can be found on the performance score card. We will continue to do so in our commitment to continuous improvement.

Finally, some of the services funded by Milwaukee County are contracted with community providers. In current state, only a few of those contracts have incorporated quality of care related performance measures. That is changing with new approaches to contracting and value based purchasing. Those new methods are in the process of being further developed and implemented, over the next several years.

Finding 2: The Mental Health Complex serves a unique role within the Milwaukee community by virtue of the high acuity population it serves. It's clear that the private hospitals rely on BHD to care for this more complex group of consumers; they in turn, have a role in serving low-moderate acuity individuals. There are processes in place to identify low-moderate individuals appropriate for care in private hospitals; yet, given the low rate of transfers of these consumers there may be opportunities to strengthen the intake and referral policies, payment incentives, etc. in order to better optimize high-acuity bed capacity at the Complex.

The Behavioral Health Division works daily with the private health systems in its efforts to find the best possible alternatives and sites for care delivery, in this context acute care services. We do have contracts in place with several other private inpatient facilities to pay for care of those for whom we don't have capacity and who are uninsured. We recognize the efforts of other local private health systems in increasing their admissions for inpatient psychiatric care, and with at least one health system, providing services for those with higher acuity illness.

Several other variables influence this issue. There is no regionally or nationally agreed upon "behavioral stability" or acuity criteria to better define levels of care needed. What one private health system considers high acuity may not be the same as another, or as BHD. BHD leaders are working with other local health systems routinely, including inpatient and emergency department representatives, to explore a regional standard for measuring acuity. In addition, law enforcement who is responsible for initial determination of need for emergency detention have done an excellent job following ongoing education to not place emergency detentions and have helped patients go directly to other community hospitals. This reduces the percentage of low acuity patients who present to PCS.

There is also no objective bed tracking system accessible for understanding capacity across different inpatient psychiatric facilities, supporting all facilities making any placement decision they deem most appropriate.

Finally, payment regulations require that we cannot pay incentives to other providers of service for care delivery beyond their defined reimbursement.

Finding 3: It does not appear that BHD has fully explored partnerships with community Federally Qualified Health Centers and approaches to integrating care.

Integration of behavioral health services as well as behavioral health and primary care services across sites remains in early stages in the Milwaukee community. It is an important area for expansion, and was even cited as a need in the recently released "Milwaukee County Outpatient Behavioral Health

Capacity Assessment” from the Public Policy Forum, HSRI, and TAC, released October 27, 2015. There are many barriers to creating a more integrated set of services across the community, including permission for information sharing, privacy regulations, technology, revenue stream issues, and more. Despite the barriers, there are great opportunities to coordinate care and support the effective and efficient care of individuals if these barriers were mitigated.

Integrating behavioral health and primary care is a critical need for comprehensive care delivery to those with serious mental illness. Good models are emerging in other cities, to guide future vision and partnerships. In fact, in Milwaukee, Whole Health Clinical Group is moving forward with a medical home model for those with serious mental illness. We will be excited to support and collaborate with them as possible. We continue to look at strategic opportunity.

Finding 4: Transformation towards a trauma-informed, recovery oriented, person centered system is still ongoing within the operations and culture of BHD and provider agency operations.

The MC3 values, fully embraced at BHD, are an ongoing journey. These include:

- Welcoming
- Co-occurring capability for environments of care
- Person-centered care
- Recovery –oriented
- Trauma-informed care
- Cultural intelligence in services
- System integration with long term linkages
- Service integration among services, resources, people and processes
- Stage-matched recovery planning across stages of change and recovery.

These values have guided strategies for care across our continuum of services. On the inpatient side, we now ask patients to complete their Personal Safety Plan upon admission. This is an opportunity to proactively ask individuals their preferred choices in the event of personal difficulty. Individuals are asked coping strategies that they want to incorporate into their plans of care including an assessment of trauma, to better inform our care teams and avoid re-traumatization. Another way those values have been highlighted was incorporating them into the Request for Proposals for acute care services. These values have provided guiding principles for the intensive, person by person focused efforts in the closure of Hilltop and Rehab Center Central, which included almost 130 individuals over a 3 year period of time. We recognize the importance of daily commitment and ongoing actions across all programs and services to bring these values to life for all persons.

Finding 5: Fifty-percent of the evidence based practices (EBP) were initiated on or after 2013; this indicates that provider agencies are at varying stages of fidelity with the EBP models.

Evidence based practices have been an evolving direction across all health care settings over the past years. The evolution has included time as well for science and care delivery to produce models and programs that meet high enough standards of evidence to warrant replication and implementation. Again, this focus of using evidence based practices remains a commitment for us and the providers with whom we work. Many of our processes and practices across BHD have been in analysis and are moving through change management approaches to enhance care and service delivery. Additionally, expectations for the use of evidence based practices will be incorporated into the contract redesign processes being built into our contracting strategy.

Finding 6: Four models have emerged for the continued provision of inpatient care to the highest acuity population. These models are informed, in part by the Wisconsin Public Mental Health and Substance Abuse Infrastructure Study (2009), options put forth in Act 203, and recently by the Analysis of Adult Inpatient Capacity (2014).

These four models include:

- Milwaukee County continuing to deliver acute services while significantly reducing the costs. Administrative leaders have reduced many expenses as able. Many county driven costs, such as the aging, too-large infrastructure and legacy pension costs, remain.
- The State assuming accountability for the Behavioral Health Complex, potentially creating a regional facility. State leaders have stated they do not plan to move in this direction.
- BHD creating a public-private partnership to manage acute services.
- BHD engaging a private entity to operate acute services.

These recommendations have formed the basis of action in releasing an RFP for Acute Services and a Facility on July 15, 2015. That RFP was withdrawn, though the work continues to move forward in different ways with a commitment to maintaining the timeline of moving out of this Watertown Plank Road facility within 2018.

A solution must be found, given the rising pressures of an aging facility, and the anxiety it creates in staff members who are concerned about the security of their jobs.

Finding 7: The federally-mandated IMD exclusion is a critical variable in the payment of behavioral health services for Medicaid beneficiaries. It is also a primary decision point for private hospitals considering acceptance of an eligible consumer from BHD. However, given the expansion of managed care in Milwaukee County in 2014 and the opportunity to encourage enrollment in Medicaid SSI HMO, the impact on the County and its partners is potentially shifting.

Most Medicaid recipients are required to sign up for a Medicaid HMO. However, clients on SSI Medicaid can, but are not required to, sign up for a Medicaid HMO. Because a mental health disability is one basis for SSI Medicaid eligibility, many BHD clients have SSI Medicaid for their

insurance. SSI Medicaid clients who do not sign up for an HMO do not have Medicaid coverage for inpatient per diem payments if they are inpatient at BHD by legal mandate. This may be changing over time, but it exists today.

BHD, for the last several years, has been actively engaged in a project to assist SSI Medicaid clients in joining a Medicaid HMO. BHD has met with significant success in this effort. Between 2013 and 2015 the percentage of Medicaid HMOs billed increased from 12% to 23%. During this same period, the percent of IMD bed days as a percentage of total bed days, decreased from 15% to 10%.

Finding 8: There is consensus on the part of stakeholders around the need to explore new delivery system options, payment/incentives and other policy levers to support the growth and development of a recovery-oriented, person centered behavioral health service delivery system.

The vision of the Mental Health Redesign initiative is grounded in a community focus, avoiding when possible acute services. BHD was built historically on an acute care and residential model, and that has been changing over the past five years. BHD has since become a continuum of services, with heavy development toward community services. It has also moved from being the provider of services, to rather the purchaser of services---a very different model. A significant change in the system and our opportunities will include new approaches to value based purchasing with contracts being driven with performance measurement.

Movement toward new delivery options is important. The movement toward developing a north side and south side community based "place" will add direction to the development of the model. This model will incorporate the MC3 values, as reflected in Finding 4. These values, including being person-centered and recovery-oriented, has been developed by and embraced across the Milwaukee community, which is powerful in fostering systems of care far beyond Milwaukee County Behavioral Health Division.

We recognize that clients move in and out of different systems and services, requiring new models, payments, and policies to look different than current state, more interconnected, and grounded with information systems and policies to share data. The "Outpatient Behavioral Health Capacity Assessment" cites this as one of the priority issues for our community. There is a need for a communitywide commitment to new delivery solutions, again, that go well beyond the Behavioral Health Division. We are optimistic that a collective response to the report may identify new solutions.

Finding 9: Additional study is needed to quantify in total, or by program, the financial investment on the part of the county, state, federal government or private sector.

Act 203 states... " The Milwaukee County mental health board shall arrange for a study to be conducted on alternative funding sources for mental health services and programs including fee-for-

service models, managed care models that integrate mental health services into the contracts with an increased offset through basic county allocation reduction, and other funding models. By March 1, 2016, the Milwaukee County mental health board shall submit to the Milwaukee County board of supervisors, the Milwaukee County executive, and the department a report of the results of the study.”

This study has been contracted through Deloitte Consulting, and should be available by March 1, 2016.

Finding 10: The differences in population demographics and statutory requirements of the emergency detention process in Milwaukee County prevent the ability to compare Milwaukee to other counties around the state. Yet, there may be opportunities to explore a broader interpretation of the statute to allow for more provision of care in the least restrictive setting.

The process of emergency detention in Milwaukee County is benefitted by the role of the Psychiatric Crisis Service. By having a physician always available to assess the client’s need for commitment, or not, right at the front door, we are able to potentially divert more individuals to a less restrictive setting. This high level clinical assessment by a physician prevents more individuals from a potentially unnecessary commitment that might be deemed by a clinical person with a different skill set.

In addition, close collaboration over time with law enforcement, as well as law enforcement’s development and collaboration with other behavioral health supports, has improved decision making about who does and likely does not need emergency detention. In fact, emergency detentions at BHD have reduced about 30% since 2010. There is a need for settings other than emergency departments, including crisis resource centers, and models such as the north side and south side “places” for assessment and support.

Further, there remain times when a person needs a higher level of care than ambulatory services, but a lower than acute level or more ongoing supportive and secured environment. We recognize the need for a “subacute” or “intensive residential” model within this community, and intend to explore that in the near term.

The state budget drafts within 2015 highlighted the potential of adapting, or even rewriting, the current Chapter 51 statutes. While that did not remain a direction in the budget, there is discussion within the professional community of how to provide leadership to ongoing analysis and redesign of this important statute.

Finding 11: There is a need for the County and/or State to invest in an interoperable IT and data infrastructure to assist in behavioral system planning and performance.

Information technology is most certainly critical to system planning, effective and efficient operations, and clinical support. The pathway with the electronic health record at BHD began in 2010 and is nearing full implementation. Despite that accomplishment and “designation”, there have been intensive and dedicated efforts to optimize this technology to make the desired impacts, operationally and clinically. While we have moved forward, there is much more to do. Interoperability is most certainly a goal. Leaders within BHD and within Milwaukee County, as well as with our provider networks, will continue to evaluate ways to optimize and analyze its use and effectiveness. The future opportunity of interoperability, whether through initiatives such as WISHIN or other models, will play a role in the future.

Finding 12: Consumers and advocates recognize investments made by BHD to rebalance the County’s behavioral health system while citing wide variation in responsiveness, quality, and recovery-orientation consumers; experience.

The journey toward a community based model of behavioral health services was visioned in 2011, and significant progress has been made in moving toward that goal. BHD is a continuum of care, a health care system that provides differing levels of care. Increasingly, that care and service is provided by a network of providers within the community who are contracted to deliver services. When acute services are provided by another partner, BHD will be structured almost completely as a purchaser of services, rather than a provider of services.

Engagement of other providers in the delivery of care requires BHD to do a better job of clarifying expectations within its contracts. As such, we are moving toward greater consistency in using performance based contracts, holding providers accountable to demonstrating that the care they provide meets the expectations of responsiveness, quality, a recovery orientation, and a positive client experience. The values of MC3 will be threaded into performance measures included in contracts.

Meetings with providers to share this direction were held in September and October of 2015. We will be enhancing ongoing communications with providers, and anticipate quarterly meetings. Our goal is to adapt all contracts (about 400 at BHD) over the next 3 years to incorporate performance measures along with new processes for assuring these are achieved.

Plans for Accreditation Process from the Joint Commission

Milwaukee County Behavioral Health Division was accredited by the Joint Commission until about 2003, when for various reasons, the accreditation process was discontinued. Joint Commission accreditation is a hallmark of commitment to standards and processes in best practice health systems and acute care settings. It has been a stated goal for the Behavioral Health Division to re-achieve Joint Commission accreditation, which would reflect use of nationally recognized processes for care and operations.

Questions have been raised regarding the value of pursuing accreditation, given the directions of finding a private partner to deliver care in the future. The rationale for us has been:

- As best we understand, transition to a private partner will be at least three years from now, which will result in a considerable amount of care yet to deliver. It is important to assure its goodness.
- Accreditation is not framed as an “award” but rather evidence that we are using nationally accepted processes for the way we work day to day. It is a way of being, and not a destination.
- It is of value to demonstrate the commitment to excellence and continuous improvement of the leaders at all levels of the Milwaukee County Behavioral Health Division. It addresses our commitment to patient and staff safety, planning for the care of patients/clients, availability of resources, commitment to competent staff, and continuous improvement of this all.
- The Joint Commission accreditation standards come with significant education and a language that is valuable for our staff to understand and use daily. Practice in a Joint Commission accredited facility will provide them with important experience for today and the future.
- The Quality Committee of the Mental Health Board has endorsed the plan to move forward with application for accreditation.

The Joint Commission processes also have standards and expectations for leadership including the governing board. These materials reflect work that is expected to be in place and used, and a commitment for leaders, at all levels, working together to achieve and support effective hospital performance.

LD.01.03.01 “The governing body defines in writing its responsibilities.”

We believe that Act 203, Mental Health Board Bylaws, and Mental Health Board Member Expectations have served as these documents.

LD.01.03.01 “The governing body approves the hospital’s written scope of services.”

See attached document A

LD.02.02.01 “The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment and services.”

Attached materials B reflect the internal conflict of interest policy for the organization and the medical staff. Because the Mental Health Board is an appointed governmental organization and membership, a

draft policy has been provided that reflects the information you have received in the past and the documents that you sign annually.

LD.02.04.01 “The governing body approves the process for managing conflict among leadership groups.”

See attached document C. This policy has been approved by the organization and the medical staff. It is shared in consideration of approval as a guide for the Mental Health Board as well.

LD.03.01.01 “Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.”

See attached document D. This policy has been approved by the organization and the medical staff. It is shared in consideration of approval as a guide for the Mental Health Board as well.

I request that these policies be approved for use by the Mental Health Board, or edited to be acceptable to reflect the commitment of the Board.

Milwaukee County Behavioral Health Division



SCOPE OF SERVICES: 2015

The Milwaukee County Behavioral Health Division provides care and treatment for adults, children and adolescents with serious behavioral health and substance use disorders both through County-operated programs and contracts with community agencies and provider partnerships. Services include intensive short-term treatment, acute psychiatric hospital services, crisis services and a full array of supportive community behavioral health programs.

Mission

The Milwaukee County Behavioral Health Division through early assessment and intervention promotes hope for individuals and their families through innovative recovery programs in behavioral health wellness, recovery, research and education.

Vision

The Milwaukee County Behavioral Health Division, through fostering strategic community partnerships, will become an Integrated Behavioral Health System providing a dynamic, and comprehensive array of services, including community based, emergency, and acute services, to meet the behavioral health care needs of individuals and families.

Philosophy of and Partnership in Care

We will provide care in a person centered, recovery oriented, trauma informed, culturally intelligent, least restrictive environment, with patient/clients and families as essential members of the care team. Partners in this vision include other stakeholders within Milwaukee County, the greater Milwaukee and Wisconsin communities, and nationally.

Culture of Quality, Safety and Innovation

We will create a culture of data driven decision making and continuous improvement, focused on quality and safety, meeting and exceeding regulatory, accrediting, best practice standards and patient and family expectations. Technology will be implemented, created, effectively used and disseminated across the continuum of services.

Healthy Learning Environment

We will create a positive learning environment and a culture grounded in respectful communication, collaboration, and healthy working relationships. Support of education of clinical disciplines in this organization, inter-professional educational models, and ongoing development of a behavioral health workforce will occur in partnership with others.

Financial Resources

We will provide leadership in creating lasting resources. Goals also include increasing operational efficiencies and minimizing tax levy exposure. This entity will meet the statutory obligations of Milwaukee County for the behavioral health services of its citizens, acting either as a provider or a purchaser of services.

Core Values

Our Behavioral Health System will support and adopt the following core values:

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible

*SERVICES AND PROGRAMS SUBJECT TO JOINT COMMISSION SURVEY:

Surveyed Under the **Hospital** Accreditation Standards:

- *Psychiatric Crisis Service (PCS)
- *Observation Unit (OBS)
- *Acute Adult and Child and Adolescent Inpatient Services (CAIS)
- *Psychiatric Crisis Line
- *Access Clinic
- *Community Consultation Team (CCT)
- *Crisis Mobile Team
- *Crisis Assessment Response Team (CART)

Surveyed Under the **Behavioral Health Care** Accreditation Standards:

- *Crisis Stabilization Houses (CSH)
- *Day Treatment

*ACUTE SERVICES

*Psychiatric Crisis Services/Admission Center (PCS)

The Psychiatric Crisis Service (PCS) is a specialized psychiatric crisis emergency department open 24 hours a day 7 days a week. PCS is the state appointed emergency detention facility and provides psychiatric emergency services including face to face assessment, crisis intervention and medication for individuals who may be in psychiatric crisis and who present to the center. A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, behavioral health emergency clinicians, psychologists, and certified nursing assistants are available on site 24/7 to provide assessments,

interventions, referrals and services as appropriate. All PCS patients who are not admitted to an inpatient unit or placed on an observation status are provided a written discharge plan to include written prescriptions, discharge teaching related to medications, self-care, healthcare and other learning needs, referrals, appointments, community resource materials and contacts with outside providers.

***Observation Unit (OBS)** If the PCS psychiatrist determines that there is a need for brief treatment and/or a more extended period of observation in order to evaluate the physical and mental status of an individual, the patient may be treated on Observation status and/or on the Observation Unit (OBS) up to 48 hours. This unit has the capacity for 18 beds available 24 hours a day and 7 days a week. The patient will be evaluated and may be discharged to another community setting, transferred to another facility for continuation of care, or considered for admission to a psychiatric hospital either at BHD or a private community hospital. A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, behavioral health emergency clinicians, psychologists, and certified nursing assistants are available on site to provide assessments, interventions, and discharge orders and referrals.

***Inpatient Services: Acute Adult and Child and Adolescent Inpatient Services**

The Milwaukee County Behavioral Health Division's Hospital Inpatient Services are provided in four-licensed psychiatric hospital units with three specialized programs for adults and one specialized unit for children and adolescents. Adult licensed units include one 24 bed adult unit called the Acute Treatment Unit (ATU), one 24 bed Women's Treatment Unit (WTU) and one 18 bed Intensive Treatment Unit (ITU). All units provide inpatient care to individuals who require safe, secure, short-term or occasionally extended hospitalization. A multi-disciplinary team approach of psychiatry, psychology, nursing, social service and rehabilitation therapy provide assessment and treatment designed to stabilize an acute psychiatric need and assist the return of the patient to his or her own community.

The 43-A - ITU program provides a safe, supportive environment for those individuals with mental health conditions who are at high risk for aggressive behavior and in need for intensive behavioral and pharmacological interventions.

The 43-B - ATU program is a general co-ed psychiatric care unit and teaching unit providing specialized services for adult men and women recovering from complex and co-occurring disorders who require safe, acute psychiatric services.

The 43-C- WTU program provides specialized services for women recovering from complex and co-occurring severe mental health disorders. A trauma-informed, person-centered approach to care and treatment for women is expected with a safe environment to support the unique needs of the population served.

The Child and Adolescent (CAIS) unit licensed for 24 beds, with an average daily census of 10 provides inpatient care to individuals ages 7- 18. The CAIS treatment unit also provides emergency detention services for Milwaukee County as well as inpatient screening for Children's Court including the provision of an adjacent educational school program operated by the Wauwatosa School District.

Patients on all of the psychiatric units can expect:

Assessment – Diagnosis – Individualized Recovery Plans – Pharmacotherapy- A Safe, Healing Environment- A Caring, Welcoming Team- Structured Programming- Patient Education- Peer Support- Family and Support Participation- Consultative Services- Spirituality Services- Music and Occupational Therapy- Comprehensive Discharge Planning- Ultimately a respectful, positive patient experience.

Each patient admitted to the psychiatric hospital will have an aftercare/discharge plan specifying services and referrals needed upon discharge. Treatment teams assure that individual patient's bio-psycho-social needs and strengths are addressed with interventions, referrals and education to prepare those receiving care for community living or another level of care in the least restrictive setting.

Patient census on all of these licensed psychiatric hospital units is adjusted based on patient needs and staffing care patterns to ensure safe, quality care. A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, psychologists, social workers, occupational therapists/music therapists, peer specialists and certified nursing assistants are available on site on all units to provide hospital assessments, interventions, referrals, supervision and intensive psychiatric hospital services as appropriate.

***BHD Crisis Services**

BHD Crisis Services works closely with CARS and provides crisis assessment, stabilization, and linkage and follow-up services to any individual experiencing a mental health crisis. Community-based crisis services include:

- **Crisis Line***

Crisis telephone services are often the first point of contact with the mental health system for an individual in crisis or a member of his or her support system. The Milwaukee County Behavioral Health Division's Crisis Line is a 24-hour a day, seven day a week telephone service that provides callers with screening and assessment, support, counseling, crisis intervention, emergency service coordination, information and referrals. Objectives of the Crisis Line service include relief of immediate distress in pre-crisis situation, thereby reducing the risk of an escalation of the crisis; arranging for necessary emergency on-site responses when necessary to protect individuals in mental health crises and emergencies; and providing callers with referrals to appropriate services when additional intervention is required. The Crisis Line may also provide stabilization, linkage and follow-up services when clinically indicated. The Crisis Line is the main access point for Mobile Crisis Team services. There were 37,493 calls to the Crisis Line in 2014.

- **Access Clinics and Mental Health Outpatient Services***

The Access Clinic – a walk-in center for outpatient psychiatric services – is part of the stabilization component of crisis services. The clinic provides walk-in services on both an unscheduled (clinical assessment and referral for services) and scheduled (medical evaluation with prescriber) basis to individuals voluntarily seeking crisis intervention, a face-to-face mental health assessment, treatment, and/or referral. Services provided may include clinical assessment, referral for individual and/or group psychotherapy and supportive counseling, evaluation for medication and ongoing psychiatric care, and referrals to outpatient psychiatric and other social services as needed. The Access Clinic is the initial access point for uninsured Milwaukee County residents in need of outpatient mental health services. The clinic operates Monday through Friday from 8:00 am to 4:30 pm. In 2014, Access Clinic South opened on the south side of Milwaukee. The Access Clinics served 3,541 individuals in 2014, of

whom 799 were new patients. Additionally, there were 484 individuals who received therapy services through the Mental Health Outpatient Program.

- **Community Consultation Team***

In an effort to support the closing of BHD's Center for Independence and Development (CID, formerly Hilltop) and to reduce utilization of Psychiatric Crisis Services (PCS), Crisis Services is expanding the Crisis Mobile Team with staff who have expertise in serving individuals who are dually diagnosed with intellectual developmental disabilities (IDD) and mental health issues. The ability to provide support during crisis situations for individuals who are relocated from the CID will be imperative to their success in the community. This service is provided by a BHD team of two Psychologists, 1 Registered Nurse and 1 Developmental Specialist Monday through Friday from 8am to 5 p.m. with 5-9 pm weekdays and 8-5pm weekend services provided by a contracted service; Dungarvin. The goal of the Community Consultation Team (CCT) is to provide individuals with IDD and mental health with services in the community as a way to support their community placements and thereby reduce the need for admission to higher levels of care such as emergency room visits and hospitalizations. The CCT provides ongoing crisis intervention, consultation, and education services to individuals who have been placed in the community from the CID. This team began full services in January 2014.

- **Crisis Mobile Team***

The Crisis Mobile Team provides crisis services on an outreach basis. This service was expanded in 2014 to have on-call clinicians to respond during third shift to provide on-site face-to-face assessments in the community. The two member team composed of either Registered Nurses, Social Workers including Behavioral Health Emergency Service Clinicians and a Psychologist responds to the individual and provides services in the setting in which the mental health emergency or crisis is occurring, virtually anywhere in the community where it is deemed safe and appropriate to meet the person. The team works with the individual and his/her significant supports, as well as referring agencies, for as long as necessary to intervene successfully in the crisis, initiating necessary treatment, resolving problems, providing high levels of support until the crisis is stabilized, and making arrangements for ongoing services. Objectives of the mobile services include relief of immediate distress in crisis and emergency situations; reducing the level of risk in the situation; assisting law enforcement officers who may be involved in the situation by offering services such as evaluations for Emergency Detention under Chapter 51, and describing other available services and intervention options; and providing follow-up contacts to determine whether the response plans developed during the emergency are being carried out. The Mobile Team also includes a Geriatric Psychiatric Registered Nurse experienced in providing assessment for mental health issues complicated by a variety of medical and social problems of the aging person. In 2014, the Mobile Team was involved in 2,008 crisis contacts in the community. Mobile hours of service include Monday through Friday 7:30 a.m. – Midnight and Weekends 11:00 a.m. – 8:00 p.m. Third Shift hours of service are via a contracted service provider (LaCausa) from approximately Midnight to 7:30 a.m.

- **Crisis Assessment Response Team***

The Crisis Services has joined with the City of Milwaukee Police Department (MPD) to create an expansion program of the Crisis Mobile Team. This expansion – the Crisis Assessment Response Team (CART) – consists of a single mobile team clinician and a single police officer partnered together as a mobile team in the community. Their primary objective is to respond to Emergency Detention calls to provide service and attempt to stabilize the individual with their own natural supports/resources or

assist them in obtaining voluntary treatment. The goal of the team is to decrease Emergency Detentions by identifying and utilizing voluntary alternatives and make a positive impact for individuals experiencing a crisis. This mobile expansion team began providing services in July 2013, and a second team began in March 2014. One CART team is available M-F from 11:00 a.m. – 7:30 p.m. Another CART team is available M-F from 4pm – Midnight.

- **Crisis Stabilization Houses***

The Crisis Stabilization Houses (CSH) are an alternative to psychiatric inpatient hospitalization. The CSHs provide a less restrictive environment in which to treat and support people experiencing psychological crises. Services include assessment, medication and medical evaluations, and counseling. There are three 8-bed CSHs in Milwaukee County which are operated by contracted agencies and their respective staff, with additional daily clinical face to face services 7 days a week from the BHD Crisis Mobile Team. CSHs served 391 individuals in 2014.

- **Day Treatment***

Medicaid-reimbursable

Day Treatment is intensive treatment for individuals 18 years of age and older who have complex and co-occurring disorders, provided in a community milieu Monday through Friday, with 24-hour crisis interventions available through links to the Milwaukee County Crisis Line. CARS psychologists facilitate sixty (60) treatment groups per week – via the Dialectical Behavior Therapy Treatment Team and the Recovery and Stabilization Treatment Team – plus monthly recovery planning conferences with clients, their families, and other involved providers. The treatment team is multidisciplinary, including psychiatry, psychology, social service, nursing, music therapy, and occupational therapy. The capacity of the program is 22 to 28 clients, based on acuity and risk concerns. There were 59 clients served in 2014.

The following services identified below are not subject to the Joint Commission Survey:

- **Crisis Resource Centers**

The services at the Crisis Resource Centers (CRC) are provided via an agency that contracts with BHD. The CRC offers a safe, recovery oriented environment that provides short-term crisis intervention to individuals. They provide a multitude of services which includes crisis stabilization, peer support, and linkage to ongoing support and services. The CRC also promotes opportunities for increased collaboration among community services and providers for the benefit of consumers and improved community health through consumers' increased quality of life. There is one CRC located on the Southside of Milwaukee that provides walk-in crisis services along with short-term stabilization services for up to seven individuals at a time. The CRC North opened in August 2014 and provides services for up to twelve individuals at a time.

- **Community Linkages and Stabilization Program**

The Community Linkages and Stabilization Program (CLASP) is an extended support and treatment program designed to support consumers' recovery, increase consumers ability to live independently in the community, and reduce incidents of emergency room contacts and re-hospitalizations utilizing

person-centered and trauma-informed focus by Certified Peer Specialists. The goals of the program are to: improve the quality of life for consumers; promote recovery in the community; increase the ability for consumers to cope with issues and avoid crisis; increase consumers' ability to manage stressors without hospitalization; connect consumers to beneficial supports and resources; and empower consumers to direct their recovery process. The services of this program are provided by La Causa through a contract overseen by BHD Crisis Services. In 2014, this program served 160 individuals.

COMMUNITY SERVICES

Community Access to Recovery Services (CARS) is the Behavioral Health Division entity that manages the public-sector, community-based mental health and substance abuse system for adults in Milwaukee County. CARS is becoming an integrated system of care for co-occurring mental health and substance use disorders, bringing together the two systems heretofore known as Service Access to Independent Living (SAIL) – for mental health – and Wiser Choice – for alcohol and other drug abuse (AODA), or substance use.

CARS – Mental Health

CARS is the central access point for Milwaukee County residents with severe and persistent mental illness who require long-term support. CARS provides – either directly or through contracts with community-based providers – the following mental health services:

- **Outpatient (Indigent Care)**

CARS provides an outpatient level of care to individuals who are indigent and uninsured. Outpatient services primarily include psychiatric evaluation, diagnosis and medication management. There are also limited individual therapy services offered by the outpatient clinics. CARS currently has contractual relationships with two outpatient providers – the Medical College of Wisconsin CCAPS Clinic and Outreach Community Health Center. Referrals for this level of care come exclusively from the Access Clinics and the BHD inpatient hospital. As individuals obtain insurance, they are moved off of the contract, but most often have the option to still be served by the same provider. There were 2,066 individuals referred for Outpatient services in 2014.

- **Care Coordination Team**

In April 2014, a six team member Care Coordination Team will begin to provide various supportive services to individuals identified through current BHD access points or by referral based upon need. This team will also be providing case management and supportive services to individuals awaiting TCM or CSP. Lastly, this team will be providing crisis stabilization services through an outreach model.

- **Targeted Case Management**

Medicaid-reimbursable

Targeted Case Management (TCM) is a service to support individuals with serious and persistent mental illness to live as independently as possible in the community. TCM must include assessment, case planning, obtaining and referral to services, ongoing monitoring and services coordination, and assurance of consumer satisfaction. A case manager can also assist a consumer in obtaining and

maintaining the following: housing; legal assistance; medication management; employment and training; money management; benefit advocacy; medical assistance; Activities of Daily Living (or ADL) assistance; social network development; AODA services and support; and peer supports. Each TCM consumer is assigned a primary case manager and develops a case plan according to the individual's needs. In addition to the traditional TCM just described, there is also an Intensive TCM with a clinic model, a Recovery TCM, and an AODA TCM. CARS contracts with eight (8) community agencies to provide TCM services:

- Alternatives in Psychological Consultation
- Bell Therapy – Phoenix Care Systems
- Horizon Healthcare
- La Causa
- Milwaukee Mental Health Associates
- Outreach Community Health Center
- TLS Behavioral Health
- Wisconsin Community Services

CARS contracts for 1152 slots of traditional TCM, 210 Intensive TCM, 40 Recovery TCM, and 60 AODA TCM. There were 1,523 individuals who received TCM services in 2014. Contracted agencies are required to submit an evaluation report to CARS twice a year, reporting on the following outcomes:

- Decreased incidence of hospitalization
- Increased client participation in own treatment, goals, and recovery planning
- Increased levels of self-determination, empowerment, and independence
- Positive movement on the recovery spectrum

There is a waitlist for TCM that had grown to over 100 in February 2015 but has since decreased to 57 as of the end of March, due to an expansion of TCM slots that was approved to begin as of January 1, 2015. There are sufficient openings for the waitlisted clients to eventually be assigned, including those clients being reassigned as a result of the closure of County-operated Community Support Programs.

- **Community Recovery Services**

- *Medicaid-reimbursable*

Community Recovery Services (CRS) is for persons with a severe and persistent mental illness, mood disorder, or other psychotic disorder only. Eligible individuals must be at or below 150% Federal Poverty Level (FPL) and at a specific functioning level. CRS reimburses three core services:

- Community Living Support Services (for transitions from a supervised living situation to a consumer's own home);
- Supported Employment Services (Individual Placement and Support model); and
- Peers as Providers.

CRS allows for co-participation in other psychosocial rehabilitation benefits and services, such as CSP, CCS, TCM, and CBRF services. A client can also self-identify and direct his or her own participation in CRS. Two CBRF providers – Bell Therapy and TLS Behavioral Health – are currently providing Community Living Support Services under CRS. The care coordination component of CRS is provided by St. Charles and La Causa. A total of 67 CBRF consumers were enrolled in CRS in 2014. There is not a waitlist for CRS services.

- **Comprehensive Community Services**

Medicaid-reimbursable

Comprehensive Community Services (CCS) is a recovery-focused, integrated behavioral health program for adults with severe mental illness and/or substance use disorders and children with severe emotional disturbance. CCS is unique for its inclusion of both children and adults and its focus on other physical illness and impact on multiple system use. CCS provides a coordinated and comprehensive array of recovery services, treatment, and psychosocial rehabilitation services that assist individuals to utilize professional, community, and natural supports to address their needs. CCS is a community-based program in which the majority of services are provided in clients' homes and communities. The program is person-centered and uses client-directed service plans to describe the individualized services that will support the client to achieve their recovery goals. Services are provided by teams of professionals, peer specialists, and natural supports, all coordinated by a CCS service facilitator. CCS reimburses services including:

- Assessment
- Recovery Planning
- Service Facilitation
- Communication and Interpersonal Skills Training
- Community Skills Development and Enhancement
- Diagnostic Evaluations and Assessments
- Employment-Related Skill Training
- Medication Management
- Physical Health and Monitoring
- Psychoeducation
- Psychotherapy
- Recovery Education and Illness Management
- Substance Abuse Treatment
- Non-Traditional or Other Approved Services
- Psychosocial Rehabilitative Residential Supports
- Peer Supports
- Functional AODA and Mental Health Screener

CARS began CCS implementation in September 2014 and has received 173 referrals through March 2015. Ninety-one (91) referrals have been sent to agencies to be screened, seventy-six (76) of which have been found fully eligible. Sixty-four (64) consumers are awaiting assignment to an agency for CCS and will be referred to agencies as soon as capacity expands. Five agencies are operating and are hiring more Care Coordinators and Ancillary service providers. Four more agencies will become CCS providers in April.

- **Community Support Program**

Medicaid-reimbursable

A Community Support Program (CSP) is an integrated community service model for persons who have the most severe and persistent mental illnesses and significant functional limitations. CSPs provide over 50% of contacts in the community in a non-office, non-facility setting. All CSPs in Milwaukee County are certified under DHS 63 and provide psychiatry, budgeting, payeeship, crisis intervention, nursing, housing, vocational, medication management, symptom management, and social skill

training. CARS serves clients in CSPs through Purchase of Service contracts with seven (7) community agencies:

- Bell Therapy North
- Bell Therapy South
- Milwaukee Mental Health Associates
- Outreach Community Health Center
- Project Access
- TLS Behavioral Health
- Wisconsin Community Services

There were 1,371 individuals who received CSP services in 2014. CARS recently completed the outsourcing all CSP services to contracted providers, closing two County-operated CSPs in December 2014 and March 2015 and transitioning those clients to appropriate services elsewhere in the community. There were a total of 267 clients transitioned in those closures. All seven CSP agencies are in the process of implementing the evidence-based practices of Assertive Community Treatment (ACT) and Integrated Dual Disorder Treatment (IDDT) with technical assistance from Case Western Reserve University.

- **Community-Based Residential Facilities**

Medicaid-reimbursable: CRS Per Diem & Crisis Per Diem

CARS works collaboratively with the Milwaukee County Housing Division to offer a wide range of supportive residential programs to individuals in our system. The highest level of supportive environments on this continuum are Community-Based Residential Facilities (CBRF). CBRFs are licensed facilities that offer 24-hour on-site supervision with a variety of rehabilitative services offered. CARS has Fee for Service agreements with three agencies – Bell Therapy, TLS Behavioral Health, and Homes for Independent Living – to provide a CBRF level of care at 18 sites. Belwood is a large facility that serves approximately 45 individuals, and the remainder of the sites range from 5 to 15 beds, with most maintaining about 8 beds.

CARS tracks several major recovery outcomes for clients with severe and persistent mental illness, including improvements in:

- Living arrangement/homelessness
- Employment (any)
- Employment (competitive)
- Criminal justice involvement
- Arrests/incarceration
- Health/dental/vision care received
- Daily activity
- Risk of suicide
- Psychiatric bed days
- PCS crisis episodes
- Consumer satisfaction

CARS – Substance Use

CARS provides substance use disorder services to Milwaukee County residents aged 18-59 and pregnant women of all ages. Eligible individuals can receive a comprehensive screen at one of four community-based Central Intake Units: IMPACT, JusticePoint, M & S Clinical Services, and Wisconsin Community Services. Central Intake Units (CIU) provide a comprehensive screen of individuals seeking to recover from substance abuse in order to determine the appropriate level of clinical care and the individual's care coordination and recovery support service needs. The CIUs refer eligible clients to the appropriate services offered by providers in a fee-for-service network operated by CARS. Substance use disorder services include:

- **Outpatient**

Outpatient is a non-residential treatment service totaling less than 12 hours of counseling per patient per week, which provides a variety of evaluation, diagnostic, crisis and treatment services relating to substance abuse to ameliorate negative symptoms and restore effective functioning. Services include individual counseling and intervention and may include group and family therapy and referral to non-substance abuse services that may occur over an extended period. The provider must be certified as a DHS 75.13 outpatient provider. There are 33 providers of Outpatient services in the CARS network. Outpatient services were provided to 2,628 individuals in 2014.

- **Recovery Support Services**

Recovery Support Services are offered to meet a client's non-clinical needs in a manner that supports his or her recovery. Services are community based, available from faith-based providers, and may include such services as childcare, anger management, transportation, educational or employment assistance, and housing support. There are 33 providers of Recovery Support Services in the CARS network. There were 1,753 individuals engaged in Recovery Support Services in 2014.

- **Recovery Support Coordination**

Recovery Support Coordination uses a strength-based approach to develop, in partnership with the client, his or her service providers, and other persons the client wants involved, an individualized single coordinated care plan that will support the client's recovery goals. There are four providers of Recovery Support Coordination in the CARS network. There were 3,912 individuals engaged in Recovery Support Coordination in 2014.

- **Day Treatment**

Day Treatment is a medically monitored, and non-residential substance abuse treatment service which consists of regularly scheduled sessions of various modalities, such as individual and group counseling and case management, provided under the supervision of a physician. Services are provided in a scheduled number of sessions per day and week, with each patient receiving a minimum of 12 hours of counseling per week. The provider must be certified as a DHS 75.12 day treatment service provider. There are 15 providers of Day Treatment services in the CARS network. There were 309 individuals engaged in Day Treatment services in 2014.

- **Medication Assisted Treatment**

Medication Assisted Treatment (MAT) in Milwaukee County has expanded in terms of providers, types of clients served, and additional services provided to the population. Vivitrol providers for both the insured and uninsured populations in the CARS network expanded in 2014, while CARS also continued to work closely with contracted Methadone clinics. As of February 2015, all clients presenting to a CIU

are now assessed to determine if they meet MAT criteria and are given information about the different choices. There are three providers of MAT in the CARS network. There were 279 individuals who received MAT in 2014.

- **Residential**

Transitional Residential is a clinically supervised, peer-supported therapeutic environment with clinical involvement. The service provides 3 to 11 hours of counseling per patient per week, immediate access to peer support through the environment, and intensive case management which may include direct education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping, and financial planning.

Medically Monitored Residential operates as a 24-hour, community-based service providing observation, monitoring, and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week for each patient.

Co-Occurring Bio-medically Monitored Residential operates as a 24-hour, community-based service providing observation, monitoring and treatment by a multidisciplinary team under supervision of a physician, and staffed 24 hours a day by nursing personnel.

CARS provides these services at seven (7) locations through Fee for Service agreements with Genesis (2), Matt Talbot (2), United Community Center (2), and Meta House (1). CARS supports a total capacity of 124 beds (59 male, 65 female) for residential substance use treatment. As of April 1, there were 76 people on a waitlist for residential treatment, with the list fluctuating daily. Pregnant clients are prioritized and are not subject to the waitlist.

- **Detoxification**

Detoxification is a set of interventions to manage acute intoxication and withdrawal to minimize the physical harm caused by the abuse of substances. Supervised detoxification can prevent potentially life-threatening complications that may arise in the absence of treatment. Detoxification is also a form of palliative care for persons who want to become abstinent from substance use. A critical component of detoxification service is preparing the individual for engagement with appropriate substance abuse treatment commensurate with his or her ongoing needs. CARS contracts with a single provider for medically monitored residential detoxification service (DHS 75.07), ambulatory detoxification service (DHS 75.08), and residential intoxication monitoring service (DHS 75.09). There were 1,911 individuals who utilized detoxification services in 2014.

CARS tracks several major recovery outcomes for clients receiving AODA services, including improvements in:

- Retention in treatment
- Completion of treatment
- Abstinence from alcohol
- Abstinence from drugs
- Living arrangement/homelessness
- Employment or school/job training
- Arrests/incarceration
- Social connectedness (family and recovery groups)
- Consumer satisfaction

For individuals in all CARS programs, a variety of demographic and services data required for State PPS reporting are also tracked, including: referral source; gender; age; race/ethnicity; primary language; education; disabilities; legal status; services received; amount/length of service; and discharge reason.

Rehabilitation Center Central

Long-term rehabilitative care for residents with complex medical and behavioral needs is provided through Rehab Center Central, a Skilled Nursing Facility. The goal is to promote optimum function and return to the appropriate community setting. This program is under active closure with all current residents being transitioned to community setting/homes. Complete closure of Rehabilitation Center Central is targeted end of year 2015.

CODE OF ETHICS FOR LOCAL GOVERNMENT OFFICIALS

Milwaukee County Mental Health Board

A MENTAL HEALTH BOARD (MHB) MEMBER SHOULD NOT:

ACT OFFICIALLY IN A MATTER IN WHICH PRIVATELY INTERESTED OR FOR AN ORGANIZATION WITH WHICH ASSOCIATED. Use his or her public position or office to obtain financial gain or anything of substantial value for the private benefit of himself or herself or his or her immediate family, or for an organization with which he or she is associated. [§ 19.59(1)(a), *Wisconsin Statutes*]

SOLICIT OR ACCEPT ANYTHING OF VALUE LIKELY TO INFLUENCE. Solicit or accept from any person, directly or indirectly, anything of value if it could reasonably be expected to influence the local public official's vote, official actions or judgment, or could reasonably be considered as a reward for any official action or inaction on the part of the local public official. (This does not prohibit a local public official from engaging in outside employment.) [§ 19.59(1)(b)]

USE PUBLIC POSITION TO OBTAIN UNLAWFUL BENEFITS. Directly, or by means of an agent, give, or offer or promise to give, or withhold, or offer or promise to withhold, his or her vote or influence, or promise to take or refrain from taking official action with respect to any proposed or pending matter in consideration of, or upon condition that, any other person make or refrain from making a political contribution, or provide or refrain from providing any service or other thing of value, to or for the benefit of a candidate, a political party, a person who is subject to a registration requirement under s. 11.05 (registration of political groups, committees, and individuals), or any person making a communication that contains a reference to a clearly identified local public official holding an elective office or to a candidate for local public office. [§ 19.59(1)(br)]

USE PUBLIC POSITION FOR SUBSTANTIAL FINANCIAL INTEREST. Take any official action substantially affecting a matter in which the official, a member of his or her immediate family, or an organization with which the official is associated has a substantial financial interest. [§ 19.59(1)(c)1]

USE PUBLIC POSITION FOR SUBSTANTIAL BENEFIT. Use his or her office or position in a way that produces or assists in the production of a substantial benefit, direct or indirect, for the official, one or more members of the official's immediate family either separately or together, or an organization with which the official is associated. [§ 19.59(1)(c)2]

ACCEPT TRANSPORTATION, LODGING, FOOD, OR BEVERAGE EXCEPT AS SPECIFICALLY AUTHORIZED. Accept or retain transportation, lodging, meals, food or beverage except items and services offered for reasons unrelated to public office, as long as not furnished by a lobbyist or by a lobbyist's employer, or items provided by or to the MHB and primarily for the MHB's benefit. [§§ 19.59(3)(a) and 19.44(h)]

PENALTY FOR VIOLATION OF ETHICS CODE. Any person who violates this Ethics Code may be required to forfeit not more than \$1,000 for each violation, and additional penalties equal to the amount or value of any political contribution, service, or other thing of value wrongfully obtained, after commencement of an action by the district attorney or attorney general's office. [§§ 19.59(7) and (8)]

STATEMENT OF ECONOMIC INTEREST

Milwaukee County Mental Health Board
c/o Behavioral Health Division
9455 W. Watertown Plank Road
Wauwatosa, WI 53226
Telephone: (414) 257-5202 * Fax: (414) 257-8018

CURRENT INFORMATION: All information given below must be current; that is, not prior to the 15th day of the month preceding the month this statement is prepared.

TYPE OR PRINT: Additional directions, definitions and other pertinent information are contained in the Instruction Sheet (yellow insert). Please read it carefully BEFORE completing the Statement. If more space is needed, please use additional sheets.

DATE PREPARED: _____
(Month) (Day) (Year)

NAME: _____
(Last) (First) (Middle Initial)

SPOUSE'S NAME: _____
(Last) (First) (Middle Initial)

POSITION SOUGHT/HELD w/ the MILWAUKEE COUNTY MENTAL HEALTH BOARD:

NAME AND ADDRESS OF PRESENT EMPLOYER AND POSITION HELD FOR WHICH YOU RECEIVE \$1,000 OR MORE OF INCOME:

NAME AND ADDRESS OF PRESENT EMPLOYER AND POSITION HELD FOR WHICH YOUR SPOUSE RECEIVES \$1,000 OR MORE OF INCOME:

ADDITIONAL SOURCE OF INCOME: LIST OTHER SOURCES OF INCOME FROM WHICH YOU OR YOUR FAMILY RECEIVED \$1,000 OR MORE OF INCOME:

1. OFFICES, DIRECTORSHIPS & POSITIONS

* In this section, "Organization" means any corporation, partnership, proprietorship, firm, enterprise, franchise, association trust, Board, Commission or other legal entity other than an individual or body politic.

IA: As of the dated cited above, were you or your spouse an officer, partner, sole proprietor director or trustee of any business or other organization? Yes No

IB: As of the date cited above, were you or your spouse an officer of or did you or your spouse hold a position with any organization doing business with Milwaukee County or receiving funds from Milwaukee County?
 Yes No

If you have answered no to both above items, please check here: **Proceed to Item #2**

If you have answered yes to either 1A or 1B above, identify each business or organization and position held:

Name of Business or Corporation	City & State	Position Held

2. SIGNIFICANT FIDUCIARY RELATIONSHIP

As of the date cited on the first page, did you or your spouse own or control any of the following directly or indirectly:

- A. At least ten (10) percent of outstanding stock of any business corporation; or
- B. Stock having a value of at least \$5,000; or
- C. An interest of at least ten (10) percent or \$5,000 of any business)?

If no to all of the above items, please check here: **Proceed to Item #3**

If yes to any of the above items, please identify the business and the type of ownership:

****Note: You need not report the actual dollar values or number of shares, etc.**

Business Entity	City & State of its principal office	Type of Ownership (e.g. Common Stock, Limited Partnership)

3. BOND, DEBENTURES & DEBT OBLIGATIONS

As of the date cited on the first page, did you or your spouse hold any bonds, debentures or debt obligations of a municipal corporation or other corporation in excess of \$5,000?

If no to all of the above items, please check here: Proceed to Item #4

If yes, please identify each Issue and place a checkmark in the proper column below to indicate the value.

Issuer Name, City & State	Value Under \$50,000	Value Over \$50,000

4. CREDITORS

As of the date cited on the first page, did you or your spouse owe, separately or together with another person, to any creditor \$5,000 or more?

If no to all of the above items, please check here: Proceed to Item #5

If yes, please identify each Issue and place a checkmark in the proper column below to indicate the value owed.

Creditor's Name, City & State	Value Under \$50,000	Value Over \$50,000

--	--	--

5. REAL PROPERTY

As of the date cited on the first page, did you or your spouse hold an interest valued at \$5,000 or more in real property other than your principal residence or other than property in which the pro rata share held is less than 10% of the outstanding shares?

**Report only on properties located in the counties of: Milwaukee, Ozaukee, Washington, Waukesha, and Racine.*

If not to all of the above items, please check here: Proceed to Item #6

If yes, please identify the property and nature of interest held.

Location of Real Property (street/rural route address; fire number & municipality)	Value Under \$50,000	Value Over \$50,000

6. TRANSFER

As of two calendar years preceding the filing of this statement, have you or your spouse transferred to any member of your immediate family any significant fiduciary relationship (as defined in the instruction sheet) or any real property or any bonds, debentures or debt obligations of municipal corporation or other corporation which is in excess of \$5,000?

Business, Issuer, Real Property, Creditor	Address	Description of Interest

- **INCUMBENTS** now in elective public office and current County employees are to *SKIP* Item #8.
- **CANDIDATES** for elective public office are to *SKIP* Item #7.

7. GIFTS, HONORARIA, FEES, EXPENSES

List each individual and organization from which you and your spouse received a GIFT, HONORARIUM, FEE and EXPENSES during the preceding taxable year. For a full understanding of this reporting requirement, it is important that you read in its entirety.

7A: GIFTS including ENTERTAINMENT. A "gift" is the receipt of anything of value, which is furnished without valuable consideration. Do not include anything received which was made for a purpose unrelated to duties or responsibilities of the position of the official or employee. List all individuals and organization from which you received in the past year entertainment or gifts having a total value of \$50 or more, not including the value of food or beverage offered coincidentally with a talk or meeting related to the business of the Milwaukee County Mental

Health Board. Include tickets to sporting or theatrical events, golfing fees, prizes, samples of promotional items from sales representatives or as part of business promotions and similar items.

7B: HONORARIA, FEES AND EXPENSES FOR TALKS AND PUBLICATIONS RELATED TO PUBLIC OFFICE. List each individual or organization from which you or your spouse received, in the past year, lodging, transportation, money or other things having a total of \$50 or more, not including the value of food or beverage offered coincidentally with a talk or meeting where the subject matter of which was related to your duties or responsibilities as a member of the Milwaukee County Mental Health Board. You do not have to list information about a payment: (1) if you returned it within 30 days; (2) If you received it from the Milwaukee County Mental Health Board.

If you or your spouse has no reporting(s), please check here: Proceed to signature section.

If you or your spouse has reporting(s) for Item #7, please use the enclosed form titled for this purpose and submit with your Statement.

8. CANDIDATES ONLY for elective public office are to furnish the following information:

Name of present employer and position you hold:

(Employer)

(Position)

By signing this form, I certify that the information contained in this Statement of Economic Interests is true, correct and complete to the best of my knowledge, information and belief.

X

Signature of person filing Statement

Date of Signature

APPENDIX A

AFFIDAVIT

Please check the appropriate boxes below and sign this form in front of a valid Wisconsin Notary Public.

STATE OF WISCONSIN)
) SS.
MILWAUKEE COUNTY)

The undersigned, being duly sworn on oath, deposes and says that *he* / / *she* is a public official by membership on the Milwaukee County Mental Health Board; that *he* / *she* has read and understands and to the best of *his* / *her* knowledge and belief, *he* / *she* has complied with the provisions of Wis. Stat. §§ 19.59 and 19.44 relating to a Code of Ethics.

Signature of Affiant

Title of Affiant

Subscribed and sworn to before me

This _____ day of _____, 2015

Signature of Notary

My commission expires on _____



Behavioral Health Division

Date Issued: 11/13/2015
Last Approved Date: 11/13/2015
Last Revised Date: 11/13/2015
Next Review: 11/12/2018
Owner: Lynn Gram: 80043-Safety Officer
Policy Area: Division Administration
References:

Conflict Management

Purpose:

Conflict is a normal response to differing opinions about needs, values and interests. While not all conflict is harmful, the purpose of this policy is to not let ineffectively managed conflict adversely affect patient safety and quality, particularly when leadership groups disagree about accountabilities, policies, practices, and procedures.

The Administration and Governing Body of the BHD have established and approved a conflict management process in order to:

- Promote productive, collaborative, and effective teamwork among and between all tiers of the organization
- Protect patient safety and quality of care.

This policy recognizes the foundational principles necessary to support conflict management include:

- A willingness to acknowledge existence of conflict;
 - Open communication;
 - Dealing with conflict within an environment of mutual respect;
 - Acceptance and tolerance of different perspectives through the process;
 - Commitment to fundamental fairness;
 - Educating all stakeholders about conflict management;
 - Developing a conflict management process with policies and procedures with input from the stakeholders;
- and
- Holding stakeholders accountable to use the conflict management process.

Scope:

All departments and areas of the Behavioral Health Division.

Policy:

- A. The BHD shall implement the conflict management process as necessary to promote organizational well-being and protect patient safety and quality of care and services.
- B. As appropriate to their role, the Administration, Governing Body, Medical Staff, and Hospital Staff shall receive conflict management education during orientation and periodically thereafter. Individuals designated as neutral conveners or conflict management specialists shall have documented training and competencies in order to fulfill their roles.

Definitions:

Conflict: Differences in beliefs, need, interests, or values among leadership groups and/or other groups or individuals within the BHD.

Dysfunction conflict: Escalating conflict that undermines productivity, demoralizes teams and/or individuals, and/or jeopardizes safety and quality of care, treatment, and services.

Conflict management: The process of identifying and handling conflict in a manner that protects patient safety, quality of care, and organizational well-being. Conflict management involves open, productive, and respectful communication that acknowledges the rights and responsibilities of stakeholder parties.

Neutral Convener: An individual with foundational conflict management training and competencies who can serve as a neutral facilitator when a conflict has not yet escalated to the point of seriously jeopardizing patient safety or quality of care.

Conflict Management Specialist: An individual with advanced conflict management training who is competent to facilitate discussions among parties in conflict when patient safety, quality of care, or the reputation of the organization are at stake.

Procedure:

A. Informal Conflict Management.

Most conflict situations can be informally resolved in a manner consistent with the organization's values and code of conduct.

1. Individuals involved in a conflict will acknowledge the conflict and respectfully listen to and consider the positions of others.
 - a. Opportunity will be provided for key stakeholders to openly discuss the situation at hand, ask questions of one another, and evaluate pertinent information.
 - b. Parties shall actively listen, treat others with respect, and refrain from behaviors and/or language that could potentially escalate the conflict to an unacceptable level. (See the Milwaukee County Behavioral Health Division Code of Conduct Policy.)
2. The individuals involved in the conflict may request the assistance of a competent neutral convener or conflict management specialist by contacting the BHD Administrator or Medical Director ("senior leader(s)").
3. If the conflict cannot be satisfactorily resolved through these informal means and/or has escalated to the point of threatening patient safety, quality, or the effective operations of the organization, the formal conflict management process will be implemented.

B. Formal

Formal conflict resolution is necessary when conflict becomes dysfunctional and threatens quality, patient safety, and/or organizational well-being.

1. If not already aware, the senior leader(s) shall be notified about the conflict and the need for implementation of the formal conflict resolution process.
2. The senior leader(s) will meet with the involved parties as soon as possible and identify the nature and extent of the conflict. The senior leader(s) will also gather additional information and determine whether internal or external resources are required to manage the conflict. External resources should

be considered when the conflict involves key organizational leaders, a particularly sensitive issue, and/or inadequate or conflicted internal resources. External conflict management resources include but are not limited to:

- a. Mental health professionals
 - b. Legal professionals
 - c. Human resource professionals
3. The most appropriate internal or external resource will be secured. The designated facilitator/ mediator will:
- a. Expeditiously meet with the involved parties to define the issues associated with the conflict and identify potential areas of common ground
 - b. Gather pertinent information about the conflict
 - c. Work with parties to manage, and when possible, resolve the conflict
 - d. Assure appropriate flow of information to leadership regarding the conflict management process and, in particular, issues that could adversely affect patient safety and quality of care.
4. Throughout and after the conflict management process, the senior leader(s) will implement all necessary actions to protect patient safety and quality of care, including, but not limited to reassigning patient care assignments and temporarily revising work schedules to prevent the conflict from affecting the safety and quality of patient care while the conflict is being resolved.

C. General Guidelines For Facilitating Conflict Management

1. Identify all parties that have a stake in the conflict.
2. Develop a brief description of the conflict and associated issues.
3. Obtain information about the conflict to include applicable documents, policies, and other pertinent materials.
4. Work with appropriate parties to establish a time and place to conduct the initial meeting.
5. Establish ground rules and expectations. Examples include:
 - a. Treating all parties in a respectful manner
 - b. Active listening with a willingness to consider different perspectives
 - c. Candor and openness
 - d. Confidentiality
 - e. Maintaining focus on the key issues
 - f. Recognizing that the resolution must comply with legal, regulatory, and accreditation requirements
 - g. Keeping clinical quality and patient safety above personal interests
6. Maintain a neutral perspective and guide conversation during the meeting.
 - a. Review ground rules and assure these are observed during the meeting
 - b. Obtain confirmation that the description of the conflict and associated issues is accurate
 - c. Establish clear goals/outcomes of the meeting
 - d. Assure that all parties are heard

- e. Work with the stakeholder to identify common ground
 - f. Identify and address barriers that have or are impeding resolution
 - g. Work with the group to resolve the conflict
 - h. Develop a plan with clear accountability for assignments, actions, and/or next steps
7. When the formal conflict management process has been activated, provide the designated organizational senior leader(s) with a summary of the meeting outcome and any ongoing unresolved issues. Determine if additional meetings or action is needed.

References:

N/A

Monitors:

Formal Conflict Management Reports are completed and reviewed by senior leadership quarterly or as needed.

Attachments:

 [Conflict Management Report Form](#)

	Committee	Approver	Date
		Alicia B Modjeska: 800101-Deputy Administrator Outpatient	11/13/2015
		Patricia S Schroeder: 80046-Executive Director 3 - Mental Health Adminis	11/13/2015

COPY



Behavioral Health Division

Date Issued: 11/25/2015
Last Approved Date: 11/25/2015
Last Revised Date: 11/25/2015
Next Review: 11/24/2018
Owner: Lynn Gram: 80043-Safety
Officer
Policy Area: Division Administration
References:

Code of Conduct

Purpose:

This Code of Conduct ("Code") is a statement of the ideals and principles which govern personal and professional behaviors at the Milwaukee County Behavioral Health Division ("BHD"). Adherence to the ideals and principles stated in this Code advances the mission of the BHD and its commitment to the core values of respect, integrity, stewardship and excellence. All Covered Persons are expected to, at all times, adhere to the BHD's Core Values of:

- **Respect:** To respect the dignity of every person.
- **Integrity:** To be honest, fair and trustworthy.
- **Stewardship:** To manage resources responsibly.
- **Excellence:** To work at the highest level of performance, with a commitment to continuous improvement.

Consistent with these values, this policy sets forth the standards for acceptable, non-disruptive, and appropriate behaviors and communication, professionalism, and interpersonal relationships within the BHD. This policy is intended to supplement other BHD policies which outline responses to and management of unacceptable personal and professional conduct by Covered Persons.

Scope:

This Code applies to all "Covered Persons", which includes but is not limited to, Administrators, Hospital Staff, Medical Staff (psychiatrists, psychologists, nurses, certified nursing assistants, social workers, etc.), and members of the Milwaukee County Mental Health Board, and persons providing patient care or other services within or for the benefit of the BHD (such as students, contractors, and individuals with temporary clinic privileges), regardless of employer ("other Covered Persons").

Policy:

DECORUM AT MILWAUKEE COUNTY MENTAL HEALTH BOARD MEETINGS: Covered Persons, other Covered Persons and all others who may attend and/or participate at Governing Body meetings are entitled to the greatest measure of respect and courtesy. All Covered Persons and other Covered Persons must be ever mindful of the obligation to be temperate, courteous, attentive and patient so as to advance these ideals of conduct and to avoid offensive or discourteous remarks or verbal chastisement which are offensive in nature and detract from the dignity and decorum expected while conducting the public's business, and thereby

eventually degrade the atmosphere within the public meeting. All Covered Persons and other Covered Persons should bear in mind the need for scrupulous adherence to the rules of fair play and the necessity of being considerate and courteous to each other and to all others in attendance.

Definitions:

“Acceptable Behavior” means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organization. Examples of acceptable behavior include, but are not limited to, the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Actively upholding public confidence in County government;
- Maintaining a respectful attitude toward Covered Persons and other Covered Persons;
- Expressions of concern about a patient’s care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any Covered Persons and other Covered Persons about patient care or safety provided by others;
- Active participation in the BHD and Organizational meetings (i.e., comments made during or resulting from such meetings will not be used as the basis for a complaint under this Code);
- Membership on other medical staffs; and
- Seeking legal advice or the initiation of legal action for cause.

Acceptable behavior is not subject to corrective action or discipline under this policy.

“Behaviors that Undermine a Culture of Safety” means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised. Examples of such behavior include, but are not limited to, the following:

- Physically threatening language directed at anyone in the BHD including Covered Persons or other Covered Persons;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution;
- Sexual harassment; and,
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

Behaviors that undermine a culture of safety by a Covered Person is prohibited.

“Inappropriate Behavior” means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “Behaviors that Undermine a Culture of Safety.” Examples of Inappropriate Behavior include, but are not limited to, the following:

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or Staff requests;
- Personal sarcasm or cynicism;
- Deliberate lack of cooperation without good cause;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
- Intentionally condescending language; and
- Intentionally degrading or demeaning comments regarding patients and their families, Covered Persons or other Covered Persons and/or the BHD, whether occurring within the BHD or in the community.

Inappropriate behavior by a Covered Person is strongly discouraged.

“Harassment” means conduct toward others based on their race, color, religion, creed, age, sex, gender, gender identity, sexual orientation, nationality or ethnicity, physical or mental disability, veteran status, genetic information, or any other basis protected by federal, state or local laws, which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

“Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment.

Also refer to the BHD’s Sexual Harassment Policy at <http://county.milwaukee.gov/SexualHarassmentPoli17546.htm>

Procedure:

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending Covered Person and protecting patient care and safety. The BHD supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate supervisor. Further interventions can include an apology directly addressing the problem, a letter of admonition, addressing the issue through the human resource process or corrective action if the behavior is or becomes disruptive. [1]

[1] Members of the Milwaukee County Mental Health Board/Governing Body are subject to removal pursuant to Article III of its By-Laws and state statutes.

The use of summary suspension should be considered only where the Covered Person’s Behavior Undermines a Culture of Safety and presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe a Behavior that Undermines a Culture of Safety is due to illness or impairment, the matter may be evaluated and managed confidentially according to established procedures of the BHD.

A. Covered Persons:

Complaints about a Covered Person regarding alleged Inappropriate or Behaviors that Undermine a Culture of Safety should be in writing, signed and directed to the BHD Administrator or Medical Director (“Senior Leader(s)”), and include to the extent feasible:

1. The date(s), time(s) and location of the Inappropriate or Behaviors that Undermine a Culture of Safety;
2. A factual description of the Inappropriate or Behaviors that Undermine a Culture of Safety;
3. The circumstances which precipitated the incident;
4. The name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. The names of other witnesses to the incident;
6. The consequences, if any, of the Inappropriate or Behaviors that Undermine a Culture of Safety as it relates to patient care or safety, or the BHD personnel or operations; and\
7. Any action taken to intervene in, or remedy, the incident, including the names of those intervening.

At the discretion of the Senior Leader(s), the duties here assigned to the Senior Leader(s) can, from time to time, be delegated to another elected member of the Covered Persons ("designee"). The complainant will be provided a written acknowledgement of the complaint. In all cases, the subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint in a timely fashion, as determined by the Senior Leader(s), but in no case more than 30 days from receipt of the complaint by the Senior Leader(s). The subject of the complaint will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action. An ad hoc committee consisting of three (3) individuals selected by the Senior Leader(s) shall make such investigation as appropriate in the circumstances which may include seeking to interview the complainant, any witnesses and the subject of the complaint. The subject of the complaint shall be provided an opportunity to respond in writing to the complaint.

The ad hoc committee will make a determination of the authenticity and severity of the complaint. The ad hoc committee shall dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity, and will notify both the complainant and the subject of the complaint of the decision reached. If the ad hoc committee determines the complaint is well founded, the complainant and the subject of the complaint will be informed of the decision, and the complaint will be addressed as follows:

1. If this is the first incident of inappropriate behavior, the Senior Leader(s), shall discuss the matter with the offending Covered Person, and emphasize that the behavior is inappropriate and must cease. The offending Covered Person may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.
2. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the offending Covered Person with notification of each incident, and a reminder of the expectation the individual comply with this Code.
3. If the ad hoc committee determines the offending Covered Person has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of Behavior that Undermines a Culture of Safety), or has engaged in Behaviors that Undermine a Culture of Safety on the first offense, a letter of admonition will be sent to the offending Covered Person, and, as appropriate, a rehabilitation action plan developed by the ad hoc committee, with the advice and counsel of the Senior Leader(s).
4. If, in spite of this admonition and intervention, Behaviors that Undermine a Culture of Safety recurs, the ad

hoc committee shall meet with and advise the offending Covered Person such behavior must immediately cease or corrective action will be initiated. (As noted previously in footnote 1, such procedures do not apply to the Governing Body.) This "final warning" shall be sent to the offending Covered Person in writing.

5. If after the "final warning" the Behaviors that Undermine a Culture of Safety recurs, corrective action (including suspension or termination of privileges) shall be initiated pursuant to the Senior Leader(s).

6. If a single incident of Behaviors that Undermine a Culture of Safety or repeated incidents of Behaviors that Undermine a Culture of Safety constitute an imminent danger to the health of an individual or individuals, the offending Covered Person may be summarily suspended as provided in the Milwaukee County BHD Employee Handbook.

7. If no corrective action is taken, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending Covered Person, shall be retained in the Covered Person's file for two (2) years, and then must be expunged if no related action is taken or pending. Informal rehabilitation, a written apology, issuance of a warning, or a referral to the Health and Wellbeing Committee (or equivalent committee) will not constitute corrective action.

8. At any time during this procedure the Covered Person has a right to personally retain and be represented by legal counsel.

B. Other Covered Persons (e.g., persons providing patient care or other services within or for the benefit of the BHD such as Contractors:

Complaints about other Covered Persons regarding allegedly Inappropriate or Behaviors that Undermine a Culture of Safety should be in writing, signed and directed to the Senior Leader(s) and include to the extent feasible:

- A. 1. The date(s), time(s) and location of the Inappropriate or Behaviors that Undermine a Culture of Safety;
2. A factual description of the Inappropriate or Behaviors that Undermine a Culture of Safety;
3. The circumstances which precipitated the incident;
4. The name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. The names of other witnesses to the incident;
6. The consequences, if any, of the Inappropriate or Behaviors that Undermine a Culture of Safety as it relates to patient care or safety, or the BHD personnel or operations; and
7. Any action taken to intervene in, or remedy, the incident, including the names of those intervening.

The complainant will be provided a written acknowledgement of the complaint. The individual who is the subject of the complaint will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code and may result in termination of their services (or the contract under which they function) from the BHD.

The Senior Leader(s) will lead a thorough investigation of the complaint to determine its authenticity and validity, and the severity of the complaint. The Senior Leader(s) will dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity, and will notify both the

complainant and the subject of the complaint (other Covered Person) and the Contractor, as applicable, of the decision reached. If the Senior Leader(s) determines the complaint is well founded, the complainant and other Covered Person (the subject of the complaint) will be informed of the decision, and, as appropriate to the other Covered Person's behavior, either be officially counseled in writing or their services terminated. Should the services of the other Covered Person be covered under a contract with a Contractor, the Contractor will either be officially counseled in writing or their services will be terminated.

ABUSE OF PROCESS

Consistent with the Code requirements stated above, the BHD strives to maintain an environment that is free from Inappropriate Behavior and Behaviors that Undermine a Culture of Safety, whether implicit or explicit, which is used to adversely control, influence or affect the well-being of any Covered Person or other Covered Person, BHD's patients or their families. Such behavior compromises performance and threatens patient safety by disrupting teamwork, communication, and collaboration.

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by Covered Persons against complainants will be addressed through the progressive disciplinary process. Retaliation or attempted retaliation by Covered Persons against complainants will give rise to corrective action. Retaliation or attempted retaliation by other Covered Persons (e.g., Contractors) against complainants will result in immediate termination of the contract. Individuals who falsely submit a complaint shall be subject to corrective action per the BHD's policies.

PROMOTING AWARENESS OF CODE OF CONDUCT

The BHD shall promote continuing awareness of this Code among the Covered Persons by:

1. Sponsoring or supporting educational programs on Inappropriate Behaviors and Behaviors that Undermine a Culture of Safety;
2. Disseminating this Code to all Covered Persons, and other Covered Persons (e.g., Contractors) upon its adoption; and
3. To all new BHD employees and Governing Body members during initial orientation.

References:

N/A

Monitors:

N/A

Attachments:		No Attachments	
	Committee	Approver	Date
		Alicia B Modjeska: 800101-Deputy Administrator Outpatient	11/25/2015
		Patricia S Schroeder: 80046-Executive Director 3 - Mental Health Adminis	11/25/2015

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

DATE: November 20, 2015

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

FROM: Clarence P. Chou, MD, 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 C¹:

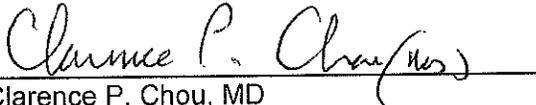
- A. New Appointments
- B. Reappointments
- C. Provisional Period Reviews / Status Changes
- D. Notations Reporting (to be presented in **CLOSED SESSION** in accordance with protections afforded under Wisconsin Statute 146.38)

As of the date of this report, there are no notations to report.

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,


Clarence P. Chou, MD
President, BHD Medical Staff Organization

cc Patricia Schroeder, BHD Administrator
John Schneider, BHD Chief Medical Officer
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

Attachment

1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
NOVEMBER / DECEMBER 2015**

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

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 4, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 19, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Mara Bach, PhD	General Psychology- Adult	Active/ Provisional	B	Dr. Kuehl and Dr. Schneider recommend appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
Emilie Padfield, MD	Psychiatric Officer of the Day; Medical Officer of the Day	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
James Stevens, MD	Psychiatric Officer of the Day; Medical Officer of the Day	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 4, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 19, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Nagwa Agaiby, MD	General Psychiatry	Affiliate/ Full		Dr. Layde recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Anna Berg, MD	General Psychiatry	Affiliate/ Full		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Kathleen Burroughs, PhD	General Psychology- Adult; Extended Psychology-Acute Adult Inpatient	Affiliate/ Full	MA	Dr. Kuehl and Dr. Layde recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Walter Drymalski, PhD	General Psychology- Adult	Active/ Full		Dr. Kuehl and Dr. Schneider recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Douglas Hardy, PhD	General Psychology- Adult; Extended Psychology-Acute Adult Inpatient	Affiliate/ Full		Dr. Kuehl and Dr. Layde recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Mark Sateriale, MD	Diagnostic Radiology- XR&y & Ultrasound Interpretation	Telemedicine Consulting/ Full	M#	Dr. Puls recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 4, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 19, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Elliott Wagner, MD	Diagnostic Radiology- XRay & Ultrasound Interpretation	Telemedicine Consulting/ Full	M#	Dr. Puls recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 1 year. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
Leah Donovan, MSN	Advanced Practice Nurse-Family Practice	Allied Health/ Full		Dr. Puls recommends repriviling, as requested	Committee recommends repriviling, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE NOVEMBER 4, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 19, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Maitrayee Vadali, MD	Cardiology-EKG & Holter Monitor Interpretation	Telemedicine Consulting/ Provisional		Dr. Puls recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileges 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 NOVEMBER 4, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 19, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Amelia Brost, PsyD	General Psychology- Adult, Child & Adolescent / Active	51.15 Treatment Director Designee (MUTT)		Dr. Schneider recommends amending privileges, as requested	Committee recommends amending privileges, as requested, subject to a minimum provisional period of 6 months	Recommends amending privileges as per C&PR Committee.	
Justin Kuehl, PsyD	General Psychology- Adult; Extended Psychology-Crisis Observation / Active	Extended Psychology-Acute Adult Inpatient		Dr. Ovide (designee*) and Dr. Layde recommend amending privileges, as requested	Committee recommends amending privileges, as requested, subject to a minimum provisional period of 6 months	Recommends amending privileging as per C&PR Committee.	

MEDICAL STAFF ORGANIZATION GOVERNING DOCUMENTS AND POLICY/PROCEDURE UPDATES	MEDICAL STAFF ACTION	GOVERNING BODY ACTION
NONE THIS PERIOD.		

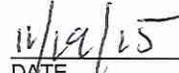


 CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE
 (OR PHYSICIAN COMMITTEE MEMBER DESIGNEE)

 DATE



 PRESIDENT, MEDICAL STAFF ORGANIZATION
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE



 DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

RECOMMENDATIONS OF THE MCBHD MEDICAL STAFF CREDENTIALING & PRIVILEGING REVIEW AND MEDICAL STAFF EXECUTIVE COMMITTEES WERE REVIEWED. ALL PRIVILEGE AND APPOINTMENTS ARE HEREBY GRANTED AND APPROVED, AS RECOMMENDED BY THE MEC, UNLESS OTHERWISE INDICATED ABOVE.

 GOVERNING BOARD CHAIRPERSON

 DATE

BOARD ACTION DATE: 12/17/2015

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
NOVEMBER / DECEMBER 2015

ADDENDUM

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

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE DECEMBER 9, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE DECEMBER 10, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Todd Cannon, DO	General Psychiatry	Active/ Provisional	M#	Dr. Layde recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
AMENDMENTS / CHANGE IN STATUS							
Cynthia Love, MD	General Psychiatry; Child Psychiatry	Return from Leave of Absence and Reactivation of Privileges and Appointment Active / Provisional	HS / SC	Dr. Schneider recommends reinstatement, as requested	Committee recommends reactivation of appointment and privileges for remainder of current biennium subject to a provisional period of 6 months due to lapse in practice for > 1 year.	Recommends appointment and privileging as per C&PR Committee.	

Charmee P. Chan (MD)
CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE
(OR PHYSICIAN COMMITTEE MEMBER DESIGNEE)

12/10/2015
DATE

Charmee P. Chan
PRESIDENT, MEDICAL STAFF ORGANIZATION
CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

12/10/2015
DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

RECOMMENDATIONS OF THE MCBHD MEDICAL STAFF CREDENTIALING & PRIVILEGING REVIEW AND MEDICAL STAFF EXECUTIVE COMMITTEES WERE REVIEWED. ALL PRIVILEGE AND APPOINTMENTS ARE HEREBY GRANTED AND APPROVED, AS RECOMMENDED BY THE MEC, UNLESS OTHERWISE INDICATED ABOVE.

GOVERNING BOARD CHAIRPERSON
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
MEDICAL STAFF CREDENTIALS & EXECUTIVE COMMITTEE REPORT TO GOVERNING BODY - DECEMBER 2015

DATE

BOARD ACTION DATE: 12/17/2015