

Chairperson: Duncan Shrout
Vice-Chairman: Thomas Lutzow
Secretary: Dr. Robert Chayer
Senior Executive Assistant: Jodi Mapp, 257-5202

**SPECIAL MEETING
MILWAUKEE COUNTY MENTAL HEALTH BOARD**

Tuesday, September 6, 2016 - 4:00 P.M.
American Serb Hall
5101 West Oklahoma Avenue
Wisconsin Hall South

MINUTES

PRESENT: Robert Chayer, Jon Lehrmann, Thomas Lutzow, Jeffrey Miller, Mary Neubauer, Maria Perez, Duncan Shrout, Michael Thorson, and Brenda Wesley
EXCUSED: Michael Davis, Ronald Diamond, and Rachel Forman

SCHEDULED ITEMS:

1. **Approval of the Minutes from the August 25, 2016, Milwaukee County Mental Health Board Meeting.**

MOTION BY: (Lutzow) Approve the Minutes from the August 25, 2016, Milwaukee County Mental Health Board Meeting. 8-0

MOTION 2ND BY: (Perez)

AYES: Chayer, Lutzow, Miller, Neubauer, Perez, Shrout, Thorson, and Wesley - 8

NOES: 0

2. **Public Comment on Behavioral Health Division Topics/Services. (Informational)**

The meeting opened for public comment on Behavioral Health Division Topics/Services. The following individuals appeared and provided comments:

- Colin Radcliffe
- Jan Wilberg, Wilberg Community Planning
- Mary Lou Burger, Mental Health Task Force
- Barbara Beckert, Disability Rights Wisconsin
- Thomas Kotowski
- Julie Meyer
- Salena Randow, Uncas Park Neighborhood Association
- Susan Sigl
- Robin Pedersen, Mental Health Task Force
- Jeffrey Butts, Grand Avenue Club
- State Representative Christine Sinicki, Assembly District 20

SCHEDULED ITEMS (CONTINUED):

	County Supervisor Dave Sartori, 8 th District Annie Woodward
3.	Adjournment. MOTION BY: (Neubauer) Adjourn. 8-0 MOTION 2ND BY: (Miller) AYES: Chayer, Lutzow, Miller, Neubauer, Perez, Shrout, Thorson, and Wesley - 8 NOES: 0 EXCUSED: 0
<p>This meeting was recorded. The aforementioned agenda items were not necessarily considered in agenda order. 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: 4:04 p.m. to 5:42 p.m.</p> <p>Adjourned,</p> <p>Jodi Mapp Senior Executive Assistant Milwaukee County Mental Health Board</p>	
<p>The next regular meeting for the Milwaukee County Mental Health Board is Thursday, October 27, 2016, @ 8:00 a.m. at the Zoofari Conference Center 9715 Bluemound Road</p>	

The September 6, 2016, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled meeting of the Milwaukee County Mental Health Board.



Dr. Robert Chayer, Secretary
Milwaukee County Mental Health Board

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

DATE: October 3, 2016

TO: Duncan Shrout, Chairperson – Milwaukee County Mental Health Board

FROM: Michael Lappen, 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

High Quality and Accountable Service Delivery

- **Northside Facility Update**

The development of the Northside Facility continues with many parallel efforts underway. Utilizing available population health data for the target area, we have projected unserved/underserved individuals with a mental health or substance use challenge within the proposed service area for the facility. Using this data, the team has developed a staffing and service model for the outpatient mental health clinic, including a new Intensive Outpatient Program (IOP), outpatient therapy, psychiatry, and crisis services. A facility “customer workflow” has been developed that focuses on assessing and addressing risk, a timely needs-driven assessment, significant roles for peer specialists, and same day service whenever possible. Our fiscal team has collaborated with clinical staff to create a draft pro forma for the proposed clinic’s financial model.

The facility will be operated as a “Health Home” - with an integrated clinic where behavioral health and medical staff work as a team to address all the wellness concerns of customers, further supported by social services staff focused on housing, benefits, employment, etc. Currently we are assessing several potential locations for remodeling costs and have engaged a developer in a parallel exploration of potential building options, should an existing sites prove to be too costly to renovate. Another major milestone we hope to achieve soon will be reaching an agreement with the medical

provider who will be our partner in this facility. Once that provider is on board, we can do a final “fit test” for the floor space and design and move forward with the remodel or build.

We believe that we are on track for presenting a definitive plan for the Northside Facility at the December Board Meeting as we proposed at the August meeting. We have a plan in place to go back to the community focus groups and stakeholders who were originally consulted in the earliest stages of the project to get feedback for the service model and include services from the actual community it will serve. The delay in the facility opening secondary to the dramatic expansion of scope will not slow down the ongoing improvements in service delivery and the development and deployment of new programs. We intend to pilot IOP, crisis, and the modified intake process well before the new facility opens. Detailed project summaries are attached (**Attachments A, B, and C**) for your review.

BHD Collaborations

- **MacArthur Grant**

On April 13, 2016, The John D. and Catherine T. MacArthur Foundation announced a \$2 million grant award to Milwaukee County to implement reforms to safely reduce Milwaukee’s jail population and address racial and ethnic disparities in the justice system. Milwaukee County is one of 11 jurisdictions in the country chosen to receive significant funding and access to expert technical assistance to implement a plan for reform over the next two years. Milwaukee County’s reform strategies focus on changing key drivers of entry into the jail, care and length of stay of individuals with significant trauma and mental health issues within the jail, as well as providing law enforcement with an expanded toolbox for responding to individuals with mental health issues.

One of the reform strategies involves methods to further promote law enforcement’s utilization of existing mental health crisis services. This strategy also includes a proposed expansion of the Crisis Assessment Response Team (CART). The existing CART, which pairs a BHD clinician with a MPD officer, responds to calls pertaining to complex mental health crisis situations. Through grant funding, there will be a new CART that partners the BHD clinician with a District Attorney investigator. This new team will complement the existing efforts and provide an opportunity for broader community engagement. In particular, the team will have County-wide jurisdiction as compared to the existing teams that are limited to the City of Milwaukee. This will increase the capacity for intervention and outreach throughout the entire County.

- **Community Access to Recovery Services (CARS) Substance Abuse and Mental Health Services Administration (SAHMSA) Grant for Drug Court**

The Milwaukee County Behavioral Health Division has been awarded a grant from the Substance Abuse and Mental Health Services Administration to span three years for a total of \$973,520. The "Treatment Service Enhancements for Milwaukee County Adult Drug Treatment Court" grant proposes to increase the completion rate and reduce recidivism by implementing evidence-based practices to serve the needs of opiate users, formalize transition to aftercare and enhance protocols and linkages for all Veterans.

- **Peer Run Respite**

On September 13, 2016, BHD co-sponsored a presentation on Peer Run Respite at Independence First featuring Laysha Ostrow, PhD. I participated in a panel discussion on Peer Run Respite and how it might be developed in Milwaukee. Peer Run Respite is a growing national model where individuals with lived experience provide community based, trauma-informed, person centered, crisis support and prevention for individuals experiencing crisis in a home like setting.

As a result of the recent event, the Milwaukee Mental Health Task Force has established a Peer Run Respite Steering Committee to move forward with the exploration of developing the model in Milwaukee and laying the groundwork for such a facility to open soon. I believe it would be reasonable for BHD to provide a planning grant to assist the project and to partner with a peer agency to move forward on this initiative, hopefully with the additional support of the State and other financial supporters. We hope to receive a steering committee proposal soon that would allow us to award a planning grant.

- **First Episode Psychosis Grant**

We were notified October 9, 2016, BHD was awarded a First Episode Psychosis Grant that will be a collaboration between CARS and Wraparound staff and will expand a successful program that provides intensive services to youth experiencing a first psychotic episode. This evidence based program significantly improves outcomes and reduces the lifelong impact of a psychotic illness.

Other Topics of Interest

- **Uncas Community-Based Residential Facility Update**

Amy Lorenz and I attended a community advisory meeting on September 26, 2016. The meeting was attended by several representatives from the Uncas neighborhood, Matt Talbot, Inc., Representative Sinicki, a representative from Senator Larson's office, and three representatives from Disability Rights Wisconsin (DRW). There was some heated discussion regarding the development of the facility and the unannounced visit described by Representative Sinicki at the last Mental Health Board meeting.

The Uncas neighbors raised a number of very reasonable concerns about the upkeep of the facility, problems with facility staff, the increase in the number of calls for service to police and fire, and neighborhood safety. There was also a discussion of patient rights versus neighborhood rights. BHD staff and DRW attempted to provide information regarding the rights of Uncas residents as far as walks in the community, use of the local park, etc., and challenged Matt Talbot on some of the concessions they were agreeing to in response to neighborhood pressure--like limiting client access to the local park and limiting walks in the community to daylight hours. There was also a lengthy discussion about how law enforcement is involved in involuntary treatment per Chapter 51, that some of the contacts would actually have been scheduled transport for court, and that the fire calls were the result of night staff burning food and an overly sensitive alarm system. In the end Mr. Rajani agreed to resolve a list of items related to the property and staff, and all agreed to meet again in January, and quarterly thereafter, so Mr. Rajani can be held accountable for fulfilling his promises. I was forwarded an email from Selena of the Uncas Park Neighborhood Association dated October 2, 2016, thanking Karl Rajani for so promptly addressing two items from the list (removing a pile of construction materials/junk and removing weeds).

I received a letter on October 5, 2016 from Disability Rights Wisconsin expressing concerns about client rights at the Uncas Facility, and promptly forwarded it to Karl Rajani. **(Attachment D)**

On October 6, 2016, the following email addressing client rights concerns was received:

Dear Mr. Colon:

I am sorry I did not pick up when you called last night at 9:15 p.m. However, I am pleased that I was able to take your call when you called earlier this morning.

Mr. Colon, as you know, some of the residents in the Uncas House neighborhood have been very vocal about the location of the CBRF within their community. The concerns that they have

expressed on many occasions include a concern about their own safety and security when the Uncas House clients are seen walking in the neighborhood or in the park. Whereas I believe I have taken strong steps to protect the constitutional and human rights of the clients to live at Uncas House, it is true that I did issue a directive to staff that the clients should not be allowed to go to the local park. My thinking was that there are numerous other opportunities that we are providing the clients in terms of recreational, vocational and therapeutic activities. Therefore, limiting them from going to the park, especially when children are present, would be a small compromise that would be acceptable to the residents and their advocates, necessary in order to achieve a measure of peace with the neighbors.

After the meeting of the Uncas House neighborhood association meeting on September 26, I did receive an e-mail from BHD Administrator Michael Lappen that the right of the clients – including specifically (a) any attempts by my staff to limit client walks to daylight hours, (b) forbidding clients access to the local park, and (c) an on-site walking path as a means of containing the clients – were not acceptable to BHD. Mr. Lappen also expressed concerns about the use of terms such as “compound” to describe the CBRF and “patient” to refer to the clients. You yourself expressed the same and other similar concerns in your call to me this morning.

Hector, after talking to you and Mike, I now realize that Matt Talbot Recovery Services, Inc. does not have any authority to limit the rights of the Uncas House clients in any way; and that the clients have the same rights as any other citizen to live freely and independently in their home. Whereas I have fought strongly against attempts by some of the neighbors to stigmatize the clients, I do now believe that the small compromises I made to in a sense limit the clients were not mine to make. And, Hector, I do understand why you needed to chastise me. Not being a lawyer, but upon reflection, you are completely right that I should not be “messing with the rights of the clients at Uncas House”. Therefore, effective immediately, we will abide by the following policies and procedures with respect to the rights of the clients at Uncas House. By a copy of this e-mail, I am directing Jennifer Giersch, our Program Director, to immediately:

1. Lift any restrictions on the rights of the clients to take walks in the neighborhood, or to visit the local park.
2. Uncas House is the residence and home of the clients. No one shall be allowed to enter the house or intrude on the clients’ quiet enjoyment except: (a) Matt Talbot employees, volunteers, healthcare providers, or contractors (all when working), (b) clients’ family members, (c) BHD or DQA officials when visiting at appropriate times in their official capacity, (d) representatives of Disability Rights Wisconsin, and (e) guests invited by the clients themselves. Anyone else who wants to visit Uncas House, we will need to get permission from BHD.
3. The clients are not be referred to as “patients”. They are either clients or residents.
4. During their walks, while in the park, etc., the clients shall be afforded the same right to interact with their neighbors and the community as anyone else would have. If the

neighbors do not wish to interact with the clients, that is their right. However, we should do nothing to impede the rights of the clients to behave and interact in the community just like anyone else.

5. Staff shall not be required, and shall not wear, medical scrubs. Uncas House is not a medical facility.
6. Both the inside and the outside of the house shall continue at all times to be clean, orderly, and beautiful – including appropriate landscaping.
7. Clients shall at all times continue to be treated with dignity and respect.
8. Ensure that all staff understand that Matt Talbot Recovery Services, Inc. recognizes its duty and legal obligation, as a housing provider, to abide by the provisions of the Fair Housing Act, and other applicable State and Federal laws concerning the rights of clients.

Hector, as you may know, my own stepson is physically and mentally challenged. Protecting the rights of the clients at Uncas House is personal to me. I can assure you that any attempts by me to limit their rights were unintentional, and a reaction to the tremendous pressure I have been receiving from some of the more vocal neighbors. I believe that the majority of the neighbors are now at least accepting if not welcoming of the clients. You have my personal commitment that going forward the rights of the clients will be fully and vigorously protected by our Company.

Respectfully submitted,

Karl Rajani
President, Matt Talbot Recovery Services, Inc.

P.S. As you may be aware, I personally worked very closely with Atty. Rock Pledl (Pledl & Cohn), who is a disability rights lawyer, when building Uncas House. Atty. Pledl was very involved and instrumental at community meetings in ensuring that the neighbors understood the rights of the Uncas House clients to live freely in the neighborhood. If you think this would be a good idea, I am willing to ask Atty. Pledl to put on some training sessions to train our staff in client rights.

- **Clarification on Community Misconceptions**

Over the past few months, there have been statements made in various public forums, including in public comments made to the Milwaukee Mental Health Board, comments made by Milwaukee County Supervisors, and in various letters and emails from the community that misrepresent facts regarding BHD. I would like to briefly address a few of them:

The closures of Rehabilitation Center Hilltop and the skilled nursing facility Rehabilitation Center Central were done "just to save money".

These long-term care facilities were closed, and the clients that resided there were moved to various community settings consistent with the Olmstead Decision, which prohibits the unjustified segregation of persons with disabilities and demands that public entities must provide community based treatment in the least restrictive setting possible.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." (From ADA.gov)

From Rehab Central, 68 residents were relocated: thirty-one (31) to adult family homes (AFH/1 to 4 beds), twenty (20) to CBRFs (6 to 8 beds), four (4) to supported apartments, four (4) to a skilled nursing facility, three (3) to a family member's home, two (2) to a hospital, two (2) to BHD Acute, one (1) to a crisis stabilization house, and one (1) to hospice. Thirty-five (35) of these individuals were served by the Family Care Program, who funded and coordinated their placements and care. From Hilltop, sixty-five (65) residents were relocated. Forty-eight (48) went to AFH, nine (9) to CBRFs, six (6) to supported apartments, one (1) to a family home, and one (1) to a private hospital. All sixty-five (65) residents were served by Family Care.

Of the twenty-five (25) clients from Rehab Central that continued to be served by BHD, many required very complex and expensive care to be served in the community. There certainly was savings to BHD, secondary to Family Care now serving a great majority of individuals in community settings, but there were several individuals whose cost of care is significantly higher in the community.

I have attached some letters (**Attachments E, F, G, and H**) from community advocacy agencies dating back to 2010 supporting the long-term care closures to provide context for the Board showing the community pressure on BHD to comply with Olmstead and close the long-term care facilities.

Privatization and the closures led to four client deaths in CBRFs, as a result of poor patient care.

There is no indication that this is true. When this was first alleged in September of 2015, an investigation identified one former resident who passed away who was still enrolled in BHD services at the time. There was no medical examiner report or reportable death indicating poor or absent care as the cause of death. Given that Rehabilitation Central was a skilled nursing facility, many residents had substantial medical issues. Also, considering that at least one resident was discharged directly to hospice care, it would be reasonable to expect that a number of former residents might have passed over the past two years as a result of natural causes. As mentioned in a previous item, the majority of residents were served by Family Care. BHD would not have access to their medical information if they were not enrolled in BHD services.

At the September Board meeting, a citizen provided an account of a "particularly heartbreaking case" she stated she learned about "from a BHD employee." She described an individual she identified by initials as a former long-term care client "with no family or friends" who passed away secondary to leaving the facility, and this would not have occurred had he stayed in long-term care since the staff there "treated him like family." This individual shared particular protected health information I would not be able to share in a public meeting and that she should not have had access to. Enough distinguishing information was provided that someone from DRW very familiar with the case was able to recognize the subject and indicated to me that the "facts" presented to the Board regarding this case, were simply not true. She shared the following letter regarding the closures:

Mike,

I'm writing you regarding the concerns that were expressed to the Milwaukee Co. Mental Health Board regarding the deaths of four residents who relocated from the long-term care units at BHD to the community. As a representative of Disability Rights Wisconsin (DRW), I served on the State relocation team as an advocate for the residents under the age of 60. Team members also included advocates from the State Board on Aging and Long-Term Care (for residents 60 and older), the State Bureau of Mental Health and Substance Abuse, the Division of Quality Assurance, Milwaukee County Behavioral Health Division, and the State Department of Health Services, among others.

The team met biweekly for four years. This time was utilized to carefully consider the long-term care needs of every resident, listen to and address the wishes and concerns of the guardians and residents, and explore the best possible services and placements available to meet the needs of the residents. Individual discharge plans for residents were reviewed and discussed by the team to ensure that the residents would be safe and their needs met in the community. The team was also aware that, under the US Supreme Court ruling *Olmstead v L.C.*, each resident had the right to live in the least restrictive, most integrated environment.

When considering the deaths of the four residents who relocated from the units, one resident in particular comes to mind. I had known this resident prior to the beginning of the relocation. He had always expressed an urgent desire to reside in the community in spite of his physical disabilities and health issues. His guardian was in full agreement with a move to the community. His wishes became a reality with the closing of the units. This was a very independent minded and active individual. Once he moved to his new home, he took every advantage to use the city bus to engage in the community. He called me to express his happiness with his new home and newfound "freedom." Knowing this individual's history and the care he was receiving in the community, I don't believe that his death occurred because he was no longer residing in an institution. However, I do know that he spent the end of his life living his dream as he chose.

Liz Ford
Disability Rights WI
6737 W Washington St.
Milwaukee, WI 53214
P-414-773-4646
F-414-773-4647

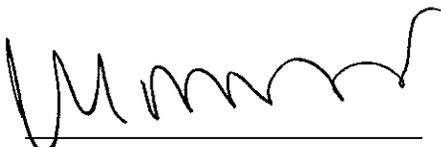
BHD has put in place a so-called "gag order" that does not allow staff or vendors to express their concerns.

There is no gag order. I welcome respectful and constructive staff and vendor feedback. I have monthly Town Hall meetings, Cake and Conversation, and have had many staff (and vendors) reach out to me with concerns and criticisms. I want to hear about concerns and opportunities for improvement and have made that clear at every opportunity. In researching this, it seems that the issue can be traced back to the Code of Conduct (**Attachment I**) issued November 25, 2015, that addresses "covered persons" including conduct at Milwaukee Mental Health Board Meetings. The policy sets forth the standards for "acceptable, non-disruptive, and appropriate behaviors and communication." There is a list of examples of inappropriate behavior, including "intentionally degrading or demeaning comments regarding patients and their families...whether occurring within BHD or in the community." I believe that this is the language that has been manipulated into something it simply isn't. To my knowledge no employee has been disciplined, nor has any contractor lost a contract for violating this policy, or for expressing concerns to BHD management.

BHD is sending many individuals that present at the Psychiatric Crisis Service (PCS) to jail.

From January 1 to June 30, 2016, there were 4306 individuals served by Psychiatric Crisis Services (PCS). Of these, 136 individuals (3%) were returned to police custody after being assessed. These individuals were not in need of an inpatient level of psychiatric care. Had they not been on a police hold for an alleged crime, they would have been sent home with appropriate aftercare instructions.

Respectfully Submitted,

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

Mike Lappen, Administrator
Milwaukee County Behavioral Health Division
Department of Health and Human Services

Attachment A

Mental Health Board Report

North Side Facility Project Summary

9/27/16

Vision 2020

- Vision 2020 is the Behavioral Health Division's (BHD) commitment to creating a simplified journey for individuals with mental illness and their families.
- This includes greater access to mental health care. The concept of, "no wrong front door", is key to our ability to help people where they are at, and before they are in crisis.
- The Northside Facility is one of our first and most visible steps.

North Side Facility Vision

- Promote individual and community wellness by creating convenient access to an array of integrated behavioral health, medical and social services through an embedded community-based center.

North Side Facility Strategy

- To create a fully integrated Health Home treating the whole person in a system that improves access to treatment, coordinates services and offers smooth transitions across the service continuum.

Service Selection

- BHD has adopted the concept of a Health Home to address the high prevalence of co-occurring medical conditions and social determinants that increase comorbidity and mortality rates in the Severe Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI) population. According to the 2015 Milwaukee County Community Health Survey Report, prevalence of chronic disease in Milwaukee County is: diabetes 11%, asthma 14%, heart disease 9%, and hypertension 29%. Literature supports the prevalence of chronic disease is approximately double these levels in the Severe Mental Illness (SMI) and Severe and Persistent Mental Illness (SPMI) population.
 - Health Home Definition: A health home (aka Medicaid health home) — as defined in Section 2703 of the Affordable Care Act — offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.
 - Program Certification Standards: BHD is exploring Medicaid, National Committee for Quality Assurance (NCQA), Substance Abuse and Mental Health Services (SAMHSA) and Joint Commission certification standards for integrated care and health homes. Adoption of these standards will provide a framework for service delivery, practice, safety and performance metrics.
 - Best Practice/Benchmarking: BHD has reviewed community assessment reports, best practice literature for health home, integrated care and specific workflow processes. Additional benchmarking is being conducted with industry leading organizations.

Mental Health Board Report
North Side Facility Project Summary
9/27/16

Target Geographic Market

- Geographic boundaries for defining Milwaukee’s north side: I-94 to the south, I-43 to the east, 76th Street to the West and Silver Spring to the North.
- Targeted zip codes for defining Milwaukee’s north side:
 - Core Region: 53205, 53206, 53208, 53209, 53210, 53216, 53218.
 - West to Northwest Perimeter Region: 53213, 53222, 53223, 53224, 53225.

Prevalence of mental illness and service concentration by zip code

- BHD compared Milwaukee County Health Professional Shortage Areas (HPSAs) against Psychiatric Crisis Services (PCS) utilization and determined a number of clustered zip code areas with concordant identification as a HPSA and high behavioral health emergency room utilization.
- To benchmark need, beyond being a HPSA, BHD determined the average rate of unserved individuals with mental illness in Milwaukee County. BHD used the Milwaukee County estimates of Any Mental Illness (AMI) (19%) and Severe Mental Illness (SMI) (4.6%) from the *Wisconsin Mental Health and Substance Abuse Needs Assessment (2/2014)* completed by Wisconsin Department of Health Services. BHD determined the percent of individuals in service by using the unduplicated count of 66,993 child and adult Medicaid enrollees residing in Milwaukee County receiving behavioral health services from the *Milwaukee County Outpatient Behavioral Health Capacity Assessment (10/2015)* completed by Public Policy Forum/Human Services Research Institute. The calculated rate of individuals not in service was 60.8% (=1 - 66,993 / 170,864).
- To benchmark the gap BHD used data for each zip code area from the US Census Community Facts website to determine the area’s census, adults at 130% FPL (=Total 130% FPL – Children 17 and Younger 130% FPL) and calculated the number of AMI, Severe Mental Illness (SMI) and the potential number of unserved individuals.
- Finally, BHD did a zip code by zip code analysis of rates of Psychiatric Crisis Services (PCS) visits and count of unique individuals to list the current utilization per area.

Target Population

Primary client population: Milwaukee County residents in crisis and/or with Severe Mental Illness (SMI) Severe and Persistent Mental Illness (SPMI) or substance use disorder

Secondary client population: individuals with moderate behavioral health needs

Other defining characteristics

- The target population for the clinical services are underserved individuals with predominantly Severe Mental Illness (SMI) who have demonstrated high Milwaukee County Behavioral Health Division Psychiatric Crisis Service (PCS) utilization and generally are below 130% of the Federal poverty level (FPL).
- Primarily Adult services. Children for Information and Referral services only.
- No one with a medical or behavioral health need will be turned away.
- All insurance types will be accepted including uninsured, Medicaid HMO and FFS. BHD will pursue Medicaid HMO contracts.

Mental Health Board Report
North Side Facility Project Summary
9/27/16

Selected Services

Medical Services

- Primary care services to manage prevention and wellness screening and chronic disease management. A medical services partner will be selected to model and provide primary care services.

Behavioral Services

- Psychiatry and therapy services include a dialectical behavioral therapy (DBT) program consisting of three different programmatic tracks of increasing intensity - Partial Hospital Program, Intensive Outpatient Therapy and Skills Training Groups. Additional services include consultation team services for providers and prescription support.
- Crisis Management/Stabilization Services
 - Crisis Line
 - Warm Line
 - CART Team triage, assessment and service referral for non-emergent clients

Social Services

Social Services provided at the north side facility will be a combination of on-site support and information, assistance and referral services.

- Case Management/Care Coordination Services
- Disability Services
- Housing Services
- Benefits Assistance Services
- Café Services
- Interpreter
- Transportation

Service Exclusions

- Psychiatric Crisis Services (PCS)
- Hospital level of care
- Detoxification Services
- Wraparound Wellness Clinic
- Court/Delinquency Services

Mental Health Board Report
North Side Facility Project Summary
9/27/16

Facility Pre-Design

Client and Community Feedback: BHD has engaged conversations with individual community members, community groups, area service providers and the Milwaukee Health Care Partnership to provide progress updates and solicit feedback. BHD is committed to continuing conversations and engaging in open dialog with clients and community stakeholders as this project advances.

Program Development: BHD has selected the Behavioral Health Home care delivery model and launched specific program development efforts to transform behavioral health care delivery in preparation for facility design. Program design efforts include development of intensive outpatient programs, case management services and crisis management services. In addition, medical services will be developed after selection of medical services provider to partner with BHD to provide primary care services. Social Services will be co-located in the facility and fully integrated in risk screening and assessment processes.

Workflow Design: Efforts are underway to redesign client registration, screening, assessment, and enrollment processes (Attachment A), case management processes and develop a single treatment plan to support service integration, improve the client experience and health outcomes. Newly designed programs and workflows will be tested and incorporated into a facility design that supports an integrated behavioral health home model.

Functional Programming/Fit Test Analysis: In addition to program and workflow design efforts, BHD has engaged Zimmerman Architectural Studios to begin functional programming, fit test analysis and facility cost estimate activities in preparation for detailed facility design.

Site Selection

Site Selection Criteria: Site selection criteria have been established and considers programmatic space requirements, client flow requirements, geographic location, parking, front and rear entrances to the facility, bus routes, and public/employee safety.

Site Search: A general search within the targeted zip codes is being conducted to identify potential existing facilities that could be renovated and to identify potential sites for new construction. The initial search focused on facilities in zip codes 53205 and 53206 and was expanded to include zip codes along the Fond du Lac Avenue and Capitol Drive corridors.

- The search resulted in touring four existing facilities. Each of these four locations require significant site preparation and facility renovation/build out. The search also identified three potential sites for new construction.
- The feasibility of these potential facilities and sites will be determined based on the fit test analysis, cost estimates for renovation/new construction and overall financial analysis.

Mental Health Board Report
North Side Facility Project Summary
9/27/16

Facility Design

An integrated care delivery model has implications on facility design. Conceptually, the facility will move away from a typical, traditional clinic design of provider offices with access to 3 or 4 physical exam rooms with co-mingle staff and client movement through the facility. The integrated clinic offers “on stage” client movement through the facility and “off stage” movement through the facility for professional staff. It also features collaborative, professional work space co-locating medical, behavioral health, social service professionals. Exam/therapy rooms have two doors – staff enter from the professional work space and clients enter from public hallways. These concepts create efficiencies and enhance the client and employee experience. Refer to Attachment B for an illustration of these concepts used in the facility layout of The Everette Clinic – Smokey Point in Marysville, WA.

Tentative Timeline:

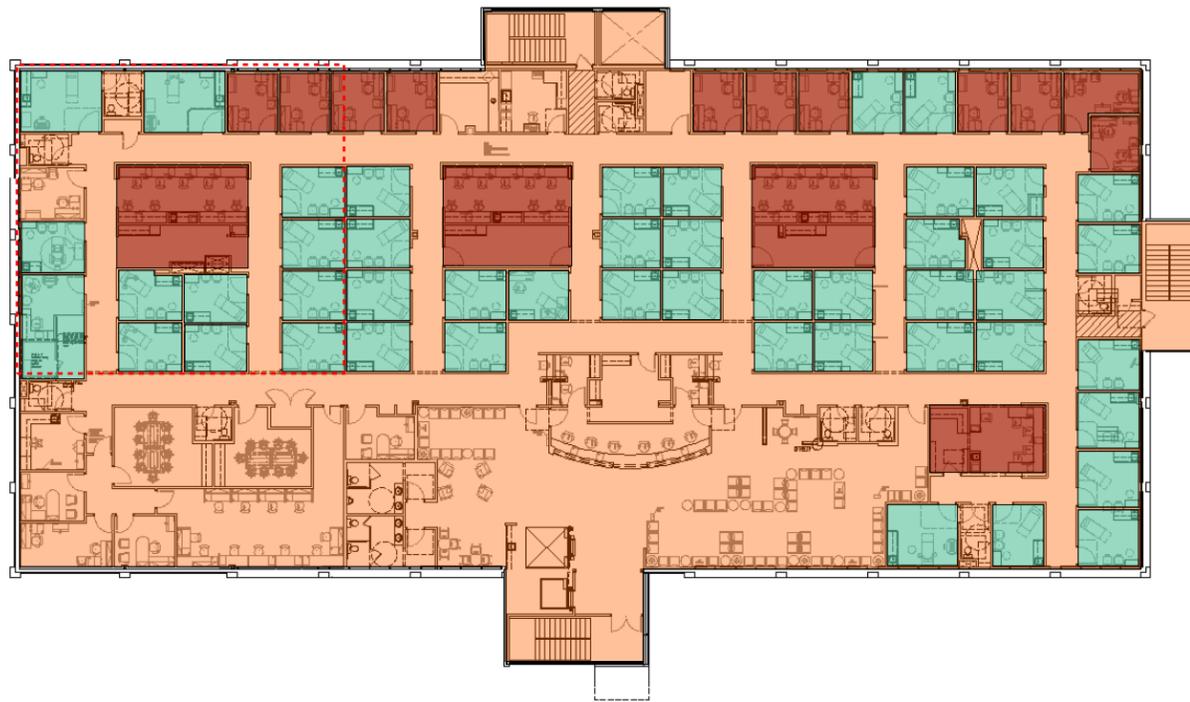
- Continued Program Development: Oct. 2016 – March 2017
- Client and Community Conversations: Oct. 2016 – March 2017
- Facility Predesign (Functional Programming, Fit Test Analysis, Cost Estimates, pro forma development): Oct. 2016 – Mar. 2017
- Site Selection: Oct. 2016 – Mar. 2017
- Detailed Facility Design, Zoning and Construction: Mar. 2017 – Q1 2018
- Facility Opening Q1-Q2 2018

Timeline contingencies: Securing collaborative partners, workforce recruitment and education, technology/information system infrastructure, securing potential revenue sources.

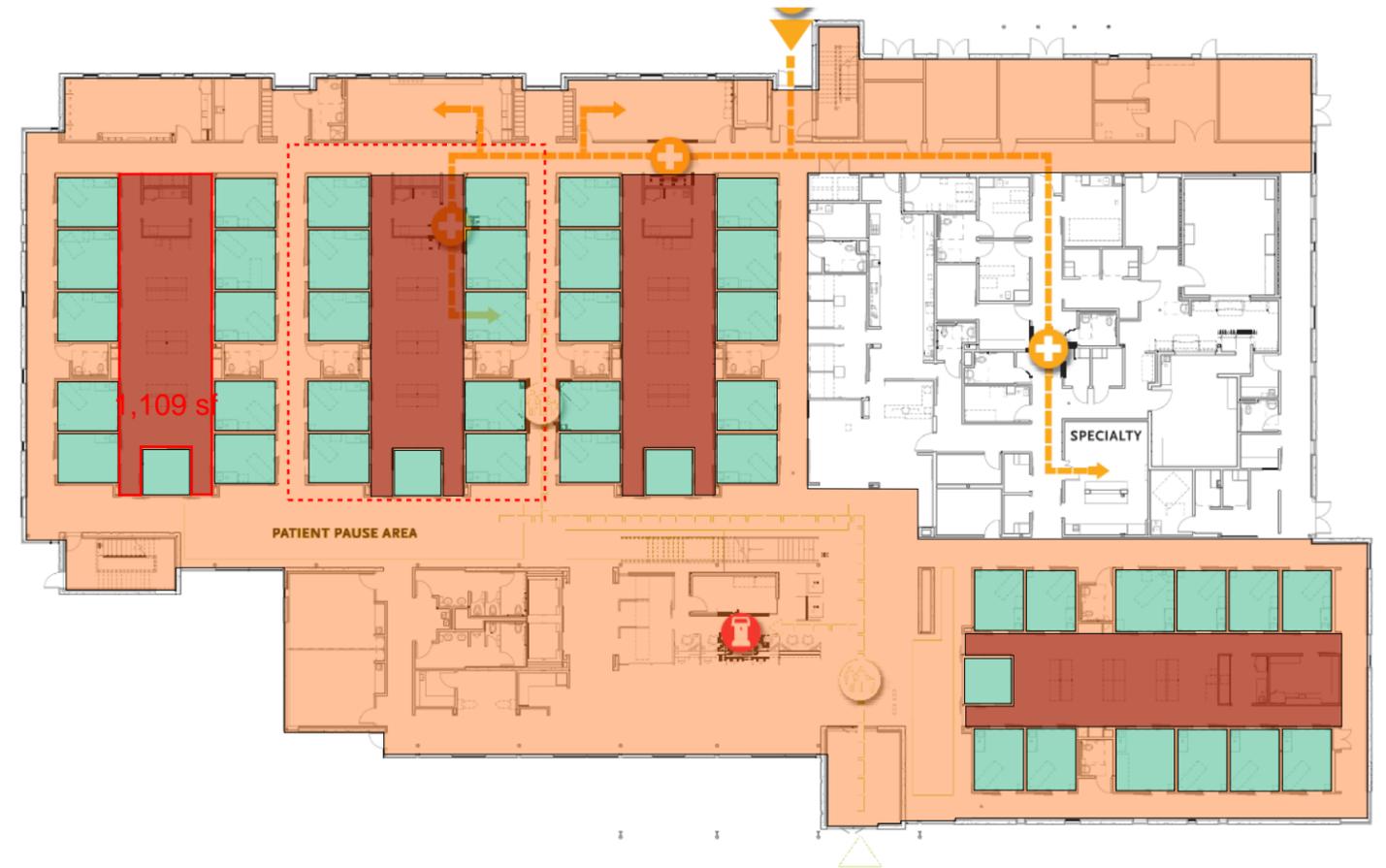
Attachment B

Typical Clinic

Integrated Clinic

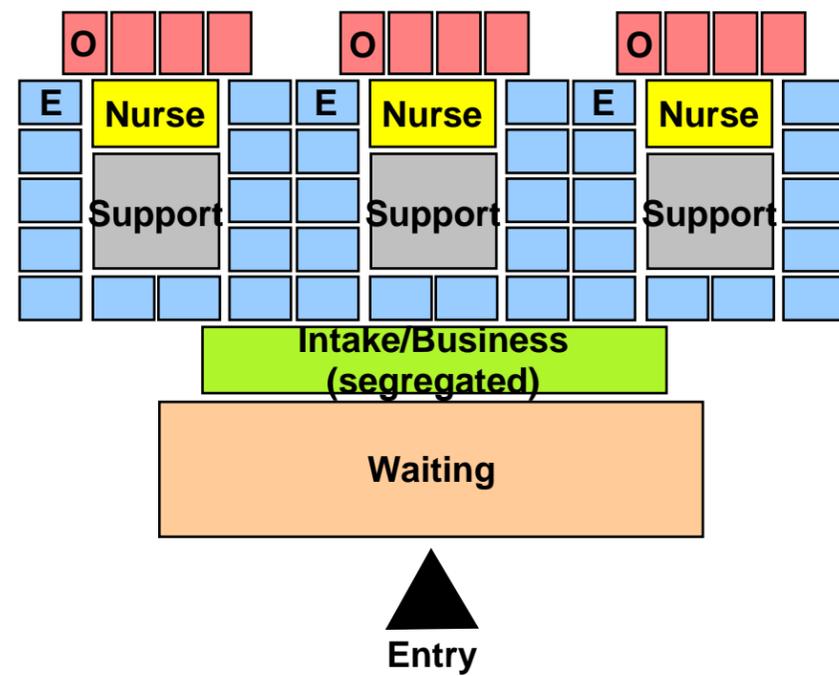


27% Patient Care Space Allocation = 6,125 s.f.
14% Care-Giver Space Allocation = 3,076 s.f.
59% Non-Patient Care Space Allocation = 13,441 s.f.
Total Plan Area = 22,642 s.f.



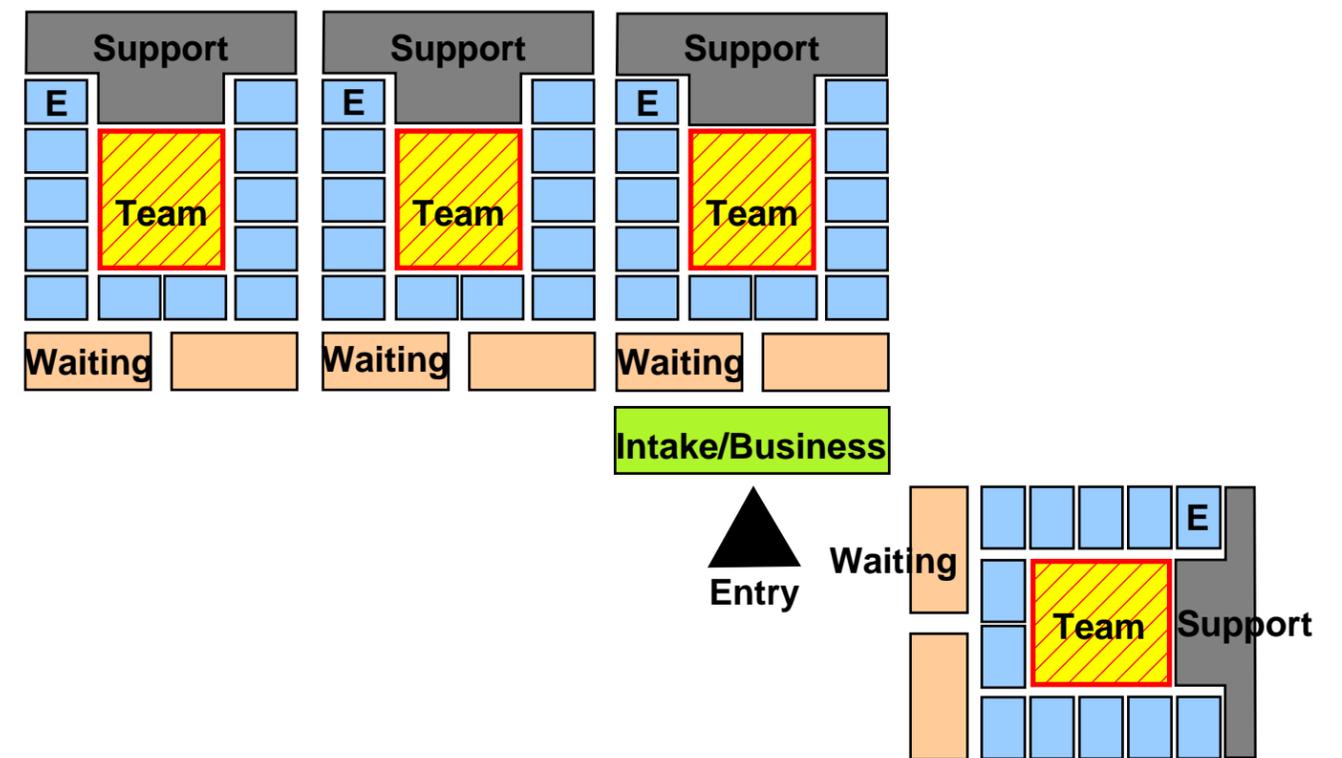
19% Patient Care Space Allocation = 5,368 s.f.
16% Care-Giver Space Allocation = 4,650 s.f.
65% Non-Patient Care Space Allocation = 18,236 s.f.
Total Plan Area = 28,254 s.f.

Typical Clinic



Racetrack - Segregated Offices

Integrated Clinic



Tree - Integrated Team

Typical Clinic

Attributes:

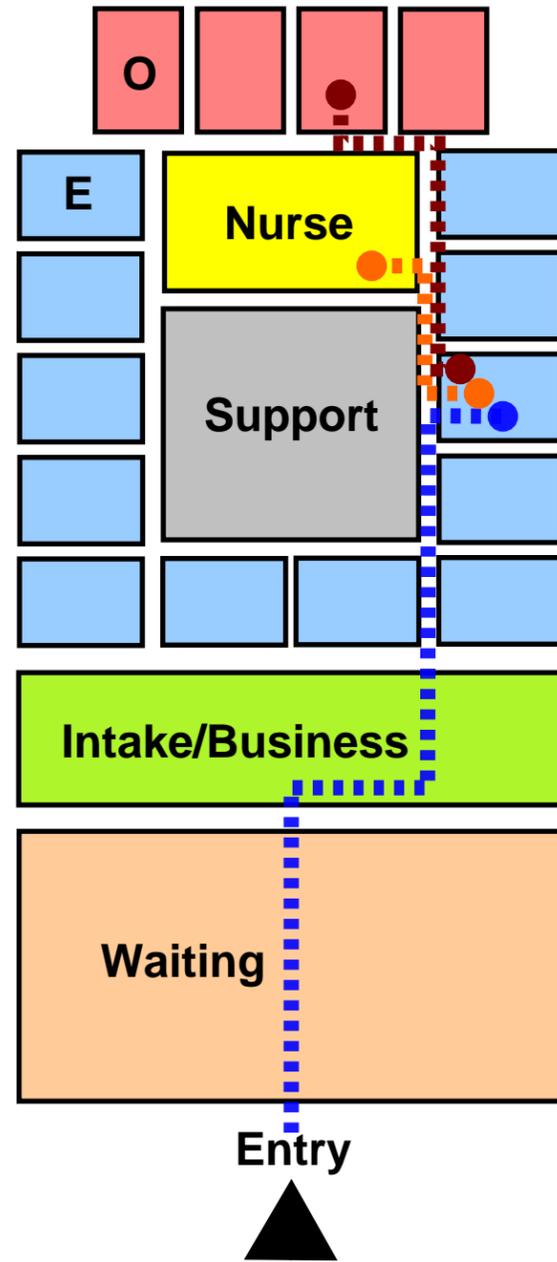
*Traditional intake model with centralized waiting

*Physicians offices further from exam rooms

*Physicians have private office space

*Patients not exposed to the nurses station but share corridor with staff

*Centralized Discharge/scheduling



- Patient
- Nurse
- Physician

Racetrack - Segregated Offices

Integrated Clinic

Attributes:

*Streamlined intake with decentralized patient pause areas

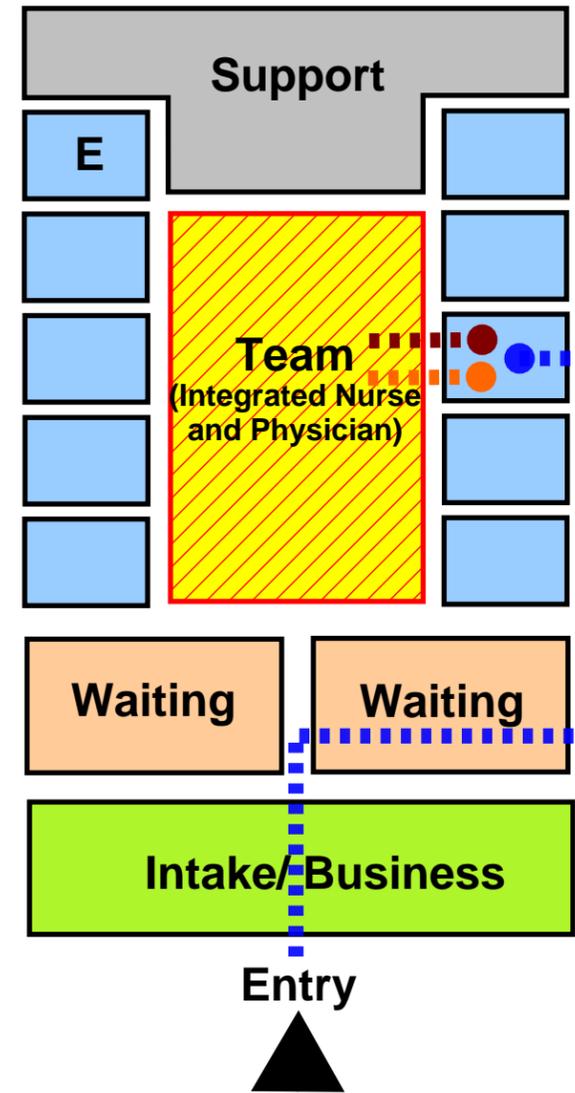
*Physicians stations have close proximity to exam rooms

*Team collaboration encouraged by centralized layout

*Fewer footsteps for care givers

*Clearly defined on-stage/off-stage circulation

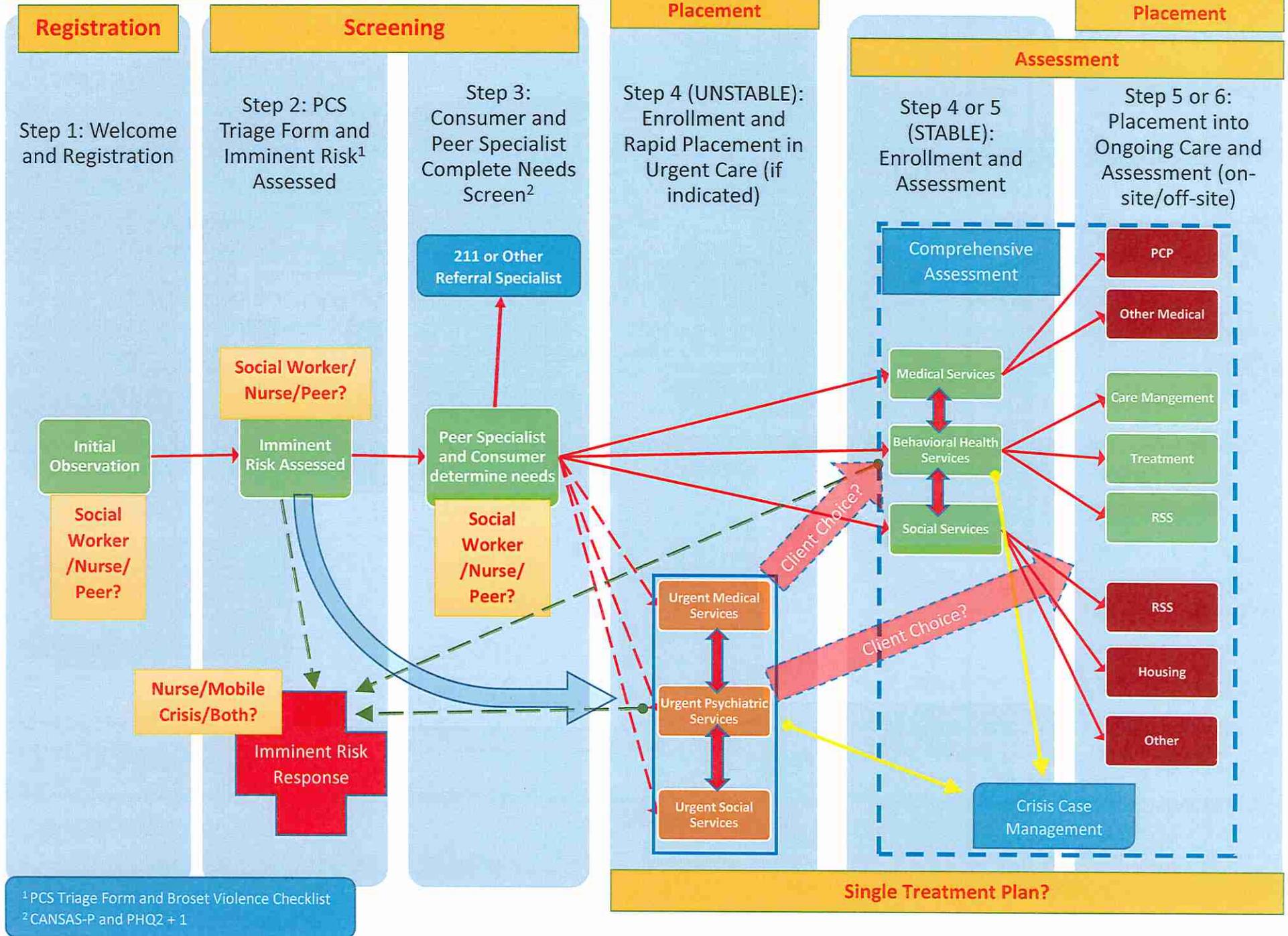
*Discharge/scheduling from exam room



- Patient
- Nurse
- Physician

Branch - Integrated Team

Attachment C: Draft Northside Facility Flow



¹ PCS Triage Form and Broset Violence Checklist
² CANSAS-P and PHQ2 + 1

Narrative:

1. Welcome and Reception
 - a. Step 1: The individual seeking services is quickly registered and initial observation begins.
 - b. The staff member (social worker/nurse/peer?) registering the client calls for the peer specialist to join the initial screening process.
2. Imminent Risk Screen
 - a. Step 2: Together with the individual seeking services, the social worker/nurse/peer? conducts the initial medical and imminent violence risk screen (page 1 of the screening, which contains the PCS Triage form and the Broset Violence Checklist).
 - b. Imminent risk is addressed, as needed.
3. Needs and Suicide Risk Screen
 - a. Step 3: If the individual is not presenting with imminent risk, the individual and social worker/nurse/peer? together complete the CANSAS-P (to screen for basic needs) and PHQ2+1 (to screen for suicide risk).
 - i. At this point, it is possible that the individual may not require any further care, urgent or otherwise, nor will they be in need of any further assessment on BHD's part. However, they may require some type of other social service for which a simple call/conversation with a 211 specialist (or 211 computer kiosk) may suffice.
4. Urgent Care Appointment (As Indicated)
 - a. Step 4: During the initial registration and/or screening process, some individuals may require more immediate medical services (though not necessarily ER services). These individuals will be enrolled and rapidly placed for same day for Urgent Care services.
 - i. Following their urgent care appointment, these individuals may be placed directly into community services (either on or off site).
 1. In this scenario, the individual should receive the Comprehensive Assessment within 30 days of his or her placement into the given service(s).
 - ii. However, individuals who received Urgent Care may also elect to continue on the in assessment process and, once stabilized, may receive a Comprehensive Assessment to determine the most appropriate service(s) for their needs.
5. Comprehensive Assessment
 - a. Step 4: Some individuals who present at the Northside Facility in a more stable state may bypass the Urgent Care process entirely and, based on the results of their two step screening, may receive further assessment with the Comprehensive Assessment.
 - b. Step 5: Other individuals who go through the Urgent Care process but who elect to continue in the larger RSAE process may elect to receive a Comprehensive Assessment to determine the most appropriate service(s) for them.
 - i. If, during the course of the Comprehensive Assessment and Placement process, the individual is determined to have services needs which are provided by DHHS, the individual will be enrolled. (Note, this enrollment would only occur for those individuals who have bypassed the Urgent Care process.)
 1. Although revisions are not yet completed, it is anticipated that the latest iteration of the Comprehensive Assessment would have three modules: Medical, Behavioral Health, and Social. Depending on the results of their screening, individuals may receive one or more of the three modules, each administered by a professional appropriate for the healthcare services grouped in each module.
6. Placement
 - a. Step 5: For those individuals who enter through the Urgent Care process and elect not to receive a Comprehensive Assessment, they will be placed directly into care and must receive a Comprehensive Assessment to verify placement appropriateness and other services needs within 30 days of placement
 - i. **QUESTION**: Will the ASAM be used at direct placement, or after they have been placed into care and received the Comprehensive Assessment?
 - b. Step 5: For those who present as stable and proceed from screening directly to the Comprehensive Assessment, they will receive ASAM placement ratings to help inform the placement into the most appropriate service(s).
 - c. Step 6: For individuals who enter through the Urgent Care process and elect to receive the Comprehensive Assessment, they will receive ASAM placement ratings to help inform the placement into the most appropriate service(s).

OTHER QUESTIONS:

1. How extensive does the medical imminent risk screen need to be?
2. What else needs to be part of the initial screen (do we have enough questions to assess for all the services provided)? There are several questions which I can think of that we might want to ask, but want to discuss with the larger groups. We don't want our screen to be unwieldy.
3. At what point in the process will we conduct more extensive risk evaluations for those clients who go through the Urgent Care process, the stable, non-Urgent Care process (for suicide, violence).
4. When is Crisis Care Management assigned (for those individuals who are placed directly into services from Urgent Care, for those who go through the larger Comprehensive Assessment process but are placed with a service that has some type of lag been placement and first service date, others)?
5. What else needs to be part of the Comprehensive Assessment?
 - a. Medical (need other health professional to weigh in
 - b. Behavioral Health
 - c. Social
6. Will the ASAM be used for all placements, or just behavioral health?

October 5, 2016

Michael Lappen

Administrator

Milwaukee County Behavioral Health Division

9455 Watertown Plank Road

Central Administration Suite 1046

Milwaukee, WI 53226

Dear Mr. Lappen;

We write today to express our significant concerns that the rights of residents of Uncas House are being violated by the housing provider. After the meeting we attended last week we became aware of the provider, Karl Rajani's, "giving away" of residents rights. Our issues are numerous.

First, it appears Mr. Rajani has issued open invitations to politicians to visit the house at anytime. Guests coming into the home should be with advance notice and permission of the people who live there. Not only does this violate the residents' right to privacy it defies common courtesy.

Second, Mr. Rajani has made agreements with neighbors limiting the movement of the residents. He has promised the residents will not go into the neighborhood park at anytime. He has promised that residents will not take walks in the neighborhood at any time after dark. He has promised that any residents walking in the neighborhood will be accompanied by at least two staff members. In addition, he said he would tell residents they should not interact with neighbors should there be a chance encounter. He also seemed to be promising that once the walking path is created on the Uncas House property there would be no need for the residents to leave the property to take a walk. These are not Mr. Rajani's rights to give away and the residents have the same right to peaceful enjoyment of their neighborhood as do any of the Uncas House neighbors.

Finally, while not strictly a violation of resident's rights, we are deeply troubled by Mr. Rajani's agreement to have Uncas House staff wear medical scrubs and his repeated referral to the residents as patients. Uncas House is not a medical facility and the people who live there are not patients. It is their home. Mental health recovery is about normalization and moving away from the medical model. Forcing residents to live like this and to be identifiable as they walk in the neighborhood (the ones not wearing scrubs), inhibits their recovery and adds to the stigma of mental illness.

MADISON

131 W. Wilson St.
Suite 700
Madison, WI 53703

608 267-0214
608 267-0368 FAX

MILWAUKEE

6737 West Washington St.
Suite 3230
Milwaukee, WI 53214

414 773-4646
414 773-4647 FAX

RICE LAKE

217 West Knapp St.
Rice Lake, WI 54868

715 736-1232
715 736-1252 FAX

disabilityrightswi.org

800 928-8778 consumers & family

As the contractor for these services, we believe Milwaukee County has a duty to protect the rights of Uncas House residents and protect them from these discriminatory practices. Given the continuing demands from the neighbors to restrict the rights of the residents of Uncas House, it is important that the provider is required to enforce a strong commitment to protecting those rights. We are asking Milwaukee County Behavioral Health Division to use its authority to ensure that the provider ceases its violation of Uncas House residents' rights.

Sincerely,

Handwritten signature of Barbara Beckert in cursive script.

Barbara Beckert, Milwaukee Office Director

Handwritten signature of Monica Murphy in cursive script.

Monica Murphy, Managing Attorney

Attachment E

Advocacy Concludes With Historic Closure of Long-Term Units at Milwaukee County

One of the core principles of our work at Disability Rights Wisconsin is full inclusion of people with disabilities in the community. This principle has been central to our advocacy in Milwaukee County, where the disability and mental health service systems historically had an overreliance on institutional and crisis services, and limited options for community based services and supports.

In 1991, DRW was one of the three plaintiffs who filed the Joan S. v. Gudeman lawsuit challenging Milwaukee County's lack of community based mental health and developmental disability services. This lawsuit was brought on behalf on plaintiffs discharged from the Milwaukee County Mental Health Complex with inadequate housing and follow-up services, and those who were stuck at the Complex because of an inadequate number of community treatment programs, or community placements. A settlement reached in 1994 resulted in initial efforts to downsize institutional services and provide residents with wraparound community services. However, after the monitoring ended minimal investments were made to expand community services.

In recent years, DRW advocated for Milwaukee County to move forward with closure of the long term care units at the Complex: Hilltop for people with a developmental disability and a co-occurring mental illness, and the Rehab Central nursing home which served individuals with a psychiatric disability.

Based on our work advocating for residents at Hilltop and Central, we saw many individuals who were warehoused and whose potential was limited by their placement in an institution, which raised

concerns about their rights under the Americans with Disabilities Act – which prohibits unnecessary segregation of persons with disabilities and requires treatment in the least restrictive setting according to a person's needs. DRW Milwaukee Office Director Barbara Beckert worked with Milwaukee County officials to support closure of the long term care units and increase services for residents in the community.

In 2013 the County Executive decided to move forward with closure of Hilltop and Rehab Central. As Wisconsin's Protection and Advocacy system for people with disabilities, DRW is a mandated member of the State Relocation Team when an institution closes and residents to be relocated are identified as having mental, developmental, or physical disabilities. For the next two years, DRW Advocacy Specialists Liz Ford and Hope Lloyd served on the closing teams for Hilltop and Rehab Central. Hope and Liz assisted with development of a plan for each resident under age 60 to transition to a community placement that met their needs and provided services and supports for a successful community placement. They helped many guardians and residents to understand and assert their rights and to ensure the choices of the resident and guardians were respected as community placements were developed.

The closing process was noteworthy for the strong collaboration among Milwaukee County's Behavioral Health Division and Disability Services staff, Managed Care Organizations (MCOs), community providers, Wisconsin's Department of Health Services, advocates from DRW and the Board on Aging and Long Term Care, and

residents and guardians throughout this transition. All parties strived to develop high quality, individualized community placements for each resident. In addition, the state of Wisconsin and Milwaukee county made a significant investment of funding that was key to develop new community capacity to support so many residents with complex needs.

By January, 2016, Milwaukee County's era of long-term institutional care for individuals with mental illness and developmental disabilities, dating to the 1880s, had ended. Because this was such a historic closure, and because many residents had complex needs which required very specialized supports, DRW wanted to follow-up with residents and their guardians after they left the Complex. With generous support from the Helen Daniels Bader Fund of Bader Philanthropies and the Stackner Family Foundation, DRW developed a protocol for follow-up visits to assess their new community placements and provide advocacy assistance when needed.

Most individuals are thriving with this opportunity for greater independence and self-determination; although a minority still experience difficulties with the transition. DRW is documenting the project's findings with lessons learned, guardian and residents perspectives, and recommendations for best practices in a report slated for release in fall of 2016.

Looking forward, the closure of Hilltop and Rehab Central should provide an opportunity to reallocate dollars used to serve the hundreds of individuals who lived at the Complex to fund a needed expansion of community services.

The majority of the former long term care residents are now enrolled in

A CAPITOL EFFORT ON THE ROAD TO FREEDOM

Mental Health Complex

Family Care which is funded by the state of Wisconsin. Milwaukee County is providing support for 23 residents from Rehab Central who are not eligible for Family Care. The County has also developed a promising new resource, the Milwaukee County Community Consultation Team (CCT). The CCT is staffed by clinicians who supported Hilltop residents and have expertise working with people with developmental disabilities, and provides training, consultation in the community and by phone, as well as Mobile Crisis response. Since the team was established in January 2014, they have provided training, and other support to hundreds including family members, providers, and consumers.

As Disability Rights Wisconsin staff follow up with guardians and former Complex residents who have relocated to the community, it has been heartening to see many examples of how individuals are flourishing and growing in the community. This is a tremendous milestone for the residents and for Milwaukee County. However, in the words of Dianne Greenley, retired DRW Managing Attorney and a lead attorney on the Joan S lawsuit: "The closure of long term care is a very positive step, but it's too soon to put up the "mission accomplished" banner. The County must make an ongoing commitment to ensure that others who need wraparound community supports have ready access to quality recovery oriented services."



Hope Lloyd and Liz Ford

The 2015 Fiscal Year brought many challenges as the Governor's budget proposed overhauling Wisconsin's nationally recognized long-term care system – Family Care and IRIS. Disability Rights Wisconsin worked with stakeholders to secure enhanced public input in the redesign process that would impact more than 55,000 individuals. Hundreds of individuals with disabilities turned out at a series of public hearings held by the state legislature's Joint Finance Committee and at Disability Advocacy Day in March, sponsored by the Survival Coalition, including DRW.

Advocates from DRW attended many meetings with staff from the Department of Health Services to discuss the contours of the proposal. DRW's involvement helped to inform both the public and policymakers of the potential impact on people with disabilities and helped shape a friendlier proposal.

DRW was instrumental in bringing the National Council on Disability to Wisconsin to hold a forum on Medicaid managed care in August, that concluded with recommendations for Wisconsin's long term care programs.

Among "wins" in public policy this year were the passage of Wisconsin's ABLE Act program to allow people with disabilities and family members to save funds tax-free while preserving eligibility for essential supports and the appropriation of \$100,000 for special education transition grants.

Meanwhile, DRW also helped to facilitate change at the federal level. Public Policy Director Lisa Pugh

represented the agency as a citizen member on both the President's Committee for People with Intellectual Disabilities (PCPID) and the US Department of Labor's Advisory Committee for Increasing Competitive Integrated Employment for Individuals with Disabilities (ACICIEID).

Each Committee made significant recommendations to the President and Congress that are aimed at national systems change. Specifically, the PCPID report shared cutting edge technology solutions for people with disabilities across education, community living, and health care.

In September of 2015 the ACICIEID issued its interim report as required by the Workforce Innovation Opportunity Act. The Committee is charged with making recommendations to increase capacity for competitive employment for individuals with the most significant disabilities while also increasing oversight and reducing the need for use of sub-minimum wage licenses. Lisa Pugh serves as Co-Chair of the Transition to Careers subcommittee and shared outcomes from Wisconsin's Let's Get to Work grant to inform national employment recommendations for youth.



*DRW Public Policy Director
Lisa Pugh at the Wisconsin Capitol*

Attachment F

disabilityrights | WISCONSIN

Date: October 26, 2010

Subject: Thoughts on the Future of Hilltop

Dear County Supervisor,

The Milwaukee County Board Finance and Audit Committee has approved an amendment to develop a plan to downsize Hilltop, the 72 bed long term care center (ICF-MR) for people with co-occurring mental health and intellectual and developmental disabilities. I hope you will support this amendment when it comes to the full board in November.

Disability Rights Wisconsin strongly supports this amendment and looks forward to working collaboratively with Milwaukee County and other stakeholders to provide input on a plan for downsizing. In the last 20 years, there has been a significant transformation in the community services system and its capacity to meet the needs of people with disabilities. Most people with disabilities, including severe disabilities, are building their lives in the community – outside of institutions - and residents of Hilltop should have that same opportunity.

This direction is in line with state and national trends to support people with disabilities in the community in a more integrated setting. Wisconsin's ICF/MR population has dropped by 2/3 in the last 8 years as more people have been served in community settings. Milwaukee, however, has lagged behind and continues to maintain an institutional capacity that most other counties have largely stopped using. Developing a plan to downsize Hilltop is also in line with the recommendations in the recent report from the Human Services Research Institute and the Public Policy Forum.

Our staff have worked with Milwaukee County and others to develop successful community placements for 100's of residents of institutions including Jackson Center, Hearthside, Northern Center, as well as other Hilltop residents. We know that our clients from Hilltop can flourish in the community if they are provided with person centered planning and appropriate community services living arrangements.

The plan for Hilltop should include the following:

- The state should be a partner, as they have been in other similar efforts, including providing additional funding to assist with relocation and supports.
- Milwaukee County should work with experienced and proven community partners to develop additional capacity in the community for relocation, such as supportive apartments.
- Relocation will require the commitment of dedicated staff resources.
- Family Care staff will need support and training to work with this new population.
- DRW staff have participated in closing teams as other institutions have downsized and we are ready to take an active role in the planning and downsizing process.
- Consumers, families, and guardians should be actively engaged as partners and learn about the possibilities for people with severe disabilities to live in the community.
- The plan should also look at the continuum of services needed to support people with co-occurring mental health and intellectual and developmental disabilities, such as crisis respite and diversion, and a specialized mobile crisis team.

I wanted to share with you the booklet, *Possibilities*, which shares stories of people with severe disabilities who have moved from institutions to community settings. Please let me know if you have questions or would like additional information (414-773-4646 office/ 414-719-1034 cell). Thank you.

With great respect,

Barbara Beckert, Milwaukee Office Director

MILWAUKEE OFFICE 414 773-4646
888 758-6049 TTY
6737 West Washington Street 414 773-4647 FAX
Suite 3230 800 708-3034 consumers & family only
Milwaukee, WI 53214 disabilityrightswi.org

Protection and advocacy for people with disabilities.

Attachment G

disabilityrights | WISCONSIN

**Statement from Disability Rights Wisconsin on
Proposed Closure of Hilltop and Rehab Central
Barbara Beckert, Milwaukee Office Director
March 12, 2013**

Thank you for the opportunity to speak with you regarding the proposed closure of the long term care facilities at the Milwaukee County Mental Health Complex: Hilltop and Rehab Central.

I am speaking you on behalf of Disability Rights Wisconsin, the protection and advocacy agency for people with disabilities in our state. DRW is part of a national network of protections and advocacy agencies established by Congress as part of the Developmental Disabilities (DD) Act in 1975 in response to deplorable conditions at Willowbrook, a large institution for people with developmental disabilities. Congress charged the Protection and Advocacy agencies with serving as the watchdog for people with disabilities with the top priority of addressing abuse and neglect of people with disabilities in institutions.

The DD Act focuses on the estimated 4.5 million children and adults in the U.S. who have developmental disabilities. The purpose of the Act is to assure that individuals with developmental disabilities and their families have the opportunity to actively participate in the design of community based programs and have access to community services, individualized supports, and other forms of assistance that promote and create opportunities for independence, productivity, and self-determination.

This is important background for your agenda item because it reinforces the right of people with disabilities to live in the community – rather than in institutional settings – as one of the core reasons that Congress established the P and A system. This was further affirmed by Supreme Court decision in *Olmstead v. L.C.*, a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. The Department of Justice under President Obama has taken aggressive action to enforce the Olmstead decision and to ensure the right of people with disabilities to live in the community in the least restrictive environment.

It is also in line with the mandates of Chapter 55 of the Wisconsin Statutes and the Wisconsin Supreme Court decision in *In the matter of Judy K.* Chapter 55 requires that protective services and placement “shall be provided in the least restrictive environment and in the least restrictive manner consistent with the needs of the individual and with the resources of the county department.” 55.12(3) Wis. Stats. The Supreme Court has interpreted the Chapter 55 mandates as requiring counties to “make a good faith, reasonable effort to find and fund” placements that meet the least restrictive standard.

Under Wisconsin law, facilities relocating 5 or more residents must file a Resident Relocation Plan with the Division of Long Term Care. This includes Nursing Homes, Facilities Serving People with Developmental Disabilities (FDD) or Community Based Residential Facilities (CBRF) considering relocation of 5 or more residents. This process is in place to protect the rights of vulnerable people and ensure that appropriate quality services and supports are in place.

DRW is mandated as one of the members of the State Relocation Team when residents to be relocated are identified as having mental, developmental, or physical disabilities. Our responsibilities include the following:

- Be available to residents and families during the relocation process to provide technical assistance and information as needed, regarding the legal framework, requirements of discharge planning and community placement options for residents with disabilities in the relocation process.
- Provide advocacy services as agreed upon to individual residents with disabilities to assist them to assert their rights and preferences during discharge planning and help them obtain proper discharge planning and appropriate amounts of quality community services.
- Advocate within the team process to ensure that the facility, governmental agency or managed care organization meet the community long-term support or other disability-related needs of the residents.

MILWAUKEE OFFICE 414 773-4646
888 758-6049 TTY
6737 West Washington Street 414 773-4647 FAX
Suite 3230 800 708-3034 *consumers & family only*
Milwaukee, WI 53214 disabilityrightswi.org

Protection and advocacy for people with disabilities.

DRW and the Protection and Advocacy system support the right of residents at the Mental Health Complex and other institutions to have the opportunity to live in the community because we believe this can provide a better quality of life, offer additional opportunities for community integration and to have closer relationships with friends and family. This perspective is informed by the many people we have advocated for who have experienced neglect and abuse in institutional settings. However, to fulfill the promise of a better life in the community, it is essential that the community setting includes quality services, supports, including adequate staffing levels, carefully developed to meet the residents' needs and with the input of each resident and their guardian or family. DRW will vigorously advocate at both the individual and system level to ensure these services and supports are in place and adequately funded.

FAMILY CARE HAS A KEY ROLE TO PLAY

The vast majority of residents of the Mental Health Complex Long Term Care facilities are eligible for Wisconsin's Family Care program which is a Medicaid waiver that provides community based long term care services. Family Care is an entitlement in Milwaukee County which means that we no longer have waiting lists and any county resident who is functionally and financially eligible must be served. Individuals in Milwaukee County residents who are eligible for Family Care receive options counseling regarding their choices for long term care. Residents who are eligible for Family Care, and their guardians, will have a choice of two Family Care Managed Care Organizations (MCOs), two Partnership programs, and IRIS which support self-direction of community long term care services. These programs will oversee the community based services that residents will receive.

To be successful in relocating Hilltop and Rehab Central residents to the community, it will be essential for the Family Care and Partnership Managed Care Organizations to develop the resources and capacity to meet these important and specialized needs and to provide the level of funding needed to support appropriate staffing and needed supports, and adequate rates to secure experienced proven providers. As a managed care program, Family Care uses a capitated rate set by the state which pays a "per-member-per-month" rate, regardless of the number or nature of services provided. Advocates have long been concerned that the capitated rate may be a disincentive to service people with complex and costly needs - and we strongly believe that an adequate Family Care capitated rate is essential to serving residents of Hilltop and Rehab Central in the community.

RECOMMENDATIONS FOR MOVING FORWARD

DRW supports the right of people with disabilities to live in the community in the least restrictive setting. We support the proposed concept of developing a plan to close Hilltop and Rehab Central in three years while concurrently developing quality community based placements for each resident. However, our support is contingent on the following safeguards:

- It is essential that all stakeholders proceed slowly and carefully to ensure that effective and appropriate supports and services are developed to provide residents with the best possible chance to have a good life in the community. This should include a careful review of best practices and lessons learned from previous institutional downsizings, and an examination of how these can be incorporated into the current closure given the relatively new role of Family Care.

We recommend that a forum or strategy session be held within the next three months to highlight lessons learned from past institution closings and share best practices, so that these can be used to benefit residents as we move forward with the Hilltop and Rehab Central closures. This should include strategies for supporting and educating guardians, who have a very important role to play in this transition.

- As noted earlier in this paper, we believe the state mandated team for institutions closings, provides a proven process and protections for residents and must be in place.
- Although there have been large institution closings in the past in Milwaukee County, this is the first closing of this size and complexity since Family Care has been in place. It will be important to determine how Milwaukee County and the Family Care MCOs can work collaboratively to develop and support the essential resources needed to successfully serve Hilltop and Rehab Central residents in the community.

This should include development of a robust continuum of community services including housing, specialized behavioral health services, crisis services including the Mobile team and respite beds. Access to quality mental health services will be critically important. Although having a mental illness alone does not provide eligibility for Family Care, all of the residents of Hilltop and Rehab Central also have a mental health diagnosis. The planned closure will require significant development of new resources and that will require ensuring provider rates that will support experienced and high quality providers. Mobile crisis teams, should be available 24/7, with specific expertise in meeting the needs of three target groups of people, those with psychiatric disabilities, those with intellectual disabilities, and those with Alzheimer's/dementia.

- **Funds saved from downsizing must be invested in developing community services and supports.** This is in line with county board resolution (RES 11-516) signed by the County Executive which states in part: "The county must commit to continued funding of mental health care services at current levels with any savings produced as a result of the transition to a community-based service delivery model reinvested into the program to allow for expanded community services". Similar language was in the adopted 2012 budget.

This is especially critical for the minority of residents who are not eligible for Family Care.

Milwaukee County must be the safety net for these residents and for others moving forward who have a mental health disability and are **not** eligible for Family Care. This will require a commitment for a long term increased investment in community services and supports including residential services. For the closure to move forward, Milwaukee County must make a commitment to develop and support community housing and services for residents who do not qualify for Family Care, and for other community members moving forward.

- The vast majority of residents of Hilltop and Rehab Central have multiple disabilities and complex needs. For Family Care to be successful in serving individuals with complex needs, an adequate capitated rate is essential. We urge Milwaukee County to advocate with the Dept. of Health Services (DHS) regarding the need to provide an enhanced capitated rate to ensure the success of this institution closure. Advocates stand ready to work with Milwaukee County leadership to make the case to DHS for an enhanced rate for residents which will cover the actual cost of relocating residents to the community and developing specialized residential settings. We welcome the DHS decision to use Money Follows the Person funds to supplement the capitated rate, with a \$1000 per member payment to the MCOs to assist with relocation. However, in many cases, this supplement to the capitated rate will not be sufficient.

Note: Until 2011, a special "first year" enhanced rate was provided for Wisconsinites relocating from an institution. This recognized that one-time investments were needed to develop specialized resources, provide environmental modifications, develop behavior plans, and recruit and train staff with specialized skills. The enhanced rate for Year 1 is a good investment because it supports development of capacity and placements for people with complex needs – we should develop a strategy to make the case to DHS to reinstate the enhanced rate for a minimum of one year.

- Ensuring a comprehensive community based continuum of services. This would provide technical assistance and crisis back-up in the community and reduce the "revolving door" where the only option in a crisis is to re-admit people to an institutional setting. This "Community Ties" model is used by Dane County Human Services in partnership with the Waisman Center to support people with developmental disabilities and challenging behaviors. It includes development of person centered behavior support plans, training providers on crisis response strategies, use of environmental adaptations and modifications, a mobile team, and a Safe House and robust quality assurance.
- Independent external advocacy resources must be available for guardians and residents.
- Vulnerable adults with disabilities of all ages rely on the Chapter 55 protective placement and guardianship systems guaranteed under state law to protect their rights at the time of crisis and to

ensure their safety This is especially true today for persons with Alzheimer's and related dementias in the aftermath of the *Helen EF* Supreme Court decision. Over the years Hilltop and Rehab Central have served in part as the County's Chapter 55 placement and treatment facilities. The plan for closure must address Milwaukee County's continuing statutory responsibility under Chapter 55 to either directly provide or ensure that there is capacity within the system for both emergency and non-emergency protective placements and services.

- The closure plan should assess the County's responsibility to ensure and fund an adequate supply of volunteer and paid guardians to protect the rights of people in Chapter 55.
- We urge Milwaukee County to fund and operationalize increased oversight and quality assurance given this major expansion of community services.



Attachment H

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

Statement from the Milwaukee Mental Health Task Force on Proposed Closing of Long Term Care Facilities at the Milwaukee Mental Health Complex March 11, 2013

In the recent State of the County Address, County Executive Abele introduced a plan to close the long term care facilities at the Mental Health Complex over the next three years and develop person centered plans to serve each resident in the community. This includes Hilltop, the 70 bed long term care center (ICF-MR) for people with co-occurring mental health and intellectual and developmental disabilities and Rehab Central, which serves people who need skilled nursing home care and also have a mental illness. Most residents will be eligible for services from Family Care, which provides community based services and supports to three target groups: frail elderly, people with developmental disabilities and people with physical disabilities.

The proposal to close the long term care facilities and development community placements over the next three years, is in line with state and national trends to support people with disabilities in the community in a more integrated setting. Wisconsin's ICF/MR population has dropped by 2/3 in the last 8 years as more people have been served in community settings. Milwaukee has lagged behind and continues to maintain an institutional capacity that most other counties have largely stopped using. Developing a comprehensive person centered plan to downsize Hilltop and Rehab Central is also in line with the recommendations in the report from the Human Services Research Institute and Public Policy Forum, as well as the Mental Health Redesign and Implementation Task Force.

Furthermore, this direction is also in line with the Supreme Court decision in *Olmstead v. L.C.*, a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. The Department of Justice under President Obama has taken aggressive action to enforce the Olmstead decision and to ensure the right of people with disabilities to live in the community in the least restrictive environment.

As advocates, we support the right of residents at the Mental Health Complex to have the opportunity to live in the community because we believe this can provide an increased quality of life and offer additional opportunities for community engagement and to be near friends and family. To realize the potential of a better life in the community, it is vital that the community setting includes quality services, supports, including adequate staffing levels, carefully developed to meet the residents' needs and with the input of each resident and their guardian or family.

FAMILY CARE HAS A KEY ROLE TO PLAY

The vast majority of residents of the Mental Health Complex Long Term Care facilities are eligible for Wisconsin's Family Care program which is a Medicaid waiver that provides community based long term care services. Family Care is an entitlement in Milwaukee County which means that we no longer have waiting lists and any county resident who is functionally and financially eligible must be served. Individuals in Milwaukee County residents who are eligible for Family Care receive options counseling regarding their choices for long term care. Residents who are eligible for Family Care, and their guardians, will have a choice of two Family Care Managed Care Organizations (MCOs), two Partnership programs, and IRIS which support self-direction of community long term care services. These programs will oversee the community based services that residents will receive.

To be successful in relocating Hilltop and Rehab Central residents to the community, it will be essential for the Family Care and Partnership Managed Care Organizations to develop the resources and capacity to meet these important and specialized needs and to provide the level of funding needed to support appropriate staffing and needed supports, and adequate rates to secure experienced proven providers. As a managed care program, Family Care uses a capitated rate set by the state which pays a "per-member-per-month" rate, regardless of the number or nature of services provided. Advocates have long been concerned that the capitated rate may be a disincentive to service people with complex and costly needs - and we strongly believe that an adequate Family Care capitated rate is essential to serving residents of Hilltop and Rehab Central in the community.

RECOMMENDATIONS FOR MOVING FORWARD

The Milwaukee Mental Health Task Force has long supported the right of people with disabilities to live in the community in the least restrictive setting. We support the proposed concept of developing a plan to close Hilltop and Rehab Central in three years while concurrently developing quality community based placements for each resident. However, our support is contingent on the following safeguards:

- It is essential that all stakeholders proceed slowly and carefully to ensure that effective and appropriate supports and services are developed to provide residents with the best possible chance to have a good life in the community. This should include a careful review of best practices and lessons learned from previous institutional downsizings, and an examination of how these can be incorporated into the current closure given the relatively new role of Family Care.

We recommend that a forum be held within the next three months to highlight lessons learned from past institution closings and share best practices, so that these can be used to benefit residents as we move forward with the Hilltop and Rehab Central closures. This should include strategies for supporting and educating guardians, who have a very important role to play in this transition.

- The state mandated team for institutions closings, which includes representatives of advocacy groups (Disability Rights Wisconsin and the Board on Aging and Long term Care) must be front and center as an essential watchdog, ensuring the integrity of this effort. We support their efforts and critically important oversight role.
- Although there have been large institution closings in the past in Milwaukee County, this is the first closing of this size and complexity since Family Care has been in place. It will be important to determine how Milwaukee County and the Family Care MCOs can work collaboratively to develop and support the essential resources needed to successfully serve Hilltop and Rehab Central residents in the community.

This should include development of a robust continuum of community services including housing, specialized behavioral health services, crisis services including the Mobile team and respite beds. The planned closure will require significant development of new resources and that will require ensuring provider rates that will support experienced and high quality providers. Mobile crisis teams, should be available 24/7, with specific expertise in meeting the needs of three target groups of people, those with psychiatric disabilities, those with intellectual disabilities, and those with Alzheimer's/dementia.

- **Funds saved from downsizing must be invested in developing community services and supports.** This is in line with county board resolution (RES 11-516) signed by the County Executive which states in part: "The county must commit to continued funding of mental health care services at current levels with any savings produced as a result of the transition to a community-based service delivery model reinvested into the program to allow for expanded community services". Similar language was in the adopted 2012 budget.

This is especially critical for the minority of residents who are not eligible for Family Care. Milwaukee County must be the safety net for these residents and for others moving forward who have a mental health disability and are **not** eligible for Family Care. This will require a commitment for a long term increased investment in community services and supports including residential services. For the closure to move forward, Milwaukee County must make a commitment to develop and support community housing and services for residents who do not qualify for Family Care, and for other community members moving forward.

- The vast majority of residents of Hilltop and Rehab Central have multiple disabilities and complex needs. For Family Care to be successful in serving individuals with complex needs, an adequate capitated rate is essential. We urge Milwaukee County to advocate with the Dept. of Health Services (DHS) regarding the need to provide an enhanced capitated rate to ensure the success of this institution closure. Advocates stand ready to work with Milwaukee County leadership to make the case to DHS for an enhanced rate for residents which will cover the actual cost of relocating residents to the community and developing specialized residential settings. We welcome the DHS decision to use Money Follows the Person funds to supplement the capitated rate, with a \$1000 per member payment to the MCOs to assist with relocation. However, in many cases, this supplement to the capitated rate will not be sufficient.

Note: Until 2011, a special "first year" enhanced rate was provided for Wisconsinites relocating from an institution. This recognized that one-time investments were needed to develop specialized resources, provide environmental modifications, develop behavior plans, and recruit and train staff with specialized skills. The enhanced rate for Year 1 is a good investment because it supports development of capacity and placements for people with complex needs – we should develop a strategy to make the case to DHS to reinstate the enhanced rate for a minimum of one year.

- Ensuring a comprehensive community based continuum of services. This would provide technical assistance and crisis back-up in the community and reduce the “revolving door” where the only option in a crisis is to re-admit people to an institutional setting. This “Community Ties” model is used by Dane County Human Services in partnership with the Waisman Center to support people with developmental disabilities and challenging behaviors. It includes development of person centered behavior support plans, training providers on crisis response strategies, use of environmental adaptations and modifications, a mobile team, and a Safe House and robust quality assurance.
- Independent external advocacy resources must be available for guardians and residents.
- Vulnerable adults with disabilities of all ages rely on the Chapter 55 protective placement and guardianship systems guaranteed under state law to protect their rights at the time of crisis and to ensure their safety. This is especially true today for persons with Alzheimer's and related dementias in the aftermath of the *Helen EF* Supreme Court decision. Over the years Hilltop and Rehab Central have served in part as the County's Chapter 55 placement and treatment facilities. The plan for closure must address Milwaukee County's continuing statutory responsibility under Chapter 55 to either directly provide or ensure that there is capacity within the system for both emergency and non-emergency protective placements and services.
- The closure plan should assess the County's responsibility to ensure and fund an adequate supply of volunteer and paid guardians to protect the rights of people in Chapter 55.
- We urge Milwaukee County to fund and operationalize increased oversight and quality assurance given this major expansion of community services.

The Milwaukee Mental Health Task Force was formed in 2004, in response to a crisis in inpatient psychiatric services that exposed major gaps in Milwaukee's system of mental health care. It includes over 40 organizations who work collaboratively to identify issues faced by people affected by mental illness, facilitate improvements in services, give consumers and families a strong voice, reduce stigma, and implement recovery principles.

Attachment I

Current Status: *Active*

PolicyStat ID: 1969674



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

Approval Signatures

Committee	Approver	Date
	Patricia S Schroeder: BHD Administrator	11/25/2015
	Alicia Modjeska: Chief Operations Officer	11/25/2015

Chairperson: Duncan Shrout
Vice-Chairman: Thomas Lutzow
Secretary: Dr. Robert Chayer
Senior Executive Assistant: Jodi Mapp, 257-5202

**SPECIAL MEETING
MILWAUKEE COUNTY MENTAL HEALTH BOARD
EXECUTIVE COMMITTEE**

Thursday, September 22, 2016 - 12:00 P.M.
Milwaukee County Mental Health Complex
Conference Room 1070

MINUTES

PRESENT: Robert Chayer, Thomas Lutzow, and Duncan Shrout

SCHEDULED ITEMS:

NOTE: All Informational Items are Informational Only Unless Otherwise Directed by the Executive Committee.

Pursuant to 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 they relate to the following matter(s):

- | | |
|----|---|
| 1. | <p>Medical Executive Report and Credentialing and Privileging Recommendations.</p> <p>Dr. Clarence Chou, President, Medical Staff Organization, Behavioral Health Division (BHD)
Lora Dooley, Director of Medical Staff Services, BHD</p> <p>MOTION BY: <i>(Lutzow) 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 #1. At the conclusion of the Closed Session, the Executive Committee may reconvene in Open Session to take whatever action(s) it may deem necessary on the aforesaid item. 3-0</i></p> <p>MOTION 2ND BY: <i>(Chayer)</i></p> <p>AYES: Chayer, Lutzow, and Shrout - 3</p> <p>NOES: 0</p> |
|----|---|

SCHEDULED ITEMS (CONTINUED):

	<p>The Committee convened into Closed Session at 12:06 p.m. and reconvened back into Open Session at approximately 12:12 p.m. The roll was taken, and all Executive Committee Members were present.</p> <p>MOTION BY: (Chayer) Approve the Medical Staff Credentialing Report and Medical Executive Committee Recommendation Contingent Upon Attainment of a Wisconsin Medical License Prior to Privilege Start Date. 3-0</p> <p>MOTION 2ND BY: (Lutzow)</p> <p>AYES: Chayer, Lutzow, and Shrout - 3</p> <p>NOES: 0</p>
2.	<p>Adjournment.</p> <p>Chairman Shrout ordered the meeting adjourned.</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: 12:04 p.m. to 12:15 p.m.</p> <p>Adjourned,</p> <p>Jodi Mapp Senior Executive Assistant Milwaukee County Mental Health Board</p>	

Chairperson: Dr. Robert Chayer
Senior Executive Assistant: Jodi Mapp, 257-5202

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
QUALITY COMMITTEE**

September 12, 2016 - 10:00 A.M.
**Milwaukee County Mental Health Complex
Conference Room 1045**

MINUTES

PRESENT: Robert Chayer, *Ronald Diamond, Jeffrey Miller, Mary Neubauer, and
Brenda Wesley

*Committee Member Ronald Diamond appeared by phone.

SCHEDULED ITEMS:

- | | |
|----|---|
| 1. | <p>Welcome.</p> <p>Chairman Chayer welcomed everyone to the March 7, 2016, Mental Health Board Quality Committee meeting.</p> |
| 2. | <p>Quality Subcommittee Updates:</p> <p>*Quality Management Services.</p> <p>Information provided under this item is the product of a collaborative effort between various workgroups and the initiatives underway redesigning care and services across all programs at the Behavioral Health Division, focusing on improvement of the client experience. Charters for each project have been drafted.</p> <ul style="list-style-type: none">• Contract Performance Management <p>Developing performance measures for contracts began last year. They are currently in place for detox providers and are in the process of being revised and implemented. A set has been created for Targeted Case Management (TCM), Alcohol and Other Drug Abuse (AODA) Residential, and Warmline services. A template has been developed focused on four broad domains within contract performance measures relevant to assessing the quality of service provided in any given contract. Those domains are access to services, transfers to subsequent programs within the continuum of care, outcomes, and the client experience.</p> |

SCHEDULED ITEMS (CONTINUED):

	<ul style="list-style-type: none">• Compliment, Complaint, and Grievances This team is comprised of representatives from the areas of clients' rights and finance and includes a clinician and a peer, who provides the voice of the customer. The mix provides very different perspectives that are all equally important. The intent is to centralize the process across the Behavioral Health Division (BHD). Community services and inpatient are currently functioning independently. Centralizing the process will assist in ensuring state and federal guidelines are being met for accreditation purposes. The team is also exploring electronic tools to assist in collecting and storing data.• Data Request Management This team is responsible for data management and preparation throughout BHD, which includes Information Technology (IT), Fiscal, and Community Access to Recovery Services (CARS). The teams' charge is to examine both internal and external data requests. BHD is currently developing methodology and a categorization system to track requests and determine if they are internal or external.• The Client Experience/Satisfaction Evaluation of the current process identified an opportunity to create a more uniform distribution and collection method of surveys. Organizations specializing in gathering client experience tools are being evaluated.
3.	<p>2016 Key Performance Indicators (KPI) Dashboard and Community Access to Recovery Services (CARS) Quarterly Report.</p> <p>Volume fluctuation of emergency detentions for 2015/2016 is due to entry of data into the system, not volume increasing. Work continues to modify the data collection forms and assist with uploading difficulties. Provider training has been deployed through Healthstream, with the assistance of Educational Services, and focuses on data entry. The goal is to have one hundred percent compliance and to reduce the lag time between admissions and the date the Program Participation System (PPS) form is entered into the system.</p> <p>The CARS quarterly report was broken down by number of clients receiving services and by program, number of admissions and by program, referrals/intakes by access point, and average days on waitlists for mental health programs and AODA residential services.</p> <p>Questions and comments ensued.</p>

SCHEDULED ITEMS (CONTINUED):

4.	<p>Joint Commission Survey Progress Update.</p> <p>Hospital treatment plans are still currently on paper. A statement of work and charter is being developed as it relates to one single care plan across all services and providers. Additionally, the medication reconciliation process is not part of the electronic system. BHD is currently reviewing its electronic health record (EHR) system and recommendations are forthcoming.</p>
5.	<p>Acute Hospital Recertification.</p> <p>On June 13, 2016, BHD participated in an unannounced recertification State survey on behalf of the Centers for Medicare and Medicaid Services (CMS). Overall, the feedback was positive. Areas recommended for improvement include contract management compliance monitoring, the electronic health record system, environment/facility issues, and infection control. A plan of correction, which included education and training, was submitted and approved based on a verification visit.</p> <p>Subsequently on August 29, 2016, CMS came and reviewed special components of the correction plan; specifically, treatment planning, active treatment, and seclusion and restraint usage. Concerns were raised on the use of ambulatory restraints. BHD was directed to address ambulatory restraints immediately. An abatement plan, eliminating the use of ambulatory restraints for patients including the incorporation of an administrative review used, was submitted surveyors immediately.</p> <p>Questions and comments ensued.</p>
6.	<p>Comprehensive Community Services (CCS) Survey.</p> <p>Surveyors were on site from August 23 through August 25, 2016. The visit resulted in a yearly provisional certification for CCS. Improvement recommendations included enrollment of adults and children. A citation was received for individual recovery plans. A plan for corrective action will be submitted on September 27, 2016.</p>
7.	<p>Community-Based Residential Facility (CBRF) Audit.</p> <p>BHD Quality and Compliance partnered to perform an unannounced site and patient care audit of the Uncas CBRF on July 12 and 13, 2016. Community-based residential facilities standards were used, in addition to adherence to the substitute care model of quality performance standards and measures. Staff spoke to residents who provided positive feedback. The audit was satisfactory.</p>

SCHEDULED ITEMS (CONTINUED):

8.	<p>Wraparound Milwaukee 2016 Resource Fair – Data And Evaluation.</p> <p>Wraparound held its Resource Fair in June where families and providers were invited. Turnout was great. The fair provides an opportunity for people to network with providers and other families to receive information about services and support. Tables were set up for vendors to distribute information, including community support services.</p> <p>A summary of the results of the survey provided to participants were presented.</p>
9.	<p>Community Access to Recovery Services (CARS) Quality Improvement Event.</p> <p>On August 17, 2016, Annual Storyboard Marketplace was celebrated. It is an opportunity for providers to showcase quality improvement projects implemented over the last year. CARS wanted to systemically look at a quality improvement project that would involve providers to understand why consumers die at an early age due to physical health issues.</p> <p>A LIFE (Learning Ideas For Enduring) event was held and all providers attended a day of training. The first part of the day was spent with a nutritionist, and the second part of the day was slated for Plan Do Study Act (PDSA), where providers concentrated on improving health outcomes.</p> <ul style="list-style-type: none">• Project: Good Nutrition is Our Mission <p>The Good Nutrition is Our Mission Committee conducted an agency-wide survey to identify barriers to eating well and having good nutrition. A pilot study of forty-eight consumers that included a five-week intervention and follow-up survey was done. Results of the surveys were explained in detail.</p>
10.	<p>Psychiatric Crisis Services (PCS) Hospital Transfer Waitlist Report: 2016 Mid-Year Update.</p> <p>When BHD has less than ten adult beds available of any type, a waitlist is instituted. Individuals at hospitals other than BHD, remain there until BHD has capacity. Walk-ins or emergency detentions are not affected. The Mobile Crisis Team evaluates individuals at other hospitals and determines if the emergency detention is, in fact, needed. The root cause of the increasing waitlist utilization is physician/nursing vacancies. Data contained in the report, which is reflective of the last twelve quarters, was reviewed in detail.</p>
11.	<p>Next Scheduled Meeting Dates:</p> <ul style="list-style-type: none">• December 5, 2016, at 10:00 a.m.• March 6, 2017, at 10:00 a.m. <p>The next meeting date was announced as December 5, 2016, at 10:00 a.m.</p>

SCHEDULED ITEMS (CONTINUED):

12.	Adjournment. Chairman Chayer ordered the meeting adjourned.
<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: 10:03 a.m. to 12:19 p.m.</p> <p>Adjourned,</p> <p><i>Jodi Mapp</i> Senior Executive Assistant Milwaukee County Mental Health Board</p>	
<p style="text-align: center;">The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is Monday, December 5, 2016, @ 10:00 a.m.</p>	

Quality Committee Meeting Packet Item 2

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: August 22, 2016

TO: Dr. Robert Chayer, Quality Committee
Milwaukee County Mental Health Board

FROM: Jennifer Bergersen, Chief Clinical Officer, Behavioral Health Division

SUBJECT: BHD Quality Management Services: Quality Re-Design Initiatives 2016 * Drafts

REQUEST: Informational

The Milwaukee County Behavioral Health Division is undergoing transformative change in the pursuit of a best practice, nationally recognized behavioral health center of excellence. Some of the quality initiatives and projects that are currently underway include the following committees. Team leaders of these projects will be present to discuss updates at the Quality Board Meeting on September 12, 2016. This report is informational only, no action required. *The work teams and chartered activities below continue to evolve are in various stages in need of executive leadership authorization.

QUALITY MANAGEMENT SERVICES (QMS):

BHD will:

Opportunity: Develop a centralized, consolidated Quality Management Department across the Behavioral Health Division.

Gap: Strengthening, measuring and assessing the performance of care and service delivery through the collection and analysis of data.

The team will work through subcommittees with individual charters to measure and assess the current performance of care and service in the following domains:

- Contract Performance Measurement
- Compliment, Complaint, and Grievances
- Data Request Management
- The Client Experience/Satisfaction
- Incident Reporting & Analysis
- Performance Improvement

The QMS project objectives are to strengthen and implement quality and performance improvement initiatives and take action where indicated. The vision includes the design of new services, and/or improvement of existing services. The achievements will focus on a systematic approach to assessing care and services and improving them on a priority basis.

Measurable steps to achieve the project objectives are to: (1) develop and formalize committee and subcommittee project charters with identified leadership; (2) facilitate the mapping of current work flows (as needed) to understand current state, and support development of transformation to future state; (3) lead the setting of timelines, milestones, reporting schedule, and communication plans; (4) Identify and utilize an evidence-based standard, published set of criteria (metrics) to assist in the process.

Contract Performance Measurement:

BHD will:

Opportunity: To develop a set of evidence-based performance measures to evaluate the quality and cost-effectiveness of care provided by BHD contracted agencies.

Gap(s): Wide variance in the types and operationalization of process and outcome measures employed by different levels of care and within different branches of BHD. Variation of reporting requirements.

This team will create a set of performance measures for contracted services. This set will include both measures which are uniform across all services and branches within BHD, as well as measures which are tailored to the given service and/or branch under question. It will not supersede existing reporting requirements to which services are already subject.

1. This team's intentions are: a. To develop a set of uniform and unique performance measures for all provider services with which BHD contracts. b. Ensure that these performance measures can be efficiently and accurately collected (e.g., by making use of existing data collection requirements) and are not unduly burdensome to consumers and provider staff. c. Ensure that they accurately represent high quality and cost effective care. d. Ensure that they accurately represent consumer recovery. e. Ensure that they are appropriate to the service being provided, with consideration for the service's mission and purpose within the recovery continuum. 2. Our vision is that our performance measures will enable us to accurately and meaningfully depict the quality of care provided, but help to inform remedial efforts should the performance measures data suggest subpar quality of care.

Measurable steps to achieve the project objectives include: (1) Regularly scheduled meetings. (2) Complete a charter. (3) Develop an overall plan in which different metrics of performance are situated within the recovery continuum and continuum of care. (4) Create a broad template applicable for performance measures for all contracts. (5) Create a list of all contracts which require performance measures to catalogue both initial completion and revision of the performance measures for each respective contract. (6) Ensure vendor and voice of the consumer.

Compliment, Complaint and Grievances:

Opportunity (ies): To develop a centralized, effective electronic methodology to track all BHD compliments, complaints, grievances and appeals, and to develop mechanisms to utilize client feedback data for service enhancement and improvement.

Gaps: Clear performance measures to determine if changes result in improvement including an initial performance baseline; a process to inform and collaborate with operations on grievance/appeals resolution.

The scope includes (1) all complaints from any client, significant others, family or support person receiving services directly provided by MCBHD or contracted providers or vendors; and (2) client concerns related to costs of care and treatment/billing across all BHD departments (CARS/WRAP/ACUTE etc.)

The project objectives are to (1) provide all BHD clients the highest quality services by effectively and promptly responding to, and addressing concerns; and (2) ensure the above process meets state, federal and accreditation requirements.

Measurable steps to achieve the project objectives include: (1) develop process map of the current systems; (2) create process map of the future state reflective of an efficient, effective, prompt and fair feedback management system; (3) plan to review, measure and identify appropriate data to provide feedback for quality initiatives and improvements; (4) use Voice of the Consumer data generated through peer specialist team membership and community conversations; (5) consult evidenced-based practices for reference and design; (6) interface with provider contract management and develop BHD mechanism to share information in performance reviews, etc.

Data Request Management

Opportunity: Healthcare analytics comprises the system of tools, techniques and people required to consistently and reliably generate accurate, validated and trustworthy business and clinical insight.

Gap: Data stored in source systems is very rarely useful on its own. Just like any raw material, data must be processed in order to become useful.

To define and implement a uniform and central reporting mechanism to manage data requests, including the determination of frequency of reporting to internal and external partners, and the direct application and usage of value-added content.

The project goals are to: (1) Develop a process mapping of how data requests are currently being managed. (2) Catalogue all regular reports (title, purpose, audience, frequency, data terms, data source); (3) Determine internal data needs and the information and content to meet those needs. (4) Identify and utilize an evidence-based standard, published set of criteria to assist in developing the data request management process. (5) Create a standardized template and process for requests. (6) Evaluate report content and frequency for value-added usage.

The Client Experience/Satisfaction

Opportunity: To develop and implement a consistent patient/client satisfaction survey process for Acute Inpatient (Acute Adult Inpatient Service & Child/Adolescent Inpatient Service), CARS Division (TCM, CSP, Day Treatment, Residential and Outpatient MH), and Wraparound Milwaukee.

Performance Gap to be addressed: • Consistent patient/client satisfaction survey tool(s) • Consistent survey distribution and collection methods • Consistent survey data entry, analysis and reporting • Consistent patient/client satisfaction survey targets.

The project scope includes all patient/client satisfaction survey tools and processes at BHD.

The project objectives are to utilize a consistent tool and methodology to collect, analyze, and report on BHD patient/client satisfaction.

Measurable steps to achieve the project objectives are: 1. Discuss patient/client satisfaction survey tools and processes currently utilized in Acute Inpatient, CARS, and Wraparound 2. Prepare flow charts of current vs. proposed patient/client satisfaction surveying processes 3. Determine potential patient satisfaction measurement firms to outsource this process to and review their patient/client satisfaction survey templates 4. Receive proposed service agreements from external patient satisfaction measurement firms to provide services for TCM and/or BHD's entire surveying process 5. Prepare a financial plan to compare costs incurred to continue current processes vs. outsourcing 6. Provide recommendations on a streamlined patient satisfaction survey process that includes: survey tools, processes, outsourcing options, resource allocation, and potential cost savings.

Project Updates Next Quarter:

- **Incident Reporting**
- **Performance Improvement**

Respectfully submitted,



Jennifer Bergersen, Chief Clinical Officer
Milwaukee County Behavioral Health Division,
Department of Health and Human Services



Milwaukee County Behavioral Health Division
2016 Key Performance Indicators (KPI) Dashboard

Quality Committee Meeting Packet Item 3

8/23/2016

Program	Item	Measure	2016 Quarter 1	2016 Quarter 2	2016 Projection	2016 Target	2016 Status (1)	2015 Actual	Benchmark Source	Formula
Community Access To Recovery Services	1	Service Volume - AODA	1,943	2,125	6,588	5,640		6,254	BHD (2)	# of clients with at least one event in any substance abuse level of care
	2	Service Volume - Mental Health	2,986	3,006	4,396	4,756		5,010	BHD (2)	# of clients with at least one event in any mental health level of care
	3	Discharge (Client Discharged During Quarter Who Stayed in Services 6 Months or Less)								
	4	Inpatient Utilization Offset	NA	27.72%	27.7%	-		-	BHD (2)	Relative change in average # of psychiatric bed days from admission to discharge
	5	Abstinence from drug and alcohol use	26.8%	18.98%	22.9%	-		-	BHD (2)	Relative change in # reporting abstinence from drugs or alcohol from admission to discharge
	6	Reduction in Homelessness or in Shelters	14.3%	21.49%	17.9%	-		-	BHD (2)	Relative change in # reporting living in shelters or homeless from admission to discharge
	7	Increase in Employment (Full or Part Time-Competitive)	9.4%	40.87%	25.1%	-		-	BHD (2)	Relative change in # reporting full or part time employment from admission to discharge
	8	6 Month Follow Up (First 6 Month Follow Up for Clients Open in Services During Quarter)								
	9	Inpatient Utilization Offset	60.4%	75.20%	67.8%	61.0%		60.3%	BHD (2)	Relative change in average # of psychiatric bed days six months after admission
	10	Abstinence from drug and alcohol use	45.5%	5.20%	25.3%	83.8%		82.5%	BHD (2)	Relative change in # reporting abstinence from drugs or alcohol six months after admission
	11	Reduction in Homelessness or in Shelters	50.0%	33.00%	41.5%	78.1%		77.3%	BHD (2)	Relative change in # reporting living in shelters or homeless six months after admission
	12	Increase in Employment (Full or Part Time-Competitive)	45.5%	-22.35%	11.6%	34.2%		33.9%	BHD (2)	Relative change in # reporting full or part time employment six months after admission
		By Quarter								
	13	Percent of clients returning to Detox within 30 days	48.02%	58.52%	53.3%	NA(s)		19.6%	BHD (2)	Percent of readmissions that occurred within 30 days of discharge from the previous admission
Wraparound	14	Families served in Wraparound HMO (unduplicated count)	2,589	3,310	3,146	3,300		3,047	BHD (2)	Families served in Wraparound HMO (unduplicated count)
	15	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.5	4.5	4.6	> = 4.0		4.6	BHD (2)	Average level of Family Satisfaction (Rating scale of 1-5)
	16	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	59.6	59	59.0%	> = 75%		62%	BHD (2)	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)
	17	Average level of "Needs Met" at disenrollement (Rating scale of 1-5)	3.12	2.94	2.9	> = 3.0		3.2	BHD (2)	Average level of "Needs Met" at disenrollement (Rating scale of 1-5)
	18	Percentage of youth who have achieved permanency at disenrollment	55%	52%	52.0%	> = 70%		58%	BHD (2)	Percentage of youth who have achieved permanency at disenrollment
	19	Percentage of Informal Supports on a Child and Family Team	42.30%	42.90%	43.0%	> = 50%		42%	BHD (2)	Percentage of Informal Supports on a Child and Family Team
Crisis Service	20	Admissions	2,138	2,169	8,614	9,000		10,173	BHD (2)	PCS patient admissions
	21	Emergency Detentions	1,074	1,118	4,384	4,500		5,334	BHD (2)	PCS admissions where patient had a legal status of "Emergency Detention"
	22	Percent of patients returning to PCS within 3 days	7.7%	7.2%	7.2%	8%		8%	BHD (2)	Percent of patient admissions occurring within 3 days of patient's prior discharge from the program
	23	Percent of patients returning to PCS within 30 days	24.5%	24.4%	24.4%	20%		25%	CMS (4)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	24	Percent of time on waitlist status	76.4%	72.3%	74.4%	10%		16%	BHD (2)	PCS hours on Waitlist Status / Total hours in time period x 100
Acute Adult Inpatient Service	25	Admissions	193	176	738	850		965	BHD (2)	Acute Adult Inpatient Service patient admissions
	26	Average Daily Census	45.4	46.0	45.7	48.0		47.2	BHD (2)	Sum of the midnight census for the time period / Days in time period
	27	Percent of patients returning to Acute Adult within 30 days	11.4%	10.7%	11.1%	7%		11%	NRI (3)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	28	Percent of patients responding positively to satisfaction survey	76.8%	69.0%	72.9%	74%		73%	NRI (3)	Percent of patients selecting "Agree" or "Strongly Agree" to survey items
	29	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	64.3%	54.4%	59.4%	65%		63%	BHD (2)	Percent of patients selecting "Agree" or "Strongly Agree" to survey item
	30	HBIPS 2 - Hours of Physical Restraint Rate	3.05	2.97	3.01	0.66		7.2	CMS (4)	Total number of hours patients were in physical restraint per 1,000 inpatient hours
	31	HBIPS 3 - Hours of Locked Seclusion Rate	0.54	0.63	0.59	0.14		0.47	CMS (4)	Total number of hours patients were in locked seclusion per 1,000 inpatient hours
	32	HBIPS 4 - Patients discharged on multiple antipsychotic medications	13.7%	17.9%	15.6%	9.5%		18%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications
	33	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96.2%	96.7%	96.4%	32.8%		98%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications with documented justification
Child / Adolescent Inpatient Service (CAIS)	34	Admissions	193	167	720	800		919	BHD (2)	CAIS patient admissions
	35	Average Daily Census	9.3	10.1	9.7	11.0		9.8	BHD (2)	Sum of the midnight census for the time period / Days in time period
	36	Percent of patients returning to CAIS within 30 days	15.1%	14.9%	15.0%	11%		16%	BHD (2)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	37	Percent of patients responding positively to satisfaction survey	83.8%	79.7%	81.8%	74%		71%	BHD (2)	Percent of patients selecting "Agree" or "Strongly Agree" to survey items
	38	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	77.8%	73.7%	75.8%	80%		74%	BHD (2)	Percent of patients selecting "Agree" or "Strongly Agree" to survey item
	39	HBIPS 2 - Hours of Physical Restraint Rate	5.31	3.44	4.38	0.22		5.2	CMS (4)	Total number of hours patients were in physical restraint per 1,000 inpatient hours
	40	HBIPS 3 - Hours of Locked Seclusion Rate	0.17	0.00	0.09	0.34		0.42	CMS (4)	Total number of hours patients were in locked seclusion per 1,000 inpatient hours
	41	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2.6%	1.8%	2.3%	3.0%		2%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications
	42	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100.0%	66.6%	87.5%	39.9%		100%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications with documented justification
Financial	43	Total BHD Revenue (millions)	-	-	\$129.4	\$129.4		\$120.2		
	44	Total BHD Expenditure (millions)	-	-	\$188.2	\$188.2		\$173.5		

Notes:

- (1) 2016 Status color definitions: Red (below 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)
- (2) Performance measure target was set using historical BHD trends
- (3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages
- (4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages

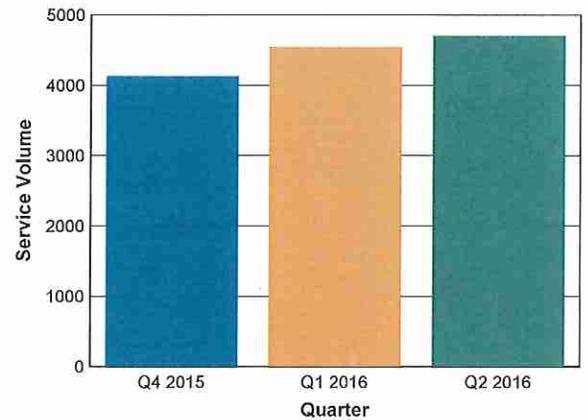
CARS Quarterly Report

Number of Clients Receiving Service, By Program

	Q4 2015	Q1 2016	Q2 2016
Adult Family Home	16	14	14
CBRF	117	123	131
CCS	244	286	388
CLASP	63	80	71
Community Support Program	1,281	1,308	1,292
Crisis Case Management	57	77	69
CRS	44	37	34
AODA Day Treatment	25	24	31
Detoxification	342	690	688
MH Day Treatment	25	26	24
Outpatient-AODA	306	309	347
Outpatient-MH	29	44	54
Recovery Support Coordination	380	418	472
Targeted Case Management	1,470	1,476	1,486
Transitional Residential	214	218	257
Total	4,131	4,545	4,706

Some programs in Q4 2015 experienced a lower number of clients receiving service due to delay of EHR implementation.

Number of Clients Receiving Service

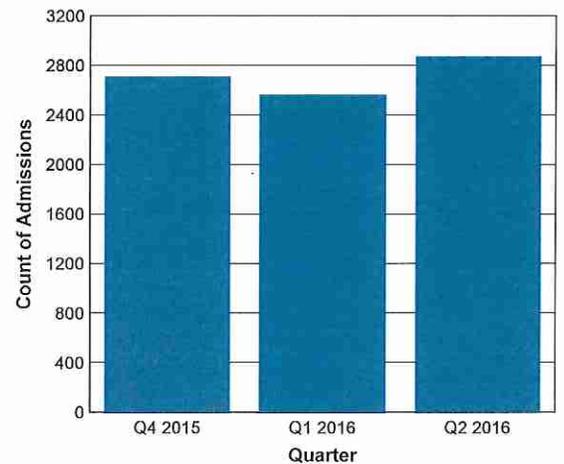


Admissions By Program

	Q4 2015	Q1 2016	Q2 2016
Adult Family Home	7	1	0
CBRF	77	12	18
CCS	125	64	121
CLASP	24	30	24
Community Support Program	119	54	50
Crisis Case Management	24	20	52
CRS	19	1	1
AODA Day Treatment	17	20	21
Detoxification	1,420	1,366	1,643
MH Day Treatment	8	10	9
Outpatient-AODA	213	200	226
Outpatient-MH	62	194	91
Recovery Support Coordination	212	274	279
Targeted Case Management	118	117	118
Transitional Residential	267	201	222
Total	2,712	2,564	2,875

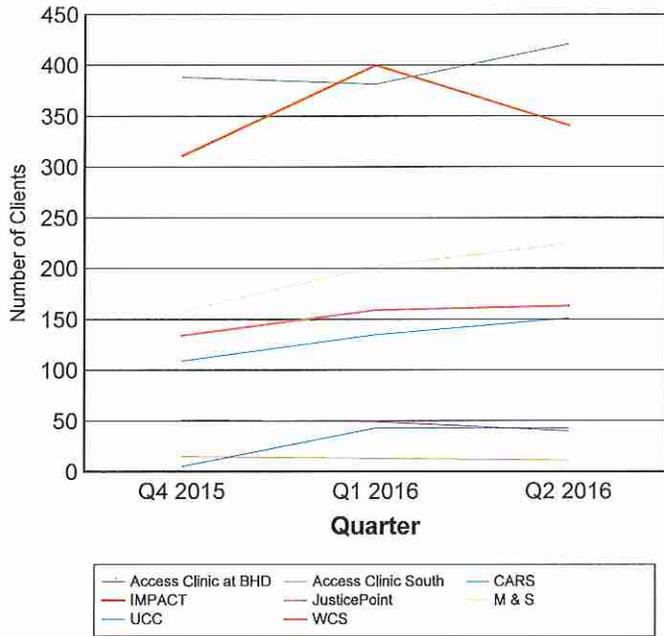
Some programs in Q4 2015 experienced a higher number of admissions due to administrative data entry after EHR implementation.

Admissions



CBRF - Community Based Residential Facility
 CCS - Comprehensive Community Services
 CLASP - Community Linkages and Stabilization Program
 CRS - Community Recovery Services

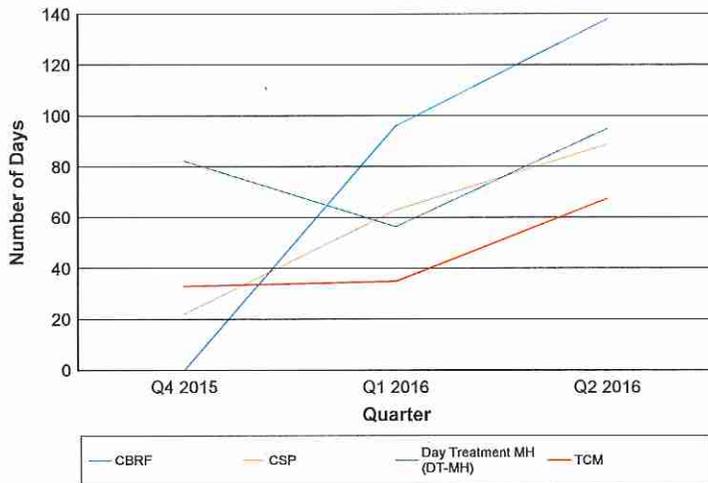
Referrals/Intakes by Access Point



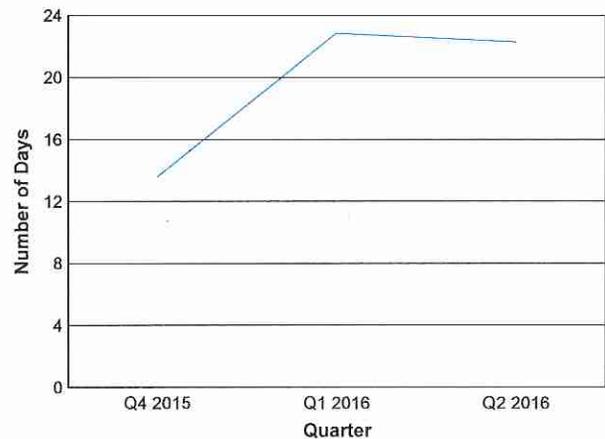
Referrals/Intakes By Access Point

	Q4 2015	Q1 2016	Q2 2016
Access Clinic at BHD	109	135	151
Access Clinic South	15	13	11
CARS	388	381	421
IMPACT	311	400	341
JusticePoint	51	49	40
M & S	158	202	224
UCC	5	43	43
WCS	134	159	163
Total	1,140	1,333	1,352

Average Days on Wait List- MH Programs



Average Days on Wait List - AODA Residential



Quality Committee Meeting Packet Item 4

August 31, 2016

BHD Report to Quality Committee of MHB

Joint Commission Readiness

Accomplishments and developments key areas that reflect current status in relation to accreditation readiness.

Care Treatment & Services
<ul style="list-style-type: none"> ⦿ Case Management Department re-design ⦿ Clinical pertinence review ⦿ Policy and procedure revision/pending ⦿ Treatment Plan workgroups
<ul style="list-style-type: none"> ● Treatment Plan not part of electronic medical record (EMR) ● Problem List not part of EMR
Leadership
<ul style="list-style-type: none"> ⦿ Redesign of Quality Management Systems Department ⦿ Redesign of Contract Management Services ⦿ Refinement of Key Performance Indicators, benchmarks and CMS/HBIPS reporting
<ul style="list-style-type: none"> ⦿ Performance Improvement (PI) training on-line, house-wide
Medication Management
<ul style="list-style-type: none"> ⦿ Accurate and complete documentation of medication administration ● Medication control and security; medication labeling
<ul style="list-style-type: none"> ● Medication Reconciliation Process remains difficult with current EMR
Safety
<ul style="list-style-type: none"> ⦿ Most Environmental risks inpatient units have been corrected. Detailed reports documented.
<ul style="list-style-type: none"> ● Infection Control Risk Assessment completed ● Interim Life Safety Measures (ILSM) Plan needs to be completed

KEY:

- ⦿ Major improvements; progressing on-schedule; at or near completion or compliant
- ⦿ Some progress; continues to be high-priority
- Little or no progress; Roadblocks or barriers encountered

Quality Committee Meeting Packet Item 5

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: August 22, 2016

TO: Dr. Robert Chayer, Quality Committee
Milwaukee County Mental Health Board

FROM: Linda Oczus, Chief Nursing Officer, Behavioral Health Division

SUBJECT: Board Report- Acute Inpatient Recertification Survey - June 2016

REQUEST: Informational

On June 16, 2016, State Surveyors from DHS completed a 3 day unannounced recertification survey for the hospital. The purpose of this survey was to review our compliance with State and Federal regulations for hospitals and the Life Safety Codes. The survey included a review of hospital systems, processes and policies, medical record documentation, a comprehensive review of the physical plant and patient and staff interviews. The survey team reviewed the hospital for compliance with not only State DHS requirements but Federal CMS requirements as well.

State and Federal citations were issued and the hospital was found to be out of compliance with one condition of participation related to the physical environment, however no citations were high level or systemic in nature. Clinical areas receiving citations included medical staff, nursing, infection control and dietary services. An onsite review of the dietary services revealed a number of infection control issues such as personnel not wearing required hair restraints and inappropriate storage of utensils in the kitchen/food prep areas. Documentation of psychiatric evaluations, H&Ps and treatment planning updates were an area of concern.

A specific plan of correction was submitted for each clinical area cited and included re-education of staff, audits of the various missing medical record components as well as onsite visits to various contractors including the food preparation areas at the House of Correction.

A number of citations were given related to the physical plant and environment, many of which require long range repairs and had improvement plans underway at the time of the survey. The majority of the life safety, or K- tag citations, consisted of a variety of concerns surrounding the sprinkler system in the building ranging from sprinkler head cover replacements to the need to install new sprinkler heads in various parts of the hospital. Short term corrections were made and long range replacement of the sprinkler heads is planned to start in September of 2016. The state engineer returned for his recertification visit on September 11th, noted several areas of correction and those citations not yet addressed were resubmitted for ongoing follow-up.

Of particular note, surveyors commented on the "tremendous progress" which has been made since their last survey of the hospital three years ago. In response to the accepted plan of correction for clinical areas of concern, a follow-up clinical review is expected within 60 days from the date of alleged compliance.

Quality Committee Meeting Packet Item 8



Wraparound Milwaukee

2016 Resource Fair - Data & Evaluations

Attendees	2016	2014
Youth & Family Members	302 (approximately)	220 (approximately)
CC/Leads/Sups	107	83
Guests	79 (59 signed-in + 20 estimated walk-ins)	46 (26 signed-in + 20 estimated walk-ins)

Vendors	2016	2014
Registered Vendors	72	72
Non-registered, showed up	2	1
Registered, no showed	7 (6 Community, 1 WPN)	4
Total Attended Event	67 vendors	69 vendors

Evaluations = 77 completed (2014 = 77 completed)

1. Was the Fair helpful in providing you with information about resources?	Yes 100%	No 0%
--	-------------	----------

2. Is meeting/networking with resources important to you?	Yes 100%	No 0%
---	-------------	----------

3. How do you prefer to meet/network with resources (check all that you prefer)? <i>In-Person = 66% Email = 27% Phone = 19% All of the above = 10% Other: Facebook, CC</i>

4. What other resources or services would you like to have at the next Fair? <i>LGBT resources for teens (Diverse & Resilient present) (2) DVR/Job Corp (present) (2) More autism programs (present) summer activities (present) law enforcement – next Fair: Work with District 7 (MUTT) for MPD Job opportunities (3) – next Fair: invite temp agencies (ie: SEEK) food banks/pantries (2) - next Fair: invite Hunger Task Force and Impact 211 again Spanish speaking vendors – next Fair: – Providers at the fair should wear name tags that state “Se hablo espanol.” Vendors should be identified on their vendor sign. schools (MPS present) housing (2) – next Fair: Invite Community Advocates again Recreational activities (Milwaukee Rec present) Independent Living (present) groups/categories by need so it is easier to maneuver per need – next Fair: how do we do this? Resources for children with special needs (present)</i>
--

5. On a scale from 1-5, how do you rate this resource fair? **4.73** (5 point scale)

6. What did you like the **least** about the Fair?

*More food options (4) not enough educational resources for older youth and adults
sharing tables (2) very closes together stations (2) no lunch air conditioning could have been higher
Hard to talk and stay out of everybody's way Not every vendor was on time parking
already have many of the services Need more space in isles Need a bigger space
PA system was very hard and speaker were directly overhead loud, bad mic system (2) speaker system was bad
scattered Too long 10-2 would be sufficient Were given a ½ a table and only one chair. We sent 2 staff people.*

7. What did you like the **best** about the Fair?

*Networking with WAM staff, CC and clients variety of resources being able to talk to vendors
People were friendly networking with other vendors (2) many resources
person in front of lobby helping us load everything inside All great and very helpful
thank you for a great job liked the drinks and snacks many resources and # of families
a lot of resources everything was great everything families many vendors
meeting other professionals attendance variety of attendees meeting new people
finding out about new resources in the community to benefit my family and family resources
resources and goodies networking everything resources variety of resources
opportunity to meet new people and gather information zoo passes
networking and meeting CC and families a lot of resources
There are all types of help in Milwaukee. You just have to search or ask questions. Goodies
getting a lot of info from people everything the range in services that were represented
a lot of great providers friendly individuals overall it was nice resources, fun for families, networking
amazing day and a reward afterwards at the zoo families, professionals, new CC diversity of people in attendance
so many resources good flow, set up lot of different resources available
enjoying time with my family good info networking meeting people I have talked to
people that were here represent the company very well organized lots of valuable info turn-out everything
lots of good resources resources all the vendors info about different services
a lot of information met some knowledgeable people/experts face-to-face with each resource variety
family engagement free stuff community resources because they are sustainable
staff great providers and staff opportunity to network with variety of service providers
very organized and respectful conversing with vendor to find out more info about programs*

8. Please check your role at the Fair:

Wraparound Network Provider = 35% (27)
Staff Member of Wraparound/REACH/FISS/O-YEAH = 26% (20)
Community Agency Representative = 21% (16)
Family Member/Family Representative = 18% (14)

Quality Committee Meeting Packet Item 9

Good Nutrition is Our Mission



Alternatives in Psychological Consultation S.C.

Change Leaders: Nicole Messer & Portia Menges

Change Team: Jeremiah Bell, Brian Costigan, Kim Rossettie, &
Abby Weatherspoon



Problem

Survey 1

- The *Good Nutrition is Our Mission Committee* conducted an agency wide survey to identify if barriers existed to eating well and having good nutrition
- 133 consumers surveyed within all departments

Results showed:

- **81.2%** said they'd like assistance with eating healthier
 - **62.1%** wanted help *Eating Healthy on a Budget*
 - **26.9%** wanted *Education on Health Eating*
 - **18.6%** wanted *Resources on where to find Healthy Food*

AIM

Survey 2

6 Weeks Later

Began Pilot Study including 48 consumers

INITIAL RESULTS:

- **71% of consumer's felt comfortable cooking, but only 45.14% considered their meals healthy**
 - This was defined as including fruits, vegetables, whole grains, proteins, low sugar, low fat

Our AIM was to increase this percentage

45.14%

Plan

5 week intervention

- Providers shared information each week regarding:
 - Eating Healthy on a Budget
 - Education on Health Eating
 - Resources on where to find Healthy Food
- We partnered with Hunger Task Force to assist us in creating packets with information and resources

Actual Outcomes

Follow-up Survey

75% retention rate between surveys 2-3

Percentage of reported healthy eating increased from
45.14% ➡ 54.57%!

- 90.6% reported being better equipped to make healthier meal choices
- 91% reported more awareness of resources in Milwaukee that provide healthy food
- 93.8% reported more awareness of ways to eat healthy on a budget
- 87% reported they will continue to use the information provided in the future

What We Learned

Feedback & Next Steps

- Feedback
 - Consumer's reported wanting more information on:
 - Where the Mobile Market will be in the future
 - Exercise Ideas
 - How to lose weight
 - How to count calories
 - Eating healthy with diet restrictions
- Next Steps
 - APC will continue partnership with the Hunger Task Force
 - The *Good Nutrition is Our Mission Committee* will utilize information gained to implement resources and information on nutrition to consumers agency wide

Quality Committee Meeting Packet Item 10_{Draft}

PCS Hospital Transfer Waitlist Report

Mid-Year Update

2016

This report contains information describing the first six (6) of 2016 are summarized as follows:

- 7 hospital transfer waitlist events occurred
- PCS was on hospital transfer waitlist status 77.2%
- The 801 individuals delayed comprised 18.6% of the total PCS admissions (4,307)
- The median wait time for all individuals delayed was 4.1 hours
- The average length of waitlist per patient is 7.4 hours

Prepared by:
Quality Improvement Department

Date: August 26, 2016

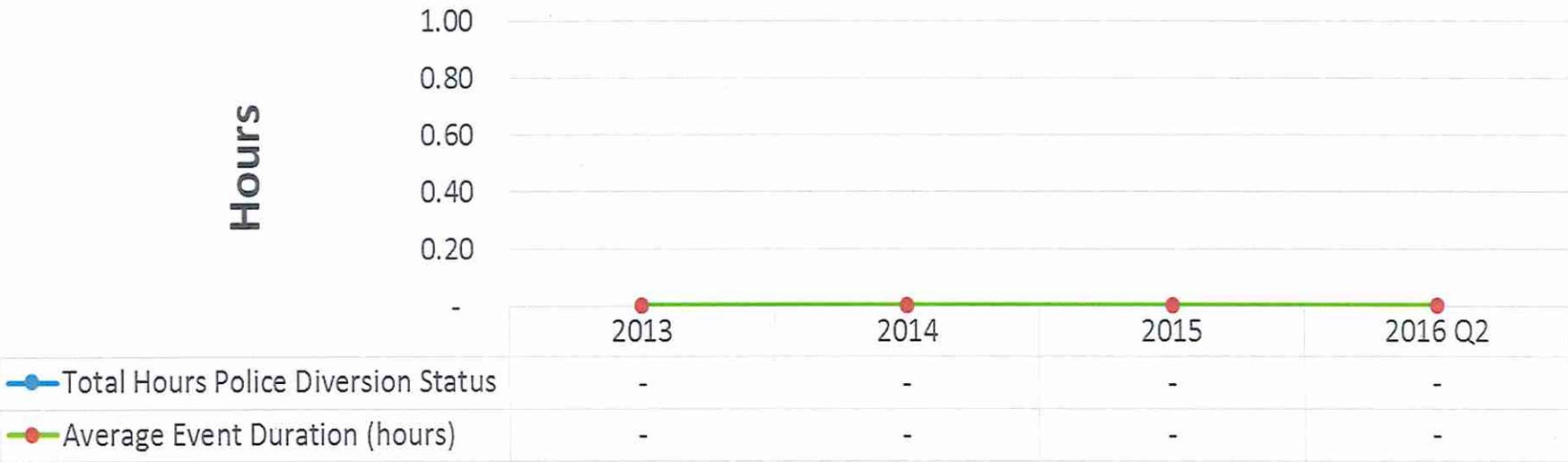
Definitions:

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

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

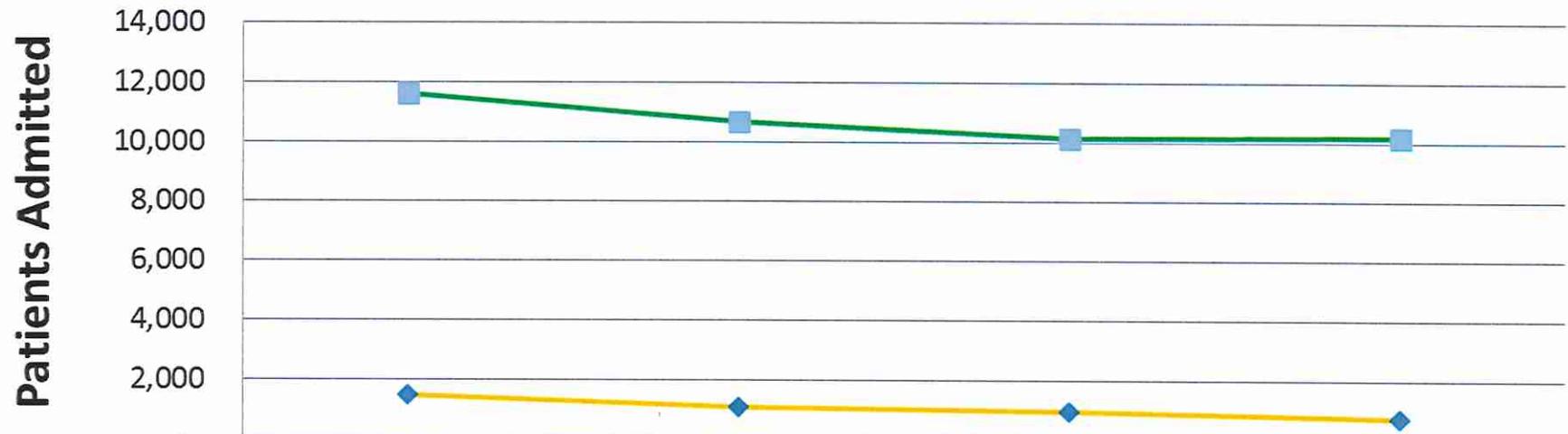
Reporting Time Period: The data in this report reflects three (3) years or the last twelve (12) quarters, unless specified otherwise.

**Figure 1. 2013-2016
BHD Police Diversion Status**



*There have been no police diversion in the last 7 year, last police diversion was in 2008

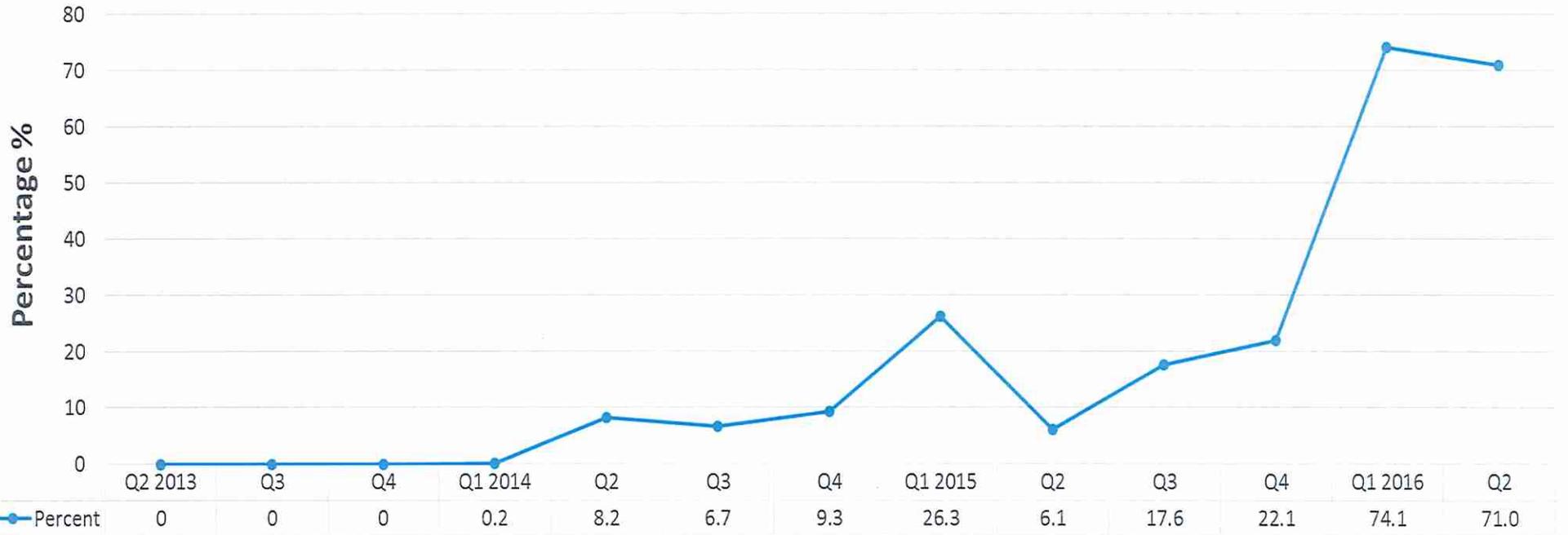
**Figure 2. 2013-2016
PCS and Acute Adult Admissions**



	2013	2014	2015	2016 Proj.
◆ Acute Adult Admissions	1,489	1,093	965	738
■ PCS Admissions	11,644	10,698	10,173	10,216

*Projected PCS Admissions = Projected Waitlist Clients + Projected PCS Clients

Figure 3. 2013-2016
Percent of Time on Waitlist Status



*Waitlist Percent = Waitlist Duration/ (Number of day in the quarter*24)

Figure 4. 2013-2016
Patients on Hospital Transfer Waitlist

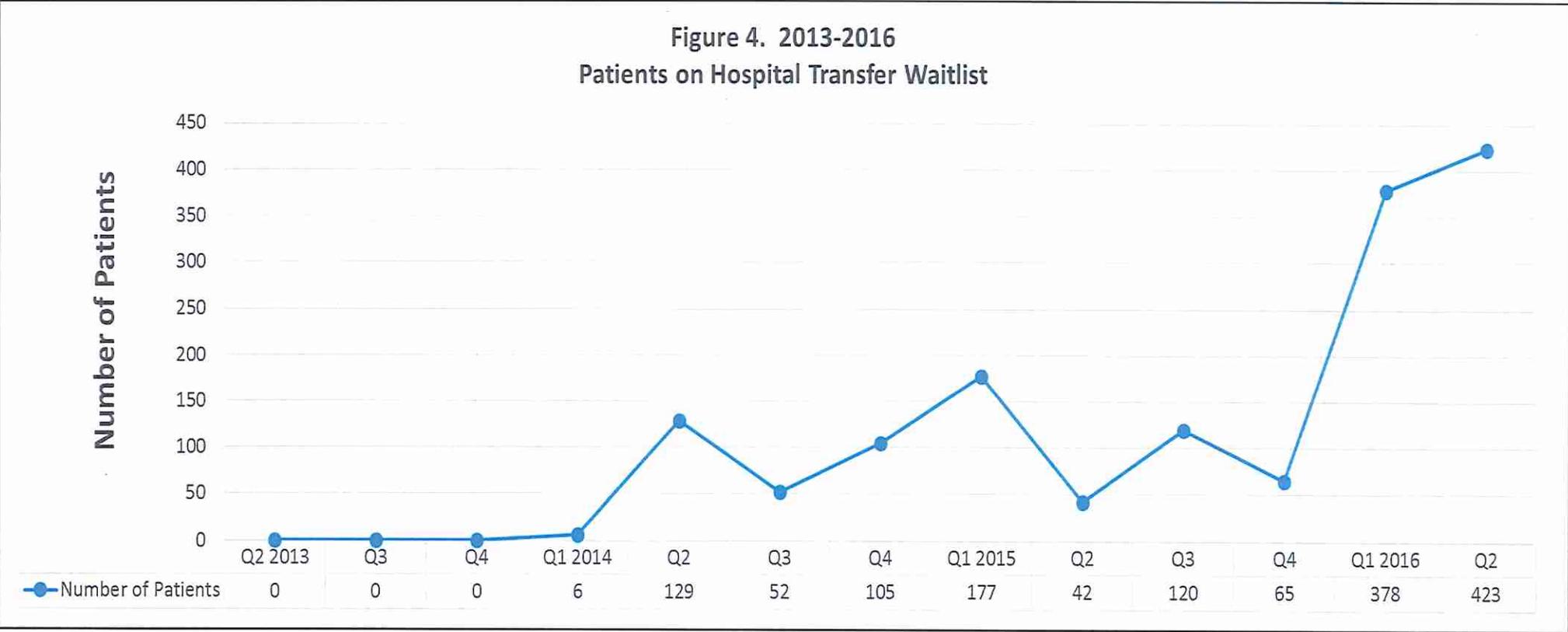


Figure 5. Waitlist Events
2013-2016



Figure 6. 2013-2016
Average Duration of Event
(Hours)



Figure 7. 2013 - 2016
Median Wait Time For Individuals Delayed
(Hours)

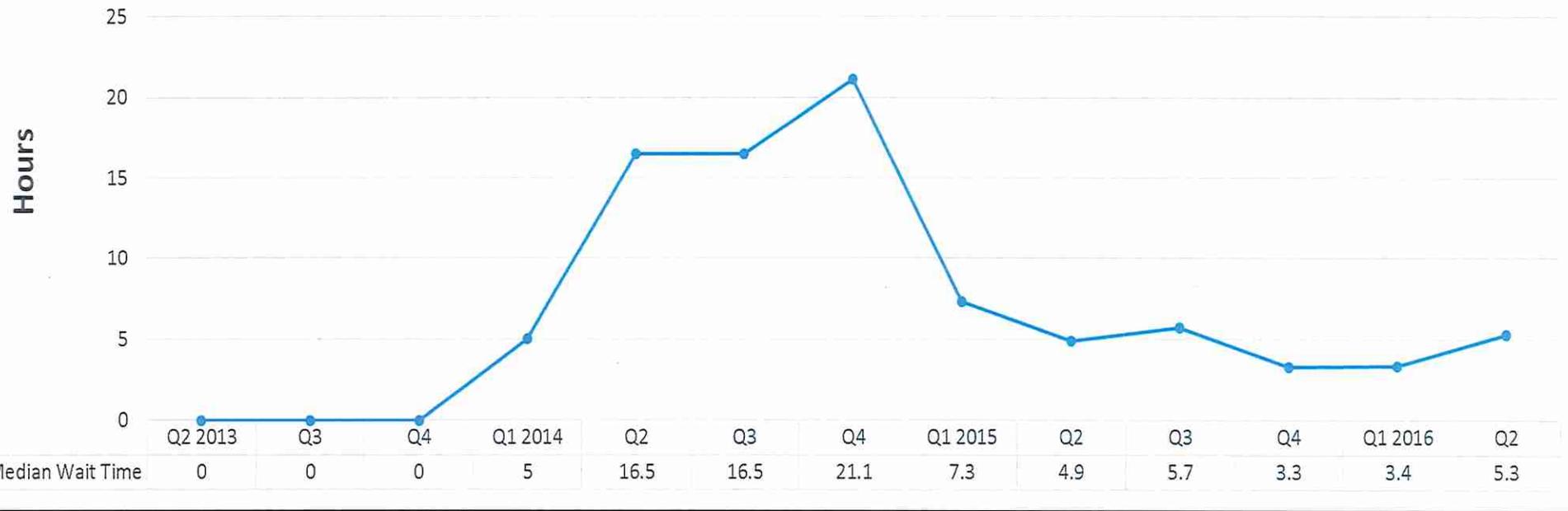


Figure 8. 2013-2016
Average Length of Waitlist For Individuals Delayed
(Hours)

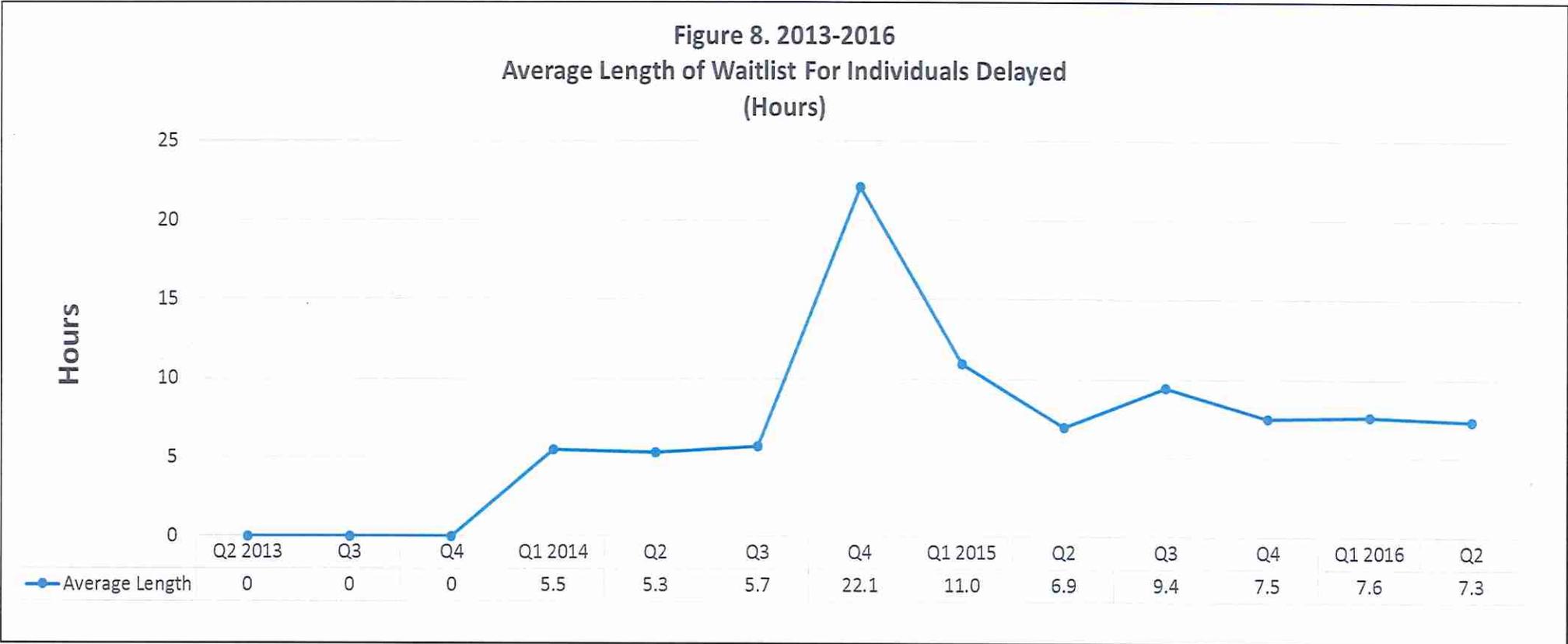
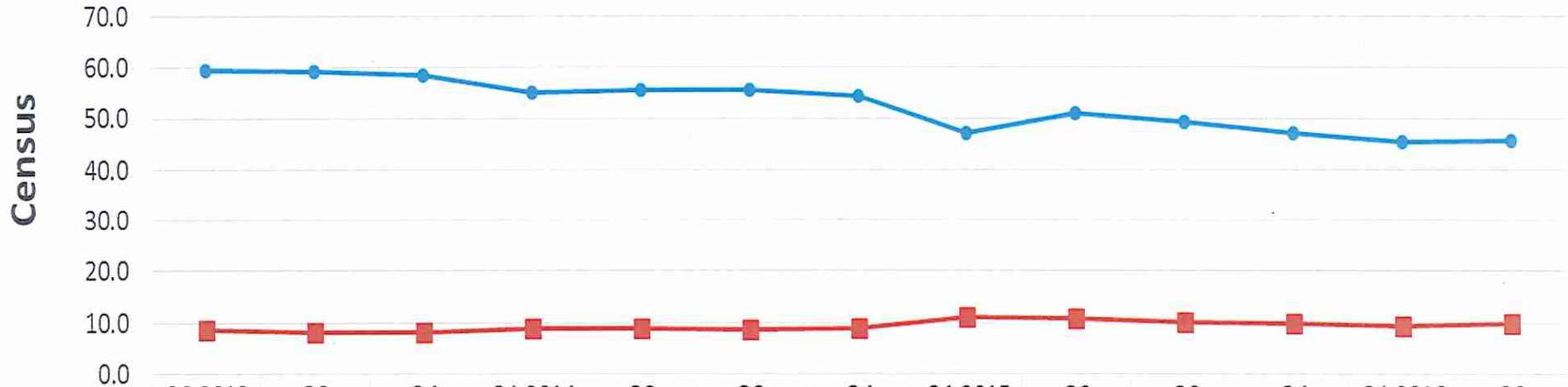


Figure 9. 2013-2016
Acute Adult/CAIS
Average Daily Census



	Q2 2013	Q3	Q4	Q1 2014	Q2	Q3	Q4	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2
Acute Adult	59.5	59.2	58.5	55.0	55.5	55.7	54.4	47.1	50.9	49.3	47.2	45.5	45.8
CAIS	8.6	8.2	8.0	8.9	8.7	8.5	8.9	11.1	10.7	10.1	9.9	9.3	9.7

*Average Daily Census = Patient days/amount of days per quarter

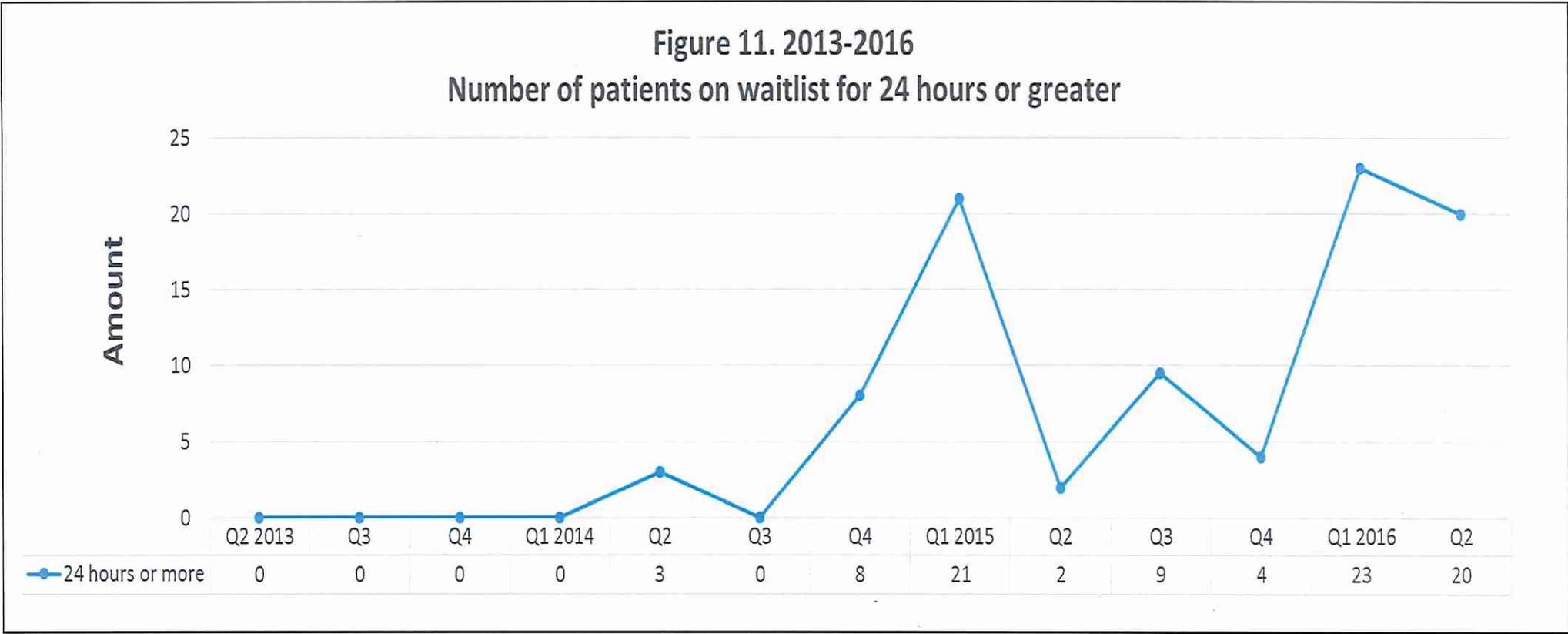
Figure 10. 2013-2016
Acute Adult/CAIS
Budgeted Occupancy Rate

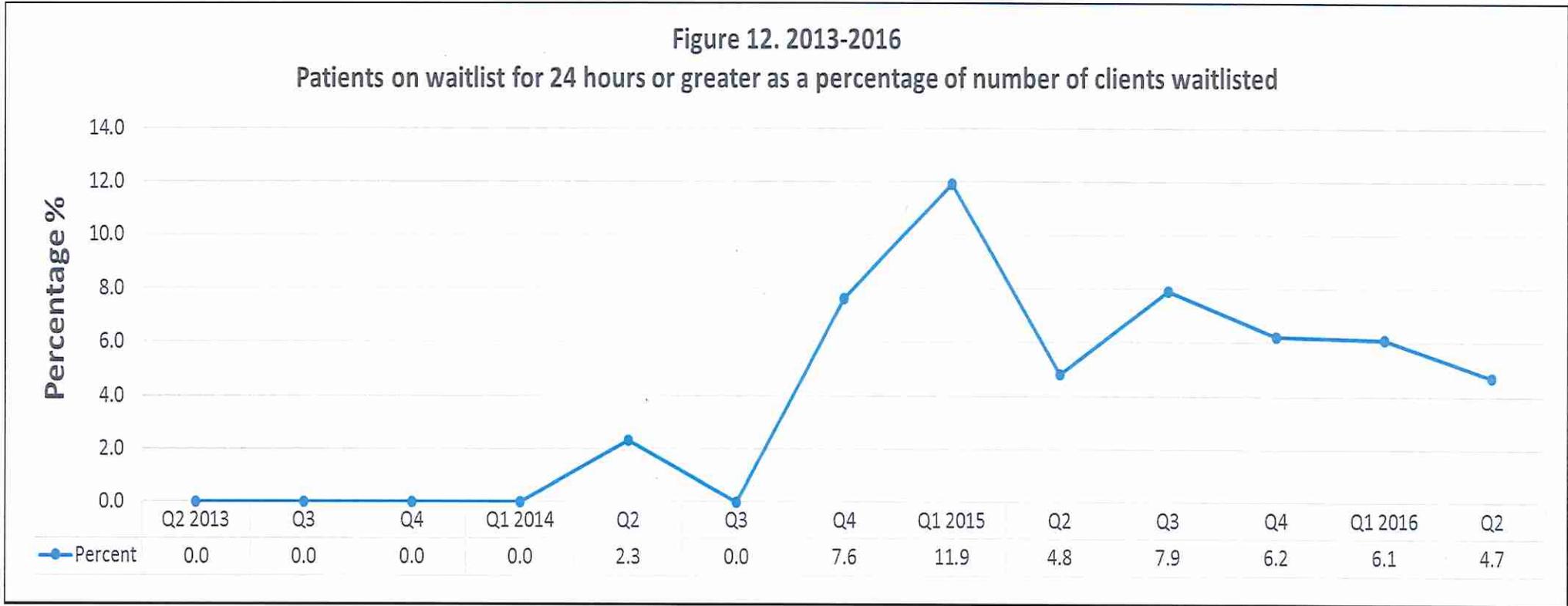


*Occupancy Rate = Patient's Day/ (Number of day in the quarter*number of beds budgeted)

*Reduced staffing impacted operation bed count

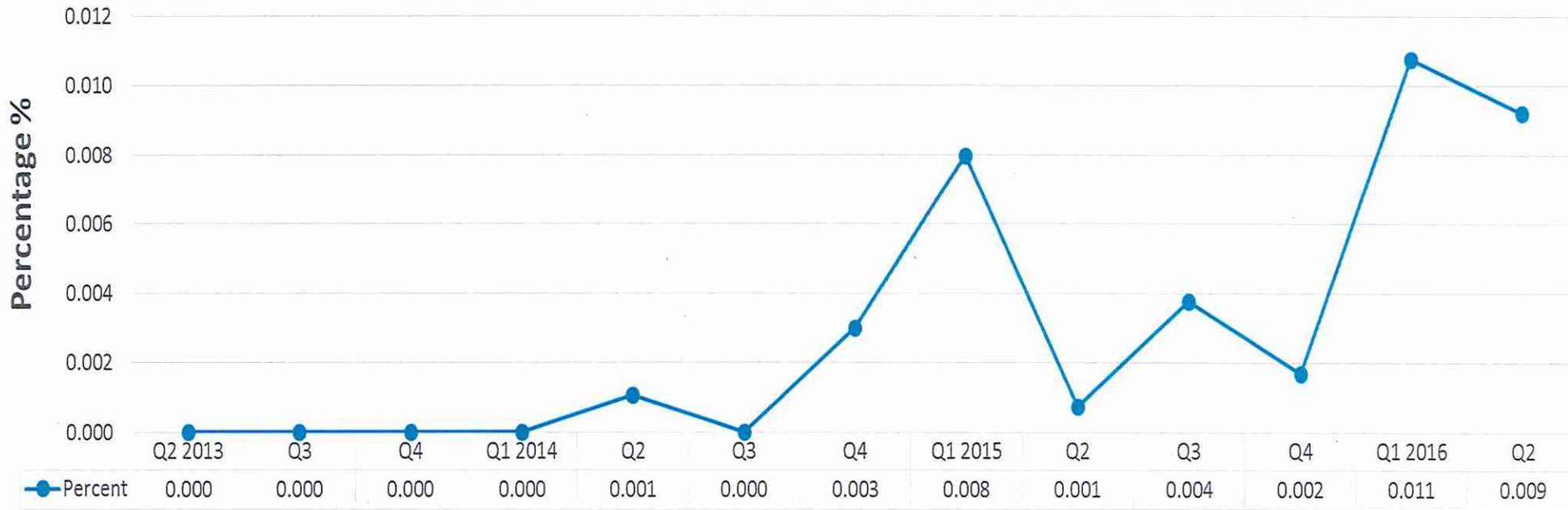
Figure 11. 2013-2016
Number of patients on waitlist for 24 hours or greater





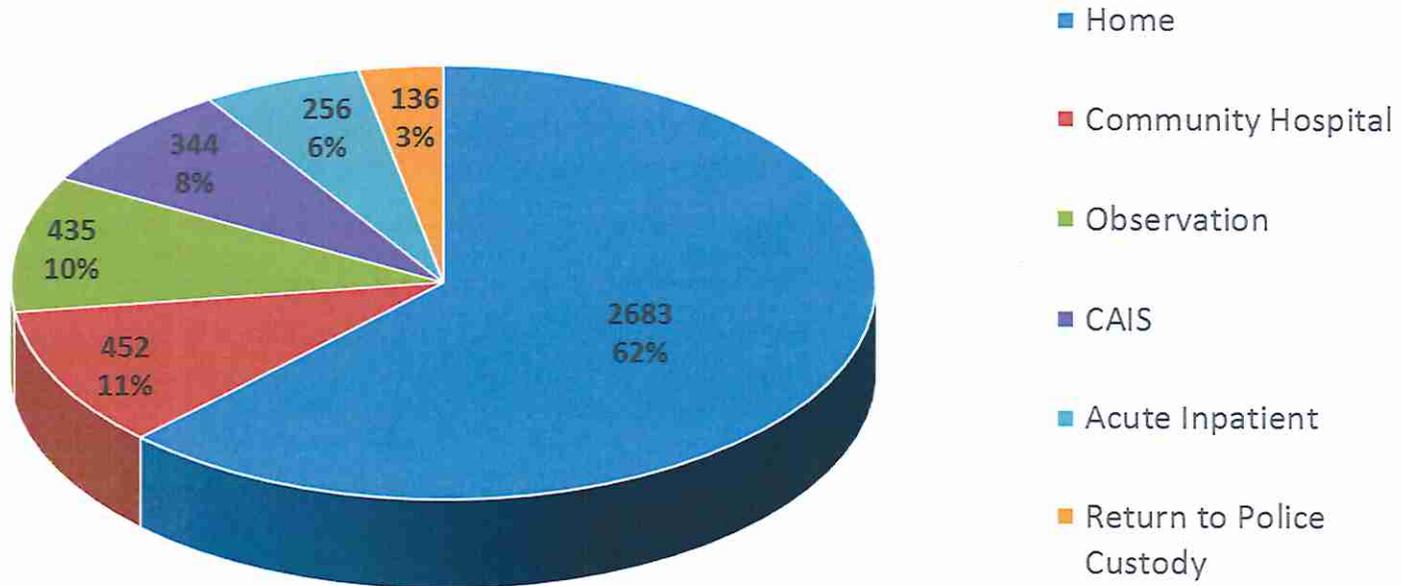
*Percent = Number of Patients on waitlist for 24 hours or greater/Number of Clients Waitlisted

Figure 13. 2013-2016
Patients on waitlist for 24 hours or greater as a percentage of PCS Admission



*Percent = Number of Patients on waitlist for 24 hours or greater/PCS Admission

Figure 14. 2016 (January 1 to June 30)
Disposition of all PCS admission



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

DATE: September 22, 2016

TO: Duncan Shrout, 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

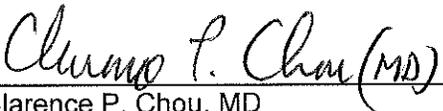
From the President of the Medical Staff and Chair of Credentialing and Privileging Review presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C¹:

- 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)

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 Michael Lappen, BHD Interim Administrator
John Schneider, BHD Chief Medical Officer
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

Attachments

1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
SEPTEMBER / OCTOBER 2016**

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 SEPTEMBER 7, 2016	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 21, 2016	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Jennifer Lippitt, MD	Psychiatric Officer of the Day; Medical Officer of the Day	Affiliate/ Provisional		Dr. Schneider 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.	
Donna Luchetta, MD	General Psychiatry	Active/ Provisional	M#	Dr. Schneider recommends appointment & privileges, as requested, contingent on Wisconsin license attainment	Chair, on behalf of Committee on 9/21/16, recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months with privilege and work start dates contingent on attaining Wisconsin medical licensure (<i>Wisconsin medical license application approval is pending completion</i>)	Recommends appointment and privileging as per C&PR Committee Chair's contingency.	Expedited approval requested due to critical inpatient need and granted by MH Board Executive Committee on 9/22/2016 (<i>Action Date</i>), as per C&PR and MEC contingency recommendations on Wisconsin medical license attainment prior to privilege start date. <i>As per MH Board Bylaws, expedited approval is provisional and expires at the next meeting of the Board. The Board may choose to ratify the MHB Executive Committee action and may, if the Board desires, make the action retroactive to the time of the MHB Executive Committee action.</i>
REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 7, 2016	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 21, 2016	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
NONE THIS PERIOD							
ALLIED HEALTH							
NONE THIS PERIOD							

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE **JULY 6, 2016**	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 21, 2016	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Anna Berg, MD	Child Psychiatry	Affiliate/ Provisional		Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	REQUESTED / RECOMMENDED CHANGE	NOTATIONS	SERVICE CHIEF* RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 7, 2016	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 21, 2016	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Justin Gerstner, MD	Psychiatric Officer of the Day; Medical Officer of the Day / Affiliate	General Psychiatry; General Medical Practice / Affiliate		Dr. Thrasher recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for remainder of current biennium.	Recommends amending privileging as per C&PR Committee.	
Michelle Heaton, MD	Psychiatric Officer of the Day; Medical Officer of the Day / Affiliate	General Psychiatry; General Medical Practice / Affiliate		Dr. Thrasher recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for remainder of current biennium.	Recommends amending privileging as per C&PR Committee.	
Deepa Pawar, MD	Psychiatric Officer of the Day; Medical Officer of the Day / Affiliate	General Psychiatry; General Medical Practice / Affiliate		Dr. Thrasher recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for remainder of current biennium.	Recommends amending privileging as per C&PR Committee.	

H. Lyons
 CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE
 (OR PHYSICIAN COMMITTEE MEMBER DESIGNEE)

9/21/16
 DATE

Clarence Chau (MD)
 PRESIDENT, MEDICAL STAFF ORGANIZATION
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

9/21/16
 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: OCTOBER 27, 2016

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
SEPTEMBER / OCTOBER 2016**

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 SEPTEMBER 7, 2016	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 21, 2016	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Donna Luchetta, MD	General Psychiatry	Active/ Provisional	M#	Dr. Schneider recommends appointment & privileges, as requested	Chair, on behalf of Committee on 9/21/16, recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months with privilege and work start dates contingent on attaining Wisconsin medical licensure (<i>Wisconsin medical license application approval is pending completion</i>)	Recommends appointment and privileging as per C&PR Committee Chair's contingency.	

H. Lyons
CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE
(OR PHYSICIAN COMMITTEE MEMBER DESIGNEE)

9/21/16
DATE

Clarence Chan (MD)
PRESIDENT, MEDICAL STAFF ORGANIZATION
CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

9/21/16
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.

[Signature]
GOVERNING BOARD CHAIRPERSON

Sept 22, 2016
DATE

MH BOARD EXECUTIVE COMMITTEE ACTION DATE: SEPTEMBER 22, 2016

In accordance with the MH Board Bylaws, this approval is provisional and expires at the next meeting of the Board. The Board may choose to ratify the MHB Executive Committee action and may, if the Board desires, make the action retroactive to the time of the MHB Executive Committee action.



Milwaukee County
Department of Health and Human Services
Behavioral Health Division
Research Synopsis

September 22, 2016

By: Jeanette May, MPH, PhD, Patina Professional



i.	Outline	Page 2
ii.	Introduction	Page 3
iii.	Key Conclusions	Page 3
iv.	Methodology	Page 6
v.	Trends/Gap Analysis	Page 11
vi.	Case Study	Page 11
vii.	Recommendations for Additional Data	Page 12
viii.	Insights for Population Health Management	Page 12



INTRODUCTION

The Milwaukee County Behavioral Health Division (“BHD”), in collaboration with the Mental Health Board (“the Board” or “MHB”), continually strives to create a system of care that meets the needs of its population. To inform its efforts, BHD leadership requested the analysis and interpretation of nine research papers authored by various organizations over the last several years. Those nine reports include:

- Analysis of Funding Alternatives (Deloitte, 2016)
- Milwaukee Health Report (Center for Urban Population Health, 2013)
- Fiscal Analysis of Mental Health Redesign (Public Policy Forum, 2015)
- City of Milwaukee Community Health Assessment (Milwaukee Mental Health Department, 2016)
- Adult Bed Capacity (Public Policy Forum), 2014
- Milwaukee County Outpatient Behavioral Health Capacity Assessment (Human Services Resource Institute, Technical Assistance Collaborative, Public Policy Forum, 2015)
- Milwaukee County Community Health Survey Report (Center for Urban Population Health and five area health systems, 2015)
- Services for Persons With Mental Illness (WI Legislative Fiscal Bureau, 2015)
- County Health Ranking (University of WI and Robert Woods Johnson Foundation, 2016)

This analysis and interpretation of those reports will assist BHD and the Board to develop and adopt strategic direction and initiatives over the next five years. The goal of the analysis is to:

- Assess and compile data to identify key trends;
- Perform a gap and needs analysis based on current state, current service offerings, policy changes and applicable innovative models being deployed successfully in other states.
- Provide recommendations and review options for the provision of behavioral health services in BHD’s service area, including the potential for advancing population health.

KEY CONCLUSIONS

Recommendations / Options

Based on the meta analysis of primary and secondary data (including the nine reports), the following recommendations and options are presented for consideration.



Reimbursement

Reimbursement trends focused on expansion of managed care and on supplemental payment strategies. Based on these trends the following options could be considered to better align with BHD's overall strategy to coordinate services in a more integrated and holistic manner.

- Partner more closely with current managed care providers to monitor care to increase the volume of services provided, associated reimbursement.
- Consider a more aggressive managed care strategy that would include creating a new managed care organization within BHD that would provide expertise in behavioral health strategies for Medicaid recipients.
- Expand efforts in programs that provide higher levels of matching such as the CCS or Health Home Models.

Measurement

The ability to better measure the progress and impact of programs and services, outpatient and inpatient alike, would promote BHD's efforts to monitor outside providers, to improve services and to assess impact on the population served. Facets of a measurement strategy include the following (predicated on the ability to gather data from multiple sources):

- Create a BHD dashboard of relevant metrics that can be tracked and monitored at a high level by BHD leadership and by the Board;
- Include specific metrics in each contract with external providers;
- Adopt metrics for monitoring the progress of the strategy implementation process;
- Adopt metrics relevant to reimbursement and accreditation.

Inpatient

Much of the primary and secondary data collected highlight the need for continued efforts to review and assess BHD's role in delivering inpatient behavioral health services. Several of the written reports offered insight into the specific number of beds needed in Milwaukee County but it is difficult to determine the exact number of beds needed without a better understanding of how to develop an outpatient suite of services and partnerships that will be able to address the expanded need once inpatient beds have been eliminated. One option is to simultaneously develop an expanded outpatient suite of services while addressing inpatient capacity. This integrated approach permits several options for consideration by BHD and the Board, as described in several of the reports (color coded orange in the following tables). It is noted that substantial progress has already been made in inpatient bed reduction.



- Assess historical inpatient volume by diagnosis and severity to forecast future need.
- Identify a partner or partners with experience and capacity to provide the identified inpatient bed need.
- Define a clear strategy for the assessment and ongoing monitoring of the inpatient relationship.
- Define a clear process of communication and data sharing among providers and patients/families regarding patient transitions from the inpatient environment to the outpatient environment.
- Identify higher revenue opportunities that align with the managed care strategy and IMD¹ exclusion.
- Create a comprehensive marketing communications plan, focused on the community and staffing pool, highlighting the continued work of BHD and its commitment to inpatient care.

Community-based Treatment and Support Services

Similar to inpatient service offerings, BHD is also addressing its community-based treatment and support services offerings. These services include outpatient services and will be referred to in this report as “community-based care.” The best practices, advancement and general data collected for this strategy work has been focused on existing and future service offerings within the community. It is clear that this is a high priority for BHD and the Board as inpatient capacity in Milwaukee County has decreased. In addition, there is general agreement in the field that clients can be better served in a community setting. With this in mind, the following options should be considered for a long-term community based care strategy.

- Offer a clear assessment of current outpatient services/contractors to include current volume and potential capacity.
- Identify historical service use and potential need.
- Develop a network of providers to meet the demand of current need and unmet need.
- Consider partnering with FQHCs² to share resources, training and services.
- Develop a comprehensive process for ongoing monitoring and assessment of the new provider network.
- Identify and implement a process for coordination and data sharing within the new network of outpatient providers to deliver continuity of care.
- Identify and implement a process of coordination and data sharing between the outpatient network and the inpatient network for seamless transitions and continuity of care.
- Work towards a population health model that emphasizes integration of clinical and behavioral health services. Figure 3, offers strategies for integration that vary in

¹ The Medicaid Institute of Mental Diseases.

² Federally-qualified health centers.



intensity and commitment from system-wide screening for behavioral health in the primary care setting to system level of integration for all client needs. Most, if not all, steps identified in the model rely heavily on teamwork and partnerships.

METHODOLOGY

We collected primary and secondary data (in addition to the nine reports) regarding internal and external factors that influence strategy decisions. *Internal* factors relate specifically to Milwaukee County and behavioral health such as inpatient and outpatient services, and current facilities. *External* factors relate to changes in public policy (primarily at the Federal level), access, funding and best practices at the state and local levels.

Primary data is data *that pertains specifically to BHD*. In this case, primary data consisted of in depth interviews with Board members, BHD leaders, community leaders and selected subject matter experts. In addition, information was collected on current policy initiatives at the federal level that may impact the Board's strategy decisions choice of a strategy as well as examples of best practices. The primary data collection sources are summarized in Table 1 below. Comments with a color code correspond to a trend area identified in the Key Trends in Figure 1. Offered in more detail in the Trends/Gap Analysis section, the color codes reference the follow trend categories:

- Green – Reimbursement
- Blue – Measurement
- ▲ Orange – Inpatient
- ◆ Purple – Community Based Care



Table 1 - Primary Data Collection

Type	Sample	Key Themes
Mental Health Board Members	8	<p>BHD Mission/Focus:</p> <ul style="list-style-type: none"> • Offering full integrated continuum of services from inpatient to outpatient and everything in between ▲◆ • Strengthen public – private partnerships ▲◆ • Develop dashboard of measures to monitor process, quality and outcomes ■ • Integration of medical and behavioral health ◆ • Must be both a provider and contractor ◆ • Complete overhaul of outpatient services currently a patchwork must be better at identifying, coordinating, monitoring outpatient service providers ◆ <p>Challenges</p> <ul style="list-style-type: none"> • Lack of identified measures ■ • Community perception and stigma • Culture seems to be less collaborative • Political environment • Reimbursement ● • Providers and staff shortage ▲ • Too much focus on inpatient ▲ <p>Other Thoughts:</p> <ul style="list-style-type: none"> • MHB and BHD must work together with other organizations ▲ • MHB would benefit from clear role and strategy • MHB would benefit from education regarding role, communication and team work • MHB must identify all outpatient providers and need/capacity ...take it apart and rebuild the outpatient system ◆ • MHB needs more data and a better process for making decisions ■
Leadership	2	<p>BHD Mission / Focus</p> <ul style="list-style-type: none"> • Expand community services and enhance visibility and accessibility ◆ • Client centered service • Expand evidence based services offerings ◆ <p>Challenges</p> <ul style="list-style-type: none"> • Political environment • Network assessment and development ◆ • Measure selection and monitoring ■ • Process to effectively assess, monitor and maintain services provider network to ensure it meets the needs of clients ◆



Subject Matter Experts	8	<p>Best Practices in Behavioral Health Models</p> <ul style="list-style-type: none"> • Collaboration and partnerships between public, private, medical etc. ▲ • Fully integrated care delivered by primary care for lower levels of behavioral health care and health homes at mental health providers for SMI population ◆ • Health IT integration to share patient information across providers and settings ■ • Integrated team based and evidence based care focus on population health with strong measures to monitor and improve ■ <p>Challenges</p> <ul style="list-style-type: none"> • Helping the behavioral health provider adapt to primary care setting ◆ • Implementing mental health system wide screening in primary care and clinical disease and risk screening in the SMI Behavioral Health Home ◆ • Information sharing and integration • Helping primary care providers understand the benefits of a behavioral health team member ◆ • Tracking outcomes ■ • All wraparound services must be addressed ◆ <p>Benefits</p> <ul style="list-style-type: none"> • Integration limits the chance for something (data, care etc) patient related to fall through the cracks • Addresses provider shortage • More clients likely to visit primary care – less stigma attached ◆ • Primary care is proactive ◆ • Offers primary care more tools for high risk populations overall ◆ • May address unmet need <p>Families and Caregivers (Interviews done by Alicia)</p> <ul style="list-style-type: none"> • Services must be delivered in a setting that offers a full set of outpatient services and coordination within outpatient and between outpatient and inpatient ◆ • Non institutionalized setting with focus on prevention and less on treatment, holistic approach ◆ • Create a strategy for marketing and outreach • Nurturing and caring environment
-------------------------------	---	--

Secondary data is relevant but *does not pertain specifically to BHD*. Each of the nine reports referenced above is secondary data because it was not produced for the express benefit of BHD. The reports, completed between 2013 – Quarter 1 2016, are summarized in Table 2 below.



Table 2 - Secondary Data Reports - Key Findings and Recommendations

Report Title	Author	Report Date	Focus	Data Source	Key Findings/ Recommendations
Analysis of Funding Alternatives	Deloitte	March 2016	Historical, current and future funding	Financial, policy	<ol style="list-style-type: none"> 25% per year reduction of Non recoverable and self pay Increase Medicaid MCO Revenue ● \$1M state share increase in supplemental payments ● Shift \$1M of IMD excluded claims to being covered 25% per year shift in Medicaid FFS to MCO ● 10% per year increase in commercial business
Mke Health Report	Center for Urban Pop Health	2013	Outcomes and determinants of health	County health rankings, zip code level information broad not focused just on mental health but on SES	<ol style="list-style-type: none"> High socio economic status group has lower scores for self perceived health and more days of poor mental health Binge drinking is the highest among high SES group and high overall compared to other states Dramatic health disparities exist by SES across the board
Fiscal Analysis of Mental Health Redesign	Public Policy Forum	March 2015	Fiscal impact of past, present and future mental health redesign	Spending and revenue	<ol style="list-style-type: none"> MKE Cty leaders should contemplate a new financial structure for the Mental Health Complex that sets it apart from the rest of the Cty Govt. ● MKE Cty and the State leaders need to work jointly to address BHD's facility needs and questions ▲ The future size, mission and location of the PCS will be central to any decision-making regarding adult inpatient bed capacity and new facility potential ▲ BHD should develop effective and transparent ways to measures the impact of its community investments on inpatient and PCS demand and to track and project community based service costs ■ BHD needs more detailed analysis of its revenue structure and revenue opportunities to guide bed capacity decisions ●
City of MKE Community Health Assessment	MHD	2016	Health outcomes and health determinants of the residents of the city for community planning purposes	Primary and secondary data sources, resident phone survey, stakeholder interviews and focus groups	<ol style="list-style-type: none"> Priority issues identified include: <ol style="list-style-type: none"> Alcohol and drug use Chronic disease Mental health Violence Higher then national and state avg for number of mentally unhealthy days



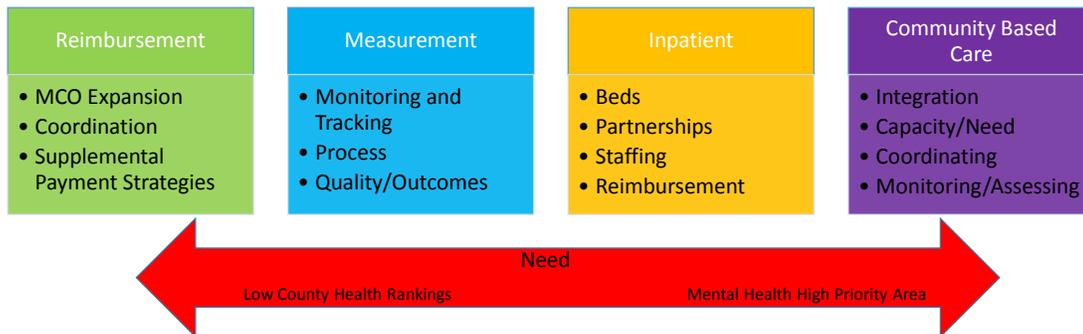
Adult Bed Capacity	Public Policy Forum et al (see below)	Sept 2014	Determination of bed capacity based on volume and outpatient community services	General utilization, stakeholder and BHD staff interviews, inpatient profile	<ol style="list-style-type: none"> 1. Adult inpatient capacity should be in the range of 167-188 beds ▲ 2. 54-60 adult beds should be for high-acuity and/or indigent and the remainder for low to moderate acuity 3. BHD should expand community-based services that have been shown to promote recovery and decrease the need for hospitalization. Further decreases in beds should be based on inpatient and outpatient metrics that demonstrate a decrease in inpatient demand ◆■ 4. Private hospitals should continue to increase their role in meeting the inpatient needs of MKE Cty residents ▲
MKE County Outpatient Behavioral Health Capacity Assessment	Human Services Research Institute, Technical Assistance Collaborative, Public Policy Forum	Oct 2015	Current community based care and assessment of opportunities for expansion	Stakeholder interviews, secret shopper analysis, outpatient information	<ol style="list-style-type: none"> 1. Adopt processes and policies that improve access to outpatient care ◆ 2. Develop strategies to increase outpatient service capacity 3. Increase access to psychiatric capacity ◆ 4. Address gaps in substance abuse disorder treatment ◆ 5. Enhance cooperation between MKE Cty and the state ▲
MKE County Community Health Survey Report	Center for Urban Pop Health with private partners – five health systems	2015	Assess health status of MKE county residents	Consumer survey	<p>Similar to City of MKE Community Health Assessment</p> <ol style="list-style-type: none"> 1. Higher than avg. binge drinking 2. Mental health one of the top 5 identified community health issues along with alcohol and drug use
Services for Persons With Mental Illness	WI Legislative Fiscal Bureau	Jan 2015	Policy and Regulation	Financial, policy	Overview of programs, MHB authority and reimbursement for services delivered through BHD ●
County Health Rankings	UW/RWJF	2016	Outcomes and Determinants of Health	County health rankings, zip code level information broad not focused just on mental health but on SES	<ol style="list-style-type: none"> 1. MKE County ranked 71 out of 72 counties overall 2. MKE County ranked 71 out of 72 in health factors, health behaviors and social/economic factors 3. MKE County ranked 72 out of 72 in quality of life factors 4. MKE County ranked 51 out of 72 in clinical care 5. MKE County ranked 59 out of 72 in physical environment



TRENDS/GAP ANALYSIS

Based on the data identified and organized in Tables 1 and 2, the following trends and gaps were identified. The trends and gaps are combined and summarized into five broad areas, and color-coded to the corresponding findings and themes outlined in the primary and secondary tables above.

Figure I: Summarized Trends and Gaps from Primary and Secondary



CASE STUDY

Missouri – The focus of the Missouri model is the development of an integrated model for Medicaid clients with severe mental illness (“SMI”). Medicaid clients with behavioral diagnoses that can be addressed in the primary care setting are integrated into the primary care setting. The SMI focus has led to the development of a holistic approach through a partnership between the Missouri Department of Mental Health, the Missouri Medicaid Agency and the Missouri Coalition of Community Mental Health Centers. At the core of the model care is delivered through the existing mental health system with additional education for providers in that system around screening and basic care delivery for chronic conditions. In addition, a primary care nurse is on site full time to assist the rest of the behavioral health staff on medical and chronic condition screening and care. Key attributes of this model that contribute to its success:

1. Focus on holistic care.
2. Strong partnership between several public and private entities.
3. Clear definition of the population served.
4. Building on an existing model of care.



5. Team approach with a medical focused team member.
6. Reimbursement enhancement through ACA-enhanced Federal match.
7. Coordinated longitudinal patient information available through a web portal easily accessed by all providers.

RECOMMENDATION FOR ADDITIONAL DATA

Based on the primary and secondary data collected, trends and gaps are identified and summarized in Figure 1 above and the Data Collection Summary Tables 1 and 2 above. While these trends and gaps are a guide to potential strategies and long term goals, there are additional data needs that would help in BHD's and the MHB's efforts to identify and implement solutions to these areas. This additional data would include:

- Analyze outpatient volume/use of community services by diagnosis and other key variables to determine current need
- Analyze inpatient volume by diagnosis to understand current and future need
- Analyze general unmet need research specific to behavioral health to understand demand not met to date
- Understand current community service offerings
- Understand community services capacity and new opportunities
- Identify process, quality and outcome measures for dashboard

INSIGHTS FOR POPULATION HEALTH MANAGEMENT

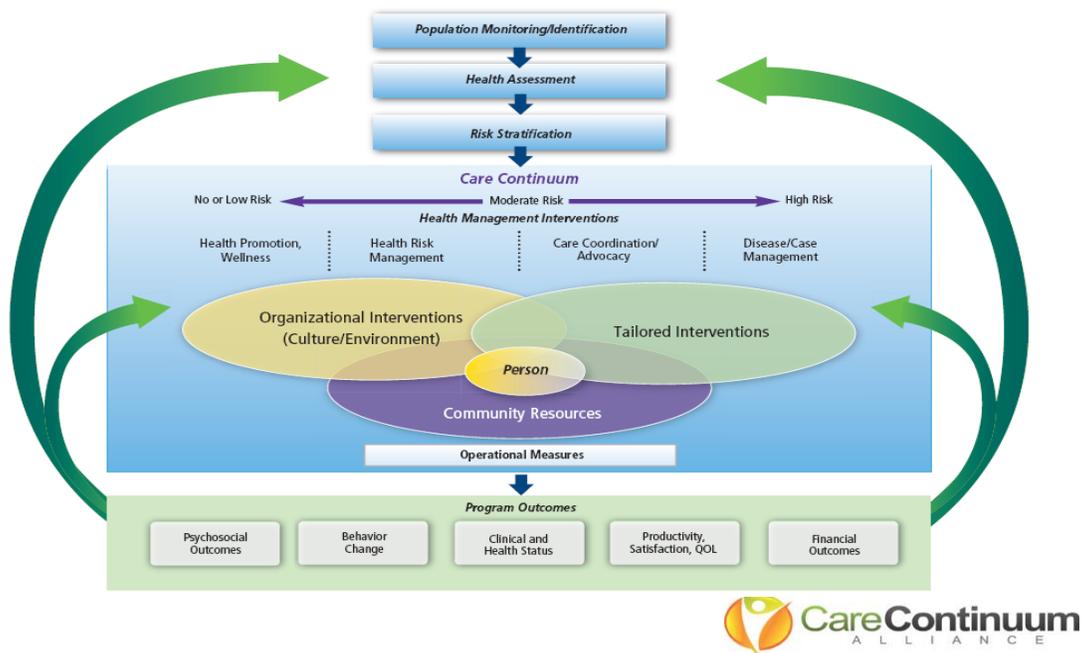
There are many different definitions of population health. The Institute of Medicine ("IOM") defines population health as, "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," (Kindig and Stoddart, 2003). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health including medical care, public health, genetics, behaviors, social factors, and environmental factors. Definitions vary but there are three generally accepted components including a holistic approach to care, measurement, and public/private partnership to address all needs along the health continuum.

Measurement is a fundamental aspect of population health management. The Agency for Healthcare Research and Quality includes measuring inputs and outcomes to set priorities as a basic characteristic of epidemiology-based population health management. This perspective points to the importance of health care organizations, public health departments, social service entities, school systems, and employers working together because no single sector alone has the capability for successfully pursuing the improved health of a population.



The individual is at the heart of a successful population health management system. The conceptual framework, shown below in Figure 2, illustrates the process, components and partners needed to fully manage a population. The individual is surrounded by those resources that would meet his or her needs. The beginning of the model represents the assessment and identification of the population while the final pieces of the model represent the measurement and analysis efforts to understand impact and improvement opportunities. Integration and coordination combined with ongoing feedback, assessment and improvement are at the core of this framework.

Figure 2 - PHM Framework
Conceptual PHM Framework



Population Health is driven by the following components:

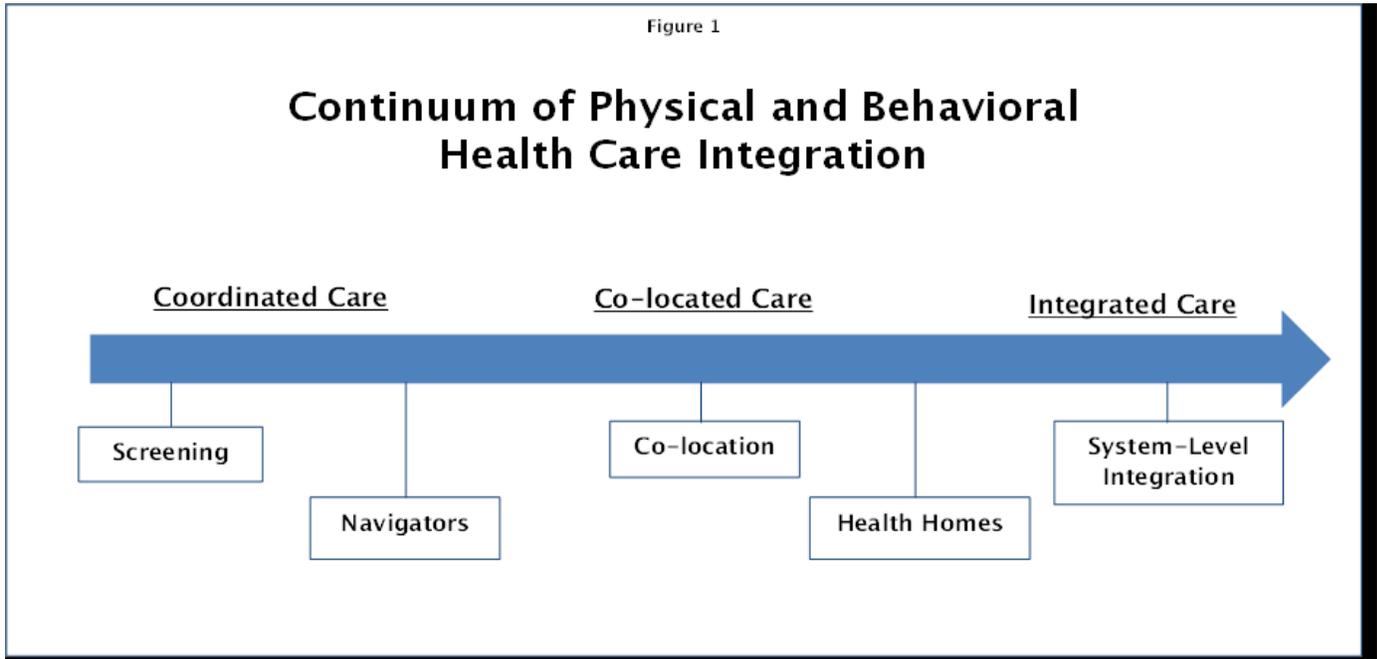
1. Whole person care across the continuum
2. Clearly identified and understood population
3. Public / Private Partnerships
4. Data and information sharing for measure monitoring for impact assessment and ongoing improvement

Milwaukee County BHD has strong leadership and expertise at the executive level and within the Mental Health Board. In addition, BHD has made great strides in the past several years to move towards an integrated outpatient approach to better serve its clients. Creating a unified umbrella strategy that incorporates all change efforts that can



be advanced and monitored by leadership and the Board can bring a higher level of awareness, increase coordination and improve dissemination. In addition, a higher level of engagement could be achieved with the staff, community, current and future clients as well as strategic healthcare partners. This strategy, at a very high level, should focus on an integrated population health with specific objectives related to the key components highlighted above. Based on these components, BHD’s current efforts and the integration model highlighted in Figure 3, the following options could be considered to advance a long-term integrated population health strategy.

Figure 3: Integration Model



*SAMHSA – HRSA Model of Integrated Care, 2013

In conclusion, we appreciate the opportunity to explore options for a long term strategy development and implementation with BHD and the Mental Health Board. We are looking forward to the next stage of this work and welcome your thoughts.



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

DATE: October 5, 2016

TO: Thomas Lutzow, Chairperson
Finance Committee
Milwaukee County Mental Health Board

FROM: Alicia Modjeska, Chief of Operations, Behavioral Health Division

SUBJECT: BHD Contract Approval Requests

REQUEST: *Authorization to enter into Fee-for-Service Agreements for Targeted Case Management and Crisis Case Management Services*

Background

BHD is in the process of switching Targeted Case Management (TCM) and Crisis Case Management services from purchase-of-service to fee-for-service (FFS) agreements. The FFS agreements contain performance measures and compliance indicators, which improve BHD's ability to track and monitor the quality of services provided to clients. Additionally, the FFS format improves and enhances utilization review at the service code level and allows for the ability to analyze network adequacy.

Starting October 1, 2016, the TCM purchase-of-service agreements with La Causa, Whole Health Clinical Group, Milwaukee Mental Health Associates, and Outreach Community Health Centers will be terminated, and the fee-for-service agreements will take effect. Wisconsin Community Services will remain on the existing purchase-of-service agreement through the end of 2016 and begin a fee-for-service agreement in 2017. The term of the contracts for TCM and Crisis Case Management services with all providers is for three (3) years from the start of the agreement and will automatically renew every year (1) thereafter, unless either party provides notice to the other of its intent to terminate this agreement not less than ninety (90) days before the end of the then current term.

Fiscal Impact

Provider Name	Q4 2016	Annual Amount
La Causa	\$163,699	\$720,276
Whole Health Clinical Group	\$294,659	\$1,296,498
Milwaukee Mental Health Associates	\$134,467	\$591,656
Outreach Community Health Centers	\$175,392	\$771,725
Wisconsin Community Services	\$ 9,000	\$1,323,208

Fiscal impact for the annuals amounts were calculated by assuming:

1. A TCM capacity increase of approximately 10% already included in the 2017 Budget and is equally distributed to all providers, and
2. No increase in rate for 2018

The costs listed in the table on the previous page represent not-to-exceed amounts based on projected budgeted volumes. These are not guaranteed payment amounts.

REQUEST: Authorization to Amend the Contract with Reinhart Boerner Van Deuren to Continue Their Assistance with the Mental Health Board's Joint Task Force Due Diligence Process.

Background

The legal firm of Reinhart Boerner Van Deuren is providing legal services to the Mental Health Board Joint Task Force's evaluation of potential acute psychiatric care vendors. BHD is requesting a \$75,000 increase to the contract for a new total of \$174,000, as well as an extension of the agreement term through December 31, 2018.

Fiscal Impact

The \$75,000 increase is included in the BHD professional services budget. There is no impact on tax levy.

REQUEST: Authorization to Extend Funding of Fee-for-Service Contracts for Community Access to Recovery and WRAP Services for Fiscal Year 2017

Background

Community Access to Recovery Services (CARS) and Wraparound Milwaukee (WRAP) have numerous fee-for-service contracts. These contracts allow CARS and WRAP to provide a broad range of rehabilitation and support services for individuals with serious emotional, behavioral, and mental health needs. In the last two years, all contracts and requests for funding were advanced to both the Finance Committee and the Milwaukee County Mental Health Board in mass at the December meeting. This year the contracts are being advanced for approval in two separate batches.

The first batch includes all fee-for-service contracts for CARS and WRAP. The second batch consists of purchase-of-service contracts and will be advanced to the Board at the December meeting.

In early 2015, the Board requested all contracts be revised to include performance based measures. Therefore, the work to redesign the contracting and network management process

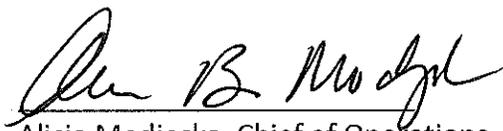
was initiated in March of 2015. The redesign process turned out to be more complex and time consuming than expected. As of October, all TCM contracts have been completed, and BHD is currently working on AODA Residential contracts. The timeline to transition each service provider has been shortened from 18 months, which included the redesign process to the current four-to-six-month process for AODA residential. The goal is to turnaround contract revisions in two months from start to finish.

A detailed description (Attachments A and B) of all programs and projected spending is attached.

Fiscal Impact

The request for **CARS** is for \$18,457,932. This amount has been built into the 2017 Budget. The request for **WRAP** is for \$45,409,663. This amount has been built into the 2017 Budget.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Alicia Modjeska". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Alicia Modjeska, Chief of Operations
Milwaukee County Behavioral Health Division, Department of Health and Human Services

cc: Hector Colon, Director, Department of Health and Human Services
Michael Lappen, Administrator, Behavioral Health Division

Attachment A

CARS 2017 SERVICE/PROGRAM DESCRIPTION SUMMARY

The following is a list of program descriptions for services provided under fee-for-service agreements for MCBHD CARS.

Anger Management – The goal of anger management is to help individuals manage their anger, and their behavior when upset, in an effective and appropriate manner. Services teach clients basic problem solving skills in order to more effectively resolve problems, utilize effective communication skills and interventions to promote non-violent conflict resolution, and increase self-awareness and knowledge of stress management concepts.

AODA Residential Treatment – AODA Residential treatment service is a clinically supervised, peer-supported, therapeutic substance abuse treatment services delivered in a residential setting with clinical involvement. Counseling is provided to consumers at a rate of 3 to 11 hours per week, in addition to education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping, and financial planning in accordance with DHS 75.14. Providers must maintain clinic certification from the State of Wisconsin throughout the entire duration of their contract.

AODA Outpatient / Day Treatment – AODA Outpatient and Day Treatment services are clinically supported therapeutic substance abuse treatment services delivered on an outpatient bases in accordance with either 75.12 or 75.13. AODA Day Treatment provides treatment in a structured format for several hours each day, most days of the week, while AODA Outpatient treatment occurs generally no more than one or two times per week in individual, group and/or family format. Providers must maintain clinic certification from the State of Wisconsin throughout the entire duration of their contract.

Recovery House – Recovery House provides a safe, clean and sober environment for adults diagnosed with substance abuse and/or mental health disorders. Providers are certified under DHS 83 and provide a structured recovery environment that provides sufficient stability to prevent, or minimize, relapse or continued use, and continued problem potential. Recovery House is intended to assist the individual to integrate relapse prevention and recovery skills to achieve autonomy, including gainful employment and independent living in the community. At this time, all of the providers of this service are also certified under DHS 75.14 as residential treatment providers.

Bridge Housing / Room & Board (AODA) – These services provide a safe, clean and sober environment for adults diagnosed with substance abuse disorders, and co-occurring substance abuse and mental health disorders. Individuals receiving housing services are required to be actively engaged in AODA treatment. Room and Board facilities must be licensed under DHS 83 and comply with the regulations of such. Bridge Housing must have staff supervision available and the units must be furnished and compliant with the Housing Quality Standard inspection conducted by the City of Milwaukee. Bridge Housing does have availability for families with children under the age of 18 years old.

Mental Health Outpatient Treatment – Mental Health Outpatient Treatment services are clinically supported therapeutic services delivered on an outpatient bases in accordance with DHS 35. Services provided to consumers include intake and assessment, evaluation, diagnosis, treatment planning,

psychotherapy and medication management. Providers must maintain clinic certification under DHS 35 from the State of Wisconsin throughout the entire duration of their contract.

Domestic Violence-Batterer and Victim Services – These services are designed to work with either the batterer OR the victim of domestic violence. The goal of batterer services is to end the physical, emotional, sexual and economic violence of an individual towards his/her partner. Program curriculum addresses the batterer’s beliefs and attitudes towards violence, power and control issues, sexism and gender role stereotyping. Personal responsibility is encouraged by challenging batterers about their negative and/or sexist attitudes and beliefs which support their abusive behaviors, and teaching skills for nonviolent behavior. The goal of victim services is to provide support to those individuals who have experienced abuse in intimate relationships, and to assist and support participants to overcome the effects of being victimized by violence. A safety assessment and the development of a Safety Plan for every participant prior to service provision is required.

Wiser Choice (WC) Ancillary Services – Ancillary services are those services that assist in an individual’s recovery from alcohol and other drugs such as Daily Living Skills, Parenting Assistance, Peer Mentoring, Spiritual Support, etc.

Community Living Arrangements (CBRF/AFH/SIL) – Community Living Arrangements are structured residential living arrangements for the purpose of providing care and support to adult clients whose mental health needs are severe enough that they are unable to safely live independently and require a more structured setting. Services include, but are not limited to, supervision, dietary, personal care, education/training, and medication management. CBRF facilities must be licensed under DHS 83, and AFH facilities must be licensed under DHS 88. Some providers are supported independent living facilities that offer a more personalized option for those suffering from severe and persistent mental illness that make living with others excessively difficult.

Recovery Support Coordination / Case Management – Recovery Support Coordination and Case Management services assist consumers in gaining access to, and receiving, a full range of services in a planned, coordinated, efficient, and effective manner. These providers are responsible for locating, managing, coordinating and monitoring all services and informal community supports needed by consumers and their families. Services may include assessment, case planning, monitoring and review, advocacy and referral.

Comprehensive Community Services (CCS) – These services are recovery-focused, integrated behavioral health care for adults and children with severe mental illness and/or substance use disorders. 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. The majority of services are provided in consumers’ homes and communities.

Spiritual Support – These are non-clinical supportive services that supports the consumer’s AODA recovery plan, and may cover spirituality in recovery and spiritual growth and development. Spiritual support specific to the provider’s identified faith or denomination is provided under the auspices of an identified church or congregation.

Employment – Employment related services are any services that provide assistance to individuals in completing the tasks, or the skills, necessary to obtain employment. This may include completion of an

employability assessment, a job development plan, a completed resume or a completed list of references. Time may be spent on job readiness skills such as mock interviewing, resume building, career exploration, filling out applications, teaching appropriate job behavior, etc. The provider may also provide on the job training for consumers, or may operate job skills certification programs such as custodial/janitorial training. Also included in this are facility- based work services that provide a variety of paid work opportunities at a fair-market hourly rate.

Medication Assisted Treatment – Vivitrol is approved by the US Food and Drug Administration for the treatment of alcohol dependence as well as for the prevention of relapse to opioid dependence, following opioid detoxification. One injection per month is all that is needed to maintain therapeutic medication levels in the body. Providers of this service must provide an initial medical assessment and ongoing nursing care associated with the administration of the injection. BHD will only pay for Medication Assisted Treatment in support of the consumers’ recovery activities as listed in their individual Single Coordinated Care Plan. Providers must maintain clinic certification from the State of Wisconsin throughout the entire duration of their contract under DHS 75.12 or DHS 75.13.

Attachment B

WRAPAROUND MILWAUKEE 2017 SERVICE/PROGRAM DESCRIPTION SUMMARY

The following is a list of program descriptions for services provided under fee-for-service agreements for MCBHD WRAP.

AODA Services – A wide range of programs for persons affected by alcohol or drugs. These programs may include, day treatment, inpatient/outpatient facilities, residential programs, and intervention/prevention efforts and provided to individuals and families.

Care Coordination – Designed to deliver services and supports to children with severe emotional and mental health needs in an individualized, strength-based and family focused manner. Care Coordinators are responsible for convening Child and Family Teams from which a Wraparound plan of care is developed based on the child and family's strengths, needs, and goals. Formal and informal resources are utilized to support the child and family's needs.

Child Care/Recreation – Programs that offer supervision and structure for youth, which include planned social and life activities to promote health, wellness and independence. Recreation Programming shall be agency-based to allow youth to experience recreational activities in conjunction with other youth. Recreation programming is designed to introduce youth to and engage youth in age-appropriate recreational activities and community-based programs or events that they can become involved in or revisit on their own, with peers or with family members. Child care is provided by a licensed provider/facility.

Crisis – These services primarily provided to Wraparound enrolled youth who, due to their emotional and/or mental health needs, are at risk of imminent placement in a psychiatric hospital, residential care center or other institutional placement. This service is used to prevent and/or ameliorate a crisis that could ultimately result in an inpatient psychiatric hospitalization or residential placement if the crisis intervention/supervision had not occurred. Mental health intervention provided in or outside of the youth's home, designed to evaluate, manage, monitor, stabilize and support the youth's well-being and appropriate behavior consistent with the youth's individual Crisis/Safety Plan.

Day Treatment – Day treatment services are day time programs that provide integrated and comprehensive treatment to include educational, vocational, activities and mental health services to youth and their families in a licensed facility. Services may include psychiatric consultation and medication management, assessment and diagnostic evaluations, group therapy, individual therapy, family therapy, school coordination and case management.

Discretion/Flex Fund – Discretionary or "flexible" funds are intended for the purchase of a service or commodity that is needed to meet a specific client mental health need.

Family/Parent Support Services – Family support allows for the development of creative, non-traditional, innovative approaches to securing services that have been identified by the family in response to their specific needs. Family Support is a category that covers the following types of services: Parent Assistant, Parent Coaching/Training, Independent Living Skills, and Household Management/Assistance Services.

Foster Care – Full-time substitute care for children who temporarily cannot live with their families. The individual caretaker's home (including the individual and others that reside in the home) must be licensed through the State of WI - Department of Children & Families.

Group Home – A licensed group home providing care and 24-hour supervision as an alternative living situation for children who temporarily cannot live with their families.

Independent Living – Affordable, well-maintained, accessible community-based housing options for adolescents age 17 to 18 and to provide a range of services to support their successful transition to independent living.

In-Home – In-Home therapy encompasses intensive, time-limited mental health and substance abuse therapy services that are provided in the client's place of residence, family's home, or when determined appropriate, in a community-based setting. The service is provided by a licensed clinician.

Inpatient – 24-hour care services, delivered in a licensed hospital setting, which is secure, protected and medically staffed, that provides clinical intervention to youth with mental health and/or substance use diagnoses. Admission is defined in DHS State Statute 51.

Life Skills – Life-skills interventions are designed to increase academic, social/communicative, and vocational competence for youth with mental/behavioral health needs. Skills to help a youth deal with challenges of everyday life, at school, work and in personal relationships. Focus is on recreation and/or leisure activities, ability to maintain a home and/or personal care and/or the ability to participate in the community.

Medication Management/Nursing – Prescription monitoring on an outpatient basis by a licensed Psychiatrist or Certified Advanced Practice Nurse Prescriber, which includes an initial evaluation of the patient's need for medication, prescribing medications and ongoing medical evaluation and monitoring.

Occupational Therapy – Occupational therapy is designed to meet functional needs associated with a serious emotional disturbance experienced by the youth. It encourages rehabilitation through the performance of activities required in daily life. Services are delivered by an Occupational Therapist licensed by the State of Wisconsin.

Outpatient – Provides intensive, clinical, therapeutic services to children, adolescents and families with identified mental health or substance abuse diagnoses. Treatment can be provided in an office, clinic, or other facility that is licensed by the State of WI.

Psychological Assessments – A process of psychological testing that uses a combination of techniques to help arrive at some hypotheses about a person and their behavior, personality and capabilities.

Residential Treatment – A licensed residential care facility providing care and 24-hour supervision as an alternative living situation for children who temporarily cannot live with their families. Provides comprehensive evaluation, assessment and treatment of a youth's emotional, behavioral, medical, educational, social and leisure needs.

Respite – Planned or emergency temporary care required to relieve the parent/guardian/caregiver of the stress in taking care of the youth or for other reasons that help sustain the family structure or meet the needs of the youth.

Shelter – A short-term, non-secured residential care facility. The facility must be licensed through the State of WI - Department of Children & Families.

Transportation – Service to transport a youth and/or family member to an activity that is based on their mental/behavioral health needs.

Youth Support Services – Youth support allows for the development of creative, non-traditional, innovative approaches to securing services that have been identified by the youth and family. These include, tutoring, mentoring, equine therapy, yoga, psychoeducational and fitness groups, peer support, art, music and dance therapies.

Provider Name	Total Estimated 2017 Expenditure	AODA Services	Care Coordination	Crisis	Day Treatment	Family/Parent Support Services	Foster Care	Group Home	In-Home	Independent Living	Medication Management	Outpatient Therapy	Psychological Assessments	Residential Care	Transportation	Youth Support Services
La Causa, Inc.	\$6,551,262.89		X	X		X	X					X				X
Lad Lake- St. Rose Rosie's Place Group Home	\$259,462.15							X								
Lad Lake, Inc.	\$2,296,987.65		X											X		
Lad Lake-St. Rose	\$259,045.87													X		
Lakeview Neurorehab Center, Inc.	\$118,364.74													X		
Lutheran Social Services-Homme Home Y&F Programs	\$759,708.67													X		
MD Therapy	\$318,698.20	x							X		X					
Milwaukee Academy/Clinicare	\$461,976.10													X		
Moe's Transitional Living Center	\$172,274.65							X								
Mt. Castle Transitional Living Services	\$236,500.00							X	X							
New Horizon Center Crisis/Mentoring Services, LLC	\$1,313,264.76			X												X
New Horizon Center, Inc. (Child Placing Agency)	\$223,236.92						X									
Next Chapter Living Center, Inc.	\$122,817.94							X								
Norris Adolescent Center	\$2,051,450.24										X	X		X		
Oconomowoc Developmental Training Ctr. of WI LLC	\$847,006.89								X					X		
Pathfinders Milwaukee, Inc.	\$117,870.00		X									X				
Pathways Group Home, LLC	\$205,510.00							X								
Psychological Assessment Services, LLC	\$105,600.00												X			
Rawhide, Inc.	\$139,135.50						X				X			X		
Revive Youth and Family Center I	\$138,262.79							X								
Right Turn II	\$211,858.48							X								
Right Turn, Inc.	\$121,804.66							X								
Rights of Passage Living Center	\$162,631.86							X								
Running Rebels Community Organization	\$324,654.15			X											X	X
SaintA, Inc.	\$3,992,269.76		X		X	X	X							X		

MCBHD Procurement Methodology

Procurement Method	Definition	General Considerations	Financial Considerations
Sole Source	Only one vendor/provider available in market with a specific skill/knowledge/product that is needed	Ensure rationale is clear for utilizing sole sourcing including a search of the marketplace.	➤ \$100,000 need MCBHD Board approval
Single Source	There are multiple vendors/providers available in the market offering the same product or service	<p>Rationale is needed when using the Single Source method. Organization needs to exercise judgement in the process not will.</p> <p>A reasonable person would arrive at the same conclusion.</p> <p>For example:</p> <ol style="list-style-type: none"> 1. the vendor/provider has been utilized before, or 2. there is a prior positive relationship, or 3. the vendor/provider understanding of the organization or has background knowledge of the problem to be solved, or 4. There is an immediate need to improve quality/safety <p>** A single source contract <\$100,000 that later grows to over \$250,000 or a higher potential should be considered for RFP.</p>	➤ \$100,000 needs MCBHD Board approval
Bidding process	Project or service is awarded to the lowest bidder based on price alone	Vendor has to be responsive i.e., completing paperwork, signature process etc. Skills and expertise to perform the job is evident	<p>Public works project > \$25,000 fall under state regulations and require 3 bids.</p> <p>BHD projects > \$10,000 require 3 bids</p> <p>Project > \$100,000 require MCBHD Board approval</p>
RFP	A competitive acquisition process where a “value” determination is necessary. The form and function of what will be provided is an essential part of the evaluation (cost/quality)	Price, responsibility and value	Projects/services >\$250,000

MCBHD Spending Authority

Title	Spending Authority (budgeted)	Contract Signature Approvals	County Approvals
Manager	Not to exceed \$5000	Director/Officer/CFO	x
Director	Not to exceed \$10,000	Officer/COO/CFO	x
Officer	Not to exceed \$50,000	COO/Administrator/CFO	x
Chief Operating Officer	Not to exceed \$75,000	Administrator/CFO	x
Administrator	Not to exceed \$99,999	CFO	x
MCBHD Board	\$100,000 +	Administrator/CFO	x

X- County approvals requirement

- Director of DHHS
- Risk Manager
- Corporation Counsel
- Comptroller
- County Executive
- Corporation Counsel

POLICY & PROCEDURE MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION BHD Mental Health Board	DATE ISSUED: October 27,2016	SUBJECT: Request for Analysis/Research		
	DATE REVIEWED* / REVISED:	SECTION:	POLICY NUMBER:	PAGE(S)
	October 27, 2016			

PURPOSE: This policy governs the process to submit Mental Health Board member requests to the Milwaukee County Department of Administrative services (DAS) for research and/or analysis.

POLICY: The 2017 Behavioral Health Division budget approved by the Mental Health Board provided the ability for board members to submit information, research, and analysis requests to the Milwaukee County Department of Administrative services (DAS) to be completed.

PROCEDURE:

- A. Board Member Request Submission:** Mental Health Board members will submit requests directly to the Mental Health Board Chairperson utilizing the approved request form.
- B. MHB Chairperson Submission:** The MHB Chairperson will review the requests of board members and forward requests to the Director of the Department of Administrative services.
- C. Department of Administrative Services:** Upon receiving the request the Director of DAS will provide the board chairperson with an estimated time to complete. DAS will track all requests by sponsor, description, and time to complete. Completed request will be sent to the board chairperson for distribution.

Authored and Approved by:

Mike Lappen, BHD Administrator Date

Duncan Shrout, BHD – Mental Health Board Chairperson Date

Milwaukee County Mental Health Board Request for Analysis or Research

Instructions: Please complete this form and submit it by e-mail to the Mental Health Board Chair.

Requestor Identifying Information

Name	
E-mail	
Phone Number	

Request Information

Date Request Submitted _____

Date Requested Information should be Returned by _____

Please provide an e-mail address where the requested Information be sent to. _____

Who should the Requested Information be sent to? _____

Please describe your request for analysis or research in the box below.

For DAS Use Only

Date Request Received		Analyst	
-----------------------	--	---------	--

Description of Scope: _____